

MRCGP Annual Report covering 2022/23

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Introduction

This report relates to the formal MRCGP assessments conducted in the academic year 2022-23 (1 September 2022 to 31 August 2023). 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 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. The RCA concluded in September 2023 and was replaced by the Simulated Consultation Assessment (SCA) in November 2023. The SCA was approved for delivery in March 2023 by the GMC.

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

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

Statistical information on the WPBA is not covered by this report. WPBA is formative, with candidate performance, development and capability being reviewed regularly by the Deaneries, a process which is quality assured by the College. Some of this report relates to WPBA as part of the MRCGP assessment program and explains some of the 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 of the same date, 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 **22.40%** of unique candidates who sat an examination this year chose not to declare at least one of either their sex or ethnicity, and **17.41%** chose to omit both their sex and ethnicity. This is an increase on both from last year.

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

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

Between 1 September 2022 and 31 August 2023, Membership of the Royal College of General Practitioners (MRCGP) comprised three sets of assessment procedures whose combined summative function is to assure the Deaneries, the College and the 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 Associates in Training, and 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 permitted to submit thirteen consultations on any clinical topic of their choosing. It became evident, however, that some candidate submissions neither demonstrated sufficient curriculum coverage nor enabled them to fully demonstrate the depth and breadth of their skills. From November 2020, after agreement with the GMC, candidates were required to provide at least one consultation within their submission relating to each of the following curriculum areas:

- 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 on-line platform 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 did not tend to score well, such as low challenge cases.

As the COVID-19 pandemic continued, the style and methods of delivery of care in everyday general practice changed. For example, telephone consulting increased markedly as face-to-face consulting fell. RCGP continued to consult with the training community so the RCA could remain flexible in the face of such changes. Further RCA 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. The ensuing performance data in this report demonstrate that RCA passing rates have remained reasonably consistent throughout.

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 **112** different countries. The number of candidates from each region of the world is presented in Table 2.1.

During the 2022-23 academic year, **5709** candidates made a total of **6506** attempts at the AKT, and **4687** candidates made a total of **5186** attempts at the RCA.

Of the **8943** unique candidates who sat the AKT and/or RCA in 2022-23, there were **4558** (50.97%) UK graduates (UKGs) and **4385** (49.03%) international graduates (IMGs).

The number of unique candidates increased by **1173** compared to the 2021-22 academic year when there were **4324** (55.6%) UKGs and **3446** (44.4%) IMGs.

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

Continent	Number of unique candidates this year
Africa	1832
Asia	1774
Australasia	3
Europe	5221
North America	93
South America	20

Considering all unique candidates sitting the AKT and/or RCA, there were **4221** (47.20%) female candidates; **3134** (35.04%) male candidates; and **1588** (17.76%) candidates who did not declare their gender.

Considering ethnicity, **2541** (28.41%) candidates declared their ethnicity as White; **4430** (49.54%) declared their ethnicity as BME; and **1972** (22.05%) 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 2022-23 academic year, the representation of each sex and ethnicity was as follows:

- **Female:** 3817 (47.92%)
- **Male:** 2759 (34.63%)
- **Sex not declared:** 1390 (17.45%)

- **Ethnicity declared as White:** 2417 (30.34%)
- **Ethnicity declared as BME:** 3847 (48.29%)
- **Ethnicity not declared:** 1702 (21.37%)

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 2022 to 31 August 2023. The cumulative pass rate is **76.49%** for the AKT and **82.29%** for the RCA.

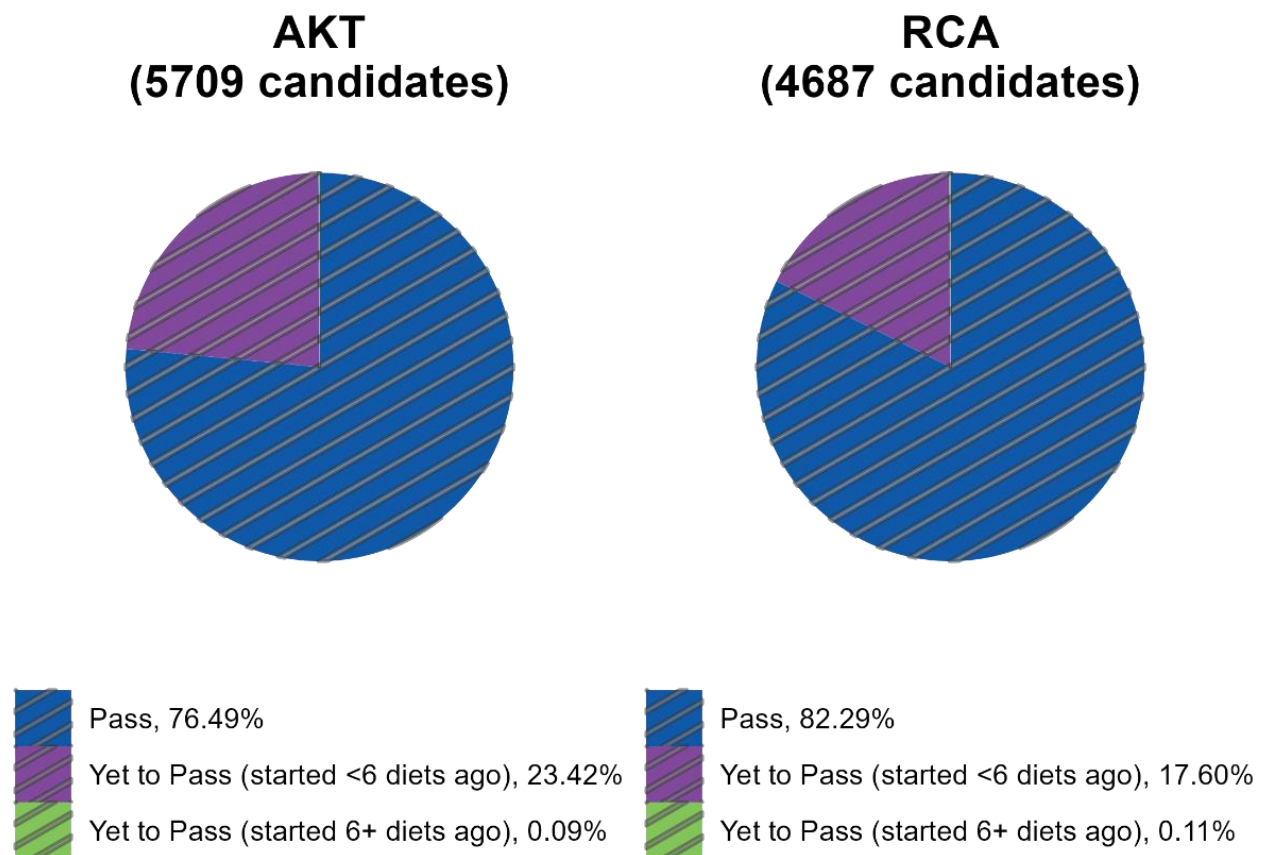


Figure 3.1: Candidates who sat the AKT/RCA between 1 September 2022 to 31 August 2023

The correlation between the scores of candidates who were FTTs of the RCA in 2022-23 with the same candidates' scores on their first attempt of the AKT (regardless of which year they first sat the AKT) was $r = 0.45$ ($N = 4093$, $t = 32.37$, $p < 0.001$).

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

Please note that Figure 3.2 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.

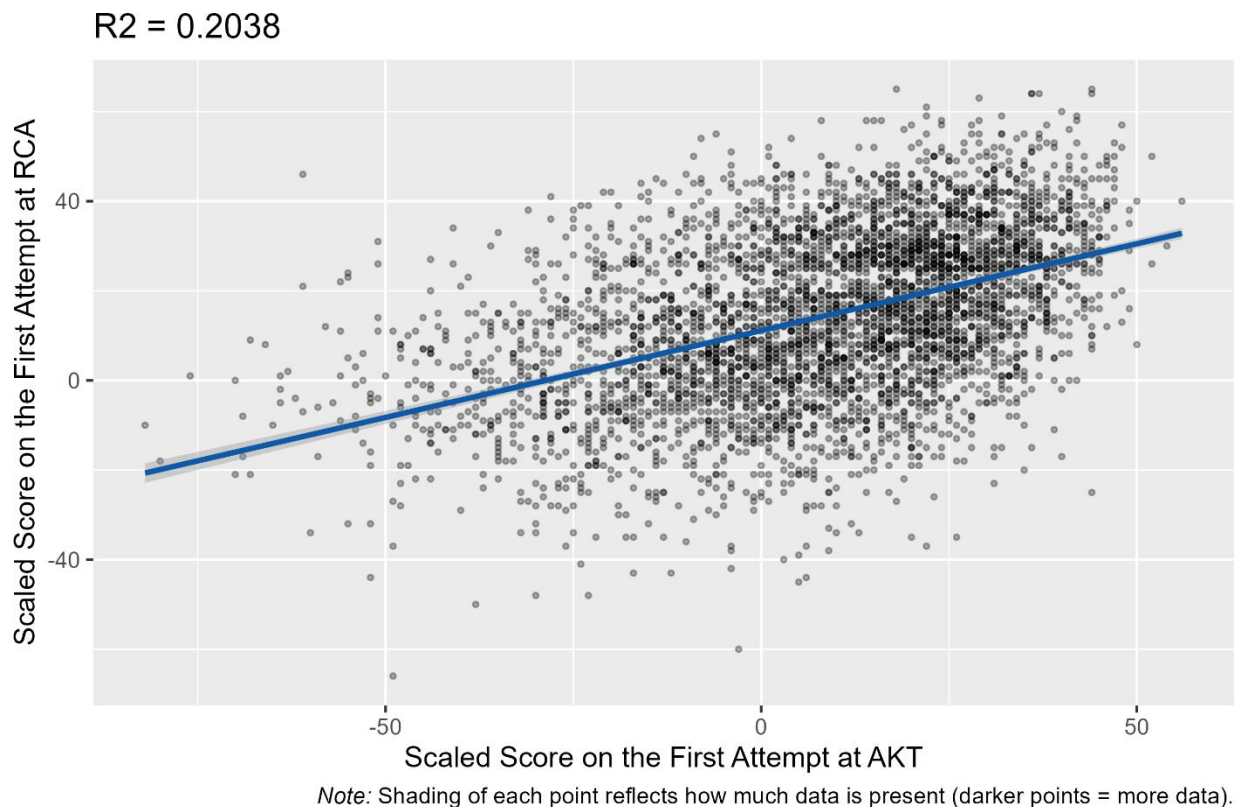


Figure 3.2: Correlation between FTTs' scaled scores on RCA and AKT

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 the data.

Notes for interpretation

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

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

Country of primary medical qualification (UK or International)

Figure 3.3 shows the scaled scores of graduates from UK medical schools (UKG) and graduates from non-UK, international medical schools (IMG) FTTS in the AKT and RCA.

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

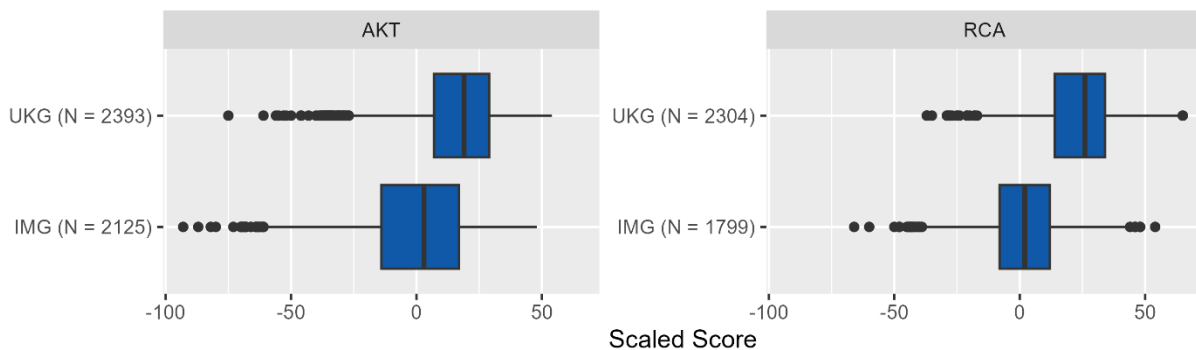


Figure 3.3: Performance of FTTS in the AKT and RCA, split by country of primary medical qualification and MRCGP module

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

Sex

In the AKT: there were **1362** female UKGs, **815** male UKGs, and **594** UKGs who chose not to disclose their sex. The UKG group was therefore **49.15%** female, **29.41%** male, and **21.44%** unknown (did not disclose).

In the RCA: there were **1268** female UKGs, **695** male UKGs, and **432** UKGs who chose not to disclose their sex. The UKG group was therefore **52.94%** female, **29.02%** male, and **18.04%** 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, **56.65%** were UKGs, while **43.35%** were IMGs. This pattern is reversed among male FTT candidates, as **44.80%** were UKGs and **55.20%** were IMGs.

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

Exam	Ethnicity	Total FTTs	UKG FTTs	IMG FTTs
AKT	Female	2106 (100%)	1193 (56.65%)	913 (43.35%)
	Male	1576 (100%)	706 (44.80%)	870 (55.20%)
	Unknown	836 (100%)	494 (59.09%)	342 (40.91%)
RCA	Female	1974 (100%)	1227 (62.16%)	747 (37.84%)
	Male	1442 (100%)	664 (46.05%)	778 (53.95%)
	Unknown	687 (100%)	413 (60.12%)	274 (39.88%)

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 **88.01%**, which was higher than the pass rate for males

(81.73%). In the RCA, the female pass rate was **96.01%**, higher than the male pass rate of **91.87%**.

Amongst IMG candidates sitting the AKT for the first time, the pass rate for females was slightly lower than the pass rate for males (**56.08%** compared to **58.51%**). In the RCA, female IMG candidates had a higher pass rate than male IMG candidates (**61.31%** compared to **53.08%**).

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

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

Exam	Sex	Overall FTT pass rate (%)	UKG FTT pass rate (%)	IMG FTT pass rate (%)
AKT	Female	74.17	88.01	56.08
	Male	68.91	81.73	58.51
	Unknown	69.02	80.57	52.34
	All FTT	71.38	84.62	56.47
RCA	Female	82.88	96.01	61.31
	Male	70.94	91.87	53.08
	Unknown	76.86	90.31	56.57
	All FTT	77.67	93.79	57.03

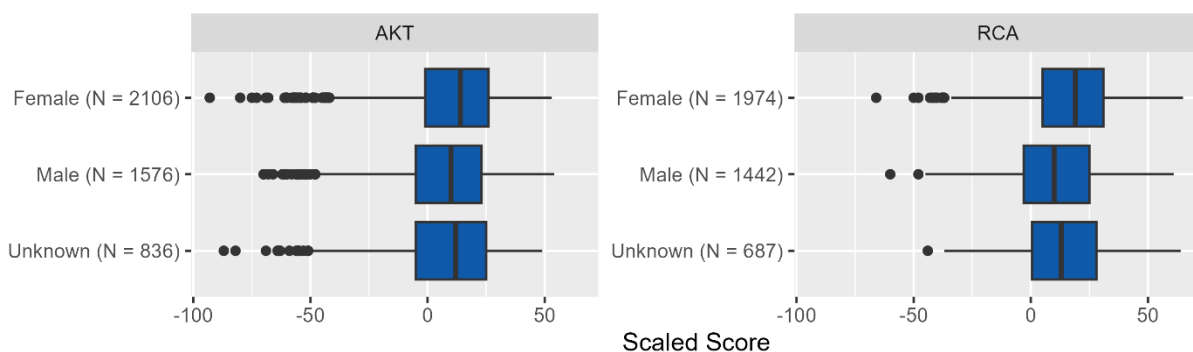


Figure 3.4: Performance of FTTs in the AKT and RCA, split by Sex and MRCGP module

Ethnicity

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

In the AKT: there were **787** BME UKGs, **1293** white UKGs, and **691** UKGs who chose not to disclose their ethnicity. The UKG group was therefore **28.40%** BME, **46.66%** white, and **24.94%** unknown (did not disclose).

In the RCA: there were **651** BME UKGs, **1230** white UKGs, and **514** UKGs who chose not to disclose their ethnicity. The UKG group was therefore **27.18%** BME, **51.36%** white, and **21.46%** 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's BME group, **29.36%** of all BME FTT candidates sitting the AKT had UK primary medical qualifications, while **70.64%** were IMGs. In the white group, **90.23%** received their undergraduate training at a UK institution whereas **9.77%** received their training abroad. Within the RCA, **31.58%** of all BME candidates were UKGs, while **68.42%** were IMGs and there were **91.45%** white UKGs and **8.55%** white IMGs.

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

Exam	Ethnicity	Total FTTs	UKG FTTs	IMG FTTs
AKT	BME	2214 (100%)	650 (29.36%)	1564 (70.64%)
	Unknown	1014 (100%)	579 (57.10%)	435 (42.9%)
	White	1290 (100%)	1164 (90.23%)	126 (9.77%)
RCA	BME	1935 (100%)	611 (31.58%)	1324 (68.42%)
	Unknown	847 (100%)	485 (57.26%)	362 (42.74%)
	White	1321 (100%)	1208 (91.45%)	113 (8.55%)

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 BME candidates sitting the AKT was **78.46%**, which was lower than the pass rate for white (**90.98%**). In the RCA, the BME candidate pass rate was **88.22%**, lower than the white pass rate of **97.76%**.

Amongst IMG candidates sitting the AKT for the first time, the pass rate for BME candidates was slightly higher than the pass rate for the white group (**58.76%** compared to **51.59%**). In the RCA, BME IMG candidates had a lower pass rate than white IMG candidates (**55.82%** compared to **66.37%**).

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

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

Exam	Ethnicity	Overall FTT pass rate (%)	UKG FTT pass rate (%)	IMG FTT pass rate (%)
AKT	BME	64.54	78.46	58.76
	Unknown	66.27	78.76	49.66
	White	87.13	90.98	51.59
	All FTT	71.38	84.62	56.47
RCA	BME	66.05	88.22	55.82
	Unknown	77.10	90.93	58.56
	White	95.08	97.76	66.37
	All FTT	77.67	93.79	57.03

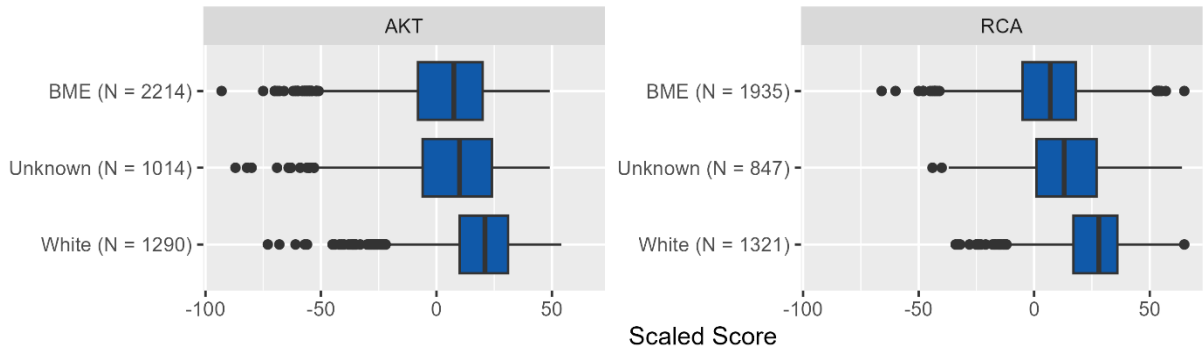


Figure 3.5: Performance of FTTs in the AKT and RCA, split by Ethnicity and MRCGP module

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. No questions were removed after sitting and prior to results for any of the three AKT examinations taken in this period. Figure 4.1 shows the spread of candidates' scores on questions across the three areas.

Data are presented using percentage scores for each domain (% of available marks achieved). Candidates performed better on Evidence-based practice questions (in terms of proportion of marks achieved) as compared to the other two domains. The median score sits on or above **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%).

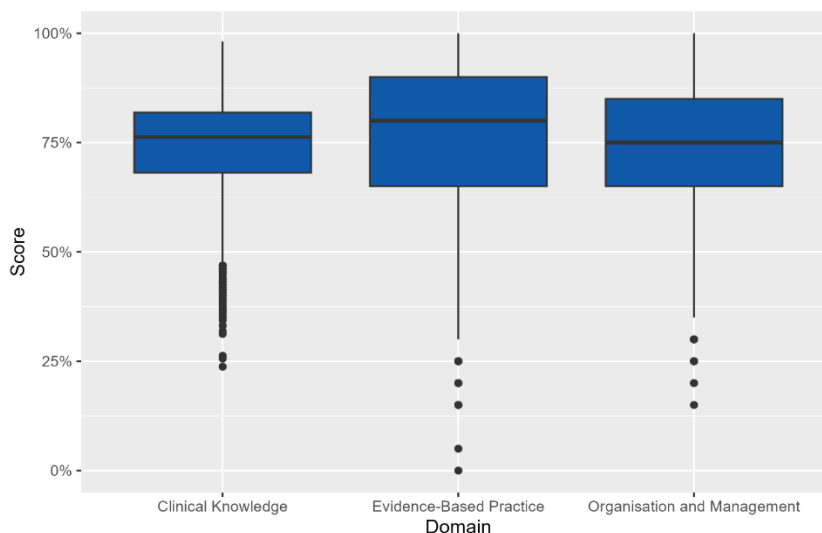


Figure 4.1: Performance of FTTs across the domains of the AKT

Insights from the item performance statistics

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

Topics causing most difficulty for candidates in recent AKT examinations 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.

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

Improving Quality, Safety and Prescribing: Antibiotic indications, guidance, and resistance, drug monitoring, adverse reactions, interactions, dose calculations, end-of-life care, safe prescribing and medicines management (including MHRA alerts).

Leadership and management: Confidentiality and privacy (including social media and digital technologies), death certification and notifications to Coroner/ Procurator fiscal, staff health, health and safety in the workplace.

Life stages topics:

Children and Young People: Consent and capacity, developmental assessment and screening, safeguarding and non-accidental injury.

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

Clinical topics:

ECG interpretation, reducing cardiovascular risk, common gynaecological problems including timely pregnancy testing, contraception (including use with teratogenic drugs), HRT, diagnosis of common oral conditions, different presentations of multi-system disease, eye and eyelid problems, mental health presentations with physical symptoms; substance abuse, neurological

diagnosis, red flags, and interpretation of examination findings, normal findings, minor illness and infections in childhood, asthma, COPD and rarer respiratory diagnoses, interpreting spirometry, suspected cancer - both diagnosis and investigation (including less common presentations), timely but appropriate referral (including emergencies and when to do nothing), prescribing in diabetes, including basic insulin management.

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 overall tend to score fewer marks for Clinical Management than they achieve for Data Gathering and Interpersonal Skills.

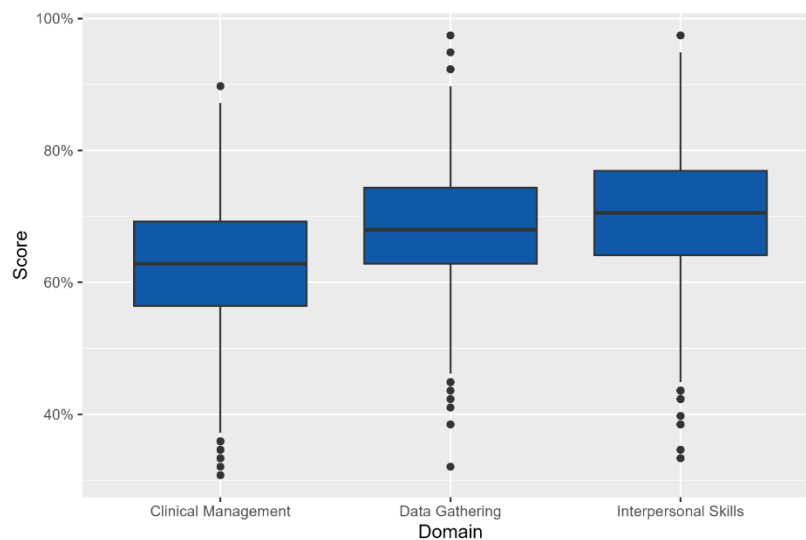


Figure 4.2: Performance of FTTs across the domains of the RCA

Feedback provided by the examiners in the RCA

Table 4.1 shows the percentage of candidates receiving each of the 24 feedback statements used by RCA examiners (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

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

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

AKT

In the category ‘all disabilities,’ there were **970** candidate-attempts at the AKT in the academic year 2022-2023, representing **14.91%** of all attempts. Of these 970 attempts, **585** (60.31%) were successful.

In the category ‘SpLD,’ there were **796** candidate-attempts at the AKT, representing **12.23%** of all attempts this academic year. Of these 796 attempts, **487** (61.18%) 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 appear to be performing at a similar level to those who have not disclosed a disability.

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

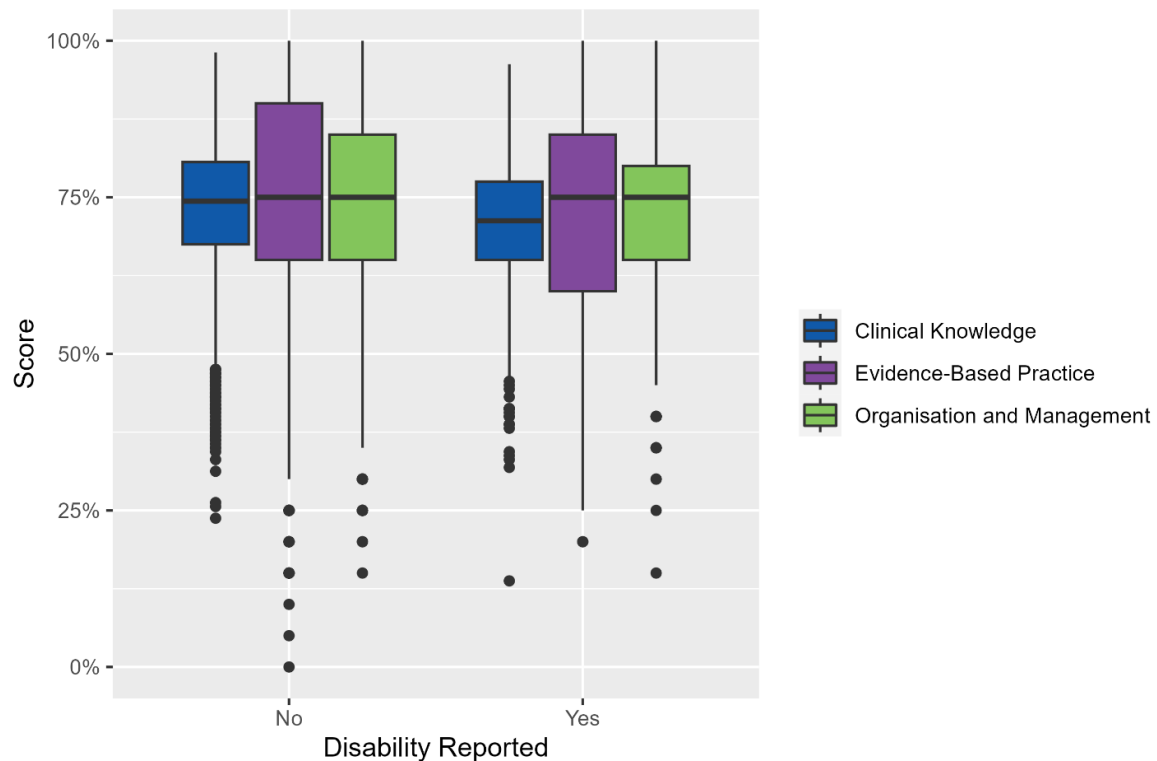


Figure 5.1: Performance (% score) of FTTs in the three AKT domains split by Disability status of FTTs in the three AKT domains split by Disability status

RCA

For the RCA, in the category ‘all disabilities’ there were **682** candidate-attempts in the academic year 2022-23, representing **13.15%** of all attempts. Of these 682 attempts, **451** (66.13%) were successful.

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

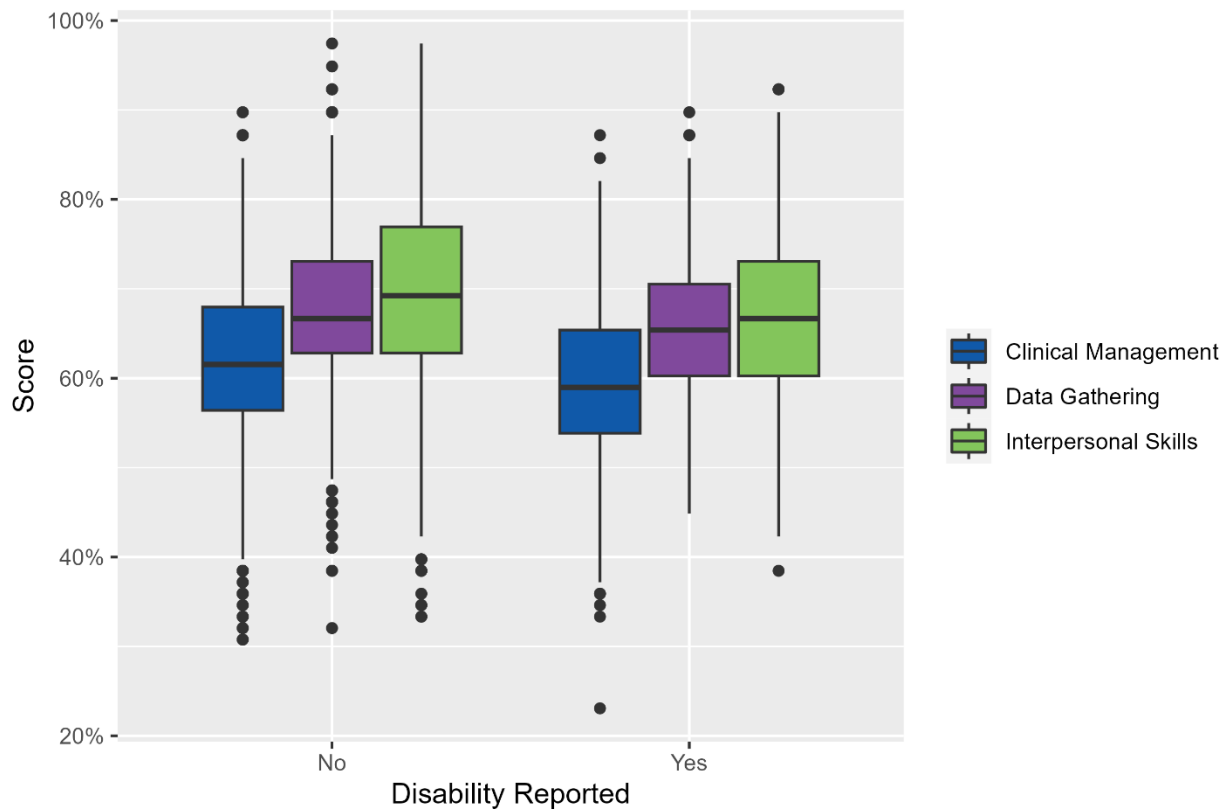


Figure 5.2: Performance of FTTs in the three RCA domains (raw score) split by Disability status

6 Update from the Workplace Based Assessments

Summary

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

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

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

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

Following the introduction of a new programme of WPBA in August 2020, work has continued to update and improve the assessment programme resources, and in training on the new portfolio in a variety of modalities, as well as evaluating the new programme post-introduction.

Specific updates

Research/Evaluation

The key focus for the year was on evaluating WPBA and three pieces of research have progressed in conjunction with the University of Lincoln, covering:

- Validity and reliability of the new workplace-based assessment (WPBA)
 - Reviewing how the whole package of WPBA assessments provides sufficient evidence on which to make a valid reliable judgement.
 - Comparing reliability between pre- and post-August 2020 changes.
 - Evaluating the added value of the global judgments in assessment of performance and supervision levels.

- Exploring perceptions of doctors in training with specific learning difficulties and undertaking clinical and workplace-based assessments for general practice licensing: interview study
 - Completed and awaiting publication
- Survey Analysis for WPBA (Quantitative and Qualitative analysis of the results of two surveys (one for GP Trainees and one for GP Trainers) carried out by the RCGP evaluating the changes to WPBA that were introduced in August 2020)
 - 1,176 trainee responses and 912 trainer responses
 - Awaiting publication

Clinical Examination and Procedural Skills (CEPS)

With the introduction of the Simulated Consultation Assessment (SCA), clinical examination in GP training will now only be assessed in WPBA. A range of ‘non-intimate’ CEPS should be completed, in addition to the GMC mandated ‘intimate’ CEPS that all trainees need to be competent in by the end of ST3.

From August 2023 the CEPS section in the Trainee Portfolio included seven additional observed and assessed CEPS categories. The guidance and documentation will also be clear to encourage the use of these CEPS to provide evidence for Educational Supervisors when grading the CEPS capability. While these additional CEPS will not initially be mandatory, completion of a range of them – along with the GMC mandated CEPS - will allow trainees to demonstrate competence in the CEPS capability and defines more clearly what is meant by a range of non-intimate CEPS.

The seven CEPS categories that were introduced from August 2023 are as follows:

- Respiratory system
- Ear Nose and Throat
- Abdominal system
- Cardiovascular system
- Musculoskeletal system
- Neurological examination
- Child 1-5 years

BLS and AED

As resuscitation training should cover the whole scope of general practice populations, guidance was updated to specifically state that BLS/AED needed to be completed for both adults and children. It became apparent that some courses such as ILS separately teach child and adult resuscitation and therefore one of these alone would not be sufficient to meet the

expected training requirements. It was not expected that ARCP panels would require specific documentation in the panels up to August 23 due to the mid-year clarification, but subsequent evidence should clearly state that both pediatric and adult resuscitation training had been completed.

GP Curriculum

The WPBA Core Group worked collaboratively with the curriculum group on the updates to the GP Curriculum. This includes a proposal to merge the progression point descriptors for ST1 and ST2 replacing it with single ST1/2 and ST3 descriptors. The varied nature of the GP training schemes, and trainee progression had risked making the previous definitions an artificial delineation. In addition, the capability descriptors are in the process of being reviewed and updates proposed, in line with changing general practice and feedback from the trainee and trainer survey and to ensure consistency across the capabilities for curriculum and WPBA.

Code of Conduct

The current Code of Conduct was updated to clarify unacceptable conduct and fraudulent use of the Portfolio, including the following additions:

- The use of dictation software used to help facilitate the written text of log entries within the Trainee Portfolio is permissible, however the content must be the trainee's original work.
- Fraudulent misuse of the Trainee Portfolio is an extremely serious offence. This would include any form of impersonation and making entries that are deliberately misleading or malicious, particularly those that relate to assessments.
- Examples of unacceptable conduct
- 4. Learning log entries:
 - b. Asking someone else to write learning log Entries and presenting it as own original work

Prescribing Assessment

A scoping exercise was undertaken to examine whether the prescribing assessment – which can currently only be completed in ST3 – could be completed in ST2. However, differences in training programme delivery across the four nations (particularly time spent in GP placements in ST2) meant that there was a risk of inequity if this change was introduced. Collaboration across the four nations will ensure consistency in assessments regimes.

WPBA Guidance on the RCGP website

The WPBA RCGP website has been updated with videos to introduce FourteenFish and also provide training resources in a variety of formats. A section on reasonable adjustments for WPBA was added signposting to various resources in conjunction with COGPED.

Care Assessment Tool (CAT) Options

Following trainee and trainer feedback (in the general WPBA evaluative survey that we ran in 2022) that they would like more examples of CATS, we have developed additional formats/options with accompanying detailed guidance that trainees will be able to undertake. These are:

- Routine Consulting Day
- Document Workflow Management
- Duty Doctor Session
- Electronic/Digital/Online Consultation review
- Decisions from Laboratory and Radiology Results.

A submission to the GMC for approval for the introduction of these new options has been made.

Trainee Portfolio

Extensive work has taken place to improve the usability of the Trainee Portfolio including additional pop-ups, update banners, trainee signoff sheet for all individual mandatory requirements, dictation facility more obvious, and an acronyms page.

Statistics

• Prescribing Assessments completed	3817
• CEPS Assessment	46126
• CEPS Reflections	6759
• LEA	18546
• COT	41367
• ESR final	4723
• ESR non-final	24475
• QIA	12847
• QIP	5109

Learning resources

AKT guidance, including new data interpretation videos and resitting the AKT advice can be found at: <https://www.rcgp.org.uk/mrcgp-exams/applied-knowledge-test>

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

WPBA guidance can be found at: <https://www.rcgp.org.uk/training-exams/training/workplace-based-assessment-wpba.aspx>

Differential attainment and differential performance

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 has our own action plan, as well as actively supporting the work led by the GMC and the AoMRC to *"Eliminate Inequality in Medical Education."*

Actions already taken by the RCGP with respect to differential attainment continue to be broad and deep. They include:

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

- Reviewing the way that results and reports are presented, with a view to reducing the risks of unconscious bias where possible. Reviewing reports and guidance against accepted guidelines for readers with disabilities, including specific learning difficulties. This includes work undertaken on the website to provide clear and unambiguous deadlines and information.
- Targeted recruitment of MRCGP panel members, including examiners and those working on the development groups of AKT, RCA and the SCA, 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 examinations (e.g., ongoing work on guidance on reflection after an unsuccessful examination sitting, and tips for enhancing success). The RCGP website contains the latest information on such documentation.
- Conducting equality impact assessments and piloting of any proposed new assessments (e.g., piloting for the prescribing assessment in WPBA, the piloting and work on the new SCA) and all policies.
- Reviewing existing assessments to reflect the demographics of UK patient populations to inform new cases for the future clinical skills assessment.
- Reviewing individual item performance in the AKT and 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.
- Details of research conducted is outlined in the next section. Research for 2023-24 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.
- Conducting Fairness Reviews. These consider how to enhance and improve items in the AKT by making best use of language, checking item performance within demographic cohorts and reviewing validity of data. A further fairness review for the AKT in Ethnicity will take place in November 2023.

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

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

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

Summary of recent RCGP related research

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

Research papers

Siriwardena AN, Botan V, Williams N, Emerson K, Kameen F, Pope L, Freeman A, Law GR. *Academic performance of ethnic minority versus White doctors in the MRCGP assessment 2016-2021: cross sectional study*. BJGP 2023; 73 (729): e284-e293. DOI: 10.3399/BJGP.2022.0474.

What this study tells us:

- This study examined differential attainment in all components of GP licensing assessments, including the Applied Knowledge Test (AKT), Clinical Skills Assessment (CSA), Recorded Consultation Assessment (RCA) and Workplace-Based Assessment (WPBA) – Annual Review of Competence Assessment (ARCP), considering scores at selection to GP specialty training.
- Multi-Specialty Recruitment Assessment [MSRA] scores were the strongest predictor of success or failure in all assessments. Ethnic minority doctors did significantly *better* compared with White British doctors in the AKT but there were no significant differences on other assessments including CSA, RCA or WPBA—ARCP.
- 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 accounted for.

What this means:

- It has been suggested that subjective bias due to racial discrimination may be a cause of examination failure for UK-trained ethnic minority candidates, but this study showed that this was unlikely to be the case.
- 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.
- Doctors admitted to GP specialty training, who are in the lowest MSRA score bands, may need additional support during training to maximise their chances of achieving licensing, regardless of their ethnic group or other demographic characteristics.

Botan V, Williams N, Siriwardena AN, Law GR. *The effect of specific learning difficulties on GP written and clinical assessments*. Medical Education 2023; 57 (6): 548-555. DOI: 10.1111/medu.15008

This paper was highly commended in the RCGP Research Paper of the Year awards announced in 2023 for papers published in 2022.

What this study tells us:

- The study aimed to investigate the performance of doctors with Specific Learning Differences (SpLDs) across the whole range of licensing assessments.
- A longitudinal design was used linking GP specialty trainees' Multi-Specialty Assessment (MSRA) records from 2016 and 2017 with Applied Knowledge Test (AKT), Clinical Skills Assessment (CSA), Recorded Consultation Assessment (RCA) and Workplace Based Assessment (WPBA) Annual Review of Competence Progression (ARCP) outcomes up to 2021.
- Candidates declaring a SpLD were significantly less likely to pass the CSA and were more likely to have a development (negative) outcome in the WPBA-ARCP but were just as likely to pass the AKT or RCA. Doctors with SpLD performed significantly less well on the CSA Interpersonal Skills and the RCA Clinical Management Skills subdomains.

What this means:

- Candidates with SpLDs encounter difficulties in multiple domains of the licensing and in-training assessments, suggesting that adjustments tailored to their needs should be put in place for the applied clinical skills tests and during training workplace-based assessment.

Botan V, Laparidou D, Phung VH, Cheung P, Freeman A, Wakeford R, Denney ML, Law GR, Siriwardena AN. *Examiner perceptions of the MRCGP recorded consultation assessment for general practice licensing during COVID-19: cross-sectional study*. BMC Medical Education 2023; 23: 65 DOI: 10.1186/s12909-023-04027-4.

What this study tells us:

- The Recorded Consultation Assessment (RCA) was introduced rapidly during the COVID-19 pandemic to enable doctors to undertake a critical clinical licensing assessment.
- The RCA was considered by MRCGP examiners to be feasible and broadly acceptable, although they experienced challenges from candidate case selection, case content and judgments leading to suggested areas for improvement.

What this means:

- The RCA was considered by MRCGP examiners to be feasible and broadly acceptable with some challenges and suggestions for improvement.

Reviews and discussion papers

Withnall R, Bodgener S, Copus S, Siriwardena N. *The MRCGP Simulated Consultation Assessment.* InnovAiT. 2023;0(0). DOI:10.1177/17557380231198825

This paper described the background to, design and format of the Simulated Consultation Assessment aimed at GP specialty trainees.

Staudenmann D, Waldner N, Lörwald A, Huwendiek S. *Medical specialty certification exams studied according to the Ottawa Quality Criteria: a systematic review.* BMC Med Educ, 2023. 23(1): p. 619. DOI: 10.1186/s12909-023-04600-x

This systematic review of medical specialty certification exams found that “The Membership of the Royal College of General Practitioners (MRCGP) exam is the most extensively studied specialty certification exam regarding the Ottawa [Quality] Criteria.”

de Silva D, Roberts R, Nayar V, Rutt G, Gregory S, Khan A. *Tackling differential attainment in specialist GP training in England and Scotland.* Education for Primary Care 2023. DOI: 10.1080/14739879.2023.2243453

This editorial describes how NHS England and NHS Education for Scotland are tackling differential attainment in GP training, through targeted training, individualised support, and system level changes to address training and assessment.

Conference presentations

Pattinson J, Akanuwe J, Emerson K, Siriwardena AN. *Exploring perceptions of doctors in GP specialty training with specific learning difficulties undertaking clinical and workplace-based assessments for GP licensing: interview study.* Oral presentation at the SAPC Annual Scientific Meeting 2023, Brighton, July 2023.

Siriwardena AN, Botan V, Elfes C, Neden K, Larcombe J. *Performance of doctors with specific learning difficulties in the UK GP licensing Applied Knowledge Test data interpretation questions.* Oral presentation at the SAPC Annual Scientific Meeting 2023, Brighton, July 2023.

Siriwardena AN, Botan V, Elfes C, Neden K, Larcombe J. *Performance of doctors in the UK GP licensing Applied Knowledge Test for different question lengths.* E-Poster at SAPC Annual Scientific Meeting 2023, Brighton, July 2023.

Siriwardena AN, Botan V, Williams N, Emerson K, Kameen F, Pope L, Freeman A, Law GR *Academic performance comparing ethnic minority and White doctors in the UK GP licensing assessment.* Research paper given at AMEE 2023, Glasgow, August 2023.

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	19
East Midlands	423	350
East of England	554	445
Kent, Surrey, Sussex	387	290
London	627	479
North West	683	604
Northern	288	221
Northern Ireland	121	104
Oxford	175	167
Scotland	421	333
South West: Severn	235	175
South West: Peninsula	154	142
Wales	218	215
Wessex	220	170
West Midlands	610	480
Yorkshire & Humber	561	494

*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.