

MRCGP Annual Report covering 2020/21

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Statistical information provided by Psychometric Solutions Group.

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Introduction

This report relates to the formal MRCGP assessments conducted in the academic year 2020-21. It presents key data summarising the candidature, quality indicators and outcomes of all the diets of the MRCGP examinations during that period — three diets of the Applied Knowledge Test (AKT) and five diets of the Recorded Consultation Assessment (RCA). In addition, it presents a summary of the development work taking place across the AKT, RCA and the Workplace-Based Assessments (WPBA).

As a reminder, delivery of the Clinical Skills Assessment (CSA) was interrupted in March 2020 by the COVID-19 pandemic and, with the General Medical Council (GMC)'s endorsement, the RCA was introduced as a temporary and emergency response. As a result, the number of exam diets in 2020-21 differs from that in 2019-20.

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

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

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

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

As introduced in the 2019-2020 Annual Report, pass rates by medical school and deanery have been removed to reduce any risk of unconscious bias. As we did last year, 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 (i.e., making them IMG candidates) compared to White candidates, comparisons based solely on ethnicity would be inappropriate.

Readers should exercise caution when interpreting some information contained in the report. The overlap of ethnicity with candidate sex and other characteristics means, for example, that International Medical Graduates (IMGs) are more likely to be from BME groups and less likely to be female. Place of primary medical qualification is also not synonymous with nationality since UK nationals choosing to study abroad are included in the IMG group. There are also missing data as **22.4%** of unique candidates who sat an examination this year chose not to declare one of either their sex or ethnicity, and **4.4 %** chose to omit both their sex and ethnicity.

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

At the time of publication, the RCGP is developing a replacement assessment for the RCA. We shall continue to provide updates on the development to trainees by email, and on our website at <https://www.rcgp.org.uk/mrcgp-exams>. We shall be piloting this assessment throughout the summer of 2022 and anticipate it will be delivered by the Autumn of 2023. We remain committed to giving trainees 6 months' notice of launch.

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 some prefer the term “ethnic minorities.” We are using “BME” as this aligns with the terminology used by the GMC in their reports. We fully accept that ethnic minorities also include White minorities.

1 The MRCGP examination

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

- a. Applied Knowledge Test (AKT): multiple choice computer-based assessment, available in test centres throughout the UK.
- b. Recorded Consultation Assessment (RCA): a summative assessment of a doctor's ability to integrate and apply clinical, professional, communication and practical skills appropriate for general practice using pre-recorded video or audio consultations).
- 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 six months thereafter. Other than UK Ministry of Defence Trainees serving in UK military establishments abroad, no candidates based in other countries take these assessments.

Applied Knowledge Test (AKT)

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

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

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

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

Recorded Consultation Assessment (RCA)

Although the RCA was developed as an emergency replacement for the CSA, the ongoing impact of the COVID-19 pandemic necessitated extension of the RCA as the MRCGP's clinical module. Hence, we have undertaken several necessary RCA developments.

Initially candidates were able to submit consultations on any clinical topic of their choosing. It became evident, however, that such candidate submissions did not always demonstrate sufficient curriculum coverage. From November 2020, candidates had to ensure that within their thirteen-case submission, there should be at least one submitted consultation relating to each of the curriculum areas of:

- Care of the elderly
- Paediatric care
- Maternal and reproductive health
- Mental Health
- Care of chronic conditions
- Care of an acute presentation
- Two cases demonstrating clinical examinations (including psychiatric examination).

The FourteenFish platform was evolved to ensure a candidate's final submission covered all these mandatory criteria. In close consultation with the training community, RCGP also provided comprehensive guidance on the RCGP website about how best to fulfil the mandatory requirements. This included guidance on known areas which tended to underscore, in particular cases of low challenge.

Working closely with the training community, RCGP presented comprehensive guidance on the RCGP website on how to fulfil these mandatory requirements. There was also guidance on known areas which did not score well such as cases of low challenge.

As the COVID-19 pandemic continued, the style and methods of delivery of care adapted to the changing conditions and pressures of UK General Practice. The RCA methodology remained flexible to those adaptations and still allowed candidates to demonstrate their clinical skills. The ensuing performance data in this report demonstrate that passing rates have remained reasonably consistent.

Nevertheless, RCGP continued to consult with the training community. Further improvements were implemented in July 2021 after it became clear that, particularly with audio only consultations, it was not possible to reliably assess clinical examination. As a result, the mandated examination criterion was removed. Apart from those associated with the post-natal period, breast lumps were also no longer allowable to fulfil the mandatory criteria of maternal and reproductive health.² We also responded to feedback around the duration of cases and increased the time allowable for each consultation from 10 to 12-minutes.

Workplace Based Assessment (WPBA)

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

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

² Full guidance on mandatory case selection criteria for the RCA was provided at:
<https://www.rcgp.org.uk/training-exams/mrcgp-exam/mrcgp-recorded-consultation-assessment/mandatory-case-selection-criteria-for-recorded-consultation-assessment.aspx>

2 Who are our candidates?

Demographic characteristics

AKT and RCA

Those sitting the AKT and/or RCA were all UK-based GP trainees who obtained their primary medical qualification from one of 97 different countries. The number of candidates from each region of the world is presented in Table 2.1.

During the 2020-21 academic year, 4600 candidates made a total of 5292 attempts at the AKT, and 3580 candidates made a total of 4044 attempts at the RCA.

Of the 6980 unique candidates who sat the AKT and/or RCA in 2020-21, there were 4368 (62.6%) UK graduates (UKGs) and 2612 (37.4%) international graduates (IMGs).

The number of unique candidates increased by 1704 compared to 2019-20 academic year when there were 3472 (65.8%) UKGs and 1804 (34.2%) IMGs.

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

Continent	Number of unique candidates this year
Africa	973
Asia	1156
Australasia	3
Europe	4792
North America	44
South America	12

Considering all unique candidates sitting the AKT and/or RCA, there were 3615 (51.8%) female candidates; 2413 (34.6%) male candidates; and 952 (13.6%) candidates who did not declare their gender. Considering ethnicity, 2674 (38.3%) candidates declared their ethnicity as White; 3695 (52.9%) declared their ethnicity as BME; and 611 (8.8%) candidates chose not to declare their ethnicity.

Looking only at First Time Takers (FTTs) for the AKT and RCA, which is those candidates sitting either or both examinations for the first time in the 2020-21 academic year, the representation of each sex and ethnicity was as follows:

- **Female:** 3041 (53.6%)
- **Male:** 1881 (33.1%)
- **Sex not declared:** 754 (13.3%)

- **Ethnicity declared as White:** 2476 (43.6%)
- **Ethnicity declared as BME:** 2554 (45.0%)
- **Ethnicity not declared:** 646 (11.4%)

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

Place of training: Deanery

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

3 How did candidates perform?

Performance across the AKT and the RCA examinations

Figure 3.1 presents the status of all unique candidates who sat the AKT or RCA between 1 September 2020 to 31 August 2021. The cumulative pass rate is **79.8%** for the AKT and **86.6%** for the RCA.

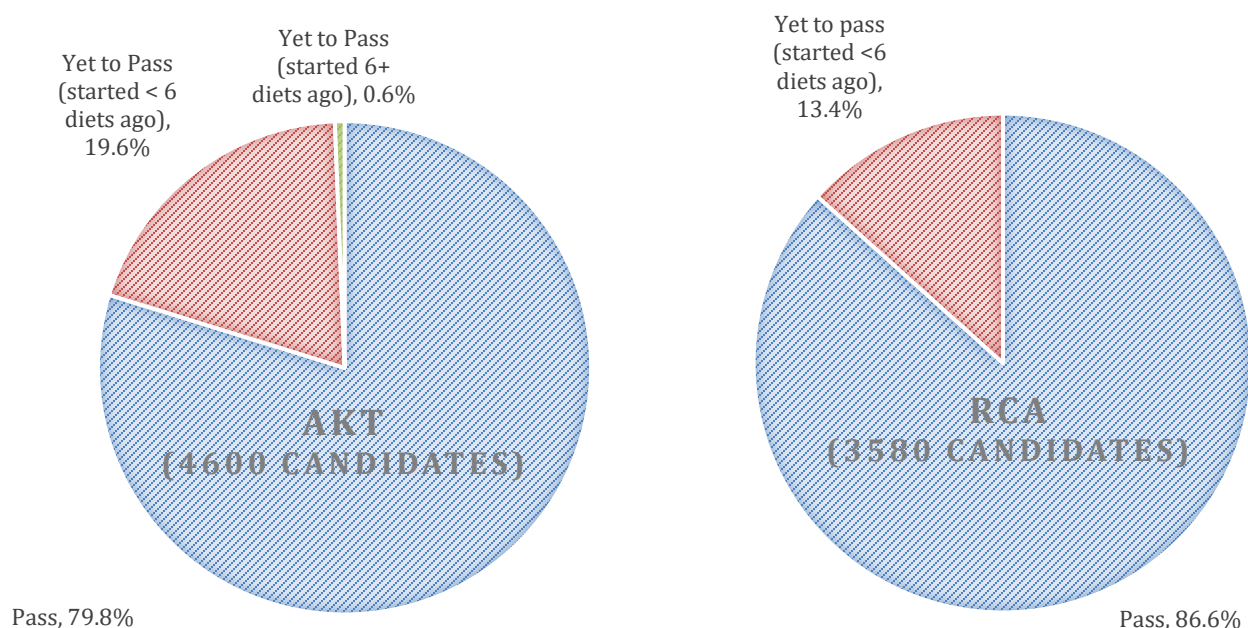


Figure 3.1: Candidates who sat the AKT/RCA between 1 September 2020 to 31 August 2021

The correlation between the scores of candidates who were FTTs of the RCA in 2020-21 with the same candidates' scores on their first attempt of the AKT (regardless of which year they first sat the AKT) was $r = 0.51$ ($n = 3221$, $t = 33.53$, $p < 0.001$). This correlation, shown in Figure 3.2, means that candidates who tend to achieve a low score on their first attempt in one 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.

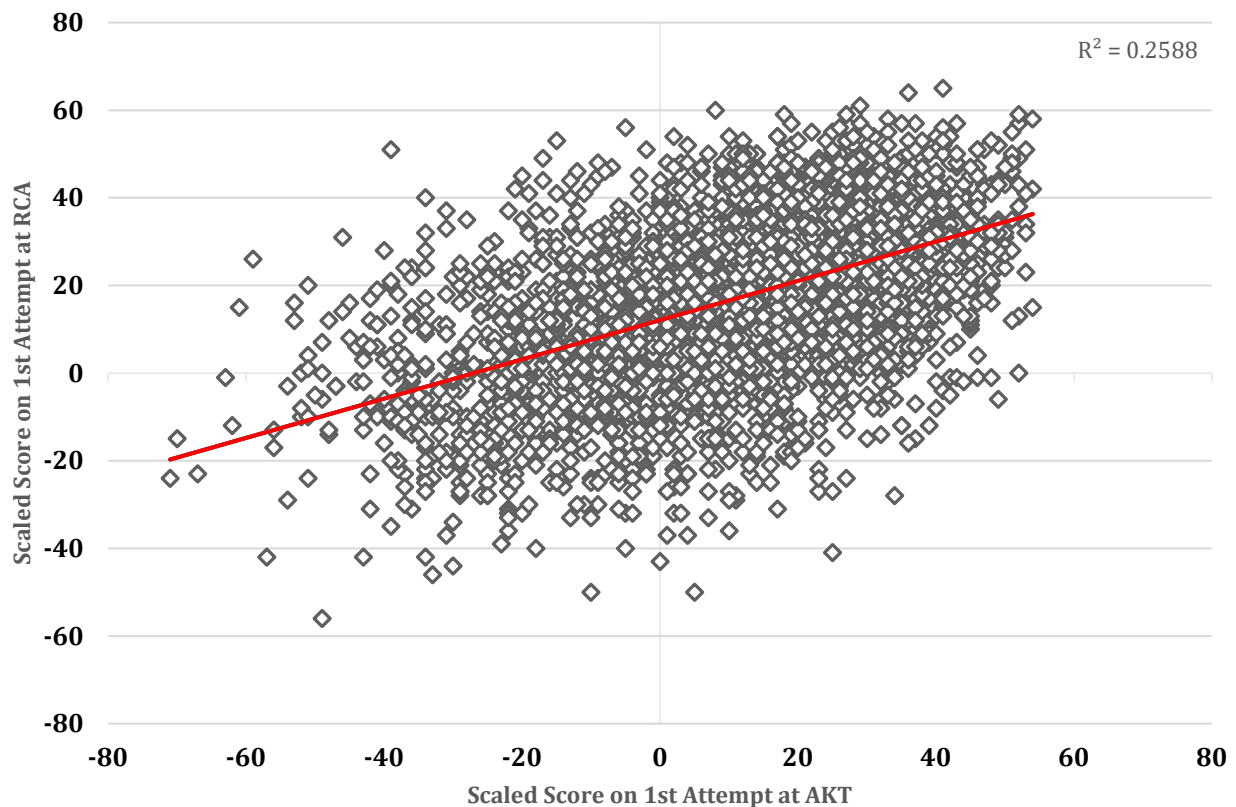


Figure 3.2: Correlation between FTTs' scaled scores on RCA and AKT

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

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

Notes for interpretation

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

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

Country of primary medical qualification (UK or International)

Figure 3.3 shows the scaled scores of UKG and IMG FTTS in the AKT and RCA.

In both the AKT and the RCA, 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.

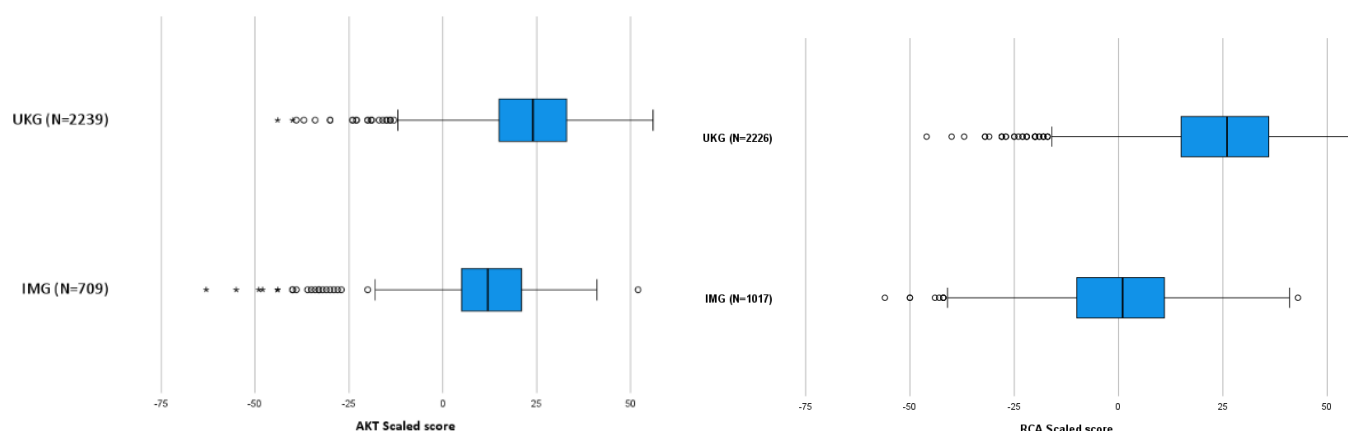


Figure 3.3: Performance of FTTS in the AKT and RCA, split by country of primary medical qualification and MRCGP module

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

Sex

In the AKT: there were 1494 Female UKGs, 852 Male UKGs, and 450 UKGs who chose not to disclose their sex. The UKG group was therefore 53.4% Female, 30.5% Male, and 16.1% Unknown (did not disclose).

In the RCA: there were 1307 Female UKGs, 704 Male UKGs, and 267 UKGs who chose not to disclose their sex. The UKG group was therefore 57.3% Female, 30.6% Male, and 12.1% 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, 78.4% were UKGs, while 21.6% were IMGs. This difference is reduced slightly among male FTT candidates, as 69% of males on their first attempt were UKGs, and 31% were IMGs.

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

Exam	Sex	Total FTTs	UKG FTTs	IMG FTTs
AKT	Female	1563 (100%)	1225 (78.4%)	338 (21.6%)
AKT	Male	960 (100%)	662 (69.0%)	298 (31.0%)
AKT	Unknown	425 (100%)	352 (82.8%)	73 (17.2%)
RCA	Female	1733 (100%)	1293 (74.6%)	440 (25.4%)
RCA	Male	1120 (100%)	674 (60.2%)	446 (39.8%)
RCA	Unknown	390 (100%)	259 (66.4%)	131 (33.6%)

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

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

Considering candidates who received their undergraduate medical training in the UK, the pass rate for females sitting the AKT was 98.1%, which was similar to the pass rate for males (98.5%). This difference was greater in the clinical assessment: in the RCA, the female pass rate was 96.0%, 6.1% higher than the male pass rate.

Amongst IMG candidates sitting the AKT for the first time, the pass rate for females was slightly lower than the pass rate for males (92% compared to 94.6%). In contrast, female IMG candidates had a higher pass rate than male IMG candidates in the RCA (60.0% compared to 45.5%).

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

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

Exam	Sex	Overall FTT pass rate (%)	UKG FTT pass rate (%)	IMG FTT pass rate (%)
AKT	Female	96.8	98.1	92.0
AKT	Male	97.3	98.5	94.6
AKT	Unknown	96.7	96.9	95.9
AKT	All FTT	96.9	98.0	93.5
RCA	Female	86.8	96.0	60.0
RCA	Male	72.2	89.9	45.5
RCA	Unknown	77.4	87.6	57.3
RCA	All FTT	80.7	93.2	53.3

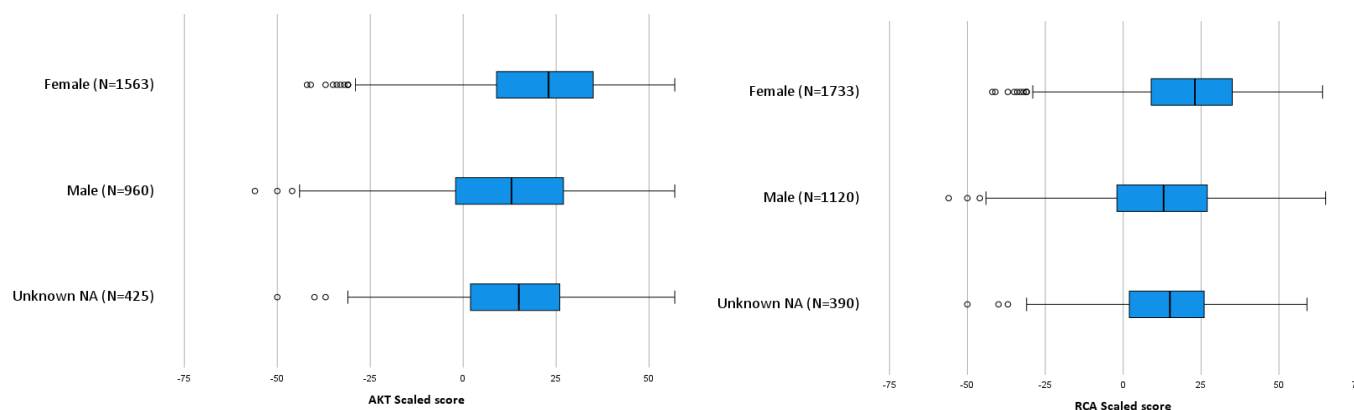


Figure 3.4: Performance of FTTs in the AKT and RCA, split by Sex and MRCGP module

Ethnicity

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

In the AKT: there were 764 BME UKGs, 1501 White UKGs, and 531 UKGs who chose not to disclose their ethnicity. The UKG group was therefore 27.3% BME, 53.7% White, and 19.0% Unknown (did not disclose).

In the RCA: there were 642 BME UKGs, 1297 White UKGs, and 341 UKGs who chose not to disclose their ethnicity. The UKG group was therefore 28.2% BME, 56.9% White, and 15.0% Unknown (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 and RCA, over nine in every ten White FTT candidates received their undergraduate training at a UK institution. The BME group was more evenly split, with 49.6% of all BME FTT candidates sitting the AKT having UK primary medical qualifications, while 50.4% were IMGs. A similar pattern was found with the RCA with 46.1% of all BME FTT candidates sitting the RCA having UK primary medical qualifications, while 53.9% were IMGs.

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

Exam	Ethnicity	Total FTTs	UKG FTTs	IMG FTTs
AKT	White	1361 (100%)	1302 (95.7%)	59 (4.3%)
AKT	BME	1086 (100%)	539 (49.6%)	547 (50.4%)
AKT	Unknown	501 (100%)	398 (79.4%)	103 (20.6%)
RCA	White	1393 (100%)	1291 (92.7%)	102 (7.3%)
RCA	BME	1336 (100%)	616 (46.1%)	720 (53.9%)
RCA	Unknown	514 (100%)	319 (62.1%)	195 (37.9%)

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

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

Considering candidates who received their undergraduate medical training in the UK, the pass rate for White candidates sitting the AKT was 98.7%, in line with the pass rate for BME candidates (98.0%). Differences were more marked in the RCA: pass rates for UKG sitting this exam were 97.1% for White candidates and 87.7% for BME candidates.

The same pattern was observed among IMG candidates, with the White pass rate in the AKT at 98.3% compared to the 92.9% pass rate by BME candidates. This difference was increased in the clinical assessment: in the RCA, the White IMG pass rate (58.8%) was 6.9% higher than the BME IMG pass rate (51.9%).

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

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

Exam	Ethnicity	Overall FTT pass rate (%)	UKG FTT pass rate (%)	IMG FTT pass rate (%)
AKT	White	98.7	98.7	98.3
AKT	BME	95.4	98.0	92.9
AKT	Unknown	95.6	96.0	94.2
RCA	White	94.3	97.1	58.8
RCA	BME	68.4	87.7	51.9
RCA	Unknown	75.5	87.8	55.4

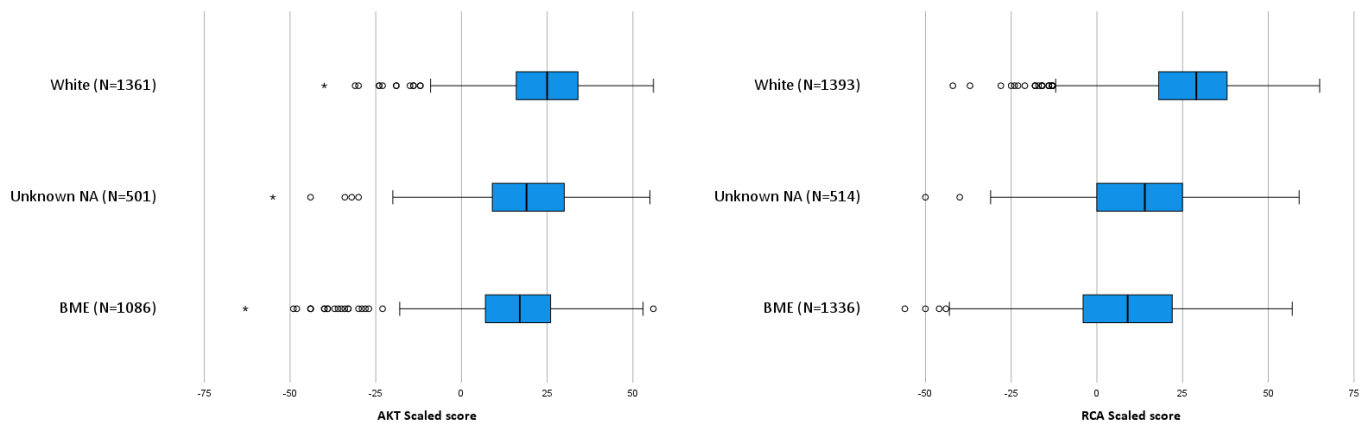


Figure 3.5: Performance of FTTs in the AKT and RCA, split by Ethnicity and MRCGP module

4 Candidate performance: Subject area and domain performance

Performance in the AKT

Subject area scores

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

Data are presented using percentage scores for each domain (% of available marks achieved). Candidates performed better on 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 80% 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%).

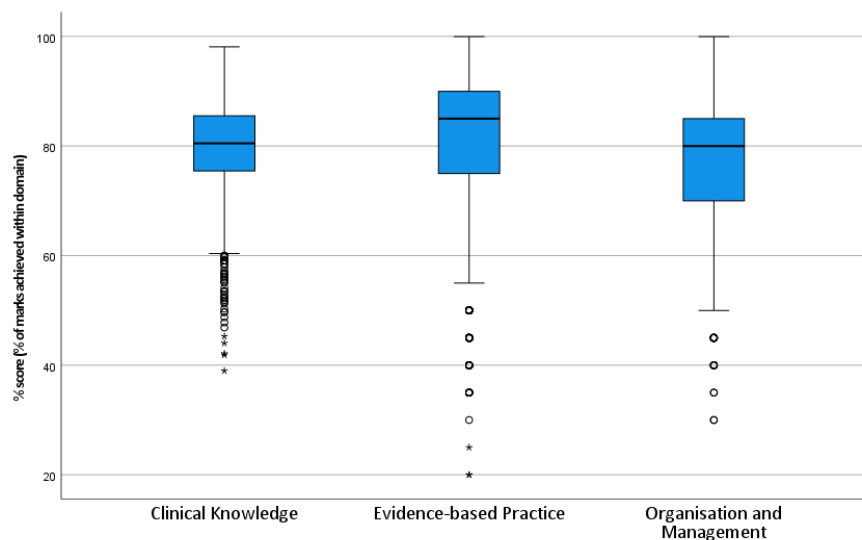


Figure 4.1: Performance of FTTs across the domains of the AKT

Insights from the item performance statistics

Candidates with less exposure at undergraduate and postgraduate training to data-interpretation and primary care administration issues find these AKT sections more difficult. This also applies to clinical topics, commonly women's health issues.

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

Professional topics:

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

Equality, Diversity and Inclusion clinical management for transgender people

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: safe prescribing including drug monitoring, important drug interactions and adverse reactions, evidence-based prescribing including awareness of MHRA alerts and legislation, antibiotic indications and resistance, dose calculations, effective use of resources, principles of prescribing in diabetes (including insulin)

Leadership and management: death certification and notifications to Coroner/Procurator fiscal, staff health, health and safety in the workplace

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

Life stages topics:

Children and Young People: safeguarding and non-accidental injury, consent and capacity, developmental assessment and screening, common childhood infections, normal findings, minor illness

Older adults: consent and capacity for decision-making and the relevant legal frameworks

People at the End-of-Life: pain management, ethics, and mental capacity

Clinical topics:

Interpretation of anaemia, management of hearing loss, menopause symptoms and HRT, common neurological findings and red flags, contraception, ECG abnormalities, recognising presentations of mental ill health (including physical symptoms), substance abuse, eye problems including abnormal retinal appearance, consideration of pregnancy in a differential diagnosis, management of minor blood test abnormalities, skin conditions (including genital)

and their appearance (represented by photos), understanding (but not detailed knowledge) of secondary care management, common urological symptoms, respiratory medicine - including asthma management , COPD and interpretation of spirometry, suspected cancer - diagnosis & investigation (including less common presentations) , timely but appropriate referral (including emergencies and when to do nothing), presentation of benign disease and appropriate management, safeguarding adults including domestic abuse, common presentations of metabolic diseases, common gynaecological problems, diagnosis of common oral conditions, different presentations of multi-system disease.

Performance in the RCA

Domain-based scores

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

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

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

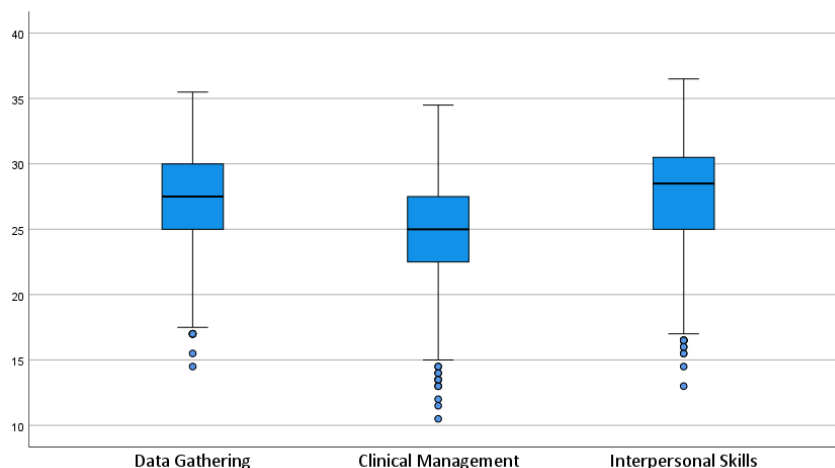


Figure 4.2: Performance of FTTs across the domains of the RCA

Feedback provided by the examiners in the RCA

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

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

Feedback Statement	Percent	Mean
CM1: Insufficient evidence of Decision Making and Clinical Management skills to demonstrate capability of safe independent UK General Practice	83.11	2.37
CM3: Does not develop a Management Plan (including prescribing and referral) reflecting knowledge of current best practice	78.23	2.01
G4: Poor choice of consultation: Does not demonstrate capability in consulting skills sufficient for independent UK General Practice	71.84	1.85
CM2: Does not identify an appropriate range of Differential Diagnoses and/or form a reasoned Working Diagnosis	67.62	1.71
IPS2: Does not demonstrate active listening skills, limited exploration, and use of cues	59.69	1.92
DG2: Inadequate history taken to enable safe assessment of disease and its severity	59.14	1.59
DG3: Does not elicit and develop adequate amounts of new information to demonstrate competence	57.75	1.54
CM4: The choice of management was unclear due to missing information	57.71	1.55
DG1: Insufficient evidence of Data Gathering skills to demonstrate capability of safe independent UK General Practice	57.27	1.49
DG4: Does not consider and/or test an adequate range of Differential Diagnoses	50.51	1.39
CM5: Does not demonstrate an awareness of management of risk or make the patient aware of relative risks of different options	49.60	1.39
IPS3: Does not develop a shared understanding, demonstrating an ability to work in partnership with the patient	48.42	1.58
DG5: Does not identify or use appropriate Psychological or Social information to place the problem in context	47.80	1.39
G3: Shows poor Time Management	44.53	1.52
DG6: Does not offer/undertake appropriate Physical/Mental examination as part of the diagnostic process	39.24	1.29
CM7: Does not make adequate arrangements for follow-up and safety netting	37.96	1.31
CM6: Does not show appropriate use of resources, including aspects of budgetary governance	31.57	1.23
IPS5: Does not use language and/or explanations that are relevant and understandable to the patient	31.31	1.48
IPS1: Insufficient evidence of Interpersonal skills to demonstrate capability of safe independent UK General Practice	29.48	1.27
IPS4: Does not acknowledge or utilise the patient's contribution to the consultation including consent	22.87	1.19
G2: Does not recognise the issues or priorities in the consultation	18.39	1.14
IPS6: Does not treat the patient with appropriate respect and/or sensitivity during the consultation	16.96	1.17
G1: Disorganised and or Unstructured Consultation	16.34	1.14
DG7: Does not recognise the implications of any abnormal findings or results	8.85	1.05

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 (SpLD) is the disability most frequently reported. Disabilities other than SpLD have been merged for reasons of small numbers and personal confidentiality, the most common ones being 'other disability,' physical disability, hearing impairment, and multiple disabilities.

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

AKT

In the category 'all disabilities,' there were 577 candidate-attempts at the AKT in the academic year 2020-2021, representing 10.9% of all attempts. Of these 577 attempts, 370 (64.1%) were successful.

In the category 'SpLD,' there were 469 candidate-attempts at the AKT, representing 8.9% of all attempts this academic year. Of these 469 attempts, 306 (65.2%) were successful. Note that candidates with SpLD and another disability who selected 'more than one disability' are not included in the SpLD group.

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

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

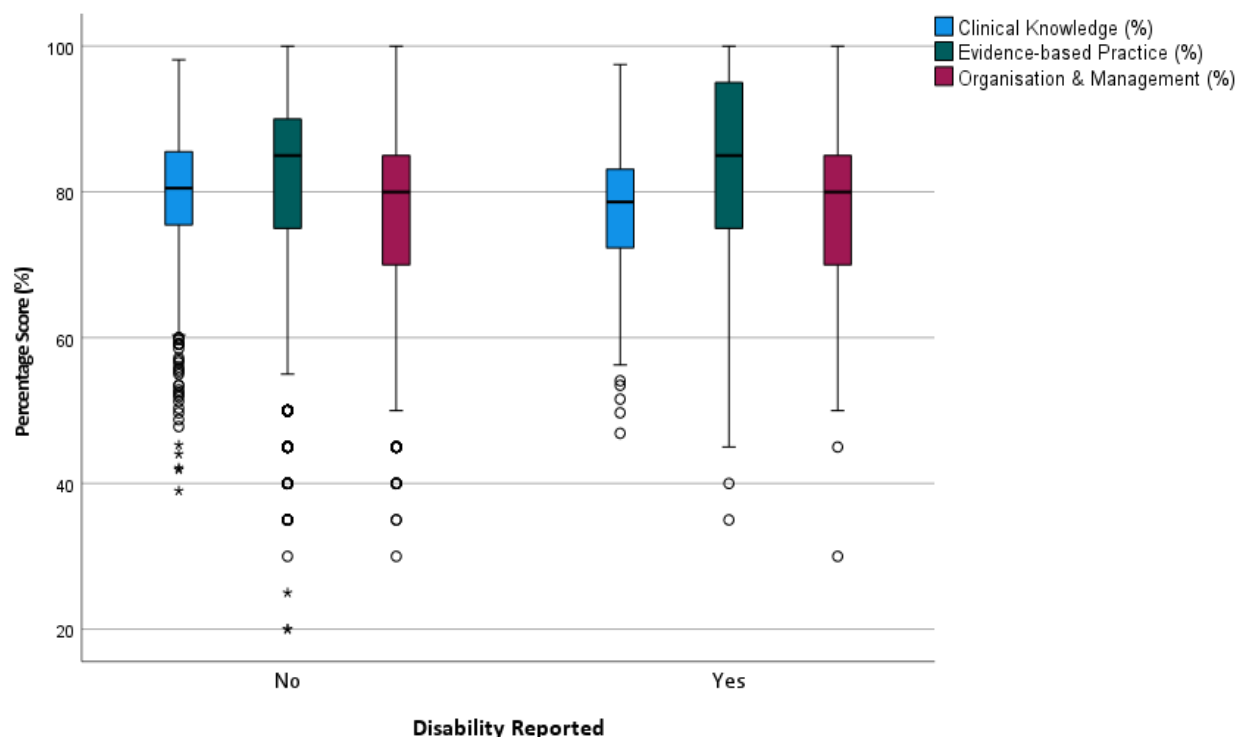


Figure 5.1: Performance (% score) of FTTs in the three AKT domains split by Disability status of FTTs in the three AKT domains split by Disability status

RCA

For the RCA, in the category 'all disabilities' there were 450 candidate-attempts in the academic year 2020-21, representing 11.1% of all attempts. Of these 450 attempts, 293 (65.1%) were successful.

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

It is important to note however that there are 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.

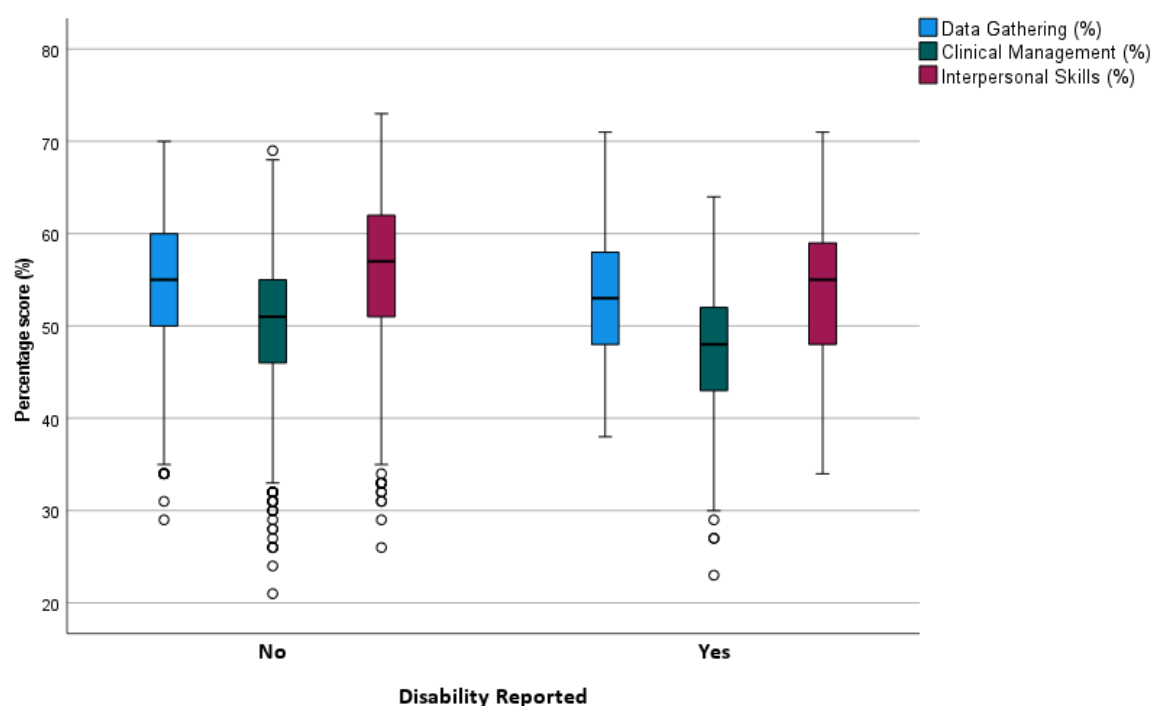


Figure 5.2: Performance of FTTs in the three RCA domains (raw score) split by Disability status

6 Update from the Workplace Based Assessments

Summary

WPBA makes up the third requirement for the UK GP licensing assessment. 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 was reviewed and updated. The changes were accepted by the GMC for implementation from August 2020.

New assessment programme and portfolio

The new WPBA assessment programme started on 5th August 2020. All trainees commencing ST1 started on the new programme. Trainees already in training moved onto the new programme when they changed training years. Trainees on extensions continued on the old programme unless they wished to change. All trainees will need to have transferred across by August 2022.

The new assessment package changes included: reducing the assessment burden; updating the assessment formats; and introducing quality improvement, leadership, and prescribing assessments into GP training.

GMC requirements

A report re-evaluating the prescribing assessment was sent to the GMC in September 2021. The report was based upon a trainer and trainee survey. Data was analysed externally by Nottingham University. Trainees and trainers agreed the prescribing assessment is useful. Few trainees reported taking longer than 4 hours to review the 50 prescriptions. As the error rate with a reduced number of prescriptions was broadly comparable to that found in 2020, the review team felt that it would be prudent not to further reduce the number of prescriptions to be reviewed. The GMC confirmed 'full approval' of the prescribing assessment in November 2021.

GMC approval was also sought for trialing non-GP assessors for some of the trainee assessments so Allied Healthcare Professionals (AHP) could be used. The GMC response included: "It is fine to use AP assessors provided it is appropriate for them to act as assessors for the specific assessment linked to them. It is important that they are trained and supported in these assessor roles."

Learning resources

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

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

RCA guidance can be found at:

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

WPBA guidance can be found at:

<https://www.rcgp.org.uk/mrcgp-exams/wpba>

Differential attainment

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

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

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

The RCGP is actively supporting the work led by the GMC and the AoMRC to *Eliminate Inequality in Medical Education* and are currently developing our own Action Plan.

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

- Aligning curriculum and assessments to the GMC's 'Excellence by design' standards which have fairness as a guiding principle.
- Developing resources and educational events to support trainers and trainees in their AKT and RCA preparation. MRCGP examiners regularly support RCGP Faculty and Deanery exam preparation courses across the UK.
- Performing regular stakeholder engagement, with particular interest to the development of a new clinical skills module to replace the RCA.

- 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.
- Targeted recruitment of MRCGP panel members, including examiners and those working on the development groups of AKT, RCA and its replacement, and WPBA from under-represented demographic groups. This has included a review of adverts and job descriptions to ensure that roles advertised are inclusive and open to all
- 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.
- 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 are collected appropriately, and in-line with GDPR regulations.
- Reviewing the feedback provided to candidates in all modules to improve usefulness to them and their supervisors (e.g., changes made in the feedback to AKT, WPBA and RCA candidates).
- Resources to support candidates to have failed exams (e.g., ongoing work on guidance on reflection after an examination of failure, and tips for enhancing success).
- Conducting equality impact assessments and piloting of any proposed new assessments (e.g., piloting for the prescribing assessment in WPBA, ongoing piloting and work on the new clinical skills assessment module) and all policies.
- Reviewing existing assessments to reflect the demographics of UK patient populations to inform new cases for the future clinical skills assessment.
- Reviewing individual item performance in the AKT and ensuring item construction is designed to reduce potential differential attainment where feasible
- Keeping research into differential attainment of MRCGP candidates as a strategic priority. Several research projects have been completed; others are in progress. RCGP aims to publish these findings in peer-reviewed journals to help shed light on differential performance in examinations.

- Detail of research conducted is outlined below. Research for 2022-23 will focus particularly on candidates with specific learning difficulties performance on data interpretation questions in the AKT, and an exploration of the perceptions of doctors in training with specific learning difficulties undertaking clinical and workplace-based assessments for general practice licensing.

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

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

For further information please email info.EDI@rcgp.org.uk

Summary of recent RCGP related research

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

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

What this study tells us:

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

What this means:

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

Papers and reports published by the RCGP and other academic teams over the past year related to the MRCGP have focused on factors related to passing the MRCGP or addressed performance problems more generally.

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

What this study tells us:

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

What this means:

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

Winter R, Norman RI, Patel R. *A qualitative exploration of the lived experience of GP trainees failing to progress in training*. Educ Prim Care 2021, 32(1):10-18.

What this study tells us:

- This qualitative semi-structured interview study of 23 GP trainees identified as failing to progress satisfactorily or failing the MRCGP examinations found that professional, personal, and social factors contributed to difficulties with progression.
- Professional factors included difficulties with managing workload and poor motivation, personal factors included psychological ill-health, while social factors included lack of family time.
- These factors arise during training and could be addressed by increasing understanding of trainees' journeys and provision of bespoke packages of support to fully address their needs and the challenges they face.

What this means:

- The performance on the day of GP trainees failing the Clinical Skills Assessment was likely to be due as much to the complex interplay between professional, personal, and social factors, as it was due to trainees' knowledge or skills.

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 2021, 32(2):85-90.

What this study tells us:

- This qualitative semi-structured interview study explored 15 GP trainee role players' perceptions of peer role play in a formative CSA and found that role play provided an insight into the exam.
- It helped trainees know what to expect and how to approach the exam, emphasised the importance of communication skills, acknowledging the patient's perspective and aided professional development, particularly in observing good feedback.

What this means:

- GP trainees who role played patients in a formative CSA reported increased confidence and educational gains from their experience

Conference presentations

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

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

Siriwardena AN, Botan V, Laparidou D, Phung VH, Cheung P, Freeman A, Wakeford R, Denney M, Law GR. *Candidate perceptions of the UK Recorded Consultation Assessment introduced during the COVID-19 pandemic: cross-sectional study*. Oral presentation online at Society for Academic Primary Care, Annual Scientific Meeting 30 June-1 July 2021, University of Leeds.

Siriwardena AN, Botan V, Laparidou D, Phung VH, Cheung P, Freeman A, Wakeford R, Denney M, Law GR. *Examiner perceptions of the UK Recorded Consultation Assessment introduced during the COVID-19 pandemic: cross-sectional study*. Poster presentation online at Society for Academic Primary Care, Annual Scientific Meeting 30 June-1 July 2021, University of Leeds.

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

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

Letters

Two letters (from Chris Williams and Roger Neighbour) and in the British Journal of General Practice discuss the problem of selecting cases of sufficient complexity in the Recorded Consultation Assessment (the 'hidden fourth construct').

Williams C. *MRCGP Recorded Consultation Assessment - the hidden fourth construct*. Br J Gen Pract 2021, 71(703):58.

Neighbour R. *MRCGP Recorded Consultation Assessment - the hidden fourth construct*. Br J Gen Pract 2021, 71(705):157.

An opinion piece from Greg Irving argues for more time to consult in the Recorded Consultation Assessment, particularly in more complex cases.

Irving G. *The MRCGP Recorded Consultation Assessment: time to drop 10 minutes as standard?* Br J Gen Pract 2021, 71(703):71.

Appendix A

Place of training: Deanery

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

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

Deanery	AKT	RCA
Armed Forces	32	32
East Midlands	361	257
East of England	404	343
Kent, Surrey, Sussex	323	303
London	529	413
North Western	550	469
Northern	234	155
Northern Ireland	120	76
Oxford	163	127
Scotland	354	270
Severn	187	168
South West Peninsula	113	80
Wales	207	136
Wessex	195	132
West Midlands	441	377
Yorkshire & Humber	387	242

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