

MRCGP Annual Report

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Introduction

This report relates to the formal MRCGP assessments conducted in the academic year 2019-20. It presents key data summarising the candidature, quality indicators and outcomes of all the diets of the MRCGP examinations during that period — four diets of the Applied Knowledge Test (AKT) and four diets of the Clinical Skills Assessment (CSA). In addition, it presents a summary of the development work taking place across the AKT, CSA and the Workplace-Based Assessments (WPBA). Delivery of the CSA was interrupted by the COVID-19 pandemic and an alternative replacement was introduced as a temporary equivalent – the Recorded Consultation Assessment (RCA). It is described later in this Report and its outcomes are summarised separately from those of the CSA. The aim throughout this report is to provide insight to educators and prospective candidates about developments in the RCGP examinations, and give information that might assist in MRCGP preparation.

The impact of the COVID-19 pandemic, an unprecedented event in our lifetime, has brought significant challenges to the whole of general practice, including clinical work, training, and examinations. The College knows that the exam cancellations, postponements, and the changes needed for the exams have been a stressful time for candidates.

The February AKT exam had fortunately concluded before the onset of national lockdown in March 2020 but the April AKT exam had to be cancelled. Contingency exams were subsequently safely held in both July and August 2020. The March CSA exams were suspended part way through due to lockdown, and the RCGP had to rapidly adapt to ensure that trainees were provided with an alternative to the CSA in order to achieve a Certificate of Completion of Training by the end of summer 2020. At the same time, the RCGP had a duty to protect patients with an equally robust and rigorous licensing assessment to maintain the high standards of general practice in the UK.

Thanks to the extra commitment of all those involved, candidates due to sit their consulting and clinical skills assessment in the remainder of March, April and May, were given the opportunity to sit this component in July and August 2020. This report therefore covers that period until the beginning of September 2020. The COVID-19 pandemic remains a rapidly changing situation, and the substantially increased workload for all concerned within the exams department of the College has meant that there was a necessary delay in the publication of this MRCGP annual report.

The Examinations team have continued to work hard to make the necessary changes required by the GMC for the licensing exam, while ensuring its reliability and validity. Changes made subsequent to September 2020 will be reported on in the following year's MRCGP annual report.

We have continued working with our psychometric experts 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 essentially formative, with candidate performance, development and capability being reviewed regularly by the Deaneries/LETBs, a process quality assured by the College. Some of this report relates to WPBA as part of the MRCGP assessment programme, and explains some of the future changes planned for the WPBA.

For presentation purposes, 'stage of training' is reported as 'year' of training, since for most trainees, the two are synonymous. For less-than-full-time trainees, 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'.

Pass rates by medical school and deanery have been removed to reduce the risk of unconscious bias. Currently we report on UK Graduate (UKG)/International Medical Graduate (IMG), Black and Minority Ethnic (BME)¹/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 (are IMG candidates) compared to White candidates, comparisons based solely on ethnicity would be inappropriate.

¹ 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 many prefer the term "ethnic minorities". For the time being we are using "BME" as this aligns with the terminology used by the GMC in their reports, and fully accept that ethnic minorities also include White minorities.

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. A large proportion (17.78%) of unique candidates who sat an examination this year chose not to declare one of either their sex or ethnicity, and 12.93% chose to omit both sex and ethnicity, leading to high rates of missing data. We have done our best in this report to represent the candidates who did not declare these characteristics, to help readers apply suitable caution in interpreting the graphs.

More exams data are available on the General Medical Council (GMC) website, including data on differential attainment.

1 The MRCGP exam

The MRCGP comprises three sets of assessment procedures whose combined summative function is to assure the Deaneries/LETBs, the College and the GMC of the competence of exiting trainee General Practitioners (GPs) across a broad and carefully defined three-year (occasionally, four) full-time training curriculum. Satisfactory completion of the three assessment components of the MRCGP means that GP trainees (also called GP Specialist Registrars) are eligible to apply for a Certificate of Completion of Training (CCT) from the General Medical Council (GMC) and for Membership of the Royal College of General Practitioners (MRCGP). The MRCGP's three assessment components are the following, each of which must be completed to an agreed standard:

- a. Applied Knowledge Test (multiple choice computer-based assessment, available in test centres throughout the UK)
- b. Clinical Skills Assessment (an integrated test of clinical and consulting skills, held at the RCGP assessment centre, London)
- c. Workplace based Assessments 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 the four Home Nations. Entry to the assessments is only available to doctors undergoing GP training within the UK state health care system or within six

months thereafter. Other than MoD Trainees based in UK armed forces 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/evidence-based practice (10%) and primary care legal/ethical/administration issues (10%) relevant to UK general practice using single best answer, extended matching, as well as a small number of multiple best answer and free text question formats. The AKT is typically scored out of 200 marks with each correct answer awarded one mark without differential weighting.

Clinical Skills Assessment (CSA)

The CSA is an integrated test of clinical and consulting skills which seeks ‘to test a doctor’s ability to gather information and apply learned understanding of disease processes and person-centred care appropriately in a standardised context, make evidence-based decisions, and communicate effectively with patients and colleagues’ while also examining ‘candidates’ ability to integrate these skills effectively’.

The CSA consists of 13 ten-minute cases, involving trained role-players who simulate real-life consultations, written by practising GPs and reflecting the breadth of the curriculum for general practitioner (GP) training. Candidates are assessed in each case by a trained GP examiner (who accompanies two different role-players over the day) against the standard of being ‘fit for independent practice as a GP in the UK’, using case-specific marking schedules for three domains of data gathering, technical and assessment skills; clinical management; and interpersonal skills.

Most GP specialist trainees sit the CSA towards the end of their three-year vocational GP training programme. Many trainees were due to take their CSA in April/May 2020 in advance of completing their training by August 2020, receiving a Certificate of Completion of Training (CCT), and entering the qualified GP workforce.

Unfortunately the delivery of the MRCGP CSA was interrupted at the end of 20th March 2020 because of the need to protect candidates, role-players, examiners and the RCGP exams team as the COVID-19 pandemic worsened.

This prevented significant numbers of trainees from taking the CSA and receiving their CCTs. The urgent need for a replacement assessment was evident and heightened by workforce needs, as well as those of the candidates.

Recorded Consultation Assessment (RCA)

Following urgent discussions between the RCGP, major NHS stakeholders and the General Medical Council (GMC) as the statutory licensing authority, it was agreed that a temporary replacement for the CSA should be developed by the RCGP (with financial support from other NHS stakeholders) as quickly as possible.

Commencing on 5th May 2020, a specially convened MRCGP Core Group, led by Professor Adrian Freeman, was convened and tasked with the development of a new emergency assessment. The group incorporated educational, technical, assessment and psychometric expertise. The assessment was named the RCA. The group developed all the necessary materials for the new examination, and the details and technology required for its delivery. The RCA was planned to run for the first time in July 2020, if approved by the GMC. Approval for the RCA was granted, and the examination could therefore provide a route for those unable to sit the CSA to enter independent practice in August 2020, if successful in the RCA.

The assessment was to involve each candidate providing 13 recorded examples (to align it to the CSA) of actual patient consultations which would then be evaluated by Examiners and marked in a parallel fashion to CSA consultations. The necessary IT platform was custom-designed by FourteenFish, such that all recordings could be assessed by College Examiners via candidates' Portfolios.

Candidates could choose to submit each consultation as either a video or audio recording. As the submitted RCA consultations would be selected by the candidates and thus unstandardised (unlike the standardised cases undertaken by candidates in the CSA), psychometric advice recommended that each submitted consultation should be marked by two examiners isolated from each other (double marked). Hence, with 13 consultations in each candidate's submission, each candidate was assessed by 26 separate examiners.

To confirm proof of principle, a small delivery pilot was held in June 2020. It involved 13 volunteer candidates. Each produced 13 consultation recordings which were marked by two sets of 13 examiners.

The RCA then ran successfully in July and August 2020, with 1551 candidates making a total of 1574 attempts.

Of the 1551 candidates who sat the RCA for the first time this academic year, 382 had already sat and failed the CSA at least once. The number of first time takers in the RCA can therefore be described in two ways, those who were sitting the RCA for the first time (N=1551) and those

who were sitting the RCA for the first time *and* that was their first sitting of any MRCGP clinical assessment (N=1169). This distinction is made throughout this document when referring to RCA analyses.

This report presents RCA results separately from CSA results as these are two different forms of assessment.

Workplace Based Assessment (WPBA)

WPBA evaluates the trainee's progress in areas of professional practice best tested in the workplace, which includes the completion of specific assessments and reports, the documentation of naturally occurring evidence as well as certain mandatory requirements such as Child safeguarding and Basic Life Support in order to: - examine 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 that are difficult to assess in the Applied Knowledge Test and Clinical Skills Assessment; - determine fitness to progress towards completion of training.

2 Who are our candidates?

Demographic characteristics

AKT and CSA

Those sitting the AKT and/or CSA were all UK-based GP trainees, who obtained their primary medical qualification from 83 different countries. The map in Figure 2.1 shows the country of primary medical qualification for all candidates sitting the AKT and/or CSA in the academic year 2019-20. The number of unique candidates from each country is represented by the size of the bubble around the capital city. The number of candidates from each region of the world is presented in Table 2.1.

During this academic year 1957 candidates made a total of 2101 attempts at the CSA and 3647 candidates made a total of 4335 attempts at the AKT.

Of the 5276 unique candidates who sat examinations in this period, there were 3472 (65.81%) UK graduates (UKGs) and 1804 (34.19%) international graduates (IMGs).

The number of unique candidates this academic year has decreased by 750 compared to the last academic year. In the last academic year there were 4434 (73.58%) UKGs and 1592 (26.42%) IMGs.

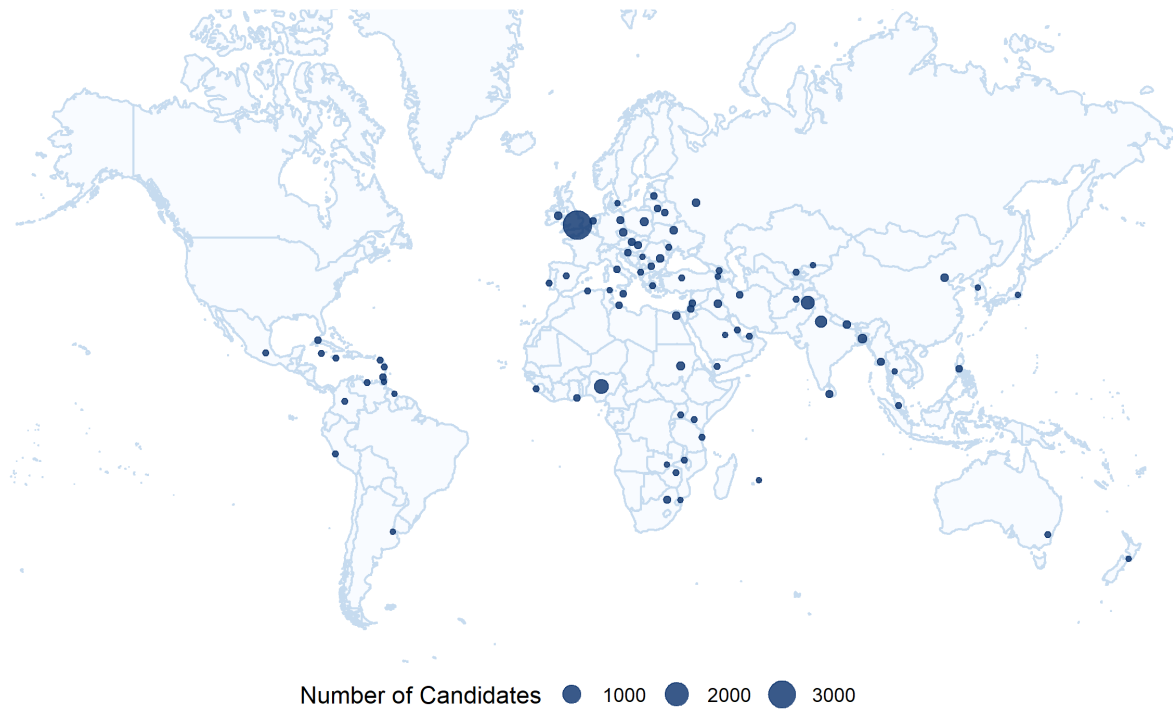


Figure 2.1: Country from which primary medical qualification was obtained for all those attempting the AKT and/or CSA in the academic year 2019-20

Table 2.1: Number of unique candidates attempting the AKT and/or CSA this academic year from each region of the world

Continent	Number of unique candidates this year
Africa	585
Asia	826
Australia	5
Central America	2
Europe	3818
North America	32
South America	8

Considering all unique candidates sitting the AKT and/or CSA, there were 2853 (54.08%) female candidates; 1736 (32.9%) male candidates; and 687 (13.02%) candidates who did not declare their gender. Considering ethnicity, 2114 (40.07%) candidates declared their ethnicity as White; 2229 (42.25%) declared their ethnicity as BME; and 933 (17.68%) candidates chose not to declare their ethnicity.

Looking only at First Time Takers (FTTs) for the AKT and CSA, that is those candidates sitting either or both examinations for the first time this academic year, the representation of each sex and ethnicity was as follows:

- Female candidates: 2476 (56.18%)
- Male candidates: 1380 (31.31%)
- Sex not declared: 551 (12.50%)
- Ethnicity declared as White: 1981 (44.95%)
- Ethnicity declared as BME: 1686 (38.26%)
- Ethnicity not declared: 740 (16.79%)

RCA

1551 candidates made 1574 attempts at the RCA in separate diets in July and August 2020, with 23 July failures re-sitting in August. Of these 1574 attempts, 36 (2.29%) were undertaken by Targeted GP Training (TGPT) candidates, and 414 (26.30%) were undertaken by candidates training less than full time.

Of the 1551 candidates, 925 (59.64%) were UKGs and 626 (40.36%) were IMGs.

Of the 1551 candidates, 185 (11.93%) did not provide information as to their sex. Of those who did, 727 (53.22%) were male and 639 (46.78%) were female. Of the 1551 candidates, 259 (16.70%) did not provide information about their ethnicity. Of those who did, 747 (57.82%) were of BME ethnicity and 545 (42.18%) were white.

Readers are reminded to exercise caution when interpreting information which has significant 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 CSA examinations

Figures 3.1 and 3.2 present the status of all unique candidates who sat their first attempt of the AKT or CSA in the ten diets up to AKT39 and CSA March 2020. For the purposes of this analysis the maximum attempt is considered to be attempt 4, however some candidates are granted additional attempts in exceptional circumstances. Twenty-three candidates passed on an additional attempt in this period and are included in the passing group. As can be seen in these Figures, the proportion of candidates who fail at their final possible attempt is below 1% in both examinations. The cumulative pass rate, when considering all candidates who took their first attempt 6-10 diets ago, is 97.47% for the AKT and 97.62% for the CSA.

AKT (8812 candidates)

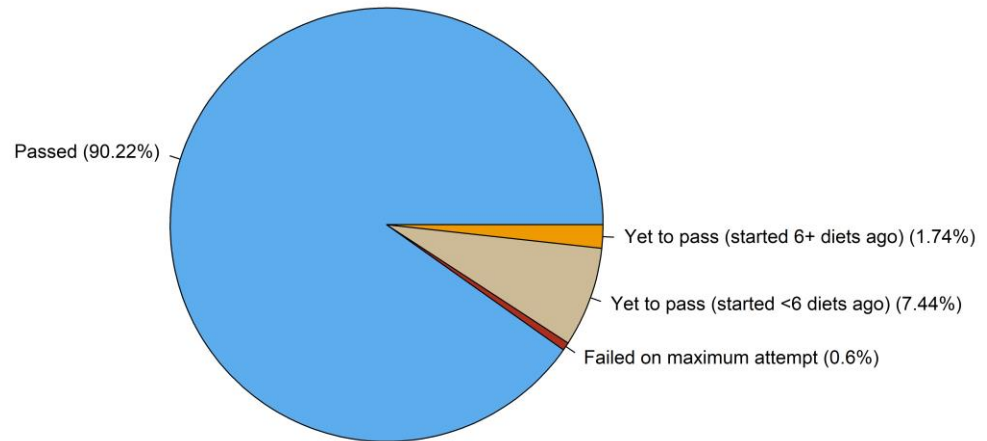


Figure 3.1: Current status of candidates who first sat the AKT within the last 10 diets

CSA (4669 candidates)

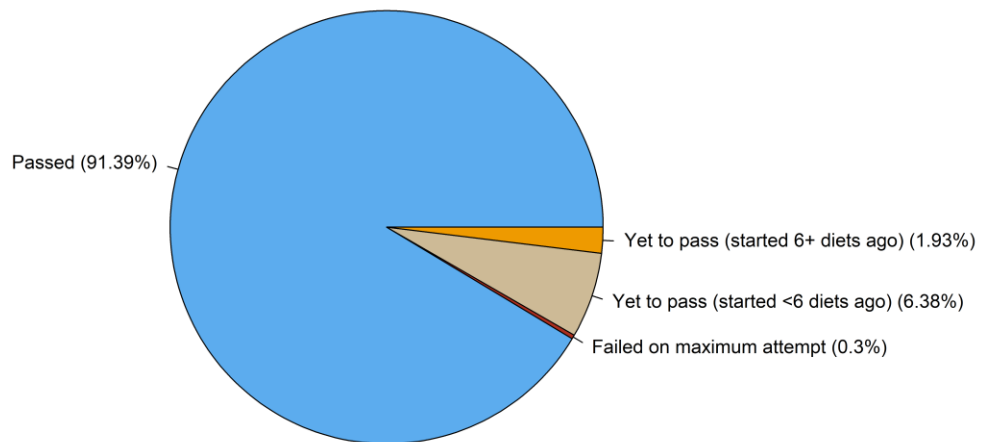


Figure 3.2: Current status of candidates who first sat the CSA within the last 10 diets

The correlation between the scores of candidates who were FTTs on the CSA this academic year with their scores on their first attempt of the AKT (regardless of which year they first took the AKT) was $r = 0.56$ ($t = 27.3$, $p < 0.001$). This correlation, shown in Figure 3.3, means that candidates who tend to achieve a low score on their first attempt in one exam also tend to achieve a low score on their first attempt in the other exam, 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: zero represents the pass mark, so a candidate at zero has achieved the pass mark and passed, those with a score greater than zero have exceeded the pass mark and passed, and those with a negative score failed to reach the pass mark and have failed.

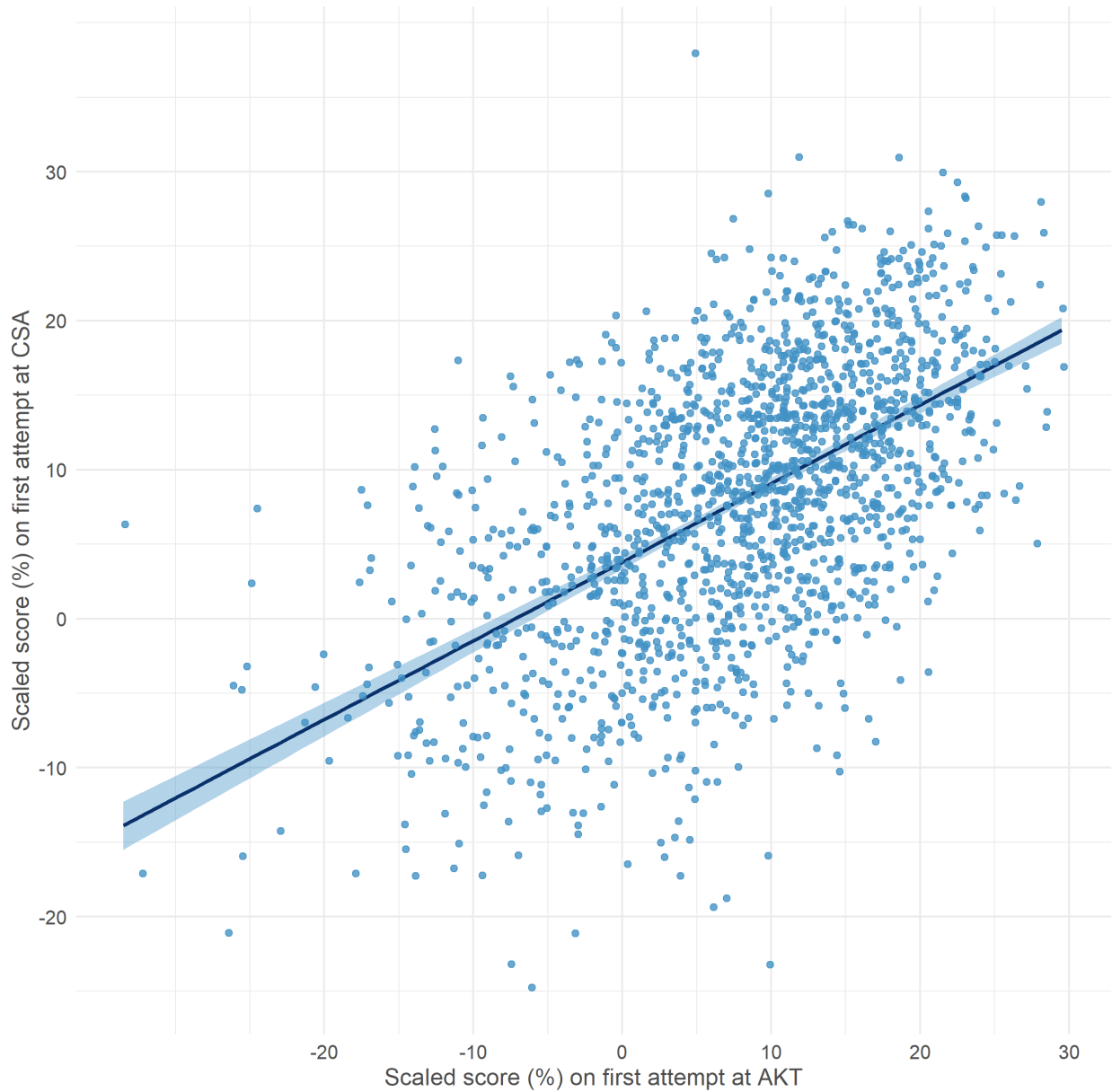


Figure 3.3: Correlation between FTTs' scaled scores on CSA and AKT

Performance in the RCA examination

Overall, 1174 of the candidates' 1574 attempts were successful, a pass rate of 74.59%. The RCA pass rates were quite similar to those of the CSA, though with rather more candidates passing

on attempts beyond the first attempt. It is currently unrealistic because of lower candidate numbers to extrapolate figures similar to those above for the AKT and CSA.

Figure 3.4 shows the relationship between the scores of candidates taking the RCA as their first attempt at any 'clinical' MRCGP assessment (i.e. they had not already attempted and failed the CSA) and their earlier first attempt at the AKT. The correlation is $r = 0.45$ ($p < 0.001$).

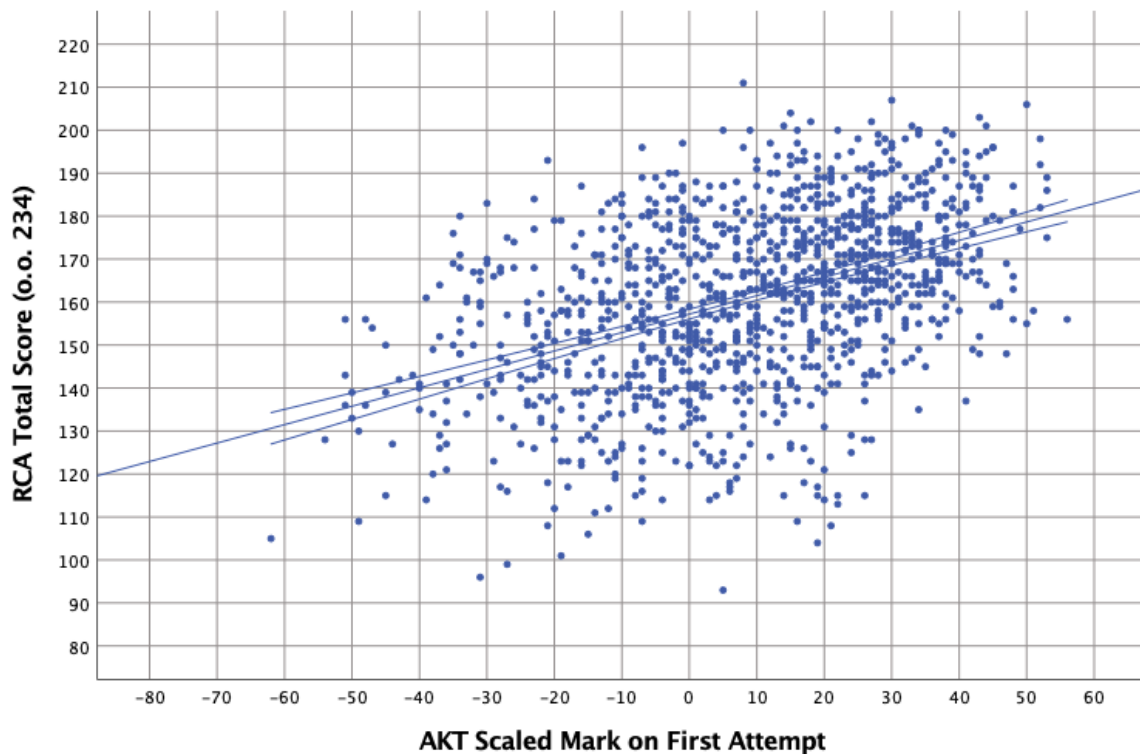


Figure 3.4: Correlation between FTTs' scores on AKT and RCA (note this excludes those who had previous attempts on the CSA)

The figures in the rest of this report show scores of FTT candidates split by demographic characteristic. **It is important to note both the large proportion of candidates who chose not to declare their sex or 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. 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. The left edge of the box to the median line is the 25th-50th percentile, and the median line to the right edge of the box is the 50th-75th percentile. The whole box (25th-75th percentile) shows the interquartile range (IQR). The end of the line to the left of the box is called the 'minimum' (the 25th percentile minus 1.5 IQR), and the end of the line extending to the right is called the 'maximum' (75th percentile plus 1.5 IQR). Dots beyond the line are outliers (extreme scores).

To help readers grasp both the number of candidates represented by each box and the distribution of their scores, we have overlaid a "beeswarm" plot on the boxplot. As each plot refers to only FTTs, each candidate is represented by one single dot within each split of the data (e.g. split by Exam, or by Demographic characteristic). Again, candidates with a scaled score of zero have achieved the pass mark and passed, those with a scaled score greater than zero have exceeded the pass mark and passed, and those below zero have scored lower than the pass mark and have failed.

Country of primary medical qualification (UK or International)

Figure 3.5 shows the scaled scores of UKG and IMG FTTs in the AKT and CSA.

In both the AKT and the CSA, the demographic characteristic which was tied to the biggest difference in performance by candidates on their first attempt was whether the candidates had obtained their primary medical qualification in the UK. As undergraduate training status has been shown to be such a strong predictor of scores and pass/fail outcomes, 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.

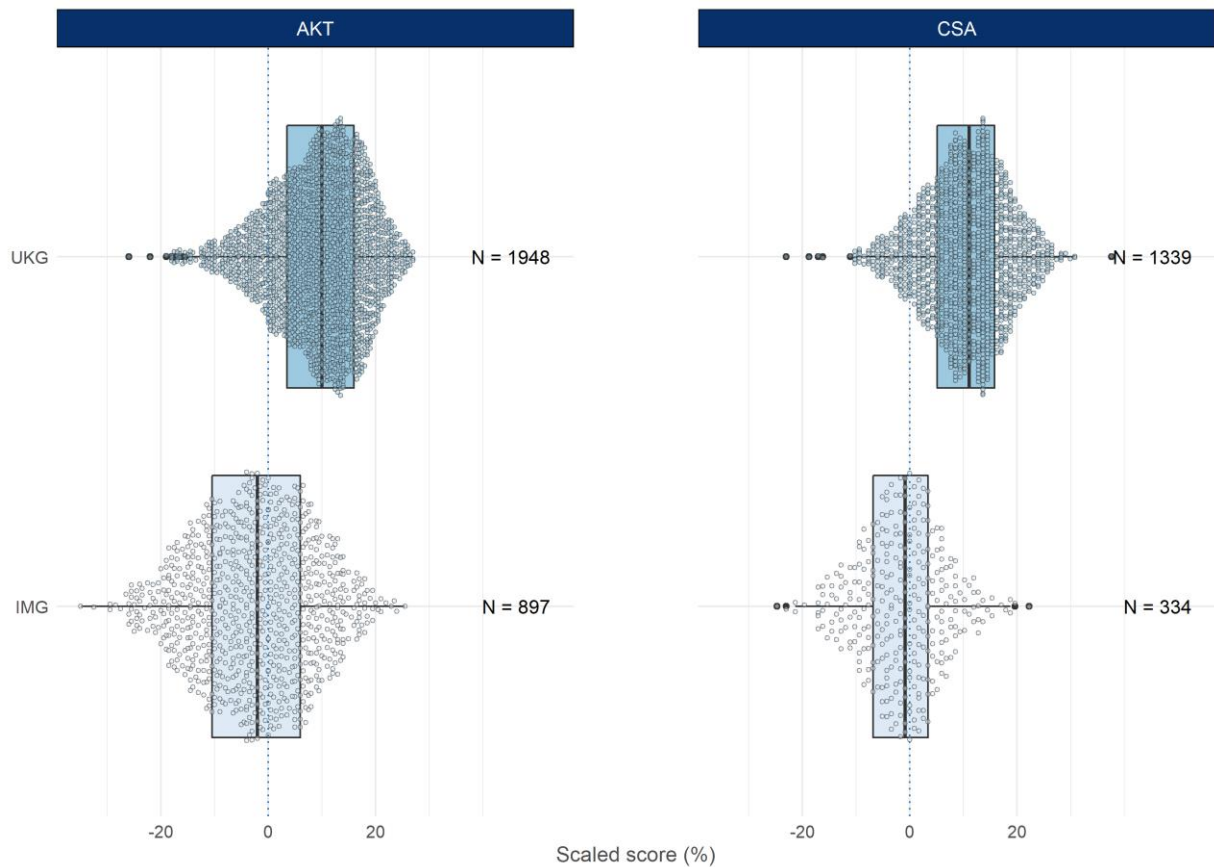


Figure 3.5: Performance of FTTs in the AKT and CSA, split by primary medical qualification and Exam

Figure 3.6 below shows overall performance on the RCA by scaled marks, comparing UKGs to IMGs. Data are limited to those of 1169 candidates on their first attempt of the RCA who had not previously attempted the CSA.

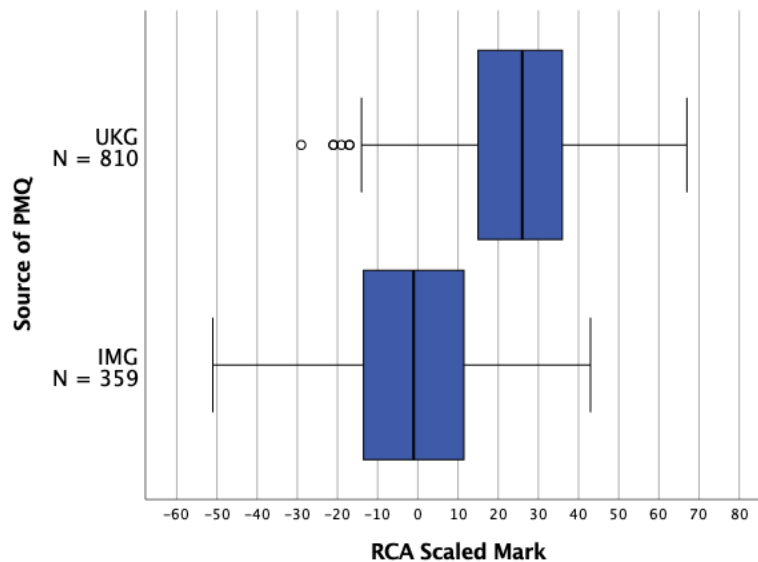


Figure 3.6: Performance of FTTs in the RCA (who had not previously attempted the CSA), split by Primary Medical Qualification

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 1289 Female UKGs, 626 Male UKGs, and 347 UKGs who chose not to disclose their sex. The UKG group was therefore 56.98% Female, 27.67% Male, and 15.34% NA (did not disclose).

In the CSA there were 852 Female UKGs, 423 Male UKGs, and 127 UKGs who chose not to disclose their sex. The UKG group was therefore 60.77% Female, 30.17% Male, and 9.06% NA (did not disclose).

In the RCA there were 476 Female UKGs, 339 Male UKGs, and 110 UKGs who chose not to disclose their sex. The UKG group was therefore 51.46% Female, 36.65% Male, and 11.89% NA (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, 73.1% were UKGs, while 26.9% were IMGs. This difference is reduced among male FTT candidates, as 58.48% of males on their first attempt were UKGs, and 41.52% were IMGs. While the UKG/IMG split among males on their first attempt at the AKT was almost 3 UKGs for every 2 IMGs, there were approximately 3 UKG males for every 1 IMG male sitting the CSA for the first time, and approximately 2 UKG males for every 1 IMG male sitting the RCA for the first time.

Table 3.1: Count and Percentage of FTTs according to sex in the AKT, CSA and RCA (note RCA FTTs are those on their first RCA attempt who have not previously attempted the CSA)

Exam	Sex	Total FTTs	UKG FTTs	IMG FTTs
AKT	Female	1543 (100%)	1128 (73.10%)	415 (26.9%)
AKT	Male	896 (100%)	524 (58.48%)	372 (41.52%)
AKT	NA	406 (100%)	296 (72.91%)	110 (27.09%)
CSA	Female	1001 (100%)	829 (82.82%)	172 (17.18%)
CSA	Male	518 (100%)	392 (75.68%)	126 (24.32%)
CSA	NA	154 (100%)	118 (76.62%)	36 (23.38%)
RCA	Female	604 (100%)	437 (72.35%)	167 (27.65%)
RCA	Male	427 (100%)	282 (66.04%)	145 (33.96%)
RCA	NA	138 (100%)	91 (65.94%)	47 (34.06%)

Table 3.2 shows the pass rate for FTTs according to sex and location of primary medical qualification (UKG or IMG), and Figure 3.7 shows the scaled scores of FTT candidates in the AKT and CSA 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 85.90%, 1.36% higher than the pass rate for males (84.54%). This difference was greater in both clinical assessments: in the CSA the female pass rate was 92.88%, 7.17% higher than the male pass rate; and in the RCA the female pass rate was 3.66% higher than the male pass rate.

Among IMG candidates sitting the AKT, the pass rate for females was lower than the pass rate for males (41.69% compared to 46.51%). However, like their UKG counterparts, female IMG candidates had a higher pass rate than male IMG candidates in the CSA (52.33% compared to 31.75%) and RCA (57.49% compared to 35.86%). **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, CSA and RCA (note FTT in the RCA refers to those on their first attempt in the RCA who had not previously attempted the CSA)

Exam	Sex	Overall FTT pass rate (%)	UKG FTT pass rate (%)	IMG FTT pass rate (%)
AKT	Female	74.01	85.90	41.69
AKT	Male	68.75	84.54	46.51
AKT	NA	73.40	85.14	41.82
CSA	Female	85.91	92.88	52.33
CSA	Male	72.59	85.71	31.75
CSA	NA	81.82	88.98	58.33
RCA	Female	85.76	96.57	57.49
RCA	Male	73.54	92.91	35.86
RCA	NA	74.81	89.01	42.55

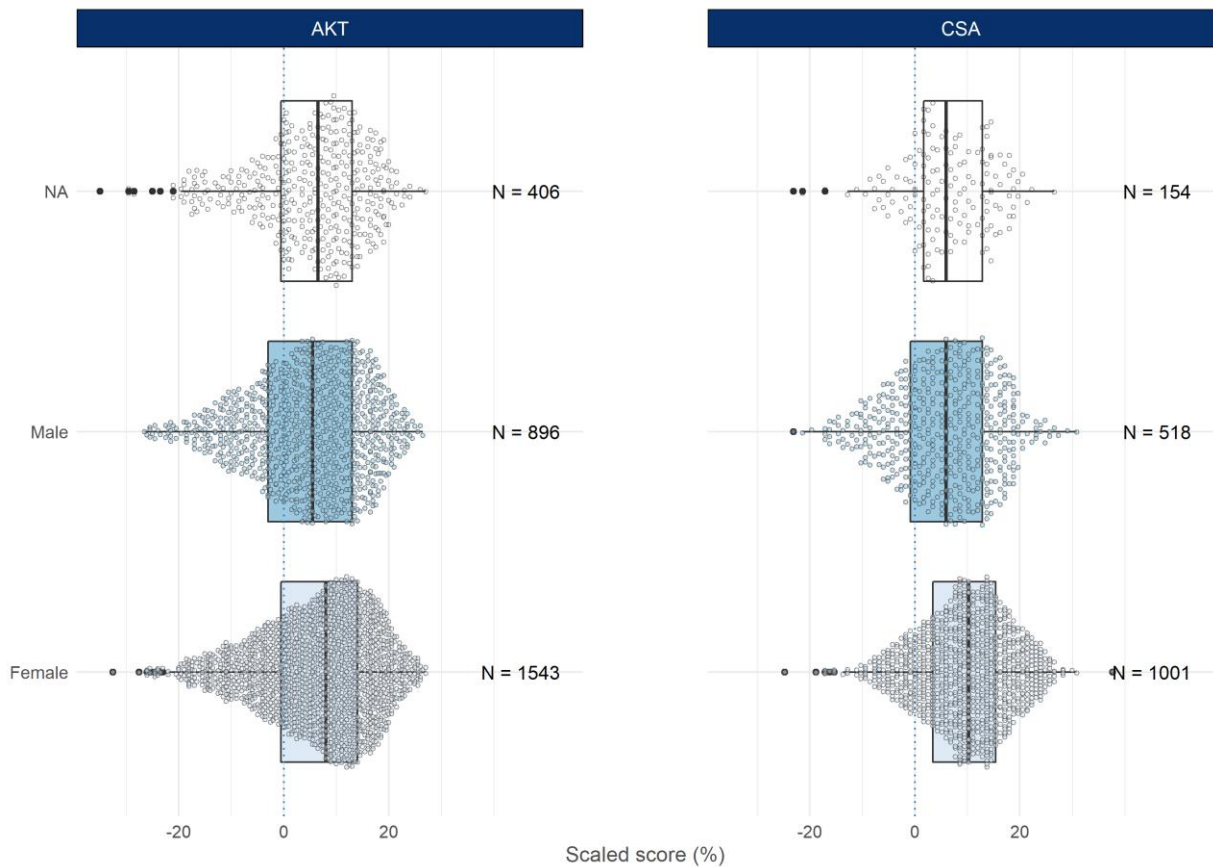


Figure 3.7: Performance of FTTs in the AKT and CSA, split by Sex and Exam

Figure 3.8 shows overall performance on the RCA by scaled marks, comparing males to females. Data are again limited to those of candidates on their first attempt who had not previously attempted the CSA. Note that 138 candidates did not declare their sex (11.80% of the sample).

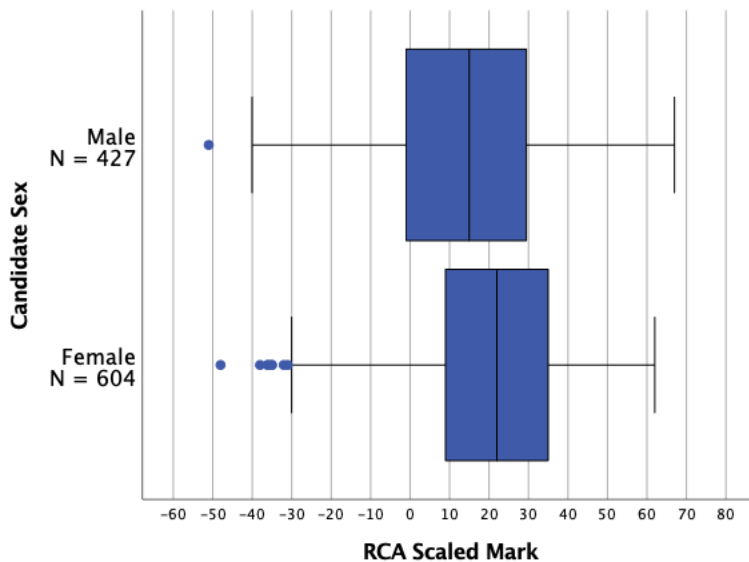


Figure 3.8: Performance of FTTs in the RCA (who had not previously attempted the CSA), split by Sex

Ethnicity

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

In the AKT there were 613 BME UKGs, 1207 White UKGs, and 442 UKGs who chose not to disclose their ethnicity. The UKG group was therefore 27.1% BME, 53.36% White, and 19.54% NA (did not disclose).

In the CSA there were 390 BME UKGs, 839 White UKGs, and 173 UKGs who chose not to disclose their ethnicity. The UKG group was therefore 27.82% BME, 59.84% White, and 12.34% NA (did not disclose).

In the RCA there were 297 BME UKGs, 484 White UKGs, and 144 UKGs who chose not to disclose their ethnicity. The UKG group was therefore 32.11% BME, 52.32% White, and 15.57% NA (did not disclose).

The remainder of this section focuses on FTT candidates only. Table 3.3 shows the representation of UKG and IMG FTTs among BME candidates, White candidates, and those who chose not to declare their ethnicity. In the AKT, CSA, and RCA, over 9 in every 10 White FTT

candidates received their undergraduate training at a UK institution. The BME group was relatively more evenly split, with 42.03% of all BME FTT candidates sitting the AKT having UK primary medical qualifications, while 57.97% were IMGs. In the CSA there were relatively more UKGs in the BME group (60.71% of the BME group were UKGs, while 39.29% of the group was IMG). Considering BME candidates sitting the RCA as their first MRCGP clinical assessment, there were almost as many with primary medical qualifications from the UK as there were those with primary medical qualifications from elsewhere in the world.

Table 3.3: Count and Percentage of FTTs according to ethnicity in the AKT, CSA and RCA (note RCA FTTs are those on their first RCA attempt who have not previously attempted the CSA)

Exam	Ethnicity	Total FTTs	UKG FTTs	IMG FTTs
AKT	White	1183 (100%)	1105 (93.41%)	78 (6.59%)
AKT	BME	1123 (100%)	472 (42.03%)	651 (57.97%)
AKT	NA	539 (100%)	371 (68.83%)	168 (31.17%)
CSA	White	869 (100%)	825 (94.94%)	44 (5.06%)
CSA	BME	588 (100%)	357 (60.71%)	231 (39.29%)
CSA	NA	216 (100%)	157 (72.69%)	59 (27.31%)
RCA	White	487 (100%)	449 (92.20%)	38 (7.80%)
RCA	BME	493 (100%)	241 (48.88%)	252 (51.12%)
RCA	NA	189 (100%)	120 (63.49%)	69 (36.51%)

Table 3.4 shows the pass rate for FTTs according to ethnicity and location of primary medical qualification (UKG or IMG) and Figure 3.9 shows the scaled scores of FTT candidates in the AKT and CSA according to ethnicity.

Considering candidates who received their undergraduate medical training in the UK, the pass rate for White candidates sitting the AKT was 90.41%, 15.20% higher than the pass rate for BME candidates (75.21%). This difference was reduced in the CSA, with a White pass rate of 94.06%, 11.43% higher than the BME pass rate, and further reduced in the RCA, in which White candidates had a pass rate that was 7.76% higher than that of BME candidates.

The same pattern was observed among IMG candidates, with the White pass rate in the AKT 20.73% higher than the pass rate of BME candidates. This difference was reduced in both clinical assessments: in the CSA the White IMG pass rate was 9.31% higher than the BME IMG pass rate, and in the RCA the White IMG pass rate was 14.64% higher than the BME IMG pass rate. **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, CSA 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	White	88.59	90.41	62.82
AKT	BME	56.01	75.21	42.09
AKT	NA	70.32	83.56	41.07
CSA	White	91.83	94.06	50.00
CSA	BME	66.16	82.63	40.69
CSA	NA	81.02	89.17	59.32
RCA	White	95.07	98.22	57.89
RCA	BME	66.33	90.46	43.25
RCA	NA	75.66	88.33	53.62

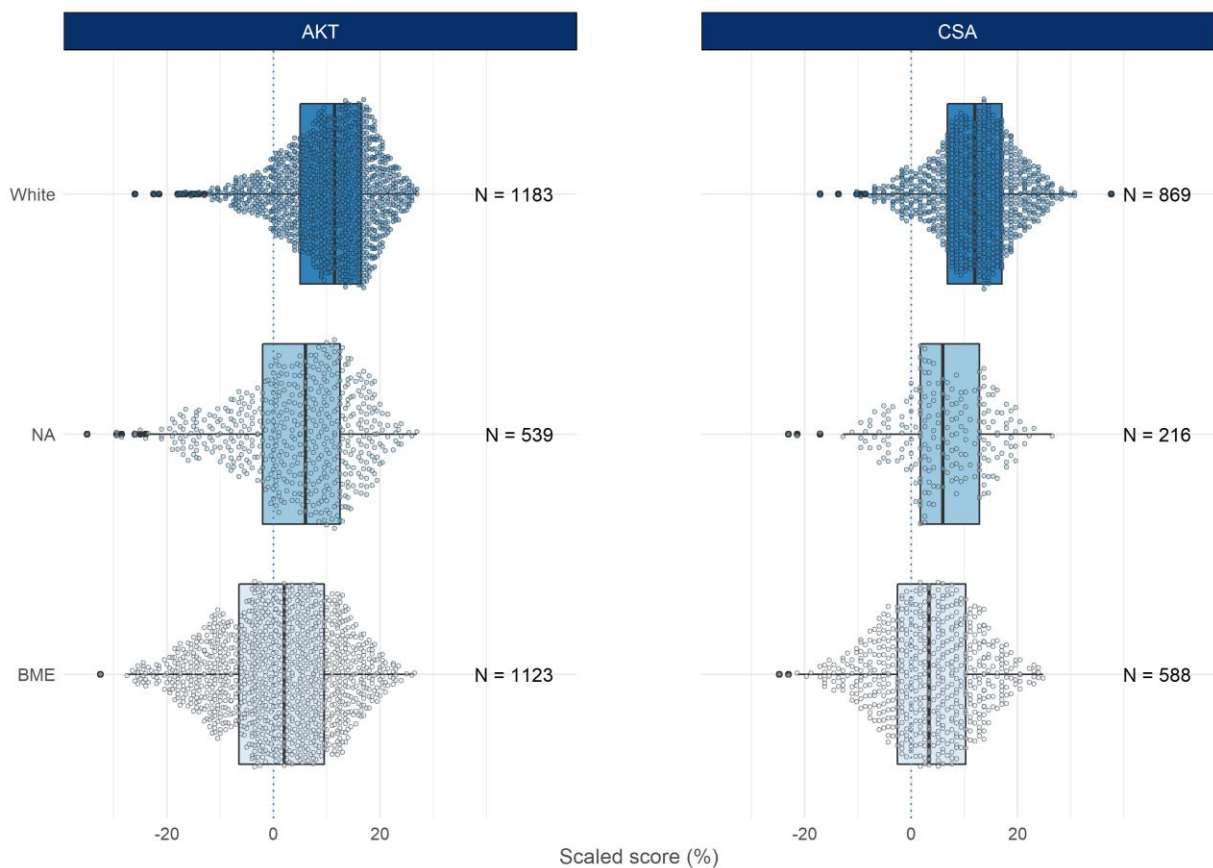


Figure 3.9: Performance of FTTs in the AKT and CSA, split by Ethnicity and Exam

Figure 3.10 shows the overall candidate performance on the RCA comparing BME candidates to White candidates. Data are again limited to those of candidates on their first attempt who had not already attempted the CSA. Note that 189 candidates did not declare their ethnicity (16.17% of the sample).

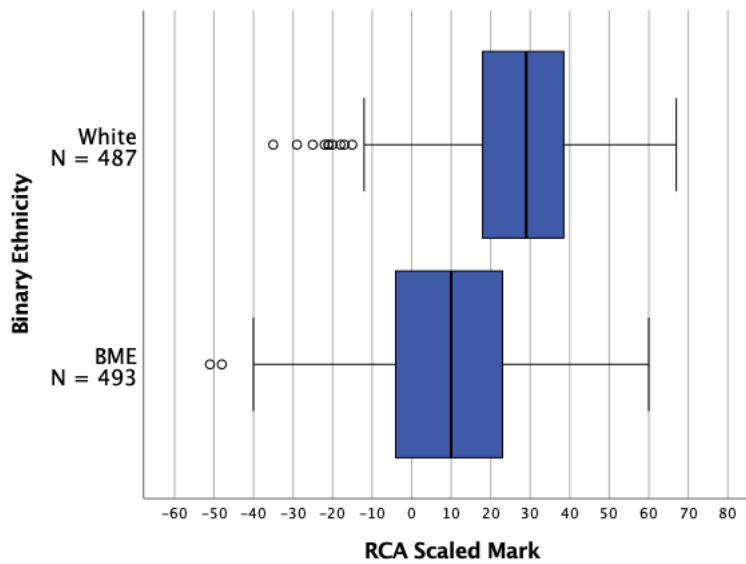


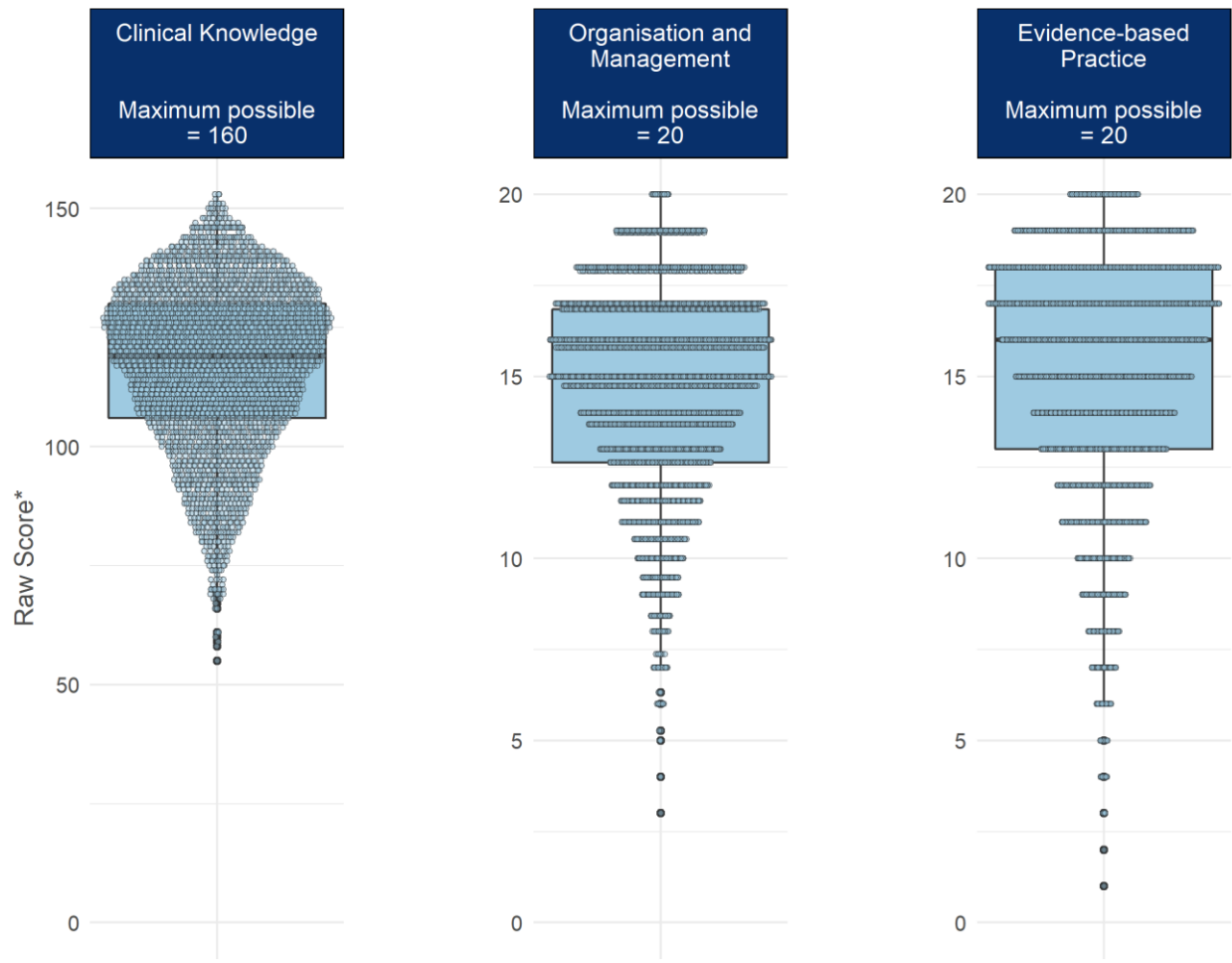
Figure 3.10: Performance of FTTs in the RCA (those who had not previously attempted the CSA), split by Ethnicity

4 Candidate performance: Subject area and domain performance

Performance in the AKT

Subject area scores

In the 200-question AKT paper, 160 of the questions relate to clinical knowledge, 20 to research/data interpretation/evidence-based practice and 20 to organisation and management/primary care legal/ethical/administration issues. Figure 4.1 shows the spread of candidates' scores on questions across the three areas.



*Note that the y-axis differs for each domain, to take into account the maximum possible

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

Insights from the item performance statistics

Topics causing most difficult for candidates in recent AKT examinations

Professional topics: Improving Quality, Safety and Prescribing: important drug interactions and side-effects, safe and evidence-based prescribing for primary care including awareness of MHRA alerts and legislation, and drug calculations, effective use of resources: doing nothing may sometimes be the best decision **Leadership and management:** staff health including pre-employment vaccination checks, notifications to the Coroner/ Procurator Fiscal **Evidence-Based**

Practice, Research and Sharing Knowledge: understanding and communicating concepts such as relative and absolute risk **Urgent and Unscheduled care:** managing acute illness e.g. collapse

Life stages topics: Children and Young People: safeguarding and non-accidental injury, developmental assessment and screening, consent and confidentiality, common childhood infections Older adults: consent and capacity for decision-making and the relevant legal frameworks People at the end of life: ethical concepts relevant to end-of-life

Clinical topics: contraception: when taking teratogenic drugs; differential efficacy of LARCs, ECG abnormalities, HRT, mental health problems associated with substance misuse, abnormal examination findings including retinal appearance, consider pregnancy in a differential diagnosis, management of minor blood test abnormalities, principles of prescribing in diabetes (including insulin), skin (including genital) conditions and their appearance (represented by photos in the AKT), understanding (but not detailed knowledge) of secondary care management, common urological symptoms, interpretation of spirometry, presentation of benign disease and appropriate management

Topics which have been highlighted several times over recent years:

Professional topics: Consulting in General Practice: communication of risk and use of risk tools **Evidence-based 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 **Improving Quality, Safety and Prescribing:** antibiotic indications and resistance, drugs: monitoring; adverse reactions; interactions; dose calculations; end-of-life care, safe prescribing and medicines management (including MHRA alerts) **Leadership and management:** death certification and notifications to Coroner/ Procurator fiscal, staff health and health and safety in the workplace

Life stages topics: Children and Young People and People at the End-of-Life

Clinical topics: Diagnosis of common oral conditions, different presentations of multi-system disease, eye problems, immunisation schedules, recognising presentations of mental ill health (including physical symptoms), management of hearing loss, normal findings, minor illness, and infections in childhood, respiratory medicine – including asthma, COPD and rarer diagnoses, suspected cancer: diagnosis & investigation (including less common presentations) , timely but appropriate referral (including emergencies and when to do nothing), prescribing in diabetes, including insulin

Performance in the CSA

Domain-based scores

Candidates in the CSA 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”.

From Figure 4.2 it can be seen that on average candidates tended to perform less well on clinical management skills, relative to the other two domains.

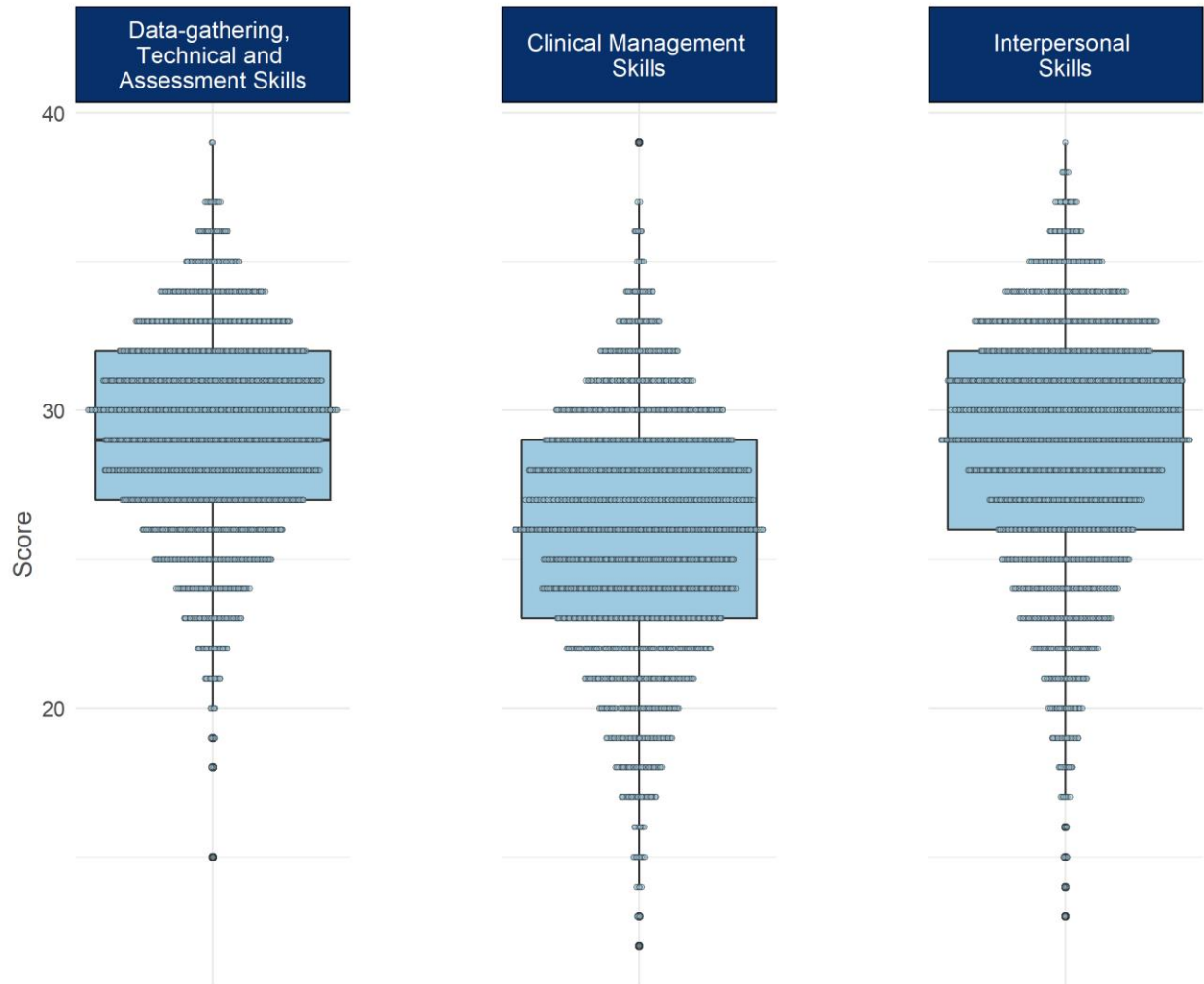


Figure 4.2: Performance of FTTs across the domains of the CSA

Feedback provided by the examiners

Candidates in the CSA are also given feedback, using a drop-down menu of standardised statements. Figure 4.3 shows how many times each feedback statement was ticked per candidate.



Figure 4.3: Number of ticks for each feedback statement, received by each FTT in the CSA this academic year

Table 4.1 shows, for each feedback statement and the percentage of FTTs who received it at least once.

Table 4.1: Percentage of FTTs who received each feedback statement at least once in the CSA

Statement	Percent
Does not develop a management plan (including prescribing and referral) reflecting knowledge of current best practice	77.23
Does not demonstrate an awareness of management of risk or make the patient aware of relative risks of different options	64.91
Does not recognise the issues or priorities in the consultation (for example, the patient's problem, ethical dilemma etc.)	63.60
Does not show appropriate use of resources, including aspects of budgetary governance	60.13
Does not make the correct working diagnosis or identify an appropriate range of differential possibilities	58.64
Does not identify abnormal findings or results or fails to recognise their implications	51.05
Does not develop a shared management plan, demonstrating an ability to work in partnership with the patient	50.81
Does not undertake physical examination competently, or use instruments proficiently	40.77
Shows poor time management	40.71
Does not use language and/or explanations that are relevant and understandable to the patient	40.11
Poor active listening skills and use of cues. Consulting may appear formulaic (slavishly following a model and/or unresponsive to the patient) and lacks fluency	39.45
Does not appear to develop rapport or show awareness of patient's agenda, health beliefs and preferences	33.17
Does not identify or use appropriate psychological or social information to place the problem in context	31.80
Does not make adequate arrangements for follow-up and safety netting	31.68
Disorganised / unstructured consultation	28.51
Does not attempt to promote good health at opportune times in the consultation	13.57

Performance in the RCA

Domain-based scores

Figure 4.4 shows that, as seen in the CSA, candidates' score on the Clinical Management domain were lower than on Data Gathering and Interpersonal Skills.

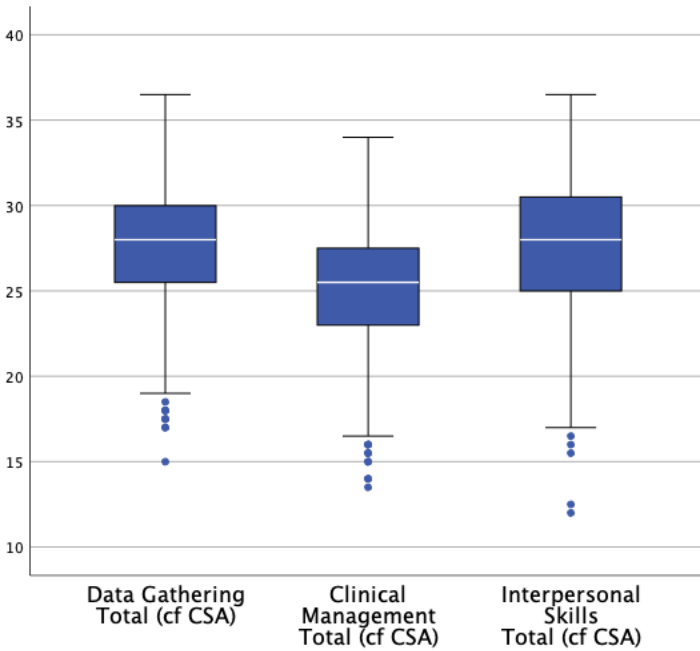


Figure 4.4: Performance of all candidates across the domains of the RCA

Feedback provided by the examiners in the RCA

Table 4.2 shows, for each of 16 feedback statements used by the RCA examiners, the percentage of candidates receiving that feedback for any of their consultations (ordered by frequency) and the mean number of times (out of 26 possibilities) each was applied to a candidate.

Table 4.2: The percentage of candidates who received each feedback statement at least once in the RCA and the mean number of times a candidate received it

Feedback Statement	Percent	Mean
Does not develop a management plan (including prescribing and referral) reflecting knowledge of current best practice	72.81	3.57
Does not identify abnormal findings or results or fails to recognise their implications	61.50	2.83
Does not make the correct working diagnosis or identify an appropriate range of differential possibilities	47.90	1.98
Poor active listening skills and use of cues. Consulting may appear formulaic (rigidly following a model and/or unresponsive to the patient) and lacks fluency	46.25	2.16
Does not recognise issues or priorities in the Consultation	45.43	1.72
Shows poor time management	40.60	1.52
Does not demonstrate an awareness of management of risk or make the patient aware of relative risks of different options	40.47	1.48
Does not develop a shared management plan, demonstrating an ability to work in partnership with the patient	40.22	1.42
Does not identify or use appropriate psychological or social information to place the problem in context	39.96	1.50
Does not make adequate arrangements for follow-up and safety netting	39.26	1.38
Does not appear to develop rapport or show awareness of patient's agenda, health beliefs and preferences	34.94	1.20
Disorganised/unstructured consultation	29.86	1.01
Does not show appropriate use of resources, including aspects of budgetary governance	29.80	1.01
Does not use language and/or explanations that are relevant and understandable to the patient	26.30	0.86
Does not undertake physical examination competently, or use instruments proficiently	19.95	0.61
Does not attempt to promote good health at opportune times in the consultation	15.25	0.42

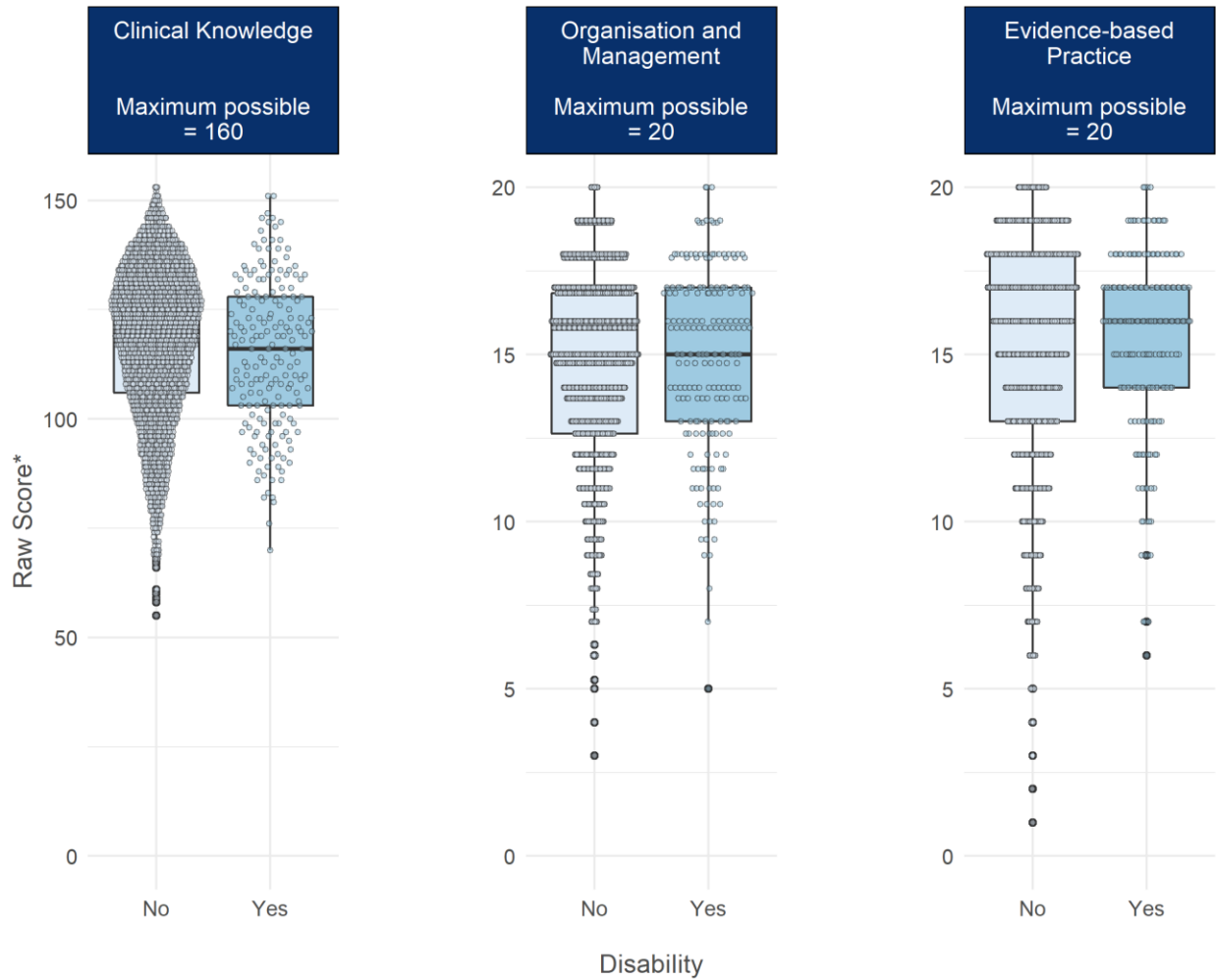
5 Candidates with disabilities: prevalence by attempt and source of PMQ; outcomes

UK Equality Legislation supports examination candidates with disabilities in requesting 'reasonable accommodations' in regard to their disabilities, provided these do not affect the standard of the examination. Specific Learning Difficulty (SLD) is the disability most frequently reported. Disabilities other than SLD 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. Note, importantly, that SLD may not be diagnosed until a second or later attempt at the assessment.

In the category 'all disabilities', there were 588 candidate-attempts at the AKT in the academic year 2019-20, representing 13.56% of attempts. Of these 588 attempts, 361 (61.39%) were successful.

In the category 'SLD', there were 507 candidate-attempts at the AKT, representing 11.7% of all attempts this academic year. Of these 507 attempts, 312 (61.54%) were successful. Note that candidates with SLD and another disability who selected 'more than one disability' are not included in the SLD 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 generally 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.**



*Note that the y-axis differs for each domain, to take into account the maximum possible

Figure 5.1: Performance of FTTs in the three AKT domains split by Disability status

For the CSA, in the category 'all disabilities' there were 151 candidate-attempts in the academic year 2019-20, representing 7.19% of all attempts. Of these 151 attempts, 100 (66.23%) were successful.

Figure 5.2 shows scores of FTTs in the CSA 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 very 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.**

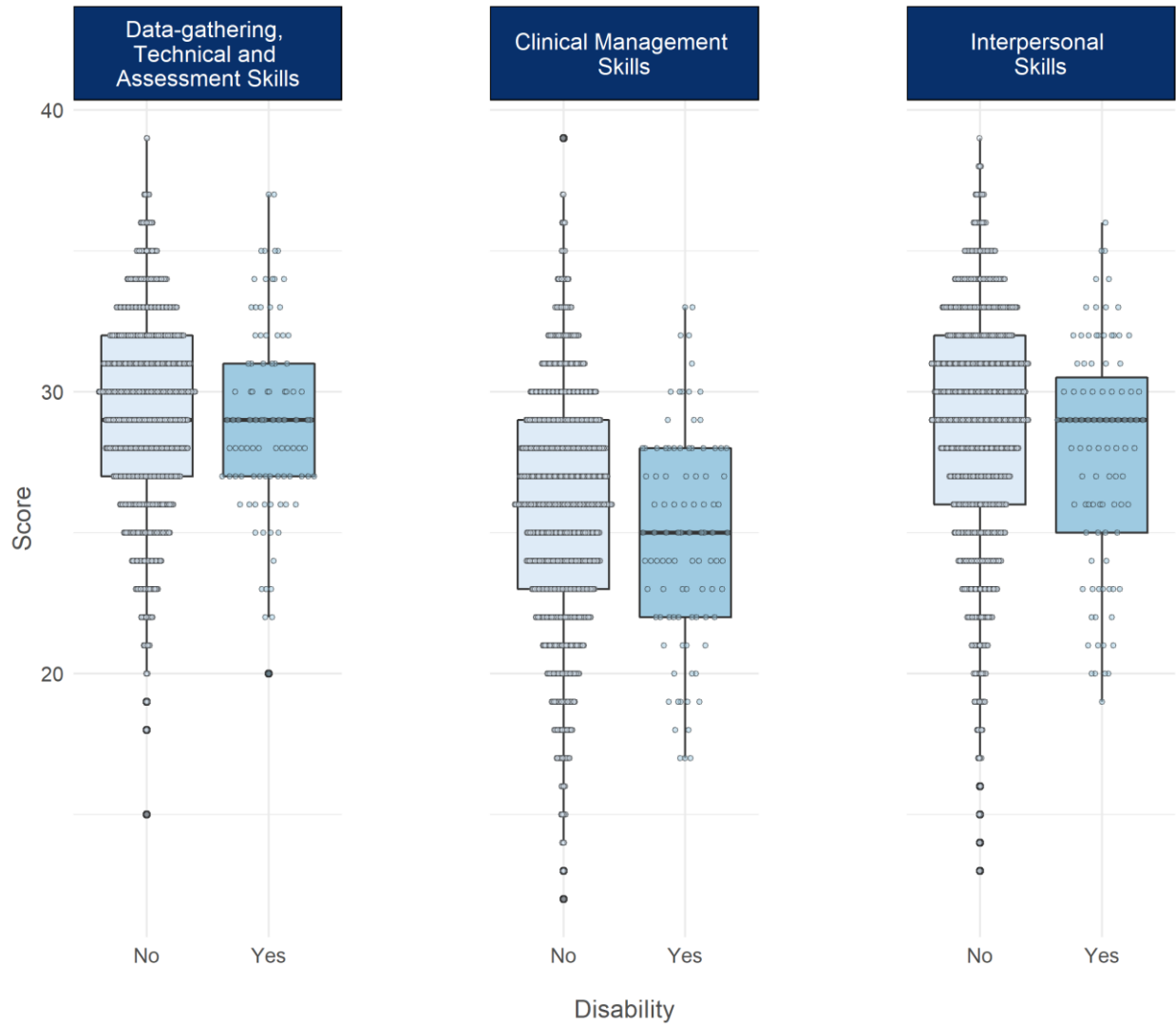


Figure 5.2: Performance of FTTs in the three CSA domains split by Disability status

As shown in Figure 5.3, the patterns observed in the RCA are very similar to those in the CSA, providing reassurance about the impact of this alternative format on candidates with a declared disability.

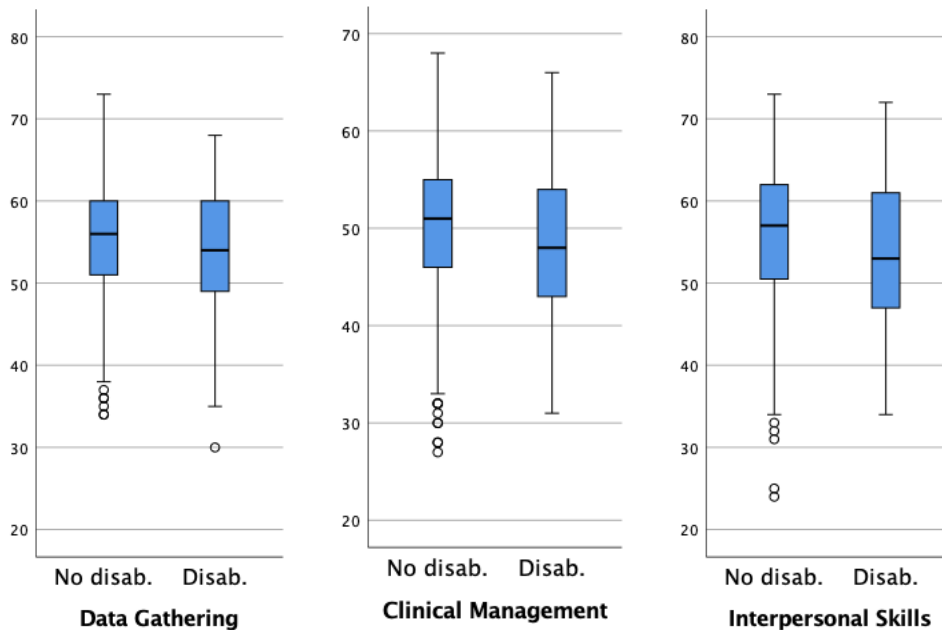


Figure 5.3: Performance of FTTs (who had not already attempted the CSA) in the three RCA domains split by Disability status

Our MRCGP disability advisor has been reviewing the website and resources available to candidates needing to declare a disability. We are currently working on simplifying and standardising how reasonable adjustment requests are made and processed. In order to reduce delays as much as possible, we have been advised to use a specific email address for candidates declaring a disability and requesting reasonable adjustments: exams.accoms@rcgp.org.uk. Future developments include a proposed new online application process to make it easier for supporting information to be submitted.

6 Update from the Workplace Based Assessments

Summary

WPBA makes up the third requirement for the UK GP licensing assessment. Following the external review of WPBA in 2018, publication of new GMC requirements, the [updated GP curriculum](#), and the future needs of a GP in the UK, the WPBA has been reviewed and updated. These changes have been piloted, submitted to the GMC, and the revised WPBA assessment programme has been accepted by the GMC for implementation from August 2020. In summary, the changes include reducing the assessment burden, updating the current assessment formats, and introducing quality improvement, leadership and prescribing assessments into GP training. Following last year's report, work this year has focused heavily on updating and improving the assessment programme for submission to the GMC.

Why was a review of WPBA needed?

An external review of the WPBA identified potential challenges, several of which were already known, with the current WPBA programme. These included:

- Largely unchanged since the 2007 version of MRCGP, WPBA needed to be updated to reflect GMC requirements, changes to the GP curriculum, and to increase its relevance to the needs of the future GP.
- Different interpretations of the WPBA requirements, due to a misunderstanding of the assessments and failures or delays in carrying them out correctly.
- Assessments and Supervisor Reports being regarded as long box-ticking forms with little constructive feedback.
- Log entries and the numbers of assessments perceived as too onerous.
- Concerns of lack of reliability within the assessment programme and the inability of the current WPBA programme to identify trainees failing to progress early enough in training or to recognise excellence.

As a result, it became apparent that to comply with the GMCs Generic Professional Competences¹ (GPCs) a revised WPBA programme was needed. This proposal for change included:

- Designing assessments on Quality Improvement, Leadership activities and Prescribing to address these GPCs. There was no assessment of trainee prescribing in the workplace and this was felt to be a shortfall in trying to maximise patient safety.
- Reducing the number of assessments used in the workplace to reduce the perceived assessment burden, and updating the current assessment format so this could be done without loss of reliability

- As with other specialities, the use of entrustable questions to support the trainee's performance and progression throughout the training programme needed to be introduced. This has also been shown to improve the reliability of the assessment
- Developing resources, which need to be more widely available, to reduce inconsistencies in the completion and understanding of both the assessments and the WPBA programme as a whole.

Following discussion with key stakeholders, a revised schedule of WPBA requirements, including piloting and evaluation, has been designed and submitted to the GMC.

In summary, these include:

- Overall reduction in assessment workload for Educational Supervisors and trainees
- A reduced number of Mini-CEXs, COTs, CbDs and the introduction of Care Assessment Tools (CATs) in ST3
- Updated PSQ, CbD, COT, Mini-CEX, CSR and ESR forms
- A reduced number of learning logs and shorter log entries
- Introduction of a shorter mid-year ESR for those trainees where no concerns had been raised
- Introduction of a Quality Improvement Project, a Prescribing Assessment and Leadership activities

The new programme was submitted to the GMC with the proposal that the prescribing assessment needed further piloting from August 2019. The provisional evaluation of the pilot was shared with the GMC who subsequently approved the assessment to become part of WPBA.

The new assessment programme started on the 5th August 2020. All trainees who are starting ST1 will start on the new programme. Trainees who are already in training will move onto the new programme when they change training years. Guidance on the transition arrangements can be found on the website.

Summary of the three new assessments to be introduced into GP training

Quality Improvement Project (QIP) –The trainee will need to identify a project looking at the quality of care provided by themselves or the practice and aim to improve it. It is expected the trainee with the support of their practice will make small incremental changes and subsequently test the impact of these changes. The QIP will need to take place in the first two years (ST stages) of GP training. Guidance materials have been written for the trainee, educational supervisor and vocational training schemes on teaching QIPs, as well as examples of QIPs and how these have been assessed by the Educational Supervisors.

Leadership Activities including a leadership Multisource Feedback (MSF) - Throughout training GP trainees need to link evidence to the competency of “Organisation, Management and Leadership”. In addition, a specific leadership activity will be required to be completed in ST3 and for this to be documented in the trainees learning log. Following this activity, a ‘Leadership Multisource Feedback’ will need to be completed with questions specifically focused on obtaining feedback around the trainee’s leadership skills. Doctors will enter GP training with a range of experience in leadership and it is important for them to consider, in conjunction with their clinical and educational supervisor, how to develop these skills further over the course of their GP training.

Prescribing Assessment - Safe prescribing is a core activity and one which is central to being a competent GP. The GMC PRACtICE study identified prescribing errors in one in 20 prescriptions. One of the educational interventions considered by the PRACtICE study was an individualised review of GP trainee prescribing. The WPBA group has worked collaboratively with the University of Nottingham to develop and pilot a tool to look at prescribing within the ST3 stage of GP training. This includes a retrospective view of 50 successive scripts, which must be analysed by the GP trainee, and a sample of these then reviewed by the Supervisor. In particular the right drug, right dose, right dosage instructions, right follow-up, right documentation to support prescribing and the right review will be covered within the assessment. The assessment will take place in the first part of ST3 to allow an action plan to be put in place if any errors are identified, and for improvements to be demonstrated before the end of training.

Changes to the existing assessments

Changing Case based discussions (CbD) to Care Assessment Tools (CAT)- CbDs are being replaced by CATs when the trainee has a post in General Practice - this allows a greater range of information and performance to be assessed and recorded against the competencies. Below are suggested learning events that may be assessed. Details of the preparation required in advance, the content of the assessment, the type of competencies that may be assessed using it, and the recording required will all be made available. It will also be possible for any event that shows a trainee’s abilities regarding specific competencies to be assessed, recorded and used as evidence towards periodic reviews and training progression.

Suggested types of CATs

- Referrals review
- Case based review
- Random case review
- Prescribing assessment follow up

- Consultation assessments - which are not COTs

Case based discussions (CbDs) will continue in non-primary care placements in ST1/2. Similarly, the miniCEX assessment will continue in non-primary care placements and the Consultation Observation Tool (COT) in primary care placements. These have all been updated to allow assessments of performance to be documented.

Multisource feedback –This will continue in its current format but the GMC have requested this is completed in every year of training and includes a minimum of 10 respondents on each occasion.

Patient Satisfaction Questionnaire (PSQ) format - the PSQ assessment has been reviewed and updated with the support of the Picker Institute.

Clinical Supervisors Report (CSR) - A new CSR has been developed which now addresses all the capabilities. The 17 questions within the existing CSR have been reduced to 7 key areas. The supervisor will also be asked about the level of supervision required by the trainee in the post, and this will help to identify trainees who may need extra support. The recommendation is for the person completing the CSR to have done at least one of the other assessments with the trainee before the CSR takes place.

The Educational Supervisors Review (ESR)- Currently the trainee completes 2 Educational Supervisors' reviews every 6 months. Providing the trainee's supervisor has no concerns about a trainee's progress, and the trainee's last ESR and/or Annual Review of Competency Progression (ARCP) outcome were satisfactory, proposals have been put forward for a shorter interim review. This needs to occur at the halfway point of each calendar year (the timing set halfway between the trainee's planned ARCP dates) and cannot be used if an ARCP is also planned. The idea of the review is for the Educational Supervisor to touch base with their trainee to review progress and to ensure they are on track for completing their Portfolio requirements, but for the process to be quicker than the current ESR. The latter will still need to take place before the trainee's ARCP.

Learning Log entry format -The learning log templates have been adjusted to make the demonstration of reflective practice simple and streamlined for trainees. The existing formats have led to too many entries simply relating to knowledge or curriculum area acquisition, with minimal reflection and little connection with demonstration of competence. They have not suited all trainees, and their approach to reflection may have been particularly hard for some trainees. The revised tools have a required or mandatory space for appropriate reflection, which encourages reflective practice. The trainee, rather than the supervisor, will now make suggested capability linkages. This should encourage the trainee to learn about and understand

the capabilities. Rather than linking their log entry to the individual curriculum headings, the trainee will now link these to Clinical Experience groups which map to the curriculum.

Learning resources

The WPBA group has started developing new resources for the WPBA programme. Resources that have been developed can be found on the WPBA section of the RCGP website².

CSA guidance was provided at:

<https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/mrcgp-clinical-skills-assessment-csa.aspx>

RCA guidance was provided at:

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

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

<https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/mrcgp-applied-knowledge-test-akt.aspx>

Progress on recommendations from the 10-year review of the MRCGP carried out by HPAC

In 2017 the Trustee Board of the Royal College of General Practitioners commissioned an external review of the MRCGP examination in recognition that it had been running for 10 years as the licensing exam for General Practice. Health Professional Assessment Consultancy (HPAC) undertook this rigorous review, and found that overall the CSA and AKT “meet or exceed the standards for procedures used for high stakes examinations in the medical profession.....and that the CSA and AKT were fit for purpose and fair for both candidates and patients.”

The reviewers also made a series of recommendations “in the spirit of continuous quality improvement” as potential enhancements to the MRCGP. These have been reported in last year’s MRCGP annual report, and have now been completed or are near completion.

For more detail on this, see Appendix B.

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. The RCGP takes the issue very seriously and remains committed to understanding and addressing differential pass rates between candidates taking the MRCGP, based on all protected characteristics. It continues to work closely with trainee and lay representatives, and organisations including the GMC, the Academy of Medical Royal Colleges, the statutory educational bodies of the four nations (HEE, NES, HEIW, NIMDTA), as well as BAPIO and BIDA, to support candidates in demographic subgroups that have traditionally performed less well in high-stakes assessments. These groups include IMG trainees, BME trainees, and trainees declaring disability. The College also recognises that within all these groups there is significant heterogeneity. Apparently 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 are likely to be higher.

Actions 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, CSA and RCA preparation (see Resources section). This includes a new section encouraging candidates to seek advice and support from their educational supervisor prior to an exam attempt, to maximise the chances of them being ready to sit a high-stakes assessment, and provide the opportunity to identify any additional support or

learning required. MRCGP examiners regularly support faculty and deanery exam preparation courses.

- Performing regular surveys of candidates, and analysing results according to demographic data (see RCA candidate survey results in Annex B)
- 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.
- Recruitment of MRCGP panel members, including examiners and those working on the development groups of each module, to specifically target those applicants 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
- Positive 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, e.g.
- Regular training of all MRCGP 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 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 to 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
- Carrying out equality impact assessments and piloting of any proposed new assessments (e.g. piloting for the new prescribing assessment in WPPA, ongoing piloting and work on the RCA)
- Reviewing existing assessments to reflect the demographics of UK patient populations, e.g. work done last year to lessen the number of Anglo-Saxon cases in the CSA (see more detail of CSA actions in Appendix C.)
- Reviewing individual item performance in the AKT and ensuring item construction is designed to reduce potential DIF where feasible

- Keeping research into differential attainment of MRCGP candidates as a strategic priority. A number of research projects have been completed, or are in progress, and we aim to publish findings and hope to shed light on differential performance in examinations. (see Research section below)

Summary of recent RCGP related research

A research study related to the AKT published in 2019 was awarded the RCGP Research Paper of the Year in Medical Education in 2020. The study findings summarised below are being presented at the RCGP Annual Conference on 11 February 2021:

Pattinson J, Blow C, Sinha B, Siriwardena AN. Exploring reasons for differences in performance between UK and international medical graduates in the Membership of the Royal College of General Practitioners Applied Knowledge Test: a cognitive interview study. *BMJ Open* 2019; 9:e030341. doi:10.1136/bmjopen-2019-030341.

What this study tells us:

- This was the first study worldwide exploring reasons for differences in performance between UK graduates (UKGs) and international medical graduates (IMGs) in a licensing (applied knowledge test) examination using in-depth cognitive (think aloud) interviews.
- There are common causes of poor performance in the AKT whatever the ethnic background of the doctor, which are related to training and educational experience, knowledge skills and insight into these.
- IMG participants experienced additional difficulties because of differences (gaps) in their previous educational experience or lack of familiarity with the UK NHS.

What this means:

- Performance could be improved for all doctors in training by emphasising: gaining clinical experience, increasing familiarity with the curriculum and receiving feedback to enhance personal insight into their knowledge and deficiencies.
- For IMGs a longer period of induction during UK training, addressing specific areas of difficulty, plugging gaps in undergraduate experience, and increasing understanding of NHS systems is also likely to aid performance.

Papers published by the RCGP team and other academic teams over the past year and related to the MRCGP have focused on helping GP trainees pass the MRCGP or addressed performance problems more generally.

Bell EA, Cleland J, Gambhir N. It clarified a lot!: GP trainees as peer role players in a formative Clinical Skills Assessment (CSA). *Educ Prim Care* 2020; 1-6.

What this study tells us:

- Deaneries have introduced formative CSAs to help candidates prepare for the CSA with GP trainees acting as peer-role players.
- This team from NHS Education for Scotland and Lee Kong Chian School of Medicine, Nanyang Technological University in Singapore undertook a qualitative study using semi-structured interviews to explore fifteen trainees' perceptions of peer role play.
- Role play was found to give participants insight into what to expect and how to approach the exam. They learned about the importance of communication skills, acknowledging the patient's perspective, and observing good feedback.

What this means:

- GP trainees who role played patients gained confidence and learning from their experience.

Winter R, Norman RI, Patel P. A qualitative exploration of the lived experience of GP trainees failing to progress in training. *Educ Prim Care* 2020 1-9.

What this study tells us:

- This was an interview study of GP trainees who failed the MRCGP examination or failed to progress in training.
- The team from Universities of Leicester and Nottingham found that a combination of professional, personal, and social factors affected trainees' ability to progress.
- The main problems for trainees were difficulty managing workload, poor motivation, lack of family time and psychological illness.

What this means:

- This study supported previous evidence that difficulties facing GPs take root in training.
- The authors emphasised that understanding trainee experiences and perspectives on their challenges helped to inform remediation and provide support that fully addresses their needs.

Siriwardena AN. Understanding and remedying the performance of doctors in training. *Medical Education* 2020; 54(12): 1090-1092.

What this study tells us:

- This was a commentary on a study by Gingerich and colleagues, 'Seeing but not believing: insights into the intractability of failure to fail'. *Med Educ.* 2020;54(12):1148-1158.
- The commentary argues that when educators see patterns and respond to them based on their expectations of trainees with limited information, errors in judgement ensue by not believing that a trainee is struggling or focusing in on particular explanations for why a trainee is failing.
- The article advocates using a framework such as SKIPE (Skills, Knowledge, Internal, Past and External factors) to help understand the complex individual and system factors leading to underperformance and to aid developing a shared understanding with the trainee.

What this means:

- Accurate, holistic assessment of underperformance is essential for successful remediation.

Conference presentations

Elfes C, Denney ML, Wakeford R. The hidden pervasiveness of therapeutics in the assessment of family medicine trainees' applied knowledge: an analysis of a year's SBA test statistics with lessons for training programmes, AMEE, Austria Centre Vienna, August 2019.

Buck S, Denney ML. UK General Practitioner trainers' views and concerns on supervising disabled GP trainees - a structured interview study to elicit these and identify relevant learning needs. AMEE. Austria Centre Vienna, August 2019.

Medical Education podcast. Performance in candidates declaring versus those not declaring dyslexia in a licensing clinical examination - interview by Kevin Eva with Niroshan Siriwardena <https://onlinelibrary.wiley.com/page/journal/13652923/homepage/podcasts.htm>

Additional publications

The list of research publications linked to the MRCGP is available via the RCGP website: (<http://www.rcgp.org.uk/training-exams/mrcgp-exams-overview/mrcgp-annual-reports.aspx>)

Asghar Z, Williams N, Denney ML, Siriwardena AN. Performance in candidates declaring vs not declaring dyslexia in a licensing clinical exam. *Medical Education*; 53 (12): 1243-1252. doi: 10.1111/medu.13953.

Withanage I, Law GR, Withnall RD, Denney ML Siriwardena AN. Factors associated with differential performance in the MRCGP Clinical Skills Assessment: cross-sectional study. Submitted to Trent Regional SAPC conference, Leicester, March 2020.

Appendix A

Place of training: Deanery

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

Deanery	AKT	CSA
Armed Forces	31	16
East Midlands	274	147
East of England	397	173
Kent, Surrey, Sussex	280	137
London	422	231
North Western	459	215
Northern	169	88
Northern Ireland	65	42
Oxford	139	67
Scotland	297	184
Severn	152	77
South West Peninsula	92	37
Wales	114	69
Wessex	131	96
West Midlands	411	196
Yorkshire & Humber	219	184

*Note that 5 candidates are in the AKT column twice and 2 candidates are in the CSA column twice, as they changed deaneries between attempts. 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.