

# MRCGP 2019 Annual Report

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Statistical information compiled by RCSEd Psychometricians

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## Introduction

This revised-style report, compiled with new expert psychometric advice, relates to the formal MRCGP assessments conducted in the academic year 2018-19. 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 six 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). 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.

Following retirement of the exam's previous psychometric experts since the last annual report, we have been pleased to appoint a team of experienced psychometricians to provide statistical analysis and guidance to the exam. As well as bringing fresh insights, they have brought a new format to the statistical information provided in this report. We have also tried to make the report more user-friendly and readable, reduce unnecessary or incomplete information, and 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 tripos, and explains some of the changes to WPBA planned for 2020 onwards.

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) is collected rather than 'gender'.

Pass rates by medical school and deanery have been removed. Deaneries will receive their own candidate data, along with anonymised comparative data, for their own internal use. *Currently we report on UK Graduate (UKG)/International Medical Graduate (IMG), Black and Minority Ethnic (BME)/non-BME and gender as candidate subgroups.* Our psychometric experts advise that comparisons of BME/non BME pass rates are potentially misleading, due to the influence of other factors on differences on pass rate, primarily UKG/IMG status. Since a greater proportion of BME candidates were trained outside the UK compared to non-BME candidates, comparisons based solely on ethnicity mask the more obvious effect of place of training.

**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 female candidates are less likely to be IMG or BME candidates. 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 (almost 30%) of candidates chose not to declare their gender or ethnicity and, because of high rates of missing data, this year will be the last for which BME/non BME pass rates will be reported.**

More exams data are available on the GMC website, including data on differential attainment.

## **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 available to doctors undergoing GP training within the UK state health care system or within six months thereafter. 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 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.

## 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;

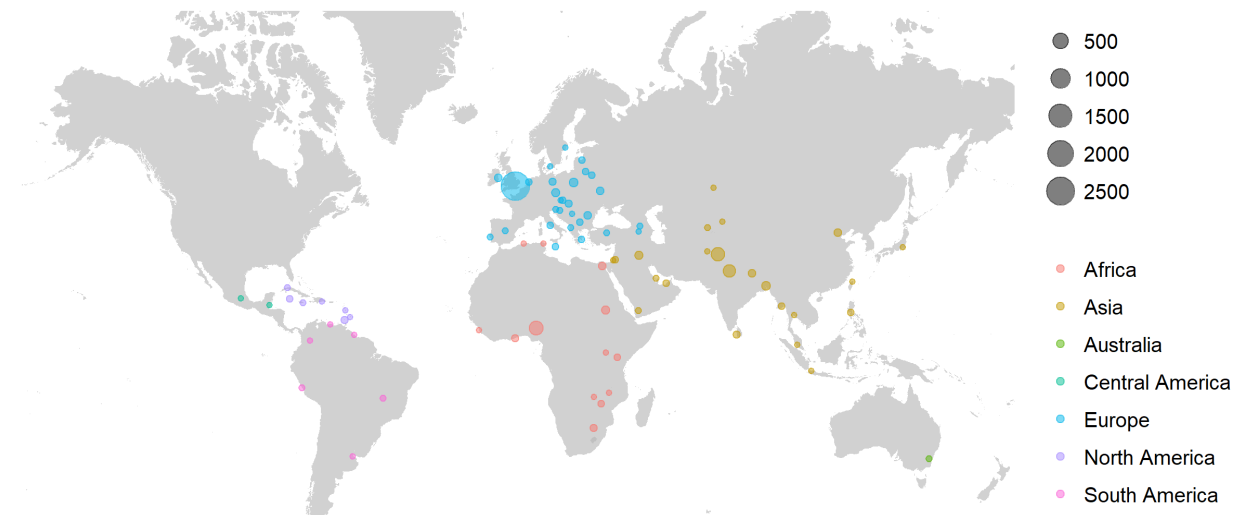
- determine fitness to progress towards completion of training.

### Who are our candidates?

Our candidates were all UK-based GP trainees, who obtained their primary medical qualification from 90 different countries. During 2018-2019, 3253 candidates made a total of 3747 attempts at the CSA and 3714 candidates made a total of 4243 attempts at the AKT.

On the map below (Figure 1) the number of candidates from each country is represented by the size of the bubble around the capital city. Of the 6026 candidates who sat examinations in the academic year 2018-19, there were 4434 (73.58%) UK graduates (UKGs) and 1592 (26.42%) international graduates (IMGs). The number of candidates overall has increased by 445 since last academic year, in which 4327 (77.53%) candidates were UKGs and 1254 (22.47%) were IMGs.

Figure 1: *Country from which primary medical qualification was obtained*



The candidates included 3340 (55%) female, 1844 (31%) males and 842 (14%) who did not declare their gender. Also, 2740 (45%) declared their ethnicity as white, 2146 (36%) stated their ethnicity to be Black, Asian and Minority Ethnic, while 1140 candidates (19%) did not declare their ethnicity. **Readers are again reminded to exercise caution when interpreting information which has significant missing data.**

## Source of Primary Medical Qualification: Medical school

A table detailing the medical schools from which all UK trained candidates obtained their primary medical qualification is available in Appendix A.

## How did candidates perform?

### Performance across the AKT and the CSA examination

For candidates who sat their first attempt of the CSA within the last ten diets of the examination, the average cumulative pass rate for candidates who passed after the maximum number of attempts allowed was 98%. For the AKT the cumulative pass rate after the maximum number of allowed attempts was ~95%.

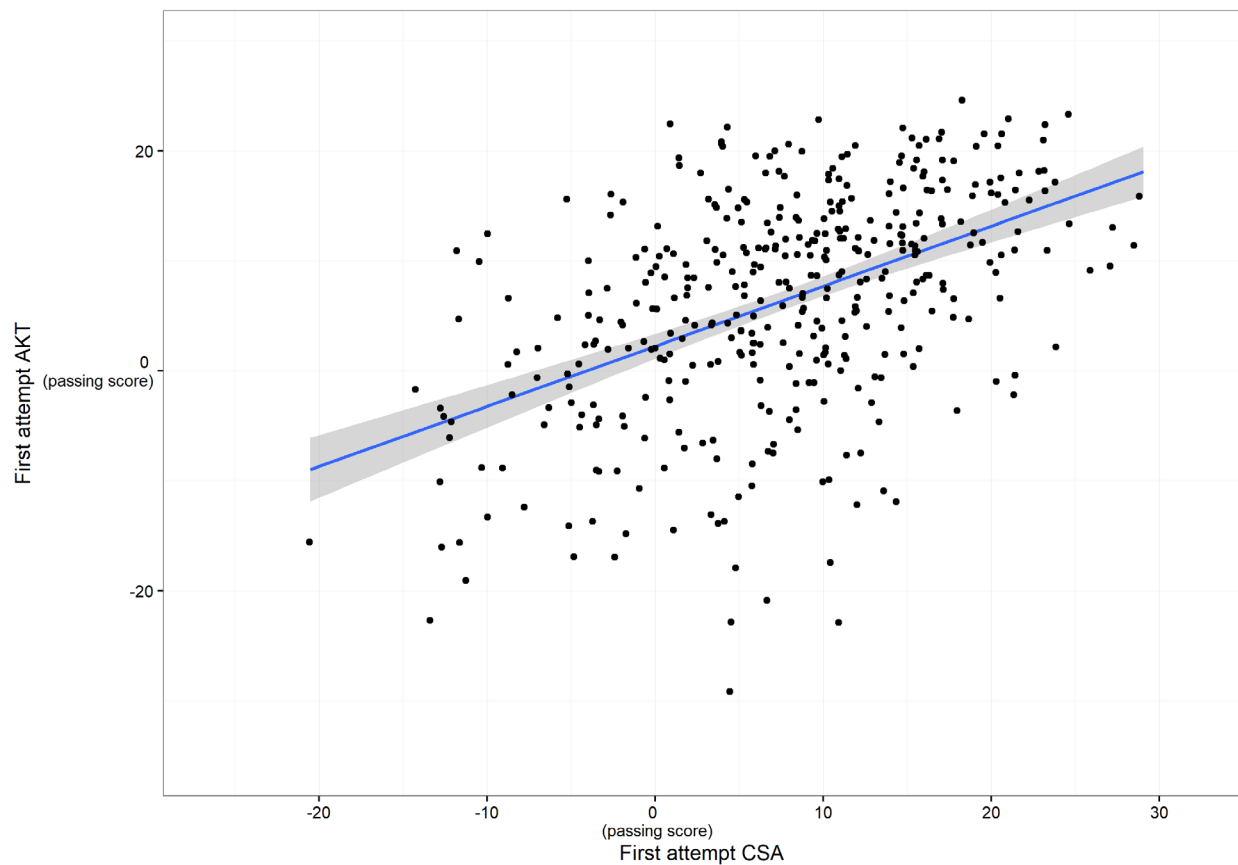
***For every 100 UKGs who pass the AKT, around 90 IMGs pass the AKT taking into account number of attempts, sex, ethnicity and declaration of dyslexia.***

***For every 100 UKGs who pass the CSA, around 97 IMGs pass, taking into account number of attempts, sex, ethnicity and declaration of dyslexia.***

Further information is available on the GMC website.

The correlation between first-time taker (FTT) scores on the AKT and the CSA in this year's diet was  $r = 0.48$  ( $t = 10.93$ ,  $p < 0.001$ ). This correlation, shown in Figure 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.

Figure 2: *Correlation between FTT scores on CSA and AKT*



Figures 3-5 below show the scores of these candidates in the AKT and in the CSA examination, split by demographic characteristic, allowing the reader to note the similarity in patterns across the two examinations.

**Again it is important to note both the large proportion of candidates who chose not to declare their gender or ethnicity, as well as the uneven representation of genders and ethnic groups in different splits in the data.**

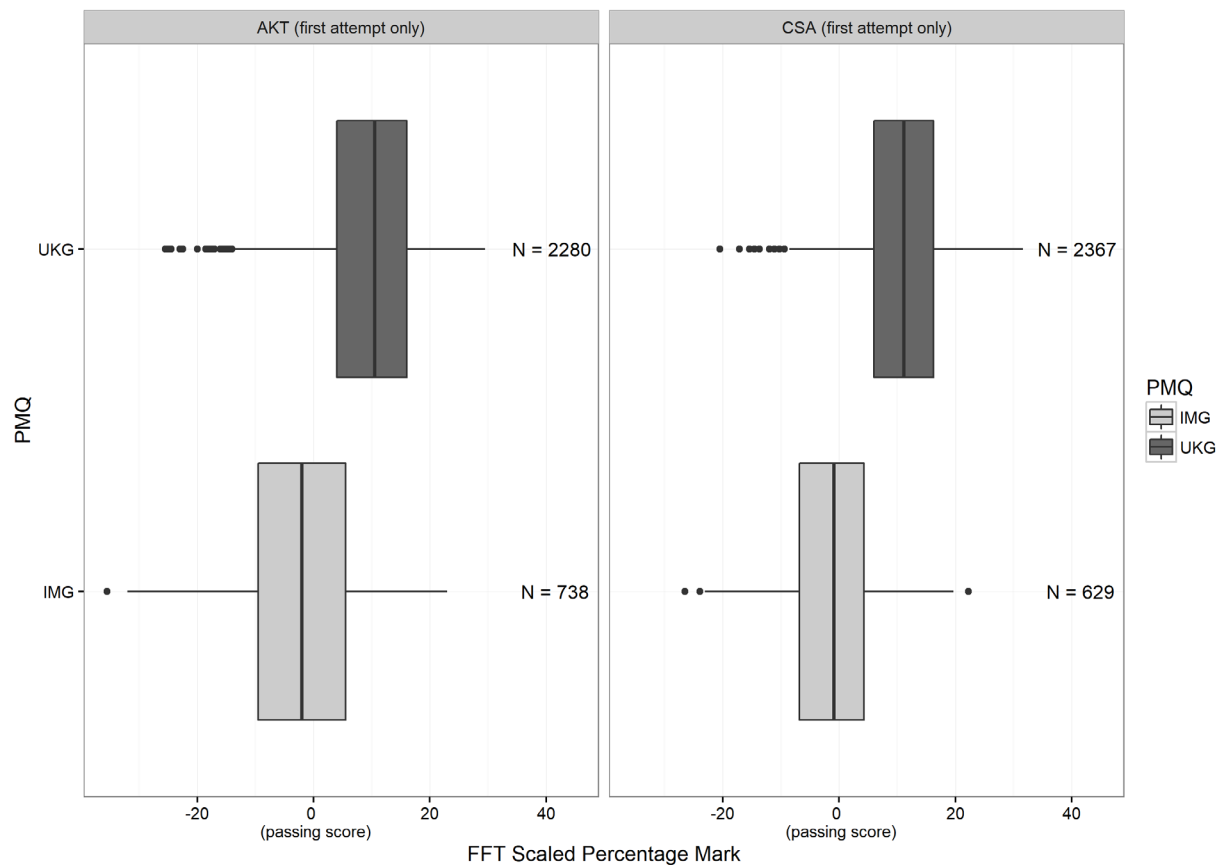


## Country of Primary Medical Qualification (UK or International)

Notes for interpretation:

Box and whisker plots show the median score (the middle score when all scores are ranked smallest to largest) as the horizontal line in the middle of the box. The left edge of the box to the median line is the 25<sup>th</sup>-50<sup>th</sup> percentile, and the median line to the right edge of the box is the 50<sup>th</sup>-75<sup>th</sup> percentile. The whole box (25<sup>th</sup>-75<sup>th</sup> percentile) shows the interquartile range (IQR). The end of the line to the left of the box is called the 'minimum' (the 25<sup>th</sup> percentile minus 1.5 IQR), and the end of the line extending to the right is called the 'maximum' (75<sup>th</sup> percentile plus 1.5 IQR). Dots beyond the line are outliers (extreme scores).

Figure 3: AKT and CSA scaled scores split by place of primary medical qualification



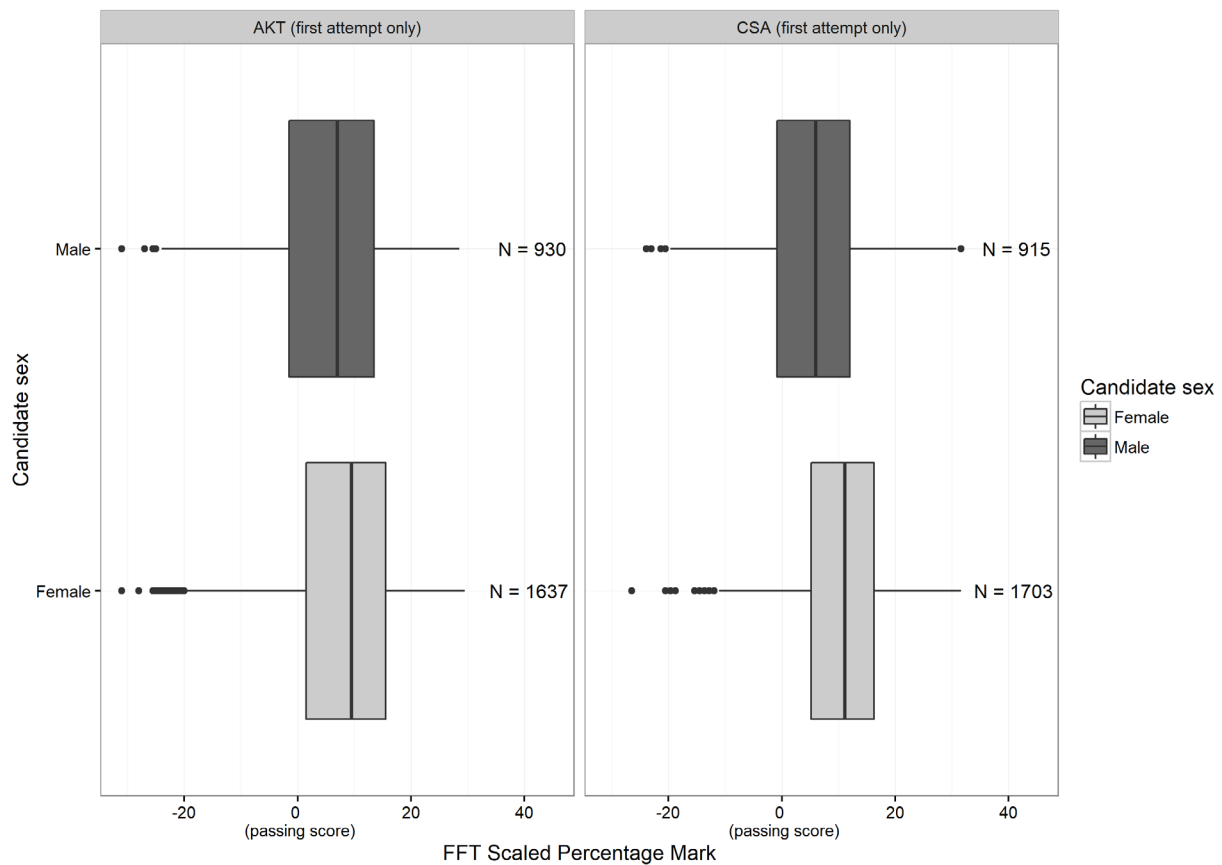
In both the AKT and the CSA, the demographic characteristic which was tied to the biggest difference in performance by candidates on their first attempt was whether or not the candidates had obtained their primary medical qualification in the UK or not. As training status has been shown to be such a strong predictor of scores and pass/fail outcomes, we have stated for each of the following groups the proportion of UKGs in each demographic group, as the

differences observed within each demographic characteristic are confounded by the proportion of UKG and IMG candidates. **Note again 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 training programmes than the candidates within different training programmes.**

## Candidate sex

For the AKT, the proportion of UK Graduates within the female group was 78%, compared to 71% within the male group. For the CSA, the proportion of UK Graduates within the female group was 83%, compared to 74% within the male group. **Not every candidate disclosed their gender, therefore data represented in the graph below are incomplete so caution should be exercised when interpreting these. Differences by gender decrease considerably in multivariable analyses.**

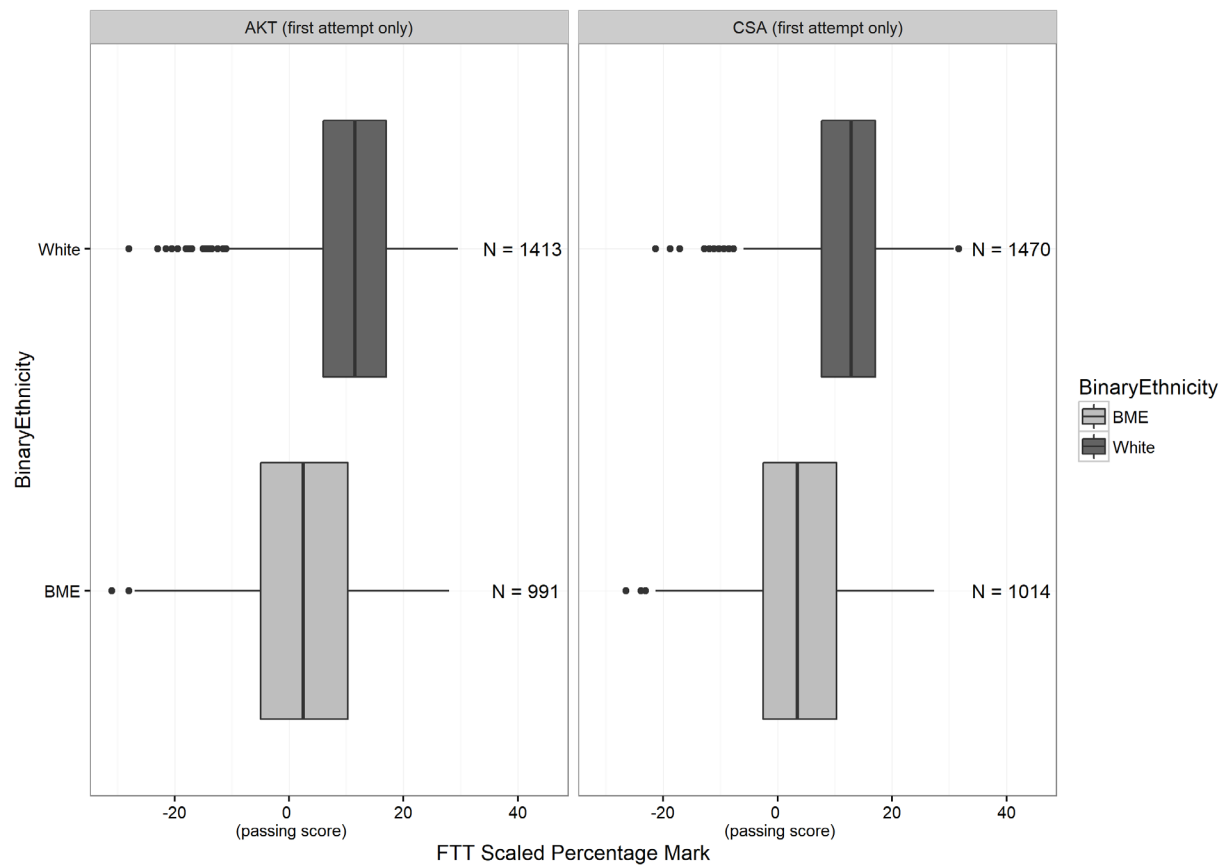
Figure 4: AKT and CSA scaled scores split by candidate sex



## Ethnicity

In this section, we have split the candidates into two groups (BME and white). For the AKT, the proportion of UKGs within the BME group was 50%, compared to 94% within the white group. For the CSA, the proportion of UKGs within the BME group was 58%, compared to 95% within the white group. Considering the very different proportions of UKGs and IMGs in the white and BME groups, the differences observed between the two ethnic groups are confounded by the differences in training, and are thereby difficult to interpret and will not be explored further in this report. **It must be stressed that not every candidate disclosed their ethnicity, therefore the data represented in the graph below do not include every candidate who sat the AKT and CSA, and caution should be exercised when interpreting these data.**

Figure 5: AKT and CSA scaled scores split by ethnicity



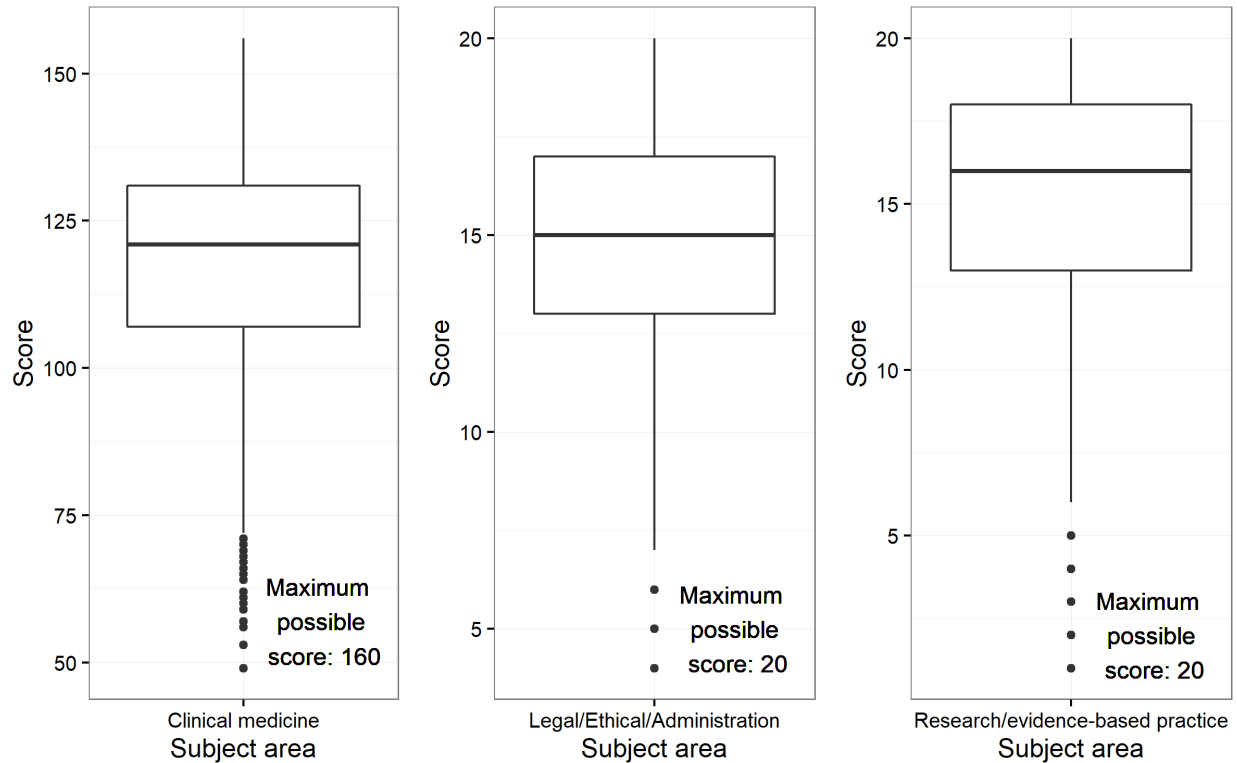
## Candidate performance in the AKT and CSA

### Performance in the AKT

#### Subject area scores

In the 200-question AKT paper, 160 of the questions relate to clinical medicine, 20 to research/evidence-based practice and 20 to primary care legal/ethical/administration issues. Figures 6-8 show the spread of candidates' scores on questions across the three areas.

Figures 6-8: AKT *subject area scores*



### Topics causing most difficulty for candidates in recent AKT exams

The AKT core group publish feedback after each exam summarising areas where candidature performance is improving or worsening. More detailed analyses by the psychometric team from the past 12 months are broadly summarised as follows:

- Female candidates tend to outperform male candidates especially with questions about antenatal issues, child development, child health, contraception and women's health.
- Male candidates tend to outperform female candidates with questions about men's health and urology
- UK graduates tend to outperform candidates with a PMQ from outside the UK with questions about safeguarding, data interpretation and in clinical areas where conditions are more prevalent in the UK than internationally or where available treatments/management pathways are different

- Candidates with a PMQ from outside the UK tend to outperform UK graduates with questions where conditions are more prevalent internationally and/or in specific ethnic groups
- Candidates omitting even only a few questions tend to have disproportionately lower scores than expected from their total number of questions answered

**Specific topic areas causing most difficulty for candidates over the previous 12 months are listed as follows:**

**AKT 36**

**2.03 The GP in the wider professional environment**

- Vaccination programmes and staff health

**3.01-3.23 Clinical modules**

- Childhood infections and ear problems
- Distinguishing between serious and non-serious disease
- Familiarity with common secondary care management
- Normal variants and the management of children
- Pregnancy-related conditions and prescribing when breast-feeding
- Principles of prescribing in diabetes

**AKT 35**

**2.02 Patient safety and quality of care**

- MHRA safety alerts

**2.03 The GP in the wider professional environment**

- General understanding of qualitative research methodology

**3.01-23 Clinical modules**

- Management and drug treatment of acute life-threatening conditions
- Drug treatment in end-of-life care
- Physical symptoms as presentations of mental health disease
- Diagnosis and management of common oral conditions

## **AKT 34**

### **2.01 The GP consultation in practice**

- Communication of risk and use of risk tools

### **2.02 Patient safety and quality of care**

- Drug interactions
- Drug dose calculations
- Health and safety in the workplace

### **2.04 Enhancing professional knowledge**

- Basic understanding of concepts and terms in research

### **3.01-23 Clinical modules**

- Childhood/ neonatal infections
- Diagnosis of rare but serious conditions e.g. endocrine
- Risks of common treatments e.g. respiratory disease
- Rheumatological disease presentations

## **Summary of topics causing most difficulty over recent years**

These are the topics causing difficulty for candidates that have been highlighted several times over recent years (\* = areas of improvement in AKT 36):

### **2.02 Patient safety and quality of care**

- Antibiotic indications and resistance
- Death certification
- Drugs: monitoring; adverse reactions; dose calculations \*
- Health and safety in the workplace

### **2.03 The GP in the wider professional environment**

- Data interpretation (both research and other data sources)
- Research methodology

### **3.01-3.21 Clinical modules**

- Diagnosis of common oral conditions
- Eye problems
- Immunisation schedules
- Knowledge and application of national guidance \*
- Management of hearing loss
- Normal findings and minor illness in childhood
- Physical symptoms presenting as part of a psychological diagnosis
- Respiratory medicine – including asthma, COPD and rarer diagnoses
- Suspected cancer: diagnosis and investigation (incl. rarer presentations) \*
- Timely but appropriate referral (incl. emergencies and when to do nothing)
- Type 1 diabetes (primary care level of knowledge expected)

## 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”.

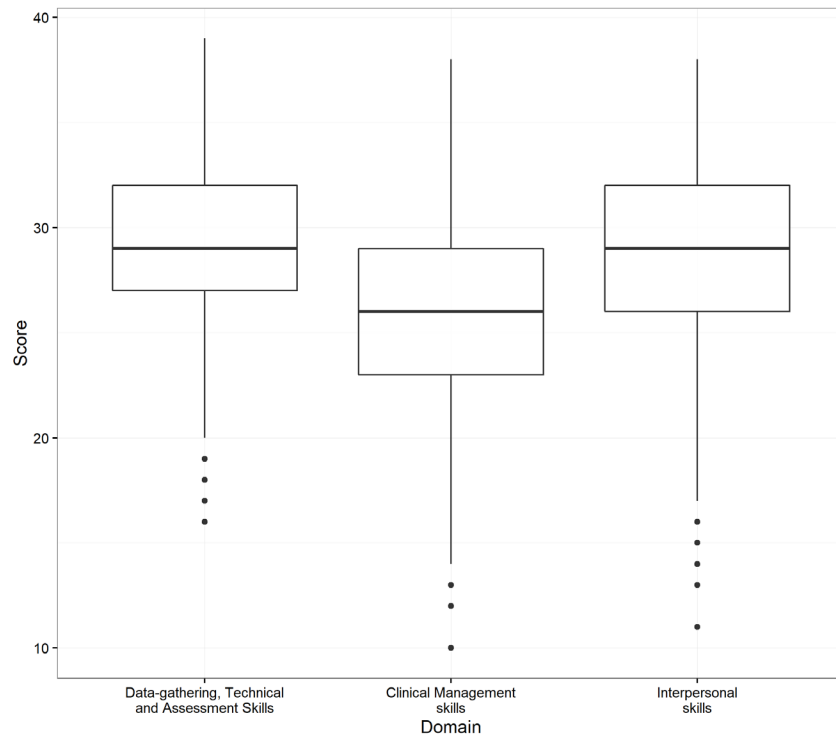
**Clinical Management skills** covers “Recognition and management of common medical conditions in primary care. Demonstrating a structured and flexible approach to decision-making, the ability to deal with multiple complaints and co-morbidity, and the ability to promote a positive approach to health”.

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



Figure 9: CSA domain scores



### Feedback provided by the examiners

Candidates in the CSA are given feedback using a drop down menu of standardised statements. Table 1 shows the percentage of first-time taker (FTT) candidates in the academic year 2018-19 who received each feedback statement at least once.

Table 1: *Percentage of candidates receiving each CSA feedback statement*

| Feedback statement   | Percent |
|--|---------|
| Does not develop a management plan (including prescribing and referral) reflecting knowledge of current best practice  | 80      |
| Does not recognise the issues or priorities in the consultation (for example, the patient's problem, ethical dilemma etc.)                                       | 65      |
| Does not demonstrate an awareness of management of risk or make the patient aware of relative risks of different options   | 64      |
| Does not show appropriate use of resources, including aspects of budgetary governance  | 62      |
| Does not make the correct working diagnosis or identify an appropriate range of differential possibilities   | 61      |
| Does not identify abnormal findings or results or fails to recognise their implications  | 55      |
| Does not develop a shared management plan, demonstrating an ability to work in partnership with the patient  | 51      |
| Does not undertake physical examination competently, or use instruments proficiently   | 41      |
| Does not use language and/or explanations that are relevant and understandable to the patient  | 41      |
| Shows poor time management   | 40      |
| 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 | 37      |
| Does not appear to develop rapport or show awareness of patient's agenda, health beliefs and preferences   | 36      |
| Does not make adequate arrangements for follow-up and safety netting   | 35      |

|  |    |
|--|----|
| Does not identify or use appropriate psychological or social information to place the problem in context | 35 |
| Disorganised / unstructured consultation   | 30 |
| Does not attempt to promote good health at opportune times in the consultation                           | 15 |

## 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 commonest ones being 'other disability', physical disability, hearing impairment, and multiple disabilities. Note, importantly, that although early identification of disability including SLD is likely to be helpful, it is possible that some candidates may not have been recognised until a second or later attempt at the assessment.

In the category 'all disabilities', there were 360 candidate-attempts at the AKT, representing 8.48% of attempts. The overall number of successful attempts by candidates with disabilities was 241 (66.94% of all attempts by candidates with disabilities in 2018-2019 diets).

In the category 'SLD', there were 196 candidate-attempts at the AKT, representing 4.62% of attempts. The overall number of successful attempts by candidates with SLD was 121 (61.73% of all attempts by candidates with SLD in 2018-2019 diets).

Figures 10-12 show scores in these subject areas split by disability status, and it is encouraging to see that those candidates with a disability generally do not appear to be performing differently from those who have not disclosed a disability. However, with such a large discrepancy in the number of candidates in each subgroup it is important that this comparison be considered with caution.

Figures 10-12: *AKT domain scores split by disability status*

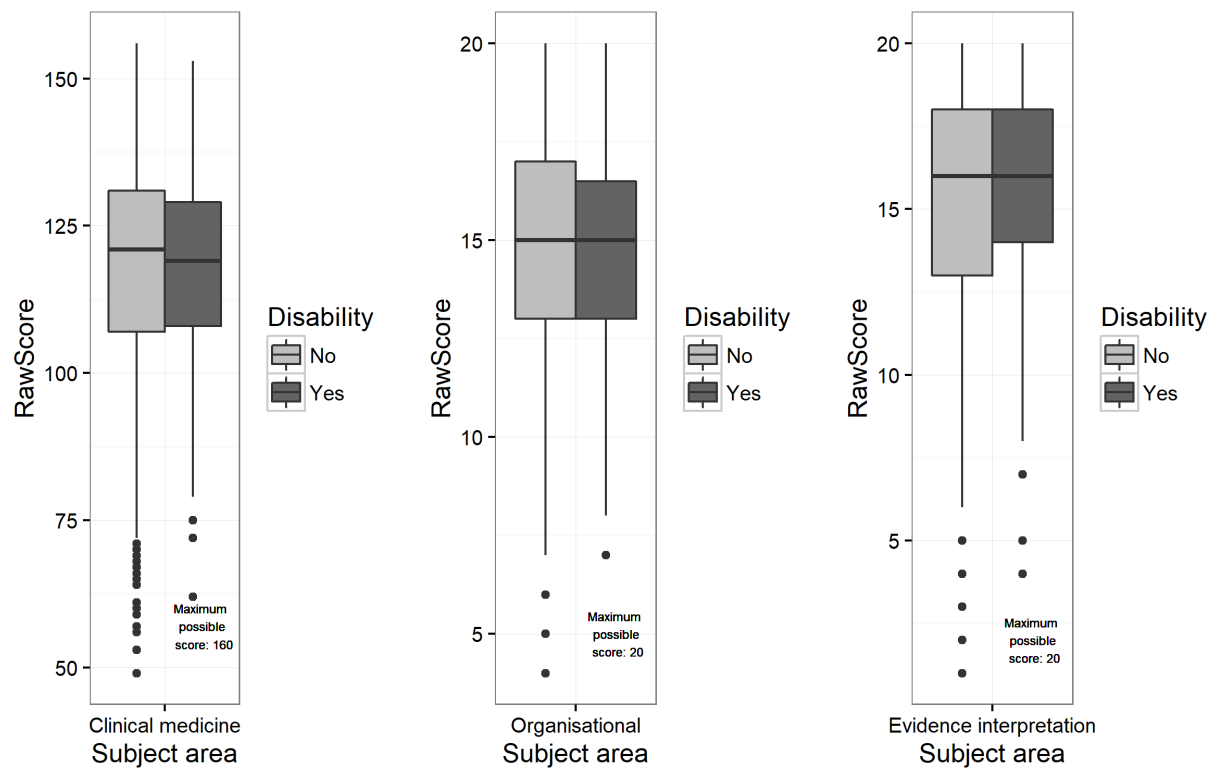
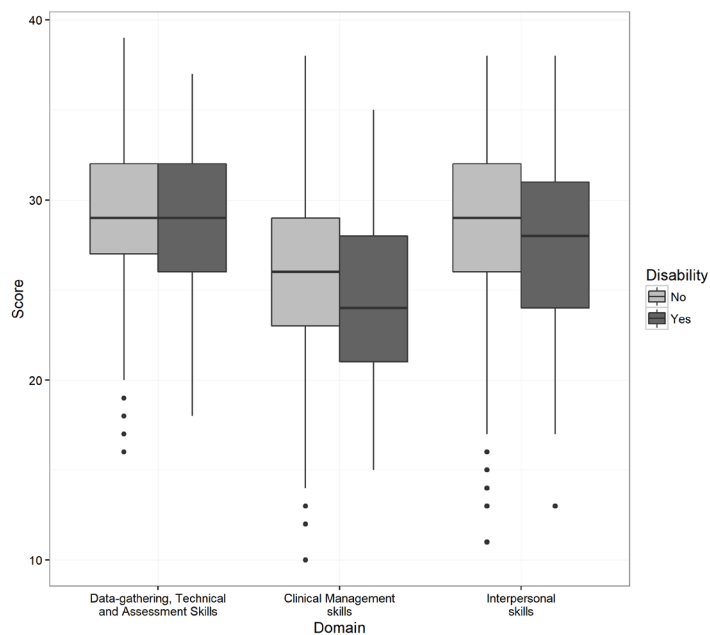


Table 2 below records the prevalence of candidates with a declared disability in attempts at the CSA in 2018-19, together with the results of the assessments. Figure 13 shows the performance in the CSA of these candidates compared to those without declared disabilities, and it is encouraging to see that 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.**

On the recommendation of our disability advisor to the exams team we have now created a specific email address for requesting reasonable adjustments: [exams.accoms@rcgp.org.uk](mailto:exams.accoms@rcgp.org.uk) .

Figure 13: CSA domain scores split by disability status



## 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 ([link](#)), 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 focussed 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 concerns, 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 Competences<sup>1</sup> (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. Providing no concerns are identified from the evaluation of the pilot it will be resubmitted to the GMC in March 2020. The provisional plan is for it be included along with all the other assessment changes planned to start in August 2020.

### **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 60 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 eportfolio 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.

Guidance on reflection written by COPMeD and the Academy of Royal Medical Colleges has been already added to the WPBA website.

## **Learning Resources**

The WPBA group has started developing new resources for the WPBA programme and these will continue into the next year. Resources that have been developed can be found on the WPBA section of the RCGP website<sup>2</sup>.

## Summary of the new WPBA changes

|   | ST1                             |   | ST2                             |   | ST3                               |   |
|---|---------------------------------|---|---------------------------------|---|-----------------------------------|---|
|   | Previous                        | New   | Old                             | New   | Old                               | New   |
| Mini-CEX/Consultation Observation Tool (COTS)       | 6                               | 4   | 6                               | 4   | 12                                | 6   |
| Audio-COT   | 0                               | 0   | 0                               | 0   | 0                                 | 1   |
| Case Based Discussions (CbD) /Care Assessment Tools | 6                               | 4 CbDs  | 6                               | 4 CbDs  | 12                                | 5 CATs  |
| Multisource Feedback (MSF)                          | 2                               | 1 (with 10 responses)   | 0                               | 1 (with 10 responses)   | 2                                 | 2 (1 MSF, 1 Leadership MSF)   |
| Patient Satisfaction Questionnaire (PSQ)            | 1 (in GP)                       | 0   | 0                               | 0   | 1                                 | 1   |
| Clinical Examination and Procedural Skills (CEPS)   | Ongoing                         | Ongoing   | Ongoing                         | Ongoing   | 5 Intimate plus a range of others | 5 Intimate plus a range of others   |
| Learning Logs                                       | Varied—depending on deanery     | 36 Case Reviews   | Varied                          | 36 Case Reviews   | Varied                            | 36 Case Reviews   |
| Placement Planning Meeting                          | Suggested                       | 1 per post  | Suggested                       | 1 per post  | Suggested                         | 1 per post  |
| Quality Improvement Project (QIP)                   | 0                               | 1 (in GP)   | 0                               | 0   | 0                                 | 0   |
| Significant Event Analysis (SEA)                    | -                               | Only if reaches GMC threshold of potential or actual serious harm to patients | -                               | Only if reaches GMC threshold of potential or actual serious harm to patients | -                                 | Only if reaches GMC threshold of potential or actual serious harm to patients |
| Learning Event Analysis (LEA)                       | Several - previously called SEA | 1   | Several - previously called SEA | 1   | Several - previously called SEA   | 1   |
| Prescribing Review                                  | 0                               | 0   | 0                               | 0   | 0                                 | 1   |
| Leadership activity                                 | 0                               | 0   | 0                               | 0   | 0                                 | 1   |
| Educational Supervisors Review (ESR)                | 2                               | 1   | 2                               | 1   | 2                                 | 1   |
| Interim ESR   | 0                               | 1   | 0                               | 1   | 0                                 | 1   |
| Clinical Supervisors Report*                        | 1 per post                      | 1 per post  | 1 per post                      | 1 per post  | 1 per post                        | 1 per post  |

- CSR required in Primary Care posts if CS different from ES or if trainee/supervisor think it is necessary to document any missing/extra evidence

## References

- 1 GMC 2017 The Generic Professional Competences available at

<https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework>

2. Further information on WPBA available at <https://www.rcgp.org.uk/training-exams/training/mrcgp-workplace-based-assessment-wpba.aspx>

## Examination developments

At present our focus for development relates to the recommendations from the ten-year review of the MRCGP carried out by the Health Professional Assessment Consultancy. For update of progress against these recommendations, please see Annex 1.

Other work includes reviewing the Fraser Rose award criteria and the “Request for an exceptional fifth examination attempt” form, which will need to be submitted by a GP Head of School, or equivalent Director of GP Education in the devolved nations.

We continue to review and enhance our QA processes across all modules to ensure fairness to candidates. The dress code for candidates attending exams has also been revised, with input from the AiT Committee.

## Work on differential attainment in the MRCGP

Much work is being done across the GP educational community to understand the reasons behind differential attainment, and which interventions and approaches are most effective in helping GP trainees pass the MRCGP and achieve their Completion of Certificate of Training. The need to help candidates prepare for the CSA was one outcome of the Judicial Review of the exam conducted in 2014. Much analysis has already been undertaken and published. One recent example of this ongoing work was in November 2018 when the RCGP hosted a Differential Attainment conference, jointly organised with COGPED, to disseminate learning and facilitate further developments. This covered interventions targeting all three components of the MRCGP, with the aim of sharing ideas on practical steps that might be taken at deanery level. To help IMG trainees achieve success, several key themes emerged, and a report on the day and its outcomes can be viewed here ([link here](#)).

The report outlines the conference keynote talks and workshops, providing not only a record of the day, but also a resource for GP educators and deaneries to use when considering which interventions to use to reduce differential attainment within their locality.

The RCGP continues to work with key stakeholders to prioritise research and development in differential attainment in the MRCGP.

We continue to be involved in the GMC’s Differential Attainment project and provide ongoing input into this with other Medical Royal Colleges. We meet regularly with representatives from BAPIO and BIDA to discuss differential attainment issues and ways to support IMGs. MRCGP examiners attend mandatory training annually in equality, diversity and fairness in assessment. The training provided in 2018 had an additional theme of the problem of bullying and harassment in medicine, with a particular focus on gender and ethnicity.

Having worked with the Academy of Medical Royal Colleges to produce the recent guidance on reasonable adjustments for disabled candidates in high stakes assessments ([link here](#)) we are

now part of the Academy's working group to produce the next guidance document on unconscious bias for assessors. The GMC has mapped the requirements for all Medical Royal Colleges to address equality and diversity across the five themes in Promoting Excellence, and has also issued guidance on evaluating the effectiveness of interventions.

Research into differential attainment of MRCGP candidates remains one of our strategic priorities, and you can read about some examples of this in the section below.

## Summary of recent RCGP research projects

Two research studies related to the AKT were completed and published in 2018-19. These are summarised below:

Asghar ZB, Siriwardena AN, Elfes C, et al. Performance of candidates disclosing dyslexia with other candidates in a UK medical licensing examination: cross-sectional study. *Postgrad Med J* 2018;94:198–203. doi:10.1136/postgradmedj-2017-135326.

### *What this study tells us:*

- This was the first study worldwide comparing performance between candidates declaring dyslexia and those not declaring dyslexia in a licensing applied knowledge test.
- Dyslexia was not associated with lower pass rates in the AKT after adjusting for other factors linked to examination success. Candidates declaring dyslexia after initially failing the AKT were more likely to have a primary medical qualification outside the UK.

### *What this means:*

- We advocate more consistent dyslexia screening during undergraduate and postgraduate medical training.

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 through an emphasis on: 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 areas of particular difficulty or gaps in undergraduate experience, together with targeted training to understand NHS systems is also likely to aid performance.

A research study related to the CSA was also completed and published in 2018-19. This is summarised below:

Asghar Z, Williams N, Denney ML, Siriwardena N. Performance in candidates declaring versus those not declaring dyslexia in a licensing clinical examination. Presented at Regional SAPC Spring Meeting, Nottingham, 19th March 2019. Published online in Medical Education 2019 doi:[10.1111/medu.13953](https://doi.org/10.1111/medu.13953)

What this study tells us:

- This was the first study worldwide comparing performance between candidates declaring dyslexia and those not declaring dyslexia in a licensing clinical skills assessment.
- Dyslexia was associated with slightly lower pass rates in the CSA after adjusting for other factors linked to examination success. Candidates declaring dyslexia after initially failing the CSA were less likely to pass and more likely to have a primary medical qualification outside the UK.

What this means:

- This study also advocated more consistent dyslexia screening during undergraduate and postgraduate medical training and further research to understand why candidates declaring dyslexia were less likely to pass the CSA and how this could be addressed.
- Many of these factors influencing differential attainment are amenable to education and training, and were covered in the November 2018 Differential Attainment conference described above.

Meiling Denney  
Chief Examiner  
October 2019

## **Annex 1:**

### **Progress on HPAC recommendations report**

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. Following a tendering process, Health Professional Assessment Consultancy (HPAC) were asked to undertake this review. Their report was completed in September 2017 and is available on the RCGP website, along with the RCGP response to the recommendations.

The reviewers were asked to undertake a rigorous review of both the CSA and AKT, to give constructive criticism to the exams team, to assess whether the assessments were fair to candidate demographic sub-groups, and to keep patient safety at the top of the agenda. The reviewers 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.”

As expected, the reviewers made a series of recommendations “in the spirit of continuous quality improvement” as potential enhancements to the MRCGP. The RCGP exam team have been working hard on the recommendations that the stakeholder group wished to prioritise, and only two recommendations are still in progress. More details can be found on the website under MRCGP Reports ([link here](#)).