

## MRCGP Annual Report covering 2021/22

Professor Rich Withnall, RCGP Chief Examiner.

Statistical information provided by **AlphaPlus**.

### Table of Contents

<b>Introduction .....</b>	<b>3</b>
<b>1 The MRCGP examination.....</b>	<b>5</b>
Applied Knowledge Test (AKT).....	5
Recorded Consultation Assessment (RCA) .....	6
Workplace Based Assessment (WPBA).....	6
Simulated Consultation Assessment (SCA).....	7
<b>2 Who are our candidates? .....</b>	<b>8</b>
Demographic characteristics .....	8
Place of training: Deanery.....	9
<b>3 How did candidates perform? .....</b>	<b>10</b>
Performance across the AKT and the RCA examinations .....	10
Notes for interpretation .....	12
Country of primary medical qualification (UK or International).....	13
Sex.....	14
Ethnicity .....	16
<b>4 Candidate performance: Subject area and domain performance.....</b>	<b>19</b>
Performance in the AKT .....	19
Subject area scores .....	19

Insights from the item performance statistics .....	20
Performance in the RCA.....	22
Domain-based scores.....	22
Feedback provided by the examiners in the RCA.....	23
<b>5 Candidates with disabilities: prevalence by attempt and source of PMQ; outcomes.....</b>	<b>24</b>
<b>6 Update from the Workplace Based Assessments .....</b>	<b>27</b>
Summary .....	27
New assessment programme and portfolio .....	27
GMC requirements .....	27
<b>Learning resources .....</b>	<b>31</b>
<b>Differential attainment.....</b>	<b>32</b>
<b>Summary of recent RCGP related research.....</b>	<b>35</b>
Conference presentations .....	37
<b>Appendix A.....</b>	<b>38</b>
Place of training: Deanery.....	38

## Introduction

This report relates to the formal MRCGP assessments conducted in the academic year 2021-22. It presents key data summarising the candidature, quality indicators and outcomes of all the diets of the MRCGP examinations during that period — three diets of the Applied Knowledge Test (AKT) and five diets of the Recorded Consultation Assessment (RCA). In addition, it presents a summary of the development work taking place across the AKT, RCA and the Workplace-Based Assessments (WPBA).

As a reminder, delivery of the Clinical Skills Assessment (CSA) was halted in March 2020 by the COVID-19 pandemic and, with the General Medical Council (GMC)'s endorsement, the RCA was introduced as a temporary and emergency response. No CSA assessments were held in 2021-22 and a new assessment module, the SCA will replace the RCA in late 2023.

The aim throughout this report is to provide insight to educators and prospective candidates about developments in the RCGP examinations and to provide information that might assist MRCGP preparation.

Collaboration with our team of external psychometric experts has continued to ensure that the report conveys all the necessary information in the most user-friendly and readable way, to reduce unnecessary or incomplete information, and to increase the focus on information that might be of more practical help to trainees and educators.

Statistical information on the WPBA is not covered by this report. WPBA is formative, with candidate performance, development and capability being reviewed regularly by the Deaneries, a process which is quality assured by the College. Some of this report relates to WPBA as part of the MRCGP assessment program and explains some of the developments therein.

For presentational purposes, 'stage of training' is reported as 'year' of training, since for most trainees, the two are synonymous. For less-than-full-time trainees (LTFT), those taking time out of training, and those provided with additional training, 'stage of training' will be longer than one year. Data on 'sex' of candidates (i.e., female or male, a legally protected characteristic) is collected rather than 'gender.'

As introduced in the 2019-2020 Annual Report, pass rates by medical school and deanery have been removed to reduce any risk of unconscious bias. As of the same date, we report on UK Graduate (UKG)/International Medical Graduate (IMG), Black and Minority Ethnic

(BME)<sup>1</sup>/White and Sex as candidate subgroups. Our psychometric experts advise that comparisons of BME/White pass rates are potentially misleading, due to the influence of other factors on differences in pass rate, primarily UKG/IMG status. Since a greater proportion of BME candidates received their undergraduate medical training outside the UK (i.e., making them IMG candidates) compared to White candidates, comparisons based solely on ethnicity would be inappropriate.

Readers should exercise caution when interpreting some information contained in the report. The overlap of ethnicity with candidate sex and other characteristics means, for example, that International Medical Graduates (IMGs) are more likely to be from BME groups and less likely to be female. Place of primary medical qualification is also not synonymous with nationality since UK nationals choosing to study abroad are included in the IMG group. Importantly, there are also missing data as **19.2%** of unique candidates who sat an examination this year chose not to declare one of either their sex or ethnicity, and **13.2%** chose to omit both their sex and ethnicity.

We have done our best in this report to represent the candidates who did not declare these characteristics, to help readers apply suitable caution when interpreting the graphs. More exams data are available on the General Medical Council (GMC) website, including data on differential attainment.

---

<sup>1</sup> Throughout this report we have used the acronym BME to refer to ethnic minority candidates. We are aware that this acronym does not suit all ethnic minority people, and that some prefer the term “ethnic minorities.” We are using “BME” as this aligns with the terminology used by the GMC in their reports. We fully accept that ethnic minorities also include White minorities.

# 1 The MRCGP examination

Membership of the Royal College of General Practitioners (MRCGP) comprises three sets of assessment procedures whose combined summative function is to assure the Deaneries, the College and the General Medical Council (GMC) of the competence of exiting trainee General Practitioners (GPs) across a broad and carefully defined training curriculum. After a minimum of three years' vocational training and satisfactory completion of the three MRCGP assessment components, GP trainees (also called GP Specialist Registrars) are eligible to apply for a Certificate of Completion of Training (CCT) from the GMC (the statutory licensing authority) and MRCGP. The MRCGP's three assessment components are the following, each of which must be completed to an agreed standard:

- a. Applied Knowledge Test (AKT): multiple choice computer-based assessment, available in test centres throughout the UK.
- b. Recorded Consultation Assessment (RCA): a summative assessment of a doctor's ability to integrate and apply clinical, professional, communication and practical skills appropriate for general practice using pre-recorded video or audio consultations).

Workplace based Assessments (WPBA): delivered throughout the training programme by Clinical Supervisors and Educational Supervisors.

The curriculum, the training and the assessments are based on medical practice in the UK National Health Service across England, Scotland, Wales, and Northern Ireland. Entry to the assessments is only available to doctors undergoing GP training within the UK state health care system (AKT & RCA) or within six months thereafter (AKT only). Other than UK Ministry of Defence Trainees serving in UK military establishments abroad, no candidates based in other countries take these assessments.

## Applied Knowledge Test (AKT)

The AKT is a three-hour and ten-minute, 200-item multiple choice test, which assesses:

- knowledge of clinical medicine (80% of questions)
- research/data-interpretation/evidence-informed practice (10% of questions)
- primary care legal/ethical/administration issues (10% of questions).

All items are contextually relevant to UK general practice. Single best answer, extended matching, multiple best answer, and free text question formats are used. The AKT is typically

scored out of 200 marks with each correct answer awarded one mark without differential weighting.

## **Recorded Consultation Assessment (RCA)**

The RCA is a summative assessment of a doctor's ability to integrate and apply clinical, professional, communication and practical skills appropriate for general practice. It uses pre-recorded video or audio consultations to provide evidence from a range of encounters in general practice relevant to most parts of the curriculum and also provides an opportunity to target particular aspects of clinical care and expertise.

The RCA has continued to be the temporary MRCGP Assessment of clinical skills during 2021-22, and while the RCGP develop the SCA. There have been no significant changes to the assessment during this period. The data outlined in the report highlights that the examination has endured with high reliability and largely a consistent pass rate.

## **Workplace Based Assessment (WPBA)**

WPBA evaluates GP trainees' progress in areas of professional practice best tested in the workplace. It includes the completion of specific assessments and reports, the documentation of naturally occurring evidence, and mandatory requirements such as Child Safeguarding and Basic Life Support with the use of Automated External Defibrillators (BLS/AED) in order to:

- examine a trainee's performance in their day-to-day practice to provide evidence for learning and reflection based on real experiences.
- support and drive learning in important areas of competence with an underlying theme of patient safety.
- provide constructive feedback on areas of strength and developmental needs, identifying trainees who may be in difficulty and need more help.
- evaluate aspects of professional behaviour which are difficult to assess in the AKT and RCA.
- determine fitness to progress towards completion of training.

## Simulated Consultation Assessment (SCA)

At the time of publication, the RCGP is nearing the completion of the Simulated Consultation Assessment (SCA) - a replacement assessment for the RCA. We continue to provide updates on the development to trainees by email, and on our website at <https://www.rcgp.org.uk/gp-training-and-exams/mrcgp-exam.aspx>. We are piloting this assessment throughout the summer of 2022 and anticipate it will be delivered by November 2023, following GMC Approval in April 2023 subject to the pilots held in summer 2023.

A scoping exercise was initiated in July 2021, to establish the views of key stakeholders in the which included world leaders in OSCE design, patients, trainees, educators, special interest groups supporting GPs, and the chief examiners/psychometricians of other speciality schools both in the UK and overseas.

The SCA will be a remote outcome-based OSCE assessment using standardised consultations, which will be marked against revised marking domains, which themselves are mapped against the MRCGP standards and reflecting current curriculum areas seen in UK-based consultations. It will be delivered in GP surgeries with professional role-players representing patients.

## 2 Who are our candidates?

### Demographic characteristics

#### AKT and RCA

Those sitting the AKT and/or RCA were all UK-based GP trainees who obtained their primary medical qualification from one of 81 different countries. The number of candidates from each region of the world is presented in Table 2.1.

During the 2021-22 academic year, **4971** candidates made a total of **5636** attempts at the AKT, and **3915** candidates made a total of **4240** attempts at the RCA.

Of the **7770** unique candidates who sat the AKT and/or RCA in 2021-22, there were **4324** (55.6%) UK graduates (UKGs) and **3446** (44.4%) international graduates (IMGs).

The number of unique candidates increased by **790** compared to 2020-21 academic year when there were **4368** (62.6%) UKGs and **2612** (37.4%) IMGs.

**Table 2.1: Number of unique candidates attempting the AKT and/or RCA in the 2020-21 academic year from each region of the world.**

Continent	Number of unique candidates this year
Africa	1429
Asia	1388
Australasia	2
Europe	4873
North America	57
South America	21

Considering all unique candidates sitting the AKT and/or RCA, there were **3913** (50.4%) female candidates; **2805** (36.1%) male candidates; and **1052** (13.5%) candidates who did not declare their gender.

Considering ethnicity, **2623** (33.8%) candidates declared their ethnicity as White; **3682** (47.4%) declared their ethnicity as BME; and **1465** (18.9%) candidates chose not to declare their ethnicity.



Looking only at First Time Takers (FTTs) for the AKT and RCA, which is those candidates sitting either or both examinations for the first time in the 2021-22 academic year, the representation of each sex and ethnicity was as follows:

- **Female:** 3471 (52.1%)
- **Male:** 2327 (34.9%)
- **Sex not declared:** 864 (13.0%)
  
- **Ethnicity declared as White:** 2478 (37.2%)
- **Ethnicity declared as BME:** 2984 (44.8%)
- **Ethnicity not declared:** 1200 (18.0%)

Readers are reminded to exercise caution when interpreting information which has missing data.

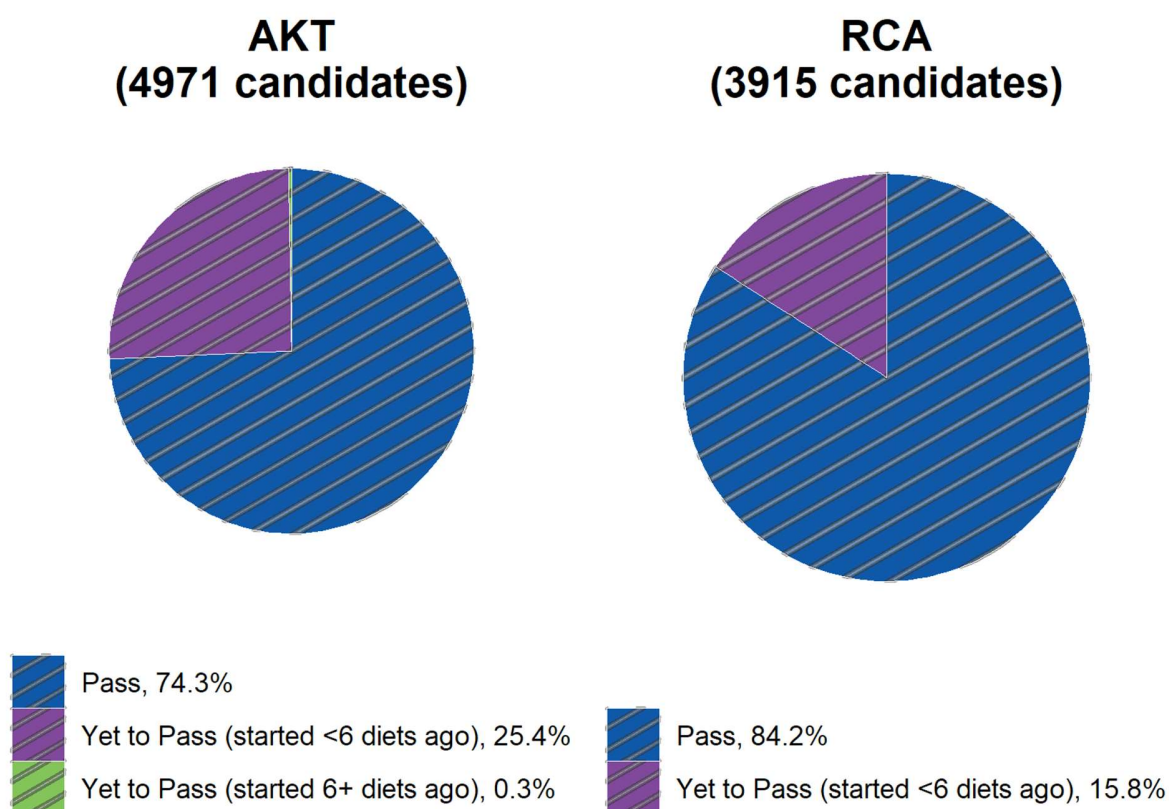
## **Place of training: Deanery**

A table detailing the deaneries in which all UK trained candidates completed their training is available in Appendix A.

### 3 How did candidates perform?

#### Performance across the AKT and the RCA examinations

Figure 3.1 presents the status of all unique candidates who sat the AKT or RCA between 1 September 2021 to 31 August 2022. The overall pass rate within this 12-month period is **74.3%** for the AKT and **84.2%** for the RCA.

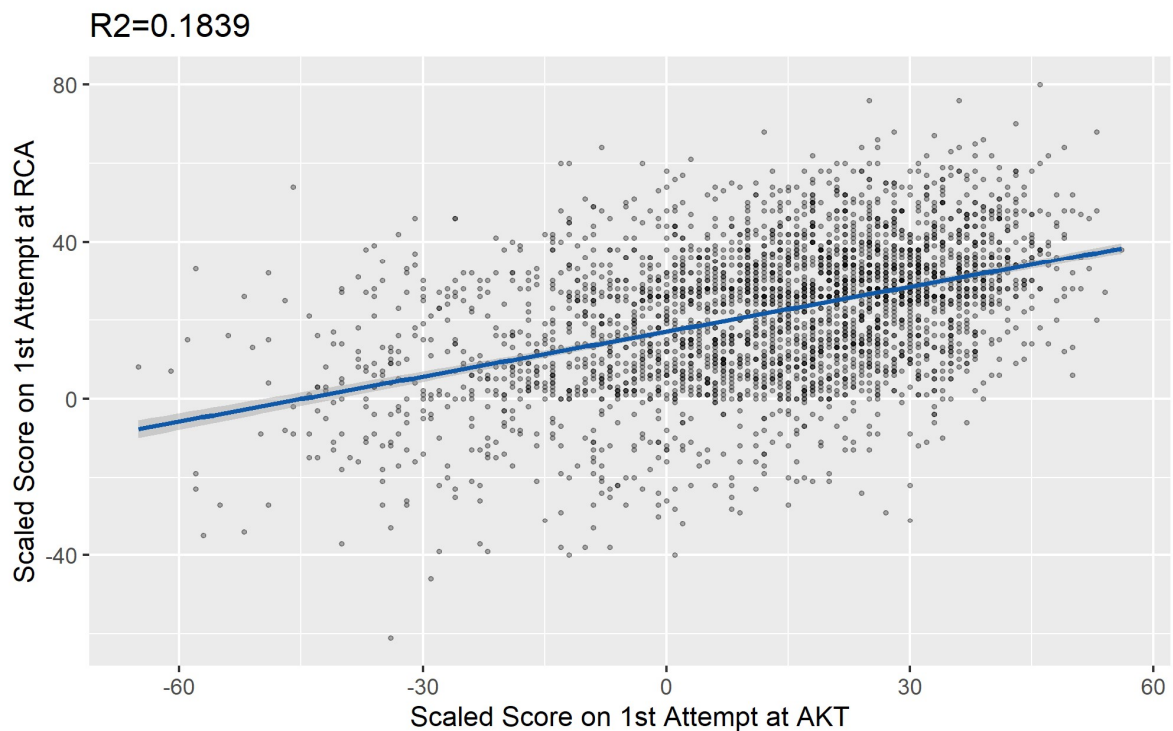


**Figure 3.1: Candidates who sat the AKT/RCA between 1 September 2020 to 31 August 2021**

The correlation between the scores of candidates who were FTTs of the RCA in 2021-22 with the same candidates' scores on their first attempt of the AKT (regardless of which year they first sat the AKT) was  $r = 0.43$  ( $n = 3108$ ,  $t = 26.47$ ,  $p < 0.001$ ). This correlation, shown in Figure 3.2, means that candidates who tend to achieve a low score on their first attempt in one examination also tend to achieve a low score on their first attempt in the other examination, and those who score high in one also tend to score high in the other. This is a useful indicator of concurrent validity of the two assessments.

Note that this plot shows scaled scores, where zero represents the pass mark. So,

- a candidate at zero has achieved the pass mark and passed.
- candidates with a score greater than zero have exceeded the pass mark and passed.
- candidates with a negative score failed to reach the pass mark and have failed.



**Figure 3.2: Correlation between FTTs' scaled scores on RCA and AKT**

The figures in the rest of this report show scores of FTT candidates split by demographic characteristic.

It is important to note both the substantial proportion of candidates who chose neither to declare their sex nor ethnicity, as well as the uneven representation of sexes and ethnic groups in different splits in the data.

## Notes for interpretation

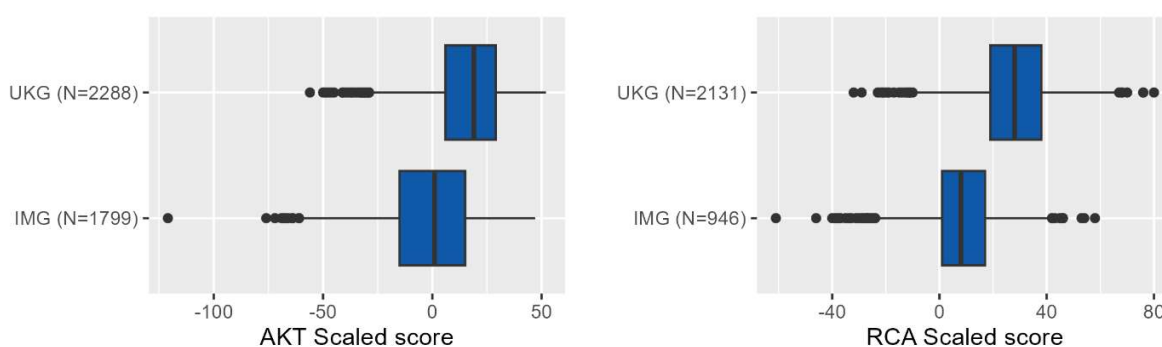
The following sections make use of box and whisker plots. To aid readers' interpretation:

- i. These plots show the median score (the middle score when all scores are ranked smallest to largest) as the vertical line in the middle of the box.
- ii. The left edge of the box to the median line is the 25th-50th percentile.
- iii. The median line to the right edge of the box is the 50th-75th percentile.
- iv. The whole box (25th-75th percentile) shows the interquartile range (IQR).
- v. The end of the line to the left of the box is called the 'minimum' (the 25th percentile minus 1.5 IQR).
- vi. The end of the line extending to the right is called the 'maximum' (75th percentile plus 1.5 IQR).
- vii. Dots beyond the line are outliers (extreme scores).
- viii. Candidates with a scaled score of zero have achieved the pass mark and passed.
- ix. Those candidates with a scaled score greater than zero have exceeded the pass mark and passed.
- x. Those candidates with a scaled score below zero have scored lower than the pass mark and have failed.

## Country of primary medical qualification (UK or International)

Figure 3.3 shows the scaled scores of UKG and IMG First Time Takers in the AKT and RCA.

Previously, undergraduate training status has been shown to be a strong predictor of scores and pass/fail outcomes in both AKT and RCA, in later sections examining differential attainment according to sex and ethnicity, we have considered undergraduate training status in addition to the demographic variable of interest.



**Figure 3.3: Performance of FTTs in the AKT and RCA, split by country of primary medical qualification and MRCGP module.**

It is important to note that place of primary medical qualification is not synonymous with nationality: UK nationals choosing to study abroad are included in the IMG group, so the comparison focuses more on the undergraduate training programmes than the candidates in different undergraduate programmes.

## Sex

In the AKT: there were **1484** Female UKGs, **861** Male UKGs, and **446** UKGs who chose not to disclose their sex. The UKG group was therefore **53.2%** Female, **30.8%** Male, and **16.0%** Unknown (did not disclose).

In the RCA: there were **1275** Female UKGs, **727** Male UKGs, and **298** UKGs who chose not to disclose their sex. The UKG group was therefore **55.4%** Female, **31.6%** Male, and **13.0%** Unknown (did not disclose).

The remainder of this section focuses on FTT candidates only.

Table 3.1 shows the representation of UKG and IMG FTTs among female candidates, male candidates, and those who chose not to declare their sex. Amongst female FTT candidates in the AKT, **61.5%** were UKGs, while **38.5%** were IMGs. This difference is reduced among male FTT candidates, as **47.1%** of males on their first attempt were UKGs, and **52.9%** were IMGs.

**Table 3.1: Count and Percentage of FTTs according to sex in the AKT and RCA**

Exam	Sex	Total FTTs	UKG FTTs	IMG FTTs
AKT	Female	2039 (100%)	1255 (61.5%)	784 (38.5%)
	Male	1483 (100%)	698 (47.1%)	785 (52.9%)
	Unknown	565 (100%)	335 (59.3%)	230 (40.7%)
RCA	Female	1648 (100%)	1212 (73.5%)	436 (26.5%)
	Male	1043 (100%)	654 (62.7%)	389 (37.3%)
	Unknown	386 (100%)	265 (68.7%)	121 (31.3%)

Table 3.2 shows the pass rate for FTTs according to sex and location of primary medical qualification (UKG or IMG).

Figure 3.4 shows the scaled scores of FTT candidates in the AKT and RCA according to sex (as above with scaled scores, a score of 0 or greater is a pass, and a negative score is a fail).

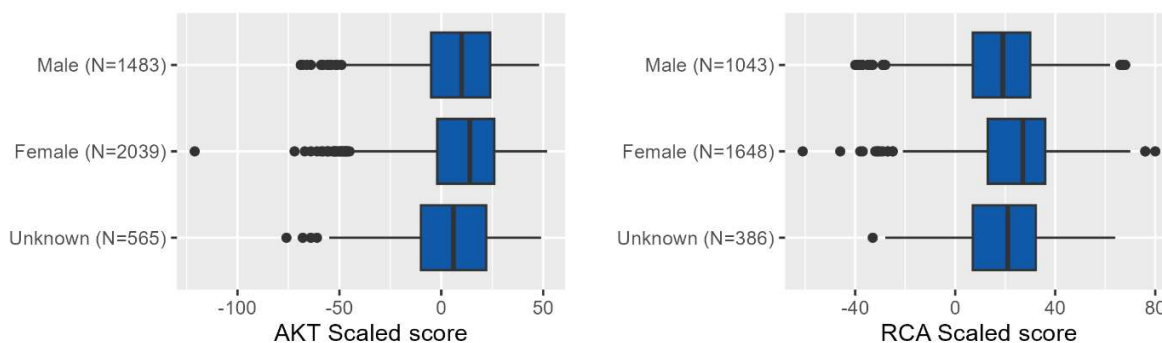
Considering candidates who received their undergraduate medical training in the UK, the pass rate for females sitting the AKT was **86.7%**, which was higher than the pass rate for males (**82.8%**). In the RCA, the female pass rate was **98.5%**, higher than the male pass rate of **97.1%**.

Amongst IMG candidates sitting the AKT for the first time, the pass rate for females was slightly lower than the pass rate for males (**52.2%** compared to **56.6%**). In contrast, female IMG candidates had a higher pass rate than male IMG candidates in the RCA (**83.0%** compared to **75.6%**).

It is important to note the discrepancies in the relative size of the female and male groups. It is also important to consider the rate at which candidates chose not to disclose their sex, meaning that these statistics do not offer a full picture of differential attainment according to sex.

**Table 3.2: Pass rate for FTTs according to sex in the AKT and RCA**

Exam	Sex	Overall FTT pass rate (%)	UKG FTT pass rate (%)	IMG FTT pass rate (%)
AKT	Female	73.4	86.7	52.2
	Male	68.9	82.8	56.6
	Unknown	59.1	71.3	41.3
	All FTT	69.8	83.3	52.7
RCA	Female	94.4	98.5	83.0
	Male	89.1	97.1	75.6
	Unknown	90.2	97.4	74.4
	All FTT	92.1	97.9	78.9



**Figure 3.4: Performance of FTTs in the AKT and RCA, split by Sex and MRCGP module.**

## Ethnicity

In this section, we have split the candidates into three groups (BME, White and Unknown).

In the AKT: there were **813** BME UKGs, **1409** White UKGs, and **569** UKGs who chose not to disclose their ethnicity. The UKG group was therefore **29.1%** BME, **50.5%** White, and **20.4%** Unknown (did not disclose).

In the RCA: there were **620** BME UKGs, **1276** White UKGs, and **404** UKGs who chose not to disclose their ethnicity. The UKG group was therefore **27.0%** BME, **55.5%** White, and **17.6%** Unknown (did not disclose).

The remainder of this section focuses on FTT candidates only.

Table 3.3 shows the representation of UKG and IMG First Time Takers among BME candidates, White candidates, and those who chose not to declare their ethnicity. In the AKT and RCA, over nine in every ten White FTT candidates received their undergraduate training at a UK institution. In the BME group **31.3%** of all BME FTT candidates sitting the AKT had UK primary medical qualifications, while **68.7%** were IMGs. The RCA was slightly more balanced with **43.5%** of all BME FTT candidates sitting the RCA having UK primary medical qualifications, while **56.5%** were IMGs.



**Table 3.3: Count and Percentage of FTTs according to ethnicity in the AKT and RCA**

Exam	Ethnicity	Total FTTs	UKG FTTs	IMG FTTs
AKT	BME	1969 (100%)	616 (31.3%)	1353 (68.7%)
	Unknown	767 (100%)	429 (55.9%)	338 (44.1%)
	White	1351 (100%)	1243 (92.0%)	108 (8.0%)
RCA	BME	1223 (100%)	532 (43.5%)	691 (56.5%)
	Unknown	548 (100%)	363 (66.2%)	185 (33.8%)
	White	1306 (100%)	1236 (94.6%)	70 (5.4%)

Table 3.4 shows the pass rate for FTTs according to ethnicity and location of primary medical qualification (UKG or IMG).

Figure 3.5 shows the scaled scores of FTT candidates in the AKT and RCA according to ethnicity.

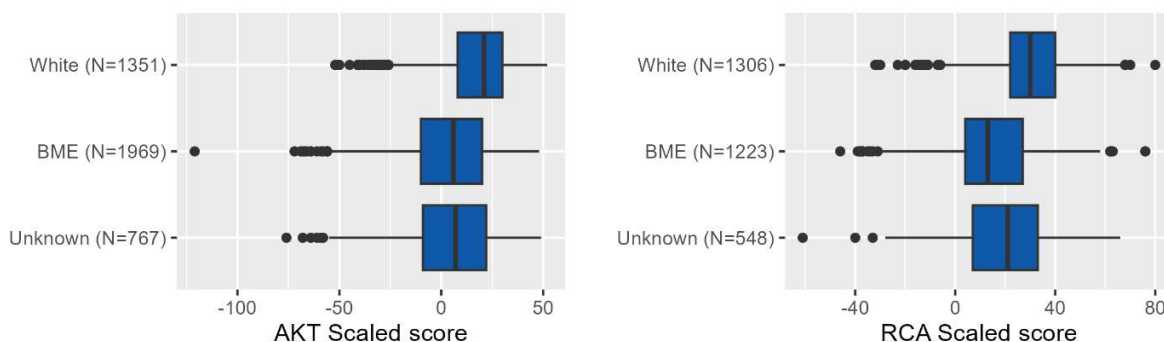
Considering candidates who received their undergraduate medical training in the UK, the pass rate for White candidates sitting the AKT was **89.1%**, higher than the pass rate for BME candidates (**77.4%**). Differences were less marked in the RCA: pass rates for UKG sitting this exam were **99.0%** for White candidates and **95.5%** for BME candidates.

Among IMG candidates, the White pass rate in the AKT was **47.2%** compared to the **55.7%** pass rate by BME candidates. This difference reversed direction in the clinical assessment: in the RCA, the White IMG pass rate (**82.9%**) was higher than the BME IMG pass rate (**79.7%**).

It is important to note the discrepancies in the relative size of the White and BME groups, particularly in the IMG group. It is also important to consider the rate at which candidates chose not to disclose their ethnicity, meaning that these statistics do not offer a full picture of differential attainment according to ethnicity.

**Table 3.4: Pass rate for FTTs according to ethnicity in the AKT and RCA (note FTT in RCA are those on their first RCA attempt who had not previously attempted the CSA)**

Exam	Ethnicity	Overall FTT pass rate (%)	UKG FTT pass rate (%)	IMG FTT pass rate (%)
AKT	BME	62.5	77.4	55.7
	Unknown	60.6	74.8	42.6
	White	85.7	89.1	47.2
	All FTT	69.8	83.3	52.7
RCA	BME	86.6	95.5	79.7
	Unknown	89.8	97.8	74.1
	White	98.2	99.0	82.9
	All FTT	92.1	97.9	78.9



**Figure 3.5: Performance of FTTs in the AKT and RCA, split by Ethnicity and MRCGP module**

## 4 Candidate performance: Subject area and domain performance

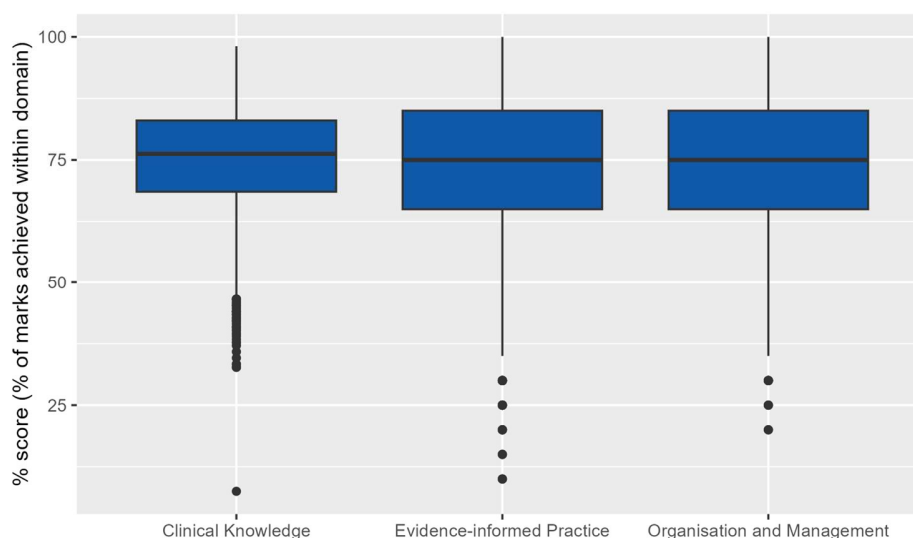
### Performance in the AKT

#### Subject area scores

In the 200-item AKT paper, 160 of the questions relate to clinical knowledge, 20 to research/data interpretation/evidence-informed practice and 20 to organisation and management/primary care legal/ethical/administration issues. There are occasions on which a question has been removed after sitting and prior to results; and this has reduced the overall number of questions to 199 in these instances. Figure 4.1 shows the spread of candidates' scores on questions across the three areas.

Data are presented using percentage scores for each domain (% of available marks achieved). Candidates performed better on Clinical Knowledge questions (in terms of proportion of marks achieved) as compared to the other two domains. The median score being 76.25% compared to 75% for the other two domains.

**It is important to interpret the graph with caution given the discrepancy in the number of marks available between the Clinical (80%) and other domains (20%).**



**Figure 4.1: Performance of FTTs across the domains of the AKT**

## Insights from the item performance statistics

Candidates with less exposure at undergraduate and postgraduate training to both data-interpretation and primary care administration issues find these AKT sections more difficult. This also applies to clinical topics, commonly women's health issues and potentially to any area where an individual has not had clinical experience.

Feedback to educators and candidates is published shortly after every AKT, but in early 2021, we produced for the first time a summary of feedback provided over the previous five years. This is also updated after every AKT exam, and published on the AKT section within the [RCGP website](#).

**Topics causing most difficulty for candidates in recent AKT examinations and/or which have been highlighted several times over recent years:**

### Professional topics:

**Improving quality, safety and prescribing:** issues concerning safe prescribing. This includes areas such as correct calculation of drug doses, awareness of side-effects and drug interactions, and monitoring of drugs. For example, drugs commonly prescribed for some mental health conditions and less common but potentially serious side-effects of drugs used to treat several long-term conditions as well as findings indicating serious side effects from DMARD drugs.

**Leadership and management:** maintaining confidentiality and access to medical records, death certification and notifications to Coroner/Procurator fiscal.

**Consulting in General Practice:** communication of risk and use of risk tools.

**Evidence-informed Practice, Research and Sharing Knowledge:** basic understanding of concepts and terms in research (e.g., absolute and relative risk), data interpretation (both research and other data sources), research methodology.

**Urgent and Unscheduled care:** managing acute illness e.g., collapse.

**Life stages topics:**

**Children and Young People:** important indications or contraindications for vaccinations, safeguarding and non-accidental injury, consent and capacity, developmental assessment and screening, common childhood infections, normal findings, minor illness.

**People at the End-of-Life:** key ethical concepts which may apply at the end-of-life, pain management.

**Clinical topics:**

- ECG interpretation.
- common genetic conditions, including their patterns of inheritance and rare but important childhood genetic conditions.
- side-effects of common treatments for cancer, and the drugs that might be prescribed to overcome side-effects.
- the relevant blood pressure and risk thresholds which guide prescribing.
- familiarity with the management of relatively common primary care presentations of jointly managed long-term gastroenterology conditions.
- asthma management including new diagnosis.
- acute exacerbation or routine review of sub-optimal asthma control.
- red flag neurological symptoms and possible underlying diagnoses.
- an awareness of the significance of common neurological examination findings relating to underlying diagnoses/lesions.
- HRT and options for treating menopausal symptoms.
- primary care monitoring.
- management of hearing loss in children.

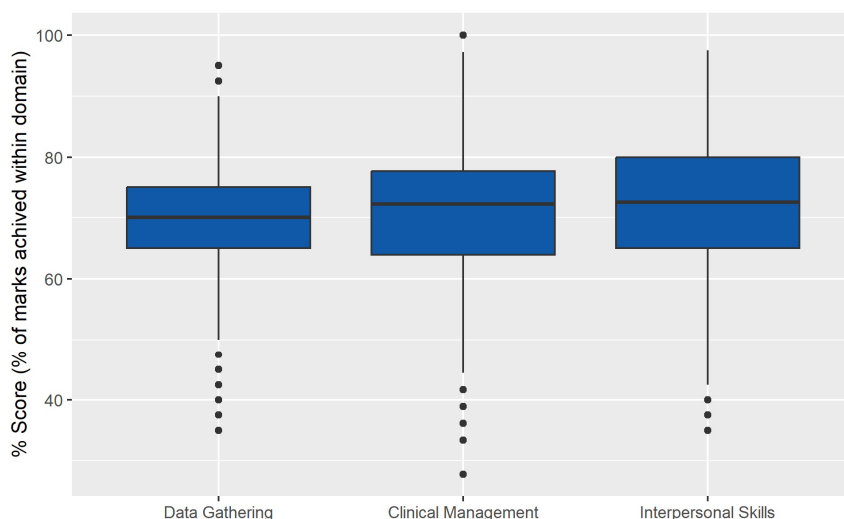
## Performance in the RCA

### Domain-based scores

Candidates in the RCA are marked on three separate domains within each station.

- **Data-gathering, technical and assessment skills:** covers *Gathering and using data for clinical judgement, choice of examination, investigations, and their interpretation; demonstrating proficiency in performing physical examinations and using diagnostic and therapeutic instruments.*
- **Clinical Management skills:** covers *Recognition and management of common medical conditions in primary care. Demonstrating a structured and flexible approach to decision-making, the ability to deal with multiple complaints and co-morbidity, and the ability to promote a positive approach to health.*
- **Interpersonal skills:** covers *Demonstrating the use of recognised communication techniques to gain understanding of the patient’s illness experience and develop a shared approach to managing problems, practising ethically with respect for equality and diversity issues, in line with the accepted codes of professional conduct.*

Figure 4.2 shows that candidates score fewer marks for Clinical Management than they achieve for Data Gathering and Interpersonal Skills.



**Figure 4.2: Performance of FTTs across the domains of the RCA**

## Feedback provided by the examiners in the RCA

Table 4.1 shows, for each of 24 feedback statements used by the RCA examiners, the percentage of candidates receiving that feedback for any one of their consultations (ordered by frequency), and the mean number of times each was applied to a candidate.

**Table 4.1: Percentage of candidates who received each feedback statement at least once.**

Feedback Statement	Percent	Mean
<b>CM1:</b> Insufficient evidence of Decision Making and Clinical Management skills to demonstrate capability of safe independent UK General Practice	80.24	2.98
<b>CM3:</b> Does not develop a Management Plan (including prescribing and referral) reflecting knowledge of current best practice	72.59	2.45
<b>G4:</b> Poor choice of consultation: Does not demonstrate capability in consulting skills sufficient for independent UK General Practice	65.99	2.19
<b>CM2:</b> Does not identify an appropriate range of Differential Diagnoses and/or form a reasoned Working Diagnosis	61.53	2.01
<b>CM4:</b> The choice of management was unclear due to missing information	61.42	1.95
<b>IPS2:</b> Does not demonstrate active listening skills, limited exploration, and use of cues	61.08	2.46
<b>DG2:</b> Inadequate history taken to enable safe assessment of disease and its severity	56.20	1.93
<b>DG3:</b> Does not elicit and develop adequate amounts of new information to demonstrate competence	55.61	1.77
<b>IPS3:</b> Does not develop a shared understanding, demonstrating an ability to work in partnership with the patient	52.10	2.02
<b>CM5:</b> Does not demonstrate an awareness of management of risk or make the patient aware of relative risks of different options	49.76	1.61
<b>DG1:</b> Insufficient evidence of Data Gathering skills to demonstrate capability of safe independent UK General Practice	49.22	1.68
<b>DG4:</b> Does not consider and/or test an adequate range of Differential Diagnoses	48.89	1.60
<b>IPS5:</b> Does not use language and/or explanations that are relevant and understandable to the patient	44.01	1.91
<b>DG6:</b> Does not offer/undertake appropriate Physical/Mental examination as part of the diagnostic process	40.57	1.57
<b>DG5:</b> Does not identify or use appropriate Psychological or Social information to place the problem in context	39.34	1.44
<b>CM7:</b> Does not make appropriate, adequate, and empowering arrangements for follow-up and safety netting	38.61	1.36
<b>IPS1:</b> Insufficient evidence of Interpersonal skills to demonstrate capability of safe independent UK General Practice	31.93	1.43
<b>CM6:</b> Does not show appropriate use of resources, including aspects of budgetary governance	30.83	1.33
<b>G3:</b> Shows poor time management	30.42	1.33
<b>IPS4:</b> Does not acknowledge or utilise the patient's contribution to the consultation including consent	28.40	1.34
<b>IPS6:</b> Does not treat the patient with appropriate respect and/or sensitivity during the consultation	22.83	1.34
<b>G1:</b> Disorganised and or unstructured consultation	22.50	1.30
<b>G2:</b> Does not recognise the issues or priorities in the consultation	20.09	1.27
<b>DG7:</b> Does not recognise the implications of any abnormal findings or results	9.29	1.10

## 5 Candidates with disabilities: prevalence by attempt and source of PMQ; outcomes

The UK Equality Legislation supports examination candidates with disabilities in requesting *reasonable adjustments* in regard to their disabilities, provided these do not affect the standard of the examination. Specific Learning Difference (SpLD) is the disability most frequently reported. Disabilities other than SpLD have been merged for reasons of small numbers and personal confidentiality, the most common ones being 'other disability,' physical disability, hearing impairment, and multiple disabilities.

It is important to note that SpLD may not be diagnosed until a second or later attempt at the assessment.



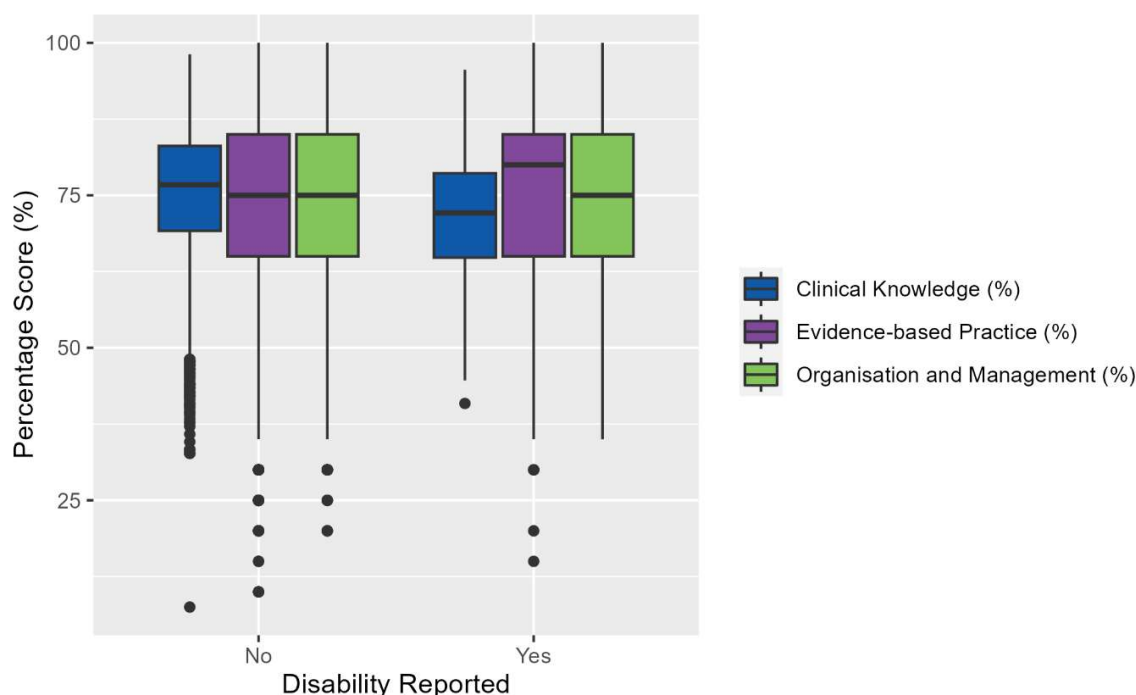
## AKT

In the category ‘all disabilities,’ there were **771** candidate-attempts at the AKT in the academic year 2021-2022, representing **10.1%** of all attempts. Of these 771 attempts, **414** (53.7%) were successful.

In the category ‘SpLD,’ there were **659** candidate-attempts at the AKT, representing **8.6%** of all attempts this academic year. Of these 659 attempts, **350** (53.1%) were successful. Note that candidates with SpLD and another disability who selected ‘more than one disability’ are not included in the SpLD group.

Figure 5.1 shows scores of FTTs in the subject areas of the AKT split by disability status. It is encouraging to see that those candidates with a declared disability do not appear to be performing differently from those who have not disclosed a disability.

**With such a large discrepancy in the number of candidates in each subgroup it is important that this comparison be considered with caution.**



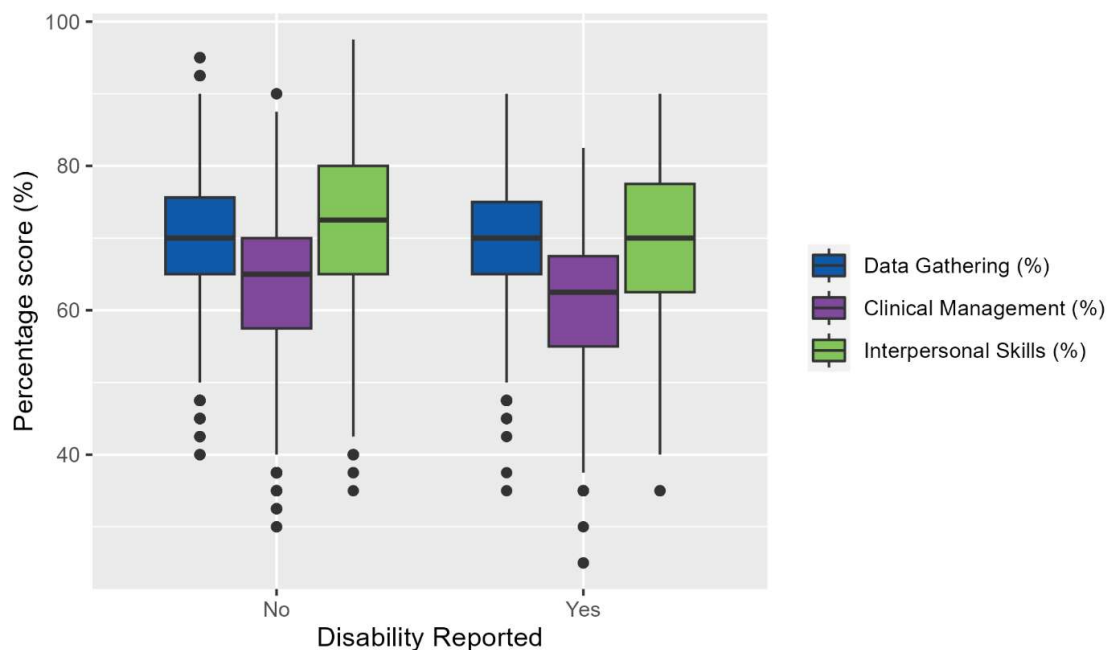
**Figure 5.1: Performance (% score) of FTTs in the three AKT domains split by Disability status of FTTs in the three AKT domains split by Disability status**

## RCA

For the RCA, in the category ‘all disabilities’ there were **493** candidate-attempts in the academic year 2021-22, representing **11.6%** of all attempts. Of these 493 attempts, **323** (65.5%) were successful.

Figure 5.2 shows scores of FTTs in the RCA with and without declared disabilities, and it is encouraging to see that the range of scores in each domain is overlapping for these two groups.

It is important to note however that there are many more candidates without a declared disability than those with a disclosed disability, so this comparison must be viewed with the uneven sample sizes in mind.



**Figure 5.2: Performance of FTTs in the three RCA domains (raw score) split by Disability status**

## 6 Update from the Workplace Based Assessments

### Summary

WPBA makes up the third requirement for the UK GP licensing assessment.

### New assessment programme and portfolio

The new assessment programme started on the 5 August 2020 and all trainees migrated over to the new portfolio irrespective of which assessment programme they were on. All trainees who were starting ST1 started on the new programme. Trainees who were already in training moved onto the new programme when they changed training years. Trainees who were on extensions continued on the old programme unless they wished to change. Trainees could request to stay on the old programme, but all trainees needed to have transferred across by August 2022.

In summary the new assessment package changes included reducing the assessment burden, updating the assessment formats, and introducing quality improvement, leadership and prescribing assessments into GP training. Work has continued on updating and improving the assessment programme resources, and in training on the new portfolio in a variety of modalities. The focus now is on evaluating the changes.

### GMC requirements

#### Prescribing assessment:

The GMC gave conditional approval for the prescribing assessment requiring a pilot and evaluation to be undertaken, following a report in September 2021. The areas for review were i) the time taken to complete the data collection and ii) to ensure the assessment remained valid, feasible and sustainable following the GMCs earlier suggestion of reducing the number of scripts reviewed by the trainee. This was achieved with a further trainer and trainee survey which was analysed by Nottingham University.

The results suggested that the prescribing assessment was taking less time for trainees to complete with fewer trainees reporting taking longer than 4 hours to review the 50 prescriptions. The error rate with a reduced number of prescriptions was broadly comparable to that found in 2020. The prescribing assessment remains valid, highlighting areas of improvement for trainees' prescribing that is in line with published literature regarding the error rate/suboptimal rate of doctors in training, and from the perspective of trainees and trainers who agreed that is a useful prescribing assessment. The review team felt that it would not be prudent to reduce the number of prescriptions to be reviewed further – and that the

learning reported from the activity was in keeping with the amount of time expended. From this we felt confident that the overall assessment burden is manageable and therefore that the assessment is sustainable and feasible. This was submitted to the GMC and in November 2021 the prescribing assessment received full approval. The GMC stated:

*“We are pleased to see that there has been a decrease in the number of trainees taking longer than four hours to review the 50 prescriptions, with no detriment to the rate of errors identified. We might expect that the time taken to complete the assessment will further reduce as it becomes embedded into training.*

*Most importantly, a significant majority of those surveyed agreed that the assessment was useful and led to a change in their prescribing practice. We are therefore happy to confirm full approval.”*

#### Non-GP assessors

GMC approval was also sought for trialing non-GP assessors for some of the trainee assessments so that *allied health care professional* could be used.

The GMC response was:

*“In general, we support the involvement of other professions in the training of doctors and providing assessments and feedback and allow flexibility in both formative and summative assessments, on the condition that a clear rationale is provided.”*

*“We don’t restrict the range of assessors that can be used, but would expect a clear explanation specifying skills, capabilities, qualifications etc. that assessors will need to fairly and effectively assess or evaluate doctors in training.”*

*“It is fine to use AP assessors provided it is appropriate for them to act as assessors for the specific assessment linked to them. It is important that they are trained and supported in these assessor roles.”*

*“It might be helpful to map what we set out in Excellence by Design against your proposal, to make sure you have considered all our expectations.”*

With the support of COGPED the requirements for training for any assessors was created mapped to the GMCs *Excellence by Design*. A scoping exercise was carried out with Roadmap supervisors in England specifically trained in GP assessments undertaking a couple of assessments on trainees. These did not count towards the trainees mandated minimum number of assessments. This was evaluated with trainer and assessor surveys, the results of which, though small in number, were positive. The pilot has been rolled out to include a variety of assessors.

### New changes and other areas

In November 2021 the new ESR outcomes went live. The ESR outcomes were changed to link these to the grading areas used in assessments.

ESR outcome options for ST1/2 and ST3 trainees who are not due to CCT at this time are:

- Making progress above the expected rate
- Making progress at the expected rate
- Making progress below the expected rate
- Making progress significantly below the expected rate

ESR outcomes for ST3 trainees who are at their currently due CCT date are:

- Competent/Excellent in WPBA requirements as evidenced by this ESR
- Progress below the expected rate in WPBA requirements as evidenced by this ESR

The ratings for this review are comparing the trainee to the standard expected at CCT

The website and training resources have been updated.

### Clinical Examination and Procedural Skills

The CEPS assessments and learning logs were also reviewed to ensure a trainee is competent in this area as the new module now called SCA will not cover this capability. The EAs reviewed the number and range of non-intimate CEPS recorded by trainees as part of the quality review and this information was used to inform changes to the CEPS recording within the portfolio. The training community and relevant bodies were consulted in order to ensure that this area is adequately assessed in light of the changes to the clinical assessment part of the tripos.

The utility of the portfolio has been reviewed and adapted to improve recording. GMC intimate CEPS have been included in the compliance passport of the portfolio and other changes including safeguarding and BLS have been made to make assessing the trainee easier for all including ARCPs. A mandatory evidence sheet has been added to the portfolio to also aid trainee preparation and knowledge of expectations.

Extensive work has taken place to improve the useability of the FourteenFish portfolio and Fishbase, including creation of a portfolio App for trainees.

### Statistics

• ST2 Trainee numbers	<b>4786</b>
• ST3 Trainee numbers	<b>5458</b>
• Prescribing Assessments completed	<b>3649</b>
• CEPS Assessment	<b>8764</b>
• CEPS Reflections	<b>7821</b>
• LEA	<b>9204</b>
• COT	<b>9209</b>
• ESR old	<b>4036</b>
• ESR new	<b>3232</b>
• ESR total	<b>7268</b>

### Recruitment

A change of leadership took place in October 2021 with Dr Susan Bodgener standing down after 8 years as the Clinical Lead. Dr Kim Emerson (a former member of the WPBA core group for nearly 10 years) was appointed as the new Clinical Lead.

The group successfully recruited in January three replacements to the Core Group, therefore further increasing the expertise and diversity of the group.

### Evaluation

The key focus for the year was on evaluating WPBA and three pieces of research are under development and progressing covering, in conjunction with Lincoln university:

- Evaluating the new WPBA assessments in terms of their validity and reliability.
- Exploring perceptions of doctors in training with specific learning differences and undertaking clinical and workplace-based assessments for general practice licensing.
- Qualitative evaluation and impact assessment WPBA evaluation of trainers and trainees.

## Learning resources

AKT guidance, including new 'clinical evidence and data interpretation workbook' and 'What can Trainers do to help AITs prepare for the AKT?', can be found at:

<https://www.rcgp.org.uk/mrcgp-exams/applied-knowledge-test>

RCA guidance can be found at:

<https://www.rcgp.org.uk/mrcgp-exams/recorded-consultation-assessment>

WPBA guidance can be found at:

<https://www.rcgp.org.uk/training-exams/training/workplace-based-assessment-wpba.aspx>

## Differential attainment

Differential attainment is a term used to describe the variations in levels of educational achievement that occur between different demographic groups undertaking the same assessment. It cannot be attributed to a single identifiable cause, but results from a combination of factors and occurs across many professions at undergraduate and postgraduate levels.

The RCGP takes the issue of fairness to all candidates very seriously and remains committed to understanding and trying to reduce differential pass rates between MRCGP candidates. Any differential that exists because of ability would be expected and appropriate, but RCGP considers any differentials which could be solely attributed to any protected characteristics to be unfair.

The RCGP continues to work closely with trainee and lay representatives, and organisations including the GMC, the Academy of Medical Royal Colleges (AoMRC), the statutory educational bodies of the four nations (HEE, NES, HEIW, NIMDTA), as well as BAPIO, BIDA and other representative bodies, to support candidates in demographic subgroups that have traditionally performed less well in high-stakes assessments. These groups include IMG, BME and those trainees' declaring disability. The RCGP recognises that there is significant heterogeneity within these groups. Simple definitions, such as that of an IMG being someone who has obtained their primary medical qualification outside the European Economic Area, covers a range of complexities, including influences from training, ethnicity, religion, gender, age, and sexual orientation. This also applies to every non-IMG doctor, but for IMGs the number of intersectional experiences is likely to be higher.

The RCGP is continuing to actively support the work led by the GMC and the AoMRC to *Eliminate Inequality in Medical Education* and have contributed our own Action Plan.

Actions already taken by the RCGP with respect to differential attainment are, of necessity, broad-brush. They include:

- Aligning curriculum and assessments to the GMC's *Excellence by design* standards which have fairness as a guiding principle.
- Developing resources and educational events to support trainers and trainees in their AKT and RCA preparation. MRCGP examiners regularly support RCGP Faculty and Deanery exam preparation courses across the UK.
- Performing regular stakeholder engagement, including a very in-depth stakeholder consultation for the SCA Assessment which is due to replace the RCA in November 2023.



- Reviewing the way that results and reports are presented, with a view to reducing the risks of unconscious bias where possible. Reviewing reports and guidance against accepted guidelines for readers with disabilities, including specific learning differences.
- Targeted recruitment of MRCGP panel members and those working on the development groups of AKT, RCA and its replacement, and WPBA from under-represented demographic groups. This has included a review of adverts and job descriptions to ensure that roles advertised are inclusive and open to all. No MRCGP examiner recruitment was carried out in 2021-22.
- Mandated annual training of all MRCGP examiners and panel members in equality and diversity issues and recognition of unconscious bias, including those specific to assessment.
- Regular review of equality, diversity, and inclusion (ED&I) monitoring to ensure that candidate data are collected appropriately, and in-line with GDPR regulations.
- Reviewing the feedback provided to candidates in all modules to improve usefulness to them and their supervisors (e.g., changes made in the feedback to AKT, WPBA and RCA candidates).
- Resources to support candidates to have failed exams (e.g., ongoing work on guidance on reflection after an examination of failure, and tips for enhancing success).
- Conducting equality impact assessments and piloting of any proposed new assessments (e.g., piloting for the prescribing assessment in WPBA, ongoing piloting and work on the new clinical skills assessment module) and all policies.
- Reviewing existing assessments to reflect the demographics of UK patient populations to inform new cases for the future clinical skills assessment.
- Reviewing individual item performance in the AKT and ensuring item construction is designed to reduce potential differential attainment where feasible.
- Continued research into differential attainment of MRCGP candidates as a strategic priority. Several research projects have been completed; others are in progress. RCGP publish these findings in peer-reviewed journals to help shed light on differential performance in examinations.

- Details of research conducted are outlined below. Research for 2022-23 has focused particularly on candidates with specific learning differences performance on data interpretation questions in the AKT, and an exploration of the perceptions of doctors in training with specific learning differences undertaking clinical and workplace-based assessments for general practice licensing.

The Annual Report is a one-off annual document acting as a retrospective on the previous academic year. Importantly, readers should direct themselves to the RCGP website for ongoing updates around our work on Ensuring Equality, Diversity and Inclusion within the organization and the examination.

<https://www.rcgp.org.uk/about-us/equality-and-diversity.aspx>

For further information please email [info.EDI@rcgp.org.uk](mailto:info.EDI@rcgp.org.uk)

## Summary of recent RCGP related research

Papers and reports published by the RCGP and other academic teams over the past year related to the MRCGP have focused on studies investigating the reliability and validity of the exam or addressed performance problems more generally.

A research study related to the Recorded Consultation Assessment was awarded the **RCGP Research Paper of the Year in Medical Education category for 2021**. Dr Vanessa Botan and the research team received the prize in June 2022 at the RCGP/WONCA conference where the study was also presented:

**Botan V, Laparidou D, Phung VH, Cheung P, Freeman A, Wakeford R, Denney M, Law GR, Siriwardena AN.** *Candidate perceptions of the UK Recorded Consultation Assessment: cross-sectional data linkage study.* *Educ Prim Care* 2022, 33(1):32-40.

### What this study tells us:

- The RCA was broadly acceptable and a feasible alternative to the Clinical Skills Assessment (CSA).
- Candidates were positive about the resources provided and the online platform, but less positive about the time they had to prepare the evidence needed and to record the consultations.
- Candidates' performance in the RCA expressed as pass or fail was not influenced by their perceptions on the assessment, but ethnicity, training, and English as first language were all significant predictors of exam pass rates.
- Recommendations were made for improvement by trainees responding including providing more guidance on case selection, more feedback, providing greater feedback, increasing consultation length and offering further support or time to candidates based in practices with a higher number of patients coming from more deprived socio-economic backgrounds or with language barriers.

### What this means:

The Recorded Consultation Assessment (RCA), introduced during the COVID-19 pandemic, was broadly acceptable but some candidates experienced challenges and suggested areas for improvement, many of which have been implemented as a result of feedback from candidates and examiners including this study.

**Botan V, Williams N, Law GR, Siriwardena AN.** *How is performance at selection to general practice related to performance at the endpoint of GP training?* Report to Health Education England. University of Lincoln, Lincoln, 2022. Available at <https://eprints.lincoln.ac.uk/id/eprint/48920/1/GPNROMRCGPstudyfinalreport.pdf>

#### **What this study tells us:**

- This is the first study to link performance at selection with all outcomes at licensing for doctors undertaking specialty training for general practice.
- The Multi-Specialty Recruitment Assessment (MSRA) scores for doctors at selection into training predicted general practice licensing outcomes for the MRCGP Applied Knowledge Test, Clinical Skills Assessment, Recorded Consultation Assessment, and Workplace Based Assessment – Annual Review of Competence Progression, within five years of starting training.
- The optimal MSRA threshold score for predicting an uncomplicated training pathway to licensing was around 500 in this large cohort.
- The Selection Centre added little to the predictive validity of the MSRA, so this analysis supports the decision made during the pandemic to discontinue the Selection Centre.
- Doctors' ethnicity did not reduce the chance of passing GP licensing tests once sex, place of primary medical qualification, declared disability and MSRA scores were taken into account.
- Doctors scoring below the MRSR threshold of 500 may need additional support during training to maximise their chances of achieving licensing.

#### **What this means:**

Ethnicity did not reduce the chance of passing GP licensing tests once gender, place of primary medical qualification, declared disability and MRSR scores were considered. Comparing candidate scores by ethnicity creates a false impression of differential attainment which should be addressed by routinely taking these factors into account.

## Conference presentations

**Botan V, Law GR, Williams N, Siriwardena AN.** *Optimising the transition from selection to licensing in general practice.* Oral presentation at the Society for Academic Primary Care, Annual Scientific Meeting 1-3 July 2022, University of Central Lancashire.

**Botan V, Law GR, Williams N, Siriwardena AN.** *Specific learning difficulties (SpLDs) differently affects performance on written compared to clinical general practice licensing tests.* Oral presentation at the Society for Academic Primary Care, Annual Scientific Meeting 1-3 July 2022, University of Central Lancashire.

**Elfes C, Denney M, Blow C, Cartwright-Terry R, Neden C.** *Dilemmas and solutions - experiences of a national Family Medicine applied knowledge licensing test during a pandemic.* Oral presentation online at AMEE 27 -30 August 2021.

**Siriwardena AN, Botan V, Laparidou D, Phung VH, Cheung P, Freeman A, Wakeford R, Denney M, Law GR.** *Examiner perceptions of the UK Recorded Consultation Assessment introduced during the COVID-19 pandemic: cross-sectional study.* Oral presentation online at AMEE 27 -30 August 2021.

## Appendix A

### Place of training: Deanery

The below table outlines the number of unique candidates from each deanery. Tables showing the performance of each deanery relative to the performance of others is available on request from [exams@rcgp.org.uk](mailto:exams@rcgp.org.uk).

**Table 10.1: Number of unique candidates\* from each Deanery in the RCA and AKT examinations this academic year**

Deanery	AKT	RCA
Armed Forces	27	26
East Midlands	389	330
East of England	425	345
Kent, Surrey, Sussex	327	246
London	514	434
North West	669	497
Northern	230	197
Northern Ireland	115	88
Oxford	185	134
Scotland	357	283
South West: Severn	197	149
South West: Peninsula	149	97
Wales	207	152
Wessex	187	161
West Midlands	526	426
Yorkshire & Humber	467	350

\*Note that all candidates from a Scottish deanery have been assigned to the 'Scotland' deanery, as local Scottish deanery regions are now considered as one Scottish deanery by NHS Education for Scotland.