MRCGP Annual Report covering 2024/25

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Statistical information provided by **AlphaPlus**.

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Introduction

This report presents key data summarising the candidature, quality indicators and outcomes of all MRCGP examinations conducted in the academic year 2024-25 (1 September 2024 to 31 August 2025): four diets of the Applied Knowledge Test (AKT) and nine diets of the Simulated Consultation Assessment (SCA).

With the aim of supporting educators and prospective candidates, in addition to examination results, this Annual Report also presents a summary of the development work taking place across the AKT, SCA and the Workplace-Based Assessment (WPBA) and provides information that might assist MRCGP preparation.

Although this Annual Report explains some changes planned for WPBA as part of the MRCGP tripos of assessment, statistical information on WPBA is not included. This is because WPBA candidate performance, development and capability are reviewed regularly by the Deaneries within processes quality assured by the College.

For presentational purposes, 'stage of training' is reported as 'year' of training, since for most GP registrars, the two are synonymous. For less-than-full-time trainees (LTFT), those taking time out of training, and those provided with additional training, the 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.'

To remain consistent with agreements with the Committee of General Practice Education Directors (COGPED) to inform the 2019-2020 Annual Report, pass rates by medical school and deanery are not included to reduce any risk of unconscious bias and we report on UK Graduate (UKG)/International Medical Graduate (IMG), Black, Asian and Ethnic Minorities (BAEM)[1]/White and Sex as candidate subgroups. Our external psychometric experts advise that comparisons of BAEM/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 BAEM 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.

As in previous years, readers should exercise caution when interpreting some data in this Annual Report as there is an overlap between ethnicity, candidate sex and other characteristics. For example, IMGs are more likely to be from BAEM groups and less likely to be female. The place of primary medical qualification is also not synonymous with nationality as UK nationals choosing to study medicine abroad are included in the IMG group.

The College also wishes to signpost the significant amount of missing data which constrains our ability to draw generalizable conclusions. **28.25%** of unique candidates who sat an examination in this reporting year chose not to declare at least one of either their sex or ethnicity. **14.98%** chose to omit both their sex and ethnicity. The former has increased since last year; the latter has decreased. Whilst we have done our best to represent the candidates who did not declare these characteristics, readers should apply suitable caution when interpreting the graphs.

The College is very mindful about the impact of missing data. We remain committed to reviewing where and how we collect examination and membership data, and our messaging around these requests. We acknowledge that candidate data will change during their training journeys. We are adding *candidate data* as a standing agenda item on the RCGP Equality, Diversity and Inclusivity (EDI) Board. This year we have reduced the number of touchpoints for when we collect examination data with the hope that it improves the declaration rates. We will continue to monitor but recognise there are multiple factors which will impact a candidate's desire to declare their data.

The College also wishes to highlight that, following the High Court ruling *Karmakar v RCGP* (2024) concerning the voiding of prior failed attempts for candidates who receive a late diagnosis of a disability, the way in which "true attempts" are recorded has necessarily changed. During the 2024–2025 academic year, individual SCA diet analyses considered candidates' ***revised*** attempt counts (reflecting any voided attempts under the new policy), whereas AKT analyses continued to use candidates' ***total*** number of attempts. For the purposes of this Annual Report, and to support consistent comparisons over time, all analyses are presented using **total attempt counts**. As a result, some values may differ slightly from those in other publications reporting on specific SCA diets.

More examinations data is available on the GMC website, including data on differential attainment and differential performance.

[1] Throughout this Annual Report we have used the updated acronym "BAEM" to refer to ethnic minority candidates. We are aware that this acronym does not suit all ethnic minority people, and that some prefer other terms. We are using "BAEM" as this terminology is consistent with that agreed for use within our SCA Interim Report. We fully accept that ethnic minorities also include White minorities.

1 The MRCGP examination

Between 1 September 2024 and 31 August 2025, Membership of the Royal College of General Practitioners (MRCGP) comprised four sets of assessment procedures whose combined summative function is to assure the Deaneries, the College and the GMC of the competence of exiting GP registrars across a broad and carefully defined training curriculum. After completing an approved GMC general practice training programme and satisfactory completion of the three MRCGP assessment components, GP 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. **Simulated Consultation Assessment (SCA)**: practical OSCE examination assessing candidates' abilities to integrate and apply clinical, professional and communication skills through simulated patient consultations delivered across an online platform.

c. **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 or within twelve months thereafter. Other than UK Ministry of Defence candidates serving in UK military establishments abroad, no candidates based in other countries take these assessments.

Applied Knowledge Test (AKT)

The AKT during this academic year was a three-hour and ten-minute, 200-item multiple choice examination, which assessed:

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

All items are contextually relevant to UK general practice. Single best answer, extended matching, multiple best answer, and free text item formats are used. The AKT is typically scored out of 200 marks with each correct response awarded one mark without differential weighting.

Simulated Consultation Assessment (SCA)

The SCA consists of twelve standardised consultations conducted with simulated patients, each lasting 12 minutes, delivered remotely through an online platform to enable candidates to sit a standardised assessment in their own GP surgeries. Prior to the examination sitting, the professional actors simulating each case meet with a senior RCGP Lead Examiner to discuss how the case should be delivered consistently and in line with guidance from the case writers. The SCA is designed to assess candidate performance against the passing standard of the "newly qualified GP, fit to consult without supervision in UK general practice," with the palette of cases selected against a blueprint that covers a range of general practice capability areas. Each case is marked against three domains:

- Data gathering and diagnosis (DG&D)
- Clinical management and medical complexity (CM&C)
- Relating to others (RTO)

To reflect the capability coverage within the CM&C domain, and in response to COGPED's request that assessment drives learning, this is weighted in comparison to DG&D and RTO. Further details of these domains and how candidate performance is assessed against them can be found here: https://www.rcgp.org.uk/mrcgp-exams/simulated-consultation-assessment/marking-and-results

Marking takes place after examination delivery by RCGP examiners on the online platform. To ensure consistency and reliability, each examiner marks multiple candidates on a single case. Hence, each candidate is marked by 12 different examiners. Prior to commencing marking, all examiners assessing a given case for that diet attend a standardization meeting. These meetings are facilitated by senior RCGP Lead Examiners and use case writer guidance to agree how each case should be marked against the passing standard.

Workplace Based Assessment (WPBA)

WPBA evaluates GP registrars' 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 GP registrar'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 GP registrars who may be in difficulty and need more help.
- evaluate aspects of professional behaviour which are difficult to assess in the AKT and SCA
- determine fitness to progress towards completion of training.

2 Who are our candidates?

Demographic characteristics

AKT and SCA

Those sitting the AKT and/or SCA were all UK-based or UK military GP registrars who obtained their primary medical qualification from **111** different countries. The number of candidates from each continent is presented in Table 2.1.

During the 2024-25 academic year **5362** candidates made a total of **6148** attempts at the AKT, and **5094** candidates made a total of **5998** attempts at the SCA.

Of the **9353** unique candidates who sat the AKT and/or SCA in 2024-25, there were **3948** (42.21%) UK graduates (UKGs) and **5405** (57.79%) international graduates (IMGs). The number of unique candidates decreased by **81** compared to the 2023-24 academic year when there were 4400 UKGs and 5034 IMGs. Notably the number of UKGs has fallen this year, whilst the number of IMGs has risen substantially.

Table 2.1: Number of unique candidates attempting the AKT and/or SCA in the 2024-25 academic year from each region of the world.

Continent	Unique candidates
Africa	2176
Asia	2297
Australasia	3
Europe	4751
North America	100
South America	26

Within all unique candidates sitting the AKT and/or SCA, **4365** (46.67%) self-identified as being female; **3479** (37.20%) were male; and **1509** (16.13%) chose not to declare their sex.

Considering candidates' self-declaration of ethnicity, **2066** (22.09%) were White; **4753** (50.82%) were BAEM; and **2534** (27.09%) candidates chose not to declare their ethnicity.

Looking only at First Time Takers (FTTs) for the AKT and SCA, which is those candidates sitting either or both examinations for the first time in the 2024-25 examination year, the representation of each sex and ethnicity was as follows:

- **Female:** 3833 (47.87%)
- **Male:** 2929 (36.58%)
- **Sex not declared:** 1245 (15.55%)
- **Ethnicity declared as White:** 1949 (24.34%)
- **Ethnicity declared as BAEM:** 4037 (50.42%)
- **Ethnicity not declared:** 2021 (25.24%)

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 SCA examinations

Figure 3.1 presents the status of all unique candidates who sat the AKT or SCA between 1 September 2024 and 31 August 2025. The in-year cumulative pass rate for candidates taking the examination once, or more than once, within this examination year is **79.24%** for the AKT and **80.45%** for the SCA.

The cumulative pass rate for all candidates over time is **96%** for the AKT.

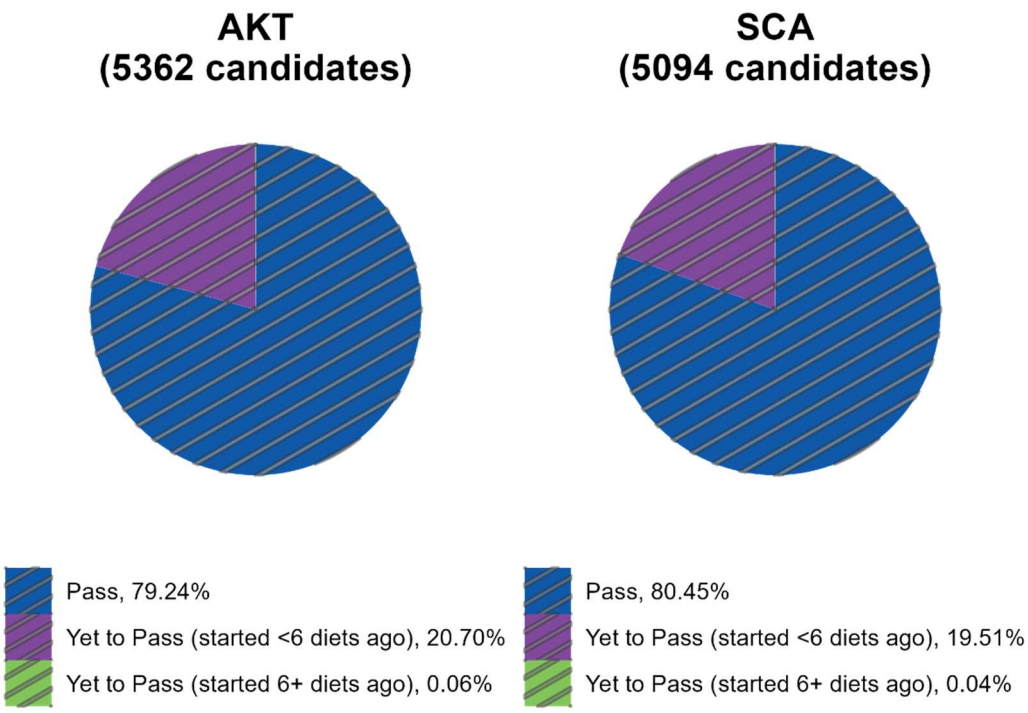


Figure 3.1: Candidates who sat the AKT/SCA between 1 September 2024 to 31 August 2025

The correlation between the scores of candidates who were FTTs of the SCA in 2024-25 with the same candidates' scores on their first attempt of the AKT (regardless of which year they first sat the AKT) was $r = 0.50$ (N = 4280, $t = 37.76$, $p < 0.001$).

This correlation, shown in Figure 3.2, means that candidates who tend to achieve a low score on their first attempt in the AKT also tend to achieve a low score on their first attempt in the SCA, and those who score high in one also tend to score high in the other.

Please note that Figure 3.2 shows scaled scores. To aid readers' interpretation:

i. Zero represents the pass mark.
ii. Candidates at zero have achieved the pass mark and passed.
iii. Those with a score greater than zero have exceeded the pass mark and passed.
iv. Those with a negative score have not reached the pass mark and have failed.

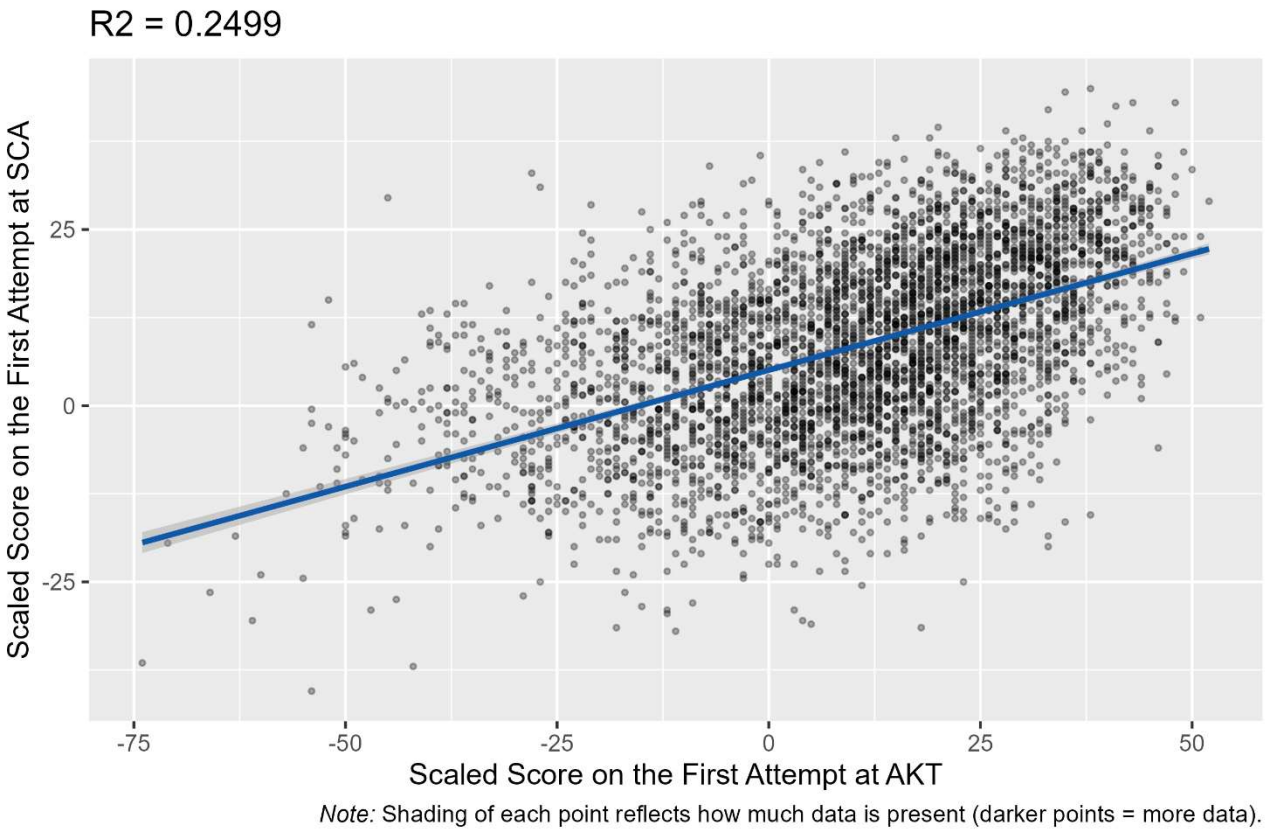


Figure 3.2: Correlation between FTTs' scaled scores on SCA and AKT

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

It is important to note both the substantial proportion of candidates who chose to declare neither their sex nor their ethnicity, as well as the uneven representation of sexes and ethnic groups within 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 graduates from UK medical schools (UKG) and graduates from non-UK, international medical schools (IMG) FTTS in the AKT and SCA.

Previously, undergraduate training status has been shown to be a strong predictor of scores and pass/fail outcomes in both the AKT and CSA/RCA/SCA. 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.

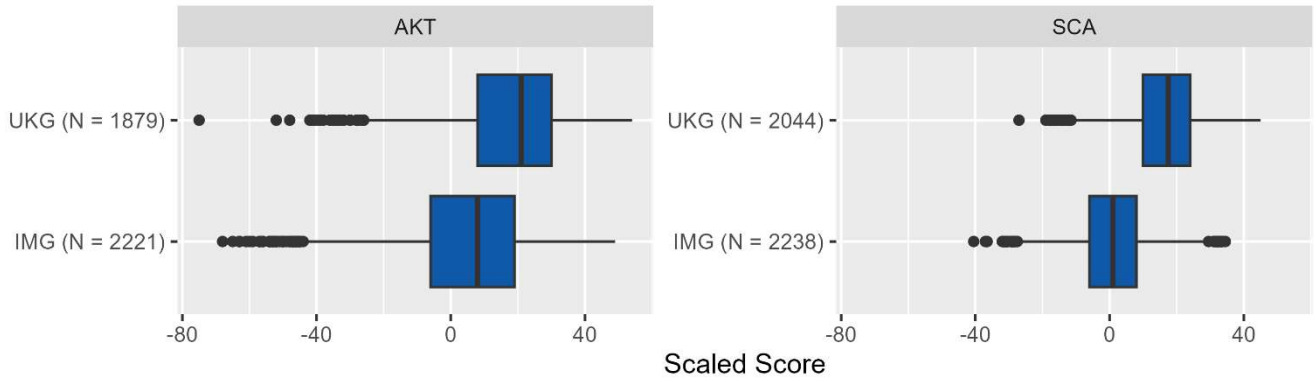


Figure 3.3: Performance of FTTs in the AKT and SCA, split by country of primary medical qualification and MRCGP module.

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

Sex

In the AKT: there were 1079 female UKGs, 704 male UKGs, and 386 UKGs who chose not to disclose their sex. The UKG group was therefore 49.75% female, 32.46% male, and 17.80% unknown (did not disclose).

In the SCA: there were 1111 female UKGs, 643 male UKGs, and 372 UKGs who chose not to disclose their sex. The UKG group was therefore 52.26% female, 30.24% male, and 17.50% 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, **49.11%** were UKGs, while **50.89%** were IMGs. This pattern is consistent among male FTT candidates, as **40.41%** were UKGs and **59.59%** were IMGs. In the SCA, **53.24%** female FTT candidates were UKGs, while **46.76%** were IMGs. **38.63%** of male FTT candidates were UKGs and **61.37%** were IMGs.

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

Exam	Sex	IMG FTTs	UKG FTTs	Total FTTs
AKT	Female	998 (50.89%)	963 (49.11%)	**1961** (100%)
	Male	910 (59.59%)	617 (40.41%)	**1527** (100%)
	Unknown	313 (51.14%)	299 (48.86%)	**612** (100%)
SCA	Female	946 (46.76%)	1077 (53.24%)	**2023** (100%)
	Male	966 (61.37%)	608 (38.63%)	**1574** (100%)
	Unknown	316 (46.95%)	357 (53.05%)	**673** (100%)

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 SCA according to sex (as above with scaled scores, a score of zero or greater is a pass, and a negative score is a fail).

UK Graduates (UKGs)

The pass rate for females sitting the AKT for the first time was **88.79%,** higher than the equivalent pass rate for males (**85.41%).**

Amongst SCA first-time takers, the female pass rate was **96.38%,** higher than the equivalent male pass rate of **90.13%.**

International Medical Graduates (IMGs)

The pass rate for females sitting the AKT for the first time was **63.73%,** lower than the equivalent pass rate for males (**66.59%**).

Amongst SCA first-time takers, the female pass rate was **62.68%**, higher than the equivalent male pass rate of **44.41%.**

It is important to note the discrepancies in the relative size of the female and male groups, and the high percentage of candidates who chose not to disclose their sex. These result in the statistics not offering a full picture of differential attainment according to sex.

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

Exam	Sex	IMG FTT pass rate	UKG FTT pass rate	Overall FTT pass rate
AKT	All FTT	64.84%	86.70%	**74.85%**
	Female	63.73%	88.79%	**76.03%**
	Male	66.59%	85.41%	**74.20%**
	Unknown	63.26%	82.61%	**72.71%**
SCA	All FTT	53.64%	93.73%	**72.81%**
	Female	62.68%	96.38%	**80.62%**
	Male	44.41%	90.13%	**62.07%**
	Unknown	54.75%	91.88%	**74.44%**

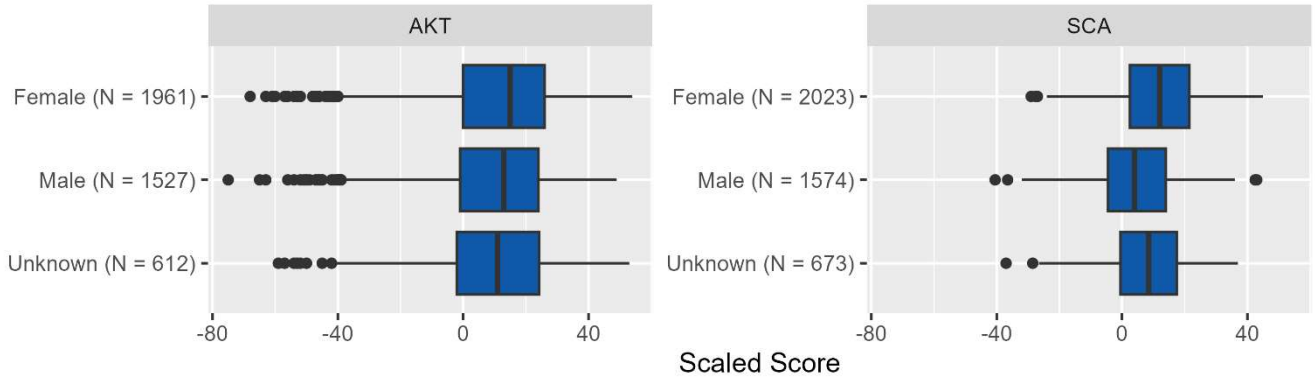


Figure 3.4: Performance of FTTs in the AKT and SCA, split by Sex and MRCGP module.

Ethnicity

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

In the AKT

There were 701 BAEM UKGs, 908 white UKGs, and 560 UKGs who chose not to disclose their ethnicity. The UKG group was therefore **32.32%** EM, **41.86%** white, and **25.82%** missing data (did not disclose).

In the SCA

There were 554 BAEM UKGs, 1029 white UKGs, and 543 UKGs who chose not to disclose their ethnicity. The UKG group was therefore **26.06%** EM, **48.40%** white, and **25.54%** missing data (did not disclose).

The remainder of this section focuses on First Time Taker (FTT) candidates only.

Table 3.3 shows the representation of UKG and IMG FTTs among BAEM candidates, white candidates, and those who chose not to declare their ethnicity:

In the AKT

26.14% of all BAEM FTT candidates were UKGs, while **73.86%** were IMGs. In the White group, **90.27%** were UKGs whereas **9.73%** were IMGs.

In the SCA

26.59% of all BAEM candidates were UKGs, while **73.41%** were IMGs. In the White group, **90.56%** were UKGs whereas **9.44%** were IMGs.

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

Exam	Ethnicity	IMG FTTs	UKG FTTs	Total FTTs
AKT	BAEM	1633 (73.86%)	578 (26.14%)	**2211** (100%)
	Unknown	498 (51.66%)	466 (48.34%)	**964** (100%)
	White	90 (9.73%)	835 (90.27%)	**925** (100%)
SCA	BAEM	1447 (73.41%)	524 (26.59%)	**1971** (100%)
	Unknown	676 (56.95%)	511 (43.05%)	**1187** (100%)
	White	105 (9.44%)	1007 (90.56%)	**1112** (100%)

Considering UKG candidates

The pass rate for BAEM candidates sitting the AKT for the first time was **81.66%,** which was lower than the pass rate for the White group (**91.62%).**

In the SCA, the BAEM candidate pass rate was **87.98%,** lower than the White group's pass rate of **97.42%.**

Considering IMG candidates

The pass rate for BAEM candidates sitting the AKT for the first time was **65.83%,** higher than the pass rate for the White group (**51.11%**).

In the SCA, the BAEM candidate pass rate was **51.49%,** lower than White group's pass rate of **68.57%.**

It is important to note the discrepancies in the relative size of the White and BAEM groups, particularly in the IMG group, and the rate at which candidates chose not to disclose their ethnicity. These missing data prevent these statistics offering a full picture of differential attainment according to ethnicity.

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

Exam	Ethnicity	IMG FTT pass rate	UKG FTT pass rate	Overall FTT pass rate
AKT	All FTT	64.84%	86.70%	74.85%
	BAEM	65.83%	81.66%	69.97%
	Unknown	64.06%	84.12%	73.76%
	White	51.11%	91.26%	87.68%
SCA	All FTT	53.64%	93.73%	72.81%
	BAEM	51.49%	87.98%	61.19%
	Unknown	55.92%	92.37%	71.61%
	White	68.57%	97.42%	94.69%

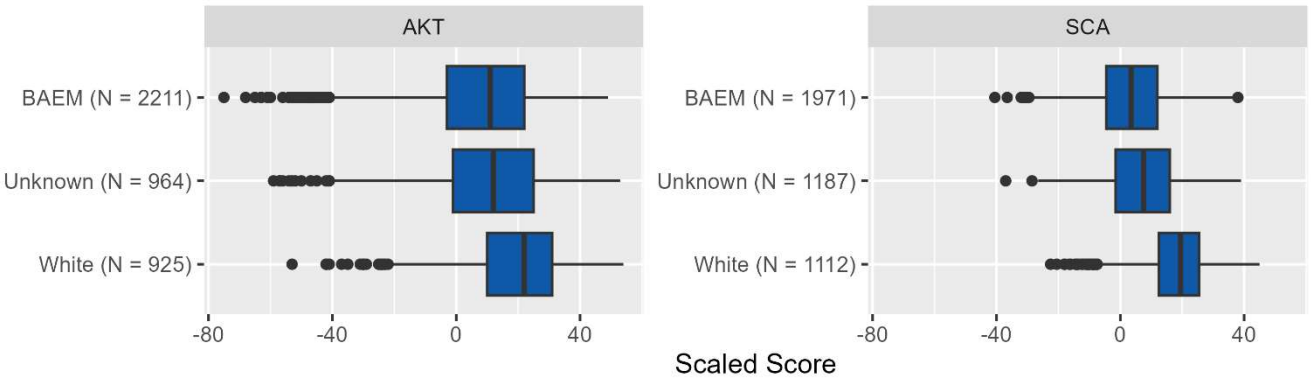


Figure 3.5: Performance of FTTs in the AKT and SCA, split by Ethnicity and MRCGP module.

4 Candidate performance: Subject area and domain performance

Performance in the AKT

Subject area scores

In the 200-item AKT paper, 160 of the items relate to clinical knowledge, 20 to research/data interpretation/evidence-based practice and 20 to organisation and management/primary care legal/ethical/administration issues. No items were redacted after sitting and prior to results for any of the three AKT examinations taken in this period. 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 Evidence-based practice questions (in terms of proportion of marks achieved) as compared to the other two domains. The median score sits on or above 75% for each domain.

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%).

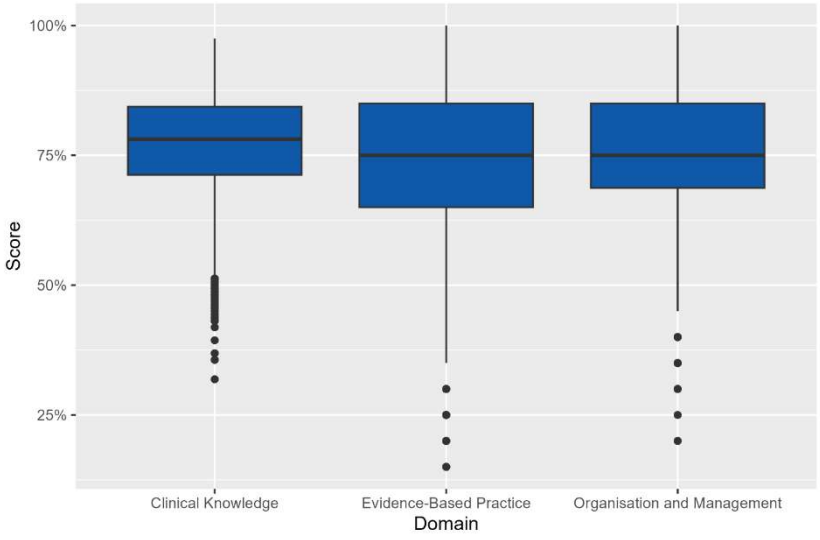


Figure 4.1: Performance of FTTs across the domains of the AKT

Insights from the item performance statistics

Candidates with less exposure at undergraduate and postgraduate training to data-interpretation and primary care administration issues can find both these AKT sections more challenging. This also applies to candidates lacking specific primary care clinical experience, for example with children and young people, or maternity and reproductive health.

Topics causing most difficulty for candidates in recent AKT examinations:

Neurology: Interpretation of **symptoms and signs, including acute presentations**

Evidence in practice, research, teaching, and lifelong learning: Data interpretation and common study design terminology

Continuity and quality of care, safety and prescribing: Prescribing in older adults, interpretation of results, drug monitoring

Leadership, management and administration: Access to medical records

Children and young people: Diagnosis and management of common urological conditions

People with long-term conditions, including cancer: Management of common long-term conditions

Dermatology: Management of common conditions

Eyes and vision: Eye signs

Gastroenterology: Colorectal and perianal conditions

Gynaecology and breast: Hormone replacement therapy

Infectious disease and travel health: Diagnostic investigations for infectious diseases

Maternity and reproductive health: Early pregnancy complications

Musculoskeletal health: Very broad - including diagnosis, investigation and management of common and long-term MSK conditions

Respiratory health: Paediatric and adult asthma management

Performance in the SCA

Domain-based scores

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

- Data-gathering and diagnosis
- Clinical Management and Medical Complexity
- Relating to Others

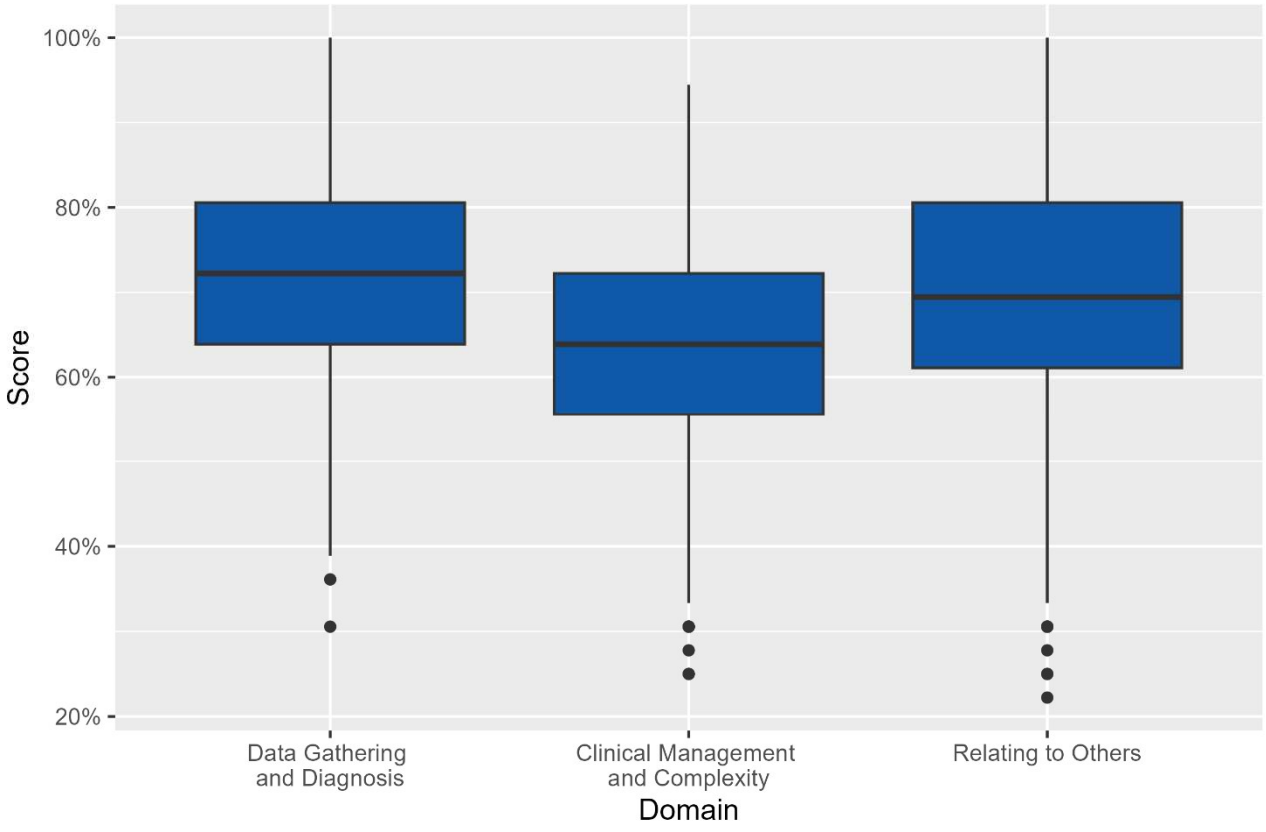


Figure 4.2: Performance of FTTs across the domains of the SCA

Figure 4.2 shows that candidates overall tend to score fewer marks for Clinical Management and Medical Complexity (weighted domain) than they achieve for Data Gathering and Diagnosis and Relating to Others.

Feedback provided by the examiners in the SCA

Table 4.1 shows the percentage of candidates receiving each of the 26 feedback statements used by SCA examiners (ordered by frequency), and for candidates that received each statement, the mean number of times the statement was applied to a candidate.

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

Feedback Statement – Data Gathering and Diagnosis	Percent	Mean
Data gathering was insufficient to enable safe assessment of the condition/situation	57.09	1.77
Existing information about the case was insufficiently utilised	27.01	1.23
Relevant psychological or social information insufficiently recognised or responded to	47.84	1.58
Data gathering was unsystematic and/or disorganised	28.27	1.40
Ineffective approach or prioritisation in data gathering, when presented with multiple or complex problems	8.01	1.05
The implications of relevant findings identified during the data gathering were insufficiently recognised or understood	32.59	1.28
Differential diagnoses or hypotheses were inadequately generated or tested	38.83	1.37
Decision-making or diagnosis was illogical, incorrect or incomplete	31.02	1.24
Feedback Statement – Clinical Management and Medical Complexity	**Percent**	**Mean**
The management plan relating to referral was inappropriate or not reflective of current practice	55.97	1.62
The management plan relating to prescribing of medication was inappropriate or not reflective of current practice	72.95	1.98
The management plan relating to investigations was inappropriate or not reflective of current practice	52.67	1.57
The management plan relating to prevention, health promotion or rehabilitation was inadequate or inappropriate	54.75	1.64
The plan relating to the medical management of risk was inadequate or inappropriate	59.44	1.67
The implications of co-morbidity were insufficiently considered	12.64	1.08
Uncertainty, including that experienced by the patient, was managed ineffectively	52.87	1.69
Inappropriate or inadequate arrangements for follow-up, continuity, and/or safety netting	53.53	1.63
Time management in the consultation was ineffective	39.56	1.48
Feedback Statement – Relating to Others	**Percent**	**Mean**
Communication skills, including non-verbal, responding to cues and active listening were insufficiently demonstrated	49.06	2.01
The person's agenda, health beliefs and/or preferences were insufficiently explored	56.20	1.83
The circumstances, relevant cultural differences and/or preferences of those involved were insufficiently responded to	34.63	1.37
Explanations were inadequately shared or adapted for the person's needs	55.71	2.22
A judgemental approach was shown to the person	7.07	1.07
Respect and/or sensitivity shown to the person was inadequate or inappropriate	25.89	1.29
Ownership or responsibility for decision-making was inadequate or inappropriate	40.11	1.40
Teamwork and/or understanding of others' roles was insufficiently recognised or responded to	8.15	1.07
Safeguarding concerns were inadequately recognised or responded to	13.07	1.05

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 Difficulty (SpLD) is the legally defined disability most frequently reported. We acknowledge that the term SpLD should be considered as a Specific Learning Difference. 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.

Statistics and figures in this chapter focus only on first-time test-takers (FTTTs).

AKT

In the category 'all disabilities', there were 444 candidate-attempts at the AKT in the academic year 2024-2025, representing **10.83%** of all attempts. Of these 444 attempts, 309 (**69.59%**) were successful. In the category 'SpLD,' there were 339 candidate-attempts at the AKT, representing **8.27%** of all attempts this academic year. Of these 339 attempts, 236 (**69.62%**) were successful.

It should be noted that candidates with SpLD and another disability who selected 'more than one disability' are not included in the SpLD group. Furthermore, the raw data above does not include confounding factors such as age, gender, ethnicity or place of primary medical qualifications.

Figure 5.1 shows the 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 appear to be performing at a similar level to 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.

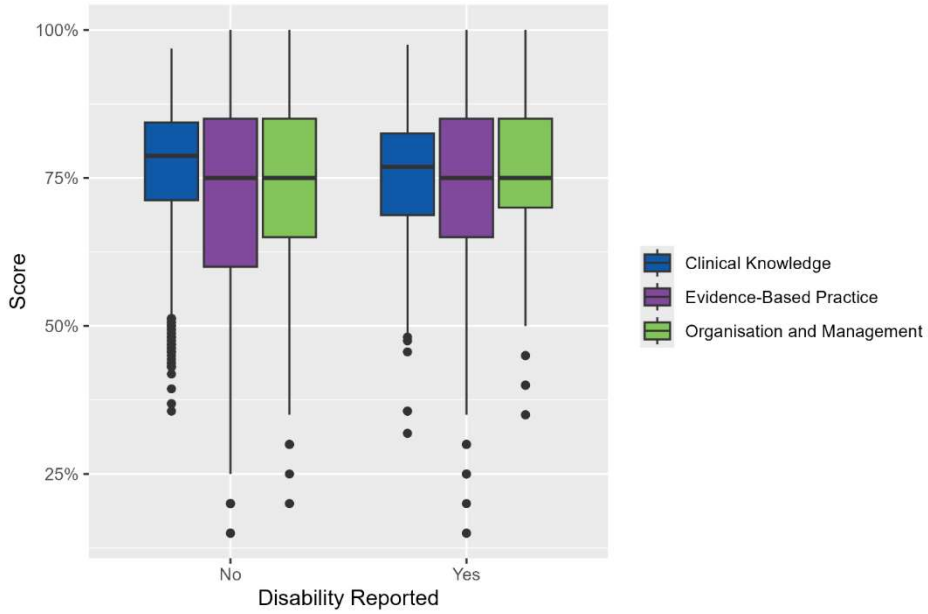


Figure 5.1: Performance (% score) of FTTs in the three AKT domains split by Disability status

SCA

For the SCA, in the category 'all disabilities' there were 568 candidate-attempts in the academic year 2024-2025, representing **13.02%** of all attempts. Of these 568 attempts, 364 (**64.08%**) were successful. In the category 'SpLD,' there were 444 candidate-attempts at the SCA, representing **10.17%** of all attempts this academic year. Of these 444 attempts, 282 (**63.51%**) were successful.

Figure 5.2 shows the scores of FTTTs in the SCA with and without declared disabilities. It is encouraging to see that the range of scores in each domain is overlapping for these two groups, albeit the comparison must be considered in the context of uneven sample sizes. There were many more candidates without a declared disability than with a disclosed disability.

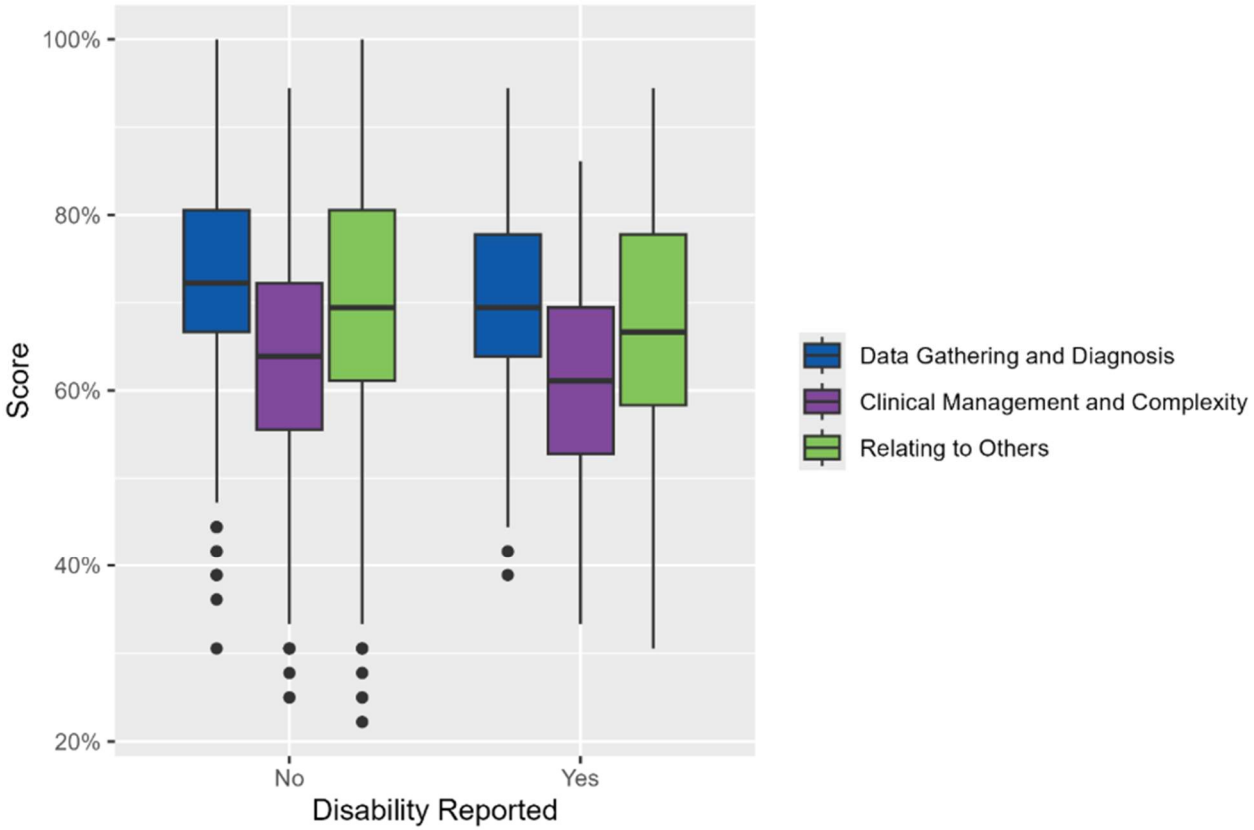


Figure 5.2: Performance of FTTs in the three SCA domains (% score) split by Disability status.

6 Update from the Workplace Based Assessments

Summary

Workplace Based Assessment (WPBA) is one of the three assessment modules that comprise the MRCGP examination. WPBA evaluates progress in those areas of professional practice and behaviours best tested in the workplace and that are less appropriate to assess in the Applied Knowledge Test (AKT) and Simulated Consultation Assessment (SCA).

WPBA assesses performance in day-to-day practice to provide evidence for learning and reflection based on real experiences. It supports and drives learning in important areas of capability with the underlying theme of patient safety and provides constructive feedback on areas of strength and developmental needs.

Evidence of WPBA, as approved by the GMC, includes:

- the completion of specific assessments and reports
- the documentation of naturally occurring evidence
- certain mandatory requirements such as Safeguarding and CPR/AED.

Research

Research/evaluation undertaken in WPBA can be found here. https://www.rcgp.org.uk/mrcgp-exams/wpba. Two new papers on WPBA were published this year and one previous publication received a commendation. Details are included in the Research section of this report.

Clinical Examination and Procedural Skills (CEPS)

Seven “system” GP focused observed CEPS categories were included in the Clinical Examination and Procedural Skills section of the Portfolio in 2023 (Respiratory system, Ear Nose and Throat, Abdominal system, Cardiovascular system, Musculoskeletal system, Neurological examination, Child 1- 5 years).

In 2024, we monitored the extent to which GP registrars were completing CEPS by reviewing how many of these 'system' CEPS they had completed at the time of finishing their training. We repeated this exercise in 2025, and the table below shows the results:

Number of "System" CEPS completed	% of July & August 2024 OC6s with this number of system CEPS	% of June and July 2025 OC6s with this number of system CEPS
0	7.72%	**0.50%**
1	4.63%	**1.43%**
2	7.02%	**3.24%**
3	16.99%	**8.90%**
4	12.78%	**11.14%**
5	11.38%	**12.63%**
6	11.10%	**15.31%**
7	28.37%	**46.86%**
Total OC6s	**712**	**1608**

GP Curriculum

Revised "Progression Point Descriptors" [PDF download] were included directly in the new Curriculum. This included unified progression point descriptors for ST1/2, rather than individual capability progression point descriptors for the end of ST1 and ST2. We undertook a consultation on this change, the results of which demonstrated that a majority of GP registrars and trainers felt that moving to single ST1/2 progression point descriptors would be a positive change.

The Clinical Experience Groups (CEGs) were reviewed with stakeholders, and it was felt that they were still current and applicable with the exception of the UUSC Urgent Unscheduled Care CEG to which Out of Hours has been added to encourage its completion.

A revised assessment blueprint was produced, setting out where each capability and learning outcome might be assessed across each element of the MRCGP (including at an individual WPBA level).

Generative AI and WPBA

Following the publication of the RCGP statement on the use of artificial intelligence (AI) in postgraduate training, examinations and registration in 2024, the RCGP - working with a wide range of stakeholders - produced further guidance covering Generative Artificial Intelligence in GP Training and Workplace Based Assessment: Guidance for GP registrars and GP Educators that builds on the previous statement.

WPBA Website updates

We have extensively updated the guidance and resources available on the RCGP website for WPBA and made the section easier to navigate and more user friendly. Changes throughout the year include:

- CEPS – new video added and content refreshed
- CbD – page rewritten with updated question generator and attribution
- COT, Mini-CEX and Audio-COT – content updated
- MSF and Leadership MSF – revised guidance published
- Learning Log – content streamlined and updated
- Prescribing Assessment – updated
- CATs – refreshed content and guidance
- WPBA homepage – refreshed with glossary and new research section
- Capability Framework / IPUs – updated
- Who can assess WPBAs – new page created and outdated PDFs removed

Care Assessment Tool (CAT) Options

We expanded the number of CAT formats available from 1 August 2024. The data below covers 1 August 2024 to 31 July 2025. Following the positive feedback we received, this review of the first years' worth of data shows that the full range of CATS are being completed including the new types in considerable numbers. 28.7 % of all CATs completed are CATS rather than CbDs and 15% of all CATS completed were of the new types.

Overview

- Total CAT entries: 28,944
- GP registrars who have completed at least one non-CBD CAT: 4,186
- Percentage completing a non-CBD CAT: 55.3%

Type of CAT	Count
Case based Discussion	20,364
Random case review	3,190
Duty/Triage Doctor Session	1,103
Routine/non-duty session	987
Referrals review	937
Laboratory and radiology results review	885
Post prescribing assessment follow up review	348
Document Management	324
Electronic/Digital/Online Consultations review	180
Other	248

ESR "Grading"

The 'descriptors' that support Educational Supervisors in grading the ESR were streamlined and clarified in July 2025. The descriptors can be found here

Assessment Statistics (1 August 2024 - 31 July 2025)

Assessment	Total completed
Prescribing Assessments	4322
CEPS Assessment	80501
CEPS Reflections	4824
LEA	18588
COT	52974
Audio COTs	10552
ESR total	25731
QIA	12560
QIP	4543

Clinical Case Reviews (CCRs)

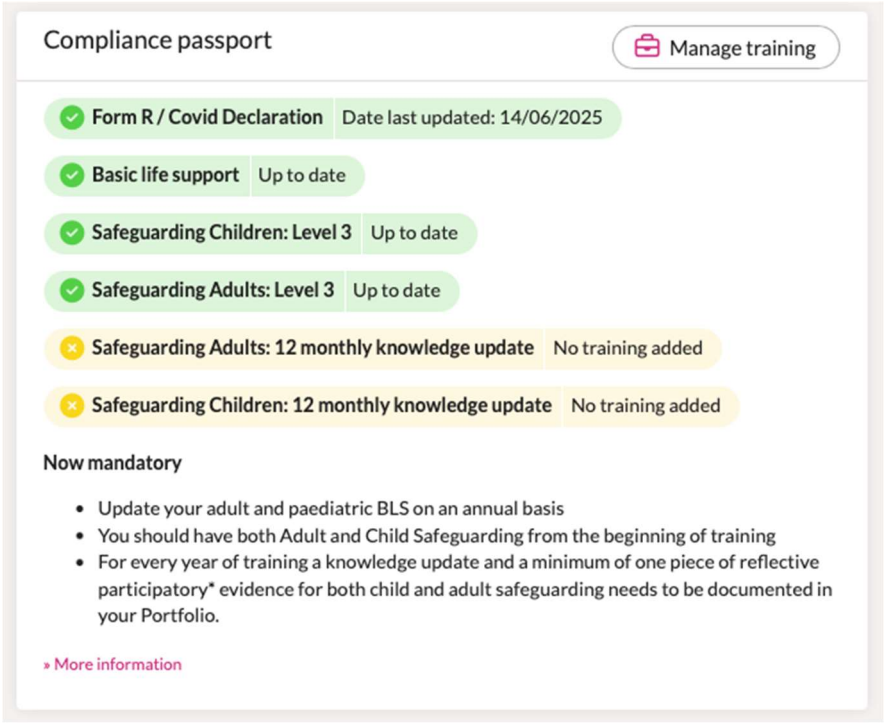
We investigated a potential issue whereby Clinical Case Reviews (CCRs) were being completed inappropriately. This included CCRs based on topics such as return to work, IT system failures, tutorials. The key central requirement for CCRs is that they "must be about real patients that the GP registrar has personally seen and should be about a clinical learning experience." As a result, we revised the guidance on the RCGP website, and on the Trainee Portfolio to make the requirements for CCRs clearer, and to signpost other learning log types that could be used to record useful learning that did not meet the requirements for CCRs. We will continue to monitor this area in future years.

RCGP Annual Conference

WPBA Core Group both ran a session on AI and presented a poster “Avoiding missing evidence leading to an adverse outcome at GP Trainee Annual Review of Competency Progression (ARCP) Panel” at the RCGP Annual Conference 2024.

Safeguarding Knowledge Updates improvements

The “Compliance Passport” in the Trainee Portfolio has also been improved to add the “12 monthly knowledge updates” for Adult and Child Safeguarding. There are no changes to the requirements – this update just aims to make it easier to keep track of this information. A screenshot of how these now appear in the Compliance Passport is below:



There was broad support for this change from both GP registrars and GP Educators. Over time, we hope this change will mean that the evidence is more easily signposted for GP registrars, GP Educators and ARCP Panels. New Safeguarding knowledge updates should be added or linked to the new knowledge update areas. Existing knowledge updates can be linked and added to the new areas (if the GP registrar wishes to) and the date of training changed to the date the update occurred. For some GP registrars, this change will have been implemented part way through their training year. As such, we advised that ARCP Panels should continue to check through the Portfolio in the event that the compliance passport does not immediately show that evidence has been provided against these requirements.

Learning resources

AKT guidance, including new **Top Tips** sections, and video recordings with GP registrars successfully resitting the AKT can be found at: www.rcgp.org.uk/mrcgp-exams/applied-knowledge-test

SCA guidance can be found at: www.rcgp.org.uk/mrcgp-exams/simulated-consultation-assessment/preparing

WPBA guidance can be found at: www.rcgp.org.uk/mrcgp-exams/wpba

Differential attainment and differential performance

Differential attainment is the systematic difference in examination outcome between different groups of students depending on their protected characteristics and socioeconomic background (i.e., pass-fail outcomes).

Differential performance is the systematic difference in the number of marks achieved in an examination between different groups of students depending on their protected characteristics and socioeconomic background (i.e., marks scored).

Differential attainment and differential performance cannot be attributed to a single identifiable cause but are the result of multifactorial influences that occur across many professions at undergraduate and postgraduate levels.

The RCGP analyses both the differential attainment and differential performance of candidates on their first attempts by PMQ, gender, and – for UK graduates only – binary ethnicity (Black, Asian and Ethnic Minorities or White).

Readers are invited to note confounding influences within the data that are outside the RCGP's control. These include the interface between candidates' self-identified ethnicity, gender, and other characteristics. For example, IMGs sitting the MRCGP are more likely to self-identify as being from Black, Asian and Ethnic Minority candidate groups and less likely to self-identify as female. Also, the place of primary medical qualification (PMQ) is not synonymous with nationality; UK nationals choosing to study medicine overseas are included in the IMG group.

We have also already outlined in this Annual Report the large proportion of candidates who exercise their right not to declare their self-identified gender and/or ethnicity.

The role of the RCGP

As the MRCGP is the UK's licensing assessment for general practice, the RCGP is a critical stakeholder in the national healthcare system, safeguarding the standards for GP training, assessment and ongoing clinical practice. The MRCGP's summative examinations—which GP registrars must pass before receiving a licence to practise from the GMC—provide a window into patterns of differential attainment and differential performance that are known to exist across medical education and other high-stakes specialty examinations. These issues remain a longstanding concern for the RCGP and all Medical Royal Colleges, and have been documented extensively in GMC reports.

The RCGP has always been, and remains, very transparent through the publication of our examination data and our work with other stakeholders to try to improve and reduce differential attainment and differential performance. We fully support the work being undertaken by the GMC and the Academy of Medical Royal Colleges (AoMRC) and contributed comprehensively to the “Bridging the Gap” initiative in 2021.

We fully acknowledge the critical role IMGs play in the NHS, and how important they will be to ongoing patient care in the future. We share the MRCGP data as part of our commitment to jointly tackling with the training community, regulators and others, the complex multiplicity of factors which contribute to these disparities.

Dr U.A Tanvir Alam’s article in the Health Leaders Journal highlights initiatives which educators could focus on moving forwards to help mitigate the risk of differential achievement and differential performance. These include enhanced induction programs, proactive examination training and preparatory courses and masterclasses, and increasing earlier access to neurodiversity screening.

The RCGP continues to recognise its key role in ensuring the MRCGP examination is fair and remains accessible to all GP registrars in training. In tackling these issues, the College wishes to draw particular attention to the below.

Actions already taken by the RCGP with respect to differential attainment continue to be broad and deep. 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 GP registrars in their AKT and SCA preparation. MRCGP examiners regularly support the RCGP Faculty and Deanery examination preparation courses across the UK.
- Reviewing and developing how the use of AI may support candidates to prepare for both the AKT and the SCA.
- Performing regular stakeholder engagement, with particular interest to the development of the SCA in 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 difficulties. This includes work undertaken on the website to provide clear and unambiguous deadlines and information.

- Open and fully anonymised recruitment of MRCGP examiners. Upwards of one hundred new examiners were recruited in 2024, from over 850 high quality applications.
- Recruitment of MRCGP lay advisors, to reflect the interests of specific demographic groups. Lay advisors are routinely involved in the development and maintenance of all modules, as well as specific projects such as those consulting with relevant stakeholders.
- 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 (EDI) monitoring to ensure that candidate data is 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 SCA candidates).
- Resources to support candidates to have failed examinations (e.g., ongoing work on guidance on reflection after an unsuccessful examination sitting, and tips for enhancing success). The RCGP website contains the latest information on such documentation.
- Conducting equality impact assessments and piloting of any proposed new assessments (e.g., piloting for the prescribing assessment in WPBA, the piloting and development of the SCA) 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 case performance in the SCA and ensuring item/case construction is designed to reduce potential differential attainment where feasible.
- Conducting Fairness Reviews. These consider how to enhance and improve items in the AKT by making best use of language, checking item performance within demographic cohorts and reviewing validity of data. Details of the Fairness Reviews held in both 2023 and 2024 can be found here. www.rcgp.org.uk/mrcgp-exams/applied- knowledge-test/further-help-support

A collaborative approach across the whole educational community will continue to be required to affect further positive change in differential attainment and differential performance. The RCGP remains committed to delivering fit-for-purpose examinations which are fair for all

candidates. Reducing differential attainment and differential performance within the MRCGP remains a high priority.

This Annual Report is a one-off annual document covering the previous year, and therefore readers should direct themselves to the RCGP website for the very latest 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

Summary of recent RCGP related research

Papers and reports published the past year related to the MRCGP have focused on factors related to passing the MRCGP or addressed performance problems more generally.

Research papers

Two new papers on WPBA were published this year and one previous publication received a commendation.

Highly Commended by the Royal College of General Practitioners (RCGP) Research Paper of the Year 2025 award: Category 3: Medical Education – with relevance to primary care

Siriwardena, AN, Phung VH, Emerson K, Anstey T. *Perceptions and experiences of trainers and trainees of UK workplace-based assessment for general practice licensing: a mixed methods survey.* Education for Primary Care 2024; 35 (5): 147–159. DOI: 10.1080/14739879.2024.2379525.
https://www.tandfonline.com/doi/full/10.1080/14739879.2024.2379525

What this study tells us:

- The study aimed to investigate GP registrar's and trainers' perceptions and experiences of WPBA regarding validity and fairness.
- A national online survey was conducted with a convenience sample of GP registrars and trainers, on their perceptions and experiences of WPBA, with 2,088 responses from 1,176 GP registrars and 912 trainers.
- Both groups were generally positive towards WPBA, with trainers more positive or similar to GP registrars towards individual assessments. GP registrars were significantly less positive than trainers while IMGs were significantly more positive than UK graduates towards WPBA. Qualitative analysis revealed varying concerns about validity and relevance, assessment burden, potential for bias, fairness to protected characteristics groups, gaps in assessment, and perceptions of individual assessments.

What does this mean:

- Trainers' greater positivity towards elements of WPBA accords with their role as assessors. Despite concerns about bias, IMGs from outside the EEA were significantly more positive towards WPBA.

Pattinson, J, Akanuwe, JNA, Emerson, K, Siriwardena, AN. *Exploring the perceptions of doctors with specific learning differences undertaking assessments for UK general practice licencing: a qualitative study.* Education for Primary Care 2025; 36 (3): 94-105. DOI: 10.1080/14739879.2025.2473396.
https://www.tandfonline.com/doi/full/10.1080/14739879.2025.2473396?src=exp-la#abstract

What this study tells us:

- This study aimed to explore perceptions of General Practice Speciality Trainees (GPSTs) with SpLDs on the challenges of UK licencing examinations and workplace-based assessment, and strategies for overcoming these.
- It used a qualitative design employing Systematic Grounded Theory with inductive methods to inform theory development. Individual semi-structured interviews were conducted, transcribed and analysed using three steps of open, axial and selective coding. It recruited from UK general practice training schemes with purposive sampling to include participants of different sex, stage of training and UK or overseas primary medical qualifications.
- It identified four core themes from the analysis: 1) Importance of early detection, screening and referral; 2) Understanding the intersection of SpLDs, culture and language; 3) Educational and organisational approaches to GP trainees with SpLDs; and 4) Addressing emotional and wellbeing impacts.

What does this mean:

- This study has identified tailored strategies to support learning and assessment for GPSTs with a SpLD, which could improve learning experiences, wellbeing and outcomes.

Pattinson, J, Akanuwe, JNA, Sonmez Efe, S, Emerson, K, Sales, B, Merali, S, Wright, A, Khan, A, Siriwardena, AN. *Experiences of UK general practice trainees undertaking workplace-based assessment who received a developmental outcome at their annual review of competency progression.* Education for Primary Care 2025; 36 (5): 226-237. DOI: 10.1080/14739879.2025.2539735.
https://www.tandfonline.com/doi/full/10.1080/14739879.2025.2539735?src=exp-la

What this study tells us:

- The study aimed to explore GP registrars' experiences of undertaking WPBA when failing to progress by receiving a 'developmental' outcome 2 or 3 at ARCP.
- The study used a qualitative design employing Systematic Grounded Theory and semi-structured interviews. A purposive sample of 20 GP trainees was recruited, at different stages of training and with varying demographic characteristics, who had a previous ARCP developmental outcome. Interviews were recorded, transcribed verbatim and analysed and facilitated by NVivo 14.
- The study identified five themes:
    - *potential for early intervention*, including personalised support and better information provision.
    - *perceptions of how WPBA reflected trainee performance* including perceptions of the validity and reliability of WPBA and the need for fair, trustworthy and transparent processes to reduce unfair discrimination.
    - *communication difficulties* arose in relation to culture, language and reflection for some study participants.
    - *relationships with peers and educational setting* were felt to affect performance.
    - some participants experienced negative *effects on wellbeing*.

What does this mean:

- The study in conclusion made suggestions aimed at supporting and overcoming potential challenges to undertaking WPBA during GP training, including personalised support, reviewing fairness of assessments, addressing communication and cultural barriers, enhancing training environments, fostering positive relationships, and mitigating negative wellbeing impacts, some of which were already in place, with others requiring development.

Appendix A

Place of training: Deanery

The table below 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.

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

Deanery	AKT	SCA
Armed Forces	21	28
East Midlands	414	443
East of England	577	508
Kent, Surrey, Sussex	364	300
London	558	560
North West	663	624
Northern	264	275
Northern Ireland	121	128
Oxford	167	147
Scotland	399	332
South West: Severn	227	210
South West: Peninsula	147	133
Wales	215	199
Wessex	179	194
West Midlands	519	508
Yorkshire & Humber	527	505

*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