Council Agenda

Via MS Teams

Wednesday 9 June 2021

09:45 – 12:15

09:45 – 09:48  M1  Chair’s business
3 mins

09:48 – 09:50  M2  Minutes of the meeting on 29 April 2021
2 mins
To approve

09:50 -10:05  M3  Chief Executive’s Report
15 mins
To discuss

10:05 – 10:20  M4  Equality, Diversity and Inclusion Update
15 mins
To discuss

10:20 – 10:40  M5  Report of the MPTS Committee
20 mins
To discuss

10:40 – 10:50  M6  Formal proposal for a university-led MLA applied knowledge test in UK medical schools
10 mins
To approve

10:50 – 11:00  Break
10 mins

11:00 – 11:25  M7  Regulatory reform consultation response
25 mins
To discuss

11:25 – 11:40  M8  Report of the Audit and Risk Committee
15 mins
To discuss
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Draft at 12 May 2021

To approve

Minutes of the meeting held on 29 April 2021

Members present – via MS Teams
Clare Marx, Chair

Steve Burnett
Vanessa Davies
Lara Fielden
Anthony Harnden (from item M6*)
Philip Hunt
Paul Knight

Carrie MacEwen
Deepa Mann-Kler
Raj Patel
Suzanne Shale
Alison Wright

Others present
Charlie Massey, Chief Executive and Registrar
Shaun Gallagher, Director of Strategy and Policy
Una Lane, Director of Registration and Revalidation
Colin Melville, Medical Director and Director of Education and Standards
Anthony Omo, Director of Fitness to Practise and General Counsel
Paul Reynolds, Director of Strategic Communications and Engagement
Neil Roberts, Director of Resources
Melanie Wilson, Council Secretary

* Anthony Harnden was attending the Joint Committee on Vaccination and Immunisation during the earlier part of the meeting
Chair’s business (agenda item M1)

1 The Chair welcomed members, the Senior Management Team (SMT) and observers to the meeting.

Minutes of the meeting on 25 February 2021 (agenda item M2)

2 Council approved the minutes of the meeting on 25 February 2021 as a true record, subject to redrafting of paragraph 19(a) in relation to education quality assurance, which the Chair was authorised to sign off.

Chief Executive’s Report (agenda item M3)

3 Council considered the Chief Executive’s Report.

4 The Chief Executive and other members of SMT gave oral updates, noting that:

   a Work was underway to develop our response to the Department of Health and Social Care (DHSC) consultation, Regulating healthcare professionals, protecting the public, along with a wider programme of work to plan for the changes.

   b The response to the consultation was likely to welcome the additional flexibility, accountability and transparency, and the introduction of regulation of physician associates and anaesthesia associates. We will also be emphasising the importance of regulators being able to act independently.

   c Around 25,000 temporarily registered doctors remain on the Register and work is underway to remove those who are not planning to return to practice.

   d The new temporary Clinical Assessment Centre is due to open in June 2021. Council will receive an update on the wider recovery, returning to the office and managing backlogs at the June meeting.

   e The next examinations for the Professional and Linguistic Assessments Board (PLAB) part 1 for international medical graduates are scheduled for 20 May 2021. Cancellations to date as a result of the pandemic are one in Canada (affecting 20 candidates), but there are concerns that the PLAB 1 tests at six locations in India could be affected, which would involve several hundred candidates.

   f Of around 8,600 PLAB 2 candidates scheduled to undergo assessments in Manchester, 2,660 have registered addresses in countries, particularly
Pakistan, India, Bangladesh and the United Arab Emirates, on the UK’s ‘red list’ banning incoming travel other than for UK or Irish nationals or residents. All the doctors affected are being contacted to reschedule dates where necessary and releasing any vacated slots for new bookings.

g The GMC remains in a financially sound position, although there have been some significant changes to financial forecasts, including:

i Income reduction of approximately £6 million before any impact from the ‘red list’ travel bans.

ii Operational expenditure reduction of approximately £6 million, resulting from lower costs for PLAB, staffing and MPTS hearings. The final cost for the new Clinical Assessment Centre is £1 million (budget £1.4 million).

iii Fluctuations in investment income, below budget in February and now on target.

h The GMC is ready to discuss with the Board of Pension Trustees the challenges arising from the government’s review of the Retail Prices Index measure

5 Council received an oral update on progress with the introduction of GMC-regulated credentials since Council approved the framework for such credentials in June 2019. Council noted:

a A proposal to adapt the framework in response to feedback, making a distinction between:

   i ‘GMC-regulated credentials’ for areas of practice where an ongoing maintenance requirement is necessary for patient safety; and

   ii a ‘credentialed training pathway’ for areas of practice where the patient safety risk can be addressed by existing quality-assured training and clinical governance systems.

b That the revised framework would be brought back to Council at a later date.

6 Council noted the Chief Executive’s report and the Performance and Corporate Opportunities and Risk Register annexes.
Council meeting, 9 June 2021
Agenda item M2 – Minutes of the meeting on 29 April 2021

Equality, Diversity and Inclusion (agenda item M4)

7 Council received a paper providing an update on an external review carried out by Campbell Tickell of the effectiveness of our equality, diversity and inclusion (ED&I) practices and compliance with relevant legislation.

8 Council noted that:

a It could draw assurance that we are compliant with our legislative and regulatory requirements and that our approach to setting measures and targets has been endorsed.

b 50% of the actions arising from the report’s recommendations have been completed, with 70% expected to be completed when the ED&I Steering Group meets in May 2021.

c Work to address issues arising from the Gender Recognition Act and the related recent employment tribunal case involving Jaguar Land Rover was in progress. The issues for the GMC are complex, balancing the rights of patient groups and of registrants, so advice is being sought from the Equality and Human Rights Commission.

d The external review and a range of ED&I data would be published by mid-May following some external engagement work on the topic.

9 During the discussion, Council noted that the data we collect from complainants would be discussed further with Raj Patel following the meeting.

10 Council noted the findings of the Compliance and Governance Review of ED&I and progress made to act on key findings.

2020 Human Resources Report and Gender Pay update (agenda item M5)

11 Council received the annual summary of HR monitoring data for 2020 including information on diversity and pay.
12 Council noted that:

a While a lot of the data had tended not to vary much from year to year, the pandemic has resulted in a significant fall in staff turnover and a decline in absence rates in 2020.

b There has been progress in attracting and recruiting a diverse mix of applicants, but turnover rates for BME staff remained above the GMC average.

c The trend in the gender pay gap remains downward but there are structural challenges, particularly in the higher pay bands.

d Role specifications for jobs were being looked at and compared with those of similar organisations to see if there is more that could be done to attract an increasingly diverse pool of candidates.

e To make the gender and BME pay gaps easier to compare, women earn on average £2,500 and BME staff on average £4,400 below the GMC average.

13 During the discussion, Council noted that:

a Our pay reporting uses full time equivalent salaries so part-time working does not impact on our reported differentials, and future reports will include an explanation of this.

b Bullying and harassment data would be included in the staff survey report to Council later in the year.

14 Council noted the 2020 Human Resources and Gender Pay Reports.

Four country update (agenda item M6)

15 Council received a paper providing a summary of our public affairs and stakeholder engagement across the four countries of the UK.

16 Council noted that:

a Public affairs engagement included building relationships with parliamentarians and legislators, reflected in overwhelmingly positive responses to a YouGov survey we commissioned in January 2021.
b Stakeholder engagement has continued to take place virtually with a wide range of stakeholders across government, the healthcare sector, other professional regulators and patient and public groups.

17 During the discussion, Council noted that a note would be provided to Council on how we recruit to online patient forums, particularly reaching seldom-heard groups.

18 Council noted our approach to four-country engagement over the previous six months.

Section 40A appeals update (agenda item M7)

19 Council received the biannual update of all the appeals under section 40a of the Medical Act 1983 heard by the Section 40a Executive Panel.

20 Council noted that:

a Following the recommendation by the Williams Review into Gross Negligence Manslaughter in Healthcare that the GMC should lose its right to appeal tribunal outcomes, legal advice had advised that until the right is removed we are legally obliged to continue to appeal where necessary in the interests of patient safety.

b Of 43 cases in the period 1 September 2020 to 28 February 2021, where the outcome did not match the GMC’s submission, 10 had been referred to the s40A Executive Panel for consideration and the Panel decided to exercise the power to appeal in two of those cases, as set out in the paper. No date had yet been set for either of those appeals.

c In cases where the Panel decided not to appeal, we still give feedback to the MPTS where appropriate.

21 During the discussion, Council noted that when the GMC’s power of appeal is removed, the intention would be to maintain the same level of transparency in making recommendations to the Professional Standards Authority (PSA) in cases where we think they should exercise their right of appeal.

22 Council noted the update.
The Professional Standards Authority’s annual review of our performance 2019/20 (agenda item M8)

23 Council received paper outlining the findings of the PSA’s annual review of our performance for the period 1 September 2019 to 31 August 2020.

24 Council noted that:

   a The GMC remains one of only two statutory health and social care regulators to have met the PSA’s requirements every year since 2012.

   b Areas of our good practice highlighted by the PSA included temporary registration, education quality assurance, ED&I and ethical guidance during the pandemic.

   c The high number of older cases had resulted from pausing cases where there wasn’t a patient safety issue and the impact of the pandemic on the availability of witnesses and experts and on delays in the justice system. Plans to deal with the backlog of cases will be included as part of Council’s consideration of the wider recovery at the June 2021 meeting.

   d The use of non-disclosure agreements for complainants was kept under review.

25 Council noted the report.

Any other Business (agenda item M9)

26 Council noted that the next seminar and meeting would be on 8 and 9 June 2021.

Council members’ register of interests (agenda item M10)

27 Council noted the Register of Members’ Interests.

Confirmed:

Clare Marx, Chair 9 June 2021
### Purpose

This report outlines developments in our external environment and progress on our strategy since Council last met. Key points to note:

- We are working on our response to the Department of Health and Social Care’s consultation on reform to professional regulation. Charlie Massey spoke at Westminster Health Forum on 11 May 2021 about our regulatory reform ambitions.

- We held successful Spring UK Advisory Fora in Northern Ireland, Wales and Scotland in May 2021, bringing together stakeholders from each country and considering issues including our shared commitment to equality, diversity and inclusion.

- This report provides an update on some of the key operational challenges from the pandemic, and how we are considering recovery and renewal. For example, we are beginning to contact doctors who hold Temporary Emergency Registration (TER) to confirm whether they still need to hold TER.

### Decision trail

Council receives this report at each full meeting.

### Recommendations

- To consider the Chief Executive’s report.
- To note the Performance and the Corporate Opportunities and Risk Register

### Annexes

- Annex A: Performance Annex
- Annex B: Corporate Opportunities and Risk Register

### Author contacts

**Iona Twaddell**, Head of the Office of the Chair and Chief Executive, [iona.twaddell@gmc-uk.org](mailto:iona.twaddell@gmc-uk.org), 020 7189 5054

### Sponsoring director

**Charlie Massey**, Chief Executive, [chiefexecutive@gmc-uk.org](mailto:chiefexecutive@gmc-uk.org), 020 7189 5037
Regulatory reform

1. We are working on our response to the Department of Health and Social Care (DHSC)’s consultation, *Regulating healthcare professionals, protecting the public,* which closes on 16 June 2021. We have been continuing to engage with stakeholders during this period and initial informal feedback on the consultation’s proposals suggest they are broadly supportive. We continue to work closely with the DHSC to resolve outstanding policy issues and to understand their timetable, to assist with our planning.

2. Charlie Massey spoke at the Westminster Health Forum on ‘Next steps for professional healthcare regulation reform’ on 11 May 2021 about our ambitions for regulatory reform. Charlie spoke about how reform would help give more flexibility in fitness to practise, more streamlined routes to the register and a greater ability to tackle the things that matter in today’s health service. Coverage of the speech featured in trade press including BMJ, Pulse and GP Online and focused on how reform will allow the GMC to focus on tackling the disadvantage ethnic minority doctors face. Charlie has also set out the benefits of regulatory reform in a [recent blog](#).

Equality, Diversity and Inclusion (ED&I) targets

3. On 18 May 2021, we publicly announced our new ED&I targets, as agreed by Council, which are commitments to:

   - eliminate disproportionate fitness to practise referrals from employers, in relation to ethnicity and primary medical qualification, by 2026
   - eliminate discrimination, disadvantage and unfairness in undergraduate and postgraduate medical education and training, by 2031.

4. We also have targets approved by Council to help us becoming a more inclusive employer by improving representation and progression across all staffing levels and remove unfair differences in pay. To support the launch of the targets, Charlie Massey took part in media interviews that were picked up in *Pulse, GP Online* and *the BMJ*. A number of stakeholder organisations supported us publicly, including the BMA, NHS Providers, MDU, MPS, Royal College of Surgeons and the Royal College of Paediatrics and Child Heath. All welcomed us setting targets for change in these areas. The BMA and NHS Providers have particularly emphasised the need for system-wide action plans and culture change to make the improvements needed. We received a joint, positive response from BAPIO, BIDA and APPNE, congratulating us on our plan and committing to supporting us. Dame Clare Marx also wrote a [message to the](#)
profession setting out the importance of these targets, highlighting that it's everyone's responsibility to address inequality and discrimination.

**Patient roundtable**

5 We held our biannual patient roundtable on 25 May 2021. We had patient representatives from the Royal Colleges as well as from groups including Action Against Medical Accidents and the Patients Association. Discussion topics included regulatory reform and *Good medical practice*. Dame Clare Marx spoke about our work on patient and public engagement, locking in positive changes post-pandemic and supporting services to restart.

**UK Advisory Fora**

6 In May we held our Spring 2021 UK Advisory Fora (on 5 May in Northern Ireland, 19 May in Wales and 20 May in Scotland). These events brought together stakeholders in each country to discuss issues of relevance to them. In NI we focused on the benefits of regulatory alignment and across all three meetings we considered our commitment to equality, diversity and inclusion and how we can work with partners to eliminate discrimination, disadvantage and unfairness.

**National training survey**

7 This year's national training survey was open from 20 April to 25 May. For the 2020 survey last year, we ran a shorter pandemic focused survey which gave us valuable insight into UK wide trends at a challenging time for the health service. This year, we continued to ask questions about the impact of the pandemic, but also returned to our regular questions. This means we will be able to provide the detailed information we and the health system need to address issues and share good practice at local, specialty and UK wide level.

8 The survey results will enable us to pinpoint where we need to focus our support, as we work with all our key partners to help training recover from the pandemic and adapt for the future. We will also use the results in our ongoing work to help create supportive and inclusive training and working environments, which prioritise staff wellbeing and deliver quality patient care. We have had positive support from a number of organisations, individual trainees and trainers who have been sharing the value of the survey on social media.

**Weston General Hospital**

9 In April 2021, HEE took the decision, with GMC support, to remove ten FY1 trainees from Weston General Hospital to ensure their safety and to protect
patients. The working conditions for medicine trainees at Weston General Hospital were unacceptable, with junior medical staff frequently left without adequate senior supervision and support on understaffed wards. The trust was not meeting the standards we require. We worked with our partners to relocate trainees to places where they can work and learn in a supportive environment. We are involved in ongoing discussions about whether further steps are required to create a safe environment for trainees at Weston.

**Professional Qualifications Bill**

10 A Professional Qualifications Bill was introduced to the House of Lords on 12 May 2021. We have been liaising with officials and with the Minister on the aims and the content of the Bill. Dame Clare Marx has been speaking to Peers and we provided a briefing in advance of the House of Lords second reading debate on 25 May. We have concerns that it could cut across our existing international routes to recognition for overseas qualified doctors by preventing us from assuring ourselves of the knowledge, skills and experience of these doctors. We have been engaging extensively with BEIS on this issue and the Minister addressed these concerns in the second reading of the Bill stating that ‘government intends to table an amendment to clause one of the Bill to ensure that flexibility, and the autonomy of healthcare regulators is preserved.’ This amendment has now been published and we believe that it provides sufficient assurance to mitigate our concerns. We will continue to liaise with peers and MPS as the Bill progress through Parliament.

**Operational recovery and renewal from the pandemic**

11 With gradual reopening and the success of the vaccine programme, we are increasingly turning our attention to how we successfully manage our transition to a new normal in our operations over the next 18 months. This report updates Council on some of the key recovery and renewal decisions we have made, how we are addressing pandemic-related backlogs and how we are making the most of the opportunities from the pandemic in the future.

**Registration**

*Temporary Emergency Registration*

12 We still have around 25,500 doctors with temporary emergency registration (TER) and around 300 have transitioned to routine registration/licence. While many doctors with TER are playing a valuable role in delivering patient care and supporting the vaccination programme, we know that large numbers aren’t using theirs, and don’t plan to do so.
13 With the agreement of the four Chief Medical Officers, over the summer we will gradually contact all those who currently hold TER to ask them to confirm whether they want to continue to hold it. We will be clear that each doctor has a choice and they can still change their mind at any time. We will also provide information about the process for transitioning from TER, to routine registration or a licence. We will give at least 10 days’ notice before removing anyone’s TER, and do this carefully so we do not create service gaps. If there are further pandemic peaks, we would also be able to quickly re-register or licence doctors who have previously asked us to remove their TER, if they want to opt back in and return to practise.

**PLAB**

14 We have continued to run PLAB1 exams across the world although these are subject to local COVID restrictions. Where possible we are expanding capacity for exams later in the year to accommodate doctors who have been impacted by recent cancellations, for example in South Asia.

15 At the start of the pandemic, we cancelled all PLAB2 tests. We restarted our PLAB2 testing with social distancing (and therefore reduced capacity) on 13 August 2020. When our new temporary exam circuit opens on 10 June 2021 our testing capacity will be back to pre-COVID levels (around 11,000 per year). Travel restrictions continue to impact PLAB candidates, so we are asking doctors who may be unable to attend our exam centre to cancel their places and we will give them an exam place in early 2022. These places are being filled by doctors who can travel, ensuring we maximise our capacity.

16 We are currently planning how to increase PLAB capacity once social distancing ends. The average wait time for a candidate from PLAB1 being able to book onto a PLAB2 exam pre-pandemic was around four months. It is currently 10 months. Our current forecasting assumes that with our extra capacity (and social distancing ending in early 2022), this would reduce to six months by June 2022 and below four months by June 2023.

**Registration**

17 Total registration applications received during 2020 were 26,000 (excluding specialist applications), down from 29,000 in 2019. The fall in application volumes corresponds to lower applications through the IMG routes from April to September 2020 (relative to 2019 volumes).

18 **ID checks:** From March 2020 we paused in-person identification (ID) checks as part of our registration process. These were resumed in October 2020 but
paused again in January 2021. There are currently around 8,000 doctors waiting for ID checks. Doctors registered during the pandemic without an ID check have a note on the public register that they have not completed an ID check to prompt employers and others to ensure a local ID check is completed. To address the backlog, we are rolling out a digital ID check process this summer (starting with a four-week pilot from 25 May). This will also be used for all new applicants in future, though we will also retain in-person ID check capacity.

19 **Specialist applications:** Applications to the Specialist and GP register via CESR/CEGPR increased during 2020. Our timelines were also delayed by our reduced ability to process applications and Royal Colleges’ ability to provide evaluations. We are currently undertaking a programme of improvement work on both aspects and anticipate processing to be back on track this summer. We will further consider changes to specialist applications as part of regulatory reform.

**Fitness to practise**

**Investigations**

20 For the duration of the pandemic we have continued with all critical services to protect patients such as investigations where there was an immediate risk to patient safety, interim orders, and convening Tribunals to review existing sanctions and interim restrictions. From March to June 2020 we paused all other investigations to minimise our impact on the profession and service. With increasing infection rates in January and February 2021, we paused investigations where responsible officers (ROs) told us that pressures were acute (for 10 ROs) and paused new cases where the doctor was unaware of the allegations. In March 2021 we restarted paused cases.

21 Because of pauses in investigation and MPTS work, our overall caseload has increased and the number of cases open for more than a year has grown significantly. A long-standing challenge in progressing investigations is the time it takes to get relevant information from organisations (primarily NHS employers but also Police and Courts), these are likely to continue with post-pandemic backlogs. Pre-pandemic we had already highlighted this issue and our remedial action (such as increased use of our legal powers to compel the provision of information) with the PSA.
Council meeting, 9 June 2021
Agenda item M3 – Chief Executive’s Report

Table 1: Total Caseload

<table>
<thead>
<tr>
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<th>Where we were 31 March 2019</th>
<th>Where we were 31 March 2020</th>
<th>31-Mar-21</th>
</tr>
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<tr>
<td>Total caseload</td>
<td>2041</td>
<td>2228</td>
<td>2230</td>
</tr>
<tr>
<td>Pre CE decision</td>
<td>1716</td>
<td>1848</td>
<td>1733</td>
</tr>
<tr>
<td>Post CE decision/awaiting hearing</td>
<td>325</td>
<td>380</td>
<td>497</td>
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<table>
<thead>
<tr>
<th></th>
<th>Pre CE</th>
<th>Post CE</th>
<th>Total</th>
<th>Pre CE</th>
<th>Post CE</th>
<th>Total</th>
<th>Pre CE</th>
<th>Post CE</th>
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<tbody>
<tr>
<td>Older cases 1-2 years</td>
<td>458</td>
<td>334</td>
<td>513</td>
<td>392</td>
<td>121</td>
<td>643</td>
<td>466</td>
<td>177</td>
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<tr>
<td>2-3 years</td>
<td>145</td>
<td>87</td>
<td>176</td>
<td>132</td>
<td>44</td>
<td>308</td>
<td>177</td>
<td>131</td>
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<tr>
<td>3+ years</td>
<td>103</td>
<td>52</td>
<td>111</td>
<td>69</td>
<td>42</td>
<td>205</td>
<td>111</td>
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Table 2: Median Case Age

<table>
<thead>
<tr>
<th></th>
<th>Pre CE Decision</th>
<th>Post CE Decision</th>
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<tbody>
<tr>
<td>2020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End Q1 Mar 2020</td>
<td>37.1</td>
<td>93.1</td>
</tr>
<tr>
<td>End Q2 June 2020</td>
<td>40.4</td>
<td>98.9</td>
</tr>
<tr>
<td>End Q3 Sept 2020</td>
<td>43.2</td>
<td>106.1</td>
</tr>
<tr>
<td>End Q1 Dec 2020</td>
<td>45.4</td>
<td>112.6</td>
</tr>
</tbody>
</table>

|                          |                 |                  |
| 2021                     |                 |                  |
| End Q1 Mar 21            | 46.1            | 114.1            |

22 To address the backlog, we have recruited additional temporary staff to our investigations and legal teams to help progress the cases. We have also implemented changes to our investigation approach. For example, we amended guidance around low level violence and dishonesty not connected to a doctor’s practice, or entirely linked to a doctor’s health, to enable more discretion around the decision to investigate and the Case Examiners decision. We have introduced greater involvement of Employer Liaison Advisers in all referrals from employers to better manage thresholds and minimise multiple referrals of allegations that do not contribute to the investigation. We expect to be back to ‘normal’ running rate by Q3 2022.

Hearings

23 The MPTS paused new substantive MPT hearings between March 2020 and July 2020. Since then MPTS has been gradually increasing the number of hearings held (both virtually and socially-distanced in the hearing centre), though during 2020 the volume remained lower than previously. Whilst social distancing measures remain in place, this will continue to limit the number of tribunals that
can be held in person. Hearing participants routinely may now face direction to self-isolate, disrupting some of the predictability that could previously be relied upon to maximise hearing throughput.

24 During 2021 the MPTS will increase capacity to enable them to run more hearings concurrently than they did before the pandemic. All other things being equal, the MPTS would have been able to address backlogs and return to pre-pandemic hearing levels by the end of 2022.

**Revalidation**

25 We pushed back revalidation dates for around 60,000 doctors during 2020 and 2021. While we moved revalidation dates, we allowed ROs to make recommendations for those doctors who were ready to revalidate, and around 44% of those doctors did manage to revalidate ahead of their new date. This flexible approach was welcomed, and we plan to implement a longer notice period for revalidation recommendations later this year to retain that flexibility which will enable ROs to smooth out peaks and troughs in recommendations falling due. We also supported the implementation of a rebalanced approach to medical appraisal with a stronger emphasis on wellbeing. We have commissioned research to help identify best practice in this approach to inform what we may want to embed in the future.

**Supporting education and training**

**Supporting trainee progression**

26 In 2020 we approved 77 derogations to curricula in order to enable safe progression of trainees during the pandemic and we have stated that these can remain in place for the period of disruption caused by the pandemic, and at least until September this year. We have since invited submissions for further derogations, subject to our principles of patient safety, maintaining standards, holistic and outcome-based assessment of competency and supporting diversity and proportionality to maintain trainee progression. We are looking at further changes we can embed from the pandemic through our Education Reform programme, together with education stakeholders in all four UK countries.

**Quality assuring education and training**

27 From March 2020 we suspended in-person visits as part of our education quality assurance approach. We introduced a programme of remote quality assurance activities including targeted on areas of risk. As social distancing restrictions ease it is likely that we will resume these in a more blended approach.
continuing to incorporate some of the benefits of remote visits supplemented with some physical presence.

**Returning to the office**

28 While some colleagues are already working in the office for a few days a week due to their roles or personal/practical reasons, the majority of staff continue to work from home. In the medium-term we will have less space in our 3 Hardman Street office due to the new temporary clinical assessment centre, however we know from our regular pulse surveys that most colleagues want to work from home more than they did previously. This gives us an opportunity to work differently.

29 We have engaged extensively with colleagues, running workshops with over 80% of the organisation to understand what has worked well, what we can continue with and what we might best use our office space for (for example providing face-to-face support for new starters, ‘over the desk’ learning and more effective collaboration). We are developing guidance to support our return to the office, and also reconfiguring our office space to help us all work better post-pandemic. Over the next three to six months we will transition from a largely home-based approach to a mixture of home and office-based working, dependent on government guidance. We will take a flexible approach, changing what we do based on what we find works best and as the situation changes.

**Inquiries and reviews**

30 Professor Colin Melville, Director of Education and Standards, spoke on Friday 21 May at the First Do No Harm APPG about establishing a register of financial and non-pecuniary interests for doctors, as recommended in the report of the Independent Medicines and Medical Devices Safety Review. Colin spoke alongside Baroness Cumberlege, campaigners and the Royal College of Surgeons. He set out the GMC’s position on the Review’s recommendation on conflicts of interest and used the opportunity to highlight the ways in which we are helping to address the underlying issues of the Review, including our updated guidance on *Decision making and consent*. We also continue to engage with the Department of Health and Social Care over their proposed response to the Review.

31 We continue to engage with a number of other reviews and inquiries across the UK. The main developments since we last reported are:

31.1 Following the publication of the interim response to the Paterson Inquiry in March, we will be engaging with DHSC shortly over
recommendation 1 of the Inquiry – the creation of a single repository of the whole practice of consultants in England – given the link to our potential work on scope of practice.

31.2 We continue to work with the Ockenden review and regularly liaise with the NMC on this. We are in the process of establishing the legal pathway for information sharing.

31.3 DHSC has recently been in contact to confirm that they are still planning to convene a stakeholder group to bring together a response to the Dixon investigation and we await further details. We met with NMC to discuss our respective likely organisational views on the recommendations. We are currently considering our approach to the response and timing.

31.4 We have been supporting the independent review into West Suffolk Hospital NHS Foundation Trust’s investigation into an anonymous letter to a deceased patient’s family and the events leading to this. We have completed information sharing with the review and are preparing for publication towards the end of summer.

31.5 We continue to support the Niche Independent Investigation into Urology Services at University Hospitals Morecambe Bay NHS Foundation Trust. Publication is due at the end of June.

31.6 We have met with the East Kent Investigation panel. We are in the process of establishing the legal basis for information sharing and are at the final stages of agreeing the search strategy.

Executive board

32 The Executive Board met on 26 April 2021 to consider items on:

a The Governance and Compliance Review on equality, diversity and inclusion, as reported to Council on 29 April 2021.

b The draft Trustees’ annual report and accounts prior to their consideration at this Council meeting.

c The draft Fitness to Practise Annual Statistics Report 2020 prior to being presented to Council at this meeting.

d The review of compliments and complaints, on the agenda for this Council meeting.
e Plans for a phased return to the office when social distancing ends, in a way that supports the effective delivery of our functions.
M3 – Annex A
Performance annex

Data presented as at 30 April 2021 (unless otherwise stated)

Working with doctors Working for patients
### Operational Key Performance Indicator (KPI) – since last report to Council

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Mar</th>
<th>Apr</th>
<th>Exception commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answer 80% of calls within 20 seconds</td>
<td>80%</td>
<td>89%</td>
<td></td>
</tr>
</tbody>
</table>
| Decision on 95% of all registration applications within 3 months | 92% | 98% | Registration and Revalidation: March performance was in-part due to the (now closed) route for EEA applications that were submitted before 1 Jan 2021. To ensure we were as fair as possible, particularly given the pandemic and the difficulties it has caused in obtaining evidence, greater leeway was provided to the affected doctors in terms of the deadlines for receiving evidence.  
| Decision on 95% of all revalidation recommendations within 5 working days | 99% | 98% |  
| Respond to 90% of ethical/standards enquiries within 15 working days | 96.5% | TBC | Fitness to Practise: The pandemic has caused some ftp investigations to be delayed. Whilst we have continued to progress investigations where possible, many organisations with whom we work are unable to provide information we request in the usual timeframes. These issues are likely to impact on the performance against these targets for the foreseeable future.  
| Conclude 90% of fitness to practise cases within 12 months | 93% | 89% |  
| Conclude or refer 90% of cases at investigation stage within 6 months | 91% | 95% |  
| Conclude or refer 95% of cases at the investigation stage within 12 months | 96% | 93% |  
| Commence 100% of Investigation Committee hearings within 2 months of referral | No cases | No cases |  
| Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral | 100% | 100% |  
| 2019/20 Income and expenditure [% variance +/- 2%] | 4.40% | 4.03% | Finance: Income is under budget due to holding fewer PLAB 2 days than planned. Expenditure is under budget as the variable costs linked to PLAB 2 days, have been removed, we expect fewer hearing days and associated legal costs than budgeted, there is lower activity than planned in a number of areas, including staff expenses, as a result of additional lockdown restrictions and there is a higher level of vacancies now forecast than assumed in budget.  
| Rolling twelve month staff turnover within 8-15% | 4% | 4.5% | HR: External turnover remains below the KPI due to low numbers of staff leaving the organisation and is unlikely to rise in immediate future.  
| IS system availability (%) – target 98.8% | 99.99% | 99.98% |  
| Monthly media score | 1963 | 43 | Media score: A rewarding month in March was fuelled by hard work to ensure coverage of the Freeman tribunal was accurate, balanced and attributed correctly. Our first response to the regulatory reform consultation also landed well despite lack of pushed out content from DHSC. |
## Operational Key Performance Indicator (KPI) – 12 month performance summary

<table>
<thead>
<tr>
<th>Indicator</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operations</strong></td>
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</tr>
<tr>
<td>Answer 80% of calls within 20 seconds</td>
<td>89%</td>
<td>76%</td>
<td>60%</td>
<td>66%</td>
<td>60%</td>
<td>49%</td>
<td>51%</td>
<td>39%</td>
<td>57%</td>
<td>83%</td>
<td>80%</td>
<td>89%</td>
</tr>
<tr>
<td>Decision on 95% of all registration applications within 3 months</td>
<td>96%</td>
<td>99%</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>92%</td>
<td>98%</td>
</tr>
<tr>
<td>Decision on 95% of all revalidation recommendations within 5 working days</td>
<td>11%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>98%</td>
</tr>
<tr>
<td>Respond to 90% of ethical/standards enquiries within 15 working days</td>
<td>89%</td>
<td>89%</td>
<td>97.4%</td>
<td>92.7%</td>
<td>95%</td>
<td>72.7%</td>
<td>88.5%</td>
<td>92.2%</td>
<td>98.7%</td>
<td>98.3</td>
<td>96.5%</td>
<td>TBC</td>
</tr>
<tr>
<td>Conclude 90% of fitness to practise cases within 12 months</td>
<td>89%</td>
<td>93%</td>
<td>92%</td>
<td>93%</td>
<td>90%</td>
<td>90%</td>
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<td>91%</td>
<td>89%</td>
<td>93%</td>
<td>89%</td>
</tr>
<tr>
<td>Conclude or refer 90% of cases at investigation stage within 6 months</td>
<td>92%</td>
<td>92%</td>
<td>93%</td>
<td>89%</td>
<td>93%</td>
<td>91%</td>
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</tr>
<tr>
<td>Conclude or refer 95% of cases at the investigation stage within 12 months</td>
<td>94%</td>
<td>96%</td>
<td>95%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
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<td>93%</td>
<td>95%</td>
<td>92%</td>
<td>96%</td>
<td>93%</td>
</tr>
<tr>
<td>Commence 100% of Investigation Committee hearings within 2 months of referral</td>
<td>No cases</td>
<td>No cases</td>
<td>No cases</td>
<td>No cases</td>
<td>No cases</td>
<td>No cases</td>
<td>No cases</td>
<td>No cases</td>
<td>100%</td>
<td>No cases</td>
<td>No cases</td>
<td>No cases</td>
</tr>
<tr>
<td>Commence 100% of Interim Order Tribunal hearings within 3 weeks of referral</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td><strong>Organisation</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019/20 Income and expenditure [% variance +/- 2%]</td>
<td>3.63%</td>
<td>3.42%</td>
<td>3.40%</td>
<td>3.61%</td>
<td>3.06%</td>
<td>3.12%</td>
<td>3.19%</td>
<td>3.07%</td>
<td>4.81%</td>
<td>3.53%</td>
<td>4.40%</td>
<td>4.03%</td>
</tr>
<tr>
<td>Rolling twelve month staff turnover within 8-15%</td>
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<td>5.6%</td>
<td>5%</td>
<td>5%</td>
<td>4.3%</td>
<td>4.1%</td>
<td>3.7%</td>
<td>3.6%</td>
<td>3.3%</td>
<td>3.6%</td>
<td>4%</td>
<td>4.5%</td>
</tr>
<tr>
<td>IS system availability (%) – target 98.8%</td>
<td>99.97%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>99.99%</td>
<td>99.61%</td>
<td>99.99%</td>
<td>99%</td>
<td>99.97%</td>
<td>99.99%</td>
<td>99.98%</td>
</tr>
<tr>
<td>Monthly media score</td>
<td>27</td>
<td>52</td>
<td>138</td>
<td>66</td>
<td>274</td>
<td>542</td>
<td>1635</td>
<td>222</td>
<td>217</td>
<td>282</td>
<td>1963</td>
<td>43</td>
</tr>
</tbody>
</table>
Enabling professionals to provide safe care

- We work with others to improve workplace cultures in healthcare environments across the UK making them safe, inclusive and supportive
- The professionals we regulate can meet the professional standards patients expect and use their judgement to apply our ethical standards and guidance
- We use and share our data and insights to improve environments and address inequalities

<table>
<thead>
<tr>
<th>2021-23 Priority activities</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Review of Good medical practice</strong></td>
<td>A high level timeline was considered at the April Planning Gateway, and SMT have since approved this project to move into the delivery phase. Discussions are underway with SMT about setting up an External Advisory Group. In June we will start structured external engagement on policy issues, our guidance model and implementation strategy. Timescales are being carefully monitored to manage stakeholder impact and align engagement and consultation with the regulatory reform programme to optimise opportunities for collaboration.</td>
</tr>
<tr>
<td><strong>State of Medical Education and Practice</strong></td>
<td>Project on track. The Barometer survey that underpins it now has a research contractor appointed and survey design is part completed. A new vacancy in the team presents some challenges, but overall delivery is not currently at risk.</td>
</tr>
<tr>
<td><strong>Supporting a profession under pressure</strong></td>
<td>Three overarching themes agreed to take this programme forward. Our ED&amp;I work on reducing differentials in fitness to practise employer referrals and education and training pathways, Leadership, and Wellbeing &amp; support. Directorates currently finalising milestone plans, whilst the programme management arrangements and narrative are being reviewed.</td>
</tr>
</tbody>
</table>

**Why:** Want to make sure our standards for professions we regulate reflect current patient and public expectations – and that our approach to embedding those with the profession maximises their relevance and application to care. Our guidance will be publicly consulted on and we will have launched an updated GMP.  
**When:** Complete by Q3 2023  
**Who:** Colin Melville; Mark Swindells

**Why:** Want to share our data and insights to highlight the experience of practising medicine in the UK and demonstrate our thought-leadership on key issues.  
**When:** Annually  
**Who:** Shaun Gallagher; David Darton

**Why:** Want to work together with partners to promote environments that support better practice and patient care as highlighted in our research. We will have implemented four country plans to address areas of greatest shared interest in each UK country, and reduced disproportionality in fitness to practise referrals from employers and attainment in medical education and training.  
**When:** Complete by Q4 2023  
**Who:** Anthony Omo; Maria Bentley
Developing a sustainable medical workforce

- We work with workforce organisations to support more professionals who meet the required standards to join and remain in the UK medical workforce.
- Education and training are relevant, accessible and supportive, giving all professionals the skills they need to better meet future patient needs.
- Training for the medical workforce is more flexible, throughout their careers.

<table>
<thead>
<tr>
<th>2021-23 Priority activities</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introducing the medical licensing assessment</strong></td>
<td>The Medical Schools Council, on behalf of UK medical schools, has submitted a formal proposal, for GMC approval, for a university-led approach to the applied knowledge test (AKT) part of the MLA in UK schools. Council is considering this proposal at this 9 June meeting. Work is again underway on aspects of the programme delayed last year in light of the pandemic, including planning the transition from PLAB to the MLA for international candidates, and developing our approach to regulatory oversight of the AKT and clinical and professional skills assessment (CPSA) for UK students.</td>
</tr>
<tr>
<td><strong>Regulating medical associate professionals</strong></td>
<td>Following confirmation of the Government’s revised approach to legislative development, the expected start date for regulation of PAs and AAs has been pushed back to the second half of 2022. We are on track to meet that timeline and progress is rated ‘green’ across all workstreams. Our external advisory group met in April and remains very supportive of the approach we’re taking to regulatory development. We’ll update Council on that approach and share some issues arising for discussion at the June meeting.</td>
</tr>
<tr>
<td><strong>Improving flexibility of postgraduate education</strong></td>
<td>Throughout the pandemic, we’ve worked with the statutory education bodies in all four countries of the UK to introduce measures that have allowed trainees to progress. The derogations we’ve already agreed will remain in place until at least September, or for the period of disruption caused by the pandemic. However, given ongoing challenges on the frontline, we’re considering additional requests that maintain standards and ensure patient safety if they’re needed to enable doctors’ continued progression. Alongside this emergency response work, we are considering further interventions to support more flexibility in education and training through our Education reform – enabling flexibility programme, which will consider flexibility in the context of preparing medical students for practice; embedding generalism throughout doctors’ careers; improving progression including consideration of assessment and exams; strengthening leadership skills for doctors.</td>
</tr>
<tr>
<td><strong>Reviewing our routes to registration</strong></td>
<td>We anticipate that the temporary Clinical Assessment Centre will open on 10 June 2021. The opening of the new centre will allow us to examine in 2021 most of those candidates who passed PLAB 1 in 2020. Work has begun on the Post-Brexit Registration Pathways project to plan the expansion of IMG pathways to include EU doctors. The current stand-still arrangements for EU doctors expire at the end of December 2022.</td>
</tr>
</tbody>
</table>

**Why?** Want to give patients greater confidence that they will receive a consistent level of core knowledge, skills and behaviours from any doctor practising in the UK. UK medical schools will deliver the Assessment embedded within final exams for a UK medical degree, overseen and regulated by us, and we will administer the assessment for IMG doctors. **When:** Q4 2025  
**Who:** Colin Melville; Judith Chrystie

**Why?** To expand the medical workforce and the contribution by our professionals to quality patient care, while continuing to safeguard patients. We will deliver equivalent statutory functions across MAPs and doctors. **When:** Q4 2021  
**Who:** Una Lane; Clare Barton

**Why?** To remove barriers to more flexible postgraduate training that will support development and wellbeing of trainees to maximise the quality and number that are retained for patient care. We will work to deliver changes to improved flexibility in medical education, training and across careers. **When:** Q4 2022/Q1 2023  
**Who:** Colin Melville; Phil Martin

**Why?** To ensure we have efficient and effective routes for skilled professionals to gain registration and maximise the number of skilled doctors available to the UK medical workforce. To start, we will expand our Clinical Assessment capacity for international medical graduates to respond to Covid and manage the UKs post-Brexit registration approach for EU professionals. **When:** Q4 2022  
**Who:** Una Lane; Kirstyn Shaw
### 2021-23 Priority activities

<table>
<thead>
<tr>
<th>Regulatory reform</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Why?</strong> To improve the design and delivery of our functions so that we can be more responsive to the changing needs and expectations of patients, the health system, and the professions. <strong>When:</strong> Changes for MAPs to come into effect Q4 2022 (TBC), remaining changes to be implemented by Q4 2024. <strong>Who:</strong> Shaun Gallagher; Tim Aldrich</td>
<td>We have completed the first draft of our response to the DHSC consultation and this has been circulated internally for final comments. We have also developed a 'narrative' that we can send to stakeholders to show how we intend to respond to the DHSC consultation - This was shared with Council at the meeting on 29 April. Work continues to develop the programme plan and we anticipate we will be in a position to share this with SMT and the Regulatory Reform programme board in June. We continue to work closely with DHSC to find out when we will have sight of the S60 Order which will help with this planning. We are recruiting for additional roles to sit in the PMO and several of the workstreams within the programme, however a Project Manager started in the PMO team in April and Tim Aldrich has been appointed as AD for the programme.</td>
</tr>
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<table>
<thead>
<tr>
<th>Understanding registrants’ practice</th>
<th></th>
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<tbody>
<tr>
<td><strong>Why?</strong> The UK medical profession will be able to use consistent categories to describe their scope and location of practice to us. As part of scoping, we will test the benefits of collecting and sharing this information to better support us, local clinical governance systems and the wider system to keep patients safe. We will assess options for collecting and sharing this information and resulting resource implications. <strong>When:</strong> End of 2021 <strong>Who:</strong> Shaun Gallagher; Richard Marchant</td>
<td>We have commissioned research to support this work. Originally scheduled to deliver by March, the research was paused as it relied on surveying the profession. This has now restarted and will likely deliver in Q3 2021. We'll then take a decision about how best to progress the research outcomes.</td>
</tr>
</tbody>
</table>
## 2021-23 Priority activities

<table>
<thead>
<tr>
<th>Investors in people (Gold accreditation)</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td><strong>Why?</strong> To ensure our approach as an organisation to leadership, support and ongoing improvement attracts and retains the right people to meet our ambitions - we will strive for Gold accreditation from Investors in People. <strong>When:</strong> Q2 2023 <strong>Who:</strong> Neil Roberts; Andrew Bratt</td>
<td>We are scheduled to undergo re-assessment against the main standard and also against the ‘We Invest in Wellbeing’ standard in November this year. In our first assessment in November 2018 we achieved silver accreditation. Since then we have been using colleague feedback and the annual progress reviews conducted by IiP to help us identify areas for improvement. A programme of work is underway to help us reach our ambition of gaining Gold standard accreditation.</td>
</tr>
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<table>
<thead>
<tr>
<th>Inclusivity</th>
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</thead>
<tbody>
<tr>
<td><strong>Why?</strong> To treat our people fairly and model the commitment we ask of the health service – that diverse and inclusive environments support better outcomes for all - we will achieve maturity against the TIDE framework. <strong>When:</strong> Q2 2023 <strong>Who:</strong> Neil Roberts; Andrew Bratt</td>
<td>We have embedded our performance measures and targets into our performance reporting framework. Training for recruiting managers on our recruitment targets has been delivered. Our Anti-racist Ally training has been piloted and is now being rolled out. We have released the tender for the targeted leadership programmes and broader inclusivity training for all managers this year. We have embedded inclusivity in OneGMC behaviours and have also embedded a requirement for all staff to have a performance objective on ED&amp;I. We have committed to becoming a Disability Confident Committed Employer – and later this year will ensure our recruitment process is inclusive and accessible, communicating and promoting vacancies, offering an interview to disabled people who meet the minimum criteria for the job, anticipating and providing reasonable adjustments as required and supporting any existing employee who acquires a disability or long term health condition, enabling them to stay in work.</td>
</tr>
</tbody>
</table>

• We’ll deliver our ambitions with flexibility, sensitivity to the external environment and leadership across all roles
• The GMC is a more diverse and inclusive organisation
• We take a more coordinated approach to our corporate responsibilities, including social, environmental and economic
Investing in our people to deliver our ambitions

- We’ll deliver our ambitions with flexibility, sensitivity to the external environment and leadership across all roles
- The GMC is a more diverse and inclusive organisation
- We take a more coordinated approach to our corporate responsibilities, including social, environmental and economic

<table>
<thead>
<tr>
<th>Underlying measures and targets</th>
<th>Actual 2020</th>
<th>Actual 2020 (Vol)</th>
<th>Actual 2021</th>
<th>Actual 2021 (Vol)</th>
<th>2023 target</th>
<th>% off 2023 target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Increase the level of BME representation at Level 3 and above</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Applications</td>
<td>22.8%</td>
<td>170</td>
<td>27.8%</td>
<td>109</td>
<td>27%</td>
<td>+ 0.8%</td>
</tr>
<tr>
<td>Interviews</td>
<td>15.2%</td>
<td>118</td>
<td>22.4%</td>
<td>36</td>
<td>22%</td>
<td>+ 0.4%</td>
</tr>
<tr>
<td>Offers</td>
<td>14.6%</td>
<td>36</td>
<td>25%</td>
<td>5</td>
<td>17%</td>
<td>+ 8%</td>
</tr>
<tr>
<td>Workforce</td>
<td>11.1%</td>
<td>64</td>
<td>10.9%</td>
<td>63</td>
<td>16%</td>
<td>-5.1%</td>
</tr>
<tr>
<td><strong>Overall level of BME representation at Level 2</strong></td>
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<tr>
<td>Applications</td>
<td>8%</td>
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<td>9.1%</td>
<td>19</td>
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<td>Interviews</td>
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<td>46</td>
<td>11.9%</td>
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<td><strong>Overall level of BME representation at level 3</strong></td>
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<tr>
<td>Applications</td>
<td>29.4%</td>
<td>663</td>
<td>35.6%</td>
<td>500</td>
<td>37%</td>
<td>-1.4%</td>
</tr>
<tr>
<td>Interviews</td>
<td>18.2%</td>
<td>118</td>
<td>27.1%</td>
<td>129</td>
<td>32%</td>
<td>-4.9%</td>
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<td>Offers</td>
<td>18.2%</td>
<td>36</td>
<td>30.9%</td>
<td>37</td>
<td>27%</td>
<td>+ 3.9%</td>
</tr>
<tr>
<td>Workforce</td>
<td>14.3%</td>
<td>211</td>
<td>14.6%</td>
<td>221</td>
<td>17%</td>
<td>-2.4%</td>
</tr>
<tr>
<td><strong>Increase the level of BME representation at all levels</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applications</td>
<td>0.8%</td>
<td>-</td>
<td>0.3%</td>
<td>-</td>
<td>2.0%</td>
<td>+ 1.7%</td>
</tr>
<tr>
<td>Interviews</td>
<td>15%</td>
<td>31</td>
<td>8.8%</td>
<td>19</td>
<td>18%*</td>
<td>+ 3.3%</td>
</tr>
<tr>
<td>Offers</td>
<td>16%</td>
<td>203</td>
<td>5.5%</td>
<td>69</td>
<td>18%*</td>
<td>-3.3%</td>
</tr>
</tbody>
</table>

* difference is not set against the 2023 figure, the target is that the proportion of staff will be equal across BME and Non-BME
** 2020 is an unrealistic baseline year given the pandemic. Retention rates for BME staff have historically been outside of this range – in 2019 the difference in retention rates against the average for BME staff was 3.9%.
Financial summary

Financial summary as at Apr 2021

<table>
<thead>
<tr>
<th></th>
<th>Budget Apr</th>
<th>Actual Apr</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Operational expenditure</td>
<td>36,164</td>
<td>34,261</td>
<td>1,903</td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pension top up payment</td>
<td>1,300</td>
<td>1,300</td>
<td>0</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>2,063</td>
<td>2,061</td>
<td>2</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>39,527</td>
<td>37,622</td>
<td>1,905</td>
</tr>
<tr>
<td>Operational income</td>
<td>37,991</td>
<td>37,522</td>
<td>(469)</td>
</tr>
<tr>
<td>Operational surplus/(deficit)</td>
<td>(1,536)</td>
<td>(100)</td>
<td>1,436</td>
</tr>
</tbody>
</table>

Financial summary as at Apr 2021

<table>
<thead>
<tr>
<th></th>
<th>Budget Apr</th>
<th>Actual Apr</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Investment income</td>
<td>751</td>
<td>1,132</td>
<td>381</td>
</tr>
<tr>
<td>Total surplus/ (deficit)</td>
<td>(785)</td>
<td>1,032</td>
<td>1,817</td>
</tr>
</tbody>
</table>

Income Variance

We are forecasting a significant drop in PLAB 1 and PLAB 2 activity compared to budget with fewer PLAB 1 candidates, holding fewer PLAB 2 test days, opening the new temporary centre later than budgeted and pushing back the assumption on resuming non socially distanced PLAB tests until at least January 2022.

Income financial risks/ forecast sensitivity

The forecast number of candidates sitting PLAB 1 & PLAB 2 may be impacted by international travel restrictions. Although we will take actions to mitigate the impact for every 10% reduction in PLAB 1 & 2 candidate volumes the reduction in income is circa £850k. While there would be some cost savings through having fewer PLAB 1 candidates we would not see significant cost reductions for PLAB 2 test days if we are unable to utilise full capacity.

Expenditure Variance

The drop in expenditure is made up of the variable costs of holding PLAB 2 test days, an anticipated increase in the vacancy factor compared to budget, holding fewer MPTS hearings, as capacity increases to manage the backlog will take effect in October rather than August & undertaking fewer performance assessments. We have also changed our assumptions for normal activity levels to resume in Q4 which reduces a number of cost areas including staff expenses.

Expenditure financial risks/ forecast sensitivity

While we don’t expect a significant increase in expenditure compared to existing forecasts there could be a notable drop as we move forward through 2021. Expenditure forecasts are linked to activity assumptions and could be impacted how and when activities return to normal and how long restrictions are in place. Key examples of where there could be changes are expenses, external engagement and event costs, associate training and office costs.
## Financial detail

### Expenditure as at Apr 2021

<table>
<thead>
<tr>
<th>Item</th>
<th>Budget Apr £000</th>
<th>Actual Apr £000</th>
<th>Variance £000</th>
<th>%</th>
<th>Budget 2021 £000</th>
<th>Forecast 2021 £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff costs</td>
<td>23,965</td>
<td>23,312</td>
<td>653</td>
<td>3%</td>
<td>74,664</td>
<td>73,048</td>
<td>1,616</td>
<td>2%</td>
</tr>
<tr>
<td>Staff support costs</td>
<td>759</td>
<td>601</td>
<td>158</td>
<td>21%</td>
<td>3,658</td>
<td>3,295</td>
<td>363</td>
<td>10%</td>
</tr>
<tr>
<td>Office supplies</td>
<td>465</td>
<td>314</td>
<td>151</td>
<td>32%</td>
<td>1,740</td>
<td>1,551</td>
<td>189</td>
<td>11%</td>
</tr>
<tr>
<td>IT &amp; telecoms costs</td>
<td>1,531</td>
<td>1,500</td>
<td>31</td>
<td>2%</td>
<td>4,508</td>
<td>4,491</td>
<td>17</td>
<td>0%</td>
</tr>
<tr>
<td>Accommodation costs</td>
<td>2,545</td>
<td>2,373</td>
<td>172</td>
<td>7%</td>
<td>7,733</td>
<td>7,522</td>
<td>211</td>
<td>3%</td>
</tr>
<tr>
<td>Legal costs</td>
<td>1,190</td>
<td>1,186</td>
<td>4</td>
<td>0%</td>
<td>4,338</td>
<td>4,060</td>
<td>278</td>
<td>6%</td>
</tr>
<tr>
<td>Professional fees</td>
<td>854</td>
<td>937</td>
<td>(83)</td>
<td>(10)%</td>
<td>3,044</td>
<td>3,139</td>
<td>(95)</td>
<td>(3)%</td>
</tr>
<tr>
<td>Council &amp; members costs</td>
<td>124</td>
<td>114</td>
<td>10</td>
<td>8%</td>
<td>384</td>
<td>366</td>
<td>18</td>
<td>5%</td>
</tr>
<tr>
<td>Panel &amp; assessment costs</td>
<td>4,246</td>
<td>3,649</td>
<td>597</td>
<td>14%</td>
<td>18,815</td>
<td>14,497</td>
<td>4,318</td>
<td>23%</td>
</tr>
<tr>
<td>PSA Levy</td>
<td>277</td>
<td>275</td>
<td>2</td>
<td>1%</td>
<td>858</td>
<td>843</td>
<td>15</td>
<td>2%</td>
</tr>
<tr>
<td>Under/over-achievement of efficiency savings</td>
<td>208</td>
<td>0</td>
<td>208</td>
<td>0%</td>
<td>(590)</td>
<td>(671)</td>
<td>81</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Operational expenditure</strong></td>
<td><strong>36,164</strong></td>
<td><strong>34,261</strong></td>
<td><strong>1,903</strong></td>
<td><strong>5%</strong></td>
<td><strong>119,152</strong></td>
<td><strong>112,141</strong></td>
<td><strong>7,011</strong></td>
<td><strong>6%</strong></td>
</tr>
<tr>
<td>New initiatives fund</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
<td>973</td>
<td>973</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>2,063</td>
<td>2,061</td>
<td>2</td>
<td>0%</td>
<td>8,266</td>
<td>7,901</td>
<td>365</td>
<td>4%</td>
</tr>
<tr>
<td>Pension top up payment</td>
<td>1,300</td>
<td>1,300</td>
<td>0</td>
<td>0%</td>
<td>1,300</td>
<td>1,300</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td><strong>39,527</strong></td>
<td><strong>37,622</strong></td>
<td><strong>1,905</strong></td>
<td><strong>5%</strong></td>
<td><strong>129,691</strong></td>
<td><strong>122,315</strong></td>
<td><strong>7,376</strong></td>
<td><strong>6%</strong></td>
</tr>
</tbody>
</table>

### Income as at Apr 2021

<table>
<thead>
<tr>
<th>Item</th>
<th>Budget Apr £000</th>
<th>Actual Apr £000</th>
<th>Variance £000</th>
<th>%</th>
<th>Budget 2021 £000</th>
<th>Forecast 2021 £000</th>
<th>Variance £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual retention fees</td>
<td>32,595</td>
<td>32,643</td>
<td>48</td>
<td>0%</td>
<td>99,259</td>
<td>99,307</td>
<td>48</td>
<td>0%</td>
</tr>
<tr>
<td>Registration fees</td>
<td>1,131</td>
<td>1,235</td>
<td>104</td>
<td>9%</td>
<td>5,666</td>
<td>5,438</td>
<td>(228)</td>
<td>(4)%</td>
</tr>
<tr>
<td>PLAB fees</td>
<td>3,064</td>
<td>2,442</td>
<td>(622)</td>
<td>(20)%</td>
<td>16,584</td>
<td>10,672</td>
<td>(5,912)</td>
<td>(36)%</td>
</tr>
<tr>
<td>Specialist application CCT fees</td>
<td>655</td>
<td>657</td>
<td>2</td>
<td>0%</td>
<td>2,755</td>
<td>2,799</td>
<td>44</td>
<td>2%</td>
</tr>
<tr>
<td>Specialist application CESR/CEGPR fees</td>
<td>395</td>
<td>379</td>
<td>(16)</td>
<td>(4)%</td>
<td>1,216</td>
<td>1,289</td>
<td>73</td>
<td>6%</td>
</tr>
<tr>
<td>Interest income</td>
<td>29</td>
<td>25</td>
<td>(4)</td>
<td>(14)%</td>
<td>78</td>
<td>66</td>
<td>(12)</td>
<td>(15)%</td>
</tr>
<tr>
<td>Other income</td>
<td>122</td>
<td>141</td>
<td>19</td>
<td>16%</td>
<td>544</td>
<td>546</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total Operational Income</strong></td>
<td><strong>37,991</strong></td>
<td><strong>37,522</strong></td>
<td><strong>(469)</strong></td>
<td><strong>(1)%</strong></td>
<td><strong>126,102</strong></td>
<td><strong>120,117</strong></td>
<td><strong>(5,985)</strong></td>
<td><strong>(5)%</strong></td>
</tr>
</tbody>
</table>
## GMCSI summary & investments

### GMCSI summary as at Apr 2021

<table>
<thead>
<tr>
<th></th>
<th>Budget Apr</th>
<th>Actual Apr</th>
<th>Variance</th>
<th>Budget 2021</th>
<th>Forecast 2021</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>%</td>
<td>£000</td>
<td>%</td>
</tr>
<tr>
<td>GMCSI income</td>
<td>88</td>
<td>49</td>
<td>(39)</td>
<td>(44)%</td>
<td>388</td>
<td>0</td>
</tr>
<tr>
<td>GMCSI expenditure</td>
<td>90</td>
<td>68</td>
<td>22</td>
<td>24%</td>
<td>384</td>
<td>0</td>
</tr>
<tr>
<td><strong>Profit/ (loss)</strong></td>
<td><strong>(2)</strong></td>
<td><strong>(19)</strong></td>
<td><strong>(17)</strong></td>
<td><strong>(4)</strong></td>
<td><strong>4</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

### Investment summary 2021

<table>
<thead>
<tr>
<th>Investment summary 2021</th>
<th>Value as at Dec 2020</th>
<th>Value at 30 Apr 2021</th>
<th>2021 returns</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>CCLA managed funds</td>
<td>£57,020</td>
<td>£58,092</td>
<td>1,072</td>
</tr>
</tbody>
</table>

*Return after fees

### Investments summary as at 31 March 2021 (figures are updated quarterly)

#### Asset Allocation

<table>
<thead>
<tr>
<th></th>
<th>GMC thresholds</th>
<th>Current allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equities</td>
<td>0% - 45%</td>
<td>32.6%</td>
</tr>
<tr>
<td>Bonds and Cash</td>
<td>20% - 80%</td>
<td>47.9%</td>
</tr>
<tr>
<td>Alternatives</td>
<td>0% - 45%</td>
<td>19.5%</td>
</tr>
</tbody>
</table>

#### Investment returns

- **1 year rolling**
  - Target (CPI + 2%) 2.74%
  - CCLA performance 10.68%
### Legal summary (as at 27 April)

<table>
<thead>
<tr>
<th></th>
<th>Open cases carried forward since last report</th>
<th>New cases</th>
<th>Concluded cases</th>
<th>Outstanding cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>s.40 (Practitioner) Appeals</td>
<td>20</td>
<td>1</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>s.40A (GMC) Appeals</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>PSA Appeals</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Judicial Reviews</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>IOT Challenges</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

#### Explanation of concluded cases

**s.40 (Practitioner) Appeals**
- a. 3 GMC successful –
  - i. 2 appeals dismissed
  - ii. 1 appeal struck out
- b. 1 GMC unsuccessful – remitted back to MPTS

**s.40A (GMC) Appeals**

**Judicial Reviews**

#### New referrals by PSA to the High Court under Section 29 since the last report with explanation, and any applications outstanding

**PSA Appeals**
- There has been one new referral by PSA to the High Court under Section 29 since the last report, and one concluded (PSA successful with appeal allowed and Doctor erased from register), therefore one appeal outstanding.

#### Any new applications in the High Court challenging the imposition of interim orders since the last report with explanation; and total number of applications outstanding

**IOT challenges**
- There have been no new applications in the High Court challenging the imposition of interim orders since the last report; and therefore a total of one application is outstanding.

#### Any other litigation of particular note

**We continue to deal with a range of other litigation, including cases before the Employment Tribunal, the Employment Appeals Tribunal and the Court of Appeal.**
<table>
<thead>
<tr>
<th>Id</th>
<th>Title</th>
<th>Category</th>
<th>Detail</th>
<th>Owner</th>
<th>Additional Details</th>
<th>Mitigation/Enhancement</th>
<th>Council and/or Board Assurance</th>
<th>Assurance</th>
<th>Further Action Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>246</td>
<td>Delivery of core statutory functions</td>
<td>Operational</td>
<td>If we fail to deliver our core statutory functions, there is a potential impact on patient safety, public confidence, and the GMC’s reputation as a leading regulator.</td>
<td>Charlie Massey</td>
<td>Highly Likely</td>
<td>Operative</td>
<td>High Risk/High Impact</td>
<td>High Risk/High Impact</td>
<td>Continue to engage with the Professional Standards Authority and other regulatory partners, coordinating the Covid-19 response and reviewing our approach as the situation evolves. We’ll consider and triage all new concerns, progressing those requiring investigation. Where we don’t receive information from healthcare providers or other healthcare professionals to support investigations where they have indicated they don’t currently have capacity to assist, unless there’s a patient safety risk that requires immediate action. This means that some ongoing investigations will be paused. We’ll progress ongoing investigations where possible and with the agreement of relevant parties, to minimise delays. We’ll continue to hear reviews of all MPT sanctions and STC orders within statutory deadlines. We’ll continue to hear reviews of all MPT sanctions and STC orders within statutory deadlines.</td>
</tr>
</tbody>
</table>

Inherently Critical

- We have restarted PLAB 2 and can currently assess a limited number of candidates.
- We’ll progress ongoing investigations where possible and with the agreement of relevant parties, to minimise delays.
- We’ll progress ongoing investigations where possible and with the agreement of relevant parties, to minimise delays.
- Auditing our decisions on a regular basis.
- Surveys of our stakeholders’ perceptions.
- Collaboration and alignment (such as through the Chief Executive Officer and the GMC’s reputation as a leading regulator).
- Develo...
<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
<th>Probability</th>
<th>Impact</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.26</td>
<td>Deriving Government availability of resources to a change in the environment</td>
<td>CRITICAL</td>
<td>HIGH</td>
<td>GOLD</td>
<td>HIGH</td>
<td>LOW</td>
<td>NOT APPLICABLE</td>
</tr>
<tr>
<td>1.31</td>
<td>Responding to a changing environment</td>
<td>CRITICAL</td>
<td>HIGH</td>
<td>GOLD</td>
<td>HIGH</td>
<td>LOW</td>
<td>NOT APPLICABLE</td>
</tr>
<tr>
<td>2.19</td>
<td>Availability of resources</td>
<td>CRITICAL</td>
<td>HIGH</td>
<td>GOLD</td>
<td>HIGH</td>
<td>LOW</td>
<td>NOT APPLICABLE</td>
</tr>
<tr>
<td>2.26</td>
<td>Government capacity</td>
<td>CRITICAL</td>
<td>HIGH</td>
<td>GOLD</td>
<td>HIGH</td>
<td>LOW</td>
<td>NOT APPLICABLE</td>
</tr>
<tr>
<td>2.37</td>
<td>Deriving more insight into our data capability</td>
<td>CRITICAL</td>
<td>HIGH</td>
<td>GOLD</td>
<td>HIGH</td>
<td>LOW</td>
<td>NOT APPLICABLE</td>
</tr>
</tbody>
</table>
## Operational Understanding and improving the experiences which patients and the public have of our regulatory services and involving them effectively in our work (such as strategy and policy development) will help us gain their trust and confidence as an effective and transparent regulator.

### Paul Reynolds

- **Champion for patients established at SMT level to ensure senior-level overview of our engagement.**
- **Strategic approach to patient and public involvement agreed by Executive Board (November 2020).**
- **Clear information easily accessible for patients and public about how we work and can support them (such as on our website).**
- **Regular assessment of patients and the public’s perceptions of our work through research (such as our bi-annual perceptions survey).**
- **Regular engagement with patient leaders in all four countries of the UK (such as through our roundtable and UKAF meetings).**
- **Accessing stakeholder networks to learn how other organisations engage meaningfully and well with patients and public.**

### QUITE LIKELY

<table>
<thead>
<tr>
<th>Category</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council</td>
<td>Strategic approach to communications and engagement update (June 2020)</td>
</tr>
<tr>
<td>Council</td>
<td>Discussions at Council Away days (July 2019) about patient and public engagement in our work and preparation Corporate Strategy 2021-2025</td>
</tr>
<tr>
<td>Executive Board</td>
<td>Paper: annual update on communications and engagement (July 2020)</td>
</tr>
<tr>
<td>Executive Board</td>
<td>Paper: Strategic approach to patient and public involvement (November 2020)</td>
</tr>
<tr>
<td>Executive Board</td>
<td>Risk deep dive (February 2021)</td>
</tr>
</tbody>
</table>

### MODERATE

<table>
<thead>
<tr>
<th>Category</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Board</td>
<td>Annual perceptions survey showing the public’s confidence in how doctors are regulated and feedback on working relationships with patient and public bodies.</td>
</tr>
<tr>
<td>Executive Board</td>
<td>L2 (Head of Section) Programme Lead to take charge of strategic delivery from Q2 2021 onwards.</td>
</tr>
<tr>
<td>Policy teams</td>
<td>Policy teams to identify opportunities during 2021 for involving patients in their work (in progress).</td>
</tr>
<tr>
<td>Policy teams</td>
<td>New guide for LGBT patients (about the care they can expect from a doctor) in development.</td>
</tr>
<tr>
<td>Policy teams</td>
<td>Factsheet explaining our threshold for acting on fitness to practise concerns in development.</td>
</tr>
<tr>
<td>Policy teams</td>
<td>Next roundtable with patient organisations likely to be held in May 2021; to include session on regulatory reform.</td>
</tr>
</tbody>
</table>
### Purpose
This item provides an update on progress against our Equality, Diversity and Inclusion (ED&I) ambitions to improve inclusivity in work and practice environments and support better patient outcomes.

### Decision trail
ED&I has been a standing agenda item since September 2020. Council agreed to establish ED&I measures and targets in February 2021.

### Recommendation(s)
- To consider progress against our ED&I ambitions.

### Annexes
None

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Background

1. Our Corporate strategy 2021-2025 commits to fostering a culture of equality, diversity and inclusion in everything we do as a regulator and employer. We specifically commit to work with partners across the UK health services to improve working environments and cultures, making them supportive, inclusive and fair for medical professionals to support workforce sustainability and better patient outcomes. In February Council agreed specific measurable targets to better define these ambitions:

   - eliminate disproportionality in fitness to practise referrals from designated bodies based on race and place of primary medical qualification (PMQ) by 2026.
   - eliminate discrimination, disadvantage and unfairness for all index measures of fair medical education and training pathways by 2031.
   - eliminate differentials within our own staffing performance, in BME recruitment, representation across staffing levels, retention, progression, pay and employee engagement by 2026.

2. This paper provides an update on implementation progress against the targets and our broader ambitions.

Targets publication and stakeholder views

3. We published our targets on 18 May 2021. Several stakeholders supported us publicly, including the BMA, NHS Providers, MDU, MPS, Royal College of Surgeons and the Royal College of Paediatrics and Child Heath.

4. All have welcomed us setting targets for change in these areas, and the desire to see real action to meet them. System stakeholders have communicated their commitment to working collaboratively with us and emphasised the need for system-wide action plans and culture change to make the improvements needed. There was recognition from stakeholders that the challenge is significant, and our ambition would need continued and significant transformation in NHS culture, particularly when it comes to addressing insider/outsider dynamics.

5. We also held a wide-ranging programme of engagement pre-publication that had indicated the positive support we have drawn. This engagement included our Strategic ED&I Advisory Forum, and our UK Advisory Forums throughout April and May.
Council meeting, 9 June 2021
Agenda item M4 – Equality, Diversity and Inclusion Update

- Northern Ireland stakeholders recognised the challenges facing the growing numbers of ethnic minority students and doctors in training in NI. Whilst there are range of initiatives in place at undergraduate and postgraduate level, a collective approach may be required to address systemic cultural issues.

- Scotland’s UKAF meeting heard positive contributions demonstrating the range of work happening across the country aimed at tackling the disproportionality which exists. We plan to focus our post-meeting work on a number of discrete areas. These are likely to include how to improve feedback conversations and improving induction. Directors of Medical Education in Scotland positively engaged with us and ED&I focused workshops are being rolled out across the health boards, to try to address some of the underlying culture and behavioural issues identified in our research. We attended the BAPIO Scotland Annual event and delivered a presentation on ‘Tackling Inequalities together’ which outlined our ambitions, was positively received, and had offers from BAPIO to collaborate around addressing unprofessional behaviours and encouraging ethnic minority doctors to speak up.

- The Welsh Government is consulting on a Race Equality Action Plan which includes commitments aimed at addressing differential attainment using our data, tackling complaints made against BME staff, and targets to improve inclusivity of NHS environments and leadership. We and our stakeholders are highly engaged with this agenda and will be providing responses, and all are keen to collaborate further. BMA Cymru have invited us to engage with their newly formed BAME Doctors Forum.

**Eliminating disproportionality in fitness to practise referrals from designated bodies based on race and place of primary medical qualification**

6. From 2019 when we published our *Fair to refer?* research, we have been having conversations with designated bodies on our research and fairness in environments. We are now targeting these engagements with a sharper focus on the data. Over the course of 2021 we will engage with the 50-60 designated bodies that ostensibly have patterns of differentials in their referrals. We are piloting these conversations with Responsible Officers (ROs) using a structured set of questions by our Employer Liaison Advisers (ELAs) drawing on *Fair to refer?* to explore drivers of differential outcomes including local induction, support, culture and leadership.

7. Many designated bodies (DBs) are already working to address these issues so we will use these conversations to understand more about how these initiatives
are working and what we can do to support them. The initial focus of our engagements is to understand their perspective of the data, consider local actions and establish the best type of support we can provide. This may include our Welcome to UK Practice workshops, Professional Behaviours and Patient Safety training, or engaging at Board level. Progress on the conversations will be reviewed monthly. This pilot phase to refine our approach began in May and will extend through till the end of July (subject to RO availability to engage with us in those timeframes). It will help us capture lessons learnt to inform the ongoing rollout for the remainder of 2021.

8 We remain on track to amend our referral form used by employers by the end of September. This change (together with our RO engagements) act on a key recommendation of our *Fair to refer?* research to systematically challenge at the point of referral that appropriate local controls are in place and require ROs to confirm steps they have taken to ensure referrals are fair and appropriate. Engagement with the RO community about these changes is planned for late Spring 2021. We are continuing to enhance the feedback between ourselves and ROs on investigation outcomes to improve the understanding of thresholds. This feedback will look at the effectiveness of prompts on referral forms, as well as insights from investigations that can be fed back to the system to improve referral practice.

**Related collaboration**

9 In England, we are developing collaborative work to support delivery of the NHSE People Plan workstream titled ‘Tackling the disciplinary gap’. We are working with NHS Resolution and NHSEI and are discussing draft plans and shared communications on the importance of this work and why healthcare organisations should prioritise it. We have approached CQC and the NMC to join the work. The aim is to reach equality in terms of the likelihood of staff entering the disciplinary process for both white and BME staff across at least 90% of all NHS organisations by 2022. This work aligns strongly with our agenda – seeking to ensure the earliest local intervention to help support staff, and promoting a fair, just culture focussed on learning and improvement. It has the potential to be an earlier upstream intervention before any point of referral to us.

10 We are also working with CQC to identify potential inequalities in CQC regulation of GP practices led by minority ethnic clinicians following concerns raised by the BMA and the RCGP. We are supporting early stage analysis using our ethnicity data to help identify correlation in the data points that can help us refine understanding of the problem.
Eliminating discrimination, disadvantage and unfairness for all index measures of fair medical education and training pathways

11 To support our work, we have appointed a new project manager and allocated additional policy resource in the education and standards directorate. We are training staff to have challenging conversations with postgraduate organisations (PGOs) and medical schools around differential attainment and our targets.

12 We continue to monitor PGOs’ progress on fairness in training through our proactive quality assurance processes. To date, 10 out of 16 PGOs have completed or are in the process of completing a self-assessment questionnaire where they must report on aspects of fairness and equality as per our standards.

13 We require Postgraduate Deans to update us annually on the actions they are taking to address the attainment gap in their region. Most have produced a formal action plan to evidence their initiatives. We will ask those who have not yet created a formal plan to do so by the end of 2021. We will monitor progress against these plans, showcasing success, highlighting issues, and embed the learnings into our Quality Assurance regime.

14 For medical royal colleges and faculties, we set the expectation in 2020 that our standards require them to take action to address the attainment gap, and that we will seek evidence of their action through our QA review. We published guidance on actions they should consider taking. We meet with colleges in July to agree the new process for submitting action plans to the GMC in 2022.

15 We continue to support the development and publication of the Medical Schools Council’s guidance on inclusivity within medical schools (the title is yet to be finalised) and its outputs e.g. identification of good practice.

16 In 2021, we will collect Medical School assessment data for the first time which will add valuable insight to our understanding of the attainment gap, prior attainment and progression.

17 We are continuing work with Health Education England (HEE) and Health Education and Improvement Wales (HEIW) and the Royal College of Psychiatrists to design and deliver initiatives to improve outcomes for Core Psychiatry Trainees. The work will build the evidence base on ‘What works’ to eliminate the ethnic attainment gap through piloting exam preparation training courses. Five courses for 120 Core Psych trainees will be run over the next 18 months and undertake qualitative interviews with attendees and track their progression into higher training as well as future exam pass rates. This initiative
has been chosen because of promising results in small-scale pilots of a similar nature by RCGP. We will publish our findings on improvements to trainee progress and exam outcomes in 2022.

18 We are also ensuring our current aspirations are considered in the context of the MLA. The MLA team continue to work closely with the MSC and has provided extensive feedback to them for their own equality considerations on the applied knowledge test they are coordinating on behalf of medical schools. Our intention is to ensure that those we work with support our own aims to fully embed an inclusive approach.

**Improving GMC inclusivity**

19 We have embedded our internal targets into our performance reporting framework, including in the CEO report annex to Council. We have delivered briefings to recruiting managers across the GMC on the application of our recruitment targets and what it means for them. Against the other commitments of our internal inclusivity, since Council last convened:

- We have finalised the design of a blended learning programme to be delivered to all GMC colleagues’ later in 2021 on Professional behaviours. This learning champions respect and inclusion and raises awareness of professional behaviour expectations, so that our people understand how to model the behaviours we want to see across the business.

- We have tendered and appointed an external supplier to lead on mandatory leadership development sessions on inclusion for level 3 managers and above; and for the talent management programmes for black and minority ethnic staff.

- We have commenced rolling out our Anti-racist ally training. The concept, design and development of which has been driven by our BME Network.

**Work with Counsel Chambers**

20 We also want to promote diversity of third parties who support the delivery of our services. We have written to all Counsel Chambers we instruct to represent us at MPTS and litigation hearings, setting out our ambition for our preferred Chambers and Counsel list: By the start of 2024, we are aiming to have one in every three (33%) additions to our Counsel list from a minority ethnic background. To track progress against this ambition, we will work with Chambers to share good practice and every 12 months will request a progress update from each Chambers, including positive actions they have taken and the
impact this has had. We will undertake a full review of Chambers’ ethnicity data in 2024 to measure change against the baseline data we secured earlier this year. We will continue to work with Chambers to promote greater diversity across all protected characteristics. We have shared our recent activity with the Bar Standards Board and welcomed a discussion on their work to tackle race inequality and how that might inform our work to promote greater diversity in our Counsel list.

**Broader agenda**

21 The value of the associated transparency, scrutiny, and spotlight on measurable progress that accompanies published targets has been a key factor in influencing our approach. Consistent with this, in April we published the complete set of protected characteristics data that we hold about our registrants (anonymised) through Data Explorer on our website.

22 We have also been working closely with NHSE on the Medical Workforce Race Equality Standard (MWRES). The MWRES is a set of indicators aiming to expose ethnic disparities in the medical workforce. We are providing data on revalidation recommendations, postgraduate training outcomes and fitness to practise complaints. To support this, we will publish an insight paper with a supporting narrative to put the observable differences in our data into context. We will also publish a blog to promote our commitment to supporting the MWRES and the broader value of data and evidence to inform the agenda moving forward.

23 We have been progressing an independent fairness audit of fitness to practice processes (Field Fisher working with the University of Edinburgh) and we are on track to publish this report this summer (final date is yet to be confirmed). When we have reflected on the outcome of this process, we intend to translate this experience into a programme of rolling audits across our functions. We will complete tendering for our next audit in registration and revalidation by end July.

24 We propose to reflect on the impact of our targets and how they are working or what we need change as part of our enhanced annual reporting against ED&I to Council in February 2022, as well as through these future updates where we identify key learnings.
Executive summary

This report gives an update on the work of the Medical Practitioners Tribunal Service (MPTS) since the last report to Council in December 2020.

Key points to note:

► The MPTS is operating hearings both virtually and at our hearing centre in Manchester.

► Our hearing centre remained open during the recent period of national restrictions in England, to consider those cases that were not suitable for a virtual hearing.

► As we continue to implement our pandemic recovery plan, we ran more hearings in Q1 2021 than we did in the corresponding period of the previous two years.

Recommendations

► Council is asked to consider the report of the MPTS Committee.
► Council is asked to note the text of the MPTS Report to Parliament 2020 (annex B).
Governance

1 The Medical Practitioners Tribunal Service (MPTS) reports twice a year to Council on how we are fulfilling the statutory duties for which we are accountable to the UK Parliament.

2 This paper is the MPTS Committee’s first report of 2021.

3 The MPTS Committee met virtually on 3 February 2021 and considered our response to the pandemic and recovery planning, adjournments, quality assurance, tribunal member training and an update on our 2020 business plan.

4 The MPTS Committee met virtually on 11 May 2021 and considered our continuing response to the pandemic and recovery planning, our annual report to Parliament, the annual reviews of complaints and compliments and the Committee’s effectiveness.

5 Two Committee members, Patricia Moultrie and Judith Worthington, will reach the end of the maximum eight-year appointment period as members of the Committee on 3 November 2021.

6 The GMC’s Remuneration Committee, at their meeting on 30 March 2021, approved arrangements for an appointment campaign. Council will be asked to confirm two appointments at its meeting in September.

7 The MPTS will lay its annual report for 2020 before Parliament later this year. A copy of the text is attached (annex B) for Council’s information.

Operational update

Responding to the COVID-19 pandemic

8 As previously reported, we took the decision in March 2020 to close our hearing centre and to begin holding virtual hearings, in order to meet our overarching objective to protect the public.

9 From August 2020 we have been running socially-distanced hearings in our Manchester hearing centre.

10 Since November 2020 hearings have only been taking place in Manchester if the needs of the participants cannot be met by a virtual hearing or the circumstances of the case make it unsuitable for a virtual hearing.

11 That has remained the position throughout the recent period of national restrictions in England.
12 By keeping our hearing centre open we have avoided postponing hearings that were ready to proceed. Concluding hearings as quickly as possible is important as delays can be stressful for doctors, patients and others involved in our hearings.

13 As national restrictions are eased, we expect to see a gradually rising demand from parties for hearings to take place at our hearing centre, rather than virtually.

14 We continue to have extensive safety and hygiene measures in place at the hearing centre.

Recovery plan

15 We have been working collaboratively with GMC SMT and colleagues from across the business to ensure the MPTS continues to have the necessary resources to deliver an effective and efficient adjudication service and to deliver our recovery plan.

16 Following a round of recruitment activity undertaken in 2020, we have colleagues in place to deliver the initial phase of the recovery plan. However, additional headcount is required for when we expect to increase our hearing capacity later in 2021.

17 Since we began to hold hearings virtually in March last year, the feedback we have received from those regularly involved in our proceedings has helped us improve and fine-tune our processes. We will continue to listen to the views of all parties as we proceed with implementing our recovery plan.

Future of virtual hearings

18 We rapidly moved to using a virtual platform for hearings in March last year. Since then we have had the opportunity to assess more fully our requirements.

19 We have established that these are:

- A simple and user-friendly interface.
- The ability to ensure appropriate entry and exit to hearings.
- Ease of movement between the hearing session and private tribunal discussions.
- A phone-in option, with number masking.
- The ability to share documents, including audio and video.
- Compatibility with our existing video conferencing technology, to allow hybrid hearings.

20 Following a review of currently available platforms with IS colleagues we will begin a staged rollout of a new virtual hearing platform later this year.
Virtual meeting technology is developing rapidly and we will remain alert to new products that could further improve the effectiveness and efficiency of our virtual hearings.

We are grateful for the feedback and support of tribunal members, MPTS and GMC Legal colleagues and doctors’ representatives in this area.

### Tribunal members

As of 31 December 2020, we had 294 tribunal members, of whom 51% were medical members and 49% lay members (including legally qualified chairs).

In total, 46% of tribunal members were female and 22% identified as coming from black, Asian and minority ethnic (BAME) backgrounds.

Each three-person tribunal is empanelled according to availability. We monitor how often this produces a diverse tribunal.

In 2020, our tribunals had both ethnicity and gender diversity on 36.9% of hearings. On 46.1% of hearings our tribunals had gender diversity only, while on 9.2% of hearings our tribunals had ethnicity diversity only. A non-BAME, single gender tribunal only sat on 7.8% of hearings.

### Quality assurance

The MPTS Quality Assurance Group (QAG) meets monthly to review a proportion of written tribunal determinations. The purpose of these reviews is to make sure determinations are clear, well-reasoned and compliant with the relevant case law and guidance.

QAG also identifies issues which can usefully be incorporated into future tribunal training sessions or included in tribunal circulars.

In 2020, the QAG reviewed 328 tribunal decisions, including 33% of all MPT decisions and 26% of new IOT decisions.

All learning points issued to tribunal members can be viewed at [www.mpts-uk.org/learning_points](http://www.mpts-uk.org/learning_points).

### Referrals and hearing volumes

Referrals of new cases from the GMC remain below pre-pandemic levels, with 76 referrals in Q1 compared to 90 in the same period in 2020.
32 Over the whole of 2020 the MPTS concluded 1751 hearings (of all types), of which 750 were virtual, 652 were reviews on the papers and 349 took place at the hearing centre.

33 By Q4 of 2020 we were running close to pre-pandemic numbers of hearing days.

34 Having gradually increased the number of hearings, by Q1 of 2021 we ran more hearing days than in the corresponding period of the previous two years.
Hearing outcomes

35 Interim orders tribunals (IOT) made decisions in new cases involving 352 doctors in 2020. As previously reported, our swift adoption of virtual hearings in March 2020 for IOT cases meant we were able to operate interim hearings at our normal level over the course of the calendar year.

36 Doctors were interim suspended in 11% of cases and received interim conditions in 66% of cases. No order was made in 22% of cases. This is a similar spread of outcomes to previous calendar years.

37 Medical practitioner tribunals (MPT) made decisions in new cases involving 143 doctors in 2020 - fewer than would normally be expected in a calendar year.

38 For most of 2020, the MPTS listed new MPT hearings on a prioritised basis, applying criteria which included whether a doctor had an interim restriction, whether a hearing was part-heard, the age of the case and how prepared parties were to proceed.

39 Due to this prioritisation, some types of cases are more likely to have proceeded than others, so it is difficult to make a like for like comparison with outcomes from previous calendar years. We will continue to report on this as we proceed with our recovery.
### Hearing outcomes 2018 – Q1 2021

#### Interim orders tribunals

<table>
<thead>
<tr>
<th>New IOT hearing outcomes</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>Q1 only 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases</td>
<td>%</td>
<td>Cases</td>
<td>%</td>
</tr>
<tr>
<td>Suspension</td>
<td>48</td>
<td>12%</td>
<td>52</td>
<td>14%</td>
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<tr>
<td>Conditions</td>
<td>247</td>
<td>64%</td>
<td>225</td>
<td>63%</td>
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<tr>
<td>No order</td>
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<td>24%</td>
<td>82</td>
<td>23%</td>
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<td><strong>Total</strong></td>
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<td><strong>100%</strong></td>
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#### Medical practitioners tribunals

<table>
<thead>
<tr>
<th>New MPT hearing outcomes</th>
<th>2018</th>
<th>2019</th>
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<th>Q1 only 2021</th>
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<tr>
<td></td>
<td>Cases</td>
<td>%</td>
<td>Cases</td>
<td>%</td>
</tr>
<tr>
<td>Impaired: Erasure</td>
<td>65</td>
<td>26%</td>
<td>55</td>
<td>21%</td>
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<tr>
<td>Impaired: Suspension</td>
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<td>41%</td>
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<tr>
<td>Impaired: Conditions</td>
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<td>Impaired: No action</td>
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<td>1%</td>
<td>4</td>
<td>2%</td>
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<tr>
<td>Not impaired: Warning</td>
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<td>4%</td>
<td>17</td>
<td>7%</td>
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<tr>
<td>Not impaired</td>
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<td>17%</td>
<td>44</td>
<td>17%</td>
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<td><strong>Total</strong></td>
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<td><strong>100%</strong></td>
<td><strong>257</strong></td>
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### Non-compliance hearing outcomes

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<th>2019</th>
<th>2020</th>
<th>Q1 only 2021</th>
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<td></td>
<td>Cases</td>
<td>Cases</td>
<td>Cases</td>
<td>Cases</td>
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<tr>
<td>Suspension</td>
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<td><strong>Total</strong></td>
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### Outcomes in restoration hearings

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<th>2018</th>
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<th>Q1 only 2021</th>
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<tbody>
<tr>
<td></td>
<td>Cases</td>
<td>Cases</td>
<td>Cases</td>
<td>Cases</td>
</tr>
<tr>
<td>Application granted</td>
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<td>8</td>
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<td>Application refused</td>
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<td>10</td>
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<td><strong>Total</strong></td>
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### Number of review hearings

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<th>2020</th>
<th>Q1 2020</th>
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<td></td>
<td>Cases</td>
<td>Cases</td>
<td>Cases</td>
<td>Cases</td>
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<tr>
<td>Medical practitioners tribunal review hearing</td>
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<td>134</td>
<td>130</td>
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<tr>
<td>Medical practitioners tribunal review on the papers</td>
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<td>7</td>
<td>26</td>
<td>4</td>
</tr>
<tr>
<td>Non-compliance review hearings</td>
<td>13</td>
<td>13</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Interim orders tribunal review hearing</td>
<td>418</td>
<td>466</td>
<td>428</td>
<td>96</td>
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<tr>
<td>Interim orders tribunal review on the papers</td>
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<td>626</td>
<td>203</td>
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<tr>
<td><strong>Total</strong></td>
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<td><strong>815</strong></td>
<td><strong>1054</strong></td>
<td><strong>333</strong></td>
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<td>Paper withheld from publication</td>
<td>Please note Annex B of this paper is being withheld from publication prior to going to Parliament. For further information, please contact the Corporate Governance team via email, <a href="mailto:GovernanceTeamMailbox@gmc-uk.org">GovernanceTeamMailbox@gmc-uk.org</a>.</td>
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**Council – 9 June 2021**

**Agenda item M6**  
A proposal for a university-led applied knowledge test for students in UK medical schools as part of the Medical Licensing Assessment

<table>
<thead>
<tr>
<th>Action</th>
<th>To approve</th>
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<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>Following the direction provided by Council in July 2020 and the March 2021 publication of the regulatory framework for the MLA, medical schools have submitted a proposal to collaborate through the Medical Schools Council (MSC). They propose to deliver the applied knowledge test (AKT) element of the MLA for their students through a centrally constructed test. If Council approves the proposal, the GMC will regulate and oversee this AKT. Having analysed the proposal, we believe that, subject to schools fulfilling the commitments in it, undertaking post-piloting refinement, and complying with our published AKT requirements, the model will achieve Council’s aim for the MLA and can be approved.</td>
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We’ve drafted a set of directions for Council to consider making if it approves the proposal, which will provide assurance on the management of progress, further technical development, implementation and risk and resources.

<table>
<thead>
<tr>
<th>Decision trail</th>
<th>MLA Programme Board</th>
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| **Recommendations** | a To approve the proposal for a university-led MLA AKT for students in UK medical schools (see Annexes A and B).  
 | b To approve the suggested directions (see Annex C).  
 | c To delegate authority to the Registrar to:  
 | i approve updates to its directions in relation to this proposal (including any new directions that may be required during the development phase);  
 | ii monitor compliance with the directions and the commitments made through the proposal, and  
 | iii approve post-piloting operational refinements to the delivery model unless Council’s strategic advice is required. |

| Annexes | Annex A: The proposal  
Annex B: Summary evaluation of the proposal  
Annex C: Draft directions  
Annex D: Equality, diversity and inclusion considerations |
|---------|--------------------------------------------------|

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|-----------------|--------------------------------------------------|

| Sponsoring director | Professor Colin Melville, Medical Director and Director, Education and Standards  
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Medical school proposal to the General Medical Council under section 4(4) of the Medical Act 1983

UK medical schools, working through their representative body the Medical Schools Council (MSC), commend to the General Medical Council (GMC) the attached proposal to set and administer a university-led and GMC-regulated applied knowledge test for students at UK medical schools (MS AKT).

This is a submission under section 4(4) of the Medical Act 1983, through which “any two or more bodies and combinations of bodies included in the list maintained [by the GMC] may, with the approval and under the directions of [the GMC], unite or co-operate in conducting examinations held for the purpose of granting primary United Kingdom qualifications”. As such, MSC understands that the awarding bodies themselves will need to confirm that they are parties to the proposal before the GMC will be able formally to approve it. However, in the meantime, the heads of UK medical schools who comprise the Medical Schools Council have affirmed that they are content for the proposal as attached to go forward for the GMC’s consideration in the names of all their schools.

The proposal brings together the work of a team and must speak to several audiences: those in medical schools and at the MSC who are committed to delivering it; the GMC as the body considering it for approval; and interested observers. As a result, it is a long, complex and detailed document.

For the avoidance of any doubt, medical schools reaffirm their commitment to the key elements of their initial proposal for a university-led AKT which the GMC accepted in July 2020. They intend to build upon and improve the mechanisms to set and deliver exams in the light of evidence obtained thus far and during the forthcoming pilots. To that end the commitments have been updated:

1. All students at UK medical schools will be required to pass the UK Medical Licensing Assessment (MLA) in order to graduate and be awarded a medical degree that is recognised as a primary medical qualification (PMQ) by the GMC.

2. Before the UK MLA goes live, the GMC will clarify how the structures and procedures, which schools and universities agree to operate through the MSC, will relate to its statutory responsibilities, and to school and university obligations under the Medical Act. During development of the UK MLA, the GMC will need to assure itself that the approach being established can secure maintenance of the required standard of proficiency.

3. When the UK MLA goes live, schools and universities will take responsibility for delivering the MS AKT using the agreed approach. The GMC’s role will be to ensure that the processes and structures, and how they are implemented, continue to secure the required standard of proficiency in those schools. The mechanisms for ensuring that the required standard is met may change over time. The MS AKT will utilise the MSC Assessment (MSCA) question bank and delivery platform with robust item development and quality assurance processes overseen by the GMC.

4. The UK MLA AKT will be delivered on-screen utilising the MSCA platform

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1 Since confirmed as being in 2024.
2 The GMC has since done so through Assuring readiness for practice: a framework for the MLA (March 2021).
5. The content for the MS AKT for students at UK medical schools will be drawn from the GMC’s MLA content map and the sampling grid developed by experts in UK medical schools and approved by the GMC. The pass mark will be set by a national exam board of experts regulated by the GMC.

6. Medical schools will continue to deliver their own CPSA in accordance with the GMC content map and in compliance with good practice requirements set out by GMC in the CPSA Requirements. Information on the CPSA is available separately.

7. Before the UK MLA goes live, the MSC will support medical schools in building consistency for all candidates, by coordinating national policy frameworks or guidance for the MS AKT in areas such as number of attempts, mitigating circumstances, reasonable adjustments, exam misconduct and appeals (see Appendices). As the MS AKT will be embedded within a medical degree, these frameworks or guidance will be applied through a medical school or parent university’s local processes, and decisions under the policies will be made locally.

8. Data sharing with the GMC will ensure robust regulation and facilitate its quality assurance and evaluation of the MS AKT and research to investigate the impact of the MLA, including the standards relevant to the points of registration for students and UK medical schools and international medical graduates.

MSC has discussed its submission with GMC colleagues whilst it has refined the processes and structures proposed in the attached document. These exchanges suggest that GMC Council would find it helpful for some aspects of the elements listed above to be expanded upon.

- Medical schools recognise the GMC’s responsibility for regulating the whole MLA programme and its application to UK schools as set out in Assuring readiness for practice: a framework for the MLA. MSC is proposing the MS AKT as a way in which medical schools can meet the AKT requirements that are part of that framework.

- Medical schools accept that the GMC’s regulatory oversight role includes approving the MS AKT’s processes before they go live in 2024 and assuring itself after go-live that schools are maintaining the approved processes. They recognise that, before and after go-live, this oversight may lead to the GMC requiring schools or MSC Assessment to take action in relation to the GMC’s input.

During the iterative process of development in the pilot phase and beyond MSC will engage with key stakeholders as part of the MS AKT’s development. The MS AKT will require significant financial resources in terms of academic and administrative time when delivered to the highest possible standard. Section 5, page 27 sets out MSC’s intention to undertake a full evaluation after one full pilot to develop a proportionate funding model. The heads of the medical schools and their colleagues, look forward to continuing to work with the GMC to develop and pilot the MS AKT for full implementation in 2024.

This decision taken, on 14 May 2021, was recorded in the MSC Council minutes as follows:

5. To agree the MSC final proposal to the GMC to set and deliver the UK Applied Knowledge Test

Members of the Medical Schools Council formally and unanimously agreed the MSC final proposal to deliver the UK Applied Knowledge Test (MSC 21-18) and the content of the covering letter to the GMC (MSC 21-19).

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3 See Assuring readiness for practice: a framework for the MLA (March 2021).
4 See Assuring readiness for practice: a framework for the MLA (March 2021).
Proposal for a collaboration between UK medical schools and the Medical Schools Council to deliver the

UK medical school MLA Applied Knowledge Test

May 2021
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Information about this version of the MS AKT proposal

Please note that this is a redacted version of the full MS AKT proposal approved by the General Medical Council. Detailed chapters containing confidential information on piloting, resourcing and security measures have been removed.

The following sections have been removed from this proposal:

- Chapter 4: Resourcing the MS AKT
- Chapter 5: AKT pilots
- Appendix 6: The standard operating procedure for student exam registration on the Exam-Write platform
- Appendix 10: The security controls for the MSC Assessment Alliance Item Bank and Exam-Write
- Appendix 14: Timeline

Information has been redacted if it:

- exposes information relevant to a live exam
- would, or would be likely to, prejudice MSC or medical schools’ commercial interests
- would jeopardise the security of MSC’s Exam-Write platform.
Executive summary

UK medical schools, working through their representative body the Medical Schools Council (MSC), commend to the General Medical Council (GMC) this proposal to set and administer a GMC regulated national assessment of applied knowledge (MS AKT) to all students graduating from UK medical schools.

Equality, diversity and inclusion considerations have been prioritised in the development of this proposal. A glossary is provided at the end of the document for terms with which members might not be familiar. Appendices are also available at the end of this document to support the areas discussed and provide greater detail.

Graduates of UK medical schools (including overseas campuses) who pass both the MS AKT and the Clinical and Professional Skills Assessment (CPSA) as part of a degree that meets the GMC’s outcomes for undergraduate medical education and training will demonstrate that they have met the GMC’s required standards of proficiency and are well prepared to practise medicine at the start of Foundation Year 1.

The two university assessments (MS AKT and CPSA) will form the Medical Licensing Assessment (MLA) which will test the core knowledge, skills and behaviours needed to practise medicine safely in the UK. Students graduating from UK medical schools from the academic year 2024-25 will need to pass the MLA as part of their medical degree before they can join the medical register with a licence to practise.

Over the intervening three years UK medical schools will collectively take responsibility for and will pilot the MS AKT. The work will be undertaken by assessment experts in UK medical schools working under the auspices of the Medical Schools Council, MSC Assessment and the MSC Assessment Alliance (see Appendix 1). These organisations are uniquely qualified to undertake the work (see also Appendix 2) and allow medical schools to utilise their secure question bank consisting of 5,000 items which have been tagged to the
MLA content map and access Exam-Write – an exam delivery platform which automatically marks and analyses candidate responses and undertakes psychometric analyses.

The proposal outlines the way in which medical schools can collaborate to deliver an exam which accurately identifies students who are safe, or not safe, to practise medicine in the UK. The GMC will confirm that the exam meets its regulatory requirements for the standard of proficiency. The proposal explains how the question bank (also known as the MSC Assessment Alliance Item Bank) will be refreshed annually. It details how the topics covered will probe patient presentations and conditions likely to be encountered by doctors in the UK Foundation Programme, as set out in the GMC’s MLA content map, and provides evidence that appropriate weight is given to the situations typically faced by doctors working in the Foundation Programme through a sampling approach to be approved by the GMC. The proposal also explains how the standard setting methodology drawing on expertise from across the UK will be used to determine the pass mark – and how the level of challenge will be maintained between papers in any one year and across subsequent years.

Medical schools have worked with the GMC to agree the proposed governance arrangements, reporting structures, evaluation mechanisms and means of continuous improvement. This proposed model builds on medical schools’ extensive knowledge and globally recognised expertise. Medical schools are confident that the model is feasible and operationally deliverable. Medical schools are also committed to providing the human and financial resources to ensure the MS AKT remains sustainable.

However, it is recognised that further detailed planning will be required both ahead of and during the development and piloting phase, to support resource planning and bolster medical school, MSC and GMC confidence in the proposal’s operational deliverability.

It is important to note that medical schools will collectively need to develop and refine the proposed model based on lessons learned from the piloting phase and any long-term
consequences for assessment strategies emerging from the COVID 19 pandemic. Evidence from these pilots will be used to determine whether any adjustments are needed to the processes summarised in this proposal. Should any adjustments be needed, GMC approval will be sought for the changes.

MSC understands that the GMC will finalise its approach to Quality Assurance once this proposal has been accepted. It is anticipated that it will closely follow the QA approach adopted by the Quality Assurance Monitoring & Improvement team and its plans for quality assuring medical schools’ CPSA.

Medical schools and the MSC agree to work with the GMC to support its regulatory processes (including compliance with any directions issued by the GMC’s Council under s4(4) of the Medical Act). Medical schools and the MSC agree to work with the GMC as it develops its own processes and structures for effective regulatory oversight of the MS AKT (including ensuring compliance with the AKT requirements). Medical schools and their universities suggest that a review and evaluation of the arrangements for the university-led MS AKT is conducted regularly and at least every five years and recognise that the GMC is planning its own evaluation of the MLA.
1. Introduction to MSC’s proposal on behalf of UK medical schools
Introduction to MSC’s proposal on behalf of UK medical schools

On 10 March 2021 the GMC published *Assuring readiness for practice: a framework for the MLA* which formally introduced the MLA and defined the GMC’s requirements of medical schools in relation to it. The MLA Framework includes a document, *Requirements for the Medical Licensing Assessment Applied Knowledge Test*, which specifies the requirements that each AKT must meet.

Section 4(4) of the Medical Act allows for any two or more primary medical qualification (PMQ) awarding bodies, under the directions and approval of the GMC, to co-operate in conducting exams for the purpose of granting a PMQ. Since July 2020, UK medical schools have worked with the MSC to develop this formal proposal to deliver an AKT which meets the requirements of *Assuring readiness for practice*.

This proposal describes what UK medical schools—working through the MSC—are committed to delivering by 1 January 2024 for students graduating in the academic year 2024-25 when the MLA will be used to assess medical students.

Under this proposal, the UK universities with medical schools will be jointly responsible for setting and administering the MS AKT to the satisfaction of the GMC and HEI regulators in the four nations of the UK. Prior to their first live delivery of the MS AKT, each medical school - facilitated by the MSC as needed - will provide a full demonstration of compliance with the AKT requirements to the GMC. During the MS AKT development phase, as medical schools prepare and submit their evidence to the GMC for evaluation, the GMC will provide support and make recommendations for how medical schools can meet the AKT requirements.

Medical schools have worked together for several years to develop a collaborative approach to many aspects of the current AKT and have demonstrated that the proposed model is feasible and operationally deliverable. They recognise that an assessment with a common binding pass mark represents a step change from earlier collaborations. A common delivery system and policy framework will underpin the process. Medical schools will work with the GMC to provide evidence that the assessments devised collectively by the universities will accurately and fairly demonstrate that when combined with the other assessments leading to a degree, the standard of proficiency required for registration is being met.

Importantly this proposal is compatible with the recent consultation: *Regulating health professionals, protecting the public*.

This proposal describes the processes by which medical schools—working through the MSC—will pilot and then deliver the MS AKT for those graduating from the academic year 2024-25 in all UK medical schools. The MSC will deliver this through its wholly owned subsidiary MSC Assessment which will provide the exam questions and the
delivery platform, Exam-Write. The item bank holds over 5,000 questions which have been rigorously quality assured and extensively utilised by UK medical schools whose assessment programmes are regulated and approved by the GMC. A number of these, along with new items, will be used for the MS AKT exams (see Chapter 6). MSC Assessment holds the copyright for the MS AKT exam questions and owns the delivery platform. Both the MSC and MSC Assessment are limited companies and registered charities.

What is the Medical School Applied Knowledge Test?

The MS AKT is a written assessment of applied clinical knowledge which will be taken by all students at UK medical schools as part of the final set of exams leading to graduation. This model builds upon current practice within medical schools as all medical students are required to demonstrate that they have the requisite knowledge to graduate and are well prepared to practise medicine at the start of the Foundation Programme. Over the last 15 years medical schools have collaborated to design questions and have demonstrated that these questions can be used to reliably test applied clinical knowledge in final assessments and evidence whether a candidate has met the GMC’s required standard of proficiency. The introduction of the MS AKT will build on and substantially extend this preparatory work.

UK medical schools propose the following:

- The MS AKT will be developed and delivered through a collaboration of UK medical schools facilitated by the MSC. There will be a common passing standard for the exam set by panels of experts from UK medical schools and the Foundation Programme based on the GMC defined standard of proficiency and regulated and approved by the GMC.

- The AKT will be formed of two papers each containing 100 exam questions. The standard time set for each paper will be two hours, not including any additional time granted for reasonable adjustments to address the needs of individual students. Similar to other assessments regulated by the GMC (eg Royal College assessments and PLAB) anchor items will be used across papers and across years to demonstrate comparability and equivalence. A sampling grid approved by the GMC will be used to ensure that the content and focus of the AKT represents the applied knowledge required to address clinical problems frequently encountered by newly appointed FY1 doctors. The questions will be based on the MLA content map.

- The assessment will be delivered online and medical students will sit the exam in their own medical schools on dates selected by their medical school within specified delivery windows.

- The MSC will work with the GMC throughout the pilot phase to design and deliver
an MS AKT that meets the AKT requirements set out by the GMC in the MLA Framework. MSC and individual medical schools will develop and pilot quality control processes to ensure that the AKT requirements are met. Medical schools will work with the GMC once it sets out the mechanisms by which it will quality assure the assessment in order to ensure that optimal procedures are put in place.

- As this proposal centralises the MS AKT development and delivery work, the MSC will coordinate evidence for use by medical schools in their individual submissions to demonstrate their compliance with the AKT requirements where these refer to nationally coordinated aspects of delivery, such as the national standard, and where medical schools cannot demonstrate compliance without the support of the MSC.

![Diagram of the suggested process for constructing and delivering the MS AKT](image-url)

*Figure 1. The suggested process for constructing and delivering the MS AKT*
Meeting the GMC AKT requirements

This proposal sets out how MSC, working on behalf of and in consultation with medical schools, intends to deliver an AKT that meets the requirements set by the GMC. Throughout the document the relevant AKT requirements are referenced at the start of each section so that a clear link can be drawn between the AKT requirements and this proposal. Not all the AKT requirements can be met through the collaborative process between medical schools which MSC is facilitating. Individual medical schools will be solely responsible for meeting requirements such as those relating to the physical test environment. Other requirements, for example those relating to feedback, will require both MSC and individual medical schools to report on compliance to the GMC. To aid this process Appendix 3 contains a grid setting out the AKT requirements which highlights where MSC will produce evidence of compliance on behalf of all medical schools and where individual schools will need to make their own report.

Future proofing, evaluation and continuous improvement

In addition to demonstrating that the newly qualifying doctors from UK medical schools meet the GMC defined standard of proficiency it is anticipated that the MS AKT will result in reduced variation between medical schools and to an enhanced quality of care and patient safety.

It is important to future-proof the MS AKT so that it can develop and be modified to reflect changes in assessment methodologies and in the professional knowledge, skills and behaviour that are essential for safe practice and that the GMC will expect of a newly graduated student from a UK medical school. Mechanisms to facilitate the future development and improvement of the MS AKT will be developed during the pilot phase and will continue once the assessment is live.

The content of the MS AKT – as with all parts of the MLA - must be mapped to the GMC content map, which will need to be updated to remain relevant to, and focused on, the professional skills, knowledge and behaviours that are essential for safe practice at the start of the Foundation Programme. Medical schools understand that the GMC is establishing a review system to allow it to scan for changes in medical practice and medical education, which will feed into updating the content map. As part of its review system, there will be an expert advisory group to work with the GMC which must contain medical school staff as core members. This group will advise on and review potential changes to the content map and make recommendations to be considered within the GMC governance for the MLA. Medical schools understand that the GMC currently plans for the first meeting of the advisory group to take place in 2022, but any changes must allow sufficient time for medical schools to review their curricula before the MLA goes live – which would be 2023-24 for those medical schools using the MS AKT in their penultimate year.
National exams can be impacted by external events and this proposal is underpinned by considerations of risk (a risk register and management plan are included as part of this proposal as separate documentation) and contingency plans to ensure continued operational feasibility.

Strategic evaluation of the MS AKT’s impact must be built into the whole process to ensure that its long-term ambitions and aspirations are met. Medical schools and their universities suggest that a review and evaluation of the arrangements for the university-led MLA are conducted regularly and at least every five years. Among other things, the reviews will consider whether the universities remain fully and properly able to discharge their responsibilities to regulators.
2. Equality, diversity and inclusion

Link to AKT requirement:

21 Describe and demonstrate how EDI considerations are applied across processes and decision-making.
**Equality, diversity and inclusion**

Equality, diversity and inclusion (EDI) will be embedded throughout the development, delivery, and post-implementation of the MS AKT. As an organisation MSC is committed to supporting medical schools to embed good practice in advancing equality across the whole range of work that they do. In 2021 MSC will publish high-level guidance on what medical schools should consider in terms of actioning inclusion across the following areas:

- selection and recruitment of medical students
- creating an inclusive environment for students within the medical school
- decolonising and diversifying curricula and assessment systems
- ensuring clinical placements are inclusive environments for all students
- how medical schools can enhance equality through supporting their staff
- best practice in being accountable organisations in terms of EDI.

This first piece of guidance will be followed by more detailed guidance and the sharing of best practice themed around the areas identified above. The GMC is represented on the working group that oversees this project. This guidance will also be supported by the development of the MSC ED&I Alliance who will provide governance oversight of the process as well as setting the direction for MSC’s wider work on EDI.

MSC, on behalf of and in consultation with medical schools, has undertaken an equality analysis to support the development of the MS AKT. The Equality Analysis covers:

- how the public sector equality duty will be enacted on behalf of medical schools through the design, development and delivery of the AKT
- how EDI will be considered within the governance framework, including identifying the groups responsible for overseeing the EDI work associated with the AKT
- the recruitment and training of individuals involved in the design and development of the AKT
- item content creation and review, standard setting and exam construction
- the impact of the AKT policy framework on groups who share protected characteristics
- differentials in the attainment levels of candidate cohorts, including those sharing protected characteristics
• the impact of implementing the MLA for medical students at UK medical schools and/or university staff.

The MSC ED&I Alliance brings together university staff responsible for embedding EDI within their medical schools. All medical schools are represented on the ED&I Alliance which also has an elected board of 10 that sets the strategic development of MSC’s policies in this area. The board will take an active role in the implementation of the EDI Action plan (an appendix to the Equality Analysis that sets out how the commitments in that document will be operationalised, see Appendix 4) and in particular will be involved in developing EDI training for all those involved in designing and delivering medical school assessments and the project to establish how protected characteristics should be covered within items in the MSC Assessment Alliance Item Bank.

Equality Analyses (EA) are living documents and the EA and EDI Action Plan will be updated at the end of each pilot session of the AKT and annually at the end of each assessment cycle when the AKT is fully implemented. The Policy Group (see chapter 3) will be responsible for this process and GMC will be invited to sit on this group.

Main findings of the Equality Analysis

Student demographics (2018 HESA data drawn from the UK Medical Education Database) *

Ethnicity – approximately 44% of students studying medicine are from an ethnic minority background

Gender – approximately 59% of medical students identify as female

Disability – 11% of students have a declared disability

*Data from UKMED (www.ukmed.ac.uk). UKMED uses data from the Higher Education Statistics Agency Limited Source: HESA Student Record 2002/03 to 2018/19 Copyright Higher Education Statistics Agency Limited. Neither the GMC (the data controller for UKMED) or The Higher Education Statistics Agency Limited can accept responsibility for any inferences or conclusions derived by third parties from data or other information supplied by it.

The two main risks identified within the EA (see Appendix 5) were award gaps (sometimes referred to as differential attainment) and unfairness resulting from how the policy framework is applied within individual medical schools.

In relation to the award gap there is evidence to show that medical students from ethnic minorities have poorer academic performance on average compared to their white peers. The Equality Analysis highlights the academic research carried out in this area including some of the projects that look at the reasons why the award gap exists. It is likely there will be an award gap linked to ethnicity resulting from the implementation of the MS AKT. The collection of data and further analysis may identify that other protected
characteristics also experience an award gap; there is some evidence that age and socio-economic background also impact on exam performance.

The main actions identified within the EA to address the award gap are:

- Collecting enhanced data on protected characteristics will help identify whether award gaps exist in relation to other protected characteristics, and the extent of any award gaps nationally and within individual medical schools. The reporting of these data to schools will allow UK medical schools to put in place actions to help address these gaps. As the reporting will be on an annual basis it will allow medical schools to monitor their progress in addressing award gaps. Reporting will be shared with the GMC.

- These data will also be used by the MSC ED&I Alliance to inform a programme of work to support medical schools in addressing award gaps. The identification and sharing of best practice between medical schools will be key to addressing these complex issues and the ED&I Alliance is ideally placed to facilitate this.

The other main risk identified in the EA is that medical schools will be responsible for applying the policy framework within individual institutions and to individual students. While this is necessary, and the EA sets out why this is the case, it does mean that there is a risk of unfairness if policies are applied differently in medical schools. To mitigate this risk MSC will:

- Collect and share information about how the policy framework is being implemented across medical schools. MSC will cross reference this analysis with the data on student demographics to assist medical schools to meet their duties under the equalities legislation.

- MSC will hold best practice workshops on running processes to make decisions on mitigating circumstances and the implementation of reasonable adjustments. The MSC ED&I Alliance will be involved in the development of these events with reports being shared with the GMC.

While the EA identified risks to groups sharing protected characteristics in relation to the introduction of the MS AKT it also identifies some benefits and opportunities to embed good practice in EDI across medical schools. The following aspects have been identified as benefits within this EA:

- The use of data throughout the MS AKT process has the potential to enhance medical school awareness of the scale of award gaps both nationally and in their own institutions. Identification and measurement of award gaps is an important first step in seeking to address the issue. Furthermore, collecting data directly from students increases transparency and accountability. Medical students will have a legitimate expectation that providing their personal data means the sector will take
positive steps to address any issues it identifies.

- The introduction of a policy framework will increase consistency across medical schools. Best practise events on how to implement the framework will have an EDI focus and increase awareness of how to mitigate against any potential unfairness identified within the EA.

The EA and Action Plan also identify a number of actions MSC can take to support medical schools to enact their obligations under equality legislation in relation to the implementation of the AKT. These include:

- developing bespoke EDI training for those involved in designing and delivering medical school assessments
- ensuring that images of clinical presentations in a range of skin tones are available in the item bank and are tested by the assessment
- investigating how protected characteristics might be added to Single Best Answer (SBA) questions to embed diversity within them.

These actions are explored in further detail in the Equality Analysis and Action Plan (see Appendices 4 and 5).

**Governance of EDI**

EDI actions will be assigned to all of the governance groups identified in this proposal and the Equality Analysis provides details of how this will take place. The overall responsibility for overseeing the governance of EDI will rest with the MS AKT Board which will undertake the following actions.

- Receive and discuss an annual report of the performance of students with protected characteristics and a report on the implementation of the policy framework by medical schools.
- Review the Equality Analysis and Action Plan developed by the Policy Group on an annual basis and make recommendations around new additions and the prioritisation of actions.
- Make recommendations to the MSC ED&I Alliance as to work that should be undertaken to address any EDI issues raised by the Policy Group in the implementation of the MS AKT. This may include delivering best practice events, commissioning further research on how to address any award gaps identified or updating the training to those involved in the design and delivery of the assessment.

In addition to the work of the MS AKT Board, the MSC Council will discuss
implementation of the policy framework, and their ambition for achieving greater consistency between medical schools on an annual basis.
3. Governance

The section below maps the proposed relationship between medical schools and universities, the MSC and the GMC.

Medical schools and their universities will take collective responsibility for delivering the MS AKT in line with structures, procedures, policies and processes coordinated through the MSC on their behalf and approved by the GMC before live implementation. Medical schools and their universities recognise that the GMC will need assurance—during and after implementation—that the MS AKT will secure the required standard of proficiency and be delivered in way that ensures the maintenance of that standard.

When the MS AKT goes live the GMC will attend each board and operational group in its regulatory capacity as an observer rather than a voting member. Its role will be to assure itself that the structures, processes, procedures and policies that it approved during the design and implementation phase are being followed and will highlight where action needs to be taken to ensure compliance. The GMC’s oversight role will include attendance at meetings (including those held remotely). The GMC will have sight of any decisions planned or made which relate to its regulatory role.

Link to AKT requirements:

6c Describe how the sampling approach is reviewed and kept up to date to reflect updates to the MLA content map.

20 Describe the boards and operational groups involved in the governance of the AKT.

22 Describe and demonstrate how stakeholders are involved across the AKT’s governance.
**Governance**

The MS AKT Board will consist of the *ex officio* heads of all the UK’s medical schools and the chair of the MSC ED&I Alliance. It will be convened by the chair of MSC and will include representation from UK foundation schools. As part of its regulatory role in overseeing the MS AKT the GMC will attend in a regulatory capacity rather than as a voting member of the board.

The MS AKT Board will be responsible for the overall governance of the construction and delivery of the MS AKT. It is anticipated that it will collate reports produced annually by MS AKT operational groups to provide a detailed overall report for the purpose of assuring the GMC that the MS AKT has been conducted in accordance with the relevant AKT requirements ([Appendix 3](#)). The annual reports will be constructed from the reports of the operational groups and medical schools in the months following the completion of each annual cycle. The precise timescale will be determined during the piloting process. These annual reports will be supplied in addition to the reports and papers that the GMC will see as an observer on other groups, such as the AKT Exam Board, where meetings may be held more frequently during the year. They will report on compliance with the AKT requirements where MSC is providing evidence on behalf of all medical schools and make recommendations for improvement. MSC will support medical schools to deliver the MS AKT and comply with best practice by sharing relevant data. Medical schools will make changes based on recommendations and requirements from the GMC.

The MS AKT Board will act on behalf of UK medical schools and be responsible for the
centrally delivered AKT policies and regulations agreed as part of this proposal. It will be responsible for the long-term sustainability and viability of the delivery of the AKT.

The MS AKT Board will undertake the following tasks:

- production and sign off the final report of the exam cycle for publication
- reviewing any recommendations for the improvement of the AKT design and delivery and tasking the relevant operational groups with carrying out this work for future implementation, subject to GMC approval
- making additional recommendations for the operational groups to carry out
- making recommendations as to how the central MSC AKT team might better support medical schools in the effective delivery of the assessment
- receiving a summative report from the GMC which collates its observations and any recommendations and requirements on the previous year’s delivery and taking any action required
- receiving the review of the Equality Analysis and Action Plan developed by the Policy Group on an annual basis and making recommendations around new additions and the prioritisation of actions
- inform the MSC ED&I Alliance, on the recommendation of the Policy Group, as to work that should be undertaken to address any EDI issues raised by the implementation of the MS AKT
- ensuring adequate resourcing of all aspects of the MS AKT and MSC Assessment
- ensuring the MS AKT meets AKT requirements and that reports to the GMC on behalf of UK medical schools also comply with the AKT requirements.

The board’s terms of reference and standard operating procedures (SOPs) will be agreed for GMC approval over the next 12 months.

**MS AKT Exam Board**

The MS AKT Exam Board will undertake the operational functions of the AKT. It will comprise up to 12 elected medical school representatives both with and without portfolio roles as chairs of the operational groups. It will have a chair elected by the board from among the medical school representatives. To perform its regulatory oversight role and support its quality assurance of the MS AKT, including ensuring that it is delivered in line with the processes approved by the GMC, the GMC will attend MS AKT Exam Board meetings in order to assure itself about the board’s work. The GMC will need to supply an observer with the appropriate experience and authority to ensure
the exam board follows the stated processes set out in this proposal or those approved following further development and testing. Academic experts on the board will have the final decision as to the required passing standard.

The exam board will assure the consistency of academic standards across assessment delivery windows by scrutinising all operational group reports. The exam board will meet after each delivery window is complete and will produce an annual report on its activities for the MS AKT Board. The report will contain comprehensive information and analysis in the form of a detailed psychometric and logistic report on the MS AKT. The review of the year’s delivery will be followed by recommendations for the improvement of the design and delivery of the MS AKT for future delivery cycles. The timing of the report will mean that it will not be able to influence the year immediately following the year to which the report refers as development work will already have begun. However, there will be a process for sharing information across operational groups and boards to take account of any important changes that might be needed prior to consideration of the annual report.

The MS AKT Exam Board will be responsible for undertaking the following tasks:

• undertaking detailed analysis at the end of each delivery window and working to an SOP to agree the release of results to medical schools

• producing the final report of the exam cycle for the MS AKT Board with an analysis of the MS AKT pass rates by paper and across medical schools – the report will also include a summary of the activities of each operational group along with any recommendations for the improvement of the AKT design and delivery

• work with the operational groups to implement and monitor aspects of the Equality Analysis and Action Plan relevant to the MS AKT design and delivery

• work with the Policy Group to consider any EDI issues raised by the implementation of the MS AKT

• support UK medical schools to meet the AKT requirements through collective evidence and coordinating activity.

The above is not an exhaustive list and the board’s terms of reference, SOP, and contents of the reports will be approved by the GMC over the next 12 months. An example of the type of information that will be provided is included in chapter 8 – Standard setting.

**MS AKT operational groups**

Distinct assessment workstreams will be managed by several operational groups. The group chairs will be members of the MS AKT Exam Board. These groups will include the following main operational groups and others as required:
1. Item Development and Management Group
2. Exam Construction Group
3. Standard Setting Group
4. Policy Group

The following chapters set out the functions and procedures for each of the groups.

The GMC’s MLA Content Map Advisory Group

The GMC’s MLA content map sets out the professional skills, knowledge and behaviours essential for safe practice that the MLA will cover across both the AKT and the CPSA. It is based on Outcomes for Graduates, the Generic Professional Capabilities framework, and relevant parts of the Foundation Programme curriculum.

The GMC has a statutory role in defining the standard of proficiency for new UK doctors, including responsibility for the MLA content map and for ongoing equality impact assessments. To ensure that the content map remains relevant and focused on the professional skills, knowledge and behaviours essential for safe practice at entry to foundation year one, the GMC will develop a review mechanism. This will include the MLA Content Map Advisory Group, which will advise on potential changes to the content map as part of the GMC’s wider governance structure for the MLA. The group will include relevant external stakeholders, in addition to representation from medical schools, to provide a comprehensive view of the appropriate skills, knowledge and behaviours expected. Any updates planned to the MLA content map will be clearly communicated by the GMC to the MS AKT Board and subsequently to the MS AKT Exam Board and its operational groups. The GMC will take into consideration whether changes require curriculum restructuring as opposed to simple updating of existing content. The issue of appropriateness to a graduate commencing FY1, curriculum expansion and assessment burden will be fully considered in updating the content map.

Graduation in medicine in the UK covers a far wider range of knowledge, skills, and behaviours than that which is required to demonstrate compliance with the standard of proficiency for the MLA. An important function of the GMC’s system of review for the content map will be to ensure the relevance of the content map to the delivery of the appropriate learning in medical school curricula, and the suitability of its content for testing in either the AKT or CPSA. The GMC’s content map review system, including the advice and recommendations received from the Content Map Advisory Group, will ensure that the content map is relevant to the primary purpose of the MLA which, in the case of UK graduates, focuses on the essential professional knowledge, skills and behaviour required to function safely as a newly qualified foundation year one doctor.
4. Resourcing the MS AKT

This section describes how the MS AKT will be delivered successfully using the resources available to medical schools, universities and the MSC.

Relevant appendices:

Appendix 2 - Achievements of the MSC Assessment Alliance

See also chapters on Item development (chapter 6) and Standard setting (chapter 8) for details of how medical school staff will contribute time and expertise; Exam delivery (chapter 9) for details of the Exam-Write platform and guidance materials that will be produced; Preparation and support of medical students (chapter 12) for details of student resources that will be developed.

Link to AKT requirements:

12 Demonstrate that the AKT takes place in a space appropriate for a high-stakes assessment with suitable provision for the delivery method.
5. AKT Pilots

This section describes the phased approach to piloting the AKT and sets out the key elements of the process that will be tested at each stage.

The pilots provide an opportunity to build on the previous work of the Assessment Alliance where a common set of items have been embedded in final exams across medical schools for a number of years (the Common Content Project). It will allow all aspects of the AKT process to be scrutinised and amended as necessary in the three years prior to full implementation. It will also facilitate increased engagement and consultation with medical schools and foundation schools through involvement in the groups as set out in the Governance section. The following processes will be tested during the piloting:

- exam construction to the agreed sampling grid including anchor items
- ensuring sufficient items are available and identifying gaps in sampling grid coverage
- standard setting of items with review of past performance data
- approval of papers and their allocation
- iterative development of a robust process for setting the pass mark for each version of the MS AKT to confirm that the exam accurately identifies students who meet the required standard of proficiency using an evidence-based approach as developed in the common content project over the past six years
- logistics of delivering a national exam on the Exam-Write platform
- detailed analysis of performance and standards, and
delivery with iterative changes as required

- detailed medical school level psychometric analysis about student and school-level performance relative to national standard and vs locally set standard

- creating reports for the MS AKT Board and MS AKT Exam Board and piloting reporting procedures for reports and QA procedures with the GMC, and clarifying the role of university external examiners.

Alongside piloting at the national level, this phase will also help medical schools prepare for the practical arrangements they will need to put in place to deliver the exam. Most importantly the pilots will allow medical schools to benchmark the performance of their students against a national standard. This will inform the approaches required by medical schools with regards to curricular change, assessment strategy policy, student learning and preparation for the MS AKT.

This section summarises the activity needed and outputs that the project will deliver in each pilot phase (phases are defined by academic year to recognise the need to map them to existing medical school assessment activity). MSC will compile a more detailed project and resource plan in collaboration with the GMC. This will help ensure that piloting of the test coordinates as closely as possible with the GMC pilots of monitoring and QA processes. Medical schools recognise that the process will need to provide the GMC with assurance that the MS AKT will enable medical schools to meet the AKT requirements.

Relevant appendices:

Appendix 2 - Achievements of the MSC Assessment Alliance
(for more detail on the Common Content Project)
6. Item development and management

This section covers the lifecycle of items, the groups responsible for their development and approval, and how the security of the items will be monitored and managed over time.

The processes outlined will build on established structures and practices that have been developed by medical school staff working together through the MSC Assessment Alliance over the past decade. These processes will be further developed and refined in the pilot phase of the MS AKT.

Relevant appendices:

Appendix 7 – Item development and management groups and their responsibilities

Appendix 8 – SOP for item writers

Link to AKT requirements:

7    Describe and demonstrate how items are created, reviewed and quality assured in a consistent and timely manner.

13   Describe and demonstrate how the security of the question bank and test papers is maintained.

14   Describe and demonstrate how exam materials (digital and/or paper) are prepared, stored and delivered.
Item development and management

Development and maintenance of a MS AKT item bank

Since 2003 UK medical schools, working collaboratively under the umbrella of the MSC Assessment Alliance have developed a large item bank of 5000 quality assured single best answer (SBA) questions, the majority of which are suitable for use when testing at the level essential for safe practice in a first appointment within the UK Foundation Programme.

Using the specifically developed bespoke software of the item bank assessment experts from a wide range of specialties and medical schools work together to write, review and edit items. A style guide and training materials are provided to ensure that items are written to a common format and standard.

This model is being further refined and scaled up for the production of an increased number of quality assured items suitable for use in the MS AKT. This work will be directed and overseen by the Item Development and Management Group (see Appendix 7 for roles and responsibilities).

Figure 4 illustrates the groups and processes involved in item development and management. The steps below expand on these in more detail.
Step 1 – Question writing

The MSC Assessment Alliance Item Bank has 5,000 single best answer (SBA) items that have passed a detailed two-stage quality assurance process. In preparation for the AKT, more than 1000 new items have been reviewed and kept secure in the bank so that they are not available for medical schools to view and use in their current assessments.

To complement these items and to ensure sufficient volume and coverage in all subject areas, new items will be commissioned from a group of experienced item writers with relevant expertise. Details on how new members will be recruited and trained and the governance around this process can be found in Appendix 7. The MLA content map and the approved MS AKT sampling grid will be used as key guiding documents. Item writers will use the item bank software to submit questions. An SBA template with automated reference ranges and other supporting tools within the software will guide them through the steps of creating items and will ensure that all required elements of an item such as appropriate tags are completed at the time of submission. The item writers will follow a ‘house style’ guide previously developed by the MSC Assessment Alliance (and subsequently adopted for PLAB part 1) and an item authoring standard operating procedure (SOP) to ensure that items are formatted correctly (see Appendix 8 for example SOP). Item writers will be required to submit their commissioned items ahead of each item review group meeting. During the piloting stage the style guide will be updated to include guidance and expectations as to how EDI considerations should be reflected in items.

A rolling review of the bank content will highlight areas requiring specific targeting/prioritisation for item development in each academic year.

Step 2 – Item review

All new questions will be reviewed at an item review group meeting. Authors work in small item review groups of 5-6 people with a mix of specialties (including generalists) and will review and discuss each item in turn. The primary author will present the item,
and through feedback, edits will be made to ensure that the item is: clinically accurate, of the appropriate quality, tagged to the sampling grid, is at the correct level (a first appointment within the Foundation Programme) and follows the agreed style. Items that cannot be edited to the appropriate standard will be discarded.

In addition to the review of new items, existing items within the bank also undergo a process of periodic review, including the use of any associated performance data, to ensure that they function well and remain accurate and contemporary.

Step 3 – Final review

Questions that have been approved by item review groups (both new and existing items) proceed to a second-tier review following a similar format but using a smaller expert item review group with extensive assessment experience. Items deemed to meet the required standard will after this second review be approved for inclusion/retention within the item bank. These items will then be copy edited and moved to a secure ‘locked away’ state for the AKT.

Selection of questions for inclusion in a MS AKT item pool

The selection of questions for inclusion in the MS AKT item pool in any given academic year will be undertaken by the MS AKT Exam Board through its operational Exam Construction Group. Item selection will be aligned to the proportion and number of questions on topics as required for the AKT sampling grid and will be facilitated by the use of item tags that are aligned with the MLA content map. The Assessment Alliance has now completed a full review of its existing item tags to ensure alignment with the MLA content map.

Development of individual MS AKT exams

The MS AKT Exam Board through its operational Exam Construction Group will be responsible for assembly of individual AKT exams for medical students at UK medical schools – details of the approach that will be followed are described in chapter 7.

Sustainability

The frequency of item and final review group meetings and projected output is set out in detail in Appendix 7. It is anticipated that two meetings will be held each year with each lasting three consecutive days. Members will be commissioned to author a minimum number of items in specific subjects in advance, with a target of ~700 items per meeting. Where shortfalls are identified the MSC AKT team will organise shorter virtual meetings. Where items are recommended for decommissioning due to poor performance data, more items will be commissioned to replace them as needed.
Training and resources

The Item Development and Management Group will undertake a review of the style guides and other training materials developed by the Assessment Alliance to support the item development process, and where appropriate will make any changes so that they are fit for purpose for the AKT. Where gaps are identified new materials will be developed. Once the initial review is complete this will be repeated on an annual basis.

Workshops to train new authors will be delivered by appropriate group members on an annual basis and will use the materials mentioned in this section. New authors will be invited to write five sample items which will be discussed during training sessions and used as a basis for constructive feedback and development. If a new author is felt to need additional training, this will be provided before joining the author bank and being commissioned to write questions.

Security of items

The Item Development and Management Group will have responsibility for ensuring the security of items. It will work with:

- approved authors to ensure that items are newly written for the AKT and have not been used elsewhere — this could take the form of an annual confidentiality agreement or a set of terms and conditions within the platform which authors need to select and agree to, prior to submitting questions

- the Standard Setting Group, to monitor the performance of items after each delivery window, investigating and taking appropriate action where data suggest that items may be compromised or are poorly performing both within the cycle and across years (further details of the Standard Setting Group responsibilities can be found in chapter 8)

- medical schools to ensure that local processes are robust and secure, and that staff and facilities are available and prepared for the delivery of a national assessment

- the MSC AKT team and Exam-Write platform technical team to ensure that protocols are followed and security measures are both in place and conducted on a periodic basis (eg environmental and penetration testing, load testing, vulnerability scanning)

- the MSC AKT communications team to carry out continuous scans of online notice boards, student boards and social media for any posts which may suggest that items may have been compromised.

Once items are written in the Exam-Write platform, they will not leave the platform at any stage ie, the review, final review and any further stages of delivery are all completed
within the secure platform. Where any issues are identified the group will agree on the appropriate action to be taken and report to the MS AKT Exam Board.

**EDI considerations**

Item writers will be recruited from all parts of the UK bringing experience of authentic patient scenarios that reflect the diversity of the national population. Appendix 7 explains how item writers will be recruited and how medical schools will be encouraged to identify potential applicants with different protected characteristics to ensure appropriate equality, diversity and inclusivity. In addition to this, the MSC will create training that is specific to the roles of item writers. MSC will also ensure that expectations around EDI are added into the multiple aspects of the work item writers carry out. The following actions will be taken.

- MSC will check that all item writers have completed their employer mandated EDI training and if this is not the case item writers will be asked to complete an MSC sponsored training package on general EDI principles.
- One of the competencies included in the job description for item writers will relate to the understanding of issues around EDI in medical education and a commitment to tackling inequality and unfairness.
- EDI expectations around language will be added to the item writing style guide.
- EDI considerations will be added to list of things item reviewers check (part of the item authoring standard operating procedure).
- MSC will create an EDI briefing for item writers covering the MSC’s expectations in terms of EDI in relation to question authorship. This will form part of the introduction to all writing and review sessions.

There is a need to consider further how protected characteristics are covered in the items within the Assessment Alliance Item Bank. As a first step all items will be audited to ensure protected characteristics are covered in an appropriate way and do not stereotype groups who share protected characteristics. Further work is needed on whether protected characteristics should be explicitly mentioned in questions and this is covered in the Equality Analysis (Appendix 5) and Action Plan (Appendix 4).
7. Exam construction

This section covers the construction of the MS AKT sampling grid, alignment with the MLA content map, the process of exam construction, paper review and exam delivery.

The exam construction will build on the way that exam papers have traditionally been put together manually to construct an automated process for exam item selection that will ensure that question papers across an exam diet and within different years will be equivalent. It is anticipated that this process will be refined in an iterative manner and will potentially allow adaptation for future innovations such as automatic item generation.

Link to AKT requirements:

6 Describe and demonstrate how the sampling approach aligns with the MLA content map, including the extent to which the sampling criteria reflect the three overarching themes and the individual domains of the content map.

a) Describe the rationale for the themes/categories of the sampling grid, including the weightings/proportions and any other factors that are applied to enable effective test construction and reporting.

b) Describe the sampling criteria and demonstrate how these are used to create a technical algorithm for item selection that produces consistent and comparable tests.

8 Describe and demonstrate how tests are created, reviewed and quality assured in a consistent and timely manner.
Exam construction

Figure 5. Outline of the main process involved in constructing assessment papers

MS AKT sampling grid

The MS AKT sampling grid is a key resource for the creation of assessment papers as it sets out the proportion of test content to be drawn from different areas of clinical knowledge and care settings, creating a standardised exam blueprint. Its use ensures that each paper will have comparable content structure, which reflects the areas of clinical practice in the UK. The sampling grid and weightings (the emphases on specific content areas) were developed in consultation with stakeholders from medical schools, the GMC, foundation schools, and other experts in medical education across the UK to reflect the knowledge required to enter the Foundation Programme. Its design reflects the sampling strategies currently used by medical schools for their own knowledge tests.

Earlier engagement between the GMC and UKFPO suggests that this sampling grid will correlate well with the new Foundation Programme curriculum and maps well to the Foundation Programme capabilities. It has also been constructed using terminology from the GMC MLA content map to ensure that there is obvious alignment with the knowledge domains in this document. The AKT pilots will provide an opportunity for testing the utility of the sampling grid, determine whether the currently proposed weightings are appropriate and ensure that the papers produced using the sampling grid are indeed comparable.
A simplified outline of the MS AKT sampling grid is shown in Figure 6.

The MS AKT sampling grid has five dimensions:

1. Areas of clinical practice
2. Areas of applied knowledge
3. Primary and secondary care setting
4. Conditions
5. Presentations

These five dimensions are discussed in more detail below.

Of note, the clinical and professional capabilities, including the practical skills and procedures detailed in the MLA content map largely pertain to skills that will be tested in the CPSA which are not covered within the AKT sampling grid.
### Dimension 1: Areas of clinical practice

<table>
<thead>
<tr>
<th>Paper</th>
<th>Section</th>
<th>Area of clinical practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>1</td>
<td>A</td>
<td>Respiratory</td>
</tr>
<tr>
<td>1</td>
<td>A</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>1</td>
<td>A</td>
<td>Medicine of older adult</td>
</tr>
<tr>
<td>1</td>
<td>A</td>
<td>Any of the above</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Section total</strong></td>
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</tbody>
</table>

<table>
<thead>
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<th>Area of clinical practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>B</td>
<td>Neurosciences</td>
</tr>
<tr>
<td>1</td>
<td>B</td>
<td>Opthalmology</td>
</tr>
<tr>
<td>1</td>
<td>B</td>
<td>Endocrine &amp; metabolic</td>
</tr>
<tr>
<td>1</td>
<td>B</td>
<td>Renal &amp; urology</td>
</tr>
<tr>
<td>1</td>
<td>B</td>
<td>Infection</td>
</tr>
<tr>
<td>1</td>
<td>B</td>
<td>Dermatology</td>
</tr>
<tr>
<td>1</td>
<td>B</td>
<td>Any of the above</td>
</tr>
<tr>
<td></td>
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<td><strong>Section total</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Paper</th>
<th>Section</th>
<th>Area of clinical practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>C</td>
<td>Cancer</td>
</tr>
<tr>
<td>2</td>
<td>C</td>
<td>Breast</td>
</tr>
<tr>
<td>2</td>
<td>C</td>
<td>Haematology</td>
</tr>
<tr>
<td>2</td>
<td>C</td>
<td>Palliative care &amp; EoL care</td>
</tr>
<tr>
<td>2</td>
<td>C</td>
<td>Peri-op med &amp; anaesthesia</td>
</tr>
<tr>
<td>2</td>
<td>C</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>2</td>
<td>C</td>
<td>Emergency medicine and intensive care</td>
</tr>
<tr>
<td>2</td>
<td>C</td>
<td>Ear, nose &amp; throat</td>
</tr>
<tr>
<td>2</td>
<td>C</td>
<td>Any of the above</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Area of clinical practice</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Paper</th>
<th>Section</th>
<th>Area of clinical practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
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<td>2</td>
<td>D</td>
<td>Mental health</td>
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<td>2</td>
<td>D</td>
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<td>D</td>
<td>Sexual health</td>
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<td>2</td>
<td>D</td>
<td>Social/population health &amp; research methods</td>
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<td>2</td>
<td>D</td>
<td>Medical ethics &amp; law</td>
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<tr>
<td>2</td>
<td>D</td>
<td>Any of the above</td>
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<td></td>
<td></td>
<td><strong>Section total</strong></td>
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</table>

**Tables 1, 2, 3, 4. MS AKT Areas of clinical practice clusters**
The MS AKT Areas of clinical practice (Tables 1, 2, 3, 4) represent the areas of clinical practice outlined in the GMC MLA content map. Each of the four clusters shown in the tables above will be used to create 50/200 items for each paper. 15n questions from each 50 will be anchor items (discussed later).

There are minor classifications to the areas of clinical practice within the AKT sampling grid and the GMC MLA content map which are listed below along with rationale for mapping them in this way.

- **Acute medicine** – Acute presentations will be represented across the range of specialties.

- **Clinical imaging** – Clinical imaging is incorporated into the domain ‘Areas of applied knowledge’ (see Dimension 2) to avoid question duplication if clinical imaging were to be included as a separate specialty.

- **General practice and community healthcare** – included as part of care settings (Dimension 3) and facilitates the inclusion of questions with a primary care focus across the specialties included in the MS AKT.

- **Surgery** – Surgical aspects of clinical care and decision making are incorporated throughout the AKT Areas of clinical practice as there are very few conditions where surgical treatment is not a part of care.

In addition, the following elements have been added to the Areas of clinical practice in the MS AKT sampling grid from the Areas of professional knowledge in the MLA content map. This was based on expert feedback from the Exam Construction Group to ensure these important specialties are always represented in the MS AKT:

- **Social/population heath and research methods**

- **Medical ethics and law**

**Importantly, all areas of clinical practice listed in the GMC MLA content map are included in the exam.** The examples above are organised differently to facilitate computer-adapted item selection and equivalence between papers.
Dimension 2: Areas of applied knowledge

<table>
<thead>
<tr>
<th>Areas of Applied Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis: History/Examination</td>
</tr>
<tr>
<td>Diagnosis: Investigations</td>
</tr>
<tr>
<td>Management: Investigations</td>
</tr>
<tr>
<td>Management: Conservative</td>
</tr>
<tr>
<td>Management: Medical</td>
</tr>
<tr>
<td>Management: Prescribing</td>
</tr>
<tr>
<td>Management: Surgery</td>
</tr>
<tr>
<td>Management: Multimorbidity</td>
</tr>
<tr>
<td>Management: Prevention</td>
</tr>
<tr>
<td>Lab: Biomedical sciences</td>
</tr>
<tr>
<td>Lab: Genetics &amp; genomics</td>
</tr>
<tr>
<td>Lab: Clinical biochemistry &amp; chemical pathology</td>
</tr>
<tr>
<td>Lab: Histopathology &amp; cytology</td>
</tr>
<tr>
<td>Lab: Laboratory haematology</td>
</tr>
<tr>
<td>Lab: Microbiology</td>
</tr>
<tr>
<td>Lab: Immunology</td>
</tr>
<tr>
<td>Lab: Clinical pharmacology &amp; therapeutics</td>
</tr>
</tbody>
</table>

The MS AKT Areas of applied knowledge (Figure 7) are aligned with the areas of professional knowledge in the GMC MLA content map. All the generic areas of professional clinical and scientific knowledge listed in the GMC MLA content map have been included. In order to facilitate computer-assisted item selection, these have been further grouped into three broad headings: Diagnosis, Management and Medical and Laboratory Sciences (see Figure 7).

Dimension 3: Primary and secondary care setting

Each item will be tagged according to the location in which the scenario is most likely to occur. Items will be tagged as either primary/community care, secondary care or both. This will ensure appropriate and broad coverage of the primary healthcare domain as set out by the GMC MLA content map.

Dimension 4: Patient conditions

Each item will be tagged according to the patient conditions listed in the GMC MLA content map.

The exam construction algorithm will ensure that there is no duplication of clinical conditions to prevent cuing of answers to other questions within the paper.
Dimension 5: Patient presentations

Each item will be tagged according to the patient presentations listed in the GMC MLA content map.

Review of each paper will include checking that there is an appropriate breadth of presentations across the paper.

Exam construction process

The exam construction process is shown in Figure 7 and will involve both automated and manual elements.

The steps involved in the construction of the exam papers are summarised below:

1. Automated selection of 60 anchor items
2. Automated check of anchor items to ensure broad sampling
3. Manual check of anchor items by members of the Exam Construction Group
4. Anchor items ratified
5. Automated selection of items to complement the anchor items and make up existing exam paper
6. Automated check to ensure appropriate sampling and avoidance of duplicates with other papers (where possible)
7. Steps 5-6 repeated to create papers to cover all the main sit exam diets for the year
8. Manual check of exam papers by members of the Exam Construction Group
9. Exam papers sent to AKT Exam Board for ratification before use

All these processes will happen within the Exam-Write platform to ensure security of the question items.

Re-sit papers

A re-sit paper will be created for each academic year. This will not contain the anchor items used during the main exam diets but will be formulated according to the following principles:

1. Use the same sampling grid as the main sit AKT exams to ensure the paper is comparable in terms of content and difficulty.
2. Use questions with good performance data wherever possible. Re-sit cohorts are small and by nature not normally distributed so psychometrics cannot be applied to these cohorts to quality assure the papers. Using questions with prior performance data provides alternative quality assurance of the items.

3. Use automated checks followed by a manual paper check using the same process as that described for the main-sit papers.

4. Require ratification by the AKT Exam Board before use.

**Delivery of exam papers**

Exam papers will be delivered using the Exam-Write platform. The MSC AKT team will work with medical schools to set up the examinations for each individual medical school on an agreed date.

There has been extensive consultation with medical schools as to the best model for exam delivery to allow sufficient flexibility for schools to deliver the assessment within the curricular framework, while ensuring item security and time to process exam results.

There will be five assessments (or diets) for main sit exams per academic year. The exact dates of these will be finalised in consultation with medical schools but will cater for those schools delivering penultimate year assessments as well as the majority whose final knowledge test is within the final academic year. There will also be a re-sit paper that schools can use at any date.

It is anticipated that there will be five defined short windows during which medical schools can deliver the assessments. The AKT will be delivered as two separate 100 question papers and ideally schools will deliver the papers over two sequential days. Medical schools are being consulted on the most appropriate dates for the delivery windows, and religious holidays and festivals will be considered in the planning.

**Exam Construction Group**

The Exam Construction Group will be responsible for manually checking the exam papers and making any manual substitutions that are required to ensure that the assessments produced are comparable both within and between years.

They will feedback on the automated exam construction process including recommendations for any changes to the automated process.

In reading the assessment papers, they will also therefore act as an additional layer of quality assurance for the currency of question content as well as feeding back to the Item Construction Group if gaps are identified in the item bank.
EDI considerations

The items present in the MLA question bank will be written adhering to best practice in terms of EDI question writing (see \textit{chapter 6}).

Exam construction will be completed using a process based on a sampling grid that draws on the GMC developed MLA content map. The process is dependent on how items are tagged within the bank – it will initially draw items together to fit the parameters described in the MS AKT sampling grid (Figure 8). These will then be reviewed by academic staff to check there is no duplication and that the selection covers an appropriate range of patient demographics, accepting that while gender and age are generally included in questions, other protected characteristics are likely to be referenced only where relevant to the question. It will review whether the current tagging and sampling structure allows construction of assessment papers that uphold current good practice in terms of EDI.

All members of the Exam Construction Group will have undergone EDI training. EDI will also be explicitly covered in the training for members of the Exam Construction Group in terms of how papers are reviewed.

Further actions which can be taken in terms of covering other protected characteristics will depend on the decisions made by the working group reviewing EDI and item development.

The conditions covered in each exam are based on the GMC MLA content map. The GMC has carefully considered the needs of a diverse population in selecting the conditions within the MLA content map. This combined with the work undertaken on the sampling criteria and rationale for paper construction will produce papers that reflect the needs of a diverse set of patients.

An audit will be undertaken at the end of each pilot cycle to assess the extent to which protected characteristics have been covered within papers and this information will inform future work plans for the Item Development and Exam Construction Group.
8. Standard setting

This section describes the process for assigning the passing standard to items selected for the AKT.

It covers the governance of the workstream tasked with standard setting. It outlines the internal processes of item performance analysis after the assessment.

Relevant appendices:

Appendix 9 – Standard Setting Group and Panels and their responsibilities

Link to AKT requirements:

3 Describe the approach to scoring candidate performance at item level and overall, including any score conversions and rounding protocols.

4 Describe and demonstrate how the national standard is determined, including input from stakeholders, piloting and review of outcomes.

5 Describe and demonstrate the underlying rationale for the chosen method and how the national standard is set and maintained, including any conjunctive standards.

18 Demonstrate how results data are processed, checked and analysed after the AKT, including criteria for making post-test adjustments, to produce test outcomes for ratification by the relevant exam board.
Standard setting

Current standard setting practice across UK medical schools involves criterion referencing using modified Angoff or Ebel processes. Modified Angoff is the most commonly used method and will be used for the MS AKT. It remains the best recognised and most defensible approach. The standard setting for the AKT will build on the work of the MSC Assessment Alliance’s national standard setting panel drawn from UK medical schools’ assessment experts that has set the pass score for common content items since 2016.

This work will be scaled up for the AKT. Assessment experts will be recruited to the Standard Setting Group and Panels. Training and SOPs will help ensure a common understanding and approach. Details on the recruitment and governance around this process can be found in Appendix 9.

Conduct of modified Angoff process and standard setting meeting

Each standard setting panel will review 100-120 items. They will standard set items from individual sections linked to the Areas of clinical practice. As such at least one panel member will be currently working in that area in each relevant meeting.

- Panel members will independently score each item between 0.2 and 1, with use of 0.05 intervals according to the defined anchor described below. A score of 1 indicates that 100% of borderline candidates should get the answer correct. Where available they will be able to review psychometric performance data.

- The following standard setting anchor statement will be used:

  "The GMC sets the standard of proficiency that all new UK medical graduates must be able to achieve. What proportion of the week 1 FY1 doctors, who are just able to meet these standards, would get the question correct?"

- Standard setting meeting process:

  Scores will be collated and all panel members will be able to see an anonymised version of these at the meeting. This will show the average score as well as the range. Each question will be reviewed with initial opinions given by two members (chosen in sequence to ensure everyone gets to comment) followed by others who wish to comment. This will focus on appropriateness of average standard and why it may be easier or harder than suggested. Psychometric data will be included in these discussions. Each panel member will then rescore the item anonymously using the online platform. Scores will be collated at the end of the meeting and a final score, which will be an average from all rates, will be attached to each item. This score would apply when the item is used in any assessment. The standard will be reviewed for subsequent reuse with analysis of performance data.
• The standard setting panel will also provide additional item quality assurance.

• Review of outcomes from each panel would be compared to identify any significant variation and individual outliers.

• Multiple items will be included in different panels to help show comparability of standard setting outcomes. The final standard for each item will be an average of scores of all raters.

• Each review meeting will require one and half days, providing approximately five minutes per question.

• Each item will have an attached standard which will be provided to the Exam Construction Group.

• As multiple different sections will be used to produce each medical school paper the final standard will be derived from multiple standard setting panels.

All elements of the standard setting process will be subject to GMC regulation to ensure they are conducted to the agreed protocol and are consistent across the panels.

**Post exam analysis**

Standard setting uses expert opinion to give an initial estimate of difficulty, however this then needs to be placed alongside performance data. The Standard Setting Group will review psychometric data using both Classical Test Theory (CTT) and Item Response Theory (IRT) data including:

• item facility

• item discrimination

• response summary (which options chosen)

• quintile plots (a visual representation of item difficulty and discrimination)

• item characteristic curves (IRT data showing probability of answering the question mapped against ability)

• infit and outfit data

• differential item function (IRT modelling showing probability of answering the question mapped against ability for different groups)

• items detracting from reliability.

For the overall “paper” they would review:
• performance mapped against exam sampling grid classifications
• score distribution
• reliability metric/alpha value
• standard error of estimate
• cut score
• pass and failure rate.

They will review performance from across multiple schools. They will review items using the following criteria:

• negative discrimination eg good candidates less likely to answer correctly
• score less than chance eg facility <20%
• items where a distractor is selected more commonly than the correct answer
• items where the standard set is >10% greater than the facility of the item ie the whole cohort has performed much worse than the pass mark
• items where facility is >30% above the standard set eg is the standard too easy?
• items where facility is >90% to ensure appropriate standards have been set for core topics.

For all these items the group will review the psychometric data from CTT and IRT focusing on performance of borderline students. The group will make one of the following recommendations:

• retain question with same standard
• retain question with adjusted standard
• remove question from assessment.

This process will provide a balance between ensuring the pass score is fair to candidates and related to safe practice. A justification will be provided for each decision and provided as a report to the MS AKT Exam Board. For common content items any adjustment could only be applied during the first assessment window, as there will be no retrospective changes. Item suppression would be an uncommon event and is only likely to apply where flaw is identified in post-exam review eg a recent change in guidelines. There is no current gold standard for such a review so this process will form part of a peer-reviewed publication with a focus on use of Rasch modelling for standard setting.
adjustment.

Further post exam analysis will be provided by performing a Hofstee method. This will provide a sense-check for the original standard setting based on observed test performance and gives an additional safety net to the pass score but is unlikely to be required.

Once this process is complete the chair of the Standard Setting Group will finalise the pass score and present the report to the MS AKT Exam Board chair. The pilot will give medical schools insight to the likely, or predicted, outcomes from a national exam. The outlined process prevents an inflated pass score that would result in a higher than anticipated failure rate.

**Standard Setting Group reporting**

The Standard Setting Group will produce an annual report submitted to the MS AKT Exam Board. This will include detail on:

- Standard Setting Group meetings and outcomes
- Standard Setting Group membership and meetings with outline of relevant medical and assessment expertise, number of items reviewed and how they map to the exam sampling grid
- initial standard for each paper
- the outcomes of post exam analysis of item performance, including adjustments in standards and removal of questions — this will provide a comparison of the standard set by standard setting panels and how this has been adjusted (the full report to the MS AKT Exam Board would be included as appendices)
- comparison of standard for each paper with pass rate and fail rate
- outcome of each medical school’s pass rate and mean score (anonymised) and how different schools perform on the same paper
- performance of common content items for each individual sitting — comparison will be made with performance of remaining items in each assessment, as well as analysing if performance varies with time of sitting
- performance broken down by protected characteristics (in part the nature of this will depend on what data is captured on candidates)
- psychometric analysis for each paper (200 items), including:
  - *Cronbach’s alpha value (this should be >0.8)*
• **standard error of the measurement**

• **test equating between the papers (using Rasch analysis)**

• feedback from each standard setting panel about conduct of meetings and their effectiveness

• feedback from Standard Setting Group members, including appointed observers, on conduct of meetings through the academic year

• summary of on-going or proposed research and planned publications

• outline of any changes to conduct of standard setting process for next academic year.

**Training**

All members selected for one of the standard setting panels that feed into the Standard Setting Group will participate in equivalent training. This will involve the following components:

• an online module outlining the principles of standard setting

• an online module of psychometric analysis including classical test theory and item response theory

• an online workshop with practical examples of standard setting and data analysis with opportunities to discuss opinions about borderline candidate performance — further material for this workshop will be drawn from ongoing common content material

• a mock mini-standard setting workshop using the Exam-Write platform where members will go through examples and carry out the modified Angoff process.

**EDI considerations**

MSC will work to ensure that a diverse set of people are involved in the standard setting process. While standard setters will not be employees of MSC a careful recruitment process will take place to ensure the diversity of individuals involved. To ensure this diversity and that the process is fair MSC will put in place the following actions.

• Medical schools will be encouraged to put forward individuals from a diverse range of backgrounds for the standard setting positions.
• All communications regarding recruitment will emphasise MSC’s commitment to equality and diversity.

• Applications will be name and institution blind to ensure that selectors focus on the competence of the applicant and not their knowledge of them.

• A defined set of criteria will be used to evaluate applications and these will be audited to ensure that they do not adversely impact on individuals with protected characteristics.

• One of the competencies included in the job description will relate to the understanding of issues around EDI in medical education and a commitment to tackling inequality and unfairness.

• An equality and diversity audit of the recruitment process will take place to ensure that it is not disadvantaging applicants with protected characteristics.

MSC will also undertake EDI monitoring of all staff involved in standard setting the AKT. This will mean MSC understands the demographics of the people involved in the process and can take action to encourage people from under-represented groups to join depending on the findings of the monitoring process.
9. Exam delivery

This section describes the software that will be used for the construction and delivery of the AKT, how the platform has been developed and used by medical schools over a number of years, and the protocols and procedures in place to support the delivery.

Relevant appendices:

Appendix 2 – Achievements of the MSC Assessment Alliance

Appendix 6 – Standard operating procedure for student exam registration on the Exam-Write platform

Appendix 9 – Standard Setting Group and Panels and their responsibilities

Appendix 10 - Security controls for the Assessment Alliance Item Bank and Exam-Write

See also Item development and management for information on the security of items.

Link to AKT requirements:

11 Demonstrate and describe that there are policies and procedures in place to ensure a fair and comparable test experience for candidates.

13 Describe and demonstrate how the security of the question bank and test papers is maintained.

14 Describe and demonstrate how exam materials (digital and/or paper) are prepared, stored and delivered.

15 Describe and demonstrate the arrangements for AKTs delivered in multiple venues or over multiple sittings.

16 Describe and demonstrate how invigilators are trained and briefed.
Exam delivery

Ensuring consistency

Using the same Exam-Write platform will help drive consistency and provide medical students with an equitable experience for their medical school exams and the AKT. Medical schools are already familiar with the item bank and the exam creation side of the system through existing use which expanded due to Covid-19 when they increasingly relied on the Exam-Write platform to deliver their summative and formative exams remotely.

Academic and administrative staff appreciate the level of control that the system provides and can use the built-in functions to take action during an exam, for example to pause the exam, allow additional minutes for an individual candidate or record information as part of the invigilator’s report. Medical students value the user-friendly design which mimics the experience of sitting the exam using pen and paper.

The results from exams are then transferred into the bank where psychometric statistical values are automatically calculated including facility, discrimination, point biserial, Cronbach’s Alpha, quintiles, and the pass rate. Metrics such as the time taken per student by exam and per item, the order of questions where these were randomised, loss of internet, keystroke data, and any incident reports from invigilators are then used by exam managers along with the data to complete the post assessment review. Exam managers can see psychometric data on the performance of their students via the blueprint. These features will be developed further during the pilots using feedback from the psychometric analysis.

Medical schools will have local procedures and policies in place for high-stakes exams and a set of common AKT policies will provide a framework within which schools can deliver the AKT. Universities will also contribute their staff, experienced in the delivery of both local and national exams (including the online Prescribing Safety Assessment), venues suitable for delivery of online examination, and hardware.

The MSC AKT team will use its experience in managing and delivering national exams such as the Situational Judgement Test and PSA to produce a set of SOPs and administrator guides to support medical schools through the set up and delivery process. These will include information to help with preparation in advance of the day, for example registering medical students for the exam, testing equipment to make sure it meets the minimum specification needed and information to support delivery on the day such as invigilator briefings and any reasonable adjustments. An example SOP for registering candidates in the Exam-Write platform is provided in Appendix 6. Other aspects of the process will also be captured in SOPs with more detail added during piloting. Training will be offered to ensure that all staff involved have the relevant knowledge and expertise to manage the software and understand whom to contact for
any queries. The MSC AKT team with technical support from epiGenesys and contracted consultants will provide support to schools remotely in advance and on the day.

Medical schools will use the information provided above to prepare for and deliver the AKT on the dates they chose and within the delivery windows mentioned in the exam construction section (see chapter 7). Along with the guides, support will be available from the MSC AKT team at every stage. It is anticipated that an online booking system will be developed to support AKT leads in medical schools to identify and reserve their dates. Automated validation checks will be put in place to ensure that no candidate can be allocated the same paper twice. Resits will be managed in the same way.

MSC has a security breach policy, which may be further developed in the light of piloting the AKT. A contingency plan for the AKT has been prepared to cover disruption to business as usual such as: one or multiple medical schools unable to deliver the AKT in invigilated venues, local delivery failure, security breach, mistake in an item or paper. The contingency plan is based on the principles of close cooperation with affected medical schools, early communications, assessment of risk to delivery and identification of mitigating actions (see risk register provided separately for more detail). The response to each challenge would be guided by flexibility, while maintaining fairness in a national assessment. Reasonable steps may include for example re-scheduling a sitting for later within the same delivery window if the cause of failure cannot be addressed at the time.

**Reasonable adjustments and accessibility**

epiGenesys’ work is developed in line with the Web Content Accessibility Guidelines (WCAG), which have led to specific design choices. For example, the use of fonts and colours throughout the system has been considered and the different elements of each page have been arranged in a logical manner with appropriate spacing to ensure that text is easy to read. This includes avoiding small elements or anything which would require particularly fine motor control to access.

The Exam-Write platform already facilitates different backgrounds and font sizes, which can be adjusted by each candidate at any point before or during the exam. Candidates can be allocated by exam managers to designated extra time sittings or have extra time allocated just to their individual account within a sitting (see example SOP on registering students to exams in Appendix 6). MSC is liaising with BMA representatives to engage with medical students who have conditions that make online assessments challenging and learn how these challenges could be addressed. Consideration is given in particular to management of rest breaks separately from extra time and compatibility with text-to-speech software.

Locally facilitated reasonable adjustments provided by each medical school are also available, such as ergonomic furniture and appropriate lighting.
Contingency planning

The risk register and management plan include information on contingency planning. Should there be any emergency situations in the future, similar to the Covid-19 pandemic, then medical schools and MSC will work with the GMC and government to determine alternative mechanisms.

EDI considerations

MSC is aware that there is an anticipatory duty with regards to facilitating requests for reasonable adjustments. At present the system has the following in place to support disabled students.

- The Exam-Write platform can be programmed at an individual student level to offer additional time for the assessment. There are no limits on the amount of extra time that the system can support. Medical students with a range of disabilities request extra time as an adjustment; students with learning difficulties commonly require extra time but there are also students with mental health conditions such as anxiety and physical disabilities who require rest breaks.

- The platform allows users to change both the background and font colours. This is important as it is a frequently requested adjustment to aid students with disabilities including dyslexia or those who are colour blind.

- Text can be enlarged to aid students with visual impairments.

- There is a Welsh version of the system for students who are bilingual Welsh/English.

MSC is keen to improve the accessibility of the delivery platform and plans to consult with medical students, and in particular students with a disability, as to what additional functionality could be added to support students with a range of disabilities. Some early suggestions include investigating the possibility of enabling text to speech functionality and allowing candidates to highlight text within the system.

Medical students will be encouraged to provide feedback on the performance of the delivery platform and this will include a question as to how well the system facilitated their needs in terms of reasonable adjustments.
10. Results and reporting

This section covers the purposes of collecting data, examples of the types of data that will be collected through assessment delivery and how they will be processed and shared.

**Link to AKT requirements:**

10  Demonstrate what results and feedback are given to candidates, as well as what support is available to unsuccessful candidates.

17  Describe and demonstrate the approach to collecting or uploading candidates’ responses on the day and dealing with missing data identified at the end of the test.

19  Describe and demonstrate how the post-test analyses feed into decision-making and quality improvement.
Results and reporting

Processing of the AKT data will be undertaken in accordance with MSC’s data management policy for the MS AKT. While delivering the AKT, MSC will collect and process data for the following purposes: operational, quality assurance and research. Data will be primarily captured and stored on the Exam-Write platform. It will also be stored in a secure MSC assessment data storage. Figure 10 illustrates the flow of data for the MS AKT, and the points where key activities take place where they relate to the Exam-Write platform.

Once the GMC has articulated how it intends to fulfil its regulatory functions relating to quality assurance, evaluation and reporting of the MS AKT (as part of wider evaluation of the MLA), medical schools, through the MSC, will liaise with the GMC to take the work forward and to determine the most effective way to do this.

Operational data processing

Operational data collection is required to enable central delivery of the assessment. This will comprise information such as the medical student’s university email address, assessment score and outcome.

Psychometric and operational analysis will take place after each delivery window as well as after each annual cycle is completed. For details of post-assessment analysis, refer to the Standard Setting section (see chapter 8). The student feedback and results return process will be accessed by logging into the Exam-Write platform and will be trialled during pilots and evidence used to inform any changes. The turn-around time for return of results after each delivery window will be in line with timelines of ratification of final-level assessment results for medical schools’ own exams. It will be provided in time to permit graduation decisions.

The medical school exam managers will be provided access to collated reports of AKT performance at their school and after the annual delivery is complete, information on achievement in their school in relation to overall AKT range of performance. They will also be able to view individual candidate scores and feedback in the same format that each medical student will see, in order to be able to discuss the results with them. Medical schools have procedures for offering academic and pastoral support to students sitting final-level assessments and may wish to build on that experience when discussing the AKT results. MSC will provide medical schools with guidelines for how to support students who may require remediation.

Quality assurance

In addition to data necessary for operational delivery, further data fields will be collected for monitoring and quality assurance, such as self-declared socio-economic disadvantage.
Figure 8. Flow of data for the MS AKT
and whether the student speaks English as an additional language. The need for additional data will be monitored and collection will be reviewed on an annual basis.

The collation and processing of assessment data along with student demographic data will ensure compliance with the standards as set out by the medical and higher education regulators. MSC is committed to ensuring that the MS AKT assessment is fair, appropriate and does not discriminate against students from particular backgrounds.

Each of the operational AKT groups will report to the MS AKT Exam Board. The exam board will scrutinise the reports and in turn submit an annual report to the over-arching MS AKT Board. This report will contain information on MS AKT pass rates, how effectively examination procedures were followed, and any wider issues raised in the course of delivery. It will be provided to the GMC to allow ongoing evaluation.

**Research**

MSC will contribute AKT data to the UK Medical Education Database (UKMED) to allow linking of AKT data to other attainment in medical undergraduate and postgraduate education. For the purpose of comparability, it is proposed that data for research via UKMED is at a similar level to other assessments already in the UKMED database, such as postgraduate exams. The exact variables will be specified in a data sharing agreement.

MSC may also produce data extracts for its own commissioned research and for the purposes of periodical independent evaluation as referenced in the Equality Analysis (see Appendix 5) in this proposal. It will also liaise with the GMC to understand any research the GMC will be undertaking to avoid unnecessary overlaps and duplication and to consider areas for collaborative research.

**EDI considerations**

The collection of student demographic data will allow the identification of award gaps using a single knowledge test taken across the UK. It will be the first time that data of this quality will be available to determine the scope of the award gap. The range of demographic data collected will also allow the potential identification of previously unknown award gaps; at present there is evidence to suggest that students from ethnic minority backgrounds, older students and students from a lower socio-economic background experience an award gap but little is known about other demographics such as religion or how different demographics intersect. These data will be available to researchers through UKMED and this will greatly expand knowledge in this field of research.

MSC’s approach to data collection is designed to empower students to contribute to the improvement of medical education. Currently students provide personal data to their
universities and are unsure as to how it might be used and what benefit it might have to them and future students. The approach MSC proposes is to be transparent with students about why data about them are needed and what will be done with it. In turn this encourages greater accountability – medical students will be able to legitimately ask how medical schools are improving the education they provide to students sharing protected characteristics.
11. AKT Policy Framework

This section describes the policy framework that has been put in place by MSC, on behalf of and in consultation with UK medical schools.

To cover the following areas:

- policies for reasonable adjustments, mitigating circumstances, number of attempts or resits, exam misconduct, complaints and appeals
- implementation
- communication with medical schools
- interface with university policies
- queries from medical students
- the future functions of the Policy Group.

Relevant appendices:

Appendix 11 – AKT Policy Framework

Link to AKT requirements:

10 Demonstrate what results and feedback are given to candidates, as well as what support is available to unsuccessful candidates.

11 Demonstrate and describe that there are policies and procedures in place to ensure a fair and comparable test experience for candidates.
AKT Policy Framework

Medical schools, through the MSC, have collaboratively developed a national policy framework (see Appendix 11) to support the delivery of the MS AKT within medical schools. The framework consists of the following documents:

- Number of attempts
- Appeals and complaints
- Mitigating circumstances
- Reasonable adjustments
- Exam misconduct

These policies have been developed for the following key reasons.

- To increase consistency between medical schools as to how issues such as reasonable adjustments and exam misconduct will be handled internally while acknowledging that individual decisions on these areas will need to be taken on a case-by-case basis.

- To ensure that students at all UK medical schools have an opportunity to demonstrate the standard of proficiency tested by the MS AKT.

- To help medical students understand the policies that will apply when they sit the AKT and how those policies relate to those set by their medical school.

- An overarching policy framework will contribute to the comparability of student experience between medical schools.

Medical schools, through the MSC, developed these policies collaboratively to gain wider views across a range of stakeholders. The following groups were represented:

- medical school staff including assessment experts and those in charge of the design and delivery of undergraduate medicine programmes
- GMC
- university registrars who set, apply and amend university policies
- foundation school directors
- medical students
- recently qualified doctors.
Outside the working group all medical schools have been offered a chance to feedback on the policy framework. Engagement on the contents of these policies has taken place at the following meetings: MSC Council, MSC Assessment Alliance Reference Group (heads of assessment at UK medical schools) and the MSC Education Leads Group (heads of education at UK medical schools).

In developing these policies, medical schools, through the MSC, drew on work the GMC had previously undertaken when developing a policy framework for a possible GMC-set AKT. As part of that work, the GMC had engaged with medical schools to discuss its proposed approach and shared its findings with the MSC. During the GMC’s engagement, medical school staff who were consulted agreed that there should be a national framework, implemented by medical schools, to ensure a holistic approach to students’ health and disability, personal circumstances, fitness to practise and academic progression. As noted above, this is the basis for the rationale of the policy framework medical schools have included in this proposal to support delivery of a university-led AKT.

Within each of these individual policies medical schools have a degree of flexibility in how they are applied and, because universities are autonomous institutions, where there is conflict between the MSC policy and university policies then university policy automatically takes preference. MSC will develop a system for collecting information about how the policy framework is being applied across UK medical schools during the pilot phase of the MS AKT development. Data from this collection will be shared with medical schools so that they are able to establish whether they are an outlier in applying the framework. The data will also be shared with GMC for QA purposes.

Medical schools understand that consistency in how the policy framework is implemented across different institutions is desirable and they are committed to fulfilling this ambition. Medical schools have committed to keeping all the policies set out in the framework under review, both as individual medical schools and through MSC led collaboration. As noted above data will be collected annually on how medical schools are implementing the policy framework and differences will be shared and discussed at MSC Council meetings on a yearly basis.

Medical schools will implement the policies locally through the school’s or their parent universities’ processes to handle exam misconduct, appeals, mitigating circumstances and requests for reasonable adjustments. MSC will manage the delivery platform and subsequently will provide information to medical schools to support this process. For example, where an individual or group experiences an IT issue with the platform MSC will provide the affected medical school with a detailed report which will help inform local appeals decisions.

Through the MSC, medical schools will produce guidance for medical students explaining how the policy framework applies to them as candidates taking the MLA. This will make clear the appropriate communication channels so medical students understand when to
contact MSC and when they need to speak to their own medical school. MSC will have a dedicated email address for student complaints but will make it clear that it can only handle complaints relating to the delivery platform and that complaints regarding issues such as how an appeal was handled should be dealt with by their medical school. This communication will be in place by the 2022-23 pilot.

Medical schools will be asked to implement the policy framework by the end of the pilot process. After the pilot sessions in 2022-23 and 2023-24 medical schools will, through the MSC, report as to how they have applied the policy framework and to feedback any changes they feel should be made to improve its implementation. Medical students will also be asked to provide feedback on the communications MSC will develop to inform students about how the policy framework will apply to them.

**Future role of the Policy Group**

Once the piloting phase of the AKT starts the Policy Group will refocus the work that it undertakes. Instead of developing policies the group will be tasked with monitoring how the policies are being implemented by medical schools. The GMC will be invited to be part of the group.

There will be an annual collection of information about how the policies are used within medical schools and feedback will be collected from medical schools on any changes they feel should be made. The Policy Group will review the results of this collection and make recommendations to the MS AKT Board for any changes they feel would be helpful. The group will take a similar role in relation to the EDI Action Plan and will monitor the progress of its implementation. It will make recommendations to the MS AKT Board if it feels that the MSC ED&I Alliance should undertake work to improve the fairness and equity of the exam or address award gaps.

**EDI considerations**

Each medical school has its own independent regulations relating to the entire assessment programme covering up to six years of undergraduate study. Students in each school are familiar with the regulations and agree to them when joining the medical school. The MS AKT sits in the context of each university’s regulations and should not introduce an entirely different set of policies compared to the rest of the programme of assessment experienced by each student. This includes policies on reasonable adjustments, mitigation, appeals and number of attempts. Conversely the MS AKT is a national assessment and students may perceive differences in regulations and policies as unfair in a national context. MSC will work closely with the medical schools to harmonise policies for the MLA to balance the regulatory context of the parent medical school with the national framework for the MS AKT. To this end the Equality Analysis and...
Action Plan highlight a number of actions medical schools and the MSC will take.

- Collect and share information about how the policy framework is being implemented across medical schools. MSC will cross reference this analysis with the data on student demographics to assist medical schools to meet their duties under equality legislation.

- MSC will hold best practice workshops on running processes to make decisions on mitigating circumstances and the implementation of reasonable adjustments. The MSC ED&I Alliance will be involved in the development of these events.

- MSC Council will discuss the implementation of the policy framework, and their ambition for achieving greater consistency between medical schools on an annual basis.

The Equality Analysis identifies a number of groups who share protected characteristics that may be adversely impacted if medical schools apply the policies in a certain way. This analysis will be shared with medical schools to inform their own thinking about applying the policy framework and to help them meet their own responsibilities in terms of enacting their duties under equalities legislation.
12. Preparation and support of medical students

This section describes how medical students will be prepared and supported to sit the MS AKT.

Medical students will be prepared and supported to sit the MS AKT by their medical schools. MSC will provide support to medical schools with necessary materials such as practice papers.

This section:

• describes and demonstrates how medical students have been given information about the MS AKT in advance and briefed on the day

• considers the MSC resources available to medical schools to help prepare medical students to sit the MS AKT

• considers how access to preparation and support for the MS AKT provided by medical schools can be made fair and inclusive.

Relevant appendices:

Appendix 12 – MSC online learning resources

Link to AKT requirement:

9 Describe and demonstrate how candidates have been familiarised with the AKT and how the AKT will be run on the day.
Preparation and support of medical students

Familiarisation with the assessment process for medical students

MSC will provide an authoritative source of information for medical schools on how the MS AKT will be delivered nationally. UK medical schools will provide support to medical students with local arrangements for the delivery of the assessment.

Providing information to medical students about the assessment

Definitive information about the assessment format, policies and standards will be provided to exam administrators in published guides. Other forms of media may be used to summarise but not replace this information, such as video tutorials, webinars and in-person lectures or conferences.

The administrators’ guide

The administrators’ guide will provide exam administrators with information about the necessary steps they must undertake prior to, during and after the assessment. This guide will include information on the venue and technical requirements, identify roles to be fulfilled by staff, and help staff to communicate information about the MS AKT to their medical students. The guide will be published at least six months before the assessment to allow exam administrators time to support medical students with preparing for the MS AKT.

Communicating arrangements for local delivery

UK medical schools will lead in communicating information about the local MS AKT delivery to their students with support provided by MSC. The key information about the delivery of the AKT will be provided to medical schools in an administrators’ guide. MSC will work with medical schools to ensure that medical students have access to clear information about the assessment and the local policies and procedures which apply. MSC will encourage medical schools to think about the range of ways in which they can communicate arrangements for the local delivery of the MS AKT to medical students. This could include the assessment staff at each medical school providing an in-person or online lecture for medical students explaining how the assessment will be delivered on the day. It is suggested that lectures are recorded and uploaded to the school’s virtual learning environment so that they can be later accessed by all medical students. In instances where the GMC plans to communicate directly with medical students, MSC and GMC will collaborate to ensure there is no duplication of messaging that may cause confusion or anxiety.
Preparing medical students to sit the MS AKT

In order to prepare medical students for the areas covered in the assessment, medical schools will ensure that their teaching concentrates on the professional skills, knowledge and behaviours which are essential for the transition to Foundation Year 1, as outlined in the MLA content map.

MSC has supported UK medical schools with the provision of online learning resources throughout the Covid-19 pandemic and will continue to support them with resources which will help their students prepare to sit the AKT. This includes supporting online learning resources which are mapped to Outcomes for Graduates and providing practice papers for medical students.

Online learning resources

Medical schools employ a wide range of educational resources in conjunction with their formal teaching and clinical placements to ensure that medical students are supported to achieve the learning outcomes required by their courses and the GMC for the purposes of registration and licensing. MSC supports medical schools in this area by providing them with access to online learning resources which have clearly defined learning outcomes. These resources currently include Virtual Primary Care, Speaking Clinically and the Clinical and Professional Studies Unique Learning Environment (CAPSULE). More detail on these learning resources can be found in Appendix 12.

Practice papers

Practice papers will be provided to medical students sitting the MS AKT so that they can familiarise themselves with the format of the assessment and the types of questions covered. All students will also have an opportunity to familiarise themselves with the delivery platform.

EDI considerations

MSC will support medical students from a lower socio-economic background by ensuring that learning resources to support preparation for the MS AKT are made available free of charge. When any national assessment is introduced a number of private commercial providers develop expensive revision guides and other materials often of low quality and utility. MSC Assessment will ensure that adequate revision materials such as formative papers are made freely available to students through their medical schools.
13. Communication and stakeholder engagement

This section describes the level of stakeholder engagement conducted to inform this proposal and how this engagement will be maintained after the implementation of the MS AKT. The engagement and consultation that will be undertaken as part of the assessment design is separate from the engagement described here. More detail can be found in the Piloting section.

Effective communication and engagement with relevant stakeholders are vital to ensure the successful implementation and delivery of the MS AKT. This section focuses on communications about delivery of the AKT only. It covers how feedback has been sought on this proposal and how engagement will be maintained after the MS AKT is fully implemented. It does not explore engagement during the piloting process which sets out how key elements of the MS AKT will be tested.

MSC will work in this area to:

• provide support and guidance to medical schools to effectively deliver the MS AKT

• meet with the GMC regularly and develop a structured approach to discussions about planning communications and engagement.

Relevant appendices:

Appendix 13 – Stakeholder engagement with this proposal

Link to AKT requirement:

22 Describe and demonstrate how stakeholders are involved across the AKT’s governance.
Communication and stakeholder engagement

Stakeholder engagement with this proposal

A detailed list of stakeholder engagement which helped inform this proposal can be found in Appendix 13. Task and finish groups with representatives from medical schools, foundation schools and the GMC were convened to help define the responsibilities and activities for the operational groups. Fortnightly meetings were held between the MS AKT task and finish group chairs, senior MSC staff and the MSC Co-Chair.

The MSC and GMC also held frequent meetings with colleagues to help inform the development of this proposal. This included monthly meetings between senior MSC and GMC staff (Transition Group) which allowed presentation of initial plans for the MS AKT, conversations on how legislative frameworks can be met and detailed discussion of written feedback on draft versions of this proposal from the GMC. In addition, MSC and GMC policy staff held frequent informal meetings to discuss specific sections of this proposal and provide more detailed feedback. GMC and MSC communications staff also met monthly to explore how best to support policy colleagues and effectively plan future communications and engagement (see below).

Types of stakeholders

Three categories of stakeholder relationship have been identified:

1. **Proximal** – operational stakeholders that are directly related to the delivery of the MS AKT. These are high priority relationships which have immediate investment in exam delivery.

   Examples: medical school/university staff, medical students, General Medical Council.

2. **External (immediate)** – strategic stakeholders that are not involved in delivery but are directly impacted due to their role within medical training. These relationships contain immediate mutual interest and strategic value.

   Examples: UK Foundation Programme Office, British Medical Association (and its committees), government and education funding bodies.

3. **External (extended)** – strategic stakeholders that have an interest in the MS AKT and MLA but will impact delivery in a limited way. There may be some shared interests.

   Examples: charities, other funders (eg research bodies), Academy of Medical Royal Colleges, sector press.

MSC will focus engagement on its proximal stakeholders and will lead all operational
communication with medical schools and students in relation to the MS AKT. Where appropriate, the GMC will also be included in this communication and in some cases coordinated communication with the GMC may be required. Close communication with the Foundation Programme will ensure inclusion of the immediate external, while engagement with extended external stakeholders is likely to be conducted jointly with the GMC as part of the overall stakeholder engagement for the MLA.

Stakeholder engagement strategy

There will be many factors that may influence approaches to engagement, and it is expected that this strategy will be a ‘living document’ and be adapted as required to meet any updated needs. The below relates to the delivery of the fully implemented MS AKT only.

Engagement types

Members of the MS AKT governance boards and operational groups are excluded from the engagement descriptions below but are all considered to fall under the ‘Partnership’ category. Details on membership and roles of these groups can be found earlier in this proposal.

- Partnership: High influence and high interest stakeholders with shared accountability; this requires two-way engagement.
- Participation: Medium influence and high interest. Involved in delivery and two-way engagement required.
- Consultation: Two-way engagement focusing on providing updates, answering questions and receiving advice/opinions.
- Push Communications: Targeted interactive communication, no requirement for feedback.
- Pull Communications: Information is available in a public or shared location but stakeholders are responsible for seeking it out – eg information on websites.
<table>
<thead>
<tr>
<th><strong>Stakeholder</strong></th>
<th><strong>Engagement type</strong></th>
<th><strong>Engagement approach (MS AKT)</strong></th>
<th><strong>Coordination with GMC?</strong></th>
<th><strong>Frequency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical schools – Deans</td>
<td>Partnership</td>
<td>Progress updates will be provided at Medical Schools Council meetings</td>
<td>GMC will be in attendance and will provide input in these discussions</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Medical schools –</td>
<td>Participation</td>
<td>Progress updates will be provided at meetings of the MSC Assessment Alliance (heads of</td>
<td>In some cases, the GMC may be invited to attend these meetings and provide input</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Academic staff</td>
<td></td>
<td>assessment and Education Leads (Clinical deans)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical schools –</td>
<td>Participation</td>
<td>Handbooks and guides developed by MSC</td>
<td>Draft versions may be shared via the MLA Communications Group</td>
<td>Annually</td>
</tr>
<tr>
<td>pastoral/ exam staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical schools –</td>
<td>Participation</td>
<td>Training calls, dedicated email and phone support via MSC AKT staff</td>
<td>Not directly but GMC assistance may be requested on some occasions (eg if a query relates to GMC's role)</td>
<td>As required by each school</td>
</tr>
<tr>
<td>pastoral/ exam staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical schools –</td>
<td>Participation</td>
<td>Q&amp;A webinars, pre-recorded videos covering national processes and exam platform training. These will build on user guides and online materials schools are already using to deliver exams in the Exam-Write platform.</td>
<td>Not directly but GMC assistance may be requested in some instances, eg to assist with some webinars</td>
<td>Requires further consultation with medical schools</td>
</tr>
<tr>
<td>all exam staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical schools –</td>
<td>Push communication</td>
<td>AKT operational newsletter providing progress updates on implementation and delivery, FAQ</td>
<td>This will be shared with GMC communications teams</td>
<td>Quarterly</td>
</tr>
<tr>
<td>all MSC groups</td>
<td></td>
<td>document, contact details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical students</td>
<td>Push communication</td>
<td>Handbooks and guides developed by MSC and distributed via medical schools</td>
<td>Draft versions will be shared via the MLA Communications Group</td>
<td>Requires further consultation with medical schools</td>
</tr>
<tr>
<td>Medical students</td>
<td>Consultation</td>
<td>Webinars, presentations, pre-recorded videos - all delivered in collaboration with medical schools</td>
<td>Not directly but GMC assistance may be requested in some instances, eg in relation to webinars</td>
<td>Requires further consultation with medical schools</td>
</tr>
<tr>
<td>Medical students</td>
<td>Consultation &amp;</td>
<td>UK medical student AKT conference to share feedback</td>
<td>GMC reps will be invited to attend</td>
<td>Annually</td>
</tr>
<tr>
<td>participation</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
**Table 5: Projected engagement with stakeholders**

*These stakeholders are observer members at MSC Council meetings. It is noted that as MSC and GMC have many shared strategic stakeholders there may be some duplication of messaging during MSC Council meetings if the MLA or MS AKT is discussed. However as these meetings are also attended by the GMC and often updates are provided jointly between the MSC and GMC this is unlikely to cause any confusion.

The risk of duplicated messaging to stakeholders from the MSC and GMC will be mitigated through open and regular discussion at the GMC-MSC MLA Communications Group, which will work to avoid a situation where stakeholders receive the same information through separate communications about the MS AKT or MLA.

**Engagement with GMC**

An MLA Communications Group has been formed with members of the MSC and GMC communications teams. This group will continue to meet regularly and develop a structured approach to discussions about planning communications and engagement and provide updates on current work. It will also provide a forum for ongoing discussions to clarify roles (such as agreeing the lead organisation for a particular workstream) and both parties will work collaboratively to identify proactive engagement opportunities and avoid any overlap of messaging.

GMC and MSC staff will also continue to engage via the governance structures and reporting methods discussed in the Governance section of this proposal (see chapter 3).

**Email**

In addition to the above, a dedicated MS AKT email address will be available to medical school staff should they wish to contact MSC with queries. Medical student queries
will be managed by the medical school, but assistance will be provided from MSC if requested.

**MSC Website**

All student handbooks and documentation will be shared directly with medical schools to disseminate to their students and may also be available to download from the ExamWrite platform (behind a firewall) to allow ease of access.

Dedicated MLA pages have been created on the MSC website with brief information on the delivery of the MLA and MS AKT. The information on these pages is generic and links to the GMC website for more detail on the MLA. UK medical students are directed to speak to their medical school for detail on MS AKT delivery. These pages will be updated as required but the information will remain generic and duplicating content that is available on the GMC website will be avoided.

**Student engagement**

MSC will assist medical schools with communicating MS AKT processes to their medical students through the creation of student handbooks, delivering presentations, webinars etc. The latter engagements will be a collaborative process with each medical school. MSC will also seek to host an annual MS AKT student conference with representatives from every medical school. The purpose of this event is to provide medical students with a forum to share feedback on current processes.

It is envisioned that day-to-day communication with medical students will be managed locally by the medical school. This includes answering student queries (eg via email) or disseminating timelines and documentation. MSC will be in continued communication with medical school exam staff and provide assistance where requested.

A large part of medical student interactions will focus on clearly communicating the mechanisms of the MS AKT. This includes explaining how it differs from other medical school or national examinations, which elements will be new to medical students and which aspects will be more familiar, with the overarching aim of managing student anxiety.

MSC will lead on operational MS AKT communications to medical students. In order to avoid mixed messaging with the GMC’s strategic and wider MLA communications, the MLA Communications Group will be used to ensure all MLA communications are aligned and effectively delivered.

**Rapport with medical school staff**

MSC staff already have a strong rapport with medical school exam staff (both at an academic and pastoral level) developed over many years through the delivery of
the Situational Judgment Test (until 2019), the Prescribing Safety Assessment and examinations via Exam-Write. This existing foundation will aid the delivery of meaningful support and engagement for the MS AKT.

**Speaking at external events**

Requests to present at external events or to external stakeholders outside of regular channels (e.g., an invitation to speak at Royal College events) will be managed by MSC and GMC communication teams and escalated as required. MSC involvement will be specific to requests relating to the MS AKT unless otherwise requested by the GMC.

**Press and public engagement**

Any requests from the public (not working within the health or medical education sector) addressed to MSC will be managed on a case-by-case basis by the MSC communications team. If queries cannot be answered by MSC (e.g., not related to the MS AKT) then they will be forwarded to the relevant GMC channels for managing MLA public enquiries.

The GMC communications teams will be notified of any AKT/MLA press enquiries received by the MSC. Where relevant the MSC will lead on any MS AKT specific enquiries unless a joint response is required.

**Branding**

The majority of MSC produced AKT materials will be aimed at UK medical schools and will follow internal MSC brand guidelines. As the MS AKT will be university-led, medical schools will be responsible for disseminating MS AKT information to their students and will likely use local style guides. The use of joint branding such as using both the MSC and the GMC logos will be determined on a case-by-case basis by the MLA Communications Group.

**Evaluation**

Regular feedback will be sought from all immediate stakeholders to ensure this communication strategy remains accurate and effective. Feedback will be sought at the events and meetings mentioned. At the end of each medical school delivery window, medical schools will be asked to complete evaluation forms to help improve future service.
EDI considerations

Throughout this strategy, MSC will embed the following principles in its engagement with stakeholders. These principles will also be reflected in the behaviours of MSC staff leading the building of these relationships and encouraged in university staff assisting with the delivery of the MS AKT.

- MSC will act in a fair and responsible way, focusing on transparency and genuine collaboration.
- MSC will ensure good understanding of all its relationships in order to provide meaningful support and mitigate any negative impact.
- MSC will ensure all communication is accessible and inclusive, particularly written or pre-recorded materials.
- MSC will focus on proactive engagement and respond swiftly to changes to ensure objectives are deliverable.
- MSC will continuously work on building and improving relationships with all stakeholders including having clear processes for feedback and reporting and resolving concerns.
14. Evaluation and quality assurance

This section describes the considerations and principles that will guide the evaluation of the AKT delivery and the mechanisms through which the ongoing quality assurance will take place.

Medical schools recognise the need to undertake further work to refine how different elements of the quality framework—including both medical schools’ internal quality processes and feedback from the GMC as part of its oversight role—will work together in supporting the continuous improvement of the MS AKT.

Link to AKT requirement:

19 Describe and demonstrate how the post-test analyses feed into decision-making and quality improvement.
Evaluation and quality assurance

EDI considerations

Demographic data collected by MSC will be used internally to assess how medical students who share protected characteristics perform on the MS AKT. For example, these data will be available to the Standard Setting Group looking at the post-hoc performance of the exams. The group will be able to make recommendations in annual reports if an item were found overwhelmingly to impact differentially upon a particular group.

Data collected from the exam will also feed into improvements in item writing. If an item is found to particularly negatively impact medical students from a particular group, then it can be assessed through the Item Development and Management Group to identify any reasons for this and it might lead to improvements in guidelines for future item writing and review. This is particularly important in the case of medical students who are bilingual or for whom English is not their first language – ensuring that items do not discriminate against this group is important.

End of cycle reports

At the end of every assessment cycle the MS AKT Exam Board will produce an annual report covering a range of aspects of the exam performance and impact. It will draw on shorter reports written after each delivery window. Key to the annual report will be publishing data on the performance of the exam by the different demographics outlined above. This will allow a national picture to be developed and differences in attainment by different groups to be highlighted.

This will constitute a major step forward in our understanding of how medical students who share protected characteristics perform in assessments of knowledge. It is well understood that students from ethnic minorities experience an award gap in medical education, but it has never been quantified at national level before. Additionally, at present there is little available evidence on whether students with other protected characteristics such as sexual orientation or lower socio-economic background experience a similar award gap and how the interplay of these characteristics might affect students.

Beyond this innovative insight, the annual reports will also reflect on more standard elements of national exam delivery, where MSC Assessment team will draw on many years of experience in evaluating national assessments. The report is expected to summarise overall delivery conditions and include impact of any major disruption on performance. It will consider differences between sittings, delivery windows, papers and
medical schools, among others. The report will identify possible improvements for future years at item-level workstream, as well as overall exam-level.

**Reporting to individual medical schools**

Each medical school will receive a report detailing the performance of its students on the AKT and indicating how the school performs in relation to the national range of achievement.

This report will include sections on performance by protected characteristics. This will allow medical schools to identify their own award gap across multiple protected characteristics and to compare themselves with the national picture. The MSC ED&I Alliance will support medical schools to address their award gap by looking at evidence as to what works and providing guidance to schools.

**Long term analysis**

MSC’s approach to data collection will represent a step change; it will be the first time that some metrics will be collected such as whether English is a student’s first language. The data will also be contemporaneous with the assessment: disability, gender identity and sexuality can change during a student’s time at medical school but most data analysis relies on data submitted months or years in the past. It will allow MSC and, once the data have been added to the UK Medical Education Database (UKMED), research teams to ask new questions about the performance of medical students from different demographics. Once sufficient data have been collected the interplay of protected characteristics can be assessed. For example, researchers using the UKMED platform will be able to identify if medical students from ethnic minorities perform better or worse if they come from a lower socio-economic background.

**Quality assurance by the GMC**

Similar to the approach taken with the CPSA, the GMC has indicated that it will work with medical schools and the MSC to develop guidance on creating, preparing and submitting an initial, and then annual, return which provides evidence of compliance with the GMC’s AKT requirements. The QA process will be developed and finalised through the AKT piloting stage with the aim of approving every medical school by 2024-25, prioritising schools with penultimate year candidates for approval by 2023-24.

Approval will be achieved through an initial return from each medical school which provides evidence of compliance with the AKT requirements. Appendix 3 sets out when MSC will collate this evidence on behalf of medical schools and where schools will be best placed to develop their own response. The GMC will assess the submission. This could be complemented with observational visits to medical schools followed by a confirmation of compliance. The GMC may request additional information in response
to risk or concerns from interested parties. Annual returns will then follow but these will only be updates rather than full submissions. The GMC has confirmed that it will provide a feedback report to medical schools. Where it sets mandatory changes or recommendations, as with the CPSA, it will request interim updates alongside evidence of progress by the following year’s submission.
15. Appendices

**Appendix 1** - The Medical Schools Council, MSC Assessment and MSC Assessment Alliance

**Appendix 2** - Achievements of the MSC Assessment Alliance

**Appendix 3** - AKT requirements grid

**Appendix 4** - AKT EDI Action Plan

**Appendix 5** - Equality Analysis for the Applied Knowledge Test

**Appendix 6** - Standard operating procedure for student exam registration on the Exam-Write platform

**Appendix 7** - Item Development and Management Group and its responsibilities

**Appendix 8** - Standard operating procedure for MS AKT item authors

**Appendix 9** - Standard Setting Group and Panels and their responsibilities

**Appendix 10** - Security controls for the Assessment Alliance Item Bank and Exam-Write

**Appendix 11** - AKT Policy Framework

**Appendix 12** - MSC online learning resources

**Appendix 13** - Stakeholder engagement with this proposal

**Appendix 14** - Timeline

**Appendix 15** - Glossary of terms
Appendix 1 – The Medical Schools Council, MSC Assessment and MSC Assessment Alliance

The Medical Schools Council is the representative body for all UK medical schools. It is a limited company (8817383) and registered charity (1155370) sitting under the umbrella of Universities UK. All UK universities with medical schools pay an annual subscription to support a secretariat to take forward the Council’s vision. In February 2014, the assessment activities of the Medical Schools Council were transferred to its wholly owned subsidiary, MSC Assessment (Company 8578576, registered charity 1153045). The trustees of both organisations are all current or retired clinical academics. The auditors have confirmed annually, and most recently in November 2020, that both companies are going concerns with appropriate reserves.

In order to enhance the evidence base and to optimise and share best practice, medical school staff work cooperatively across domains of activity affecting their mission including selection, education, fitness to practise, equality, diversity and inclusion, and assessment. The MSC Assessment Alliance is a partnership of UK medical schools to improve undergraduate assessment practice. Its aim is to help ensure the confidence of the public, employers, and the regulator in the quality of medical school graduates by demonstrating that the assessments used are valid and reliable and discriminate fairly between able and less able students. The group initiates research across a full spectrum of assessment activities to enhance the evidence base of UK medical schools’ assessment practices (see Appendix 2 on the achievements of the Assessment Alliance and the publications which have emanated from its work).

Throughout the pandemic the higher education sector moved at pace to find solutions to the complex challenges posed by Covid-19 for delivering assessments. UK medical schools were helped in adjusting to remote assessments as the MSC Assessment Alliance, a longstanding partnership of UK medical schools had already developed a large, quality assured question bank and mechanisms for online and remote delivery.

www.medschools.ac.uk
For a number of years, the Assessment Alliance has worked collaboratively to create and quality assure exam questions which are mapped to the standards of UK undergraduate medical curricula. The Assessment Alliance also operates the secure online platform Exam-Write which allows UK medical schools to author, review, standard set and deliver assessments all in one space.

In the academic year 2019-20, 25 medical schools successfully delivered 343 exams to students in all years of the programme (with an average of 217 candidates per exam) through the Exam-Write platform. Thousands of students took the exams at the same time with no technical issues. Despite the challenges raised by the pandemic for conducting assessments medical schools working with MSC Assessment demonstrated that they could deliver the MLA in the context of the pandemic. These assessments were developed with discussions and approval by the GMC such that the entire cohort of students graduated many of them several months early joining the NHS as interim FY1 doctors.
Appendix 2 – Achievements of the MSC Assessment Alliance

21st century UK medical school collaborations to improve assessment quality

The Universities Medical Assessment Partnership (UMAP) was set up in 2003 with the aim of developing a high quality bank of written assessment items for use in high-stakes examinations at medical schools. The partnership’s aims were:

- to become a national opt-in system for assessments in undergraduate medicine
- to develop a bank of sufficient size such that security became a non-issue
- to sustain and build on quality in question writing and question review
- to output evidence-based research on assessments in undergraduate medicine.

The project, seed funded by HEFCE (now Office for Students), began as a partnership of Leeds, Liverpool, Manchester, Newcastle and Sheffield medical schools and grew to include 16 medical schools.

By 2005/6 the item bank had grown sufficiently that 18 high-stakes examinations were able to take place across partner medical schools using items from UMAP. The project team recognised the need to develop a software tool to support storage, exchange and analysis of high-stakes assessment items and received funding in 2005 from the Joint Information Systems Committee to embark upon this development.

In 2009 the heads of all the UK medical schools agreed that all medical schools would work together as the MSC Assessment Alliance. The Assessment Alliance’s agreed mission statement was:

- to improve patient care and the student learning experience by raising the quality of medical student assessments through sharing best practice in the development, testing and validation of examination questions – both formative and summative - across the UK, and internationally
- to achieve this aim through co-operation between all 31 medical schools in the UK.

The target outcomes for the first three years of operation were:

- a common question bank with 1500 knowledge-based items (MCQs and EMQs)
- 200 OSCE stations linked to specific learning outcomes
- a range of situational judgement tests designed to assess professional judgement and likely behaviour in scenarios based on complex situations encountered in
foundation training

• enhancement of the QA process for item generation

• consistency in the pass mark based on performance data and internationally accepted standard setting procedures

• formative, structured feedback to medical students regarding their performance compared with the performance of those in different medical schools

• the establishment of a standard template for monitoring the performance of assessments from the common bank to evaluate accessibility, validity and reliability as well as inter-institutional variability

• improved individual and institutional skills in the development of high-quality assessments in medicine.

UMAP was thus transformed from a 16-member partnership to a 31-member consortium, under the auspices of the Medical Schools Council. In 2009 all items were designed to assess the application of medical knowledge through vignette-based questions in either single best answer (SBA) format or extended matching question (EMQ) format. The consortium had a well-established process for generating and quality assuring high-quality questions. This concentrated on pre-assessment quality assurance, with items being developed at one medical school, reviewed and modified if necessary at another, with a third-level review by a small expert team. There was little effort to evaluate items post-test, partly due to a lack of central resources.

Evaluation

The new Assessment Alliance was determined to improve the process and product quality through providing evidence-based feedback to:

• item writers

• item review teams

• test designers

• assessment teams

• curriculum designers

• individual medical schools.

It was recognised that the evaluation and feedback proposed would require detailed information on test-takers and their responses to individual items. Those analysing
the responses would need to know how an individual (anonymised) medical student responded to each item, including which response choice was selected. To be able to evaluate equity in assessment, the demographic characteristics of each (anonymised) student would also need to be collected. Typically, such background data would include gender, ethnicity and possibly disability. Year of study would also be important because items are given to students at all stages, especially in progress testing, even though they were designed at graduate level. Pooling data from common assessment items was identified as a mechanism for medical schools to gain evidence of student performance across the country and provide a united approach. It would reveal which areas medical students were performing best in and which worst and provide feedback on curriculum performance to individual medical schools.

Research proposals in 2010

The creation of the pan-UK Alliance highlighted a number of areas where collaboration could provide valuable research opportunities which did not present themselves to single institutions.

The first research opportunities related to questions about whether assessments were equitable across the UK medical student body. A number of studies had suggested variations in performance in relation to gender and ethnicity. However, these were relatively small-scale studies and the ethnic and gender mix was specific to those schools. Pooling data on all students in all UK medical schools provided a means of answering this question for one method of assessment – knowledge tests. Another area of importance related to the performance of students with disabilities. No single medical school had large numbers of students with disabilities but the UK as a whole did. It was agreed that answering these questions would help medical schools to understand how the GMC’s wish to have a greater diversity of doctors was working across UK medical schools.

Other areas of research were more methodological. It was widely recognised that Generalisability Theory could provide a valuable framework for understanding sources of variation in assessments and for helping to devise better tests. The most common source of variation in knowledge tests is the sample of items. When tests are repeated (as in progress testing) then test occasions form another source of variation. When tests are administered across many schools then the schools form another source. Using Generalisability Theory to analyse multi-school assessment data could provide valuable insights into the relative importance of inter-school variation in the assessment of medical graduates.

Another challenge was to try to devise tests at exactly the same level, or to be able to compare test scores across different implementations of the same test format: ‘test equating’. Most methods require quite large numbers of test-takers. The easiest solution was to have common test material used in different schools. This could also
lead to better comparisons across schools and from year to year. Through this route the ‘common content project’ was born.

In order to achieve this, from 2012 each member of MSC agreed to integrate a minimum of 15% of questions, from the common question bank that had been developed through collaboration between all medical schools, into its final undergraduate assessments. Collaboration in assessment on this scale was unprecedented. In the same year an independent review of the workings of UMAP/the Assessment Alliance was commissioned. It made some important recommendations which led to the professionalisation of the operation.

The Assessment Alliance began to develop guidance for those creating exam questions. It gave the following advice:

Items should test the utilisation of knowledge within clinical scenarios commonly encountered by FY1 doctors.

- Examine common, core and essential conditions.
- Test potentially ‘disastrous if missed’ clinical problems.
- Avoid trivial and highly-specialised materials.

Vignettes must:

- ensure scenarios have both logic and immediacy
- encourage synthesis of information from the stem
- use simple sentences and eliminate redundant words
- describe standard/good medical practice
- provide the information that would normally be available.

The advice was that clinical scenarios are key. They need to contain enough material to enable the student to reach the correct answer but not too much that they are overwhelmed. Generally material, whether history, examination or investigations, should be presented as raw data as this is the way clinicians will encounter it and will encourage understanding and interpretation rather than repetition of facts. Therefore history should use lay language, physical findings should be as found and investigations as results without interpretation. So ‘a patient complains of central squeezing chest pain’ not ‘a patient complains of angina’; ‘results show a haemoglobin of 85g/L (130–180), MCV 75fL (80–96)’ not ‘microcytic anaemia’. Scenarios should not contain distractors such as a second diagnosis not relevant to the problem; even good final year medical students may not always have the experience to separate out such material.
The options provided must be:

- relevant to the stem and follow logically from it
- plausible
- supported by information in the stem, so that candidates can anticipate their appearance
- related to the lead-in
- balanced in length and content, and not overcomplicated.

In order to enhance quality assurance processes, a Final Clinical Review Group (FCRG) was established by the Assessment Alliance Board early in 2013 to provide a final quality control check on items in the online Assessment Alliance Item Bank, thus ensuring that only high-quality items, without errors, are available for use by medical schools in formative and summative assessments, including those provided to schools as part of the common content project.

In the same year it became clear that items stored in the Assessment Alliance Item Bank needed to be appropriately tagged to taxonomies that reflected the aims of Tomorrow’s Doctors 2009. Tagging items would also ensure that medical schools were able to identify questions rapidly and accurately using a variety of different search requests and other appropriate materials. A group was formed under the chairmanship of Dr Amir Sam to carry out the tagging of items and its work led to a significant enhancement of the utility of the item bank and laid the foundations for the ability to link MSC Assessment Alliance items to the GMC’s content map and to extract items matching the agreed requirements for individual examinations.

Publications emanating from or related to the work of the Assessment Alliance


Further publications are currently being drafted or in peer-review.
## Appendix 3 – AKT requirements grid

<table>
<thead>
<tr>
<th>AKT Requirement</th>
<th>Relevant section within the proposal</th>
<th>Engagement approach (MS AKT)</th>
<th>Reporting and evidence - MSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Describe and demonstrate how the AKT sits within the overall assessment strategy.</td>
<td>Executive summary</td>
<td>N/A</td>
<td>Medical schools to report to GMC on how the AKT fits within their overall assessment strategy.</td>
</tr>
<tr>
<td>2 Describe the rationale for the design of the AKT.</td>
<td>Executive summary</td>
<td>MSC to produce this information on behalf of medical schools for reporting to GMC.</td>
<td>GMC will be informed if and when the structure is changed, and this will be subject to approval.</td>
</tr>
<tr>
<td>3 Describe the approach to scoring candidate performance at item level and overall, including any score conversions and rounding protocols</td>
<td>Standard setting</td>
<td>MSC to produce this information on behalf of medical schools for reporting to GMC.</td>
<td>GMC will be informed if and when the structure is changed, and this will be subject to approval.</td>
</tr>
<tr>
<td>4 Describe and demonstrate how the national standard is determined, including input from stakeholders, piloting and review of outcomes.</td>
<td>Standard setting</td>
<td>MSC to produce this information on behalf of medical schools for reporting to GMC.</td>
<td></td>
</tr>
<tr>
<td>5 Describe and demonstrate the underlying rationale for the chosen method and how the national standard is set and maintained, including any conjunctive standards.</td>
<td>Standard setting</td>
<td>GMC will be informed if and when the structure is changed and this will be subject to approval.</td>
<td></td>
</tr>
</tbody>
</table>
6. Describe and demonstrate how the sampling approach aligns with the MLA content map, including the extent to which the sampling criteria reflect the three overarching themes and the individual domains of the content map.

- a. Describe the rationale for the themes/categories of the sampling grid, including the weightings/proportions and any other factors that are applied to enable effective test construction and reporting.

- b. Describe the sampling criteria and demonstrate how these are used to create a technical algorithm for item selection that produces consistent and comparable tests.

- c. Describe how the sampling approach is reviewed and kept up to date to reflect updates to the MLA content map.

7. Describe and demonstrate how items are created, reviewed and quality assured in a consistent and timely manner.

8. Describe and demonstrate how tests are created, reviewed and quality assured in a consistent and timely manner.

9. Describe and demonstrate how candidates have been familiarised with the AKT and how the AKT will be run on the day.

<table>
<thead>
<tr>
<th></th>
<th>Exam construction</th>
<th>Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>MSC to produce this information behalf of medical schools for reporting to GMC.</td>
<td>GMC will be informed if and when the structure is changed and this will be subject to approval.</td>
</tr>
<tr>
<td>b</td>
<td>MSC to produce this information behalf of medical schools for reporting to GMC.</td>
<td>GMC will be informed if and when the structure is changed and this will be subject to approval.</td>
</tr>
<tr>
<td>c</td>
<td>MSC to produce information on behalf of medical schools setting out the measures put in place to familiarise students with the AKT on a national level for reporting to GMC.</td>
<td>Medical schools to report to GMC what steps they took to familiarise students with the AKT on a local level.</td>
</tr>
<tr>
<td>10</td>
<td>Demonstrate what results and feedback are given to candidates, as well as what support is available to unsuccessful candidates.</td>
<td>Results and reporting, Policy framework</td>
</tr>
<tr>
<td>11</td>
<td>Demonstrate and describe that there are policies and procedures in place to ensure a fair and comparable test experience for candidates.</td>
<td>Exam delivery, Policy framework</td>
</tr>
<tr>
<td>12</td>
<td>Demonstrate that the AKT takes place in a space appropriate for a high-stakes assessment with suitable provision for the delivery method.</td>
<td>Resourcing the MLA</td>
</tr>
<tr>
<td>13</td>
<td>Describe and demonstrate how the security of the question bank and test papers is maintained.</td>
<td>Item development and management, Exam delivery</td>
</tr>
<tr>
<td>14</td>
<td>Describe and demonstrate how exam materials (digital and/or paper) are prepared, stored and delivered.</td>
<td>Item development and management, Exam delivery</td>
</tr>
<tr>
<td>15</td>
<td>Describe and demonstrate the arrangements for AKTs delivered in multiple venues or over multiple sittings.</td>
<td>Exam delivery</td>
</tr>
<tr>
<td>16</td>
<td>Describe and demonstrate how invigilators are trained and briefed.</td>
<td>Exam delivery</td>
</tr>
<tr>
<td>17 Describe and demonstrate the approach to collecting or uploading candidates’ responses on the day and dealing with missing data identified at the end of the test</td>
<td>Results and reporting</td>
<td>MSC to produce this information on behalf of medical schools for reporting to GMC. GMC will be informed if and when the structure is changed and this will be subject to approval.</td>
</tr>
<tr>
<td>18 Demonstrate how results data are processed, checked and analysed after the AKT, including criteria for making post-test adjustments, to produce test outcomes for ratification by the relevant exam board</td>
<td>Standard setting</td>
<td>MSC to produce this information on behalf of medical schools for reporting to GMC. GMC will be informed if and when the structure is changed and this will be subject to approval.</td>
</tr>
<tr>
<td>19 Describe and demonstrate how the post-test analyses feed into decision-making and quality improvement.</td>
<td>Results and reporting, Evaluation and quality assurance</td>
<td>MSC to produce this information on behalf of medical schools for reporting to GMC. GMC will be informed if and when the structure is changed and this will be subject to approval.</td>
</tr>
<tr>
<td>20 Describe the boards and operational groups involved in the governance of the AKT.</td>
<td>Governance</td>
<td>MSC to produce this information on behalf of medical schools for reporting to GMC. GMC will be informed if and when the structure is changed and this will be subject to approval.</td>
</tr>
<tr>
<td>21 Describe and demonstrate how EDI considerations are applied across processes and decision-making.</td>
<td>Equality, diversity and inclusion</td>
<td>MSC to produce this information on behalf of medical schools for reporting to GMC through a regularly updated EA and associated action plan. Medical schools may need to show how they consider EDI in relation to actions such as making reasonable adjustments or deciding on mitigating circumstances applications.</td>
</tr>
<tr>
<td>22 Describe and demonstrate how stakeholders are involved across the AKT’s governance.</td>
<td>Governance, Communication and stakeholder engagement</td>
<td>MSC to produce this information on behalf of medical schools for reporting to GMC. GMC will be informed if and when the structure is changed and this will be subject to approval.</td>
</tr>
</tbody>
</table>
## Appendix 4 - AKT EDI Action Plan

<table>
<thead>
<tr>
<th>Action number</th>
<th>Issue</th>
<th>Action</th>
<th>Person responsible</th>
<th>Progress</th>
<th>Protected characteristics</th>
</tr>
</thead>
</table>
| 1             | Recruitment to posts overseeing the design, development and governance of the AKT must be fair and transparent | Create recruitment policy for the following roles:  
  - Item writers  
  - Standard setters  
  - Exam Construction Group members | Veronica Davids | Good practice is set out in the EA and once active recruitment starts will be followed in 2022/23. | All                         |
|               |                                                                     | Develop EDI focused competency for all job descriptions for roles associated with the design and delivery of the AKT.         | Clare Owen & MSC EDI Alliance   | To be discussed at an MSC EDI Alliance Board meeting in 2021. To be completed by Q4 2021. | All                       |
|               |                                                                     | Consider whether name and university blind applications should be used to ensure the focus is on the experience applicants bring to the role. | Veronica Davids | Agreed internally to be actioned in 2022/23 recruitment cycle. | All                       |
| 2             | Equality and diversity monitoring should take place of all individuals involved in the design development and governance of the AKT. | Create Equality and Diversity monitoring form.                                                                                 | Clare Owen | Currently being piloted with individuals taking part in item development workshops. | All                       |
|               |                                                                     | Ensure form sent to all those taking part in the following events:  
  - Item development  
  - Item review  
  - Standard setting | Veronica Davids | Currently being piloted with individuals taking part in item development workshops | All                       |
|               |                                                                     | 2 Evaluate results of E&D monitoring and put in place plans to encourage applications from any groups found to be underrepresented. | Clare Owen & EDI Alliance Board | To take place once the first round of active recruitment takes place in 2022/23. | All                       |
3. Encourage applications from diverse individuals to roles involved in the design, development and governance of AKT. MSC’s commitment to EDI to be included in all adverts for roles along with a statement saying applications from people from diverse backgrounds are welcomed.

| 3 | To facilitate the involvement of a diverse range of individuals within the AKT process. Training and development opportunities need to be provided to give the next generation of staff the skills they need to get involved. | MSC will encourage medical schools to put forward staff from diverse backgrounds to developmental roles within the AKT process. For item writers this means putting staff forward to attend item writing events, run by MSC, that produce items for general use within schools rather than for the AKT. For standard setters appropriately skilled staff should be put forward for standard setting panels to prepare them to apply to join the Standard Setting Group should they wish to. | Veronica Davids | Statement to be drafted for approval by MSC EDI Alliance by Q1 2022. | All |

### Assessment specific training development

<p>| 4 | Develop training for those involved in assessment in medical education – this should cover both those involved in the design and development of clinical skills and applied knowledge tests. | Investigate what training is in place specifically for staff involved in assessment and focused on that role across UK medical schools. Bring together experts to design training. Roll out training including ensuring all those involved in the design and delivery of AKT have taken the training. | Clare Owen and MSC EDI Alliance | This will be an item on the agenda for the first meeting of the MSC EDI Alliance. | Imperial has indicated it would like to support the development of this training. | All |</p>
<table>
<thead>
<tr>
<th></th>
<th>Item Development</th>
<th>Responsible</th>
<th>Description</th>
<th>Timeframe</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>All those involved in the design of items used in the AKT must have appropriate EDI training for the role. All university staff should have received basic EDI training therefore training can focus on the assessment element of their work and the EDI implications of this. All briefings for item writers to include the EDI expectations of MSC in terms of item design.</td>
<td>Create EDI briefing for item writers covering the MSC’s expectations in terms of EDI.</td>
<td>Clare Owen &amp; Veronica Davids</td>
<td>Clare to create briefing slides setting out MSC’s approach to EDI based on the guidance to medical schools currently called <em>The inclusive medical school.</em></td>
<td>All</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Put in place systems to check that all item writers have EDI training.</td>
<td>Veronica Davids</td>
<td>The approach to this is being considered – possibly self-certification will be used.</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add EDI expectations around language etc. to item writing style guide.</td>
<td>Veronica Davids &amp; Clare Owen</td>
<td>To be developed by the next round of item writing.</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Item review events will check items from an EDI perspective to ensure that protected characteristics are only mentioned in questions when it is clinically relevant.</td>
<td>Add EDI to list of considerations for item reviewers to check.</td>
<td>Chee Yeen Fung</td>
<td>See above</td>
<td>All</td>
</tr>
<tr>
<td>6</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Existing items in the item bank that will be used for the AKT should be audited to ensure they are compliant with existing expectations around EDI.</td>
<td>EDI audit to take place of existing items in the item bank.</td>
<td>Clare Owen &amp; MSC EDI Alliance</td>
<td>To take place by the end of 2021.</td>
<td>All</td>
</tr>
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<tr>
<td></td>
<td>Formalise the approach for potentially extending coverage of protected characteristics within items in the item bank.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Set up a working group that brings together EDI and assessment experts to decide how protected characteristics are covered within individual items.</td>
<td>Clare Owen &amp; MSC EDI Alliance</td>
<td>This will be an item on the agenda of the first MSC EDI Alliance Board meeting and they will be asked to advise how to take this forward in partnership with the MSC Assessment Alliance. Group to be set up by Q2 2022.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag items in the item bank by protected characteristic depending on the outputs of the working group.</td>
<td>Veronica Davids</td>
<td>Dependent on outcome of working group described above.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exam construction</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9</td>
<td>The content of papers is drawn from the item bank and the diversity of patients covered in each paper is reliant on tagging. Currently only gender and age are consistently covered in the item bank.</td>
<td>Ensure the final check of exam papers takes into account ensuring that the questions cover an appropriate range of ages and genders.</td>
<td>Veronica Davids</td>
<td>To be tested in pilot 2022/23.</td>
<td>Gender &amp; Age</td>
</tr>
<tr>
<td>10</td>
<td>Audit items used in pilots to assess if and how other protected characteristics were covered in the papers.</td>
<td>Gender and age are covered throughout the papers as noted above. There are items that include other protected characteristics in the bank and this process will identify what coverage there was.</td>
<td>Veronica Davids &amp; Clare Owen</td>
<td>To start in pilot 2022/23.</td>
<td></td>
</tr>
<tr>
<td><strong>Standard setting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Recruitment of standard setters should be open and transparent.</td>
<td>The appointment of standard setters will follow MSC's policy on recruitment set out above.</td>
<td>Veronica Davids</td>
<td>See above the first recruitment round will take place for pilot 2022/23.</td>
<td>All</td>
</tr>
<tr>
<td>12</td>
<td>Standard setters will be appropriately trained for their role.</td>
<td>Standard setters will take the MSC designed training on EDI for medical school assessors.</td>
<td>Veronica Davids</td>
<td>Timing dependent on development of training outlined above.</td>
<td>All</td>
</tr>
<tr>
<td>13</td>
<td>The delivery platform can currently accommodate a number of reasonable adjustments but there is a need to engage with students on what more can be done.</td>
<td>Hold a focus group with students as to what they would like to see from the delivery platform in terms of accessibility.</td>
<td>Olga Sierocinska King</td>
<td>To be completed by Q3 2021.</td>
<td>Students with a disability</td>
</tr>
<tr>
<td>14</td>
<td>MSC will collect demographic data directly from medical students to support psychometric analysis and policy development. Student buy-in will be essential as the EDI monitoring form will be voluntary.</td>
<td>Develop EDI monitoring form for students.</td>
<td>Clare Owen &amp; Olga Sierocinska King</td>
<td>To be based on the standard MSC monitoring form currently being piloted.</td>
<td>All</td>
</tr>
</tbody>
</table>

**Exam delivery**

- Hold a focus group with students as to what they would like to see from the delivery platform in terms of accessibility. (Olga Sierocinska King) To be completed by Q3 2021. Students with a disability

- Develop feedback form to allow students to feedback on the performance of the delivery platform. (Olga Sierocinska King) To be piloted in pilot cycle 2022/23 and in place by 2023/24 pilot. Students with a disability

**Data Collection**

- Develop EDI monitoring form for students. (Clare Owen & Olga Sierocinska King) To be based on the standard MSC monitoring form currently being piloted. All

- Early engagement with bodies representing students on acceptability of data collection. (Clare Owen & Olga Sierocinska King) Initial conversation has taken place with BMA MSC. This will be ongoing. All

- Produce communications plan for engagement with students about this data collection. (Fahmida Yasmin) To be in place by 2022/23 pilot. All
<table>
<thead>
<tr>
<th>Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of attempts</td>
</tr>
<tr>
<td>15. Collect data on how many attempts students are allowed in each medical school.</td>
</tr>
<tr>
<td>16. Medical schools are committed to the ambition that there should be consistency in how the policy framework is applied across UK medical schools.</td>
</tr>
</tbody>
</table>

| Mitigating circumstances |
| 16. MSC will hold an annual good practice sharing event on how to handle requests for mitigating circumstances and appeals. All UK medical schools will be invited to take part. | Liaise with MSC EDI Alliance Board and MSC Assessment Alliance as to what these sessions could cover and when would be best to hold them. | Clare Owen | First event to take place in Q2 2022. | All |

| Appeals |
| 17. MSC will hold an annual good practice sharing event on how to handle requests for mitigating circumstances and appeals. All UK medical schools will be invited to take part. | Liaise with EDI Alliance Board and MSC Assessment Alliance as to what these sessions could cover and when would be best to hold them. | Clare Owen | First event to take place in Q2 2022. | All |

| Reasonable adjustments |
| 18. Collect data on the number and type of adjustments requested and approved for the AKT. | Develop an annual return from medical schools on how policies are implemented. | Clare Owen | To be implemented by 2022/23 pilot cycle. | Students with disabilities |
| 19. MSC will work with GMC to run training sessions on best practice in making adjustments for applied knowledge test. | Liaise with EDI Alliance Board and MSC Assessment Alliance as to what these sessions could cover and when would be best to hold them. | Clare Owen | First event to take place in Q1 2022. | Students with disabilities |
### Identifying potential unfairness

| 20 | To establish whether the variability in application causes indirect discrimination MSC will undertake data analysis. | Match data on how policies are being applied with demographic data of individual medical schools to examine the potential for indirect discrimination. | Clare Owen | To take place at end of 2023/24 cycle. | All Supporting students |

### Supporting students

| 21 | Communications – ensure students understand the implications of the introduction of the MLA. There will need to be transparency as to what is the same and what is different about the introduction of the MLA. | Develop a communications plan for engaging with students including testing with them what they would like to know and the best ways of engaging with them. | Clare Owen, Fahmida Yasmin & GMC Comms | Communications plan to start with first pilot and build in coverage and frequency by 2024. | All |

| 21 | MSC will support medical schools in meeting the GMC’s requirement on student preparedness by providing additional resources and familiarisation activities. | Produce practice papers students can use to understand the style of item used in the AKT. | Veronica Davids | To be completed by 2022/23 cycle. | All |

| 21 | Provide opportunities for medical students to familiarise themselves with the delivery platform. | | Veronica Davids | Already underway. | All |

| 21 | Investigate how existing MSC learning resources could be tagged so students understand how the content is linked to the content tested by the AKT. | | Veronica Davids | Speaking Clinically has been tagged to the MLA content map headings. | All |

<p>| 21 | Investigate how MSC learning resources might be adapted to provide for free replicas of the paid resources students invest in to prepare for finals. | | Clare Owen &amp; Fahmida Yasmin | To be completed by 2024 | All |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Engaging medical schools on the EA and Action Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>The EA and Action plan were developed by MSC on behalf of medical schools and they have been informed about the development throughout the process.</td>
<td>Inform medical schools about key findings in the EA.</td>
</tr>
<tr>
<td></td>
<td>When the EA and Action Plan is updated by the Policy Group this will be fed back to all medical schools.</td>
<td>To be added to agendas of the following groups on an annual basis;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Regular review of EA and Action Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>The EA is a living document and needs to be updated at regular intervals.</td>
<td>The EA and Action Plan will be updated on an annual basis. This will take place after each exam cycle. The Policy Group will meet and put together the updated version for sign off by the MS AKT Board.</td>
</tr>
</tbody>
</table>

*Table 7: AKT EDI Action Plan*
Appendix 5 - Equality Analysis for the Medical School Applied Knowledge Test

Key findings

This Equality Analysis (EA) has been carried out by the Medical Schools Council (MSC) on behalf of UK medical schools to support them in meeting both the regulatory requirements set by GMC in relation to equality, diversity and inclusion (EDI) and their own statutory duties to ensure education and training is fair and equitable.

The two main risks identified within the EA are award gaps (sometimes referred to as differential attainment) and the potential for inconsistent application of the policy framework across medical schools leading to students receiving different treatment depending on the school they attend.

In terms of the award gap there is evidence to show that medical students from ethnic minorities have poorer academic performance on average compared to their white peers. This EA highlights the academic research carried out in this area including some of the projects that look at the reasons why the award gap exists. It is likely there will be an award gap linked to ethnicity resulting from the implementation of the Applied Knowledge Test (AKT) element of the Medical Licensing Assessment (MLA). The collection of data and further analysis may identify that other groups who share protected characteristics also experience an award gap; there is some evidence that age\(^1\) and socio-economic background\(^2\) also impact on exam performance.

The main actions identified within the EA to address the award gap are:

- Collecting enhanced data on protected characteristics that will help identify whether award gaps exist in relation to other groups who share protected characteristics, and the extent of any award gaps nationally and within individual medical schools. The reporting of these data to medical schools will allow them to put in place actions to help address these gaps and as the reporting will be on an annual basis it will allow schools to monitor their progress in addressing award gaps.

- These data will also be used by the MSC ED&I Alliance to inform a programme of work to support medical schools in addressing award gaps. The sharing of best practice between medical schools as to what works will be key to addressing these complex issues and the ED&I Alliance is ideally placed to facilitate this.

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The other main risk identified in this EA is that medical schools will be responsible for applying the policy framework within individual institutions and to individual students. While this is necessary, and the EA sets out why this is the case, it does mean that there is a risk of unfairness if policies are applied unevenly across schools. To mitigate this risk MSC will:

- Collect and share information about how the policy framework is being implemented across medical schools. MSC will cross reference this analysis with the data on student demographics to assist medical schools to meet their duties under equality legislation.

- MSC will hold best practice workshops on running processes to make decisions on mitigating circumstances and the implementation of reasonable adjustments. The MSC ED&I Alliance will be involved in the development of these events.

While this EA has identified risks to groups sharing protected characteristics in relation to the introduction of the MS AKT it also identifies some benefits and opportunities to embed good practice in EDI across medical schools. The following aspects have been identified as benefits within this EA:

- The use of data throughout the MS AKT process has the potential to enhance medical school awareness of the scale of award gaps both nationally and in their own institutions. Identification and measurement of award gaps is an important first step in seeking to address the issue. Furthermore, collecting data directly from students increases transparency and accountability. Students will have a legitimate expectation that providing their personal data means the sector will take positive steps to address any issues it identifies.

- The introduction of a policy framework will increase consistency across medical schools. Best practise events on how to implement the framework will have an EDI focus and increase awareness of how to mitigate against any potential unfairness identified within the EA.

As well as identifying risks the EA and the associated action plan identify a number of actions MSC can take to support medical schools to comply with their legal responsibilities in relation to EDI and the implementation of the AKT. These include:

- developing bespoke EDI training for those involved in designing and delivering medical school assessments

- ensuring that images of clinical presentations in a range of skin tones are available in the item bank and are tested by the assessment

- investigating how protected characteristics might be added to exam questions to embed diversity within them.
About MSC and its approach to equality, diversity and inclusion

The MSC is the representative body for UK medical schools. The council is made of the heads of UK medical schools and meets in order to shape the future of medical education in the UK.

Its mission is:

- to be the authoritative voice of UK medical schools
- to ensure the world-class quality of UK medical education
- to be a global leader in medical assessment
- to focus on equality, diversity and inclusivity, to enhance clinical leadership and develop leaders within medical schools
- to maintain and build on the close relationship between universities and the NHS
- to explore the public’s needs of doctors and the changing role of the doctor in the future of healthcare
- to promote clinical academic careers and the conduct of high-quality research in medical schools
- to facilitate the transition between undergraduate and postgraduate environments
- to support all aspects of medical schools’ work and add real value for members
- to provide a supportive network for medical school deans and their colleagues.

In 2021 the MSC established the MSC Equality, Diversity and Inclusion Alliance. This alliance brings together those responsible for EDI across all UK medical schools. It aims to share best practice and resources between medical schools to address inequality and disadvantage for all groups of students who share protected characteristics as well as students from a lower socio-economic background.

Introduction to this Equality Analysis

UK equality legislation

English, Welsh and Scottish universities are subject to the PSED, established by the Equality Act 2010, which requires universities and their medical schools to:

- pay due regard to the needs to advance equality of opportunity
- foster good relations between people with different characteristics, ie tackling prejudice and promoting understanding between different groups
- eliminate unlawful discrimination and harassment.

Medical schools in Northern Ireland are bound by similar demands under the Northern Ireland Act 1998.
The Equality Act defines nine protected characteristics. It is against the law to discriminate against individuals or groups on the basis of:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

This document will look at the impact of the introduction of the AKT on UK students who share the protected characteristics defined by the 2010 Equality Act.

While the Equality Act does not cover socio-economic background\(^3\) this is a characteristic considered within this analysis where relevant. Medical schools are all committed to widening participation (WP) to students from lower socio-economic backgrounds and therefore wish to understand the impact the introduction of this assessment will have on widening participation students and what steps might be needed to mitigate against this.\(^4\)

The scope of this document is the AKT which is one of two parts of the MLA. The second element is the Clinical and Professional Skills Assessment (CPSA) which is run by individual medical schools and quality assured separately by GMC so is therefore not covered by this analysis. The high-level content of the assessment is also not considered within this analysis as this is the responsibility of the GMC who develop the content map which covers both parts of the MLA. The way the content map is operationalised to create the AKT is covered as this is an MSC responsibility discharged on behalf of medical schools.

**What is the MLA?**

The MLA will test the essential professional knowledge, skills and behaviours needed to practise safely in the UK. It will ensure that doctors seeking registration with a licence

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3 Some duties towards individuals from a lower socio-economic background exist in Scotland and are being implemented in Wales but it is currently unclear how these relate to universities.

4 Widening participation in a medical education context normally refers to increasing the proportions of students studying medicine from a lower socio-economic background. The reasons for this are outlined in the final report of the Selecting for Excellence project. More information on MSC’s work on selection and widening participation is available on the MSC website.
to practise medicine in the UK have met a common threshold for safe practice that is appropriate to their point of entry to the medical register. For UK medical graduates, this means provisional registration with a licence to practise which allows doctors to take part in an approved Foundation Year 1 programme in the UK.

The MLA will consist of two parts:

- an AKT (a written assessment of applied clinical knowledge)
- a CPSA (a performance-based assessment of clinical and professional skills, knowledge and behaviours).

The MLA will be set and delivered by:

- UK medical schools for medical students in their penultimate or final year of undergraduate education
- the GMC for those international medical graduates (IMGs) who wish to practise medicine in the UK and must demonstrate their knowledge and skills through taking the MLA.

The content of every AKT and CPSA will be mapped to the MLA content map, which sets out the core knowledge, skills and behaviours needed for UK practice. All AKT and CPSA content derives from the content map and it is underpinned by three themes:

- readiness for safe practice
- managing uncertainty
- delivering patient centred care.

**What is the AKT?**

For UK students, the AKT is a knowledge test that will be sat as part of the final set of assessments, including the MLA CPSA, that they are required to pass in order to graduate with a UK Primary Medical Qualification (UKPMQ). In order to graduate with a UKPMQ, UK medical students must pass all other requirements set by their medical school as part of their degree programmes. UK medical schools, coordinated by MSC, will set and deliver the AKT which builds upon current practice within medical schools, as all students are already expected to demonstrate they have the required knowledge to graduate. For over 10 years medical schools have collaborated to design common content items that can be used in these important assessments and therefore the introduction of the AKT can be seen as an extension of previous work in this field.

The crucial difference is that all aspects of the AKT, not just question design, will be developed and delivered through a collaboration of all UK medical schools, coordinated by the MSC. The AKT will be set to a common standard that students must meet in order to secure a pass in this part of the MLA.
The assessment will be delivered online and students will sit an AKT paper designed by a collaboration of medical school representatives, coordinated by the MSC. Students will sit the AKT on a date selected by their medical school.

**Governance of AKT**

Medical schools and universities will take collective responsibility for delivering the MS AKT in line with structures, procedures, policies and processes coordinated through the MSC on their behalf and approved by the GMC before live implementation.

EDI actions will be assigned to all of the governance groups identified in this proposal and this document provides details of how this will take place.

**MS AKT Board**

The group with overall responsibility for overseeing the governance of EDI will rest with the MS AKT Board. They will undertake the following actions:

- Receive and discuss an annual report of the performance of students with protected characteristics and a report on the implementation of the policy framework by medical schools.
- Review the Equality Analysis and Action Plan developed by the Policy Group on an annual basis and make recommendations around new additions and the prioritisation of actions.
- Make recommendations to the MSC ED&I Alliance as to work that should be undertaken to address any EDI issues raised by Policy Group in the implementation of the MS AKT. This might include holding best practice events, commissioning further research on how to address any award gaps identified or updating the training to those involved in the design and delivery of the assessment.
In addition to the work of the MS AKT Board, the MSC Council will discuss the implementation of the policy framework and their ambition for achieving greater consistency between medical schools on an annual basis.

**MS AKT Exam Board**

This board will undertake the operational functions of the AKT. The GMC will attend the exam board, to assure itself that the MS AKT is being delivered in line with the processes approved by the GMC. In relation to EDI this board will receive detailed reports on how individuals with specific protected characteristics have performed on the assessment including any differences between papers. The board will work with the MSC ED&I Alliance and Policy Group to consider any EDI issues raised by the implementation of the MS AKT.

**MS AKT operational groups**

There will be a number of operational groups and the chairs of these will be members of the MS AKT Exam Board. These subgroups will include the following main groups and others as required:

1. Item Development and Management Group
2. Standard Setting Group
3. Exam Construction Group
4. Policy Group

The GMC will be an observer on all of the operational groups listed above.

In relation to this EA and associated action plan, the Item Development and Management Group will be tasked with overseeing the work described below to consider how protected characteristics are considered in item development.

The Standard Setting Group will be the first group that looks at EDI data and performance. They will check that on an item level the AKT is not disadvantaging students who share a protected characteristic. They can recommend to the exam board that an item is removed at the end of the assessment cycle if it is shown to significantly impact on groups who share protected characteristics. They will also make recommendations to the Item Development Group to investigate why an item might be negatively impacting on those groups.

The work of the Exam Construction Group in relation to EDI will depend on the outcome of the work to look at how protected characteristics are included in items and why, which is outlined below. They will be responsible for making a final check of items to ensure an appropriate mix across demographics is covered in the papers.

Once the piloting phase of the AKT starts the Policy Group will refocus the work that it
undertakes. Instead of developing policies the group will be tasked with monitoring how the policies are being implemented by medical schools. The GMC will be invited to be part of the group.

There will be an annual collection of information about how the policies are used within medical schools and feedback will be collected from medical schools on any changes they feel should be made. The Policy Group will review the results of this collection and make recommendations to the MS AKT Board for any changes they feel would be helpful. The group will take a similar role in relation to the EDI Action Plan and will monitor the progress of its implementation. It will make recommendations to the MS AKT Board if it feels that the MSC ED&I Alliance should undertake work to improve the fairness and equity of the exam or address award gaps.

**Advancing and embedding equality**

Legislation requires UK universities and their medical schools to pay due regard to the need to advance equality of opportunity, foster good relations between people with different characteristics, and eliminate unlawful discrimination and harassment.

This section will go through the actions MSC can take to support medical schools to enact this duty in relation to the AKT. However, it should also be noted that the AKT is only a small part of the work of a medical school. For equality to be advanced action needs to be taken across all the different aspects of their work.

MSC is committed to supporting medical schools to embed good practice in advancing equality across the whole range of work that they do. In 2021 the MSC will publish high-level guidance on what medical schools should consider in terms of actioning inclusion across the following areas:

- selection and recruitment of medical students
- creating an inclusive environment for students within the medical school
- decolonising and diversifying curricula and assessment systems
- ensuring clinical placements are inclusive environments for all students
- how medical schools enhance equality through supporting their staff
- best practice in being accountable organisations in terms of EDI.

This first piece of guidance will be followed by more detailed guidance and the sharing of best practice themed around the areas identified above. The GMC is represented on the working group that oversees this project. This guidance will also be supported by the development of the MSC ED&I Alliance which will provide governance oversight of the process as well as setting the direction for MSC’s wider work on EDI.

This ED&I Alliance replicates the successful model of the MSC Selection Alliance which has greatly improved understanding within medical schools of how best to
widen participation and the importance of supporting WP students once they are in medical school. The Selection Alliance does report on medical school progress in increasing widening participation, especially for students from lower socio-economic backgrounds, but it does not seek to hold individual schools to account for the results of that monitoring. Holding medical schools to account is not the job of MSC, which as a membership organisation supports its members and facilitates opportunities for them to share best practice.

MSC’s approach to advancing equality through the AKT will take a similar line. The GMC has responsibility for holding medical schools to account on a number of areas highlighted in this analysis and will produce guidance to support medical schools in meeting the AKT requirements. MSC’s role will be to collect information about how the policy framework is being applied and to share data about student performance on the AKT to schools. MSC will support them to consider what changes they may need to make as result of the information. Key to this will be running workshops on the following areas:

- best practice in making decisions around reasonable adjustments
- sharing best practice events on how to address award gaps
- best practice in handling appeals and mitigating circumstances.

The ED&I Alliance will be involved in the development of these events and it is hoped GMC will be involved to ensure the needs of schools in constructing and delivering the CPSA are also considered.

MSC will also facilitate annual discussions at MSC Council meetings on how medical schools can fulfil their ambition to increase consistency in how the policy framework is applied across different institutions, particularly in relation to the number of attempts students are allowed to take the AKT.

The AKT is a test focused on the knowledge required to practice medicine safely as an FY1 doctor. It is intended to test core knowledge that is essential to patient safety. However, patient safety is also ensured by many other factors including doctors communicating well with their patients and colleagues, working well within teams and having cultural competency in understanding the needs of a diverse set of patients.

The extent to which the AKT can be used as a mechanism to promote equality is limited by its focus on knowledge rather than skills. The CPSA is more suited to testing a student’s cultural competency and communication skills in comparison to a test of knowledge like the AKT.

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[5] Every iteration of the AKT will need to satisfy the GMC’s AKT requirements. These requirements are criteria through which medical schools can demonstrate the quality, consistency and fairness of their AKT to a standard that the GMC requires for it to count towards a candidate’s MLA.
While there are limits to what an AKT can achieve in terms of enhancing diversity this analysis does identify a number of areas where positive action can be taken. These include:

- ensuring that images of clinical presentations in a range of skin tones are available in the item bank and are tested by the assessment
- investigating how protected characteristics might be added to AKT questions to embed diversity within them
- establishing training on EDI specific to the role of assessors in medical education.

**EDI Training**

*Maps to Action 4 - Equality Action Plan*

Throughout this section training for those involved in the design and development of the assessment will be highlighted as an important action. The approach to training will be twofold:

1. MSC will ask all those taking part in the design and development of the AKT to confirm that they have received general EDI training from their employers. Where individuals have not had this training, they will be asked to take a general EDI training module supplied by MSC.

2. All those involved in the design and development of the AKT will also be asked to undertake an additional training module designed by MSC that will be specific to their involvement in assessment in medical education.

This training has yet to be designed but the broad plan for its development will involve the MSC ED&I Alliance working closely with the MSC Assessment Alliance to develop content. Both groups will supply membership of a working group to oversee the development of the training. They will oversee the project that will complete the following tasks:

- Medical schools will be surveyed to determine if they have examples of training for staff involved in assessment they wish to share. This will allow the working group to get a sense of what is currently available and to assess if there is a good practice model that could be built on to develop training for individuals involved in the AKT.
- A framework for the training will be developed setting out what the training should cover and how it should be delivered eg online, in person or a combination of the two.
- Content development – the group will need to decide if they wish to develop the content in-house or commission an external body, for example a medical school, to do the work.
- A strategy will be developed for piloting and evaluating the impact of the training.
At present it has not been decided whether the training will cover only issues relating to the design and delivery of the AKT as opposed to developing training that covers the design and development of the CPSA as well. The latter may be more helpful, especially if it had an element that could be undertaken by assessors of students taking the CPSA. However, this proposal relates to the AKT only and therefore this does need careful consideration and should not be considered as something medical schools have committed to undertaking.

**Supporting staff development within medical schools**

*Maps to Action 3, Equality Action Plan*

An important part of embedding EDI within institutions is to ensure there is equal access to training and development for groups of staff who share protected characteristics. MSC will support this process by encouraging schools to put forward a diverse set of staff to be involved in the design and development of the AKT and also by providing training and development activities to allow them to develop their skills.

There are two main roles that this will apply to: item writers and standard setters. As well as designing items for the AKT, MSC has a programme of work to write items for general use within medical schools i.e., use in exams that are not the AKT whether they be summative or formative. Therefore, staff can engage in item writing activities and gain the experience they need to become an item writer for the MS AKT item bank.

For standard setters MSC has committed to developing training on standard setting which will be available to all medical school staff. Additionally, there will be standard setting panels that will involve all schools on deciding the standard for the exam as well as a smaller group of individuals who will sit on the Standard Setting Group which will have more responsibilities, including post exam analysis. This system will allow staff to gain the experience they need to become more central to the delivery of the AKT.

EDI monitoring, as set out below, will enable MSC to identify gaps in representation and encourage medical schools to put forward staff with the relevant knowledge and skills for these developmental roles. This will be based on data relating to the representation of different groups sharing protected characteristics.

**Analysis of the impact of the key technical elements of AKT delivery**

This section of the analysis will look at the potential impact on groups who share protected characteristics as a result of the proposed design and delivery of the AKT for UK medical students.

**Exam format**

The AKT will be formed of two papers each containing 100 exam questions (known
as items in this process). The standard time set for each paper will be two hours, not including any additional time granted as reasonable adjustments to address the needs of individual students.

The format of items is multiple choice, also termed single best answer (SBA), with five possible options and one correct answer. Each item has a stem which sets out the clinical presentation covered by the question. The student is then asked to pick the appropriate answer which may include the correct diagnosis or investigation or the next action to manage the patient.

The assessment will be electronically marked by the delivery platform.

This style of question is commonly used by medical schools and other higher education institutions and while differential attainment for students from ethnic minorities has been found across all medical school exams, the evidence shows that the award gap is less for this style of assessment in comparison to tests of clinical skills and professionalism assessments. In addition this style of assessment has been found to be most efficient, valid and reliable form of written assessment. There will be students that require more time to read the questions because they have a disability and this will be dealt with through the reasonable adjustments policy developed by medical schools and MSC.

As the assessment is marked electronically within the delivery platform, there is no scope for individual examiners marking papers while susceptible to bias, either at an individual level or with respect to any protected characteristics.

**Item development**

Care is taken as to ensure the items within the MSC Assessment Alliance Item Bank are of the highest quality. The diagram below explains the process for developing items that form part of final assessments for medical students.

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6  Woolf K, Potts HWW, McManus IC. Ethnicity and academic performance in UK trained doctors and medical students: systematic review and meta-analysis. BMJ2011;342:d901. doi:10.1136/bmj.d901 pmid:21385802

7  Paul McCoubrie (2004) Improving the fairness of multiple-choice questions: a literature review, Medical Teacher, 26:8, 709-712, DOI: 10.1080/01421590400013495
Training

From an EDI perspective, one of the crucial actions MSC will undertake is to ensure that all those involved in the item development process are appropriately trained to consider the EDI aspects of the work they are undertaking. Those working to develop MSC items are normally university and/or NHS employees. Both types of institutions are likely to require staff to take general EDI training. For this reason, MSC feels that the training for those involved in item writing can be assessment focused on the specifics of the role rather than the general EDI training that employers mandate. MSC will create training that is specific to the roles of item writers and assessors working in medical education.

MSC will also ensure our expectations around EDI are added into multiple aspects of the work item writers do. The following additional actions will also be taken:

- MSC will check that all item writers have completed their employer mandated EDI training. If this is not the case item writers will be asked to provide evidence of completion or undertake an MSC sponsored general EDI training package (see Action 5, Equality Action Plan).
- MSC will create an EDI briefing for item writers covering the MSC’s expectations in terms of EDI. This will form part of the introduction to all writing and review sessions.
- EDI expectations around language etc. will be added to the item writing style guide (see Action 6, Equality Action Plan).
- EDI considerations will be added to list of considerations for item reviewers to check.

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8 This training will be mandated for those involved in the AKT and made available to medical schools so they can make it available to all staff responsible for assessment in their institution if they feel this would be helpful.
Recruitment

Maps to Action 1, Equality Action Plan

While item writers will not be employees of MSC a careful recruitment process will take place to monitor the characteristics of individuals involved and encourage diversity. This will be an open recruitment process and will be advertised directly to medical school staff as well as on MSC’s website. To ensure this and that the process is fair MSC will put in place the following actions:

- medical schools will be encouraged to put forward individuals from a diverse range of backgrounds for the standard setting positions
- all communications regarding recruitment will emphasise MSC’s commitment to EDI
- applications will be name and institution blind to ensure that selectors focus on the competence of the applicant and not their knowledge of them
- a defined set of criteria will be used to evaluate applications and these will be audited to ensure that they do not adversely impact on individuals on the basis of any protected characteristics
- one of the competencies included in the job description will relate to the understanding of issues around EDI in medical education and a commitment to tackling inequality and unfairness
- an equality and diversity audit of the recruitment process will take place to ensure that applicants are not being disadvantaged on the basis of protected characteristics as they progress through the recruitment process.

Monitoring

Maps to Action 2, Equality Action Plan

Another crucial action MSC will undertake is to ensure that EDI monitoring takes place of all those involved in the item writing and review process. This will mean MSC understands the demographics of the people involved in the process and can take action, where gaps in representation are identified, to encourage people from under-represented groups with the relevant knowledge and skills to join depending on the findings of the monitoring process.

How protected characteristics are considered in items

Maps to Action 8, Equality Action Plan

Currently items within the bank tend towards being neutral in terms of protected characteristics. Age and sex are the most frequently mentioned protected characteristics in items as these are often crucial pointers towards the condition a patient may have, or
the best treatment for them. Ethnicity is mentioned variably within items in the bank; it is sometimes used if it might be relevant to the clinical scenario being considered. There is also ongoing work to include images that cover conditions in different skin tones.

MSC accepts that the approach to protected characteristics within the bank needs to be formalised. A working group will be established to look at this issue which will bring together experts in EDI, particularly those involved in work to diversify medical school curricula, with assessment experts that understand how SBA questions work and how students perform in relation to question type.

This is not a simple area to get right; medical schools fear that adding more information to questions may add to the cognitive load on students and can be detrimental of those with learning difficulties as it increases the number of words in each question. It is important also to ensure that areas such as ethnicity and sexuality are not used in a way that stereotype these groups. It would be important to ensure, for example, that not all patients with HIV are gay men within the bank. Some medical schools feel that adding ethnicity information can also inappropriately lead students to the correct answer - for example, if a question around sickle cell anaemia states the patient is Black it reinforces the idea that the only patients with this condition are Black.

MSC expects that this work will be undertaken throughout the development stages of AKT development. But, as a first step, all items within the bank that will be used for AKT will be audited to ensure that they are not stereotyping individuals or groups who share protected characteristics.

The extent to which the representation of protected characteristics in the MS AKT item bank encourages EDI best practice in medical students needs to be balanced with the fact that the AKT is only one aspect of the MLA and that the MLA is only a small part of the 4-to-6-year journey of medical students. Important skills in dealing with patients from a variety of backgrounds and with protected characteristics will be tested through the CPSA. The CPSA is more likely to be suited to testing a student’s cultural competency and communication skills in comparison to a test of knowledge like the AKT.

**Exam construction**

*Maps to Action 9, Equality Action Plan*

Exam construction will be undertaken using a process based on a sampling grid that draws on the GMC developed MLA content map. The development and ongoing review of the content map is a GMC responsibility, and steps were taken to ensure its development was inclusive and EDI issues were considered throughout.

The process is dependent on how items are tagged within the bank – it will initially draw items together to fit the parameters described in the sampling grid. These will then be reviewed by academic staff to check there is no duplication. The demographics of the
patients will be relevant to the conditions and presentations tested in the assessment. The sampling grid will ensure that both medicine of older adults and child health are covered in the AKT. The sampling grid also covers obstetrics & gynaecology, and questions on sexual health will also be included which is important in ensuring sex is properly covered in the assessment.

What can be done in terms of covering other protected characteristics will depend on the decisions made by the working group reviewing EDI and item development and is likely to evolve over time.

In terms of the conditions covered in each exam these are based on the MLA content map. At present the process looks at ensuring that all areas of clinical practice represented in the content map are covered in the AKT. The GMC has carefully considered the needs of a diverse population in selecting the conditions within the MLA content map and therefore it is to be anticipated that any exam that draws from this will accurately reflect the needs of a diverse set of patients. The content map will continue to be reviewed via a horizon scanning function, coordinated by the GMC, to ensure it continues to remain fit for purpose and reflects the situations typically faced by doctors working in the UK Foundation Programme.

MSC will carry out an audit of the items used in pilots to assess if and how other protected characteristics were covered in the papers. Gender and age are covered throughout the papers as noted above. However, there are also items that include other protected characteristics in the bank, for example when they are clinically relevant to the question, and this process will identify what coverage of these ended up in the papers sat by students. This will be used to inform the work set out in the Item Development section that will look at the formalisation of how protected characteristics are included in items (see Action 10, Equality Action Plan).

**Standard setting**

A crucial part of the delivery of any assessment is the standard set for the exam. For the AKT this process will be overseen by a Standard Setting and Psychometric Group who will oversee a number of standard setting panels.

**Recruitment of standard setters**

*Maps to Action 1, Equality Action Plan*

While standard setters will not be employees of MSC a careful recruitment process will take place to monitor the characteristics of individuals involved and encourage diversity. This will be an open recruitment process and will be advertised directly to medical school staff as well as on the MSC website. To ensure this and that the process is fair MSC will put in place the following actions.
• Medical schools will be encouraged to put forward individuals from a diverse range of backgrounds for the standard setting positions.

• All communications regarding recruitment will emphasise MSC’s commitment to equality and diversity.

• Applications will be name and institution blind to ensure that selectors focus on the competence of the applicant and not their knowledge of them.

• A defined set of criteria will be used to evaluate applications and these will be audited to ensure that they do not adversely impact on individuals on the basis of any protected characteristics.

• One of the competencies included in the job description will relate to the understanding of issues around EDI in medical education and a commitment to tackling inequality and unfairness.

• Equality and diversity monitoring of the recruitment process will take place to ensure that it is not disadvantaging applicants on the basis of protected characteristics.

**Monitoring**

*Maps to Action 2, Equality Action Plan*

Another crucial action MSC will undertake is to ensure that EDI monitoring takes place of all those involved in the item writing and review process. This will mean MSC understands the demographics of the people involved in the process and can take action, where gaps in representation are identified, to encourage people from under-represented groups with the relevant knowledge and skills to join depending on the findings of the monitoring process.

**Standard setting process**

Modified Angoff will be used for standard setting as it is the most commonly used approach across medical schools. It remains the best recognised and most defensible approach. There has been no analysis in academic literature of the impact that that using Modified Angoff might have people sharing protected characteristics. The literature says that there is no single recommended approach to setting standards, and that all standard setting is a judgemental process based on arbitrary decisions.  

**Exam delivery**

The exam will be delivered online using a bespoke system created by MSC. Medical schools will be responsible for ensuring that students sit the exam in a suitable space with appropriate IT access. Medical schools will also be responsible for invigilating the

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9 Paul McCoubrie (2004) Improving the fairness of multiple-choice questions: a literature review, Medical Teacher, 26:8, 709-712, [DOI: 10.1080/01421590400013495](https://doi.org/10.1080/01421590400013495)
exam. GMC, through their regulatory oversight role, will quality assure these processes against the AKT requirements.

MSC is aware that there is an anticipatory duty with regards to facilitating requests for reasonable adjustments. As the owner of the delivery platform MSC Assessment has taken steps to make it as accessible as possible. At present the system has the following in place to support disabled students:

- The system can be programmed at an individual student level to offer additional time for the assessment. There are no limits on the amount of extra time that the system can support. Students with a range of disabilities request extra time as an adjustment; students with learning difficulties commonly require extra time but there are also students with mental health conditions such as anxiety and physical disabilities who require rest breaks.
- The system allows users to change both the background and font colours. This is important as it is a frequently requested adjustment to aid students with disabilities including dyslexia or those who are colour blind.
- Text can be enlarged to aid students with visual impairments.
- There is also a Welsh version of the system for students who are bilingual.

MSC is keen to improve the accessibility of the delivery platform and plans to consult with medical students, and in particular students with a disability, as to what additional functionality could be added to support students with a range of disabilities. Some early suggestions include investigating the possibility of enabling text to speech functionality and allowing students to highlight text within the system.

As noted above there will elements of the exam delivery that will be the responsibility of individual medical schools. Where a student needs a reasonable adjustment to the physical environment such as a quiet space to take the exam then their medical school will facilitate this. There is a risk that different medical schools will take different approaches to these requests and this issue is discussed below in the policy section.

Students will be encouraged to provide feedback on the performance of the delivery platform and this will include a question as to how well the system facilitated their needs in terms of reasonable adjustments. By gaining this feedback MSC can ensure that it is aware of improvements that may need to be made to the platform as well as identifying any adjustments that it does not facilitate but could do in the future (see Action 13, Equality Action Plan).

**Evaluation and feedback**

MSC is committed to ensuring that equality and diversity is a key element of the evaluation and feedback provided to both improve the AKT itself and to drive continuous
improvement in undergraduate medical education. Central to the plans in this regard is the collection of equality and diversity data from those taking the assessment.

**Data collection**

*Maps to Action 14, Equality Action Plan*

MSC plans to collect the following data from students when they sign up to use the delivery platform:

- Student’s locally facilitated reasonable adjustments (other than extra time)
- DOB
- Nationality
- Ethnicity
- Disabilities
- Sex
- Gender Identity
- Sexual orientation
- Religion or belief
- Caring responsibility
- Dependents
- English as Additional Language
- Multilingual including English
- Home postcode
- Self-declared socio-economic status

This collection covers the protected characteristics listed in the Equality Act 2010 and goes further by looking at socio-economic background.

MSC, on behalf of medical schools, has chosen to collect these data directly from students rather than using existing data sources because it would like students to be active partners in the development and improvement of medical education in the UK. At present student understanding of how data about them are collected and used is variable – this approach requires MSC to be transparent and proactive about why it is collecting these data and what they will be used for.

Key to the success of this approach will be ensuring that students understand why MSC wishes to collect these data and what it will be used for. MSC will seek to engage extensively with medical students to ensure that they understand that these data are being collected to drive improvements in medical education and not stereotype or make
adverse inferences about students from particular groups or individual students.

A range of communication approaches will be needed including asking medical schools to provide information to students in a range of formats and engaging with groups representing students including the British Medical Association (BMA).

The management and governance of this data collection is set out in the main body of the medical schools’ proposal to the GMC for a university-led AKT, coordinated by the MSC.

**Evaluating the performance of AKT and driving improvements**

These data collected by MSC will be used internally to assess how students who share protected characteristics perform on the AKT. For example, these data will be available to the group looking at the post-hoc performance of the exams which will be able to make recommendations in annual reports if an item was found to overwhelmingly impact a particular group.

Data collected from the exam will also feed into improvements in item writing. If an item is found to particularly negatively impact students from a specific group then it can be assessed through the item writing group to identify any reasons for this. This is particularly important in the case of students who are bilingual or for whom English is not their first language – ensuring that items do not discriminate against this group is vital.

**End of cycle reports**

At the end of every assessment cycle the AKT Exam Board will produce an annual report covering a range of aspects of the exam performance and impact. Key to this will be publishing data on the performance of the exam by the different demographics outlined above. This will allow a national picture to be developed and differences in attainment by different groups to be highlighted. This report and data will be shared with all medical schools and the GMC for the purposes of quality assurance.

This will constitute a major step forward in our understanding of how students who share protected characteristics perform in written knowledge tests. It is well understood that students from ethnic minorities experience an award gap in medical education (the reasons for this are discussed below) but it has never been quantified at national level, using a single exam, before. Additionally, at present there is little available evidence on whether students with other protected characteristics such as sexual orientation or lower socio-economic background experience a similar award gap.

**Reporting to individual medical schools**

Each medical school will receive a report detailing the performance of their students on
the AKT. This report will include sections on performance by protected characteristics. This will allow medical schools to identify their own award gap across multiple protected characteristics and to compare themselves with the national picture. The MSC ED&I Alliance will support schools to address their award gap by sharing examples of interventions that have been evaluated to show they reduce award gaps and by providing guidance to schools. There will also be opportunities for medical schools to come together and share best practice on reducing the award gap.

Medical schools will also be given the opportunity to feedback as to how they feel the design and delivery of the AKT could be improved to reduce the award gap and why they think this is. This feedback will be considered by the MS AKT Board and used to improve the fairness of the AKT.

**Long term analysis**

MSC’s approach to data collection will represent a step change; it will be the first time that some metrics will be collected, such as whether English is a student’s first language. It is also data that is contemporaneous with the assessment; disability, gender identity and sexual orientation can change during a student’s time at medical school, whereas most data analysis relies on data submitted months or years in the past. It will allow MSC and, once the data is added to the UK Medical Education Database (UKMED), research teams to ask new questions about the performance of medical students from different demographics. Once enough data has been collected the inter-play of protected characteristics can be assessed. For example, researchers using the UKMED platform will be able to identify if students from ethnic minorities perform better or worse if they come from a lower socio-economic background. There will also be the chance to link data from the AKT to postgraduate performance and progressions.

**Policies and implementation**

Medical schools, through the MSC, have developed a number of policies to support the delivery of the AKT. A working group has developed these policies and allowed MSC to gain wider views as to the acceptability of the policy framework to a wide range of stakeholders. The medical schools, through the MSC, developed these policies in collaboration with the following groups who were represented on the group:

- medical schools staff including assessment experts and those in charge of the design and delivery of undergraduate medicine programme
- university registrars who set, apply and amend university policies
- foundation school directors
- medical students
- recently qualified doctors
• GMC colleagues.

In developing these policies, medical schools, through the MSC, drew on work the GMC had previously undertaken when developing a policy framework for a GMC-set AKT. As part of that work, the GMC had engaged with medical schools to discuss a proposed approach and shared their findings with the MSC. During the GMC’s engagement, medical schools agreed that there should be a national framework, implemented by medical schools, to ensure a holistic approach to students’ health and disability, personal circumstances, fitness to practise and academic progression. As noted above, this is the basis for the rationale of the policy framework medical schools have included in this proposal to support delivery of a university-led AKT.

The policies will be applied by medical schools across the UK and they have signed up and committed to this. The policies themselves do offer schools a degree of flexibility in how they are implemented internally within their institution (the reasons for this are set out in the sections below) which does risk that implementation becomes variable.

Medical schools understand that consistency in how the policy framework is implemented across different institutions is desirable and they are committed to fulfilling this ambition. However, it should be noted that there are ongoing tensions, particularly around the number of attempts that a student is allowed to have at taking the MS AKT. Medical schools have committed to keeping all the policies set out in the framework under review, both as individual medical schools and through MSC led collaboration. Data will be collected annually on how medical schools are implementing the policy framework and differences will be shared and discussed at MSC Council meetings on a yearly basis.

**Number of attempts**

*Action 15, Equality Action Plan*

This has been one of the most difficult areas to develop a national, consistent policy on. The progression and graduation of students is a core responsibility of universities and it is not possible to agree a single approach at present. The rules that apply to the number of attempts a student may have for the AKT may therefore ultimately be the rules set by a student’s university as they have the final responsibility for ensuring that every student has met the outcomes required by that university for graduation. However, medical schools have committed to keep discussing how they can fulfil their ambition to have a consistent policy on the number of attempts and MSC will facilitate opportunities for them to discuss this at MSC Council meetings.

MSC does make a recommendation to medical schools on how many attempts students should have to pass the AKT. This recommendation is that UK medical students will normally be entitled to no more than four valid attempts at the AKT. The expert working group considered this recommendation carefully and their decision was based on the
average number of attempts medical schools across the UK allow their students to have at examinations.

It should be noted that it is four valid attempts, as decided by the medical school - if a student makes a successful appeal or if their mitigating circumstances are supported by their medical school then that sitting does not count towards the overall number permitted. This provides protection for students as the relevant policies developed as part of the national policy framework set consistent guidelines for these areas. For example, the mitigating circumstances policy defines what may count as ‘mitigating’ for the AKT, and so any student with a disability at any medical school who experiences a worsening of their condition should be able to make a successful application for mitigating circumstances in line with the policy. This also applies to students with children, as unexpected family circumstances such as a child becoming ill, are also included in the policy as a consideration that may be ‘mitigating’ for the AKT. This would also apply to students who have significant caring responsibilities if an unexpected incident occurred and affected a student’s AKT performance or ability to attend.

The policy on number of attempts encourages schools to take a flexible approach. For example, when the policy talks about resits it states that ‘If a student fails a first sitting, all subsequent attempts should be taken at the next available sitting, as decided upon by the medical school, unless the medical school is satisfied that another sitting is more appropriate (for example, due to a student’s health or other mitigating circumstances).’ This encourages medical schools to take into account the needs of individual students, including the impact of any protected characteristics, rather than taking a process-driven approach to these matters.

**Driving consistency**

MSC will inform medical schools on an annual basis the number of attempts being permitted across all schools delivering the AKT. It is expected that this will drive consistency as no medical school will want to be an outlier and medical students are likely to strongly question their university if they are applying very different policies to other schools.

Furthermore, medical schools have committed to keep discussing how they can fulfil their ambition to have a consistent policy on the number of attempts and MSC will facilitate opportunities for them to discuss this at MSC Council meetings.

**Mitigating circumstances**

*Maps to Action 16, Equality Action Plan*

This policy covers mitigating circumstances which are serious or significant events beyond a student’s control that adversely affect their performance or ability to attend or complete the AKT. Where an application for mitigating circumstances is supported by a
medical school and the student’s attempt at the exam is voided by the medical school or university, it does not count towards the total number of attempts they are allowed to have.

MSC will not be making decisions about individual students with regards to mitigating circumstances – this will be the responsibility of individual medical schools who will use their own established processes for doing this. This approach has been taken as MSC is co-ordinating the delivery of the AKT on behalf of medical schools, who retain the overall responsibility for delivering the AKT. Furthermore, MSC is a membership organisation and has no role in the relationship between students and their medical schools.

MSC accepts that as medical schools will handle this process there is a risk that students will be treated differently across the UK. In particular, there is a risk that specific groups of students who share protected characteristics may not be treated the same by different medical schools. For example, if a school were not to accept mitigating circumstances in relation to a sudden need to undertake caring responsibilities, it could have a more significant impact on women than men as women are more often responsible for the care of children and relatives. Women are more likely have significant caring responsibilities as are older medical students who are also more likely to have children as well as elderly parents.

MSC held a focused meeting with the BMA Medical Students Committee to discuss the examples used in the draft mitigating circumstances policy, in particular around how health is covered, in order to produce the final version. This meeting led to a redrafting of the statements around health to make it clear that negative fluctuations of a known or previously undiagnosed physical or mental health condition or disability are covered by mitigating circumstances. They felt, and MSC agreed, it was important to make it clear that health and disability is complex and individuals can experience a negative fluctuation to their condition without warning. It was also agreed that the policy should emphasise that decisions about mitigating circumstances should be made on a case-by-case basis and blanket policies cannot, under UK equality legislation, be applied to individual students.

**Mitigating the risks and encouraging consistency**

At present MSC is not proposing that it collects information about whether individual students have made successful or unsuccessful applications for mitigating circumstances. This means it will not be possible to analyse the impact across schools of the policy on groups who share protected characteristics. This decision has been made to limit the amount of personal information about individual medical students that MSC holds. The working group that developed the policy felt that even if MSC were to collect these data there is little meaningful analysis it could undertake. This is because schools are asked to make these decisions on a case-by-case basis and therefore without collecting the entire reasoning for why the decision was made no judgement can be made as to its fairness.
MSC will hold workshops for medical schools on mitigating circumstances to allow them to share best practice on how to manage the process. The MSC EDI Alliance will be asked to feed into these events to ensure there is a chance for schools to explore how they can make sure their policies do not negatively impact on groups of students who share protected characteristics. MSC is also aware of wider work relating to this across the sector, the outputs of which may be used at these events. For example, in 2019/20 the Office of the Independent Adjudicator for Higher Education undertook work on ‘additional consideration’ across UK universities, or as it is referred to for the AKT, ‘mitigating circumstances.’ It invited comments on a discussion paper which posed a series of questions on special consideration including what situations might need special consideration and what a fair process might look like. It has since published The Good Practice Framework: Requests for additional consideration, which offers guidance for providers of higher education on dealing with such requests. This work will feed into the content of the proposed workshops on handling mitigating circumstances.

**Appeals**

*Maps to Action 17, Equality Action Plan*

Appeals are very similar to mitigating circumstances and many medical schools consider both issues through a single process. The AKT appeals policy only allows appeals on the basis there was a material irregularity in the conduct of the examination, for example students being asked to take the exam in an unsuitable venue. This is standard procedure across universities and medical schools where students are not allowed to challenge the academic judgement of their universities, so this policy also excludes that as grounds for appeal.

As with the policy about mitigating circumstances, the appeals policy will be applied by individual medical schools. If the appeal relates to the performance of the platform through which the AKT is delivered then MSC will provide evidence to schools to support them in their decision.

Because there is only one ground of appeal and it is based on the overall conduct of the exam, rather than an individual student’s performance, the risk of unfairness to groups of students who share protected characteristics is likely to be lower than with the policy on mitigating circumstances. The biggest risk will likely be to students with disabilities for a number of reasons, including that they are more likely to be badly affected if there is a problem with the delivery platform or IT systems. They are also more likely to take the exam in a separate room from other students to facilitate rest breaks, meaning that there is a greater risk of the room being unsuitable. The appeals process covers such circumstances but as it is applied by individual medical schools there is a risk that differing approaches will be taken. However, the AKT requirements, set by the GMC under their regulatory oversight role, state that all students must have a suitable environment to sit the exam and medical schools must report against this requirement.
as part of the GMC’s quality assurance processes. All medical schools must deliver an AKT that is compliant with the AKT requirements for it to count towards a candidate’s MLA, which acts as a mitigation to the risk of unfairness as a result the delivery of the AKT.

At present MSC is not proposing that it collects information about whether individual students have made successful or unsuccessful appeals. This means it will not be possible to analyse the impact of the policy on groups who share protected characteristics across schools. This decision has been made to limit the amount of personal information about individual medical students that MSC holds. The working group that developed the policy felt that even if MSC were to collect these data there is little meaningful analysis it could undertake. This is because schools are asked to make these decisions themselves and therefore without collecting the entire reasoning for why the decision was made no judgement can be made as to its fairness.

MSC will hold workshops for medical schools on appeals to allow medical schools to share best practice on how to manage the process. The MSC ED&I Alliance will be asked to feed into these events to ensure there is a chance for schools to explore how they can make sure their policies do not negatively impact on groups of students who share protected characteristics.

**Exam misconduct**

This is a straightforward policy that sets out what constitutes exam misconduct and how medical schools will deal with allegations of misconduct. Medical schools will deal with these allegations as they have established processes for doing this and will be responsible for the invigilation of the AKT.

At present MSC is not proposing that it collects information about whether individual students have had an allegation of exam conduct raised against them. This means it will not be possible to analyse the impact across schools of the policy on groups of students who share protected characteristics. This decision has been made to limit the amount of personal information about individual medical students that MSC holds. Additionally, the working group overseeing the development of the policy felt that the numbers of misconduct cases arising from the delivery of AKT would be so small that it would not be possible to come to any conclusions on fairness if MSC did collect these data.

It should be noted that data around exam misconduct and other fitness to practise issues are already shared by medical schools with the GMC. Medical students are also asked to declare any investigation into their professionalism when they apply for provisional registration. Therefore, GMC has a rich data source on all aspects of misconduct as well as the overall responsibility to quality assure medical school’s fitness to practise processes in line with the standards it sets for medical education. MSC feels the GMC are best placed to examine any EDI implications arising from exam misconduct as part of their overall quality assurance processes.
Reasonable Adjustments

See Actions 18 and 19, Equality Action Plan

The policy MSC has put in place on behalf of medical schools on reasonable adjustments is strongly based on the GMC guidance Welcomed and valued. Medical schools will make decisions on reasonable adjustments for their students in line with Welcomed and valued.

At the core of the MSC’s approach to reasonable adjustments put in place on behalf of medical schools is that any adjustment will be made for a student if the medical school has agreed that it is necessary to remove a disadvantage related to a student’s disability. The MSC will not be implementing any blanket policies in terms of what is acceptable or not in relation to adjustments as these are unlawful. MSC will endeavour to support all requests for reasonable adjustments that have been approved by a candidate’s medical school. For example, MSC will provide any length of extra time for this assessment that has been deemed reasonable by a medical school to mitigate the impact of student’s disability. Where the delivery platform cannot accommodate a requested adjustment MSC will work with medical schools and students to find an appropriate solution.

Some adjustments, particularly those relating to the physical test environment when the assessment is sat on campus, such as ergonomic seating or a quiet room, will be provided by the candidate’s medical school.

By providing for medical schools to make decisions about reasonable adjustments for their students there is a risk that different decisions will be made by different medical schools. Reminding schools that they should follow the guidance in Welcomed and valued on how to make decisions on reasonable adjustments and what factors they should take into account should mitigate this risk. The AKT policy on reasonable adjustments does clearly state that universities should not have blanket policies because they are unlawful. Throughout the document MSC encourages schools to make decisions on a case-by-case basis and to consider the best practice set out in Welcomed and valued. In addition, all AKTs delivered by medical schools must meet the GMC’s AKT requirements, which include the requirement to have in place appropriate policies and procedures for the test, including polices on reasonable adjustments.

Driving consistency

MSC has committed to providing an annual report to medical schools on the number and nature of adjustments students receive both UK-wide and by individual school. This will allow schools to understand the nature of adjustments being made across the country for the AKT, and through the provision of anonymised case studies will support universities and schools in making reasonable adjustments for their students.

It should be noted that the AKT is just one assessment in an ongoing programme
that starts when students enter medical school. Therefore, good practice in making reasonable adjustments needs to be embedded across medical education and is regulated by the GMC as part of their duty to ensure medical education and training is fair and supportive of medical students with disabilities. MSC will work with GMC to run training sessions on best practice in making adjustments for both applied knowledge tests and clinical and professional skills assessments.

**Impact on students in relation to the implementation of an AKT**

This section will assess the impact on students relating to the introduction of the AKT and identify ways in which this could be mitigated. It will start by looking at the student body more generally and then move onto considering the impact on students who share protected characteristics.

**Impact on all students**

**Student reaction to the introduction of the AKT**

*Maps to Action 21, Equality Action Plan*

The introduction of the AKT will not necessitate a huge change in the way students are currently assessed at the end of their course. The majority of students are required to pass a knowledge test before they are allowed to graduate. All medical school final knowledge tests currently use SBA items in some form, and many already use items from the item bank from which AKT papers for UK students will be constructed. This means that the AKT will look and feel very familiar to students.

However, it is likely that students will still be concerned about its introduction. Students may perceive it as an additional step they need take towards graduation and the association with the GMC may provoke negative feelings as they tend to associate the GMC with fitness to practise issues. Additionally, some students will feel uncomfortable if they perceive that responsibility for decisions about assessment is being delegated to a central body like MSC rather than being managed by their university that they have an ongoing relationship with. This would be an incorrect perception as the responsibility for the AKT rests with medical schools rather than MSC which is co-ordinating work on their behalf but it is likely to arise as MSC branding will be on documents and the delivery platform for example.

To offset this anxiety MSC will work with medical schools and the GMC to emphasise the continuity of the process and communicate this to students. The fact that the AKT remains the ultimate responsibility of their medical school may also provide reassurance to students. For example, reasonable adjustments will continue to be managed by a student’s medical school meaning continuity can be applied across all of the assessments taken by students over the course of their degree.
The risk the AKT adds to the burden of assessment on students

While it is hoped that the introduction of the AKT will replace the need for medical schools to run their own final knowledge assessment it is not a mandatory requirement. Therefore, there is a risk that the AKT will become another assessment that medical students need to pass in order to graduate. This would mean more time revising for medical students and increased levels of anxiety as some, if not all, students do find assessment stressful to some extent.

The design of assessment systems is a university responsibility so there is no clear way to mitigate against this risk. However, MSC, working with medical schools, will be transparent about all aspects of the AKT including pass rates and student feedback. It is hoped that by providing this information to medical schools and showing that the AKT is a high-quality assessment there may be movement in time and that all schools will consider using the AKT as their final knowledge assessment.

Differing rules across medical schools

While some students will welcome the application of familiar rules and processes covering aspects of the assessment such as mitigating circumstances and reasonable adjustments others will question why different rules are applied by different schools for something they perceive to be a national exam. This is an understandable concern which MSC and medical schools are very conscious of. Therefore the policy framework provides a high degree of detail as to what factors medical schools can consider when thinking about dealing with mitigating circumstances and making reasonable adjustments. This level of detail will help schools understand best practice and helps to develop a shared understanding of what is appropriate in terms of applying the policy framework.

Communications with students will need to explain that medical schools are autonomous institutions and therefore policies will differ across institutions and also encourage students to consider that this approach maintains their existing relationship with their medical school and means rules that have been applied to them throughout their course will be applied for this high-stakes assessment.

The policies that medical schools have agreed, through the MSC, are the first time that national policies have been put in place for knowledge assessments. The aim is to drive consistency between medical schools and universities on these important areas. As part of the implementation of AKT MSC will share information with schools about how all medical schools are applying the policies and will run best practice events for schools to learn from each other. It is anticipated that this will, over time, mean that medical schools start to coalesce around best practice which will be of benefit to all students. Where medical schools find that their university regulations differ from the national policy framework, for example on the number of attempts students are permitted at examinations, they may be able to use this best practice sharing ethos to press for
changes at an institutional level, further driving consistency and improvements.

**Avoiding unfairness**

*Maps to Action 20, Equality Action Plan*

Although the policy framework has been developed in order to mitigate against the possibility that medical students sitting the AKT may have different experiences based purely on the institution they attend, the potential for the national policies to not be applied evenly across UK medical schools should be considered. Ultimately, the policies MSC has put in place on behalf of medical schools will be applied in the way each school chooses, and there may remain discrepancies at national and local levels. The risk remains that a school may apply policies differently to another school, and it may apply policies inconsistently internally. The GMC remains responsible for quality assuring medical schools and will be able to take action if a school is found to be applying policies inappropriately or inconsistently internally. Additionally, the MLA oversight body will be able to observe the application of these policies at a national level and may make future directions to medical schools as to how they should respond to any identified issues.

It is clear from GMC data that the diversity of medical school populations is variable across different medical schools. This means that there is a potential for differential outcomes if, for example, a school with a large number of students from ethnic minorities has a particularly strict policy in terms of the number of attempts students have to pass the AKT. This potential for differential outcomes may apply across many different protected characteristics and apply to most of the policies put in place. For example:

- Schools that have blanket policies in place for reasonable adjustments mean those students at that school with a disability may experience differential outcomes compared to students at schools who look at applications on a case-by-case basis.
- Students with significant caring responsibilities for children, disabled adults or older relatives may experience differential outcomes if their school omits the need to unexpectedly have to provide care as a ground for mitigating circumstances as included in the policy MSC has developed on behalf of medical schools.

While the demographics of students are known by medical schools for some protected characteristics, others, such as religion, are not regularly reported on. Nor is up to date information on the scope of current medical school policies on areas such as number of attempts available. These data will need to be collected and would need to be cross referenced with school demographic data to identify differential outcomes. MSC will do this in regard to number of attempts and the provision of reasonable adjustments. As noted above MSC is not proposing to collect detailed data on how the other policies are implemented as any data it did collect would not lend itself to the drawing of robust conclusions.
However, as stated above, MSC intends to collect a detailed data set on the protected characteristics of medical students. By collecting these data from medical students and collecting information as to how medical schools are applying the policy framework it may be possible to look at some aspects of differential outcomes in more detail.

**Using data to highlight inequality**

*Maps to Action 14, Equality Action Plan*

As previously stated MSC has plans in place to collect wide ranging data from students about protected characteristics. This collection of data will allow inequalities to be highlighted using one data set from a national exam that is treated the same in every medical school. Data available at present often come from only one or two institutions or are drawn from exams that are not implemented consistently across medical schools, such as the Prescribing Safety Assessment.

It is a well-documented fact that an award gap exists for students from ethnic minorities.\(^{10}\) What is unclear is whether this gap exists in relation to other protected characteristics. Comprehensive data collection and the plurality of a national exam will, for the first time, allow medical schools to look at some of these issues. It will also allow intersectionality to examined and give researchers the chance to look at the interplay between protected characteristics such as ethnicity and gender or gender and religion.

Having the ability to look at and analyse these data has the potential to drive improvements across medical education for all medical students. These data will also be added to UKMED which will allow research teams to look at the award gap in more detail.

**Impact on students with specific protected characteristics**

Data on the current demographics of medical students have been presented in this section where they are available.

**Age**

Just over a third of all doctors who joined the GMC register between 2019 and 2020 were between the age of 25 and 29. Of these doctors, around 13% applied via the UK route and around 12% via the PLAB route. The next most common age group was those under the age of 25 (27%), of which almost 25% joined via the UK route (see footnote 1).

There is some evidence to suggest that older students perform less well in assessments than their younger peers (see footnote 1). However there is also data to suggest that

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\(^{10}\) Woolf K, Potts HWW, McManus IC. Ethnicity and academic performance in UK trained doctors and medical students: systematic review and meta-analysis. BMJ. 2011;342.
failure rates are similar for students on graduate entry courses compared to students on standard entry courses (see footnote 1). Collecting data on the age of students taking the AKT will provide insight into this issue and as noted above MSC has committed to analysing results by protected characteristics and making data available to research teams through UKMED.

Older students are more likely to have greater caring responsibilities than their younger peers. MSC will ensure, through best practice sharing events, that schools understand that they should deal with applications for mitigating circumstances on a case-by-case basis and that caring responsibilities should be taken into account.

**Disability**

![Disability Chart]

10.9% of medical students have a declared disability, this contrasts to the number of doctors joining the medical register where the figure is just under 6% of doctors in 2019/20. Just over 5% of those who declared a disability were UK applicants, with the most common disabilities declared by this group being a learning disability (37%), mental illness (21%) or another impairment such as cancer or asthma (21.5%) (see footnote 1).

MSC has taken a flexible approach to the provision of reasonable adjustments which will support medical students with disabilities taking this assessment. Key to MSC’s approach is not putting in place any blanket policies for what reasonable adjustments can be made for this exam, including the amount of extra time permissible to remove any disadvantage an individual student has as such policies are unlawful. MSC has also
been proactive in operationalising the anticipatory duty to make reasonable adjustments by ensuring the delivery platform is able to accommodate adjustments that students commonly require and by advocating the approach set out in *Welcomed and valued*.

MSC plans to work with medical students to see what further improvements can be made to the delivery platform to facilitate adjustments and improve its accessibility for all students. MSC will also ask students to give feedback on the delivery platform including its accessibility, and this will be used to improve the user experience for all students but particularly those with a disability.

As noted above there is a risk that by asking schools to make decisions on whether a student can have an adjustment for the AKT, and what that adjustment should be, different decisions will be made across UK medical schools. This is entirely legal under UK equality legislation as decisions must be made on a case-by-case basis and so different outcomes are justified. To mitigate the risk of unfair treatment of any groups who share protected characteristics in the making of reasonable adjustments for the AKT the MSC will:

- remind schools that blanket policies must not be applied to the provision of reasonable adjustments
- direct schools towards the GMC guidance *Welcomed and valued* and encourage them to follow the best practice guidance contained within it
- share anonymised information about the number and nature of adjustments students taking the AKT have received
- give schools the chance to share best practice in making reasonable adjustments.

Going beyond the provision of reasonable adjustments, MSC has encouraged schools to be flexible when making decisions around mitigating circumstances decisions by stating these should be made on a case-by-case basis. The policy also highlights that students with long term health conditions may experience unforeseen negative fluctuations of these conditions and schools should be mindful to this when making decisions on mitigating circumstances.

**Gender reassignment**

No data are currently available on the number of students or GMC registrants who intend to, who are, or who have undergone the process of reassigning their gender.

MSC is not aware that there is evidence to suggest that there will be any negative impact on students undergoing or who have undergone gender reassignment from the introduction of the AKT. However, MSC has committed to collect data on gender reassignment, something that is not currently collected and/or analysed and will look at whether there is an award gap for this protected group, or if there are any other issues associated with this protected characteristic.
Marriage and Civil Partnership

No data are currently available on the number of medical students who are married or in a civil partnership.

MSC is not aware that evidence any exists to suggest that that students being married or in a civil partnership will have an impact on their performance in the AKT. Nor will any of the policies implemented to support the delivery of the AKT for UK students have a negative impact on this protected group. As with all groups who share protected characteristics, MSC will collect data on this demographic of students and test whether it is the case that marriage and civil partnership does not lead to an award gap, or if there are any other issues associated with this protected characteristic.

Pregnancy and maternity

No data are currently available on the number of medical students who are pregnant or who have given birth while at medical school.

Little work has been done to establish whether pregnancy and maternity have an impact on student performance in knowledge tests like the AKT. MSC will collect and analyse data on this protected group.

The MSC policy on the number attempts that a student is permitted states that a pass on the AKT is valid for two years. This should be supportive of students who wish to take a break from their course to go on maternity leave. Additionally, MSC encourages medical schools to be flexible in how they apply rules on the number of attempts students in this position are allowed to have to pass the exam which will also support these students.

Race and ethnicity

![Race and ethnicity chart]

Legend:
- Asian or Asian British
- Any other Asian background
- Black or Black British
- Any other Black background
- Mixed
- Other Ethnic Group
- White
- Other White background
- Not recorded
There is evidence to show that medical students from ethnic minorities have poorer academic performance on average compared to their white peers. The type of examination that students sit is not thought to impact on this award gap and the same differentials exist in machine marked assessments suggesting that examiner bias is not the root cause of the difference. Instead, research on this award gap makes it clear that this difference in performance is not due to any deficit in the students themselves but is instead likely caused by policies and learning environments within medical schools and clinical training. One research project found that ‘examiner bias does not appear to explain the differential attainment of Asian students in UK medical schools. Future efforts to address differential attainment by BME students may be best directed at understanding detrimental influences on their learning or performance.’ Another project found that due to disparities in ‘cultural capital’, minority students may be cut off from potential and actual resources that facilitate learning and achievement, including tutors and clinicians.

Because of this well documented award gap it should be expected that students from ethnic minorities will perform less well on the AKT than their white peers. As the causes for this are complex and seemingly originate from the culture of learning environments that students will have experienced throughout their time at medical school, a final knowledge test like the AKT has limited scope to address this. However, any observed variations in award gaps from across institutions represent opportunities for medical schools to focus their efforts on addressing the root causes of unjustified gaps. MSC does have a commitment to addressing some of the issues that lead to award gap. The newly established MSC ED&I Alliance will provide medical schools the opportunity to come together and share best practice in tackling the issues that lead to the award gap that students from minority backgrounds face, including those faced by students from ethnic minorities.

In 2021 MSC will publish overarching guidance on the steps that medical schools need

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11 Woolf K, Potts HWW, McManus IC. Ethnicity and academic performance in UK trained doctors and medical students: systematic review and meta-analysis. BMJ. 2011;342.
to take to ensure that they provide a learning environment for all students that is welcoming and inclusive. It will also cover the positive action that needs to take place to tackle the fact that some students are excluded, experience inequity and injustice, or unfair advantage, precisely because of who they are and where they are positioned within an unequal socio-political structure. This will support medical schools in meeting their duties under equality legislation to advance equality of opportunity people who share a protected characteristic and those who do not.

These strands of work should, over time, help to reduce the award gap experienced by students from ethnic minorities. In the short term, while there is little the AKT can do to directly address the award gap, there are actions that can be taken through the development of AKT to address the wider culture issues that contribute to it. It will be essential that the development of the AKT is founded on the principles of fair assessment to ensure it does not make additional contributions to the award gap. One proactive step MSC will make is to audit the items in the item bank to ensure that they do not stereotype patients from ethnic minorities. Another action MSC will take is to ensure that the images within the item bank that will be used for the AKT show clinical presentations on a range of skin tones. These changes will ensure that the exam itself feeds into a culture change within medical education.

It should also be noted that the introduction of a national exam like the AKT will be a positive step in addressing the award gap for students from ethnic minorities. It will, for the first time, establish the scale of the issue on a national level. It will also provide individual medical schools with a chance to compare their award gap to other medical schools’ and will give them the opportunity to track their progress in trying to eliminate it as they will receive annual reports on the performance of their students by demographic.

**Religion and belief**
38% of medical students identify having no religious affiliation. However, a significant number of medical students identify as Christian (28.8%), Muslim (13.9%) and Hindu (7.8%) (see footnote 1).

There is no specific evidence that religion will have a negative impact on the performance of students taking the AKT. Collecting data on the religious beliefs of students taking the AKT will provide insight into this issue, and as noted above MSC has committed to analysing results by protected characteristics, including religion, and making our data available to research teams through UKMED.

Medical schools will schedule the timings of when their students take the exam and apply their policies as to how they accommodate the needs of students from specific religious backgrounds. The windows that the exam will be available for schools to pick a date from to run the assessment have been mapped so they avoid major religious festivals.

One useful analysis that MSC will undertake will be to look at the interplay between race and religion. It is accepted¹⁴ that students from ethnic minorities experience prejudice while they are at medical school, particularly when they are on clinical placements and that this is likely to contribute to the award gap discussed above. Discrimination and prejudice surrounding religion such as Islamophobia and Anti-Semitism also exist within society and it may be possible to use our data analysis to understand more about how religion and belief have an impact on student performance.

Sex


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MSC does not anticipate that the AKT will have any direct negative impact on students dependent on their sex. However, data will be collected and analysed to confirm this. Medicine is a subject that more women than men study which is linked to the trend of women performing better at both GCSEs and A levels than men.

The fact that more women than men will be taking this exam does highlight that, as discussed above, schools need to be aware that caring responsibilities are included as a grounds for mitigating circumstances as more women than men have responsibility for children and older relatives.

**Sexual orientation**

![Chart showing the percentage of students by sexual orientation from 2007 to 2018.

A key finding from these data is that while the number of unrecorded data fields has reduced it is clear that more needs to be done to create confidence in students to declare their sexual orientation (see footnote 1).

There is no specific evidence that sexual orientation will have a negative impact on the performance of students taking the AKT. Collecting data on the sexual orientation of students taking the AKT will provide insight into this issue and as noted above MSC has committed to analysing results by protected characteristics, including sexual orientation, and making our data available to research teams through UKMED.
Lower socio-economic background

The chart below uses POLAR data which measures how many people from geographical areas participate in higher education. It splits the UK into distinct areas, searchable by postcode, and assigns the area a quintile depending on how many 18-year-olds enter higher education in that area. These data show that there is an over representation of students attending medical school who come from areas where it is common for young people to attend university. However, these data also show that the numbers of students from lower participation areas is increasing slowly over time (see footnote 1).

The chart below uses the Index Multiple Deprivation, a measure that looks at how deprived a geographical area is. These data show that the number of medical students who come from deprived areas is increasing year on year (see footnote 1).
While not a protected characteristic, MSC is keen to ensure the needs of students from a lower socio-economic background are considered in the development and implementation of the AKT.

There is some evidence to suggest that an award gap exists for students from a lower socio-economic background and it would not be surprising if this was found to be the case with regards to the AKT. The effects of disadvantage do not disappear once students are accepted into medical school. These students are more likely to need to work to financially support themselves and their families. They are also more likely to have significant responsibilities at home, including supporting their parents and siblings. Both of these factors mean they may be less able to focus on their education compared to their more privileged peers. While medical schools work hard to support these students by providing targeted support and hardship funds it is not possible to erase disadvantage caused by economic hardship.

One crucial action MSC can take to support these students is to ensure that learning resources to allow students to prepare for the AKT are made available for free. When any national assessment is introduced a number of private companies set themselves up as experts in helping students pass the exam. They charge for these services and the cost is often prohibitive for students from a lower socio-economic background which impacts their confidence in taking these assessments. This can be seen in relation to both the Prescribing Safety Assessment and the Situational Judgement Test. It is really important that with the AKT students are reassured that they can pass the assessment without seeking to pay to undertake additional courses or buy additional resources such as books or apps.

Chapter 10 sets out how MSC and individual medical schools will support and prepare students to take the AKT. Strong commitments are made to support students by ensuring they have access to practice papers and a chance to familiarise themselves with the online delivery platform. In addition MSC will seek to ensure that the online learning resources it provides to medical schools are able to be used for AKT preparation (see Action 21, Equality Action Plan).

Impact on medical schools

This section will outline the impact on individual medical schools from the introduction of the MLA.

Responsibility for implementing AKT policies

The way the policy framework for AKT has been developed relies on medical schools making decisions on and running processes to deal with appeals, mitigating circumstances, exam misconduct and reasonable adjustments in line with the national standards set by the regulatory body.
policy framework established by MSC on behalf of medical schools. This is positive as it embeds the assessment within existing processes and the wider degree programme and allows a holistic approach, for example, to fitness to practice and academic progression. However, it also places a degree of responsibility on medical schools and creates a tension between applying a national policy using local systems. To address this tension MSC has put in place a framework that is flexible and accommodates local processes. For example, some medical schools run the same process for appeals and mitigating circumstances while others deal with them separately. The guidance MSC has provided is that either approach is acceptable and schools can choose which works best for them.

It should also be noted that medical schools all run these processes for their existing assessments throughout the course, not just for finals. They are not being asked to undertake more work; these are essential elements of exam delivery that have to happen for every high-stakes assessment.

**Pressure to change institutional policy**

This is particularly relevant to the policies on the number of attempts students are permitted to take the AKT and on reasonable adjustments. MSC is aware that in both cases there is variety across schools as to what institutions allow and consider reasonable. The AKT will highlight this variety and students will consider this disparity to be unfair as this is a national exam. This will put medical schools under some pressure. Policies around reasonable adjustments may be easier to address as medical schools have more control over them but the number of attempts students are allowed is often set at the university level rather than course level. Making changes to policies set at university level can be a slow and difficult process and will put pressure on medical schools.

However, medical schools understand that consistency in how the policy framework is implemented across different institutions is desirable and they are committed to fulfilling this ambition. Medical schools have committed to keeping all the policies set out in the framework under review, both as individual medical schools and through MSC led collaboration. MSC will support schools in doing this by providing data they can share with their institutions to show how other universities are dealing with the issue and by bringing them together to discuss the issue on an annual basis.

**University resources and staff time**

Medical school staff will be involved in doing much of the work to deliver the AKT, including contributing to item development, being involved in standard setting panels and exam construction groups on a national level on behalf of MSC. More can be read about medical school involvement in these processes in the [governance](#) section of this EA. Therefore medical schools will contribute staff time to the delivery of the assessment. It should be acknowledged that for some schools this will be an additional
assessment they need to manage. On the other hand, many schools have indicated that they intend on replacing their current final knowledge test with the AKT.

**Benefits for schools**

The design and delivery of the AKT relies on collaboration between medical schools. As a direct result, staff from UK medical schools will work together on item development, exam construction and standard setting. This coming together of medical schools will raise the standard of knowledge and skills in assessment across UK medical schools as experiences and best practice are shared. There will also be chances for individual medical school employees to get involved in project development and research projects that will support their own career goals and aspirations.

Medical schools through MSC’s commitment to collect a broad range of data about students who share protected characteristics will be of major benefit to medical schools. It will provide them with a detailed set of data with which to analyse the performance of their students by protected characteristics and, in turn, this will allow them to address any award gaps that are identified. The recent establishment of the MSC ED&I Alliance will also support them on a national level to do this.

**Next steps**

*Maps to Action 23, Equality Action Plan*

MSC will keep this EA under review and will continue to work closely with UK medical schools and other groups such as the MSC ED&I Alliance to update it as and when required. This will ensure potential EDI issues are identified and explored, and EDI continues to be considered in the ongoing development, implementation and monitoring of the AKT for UK students.
Appendix 6 – Standard operating procedure for student exam registration on the Exam-Write platform (redacted)
Appendix 7 – Item Development and Management Group and its responsibilities

Item Development and Management Group

The Item Development and Management Group is responsible for:

- appointing members to final review groups
- establishing item review groups and ensuring a sufficient spectrum of specialty knowledge to ratify question content across the MS AKT sampling grid
- policies and procedures for item development and management
- identification of gaps in the item bank and commissioning of new items
- taxonomies in the bank and appropriate item tagging to the content map
- QA of items and decommissioning of items with poor performance data
- ensuring EDI representation across the groups
- design and delivery of relevant training material for item authors
- ensuring the security of items
- reporting to the MS AKT Exam Board through an annual report of output and recommendations
- identifying improvements to the functionality of the item creation and storage platform.

The group will consist of eight members including the chair and deputy chair. Appointments will be by application. It is anticipated that members will also be embedded in the item writing process through final review groups or item review groups and so will already be familiar with the quality of items and any issues. A lay representative with a background in education and assessment will also be sought. The GMC may attend as observers.

Final review groups

A model for final review groups already exists in the MSC Assessment Alliance Final Clinical Review Group (see Appendix 2, History of the MSC Assessment Alliance) and has proved to be successful with support across all medical schools. The MLA final review groups will build on that process, with a group of 20 assessment experts providing the final approval of items for the MS AKT bank. Experts with the relevant skills and expertise will be invited to apply against set criteria.

These groups will be responsible for ensuring that:

- only high-quality assessment items are approved for the MS AKT
items are tagged appropriately.

This will be achieved through the following objectives.

- conducting a final review of items that have been edited and accepted by the item review groups
- amending items where errors or inappropriate writing style are identified
- undertaking the quality assurance of items at the end of the assessment cycle and considering their performance data
- undertaking a periodic review of items to ensure that their content remains accurate and up to date including justifications
- proposing changes to the taxonomies where appropriate while ensuring that the tagging system reflects the sampling grid
- providing feedback to item review groups to promote consistency and standards
- making recommendations for improvements to the process and policies including training materials for item development and management.

The final review groups will report to the Item Development and Management Group.

Essential experience will include evidence of the following points (although not all will be required to be current):

- education of final year medical students
- working with foundation year doctors (GPs will be exempt from this as not all GPs have contact with FY doctors)
- currently practising clinicians
- writing Single Best Answer (SBA) items for knowledge tests for medical school or post-graduate exams
- possesses an appreciation of methods for standard setting for high-stakes medical assessments
- experience of participating in exam boards and/or external examiner for medical school exams (desirable)
- experience of existing Assessment Alliance pathways for item development and review (desirable).

Although the majority of members will be medically qualified medical educators, other professionals and those who have recently demitted practice will be considered where they can demonstrate the relevant skills and experience.

Applications will be reviewed and appointments made by the Item Development and Management Group. Terms of office will vary in length on appointment providing a
staggered end/renewal date for each member. Members can apply to continue when their term of office finishes and can be re-appointed on a five-year cycle.

**Item review groups**

A group of 70-80 approved authors will be established. These approved authors will be responsible for writing new SBAs as commissioned/identified by the Item Development and Management Group. All medical schools will be asked to nominate two members. Members will have local and/or national experience of writing SBA items at finals-level or similar. This could include trainees who are at least three years post-graduation and who have completed the Foundation Programme.

MSC will strongly encourage medical schools to identify potential applicants with different protected characteristics to ensure appropriate equality, diversity and inclusivity among all groups. The item review groups will also require regional and four nation representation.

Members will have expertise in assessment, item writing and medical student education. They will often be working with foundation doctors, including in their supervision. The group will have a wide variety of medical expertise in community and hospital settings including:

- General practice
- Acute medicine
- Surgery
- Anaesthetics
- Obstetrics and gynaecology
- Psychiatry
- Medicine of elderly
- Paediatrics
- Public health
- Sub-specialist expertise (to cover all areas of clinical practice)

Applications will be mapped to an “expertise grid” (see an example in Table 8) to ensure all elements are covered. The final selection will be determined by the Item Development and Management Group which will review anonymised applications and ensure all components of the grid are covered.
Table 8. Example expertise grid for item development

The following bullet points summarise the composition and projected output of item review group meetings.

- Each item review group would have a minimum of five members. Experience shows that this number gives breadth of clinical and assessment experience, while maintaining manageable discussion. The group can be expanded to six if a new member joins allowing the output of the group to remain stable.
• At least one member of the final review groups would chair each item review group.
• Item review group members would be expected to attend at least one event held each year and attendance will be based on the needs at that time.
• Members will be required to write a minimum of 15 items per event.

Frequency of item and final review group meetings and projected output

• Two in-person item development and review meetings will take place each year. As with the current model this will involve a three-day meeting with the item review groups providing an initial review of items, immediately followed by final review groups which will provide the final review and approval.
• It is anticipated that eight item review groups will work in parallel, chaired by at least one member of the final review groups. Members will be expected to write 15 items for each event which will result in ~600-720 items per event and 30 items for each author for the year.
• The acceptance rate at each event is around 70% so the two in-person events will produce ~1000 approved items.
• When needed the team will organise shorter virtual item and final review events to supplement the in-person meetings.
• The intention is for each event to clear the items authored for that event. If there are outstanding items awaiting final review group scrutiny after each event then one or more remote final review group meeting(s) will be convened to complete the reviews.

Figure 10. The relationship between the Item Development and Management Group and associated groups, including the Exam Construction Group and Standard Setting Group
Appendix 8 – Standard operating procedure for MS AKT item authors

This is a short reference to ensure that you have completed all the steps before submitting your questions. Please refer to the MSC Assessment Alliance style guide for information about how to write and format questions.

Overview

The overview of the question should help direct a student to the relevant learning outcome to review without giving away the answer or aiding memory of the question.

Examples: management of acute chest pain, principles of screening.

Question content

Check that your question conforms to the following:

- appropriate knowledge for a week 1 Foundation Year 1 doctors
- written in present tense
- presenting complaint (where appropriate) should begin the vignette
- only abbreviations listed in the style guide should be used
- blood results should be inserted using the reference tables
- options in alphabetical order.

Justification for correct answer

You must provide a justification for your answer. This explains the correct answer for non-specialists reading the question. Where the justification is evidenced-based (eg based on guidelines), please provide a reference (eg a NICE guideline).

Tagging

You are able to select more than one tag for each domain but must select a primary tag for each domain. Please complete at least a primary tag for each of the following:

1. **Specialty**: This should be the specialty most likely to be involved within the context of the vignette, eg interaction of antibiotics and statin for community acquired pneumonia are most likely to be GP not cardiology.

2. **Skill**: The lead-in will define this in the majority of circumstances, eg the question may ask for the most important management step but the vignette also requires the student to first make a diagnosis. The skill here would be patient management.
3. **Condition:** The primary condition relates to the presenting symptom in the vignette where there is one. This may be ‘bowel cancer’ for a question on screening where there is no patient in the vignette.

4. **Presentation:** The presentation also relates to presenting symptom in the vignette where there is one.
Appendix 9 – Standard Setting Group and Panels and their responsibilities

Establishing the Standard Setting Group

The Standard Setting Group will comprise 12-15 members with representation from medical schools and foundation schools. Members will also be involved in standard setting panels. At least one member will be a psychometrician. Responsibilities of the Standard Setting Group will be to:

- appoint members to standard setting panels
- oversee standard setting procedures and policy
- allocate items to standard setting panels
- review outcomes of each standard setting panel
- design and deliver relevant training material
- review performance of each assessment and completion of post-hoc analysis
- verify passing standard for each assessment and report to MS AKT exam board
- produce annual reports of performance and outcomes of standard setting.

Essential experience for the Standard Setting Group will include evidence of the following (although not all are required to be current):

- education of final year medical students
- working with foundation year doctors
- item writing for knowledge tests for medical school or post-graduate exams
- standard setting for high-stakes medical assessments
- exam board member and/or external examiner for medical school exams.

There will also be a reserved place for a psychometrician.

Medically qualified members should be of Consultant, General Practitioner (or equivalent senior academic status) or Specialist Trainee (ST3 and above) or equivalent Staff and Associate Specialist (SAS) grade. Although the majority of panel members will be medically qualified medical educators, other professionals and those who have recently demitted practice will be considered where they can demonstrate the relevant skills and experience.
Each member of the Standard Setting Group will be appointed for 2-4 years with an option of a second three-year term. This will mean there may be a change of members after two years and would lead to change in personnel between years 5-7. The Standard Setting Group will be appointed by the MS AKT Exam Board. The Standard Setting Group will have two appointed observers including one lay representative and one representative of junior doctors.

**Figure 11. Relationship between the Exam Construction Group, Standard Setting Group and standard setting panels during exam design and initial delivery**

**MS AKT standard setting panels**

The AKT standard setting panels will seek to recruit 60 standard setters from across UK medical schools and relevant stakeholders including those involved in the Foundation Programme and postgraduate training.

- All medical schools will nominate three members. They will have local and/or national experience of standard setting at Finals-level or similar. Where possible this should include trainees who are at least three years post-graduation and who have completed the Foundation Programme.

- Each foundation school will nominate two individuals. Previous standard setting expertise will not be a requirement. They must be involved in the training of Foundation Year 1 doctors.

- Medical schools and foundation programmes will be encouraged to identify potential applicants with different protected characteristics to ensure appropriate equality, diversity and inclusivity among standard setters.
The majority will also have expertise in assessment, item writing and medical student education. They will often be working with foundation doctors, including their supervision. The panel will have a wide variety of medical expertise in community and hospital settings including:

- General practice
- Acute medicine
- Surgery
- Anaesthetics
- Obstetrics and gynaecology
- Psychiatry
- Medicine of elderly
- Paediatrics
- Public health
- Sub-specialist expertise (to cover all areas of clinical practice including medical ethics and law)

Panels will also require representation from the MS AKT Exam Board and members of the item writing and review groups, as well as having regional and four nation representation. Applications will be open to all relevant stakeholders and mapped to an “expertise grid” (see Table 9 for an example of the expertise grid) to ensure all elements are covered. The final selection would be determined by the Standard Setting Group reviewing anonymised applications and ensuring all components of the grid are covered.
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*Table 9. Example expertise grid for MS AKT Standard Setting Panels*

Each panel sitting would have 15 members. There is no gold standard for number of standard setters. Practical experience shows that this number gives breadth of clinical and assessment experience, while maintaining manageable discussion. At least one member of the Standard Setting Group would sit on each panel.
Appendix 10 - Security controls for the MSC Assessment Alliance Item Bank and Exam-Write (redacted)
Appendix 11: AKT Policy Framework

Number of attempts

Purpose

In relation to the MS AKT, this policy sets out:

• why universities limit the number of times medical students may take the AKT
• what is meant by a valid attempt
• how many valid attempts MSC recommends medical students should have to pass the MS AKT
• how resits will be dealt with.

All of the policies relating to the MS AKT have been put in place to facilitate this national assessment while acknowledging that there will inevitably be slight variations between medical schools. The rules that apply to the number of attempts will ultimately be the rules set by a medical student’s university as it has the final responsibility for ensuring that every student has met the outcomes required for graduation. Medical students are made aware of a university’s regulations when they apply and on registration agree to abide by the rules and regulations.

Why the number of times medical students may take the MS AKT is limited

It is essential that the number of attempts medical students are allowed to have to pass the MS AKT is limited to ensure public confidence in the examination and to demonstrate that medical students have met the required standard of proficiency to become doctors.

Universities have their own local policies for the number of times students may take and re-sit examinations. As a national assessment set to a common passing standard, universities have indicated that they hope, with time, to bring together their policies for students at UK medical schools.

What is meant by a valid AKT attempt?

All MS AKT attempts are valid and count towards the maximum number of permitted attempts, unless an attempt is nullified as a consequence of:

• a student’s mitigating circumstances

Or

• a successful MS AKT appeal.

Attempts nullified in accordance with policies for mitigating circumstances and MS AKT appeals do not count towards the number of permitted attempts.
If students are found by their medical school to have committed exam misconduct then their results for that sitting will be nullified but the attempt would still count towards the maximum number of attempts permissible. MSC has produced separate guidance that defines exam misconduct and explains how medical schools will deal with situations where it has been alleged to have occurred.

Non-attendance at the AKT is considered a valid attempt, unless mitigating circumstances are accepted, and the non-attended ‘attempt’ will count towards the maximum number permissible.

**Permissible number of valid attempts**

The recommendation from MSC is that UK medical students will normally be entitled to no more than four valid attempts at the AKT. Ultimately the rules that apply to the number of attempts will be the rules set by a student’s university as it will have the final responsibility for ensuring that every student has met the outcomes required for graduation.

Medical students may, at the discretion of their medical school, be allowed additional attempts in very exceptional circumstances. This may include circumstances which are unable to be considered under a university’s mitigating circumstances procedure, but nonetheless are sufficiently exceptional as to warrant a further attempt, or attempts, being permitted.

**How resits will be dealt with**

The recommendation from MSC is that UK medical students will normally be entitled to no more than four valid attempts at the AKT. The sequencing of attempts is decided by individual medical schools but it is likely that it will take place over two academic sessions. This is so that medical schools can put in place plans for remediation between attempts and for reasons of operational feasibility.

If a medical student fails a first sitting, all subsequent attempts should be taken at the next available sitting, as decided upon by the medical school, unless the medical school is satisfied that another sitting is more appropriate (for example, due to a student’s health or other mitigating circumstances). This is so that medical schools can put in place plans for appropriate remediation within their assessment cycles.

Medical school programme progression rules will apply when a student has either passed the MS AKT but has not met other academic requirements of their degree programme; or has not passed the MS AKT but has passed all other academic requirements of their degree programme. Medical students are required to pass the MLA and any other assessments deemed necessary by their medical school in order to graduate. Medical school rules may also require medical students to pass their clinical and knowledge assessments in the same year in order to graduate. This may mean a
medical student who had previously passed the MS AKT may need to retake it if they fail their clinical assessment and are required to repeat a year.

If medical students are permitted to take a break from their studies, a pass result in the MS AKT will remain valid for two years. Once this period has expired, the MS AKT will need to be retaken. In these exceptional circumstances medical school progression rules will apply in relation to the academic requirements of the programme. This will include an agreement on the number of further attempts of the MS AKT that are permissible that will also consider individual circumstances. Medical students are required to pass the MLA and any other assessments deemed necessary by their medical school in order to graduate after a break in their studies.

**Appeals and complaints**

**Purpose**

In relation to the MS AKT, this policy sets out:

- the grounds on which medical students may and may not appeal the MS AKT that they sat
- how such MS AKT appeals by medical students will be dealt with
- how candidates may provide feedback or complain about the MS AKT.

All of the policies relating to the MS AKT have been put in place to facilitate this national assessment while acknowledging there will inevitably be slight regional variations between medical schools.

**Permissible grounds of appeal to universities and medical schools**

Universities recognise that serious circumstances beyond a candidate’s control might have adversely affected their performance. MS AKT candidates should follow this appeals policy which will be interpreted locally by the university at which they are registered if they think mitigating circumstances apply in their case. Some medical schools handle appeals and mitigating circumstances through the same process; this is acceptable and the two policies should be read together.

In respect of the MS AKT which they sat, medical students may appeal to their university on the grounds that there was a material irregularity in the conduct of the examination, for example through their medical school or their university not properly following operating MS AKT policies and procedures.

Material irregularities may also arise from the performance of the exam delivery platform or the technical process used to construct the exam paper. As these irregularities relate to a national process the MSC will need to be involved in the investigation of the issue. Other categories of appeal may be considered in exceptional...
circumstances.

All MS AKT appeals must be supported by cogent evidence.

**Grounds of appeal that are not permissible**

MS AKT candidates may not appeal under this policy to challenge:

- expert or academic judgement in relation to the MS AKT
- their marks if, for example, they believe they should have passed when they did not or, even if they passed, they should have received higher marks than awarded
- findings of examination misconduct
- decisions not to accept mitigating circumstances.

**MS AKT appeals**

**Process**

MS AKT appeals by medical students will be dealt with through their medical school. The medical school should follow the parent university’s procedure for dealing with appeals against decisions on academic progression.

Where the material irregularity arises from the performance of the exam delivery platform or the technical process used to construct the exam paper, medical students should appeal to their medical school which will consult MSC to determine whether the disruption was caused by a local or a national issue. MSC will investigate the irregularity in partnership with individual medical schools. The MS AKT Exam Board will consider the evidence and make a report to the student’s medical school which will then make a final decision as to whether the appeal is upheld and what action will be taken in light of that decision.

**Outcomes**

Medical schools will inform the MSC of the outcome of MS AKT appeals by their students. The information supplied at this point need not identify individual medical students.

MSC will collate information about appeals for the GMC in an annual report at the end of assessment cycle. This will enable the GMC to consider this information in the quality assurance of the assessment.

**Feedback and complaints**

Medical students must send feedback or complaints about the delivery of the AKT through their university’s existing procedures within any stipulated timescales. Any
complaints about individual questions should be flagged immediately to medical schools which will pass these concerns on to MSC. They will be considered by the MS AKT Exam Board in a timely fashion.

Complaints and feedback about the MS AKT delivery platform can be submitted by medical schools to the MSC through a designated email address. Medical students should ensure technical complaints are submitted to their medical school which will be responsible for communicating any concerns to MSC.

Medical students should send any complaints, feedback or concerns about the quality of the delivery of their university undergraduate medical programme, including teaching or supervision, to their medical school in the first instance. The GMC will consider general feedback about the quality of medical education but is unable to enter into a dialogue about a medical student’s individual circumstances.

**Timescales**

Timescales for handling appeals and complaints will be set out in standard operating procedures which will be developed throughout the piloting stage of the AKT.

**Mitigating circumstances**

**Purpose**

In relation to the MS AKT, this policy sets out:

- what universities mean by mitigating circumstances
- how mitigating circumstances will be dealt with for UK medical students
- non-exhaustive examples of circumstances that may or may not be considered mitigating.

All of the policies relating to the MS AKT have been put in place to facilitate this national assessment while acknowledging that there will inevitably be slight regional variations between medical schools. Additionally, medical schools will apply this policy on a case-by-case basis taking into account the circumstances of individual medical students.

**What universities mean by mitigating circumstances**

In relation to the MS AKT, mitigating circumstances are serious or significant events beyond a candidate’s control that adversely affect their performance or ability to attend or complete the MS AKT.

Each university has its own regulations around its approach to students whose performance in assessments might have been impacted by circumstances beyond the candidate’s control. These processes are sometimes called something other than mitigating circumstances eg extenuating circumstances or special circumstances but
they generally fit the definition set out above. There is no need for medical schools or universities to change the name of the process they use.

Some medical schools and universities consider appeals and mitigating circumstances through the same process. This is acceptable and the two policies set out for the AKT can be used in a single process.

UK universities with medical schools intend to work together over the next two years to align their definitions of what constitutes mitigating circumstances. However, it is important to note that the rules that apply to mitigating circumstances will ultimately be the rules set by the medical student’s university.

Some universities deem that all students presenting themselves are fit to sit the examination and their sitting will therefore usually be a valid attempt and count towards the maximum number of attempts stipulated by the university. Medical students must inform an invigilator immediately if, during the MS AKT, they become ill to the extent that their health is adversely affecting their performance or ability to complete the MS AKT. Some medical schools also allow students to self-certify that they have experienced mitigating circumstances. Where this is the case both these processes are deemed to be compatible with this policy covering the MS AKT.

Universities also recognise that there may be serious or significant events beyond a candidate’s control that affect their ability to demonstrate that they have met the standard of proficiency required in the MS AKT.

**Consequences of decisions on mitigating circumstances**

If mitigating circumstances are supported the attempt will not count towards a medical student’s permitted number of attempts. Please see the [Number of attempts](#) guidance for more details on this policy.

**Circumstances that may be considered to be mitigating circumstances**

In relation to the MS AKT, the following non-exhaustive list of circumstances may be accepted as mitigating circumstances by universities:

- acute mental or physical illness
- negative fluctuation of a known or undiagnosed physical or mental health condition or disability
- significant adverse personal circumstances, for example being a victim of crime or significant domestic disruption
- hardware or software problems
- serious illness or death of a family member or close relative
- jury service or legal requirement to participate in civil, criminal or regulatory hearings
- major travel disruption such as extreme weather events.

**Circumstances that might not be considered to be mitigating circumstances**

In relation to the AKT, the following non-exhaustive list of circumstances may not be considered as mitigating circumstances:

- minor transport disruption
- minor illnesses (such as coughs and colds)
- stress and anxiety caused by the MS AKT (unless supported by medical evidence)
- misreading or misunderstanding published MS AKT timetables, timings or location details
- the proximity of the MS AKT with other final assessments and examinations
- moving house or attending events (such as weddings) including those that are planned before MS AKT timetables are published
- holidays
- paid or unpaid (including voluntary) work.

**How mitigating circumstances are dealt with**

Medical students must apply through their university’s local procedure if they believe mitigating circumstances will adversely affect, or have adversely affected, their ability to complete the MS AKT or their performance during the MS AKT. They must apply within the timeframes stipulated by the medical school or university.

Medical students must provide the evidence required by their medical schools and universities to support applications for mitigating circumstances.

**Sharing information with MSC**

Medical schools will be asked to share the number of nullified attempts as a result of accepted requests for mitigating circumstances. This information will be sent to the GMC as part of the end of cycle report for the MS AKT. No personal information about medical students will be shared through this process.

**Reasonable adjustments**

**Purpose**

In relation to the MS AKT, this policy:
• sets out why reasonable adjustments must be made for students who are entitled to them
• explains why and how requests for reasonable adjustments for individual medical students will be dealt with by their medical school and parent university.

All of the policies relating to the MS AKT have been put in place to facilitate this national assessment while acknowledging there will inevitably be slight variations between medical schools. Medical schools will apply this policy on a case-by-case basis taking into account the circumstances of individual medical students.

**Why reasonable adjustments must be made for MS AKT candidates who are entitled to them**

*The legal requirement to provide reasonable adjustments for MS AKT candidates*

UK equality legislation provides protection against discrimination, harassment, and victimisation on the grounds of disability and other protected characteristics.

Reasonable adjustments must be made for students who require them because UK equality legislation places an obligation on organisations to provide reasonable adjustments, in certain circumstances, where not doing so would place a candidate with a disability at a substantial disadvantage relative to those without a disability.

*Making reasonable adjustments*

Organisations must take positive steps to make sure disabled learners can fully take part in education and other benefits, facilities and services. This includes:

• anticipating the needs of disabled learners
• thinking again if an adjustment has not been effective
• considering support on a case-by-case basis and deciding what adjustment(s) would be ‘reasonable’ for each person’s circumstances and the barriers they are experiencing.

There is no duty to make adjustments which are not considered reasonable.

Organisations must consider reasonable adjustment requests and make them where appropriate in order to comply with UK equality legislation and the GMC’s standards for medical education and training set out in *Promoting excellence*.

*Purpose of providing reasonable adjustments*

A person has a disability if they have a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.
For the MS AKT, a reasonable adjustment is a modification to the conduct of the MS AKT (for example, the provision of assistive equipment, changes to the physical environment, or changes to the way things are done, such as policies and procedures) to enable disabled students to meet the required standard set by the universities and regulated by the GMC.

UK equality legislation places no duty to make adjustments which would alter the standard of competence required. The standard of the MS AKT must apply equally to all medical students and reasonable adjustments must not affect a candidate’s ability to demonstrate they have attained the required standard of competence.

What is reasonable depends on the individual circumstances of each case. This is because the lived experience of a candidate’s disability and how it affects them day-to-day will differ according to the individual. The decision-making process for reasonable adjustments should reflect this, with decisions made on a case-by-case basis. Universities cannot set blanket policies for adjustments that may be considered reasonable for MS AKT students.

**Examples of reasonable adjustments**

As reasonable adjustments are considered on an individual, case-by-case basis, a diverse range of adjustments may need to be put in place for students. This may involve an accommodation or alteration to existing examination arrangements and rules where these contain barriers for students with disabilities. The GMC has set out a wide range of examples of reasonable adjustments as part of its guidance in *Welcomed and valued*. Examples include (but are not limited to):

- extra time
- rest breaks
- use of a scribe and/or reader
- alternative format or font for exam papers (hard copy or on screen)
- coloured overlays
- provision of an adjustable chair and/or desk/footrest/writing slope
- permission to eat and drink or to use medication, eye drops or inhalers during the examination
- scheduling so that a medical student does not take two exams in one day.

**Determining reasonable adjustments**

To support consistency in the decision-making process, those considering reasonable adjustment decisions should have due regard to the GMC’s guidance in *Welcomed and valued*. This guidance sets out what is expected of all medical education organisations.
with respect to disability and aims to help organisations consider how best to support disabled learners.

There is no checklist against which judgments can be made to determine what is reasonable. In *Welcomed and valued* the GMC notes that the following factors that should be considered when making reasonable adjustment decisions:

- how effective the change is at overcoming disadvantage
- how practicable changes are
- the cost of making changes
- the organisation’s resources
- the availability of financial support.

A UK primary medical qualification entitles the holder to provisional registration with a licence to practise from the GMC. The MLA’s competence standards are informed by this as they are based on the GMC’s *Outcomes for Graduates*. As explained above, adjustments should not be made where doing so would alter the standard of competence.

**UK medical students’ requests for reasonable adjustments for the MS AKT**

UK medical students must apply for reasonable adjustments for the MS AKT in line with their medical schools’ and/or parent universities’ policies and procedures for any assessment component of undergraduate medical degree programmes. This is so that a holistic approach is taken to adjustments that UK medical students need for any assessment component of their undergraduate programme, based on their individual needs.

Medical schools and/or their parent universities will consider and determine any applications by students for reasonable adjustments for the MS AKT in line with their policies and procedures, having due regard to the guidance and the approach advocated in *Welcomed and valued*. If a medical student disagrees with the outcome of a reasonable adjustment decision, they must follow their university’s processes for challenging the decision.

The guidance in *Welcomed and valued* highlights the importance of a process for balanced and fair decision making that will apply across all cases. One approach medical schools are encouraged to consider as good practice is the case management model. Medical schools and their parent universities can use the stepwise process advocated in *Welcomed and valued* to embed balance and fairness in their decision making on reasonable adjustments.

The MS AKT is intended to be an on-screen, campus-based exam. The MS AKT delivery
platform is designed to accommodate a broad range of the reasonable adjustments including commonly requested adjustments such as additional time and/or rest breaks and accessible text. MSC will endeavour to support all requests for reasonable adjustments that have been approved by a candidate’s medical school. For example, MSC will provide any length of extra time for this assessment that has been deemed reasonable by a medical school to mitigate the impact of student’s disability. Where the delivery platform cannot accommodate a requested adjustment MSC will work with medical schools and students to find an appropriate solution.

Some adjustments, particularly those relating to the physical test environment when the assessment is taken on campus, such as ergonomic seating or a quiet room, will be provided by the candidate’s medical school.

Examination misconduct

Purpose

In relation to the MS AKT, this policy sets out:

- universities’ expectations of medical students’ professional behaviour
- what universities mean by examination misconduct
- how concerns about suspected examination misconduct by UK medical students will be dealt with
- penalties for examination misconduct
- how information about exam misconduct will be shared with the MSC and GMC.

Universities’ and the GMC’s expectations of medical students’ professional behaviour

The MS AKT is an exam quality assured by the GMC. Both universities and the GMC require all medical students to act professionally in relation to the MS AKT. Unprofessional behaviour, such as cheating or gaining an unfair advantage, would undermine confidence in the MS AKT.

Fitness to practise at the point of registration

Medical students with a UK primary medical qualification are entitled to provisional registration and a licence to practise if their fitness to practise is not impaired.

Examination misconduct in relation to the MS AKT may bring into question a candidate’s fitness to practise as such behaviour falls below the standards of professional behaviour that the GMC and universities expect.
The GMC expects doctors to act with honesty and integrity

Patients must be able to trust doctors with their lives and health. To justify that trust, all doctors registered with the GMC must show respect for human life and make sure their conduct and practice meet the standards the GMC has set out in its core guidance, Good medical practice.

In relation to acting with honesty and integrity, the GMC states that all registered doctors must make sure that their conduct justifies their patients’ trust in them and the public’s trust in the profession.

The GMC and MSC guidance for medical students, Achieving good medical practice, shows how Good medical practice applies to them as students. Medical students are expected to mature while they are at medical school and learn about professionalism as they progress through their course. Understanding how the GMC’s core guidance for doctors applies during their course and in their future careers will help them be good students and, in the future, good doctors.

The GMC and MSC make clear in Achieving good medical practice that medical students are expected to act with integrity. The guidance highlights, in the section Professionalism – key areas for concern, that cheating and plagiarism, including sharing the details of questions or tasks from exams, are behaviours that may lead to FTP action being taken against students.

What universities mean by examination misconduct

In relation to the MS AKT, the following non-exhaustive list of behaviours may be considered to be unprofessional as they fall below the standards the GMC and universities expect; and, if proven, could amount to examination misconduct:

- sharing, or attempting to share, any MS AKT exam content not published as formative material by including on social media and other online fora
- not complying with the reasonable instructions of an invigilator or other examination official
- viewing, or attempting to view, the work of another candidate
- removing, or attempting to remove, materials or content (including through the use of recording devices) from an examination other than those specifically permitted
- bringing, or attempting to bring, materials or devices (including internet-enabled devices) other than those specifically permitted into the examination
- releasing, or attempting to release, content from any examination to a third party/commercial organisation
- communicating, or attempting to communicate, with another candidate while
under examination conditions

- gaining, or attempting to gain, information about the examination questions, other than any in the public domain, in advance of an examination date
- impersonating, or attempts to impersonate, a candidate
- bribery or attempted bribery (of another candidate, examination official or other relevant person)
- disruptive behaviour during an exam
- aiding or abetting, or attempting to aid or abet, any of the above.

**How concerns about suspected examination misconduct will be dealt with**

**How examination misconduct is detected**

In relation to the MS AKT, suspected examination misconduct may be detected and reported by:

- invigilators
- candidates
- university staff or other persons responsible for delivering the MS AKT in the UK or overseas at campuses of UK universities
- any other person who becomes aware of suspected examination misconduct
- any software used by MSC or the university to detect cheating during the MS AKT.

Anonymous reports of examination misconduct will only normally be acted on if there is supporting evidence. However, medical schools will investigate any information about examination misconduct brought to their attention.

**Examination misconduct**

Any suspected examination misconduct by a UK medical student will be dealt with under the medical school’s or parent university’s procedures for investigating and dealing with examination misconduct, unprofessional student behaviour or fitness to practise issues.

The release of scores to medical students may be delayed if a medical school is investigating a potential instance of exam misconduct.

This is so that a holistic approach to a medical student’s fitness to practise is taken and any previous instances of examination misconduct, fitness to practise history and/or unprofessional behaviours are considered.
Sharing information about exam misconduct

If a medical school suspects exam misconduct they may need to contact MSC to allow technical reports to be reviewed for anomalies detected by the exam delivery platform or an early indication of the candidate’s score. In these instances it is likely that a student will need to be named so that an investigation can take place.

In all other circumstances medical schools need not identify individual medical students but should supply MSC with:

- details of suspected examination misconduct during the MS AKT in the exam report they will submit to the MSC
- details of any concerns about examination misconduct that arise following submission of their exam report
- the outcome of any investigations.

This information must be shared to allow MSC to maintain the integrity of the items used in the MS AKT, improve the security of the online delivery platform where necessary and fulfil its obligation to GMC with respect to quality assurance of the MS AKT.

Medical schools should ensure that any suspected examination misconduct (whether during or after the MS AKT) is dealt with through either the medical school’s or the university’s procedures for dealing with concerns about examination misconduct, professional behaviours or fitness to practise (whichever is appropriate). Details of any investigation will be submitted to the GMC as part of the provisional registration process.

MSC will provide GMC with details of any instances of exam misconduct and any steps taken to address these as part of the annual report submitted at the end of the assessment cycle.

Penalties for examination misconduct

In relation to their students, medical schools and/or universities will apply penalties for MS AKT examination misconduct applicable under their procedures for dealing with concerns about examination misconduct, professional behaviours and/or fitness to practise (whichever is appropriate).

Declaring findings of examination misconduct

In relation to the MS AKT, UK medical students must declare any findings of examination misconduct and any penalty applied when they apply for GMC provisional or full registration with a licence to practise.
Appendix 12 – MSC online learning resources

The MSC currently offers several online learning resources to medical schools as part of their membership, including Virtual Primary Care, Speaking Clinically and CAPSULE. These learning resources have been mapped to *Outcomes for graduates* and will form a key source of support in helping medical schools to prepare medical students to sit the AKT.

**Virtual Primary Care**

Virtual Primary Care (VPC) is a general practice based educational resource offering access to diverse, real life primary care consultations recorded in NHS consulting rooms throughout the UK. The resource provides access to 150 videos which have been tagged by clinical condition, symptom and problem, by the [GMC’s *Outcomes for graduates* (2018)](https://www.gmc-uk.org/standards-and-guidance/standards-outcomes-for-graduates) and by the RCGP and SAPC’s *Teaching general practice* (2018). To ensure that the resource acts as an appropriate teaching aid, each video is accompanied by associated learning and discussion points as well as links to further reading.

Developed by the Medical Schools Council and the Society of Academic Primary Care Heads of GP Teaching Group, VPC has been designed to provide vital support to medical students training in a changed primary care environment as a result of the Covid-19 pandemic. The resource is an example of the extensive collaboration which has taken place between UK medical schools to ensure that medical students are supported to meet the learning outcomes of their courses. The educational material which accompanies the consultations in VPC has been written by clinicians and educators from over 30 UK and Irish medical schools and is annually reviewed for accuracy by the resource’s editorial board.

**Speaking Clinically**

The ability to make diagnoses by listening to patients describe their symptoms is one of the fundamental skills medical students need to acquire before they graduate as doctors. Speaking Clinically is a video archive of 900 patient interviews, forming a comprehensive learning resource of case studies of different diseases.

The resource provides medical students with the opportunity to listen to real patients talking about their diseases, furthering students’ understanding and practice. The patients talk frankly about their medical conditions and the videos are unrehearsed, capturing the nuances of communication. Each case is accompanied by a synopsis and links to further reading and theory where medical students can expand their knowledge of the relevant clinical condition.
CAPSULE

CAPSULE is a quiz-based learning resource designed to support undergraduate medical students in the application of medical knowledge in a clinical setting. The resource contains over 680 clinical cases which are mapped to Outcomes for graduates and linked to more than 3500 questions across 39 disciplines. The clinical cases cover all the clinical specialties encountered in years 4 and 5, including medicine, surgery, paediatrics, psychiatry, therapeutics, obstetrics and gynaecology, general practice and professional studies. Clinical case questions have multiple choice answers and cases are image rich with over 450 images including radiology, ECG and clinical photos.

This resource is the result of a collaboration between Brighton and Sussex Medical School (BSMS) and Ocasta, a learning technology company. The content has been written by senior clinicians within Brighton and Sussex Medical School. CAPSULE is reviewed and updated regularly by an editorial board and provided through dedicated high quality mobile applications on both Apple and Android phones as well as tablets and through the web. Throughout the Covid-19 pandemic the Medical Schools Council has sponsored CAPSULE for all UK medical schools and students to use free of charge.
Appendix 13 – Stakeholder engagement with this proposal

The following stakeholder engagement was sought to help inform this proposal. Task and finish groups with representatives from medical schools, foundation schools and the GMC were convened to help define the responsibilities and activities for the operational groups. In addition to the below, fortnightly meetings were held between the MS AKT task and finish group chairs, senior MSC staff and the MSC Co-Chair.

<table>
<thead>
<tr>
<th>Group</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>September 2020</strong></td>
<td></td>
</tr>
<tr>
<td>MLA Transition Group</td>
<td>Two meetings held. Membership includes senior GMC and MSC staff.</td>
</tr>
<tr>
<td>MSC Executive</td>
<td>The MSC Executive steers the work of the Medical Schools Council. Representatives are elected from the main MSC membership and is also attended by the GMC, Academy of Medical Sciences and AoMRC. A progress update was provided and feedback sought.</td>
</tr>
<tr>
<td>MSC Education Leads</td>
<td>A meeting of heads of education at UK medical schools. Presentations and progress on AKT and MLA discussions were shared.</td>
</tr>
<tr>
<td><strong>October 2020</strong></td>
<td></td>
</tr>
<tr>
<td>MSC Council</td>
<td>Heads of UK medical schools attend this meeting. The GMC and representatives from the BMA MSC also attend. A progress update was provided and feedback sought.</td>
</tr>
<tr>
<td>AKT Exam Construction Task and Finish Group</td>
<td>Membership includes medical school assessment experts. GMC in attendance. Proposed model presented for discussion and feedback.</td>
</tr>
<tr>
<td>AKT Standard Setting Task and Finish Group</td>
<td>Membership includes medical school assessment experts. GMC in attendance. Proposed model presented for discussion and feedback.</td>
</tr>
<tr>
<td>MLA Transition Group</td>
<td>Membership includes senior GMC and MSC staff.</td>
</tr>
<tr>
<td><strong>November 2020</strong></td>
<td></td>
</tr>
<tr>
<td>MSC Executive</td>
<td>A progress update was provided and feedback sought.</td>
</tr>
<tr>
<td>MSC Assessment Alliance Advisory Board</td>
<td>A progress update was provided and feedback sought.</td>
</tr>
<tr>
<td>MLA Transition Group</td>
<td>Membership includes senior GMC and MSC staff.</td>
</tr>
<tr>
<td>MSC Education Leads</td>
<td>A progress update was provided and feedback sought.</td>
</tr>
<tr>
<td>December 2020</td>
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<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>MSC Council</td>
<td>A progress update was provided and feedback sought.</td>
</tr>
<tr>
<td>AKT Policy Task and Finish Group</td>
<td>Membership includes medical school assessment and education experts. GMC and BMA MSC student representatives in attendance.</td>
</tr>
<tr>
<td>MLA Transition Group</td>
<td>Membership includes senior GMC and MSC staff.</td>
</tr>
<tr>
<td>AKT engagement sessions</td>
<td>Held by GMC with MSC attendance to assist with queries. These sessions invited medical school staff to comment on the AKT.</td>
</tr>
<tr>
<td>MSC AKT Newsletter</td>
<td>Newsletter to all MSC medical school contacts (academic and pastoral) with updates on current work. GMC also received this email. The newsletter discussed the development of task and finish groups, highlighted key documents and provided staff with a generic Q&amp;A for staff and students</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>January 2021</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MSC Exec</td>
<td>A progress update was provided and feedback sought.</td>
</tr>
<tr>
<td>MSC Assessment Alliance Advisory Board</td>
<td>Two meetings held. A progress update was provided and feedback sought on the proposals.</td>
</tr>
<tr>
<td>AKT Policy Task and Finish Group</td>
<td>Continuation of work.</td>
</tr>
<tr>
<td>MLA Transition Group</td>
<td>First draft proposal shared.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>February 2021</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AKT Exam Construction Task and Finish Group</td>
<td>Continuation of work.</td>
</tr>
<tr>
<td>AKT Standard Setting Task and Finish Group</td>
<td>Continuation of work.</td>
</tr>
<tr>
<td>MLA Transition Group meeting</td>
<td>Second draft proposal shared.</td>
</tr>
<tr>
<td>AKT Policy Task and Finish Group</td>
<td>Continuation of work.</td>
</tr>
<tr>
<td>MSC Education Leads</td>
<td>A progress update was provided and feedback sought. GMC colleagues presented at this meeting.</td>
</tr>
<tr>
<td>MSC Council</td>
<td>A progress update was provided and feedback sought.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>March 2021</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MSC Assessment Trustee Board</td>
<td>A progress update was provided and feedback sought.</td>
</tr>
<tr>
<td>MSC Assessment Alliance Reference Group</td>
<td>Heads of assessment from UK medical schools. This meeting took the form of a Q&amp;A session on the MS AKT.</td>
</tr>
<tr>
<td>Group</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------------------</td>
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</tr>
<tr>
<td>MLA Transition Group</td>
<td>Third draft proposal shared.</td>
</tr>
<tr>
<td>AKT Policy Task and Finish Group</td>
<td>Continuation of work.</td>
</tr>
<tr>
<td>MSC AKT Group Sessions</td>
<td>Four meetings held. These meetings were open sessions for medical school assessment and academic staff to ask questions and provide feedback about the MS AKT. Chaired by members of the MSC Assessment Alliance Advisory Board.</td>
</tr>
<tr>
<td>MSC Executive</td>
<td>A progress update was provided and feedback sought. A draft proposal was shared with the executive (medical schools only).</td>
</tr>
<tr>
<td>MSC Assessment Alliance Advisory Board</td>
<td>A progress update was provided and feedback sought.</td>
</tr>
<tr>
<td><strong>April 2021</strong></td>
<td></td>
</tr>
<tr>
<td>MSC AKT Group Sessions</td>
<td>Two meetings held. These meetings were open sessions for medical school assessment and academic staff to ask questions and provide feedback about the MS AKT. Chaired by members of the MSC Assessment Alliance Advisory Board.</td>
</tr>
<tr>
<td>AKT Policy Task and Finish Group</td>
<td>Continuation of work.</td>
</tr>
<tr>
<td>MLA Transition Group</td>
<td>Final draft proposal shared.</td>
</tr>
<tr>
<td>MSC Education Leads</td>
<td>A progress update was provided and feedback sought.</td>
</tr>
<tr>
<td>MSC Assessment Alliance Reference Group</td>
<td>A progress update was provided and feedback sought.</td>
</tr>
<tr>
<td><strong>May 2021</strong></td>
<td></td>
</tr>
<tr>
<td>MLA Transition Group</td>
<td>Final GMC feedback received.</td>
</tr>
<tr>
<td>MSC Council</td>
<td>Final proposal submitted for review to all heads of UK medical schools.</td>
</tr>
</tbody>
</table>

Table 10: Engagement with proximal stakeholders September 2020 – May 2021
Appendix 14 - Timeline (redacted)
### Appendix 15 – Glossary of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Common Content</strong></td>
<td>The use of a set of common single best answer items in graduation-level examinations at UK medical schools, and the comparison of the passing standards set for those items across schools.</td>
</tr>
<tr>
<td><strong>Education Leads</strong></td>
<td>The heads of medical education from UK medical schools. They work together as the MSC Education Leads on matters relating to medical education.</td>
</tr>
<tr>
<td><strong>epiGenesys</strong></td>
<td>epiGenesys is a software development company based in Sheffield, UK. epiGenesys developed and supports the Exam-Write platform and item bank.</td>
</tr>
<tr>
<td><strong>Exam-Write</strong></td>
<td>MSC’s exam delivery platform. This platform will be used to deliver the MS AKT. Exam-Write was originally developed through the MSC Assessment Alliance and created by epiGenesys.</td>
</tr>
<tr>
<td><strong>Final Review Clinical Group (FCRG)</strong></td>
<td>In order to enhance quality assurance processes, a Final Clinical Review Group (FCRG) was established by the MSC Assessment Alliance to provide a final quality control check on items in the Assessment Alliance Item Bank, thus ensuring that only high-quality items, without errors, are available for use by medical schools in formative and summative assessments, including those provided to schools as part of the Common Content project.</td>
</tr>
<tr>
<td><strong>Item bank</strong></td>
<td>MSC’s secure exam question bank. It is sometimes referred to as the MSC Assessment Alliance Item Bank as it was developed through this group and created by epiGenesys.</td>
</tr>
<tr>
<td><strong>MSC</strong></td>
<td>Medical Schools Council. The representative body for UK medical schools.</td>
</tr>
<tr>
<td><strong>MSC Assessment</strong></td>
<td>MSC Assessment is a registered charity (charity registration number 1153045) and a company limited by guarantee (company number 8578576). Since February 2014, MSC Assessment has delivered the assessment activities of the Medical Schools Council.</td>
</tr>
<tr>
<td><strong>MSC Assessment Alliance</strong></td>
<td>The MSC Assessment Alliance is a partnership to improve undergraduate assessment practice. This partnership consists of all undergraduate members of the Medical Schools Council. Often referred to as the Assessment Alliance.</td>
</tr>
<tr>
<td><strong>MSC Council</strong></td>
<td>A meeting of the heads of UK medical schools which steers the work of the Medical Schools Council.</td>
</tr>
<tr>
<td><strong>Prescribing Safety Assessment (PSA)</strong></td>
<td>An online assessment of the outcomes required of newly qualified doctors in Outcomes for Graduates as they relate to prescribing. Designed and delivered to medical schools by MSC Assessment and the British Pharmacological Society.</td>
</tr>
<tr>
<td><strong>Primary Medical Qualification (PMQ)</strong></td>
<td>For UK graduates, the Primary Medical Qualification (PMQ) is a first medical degree that is recognised by the GMC. The GMC provides a list of accepted PMQs.</td>
</tr>
<tr>
<td><strong>MS AKT</strong></td>
<td>The Applied Knowledge Test which will be taken by all students at UK medical schools.</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>UKMED</strong></td>
<td>UK Medical Education Database. It provides a platform for collating data on the performance of UK medical students and trainee doctors across their education and future career. See <a href="http://www.ukmed.ac.uk">www.ukmed.ac.uk</a></td>
</tr>
<tr>
<td><strong>Universities UK (UUK)</strong></td>
<td>Universities UK (UUK) works as the national voice of universities, helping to maintain the world-leading strength of the UK university sector. Its members are the vice-chancellors or principals of universities in England, Wales, Scotland and Northern Ireland. The Medical Schools Council is an associated organisation of UUK.</td>
</tr>
</tbody>
</table>

*Table 11: Glossary*
The Medical Schools Council is the representative body for UK medical schools.

www.medschools.ac.uk

© Medical Schools Council 2021
M6 – A proposal for a university-led applied knowledge test for students in UK medical schools as part of the Medical Licensing Assessment

Evaluation of the proposal

1. The MLA’s aim is to ensure that doctors seeking registration with a licence to practise medicine in the UK have met a common threshold for safe practice that is appropriate to their point of entry to the medical register. The introduction of the MLA brings a range of benefits:

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<tr>
<th>Patient safety and quality of care</th>
<th>Assurance for us and confidence for the public</th>
<th>Consistency and fairness</th>
<th>Upholding excellence in a time of change</th>
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<tbody>
<tr>
<td>The MLA will make sure that UK students and international candidates take assessments mapped to the same core knowledge, skills and behaviours for UK practice.</td>
<td>The MLA will assure us and the wider healthcare system that doctors have demonstrated the core knowledge, skills and behaviours that we require for their point of registration.</td>
<td>The MLA will improve consistency by introducing a shared set of topics to the assessments taken in UK medical schools and by international candidates.</td>
<td>As the number of UK medical schools and the number of overseas applicants continue to grow, the MLA will help to maintain the high standards required of doctors new to the UK register.</td>
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<td>The MLA will strengthen our ability to monitor and approve the standard for</td>
<td>The MLA will bolster the confidence that patients,</td>
<td>The MLA will improve fairness by introducing comparable assessment</td>
<td>The MLA will allow us to collect data and evidence on</td>
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</table>
entry to the profession over time. In this way, we will be able to ensure that our standards match patient need and doctors new to the register are well prepared to provide safe care.

| employers and colleagues can have in doctors new to the register, regardless of the medical school or the country where those doctors received their training. |
| experiences across UK medical schools and for international candidates. |
| which we can make the decisions that will help us contribute to the development of a diverse and sustainable medical workforce. |

2 We’ve evaluated the proposal at Annex A against a set of principles approved by the MLA Programme Board – the Senior Management Team and the senior responsible owner (the MLA assistant director). These principles and our headline evaluation against them are outlined below. As a result of this evaluation, we recommend that Council approves the proposal, subject to:

- medical schools and the MSC meeting the commitments given within the proposal and complying with the draft directions we’re inviting Council to make in relation to approval (Annex C);
- further development, piloting, and post-piloting refinement (see paragraph 4 below); and
- medical schools demonstrating compliance with the AKT requirements included in Assuring readiness to practice: a framework for the MLA.

3 We sought to work collaboratively with the MSC to develop the proposal. It has been an iterative process. We shared the criteria against which we have evaluated the proposal with the MSC at an early stage and have provided feedback and support as they developed and refined the proposal on behalf of medical schools. Feedback has been provided in a variety of ways: through group meetings, through individual conversations and in writing. We identified the aspects of the proposal that we regarded as areas of high priority in enabling us to take a view about whether we could confidently present the plans for a university-led AKT (the ‘MS AKT’) to Council as a model that would deliver the aim and benefits of the MLA and compliance
with the AKT requirements. We were clear where our feedback had to be actioned before the proposal could be recommended to Council, and where the feedback was more discretionary in nature or related to future work and planning.

4 Medical schools recognise that further development work remains to be done to refine the delivery model before it can be implemented in full, as would be expected before any new assessment is introduced. They’ve made commitments throughout the proposal to undertake this work. On the assumption that Council accepts our recommendation to approve the proposal, the draft directions at Annex C provide a mechanism for the GMC to monitor fulfilment of the medical schools’ commitments, and progress against delivery.

The principles

5 The table below sets out and describes the principles against which the MLA Programme Board agreed we should evaluate the proposal at Annex A. We shared these principles with Council when it discussed the MLA at its February 2021 seminar.

<table>
<thead>
<tr>
<th>Principle</th>
<th>What this means</th>
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<tr>
<td>Provides a single UK standard</td>
<td>There must be a single UK standard and commonality of content coverage across all medical schools. The MS AKT must be set for all UK medical students at a national standard appropriate for provisional registration. The standard for the MS AKT must be created using a recognised methodology and procedures. The standard setting processes must include a mechanism for maintaining a consistent level of challenge for each administration within a single year and over time.</td>
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<tr>
<td>Ensures GMC can be satisfied about the pass mark</td>
<td>The GMC can be confident and has overseen, or received evidence to demonstrate, that the level of performance required of candidates for a pass in the MS AKT reflects the standard of knowledge required in week 1 of F1. The GMC must have an active oversight role in overseeing the pass mark.</td>
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<thead>
<tr>
<th>Principle</th>
<th>What this means</th>
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<tr>
<td>Maps to MLA content map – and the AKT to sampling approach</td>
<td>In order to ensure consistency in the content coverage for all candidates, medical schools must ensure that all MS AKT test content is derived from the GMC’s MLA content map. To ensure fairness for all candidates, MS AKT content cannot include topics not included in the content map.</td>
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<tr>
<td>Allows the MLA to be evaluated and reviewed</td>
<td>Although medical schools will coordinate to deliver the MS AKT to their students, the GMC remains able to evaluate the performance and contribution of the MS AKT to the MLA overall. Mechanisms for data sharing are established.</td>
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<tr>
<td>Ensures GMC can take corrective action</td>
<td>Although medical schools will coordinate to deliver the MS AKT to their students, the GMC has regulatory oversight of the MS AKT to ensure compliance with its regulatory requirements and is able to take action if it identifies concerns about compliance with its requirements.</td>
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<tr>
<td>Operationally feasible</td>
<td>That all aspects of development and delivery of the MS AKT are appropriately planned and resourced to ensure the quality of the MS AKT, realisation of its aim and benefits, and candidates’ experiences of the AKT, are not undermined. When implemented, appropriate resources are in place to maintain delivery and maintenance of the MS AKT over time. The MS AKT is practically and logistically feasible for medical schools to deliver to their students.</td>
</tr>
<tr>
<td>Delivers a comparable test experience for candidates</td>
<td>The MS AKT delivers a fair and comparable test experience for all candidates so that the GMC is assured that the standard of proficiency required is maintained</td>
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6 The proposal also had to demonstrate how medical schools had considered equality, diversity and inclusion (ED&I) in all aspects of the MS AKT.
Evaluation of the proposal

The table below provides headline evaluation of how the proposal at Annex A meets the principles agreed by the MLA Programme Board and shared with Council, either in its current form or after subsequent development and refinement to which schools and the MSC are committed.

<table>
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<tr>
<th>Principles</th>
<th>Headline evaluation</th>
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<tbody>
<tr>
<td>Single national UK standard</td>
<td>The proposal gives assurance that medical schools will:</td>
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<td>- set a national standard through a recognised and widely used standard setting methodology; and</td>
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<td>- ensure that they maintain a consistent level of challenge for each administration of the MS AKT within a single year and over time.</td>
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The processes need, necessarily, to be piloted and refined in the light of piloting. The GMC will be actively involved in monitoring pilot progress and discussing piloting outcomes.

The GMC will have a regulatory role in:

- the development and implementation of the procedures, processes and policies through the MS AKT governance framework, and in the governance structure when the MS AKT has been launched;
- monitoring compliance with the AKT requirements; and
- taking action where compliance concerns are identified.
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<tr>
<th>Principles</th>
<th>Headline evaluation</th>
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| The GMC must approve any changes needed to the proposed standard setting methodology in the light of piloting, before the MS AKT is implemented and subsequently should any future refinements be needed. | The proposal sets out how medical schools intend to construct and standard set the MS AKT and how, through the governance framework, they will analyse and ratify pass marks and results. These processes need, necessarily to the piloted and refined in the light of piloting. The GMC will be actively involved in monitoring pilot progress and discussing pilot outcomes. The GMC will have a regulatory role in the development and implementation of the procedures, processes and policies through the MS AKT governance framework. The GMC will:  
  - observe the MS AKT Exam Board;  
  - oversee the work in the operational groups established to manage items (questions) for use in each MS AKT, construct the papers, set the standard for each paper, and conduct post-exam analysis to allow results to be ratified;  
  - participate in the overarching MS AKT Board;  
  - monitor compliance with the AKT requirements; and  
  - require mandatory changes where compliance concerns are identified.  
The GMC must approve any changes needed in the light of piloting to the proposed exam construction and standard setting methodologies, and pass mark and results management by the MS AKT Exam Board, before the MS AKT is implemented. |
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<tr>
<td>The GMC will receive an annual report, data and information, to allow it to be assured that the MS AKT has been conducted in accordance with the relevant AKT requirements, and to conduct quality assurance.</td>
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</table>
| Maps to MLA content map – and the AKT to sampling approach | Medical schools accept that the MS AKT must be mapped to the GMC’s MLA content map and that the exam construction methodology (which includes sampling) must be piloted to ensure that the MS AKT maps appropriately to the MLA content map. Medical schools will audit the question bank and ensure it contains sufficient items to cover the breadth of the content map.  

The GMC will have a regulatory role in the development and approval of the item development and exam construction processes. The GMC will:  

- observe the item development and exam construction groups;  
- monitor compliance with the AKT requirements;  
- require mandatory changes where compliance concerns are identified; and  
- approve the MS AKT sampling grid. |
<p>| Allows the MLA to be evaluated and reviewed          | Medical schools have committed to sharing report data with the GMC so that the GMC can effectively quality assure the MS AKT. They recognise in the proposal that medical schools’ internal quality processes, and feedback from the GMC as part of its oversight role, will together support the continuous improvement of the MS AKT, and they note that further work is needed to refine how this is accomplished. |</p>
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<td>They also recognise that data from the MS AKT will feed into the GMC’s wider evaluation of the MLA: they have committed to sharing data with UKMED and to identifying opportunities for undertaking research (separately or in collaboration with the GMC).</td>
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<td>Ensures GMC can take corrective action</td>
<td>The GMC will:</td>
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<td>- approve any changes to the proposal at Annex A which medical schools request in the light of piloting, and before the MS AKT is implemented;</td>
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<td>- observe all components of the MS AKT governance framework and operational groups during piloting phases and after implementation, to monitor compliance with the procedures, processes and policies approved by the GMC for use;</td>
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<td>- monitor compliance with the AKT requirements through its ongoing quality assurance mechanisms; and</td>
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<td>- require medical schools to make mandatory changes where compliance concerns are identified.</td>
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<td>Operationally feasible</td>
<td>The proposal accepts that the GMC’s regulatory oversight role includes approving the MS AKT’s processes before they go live in 2024 and assuring itself after go-live that schools are maintaining the approved processes. It recognises that, before and after go-live, this oversight may lead to the GMC requiring schools or MSC Assessment to act in relation to the GMC’s input.</td>
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<td>The proposal includes initial resource and pilot plans, and the team leading work on the proposal has shared its risk management plan (available as background material to this paper). These indicate that those coordinating the proposal are aware of the practical challenges involved in the MS AKT’s operational delivery. Medical schools have committed to working with the GMC to produce more detailed</td>
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<td>plans so that we have additional reassurance about the proposal’s operational feasibility and that piloting of the test coordinates as closely as possible with the GMC pilots of monitoring and QA processes.</td>
<td>However, the proposal stresses—and we accept—that that further detailed planning will be required both ahead of and during the development and piloting phase, to support resource planning and bolster medical school, MSC and GMC confidence in the proposal’s operational deliverability. For example, exam delivery processes, including the delivery platform, will need to be piloted and refined in the light of pilot findings. The GMC’s regulatory oversight role in approving the MS AKT’s processes before they go live in 2024 will include monitoring the practical deliverability of those processes.</td>
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<td>The proposal accepts the need for universities to maintain and direct the resources needed to support the MLA (in terms of both individual medical school staff and facilities, and financial support for the MS AKT’s central coordination) and notes that heads of UK medical schools are committed to this. It recognises that significant scaling up of administrative processes will be required within the MSC to deliver the AKT. It commits to regular reviews of how resources will be allocated, including during the piloting stage.</td>
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<tr>
<td>Delivers a comparable test experience for candidates</td>
<td>The proposal sets out how medical schools intend to construct and deliver the MS AKT. The MS AKT will comprise two papers, each paper will be two hours long (with provision for extra time for those who need reasonable adjustments) and contain 200 questions. All content will be drawn from the same question bank and must be mapped to the GMC’s MLA content map using the sampling grid approved by the GMC. However, medical schools will be free to choose whether their students sit the two papers on the same day or over consecutive days, which means test experiences might differ.</td>
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<td>Through the MSC, medical schools have developed a national MS AKT policy framework that will support a fair test experience. Decisions under this framework will necessarily take into account individual candidates’ personal circumstances (for example on reasonable adjustments and mitigating</td>
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<td>Principles</td>
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<td>circumstances) but the aim is to provide a consistent framework within which decisions will be made locally under university procedures. Medical schools have acknowledged in the proposal that this local application of the national framework will mean that some candidates might be treated differently. However, they will pilot the framework and refine in light of the pilot findings. Furthermore, through the MS AKT governance framework, medical schools will monitor the application of the policy framework and, in the light of the findings, discuss how they can increase consistency. This is included in their ED&amp;I action plan. The GMC will have a regulatory role in the development and implementation of the exam construction and exam delivery processes, and the policy framework through the MS AKT governance framework. The GMC will:</td>
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<td>■ observe the AKT Exam Board and other operational groups;</td>
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<td>■ monitor compliance with the AKT requirements; and</td>
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<td>■ require mandatory changes where compliance concerns are identified. The GMC must approve any changes needed in the light of piloting to the proposed exam construction and exam delivery processes, and the MS AKT policy framework, before the MS AKT is implemented.</td>
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<tr>
<td>ED&amp;I</td>
<td>Medical schools have woven ED&amp;I considerations through the proposal at Annex A to demonstrate how they have taken ED&amp;I into account as they have developed the MS AKT. They have also, through the MSC, undertaken an equality analysis which identifies both risks to, and opportunities for, advancing equality of opportunity. The equality analysis has an accompanying action plan which sets out how medical schools intend to mitigate the identified risks.</td>
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<tr>
<td>Principles</td>
<td>Headline evaluation</td>
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<tr>
<td>Responsibilities for ED&amp;I will be threaded through the MSC governance framework and the GMC will approve the relevant terms of reference. Medical schools have recognised the importance, and value, of sharing MS AKT data with UKMED, with a commitment to a data sharing agreement. This data will provide important evidence to support the GMC in taking forward the accelerated ED&amp;I KPIs that relate to medical education and training.</td>
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M6 – A proposal for a university-led applied knowledge test for students in UK medical schools as part of the Medical Licensing Assessment

Draft directions for Council to consider making

1. Any directions that Council makes in relation to the proposal at Annex A may only attach to the awarding bodies (in practice, the medical schools). But, given the basis of the proposal (which is for a collaboration between medical schools and Medical Schools Council [MSC]), Council may direct that the medical schools undertake activity through the proposed collaboration with the MSC.

2. The directions must be sufficiently specific, clear and reasonable so that medical schools are able to comply with them.

3. On the assumption that Council approves the proposal at Annex A, the table below contains draft directions for Council to consider making in relation to it.

Subject to medical schools fulfilling the commitments set out within its proposal dated May 2021, and in the covering sheet dated 14 May 2021, and complying with the directions set out below, in accordance with the provisions of s4(4) of the Medical Act 1983, Council approves the proposal for a collaboration between UK medical schools and the Medical School Council (MSC) (‘the proposal’) to deliver an applied knowledge test for students in UK medical schools (the ‘MS AKT’) as a way to meet the AKT requirements annexed to Assuring readiness for practice: a framework for the MLA.
This approval is based on Council’s assumption that medical schools will work with the GMC to develop and pilot the MS AKT for full implementation by 1 January 2024, and that the GMC will have regulatory oversight of the MS AKT. Council welcomes schools’ recognition that:

- the GMC’s regulatory oversight role includes approving the MS AKT’s structures, procedures, processes and policies before they go live in 2024, and assuring itself after go-live that schools are maintaining the approved structures, procedures, processes and policies; and

- before and after go-live, this oversight may lead to the GMC requiring schools, MSC or MSC Assessment to take action in relation to the GMC’s input.

Council directs that:

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<th>Council directs that:</th>
<th>Time frame</th>
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<tr>
<td>1. Medical schools, through the MSC, establish a joint GMC/MSC group with formal terms of reference to oversee the further work required to implement the MS AKT. In advance of the establishment of the governance structure outlined in the proposal, and running parallel to that structure as needed, the group will:</td>
<td>30 June 2021</td>
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<tr>
<td>a Develop a detailed project plan by 30 September 2021. The plan will demonstrate that piloting is feasible, inclusive of all UK medical schools participating in the proposal (including overseas programmes delivered by UK medical schools that lead to the award of a UK PMQ) and leads to reliable insights into the appropriateness of the design, mode of delivery, and national outcomes of the MS AKT.</td>
<td>(a) 30 September 2021</td>
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<tr>
<td>b Review pilot progress and how piloting outcomes inform subsequent pilot phases.</td>
<td>(b) to (l) Ongoing</td>
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<td>c Review progress on project milestones and any contingency planning required.</td>
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</table>
|   | d Review the risk management plan and how medical schools are identifying and managing risks. This will include risks around item, data and results security, schools’ readiness, and contingency planning.  
|   | e Review the resourcing plan to provide assurance that appropriate resources are in place to deliver and maintain the MS AKT.  
|   | f Review medical schools’ progress on establishing the MS AKT governance framework, the draft documentation needed to support its functions and how the framework aligns with the GMC’s framework to govern the wider MLA.  
|   | g Update the GMC on decisions taken on developing the MS AKT while the governance framework is being established.  
|   | h Review continuous improvement of the MS AKT model for delivery in 2024 in the light of feedback, including from the GMC.  
|   | i Consider research proposals, including opportunities for collaborative research and other work to enhance understanding of the standards and performance of the MS AKT and the GMC’s AKT for international medical graduates.  
|   | j Review progress on developing data sharing agreements with the GMC and UKMED.  
|   | k Review progress on the ED&I action plan.  
|   | l Consider any other issues required.  

2. Individual awarding bodies confirm to the GMC in writing that they intend to collaborate with other awarding bodies in line with the approved proposal.  

|   |   | 30 September 2021 |
3. Medical schools, through MSC, share information with the GMC throughout the pilot process, and provide a synoptic report at the end of each pilot session, covering pilot performance, the lessons learned from the pilot, the implications for the proposal as a result of the pilot findings, what changes are proposed to the proposal dated May 2021 for GMC approval and how these changes have been informed by testing and consultation with external stakeholders. The report should include:

   a. how medical schools are creating a national standard and will maintain it over time;
   b. medical schools’ readiness for implementation;
   c. psychometric analysis of cohort and test performance, including predicted national outcomes, outcomes by individual medical schools, and, where data are available, analysis of outcomes for candidates by demographic and protected characteristics;
   d. how medical schools are developing a comparable test experience for candidates (including exam format, delivery, level of challenge and policy framework); and
   e. the ongoing operational sustainability of delivering and maintaining the MS AKT.

   Throughout the pilot phase (information sharing) and at the end of each pilot phase (report)

4. Awarding bodies:

   a. inform the GMC if they no longer wish to collaborate with other awarding bodies in the approved proposal; and
   b. submit a plan for GMC approval to demonstrate how their MLA AKT will meet the GMC’s AKT requirements and incorporate regulatory oversight by the GMC.

Enduring
Equality, diversity and inclusion (ED&I) considerations

**UK equality legislation and approach to ED&I for the MLA**

1. The GMC and individual universities in the UK are subject to the public-sector equality duty (PSED) established by the Equality Act 2010. However, to meet our own responsibilities under the Act, we must understand how universities have addressed their legal obligations under equality legislation as part of their work to develop and deliver the AKT for their students.

2. We’ve worked with the MSC on producing an equality analysis (EA) on behalf of universities, which forms part of the formal proposal (pages 112-153 of Annex A). The universities’ EA focuses on the AKT for UK students. The analysis presents potential impacts on groups of UK students who share protected characteristics as a result of the introduction of the AKT and mitigating steps to limit these potential impacts. It also presents opportunities for advancing equality between groups of UK students who share protected characteristics and those who do not.

3. We’ve produced our own EA for the MLA programme as whole, which we’ve shared with Council as background information. It explores the potential impact on groups of all MLA candidates, both UK students and international medical graduates (IMGs), who share protected characteristics. We’ve also identified mitigating steps to limit any potential impacts on groups of MLA candidates who share protected characteristics, presented opportunities for advancing equality between groups of MLA candidates who share protected characteristics and those who do not, and noted wider ED&I work and ambitions within the GMC and across the wider sector that we must consider for the MLA.

1. Under the Northern Ireland Act 1998, Northern Ireland is covered by different PSED legislation to the rest of the UK and places its own statutory duties on public authorities.
Universities’ equality analysis of the AKT for their students

Overview of ED&I considerations

4 Universities’ EA, produced on their behalf by the MSC, focuses on the proposed design and delivery features of the AKT. This includes the proposed approach to:

- Exam format.
- Item development.
- Exam construction.
- Standard setting.
- Exam delivery.
- Evaluation and monitoring.
- The policy framework.

Addressing the potential ED&I impacts

5 In their EA, universities explore the potential impacts on groups of UK students who share protected characteristics as a result of the introduction of the MLA. This includes the potential impact on groups of UK students as a result of:

- the local, and varied, application of the policy framework for the AKT.
- the award gap that might be exposed in AKT scores, given existing evidence of award gaps in undergraduate education.

6 Within their EA, universities have developed an ED&I action plan in order to mitigate the potential impacts on groups of UK students who share protected characteristics. In the action plan for the AKT for UK students, universities have committed to:

- Developing a governance structure that embeds ED&I across all functions.
- Developing bespoke ED&I training for those involved in designing and delivering medical school assessments.
- Ensuring that images of clinical presentations in a range of skin tones are available in the AKT item bank and are tested within the AKT.
- Investigating how protected characteristics might be added to Single Best Answer (SBA) questions to embed diversity within them.
Monitoring the application of the AKT policy framework across UK medical schools to expose any differential or unfair treatment with a view to increase consistency over time. The framework will be piloted, data will be collected, and mechanisms will be in place through their AKT governance to consider refinements.

Establishing an approach to data and evaluation that allows medical schools to understand to extent of differentials in test performance across different groups of UK medical schools and, over time, address any award gaps.

**Opportunities for advancing equality through the MLA**

In recognition that compliance with the PSED requires a conscious approach and that general regard to the issue of equality is not enough to comply, in their EA, universities have identified several opportunities to advance equality between groups of UK students who share protected characteristics and those who do not. These include:

- AKT performance data provides the opportunity to enhance medical school awareness of the scale of award gaps both nationally and in their own institutions so that they can take steps to address any gap.

- The introduction of a policy framework for the AKT will increase consistency across medical schools in some key areas such as number of attempts students are permitted at the test. Universities, through the MSC, have committed to running best practice events to explore, with medical schools, how to implement the framework and how to mitigate any potential impacts identified within their EA.

**GMC’s equality analysis for the MLA**

**Overview of ED&I considerations**

In our EA, we focus on key features of the MLA that may lead to potential ED&I impacts. These features are:

- UK students and IMGs will sit different versions of the AKT. Although all AKTs (and CPSAs) will be mapped to the MLA content map, there will be important differences in the design and construction of AKT papers for each cohort.

- The MLA will introduce a common threshold that could be used to compare performance of UK medical students, and medical schools, at final examinations.

- The MLA for UK students will be embedded within degree programmes. These have their own distinct examination frameworks with varied approaches to policies such as number of attempts and reasonable adjustments. The MSC, on behalf of universities, has developed a national policy framework for the AKT that will be applied locally. While universities intend to move towards consistency over time, the local application of the policy framework may mean ongoing variation in some policy areas.
In the EA we explore in detail the potential ED&I impacts as a result of the introduction of the MLA. This includes the potential impact on:

a. IMG candidates\textsuperscript{2} as a result of there being one distinct approach for UK students and another for IMGs. The differences in approach mean that the AKT papers for each cohort will be made up of different items and set at different standards, supported by different policy frameworks.

b. UK medical students as a result of:
   i. local variation in the application of the policy framework for the AKT and
   ii. the potential to use MLA scores for ranking. While we have no intention of using MLA scores for ranking purposes, these data will be of interest to others, including educational researchers.

Addressing the potential ED&I impacts

In the EA we present steps for mitigating the potential impacts of the MLA on people who share protected characteristics. This includes:

- Embedding ED&I in the criteria developed to review whether the proposal for a university-led AKT can be recommended to GMC Council.
- Developing an effective governance structure for the GMC-owned elements of the MLA that will allow us to perform our regulatory oversight role and will give us assurance that regulatory action could be identified and taken on ED&I issues.
- Developing an approach to data, evaluation and monitoring that allows for proper and unbiased analysis and is able to expose differentials in test performance.
- Ensuring the GMC-owned MLA content map continues to reflect the essentials of safe practice, and adapts to changes in UK health needs, policy, and guidelines.
- Incorporating ED&I expectations throughout our AKT and CPSA requirements which will enable us to check that ED&I is considered in both parts of the MLA.

Opportunities for advancing equality through the MLA

Our EA also identifies several opportunities for advancing equality through the MLA. These include:

\textsuperscript{2} Of whom a large number are BME: between 2019 and 2020, almost 90\% of doctors who joined the register via the IMG PLAB route identified as BME.
The introduction of a common threshold for UK students means that unexplained differentials in performance will be exposed to a greater extent. This should encourage medical schools and the wider sector to look at how they can address these differentials and, over time, close the attainment gap.

The opportunity to advance equality with regards to disability and reasonable adjustments through advocating GMC *Welcomed and Valued* guidance as a best-practice approach to supporting all MLA candidates, including IMG doctors.

The role of the MLA content map in setting out the range of essential professional knowledge, skills and behaviours expected of all doctors joining the register.

Work on the CPSA, including developing global grade descriptors to support examiners’ unbiased decisions and developing station scenarios that are difficult to assess such as professionalism and ethics, which includes working to remove bias within stations.

**Wider ED&I considerations**

12 Our EA notes wider pieces of work relating to ED&I that we must consider. These include:

- The organisation’s accelerated focus of ED&I, which includes a target to: *eliminate discrimination, disadvantage and unfairness for all index measures of fair medical education and training pathways by 2031*. We’re working closely with the GMC’s central ED&I team to ensure we consider how the development of the MLA relates to and impacts this target.

- Work in the sector, such as the MSC ED&I Alliance set up to ensure diversity is better reflected in curricula and in all aspects of medical teaching and learning.
| Paper withheld from publication | Please note this paper is being withheld from publication prior to receiving Council’s approval.  
For further information, please contact the Corporate Governance team via email, GovernanceTeamMailbox@gmc-uk.org. |
<table>
<thead>
<tr>
<th>Action</th>
<th>To note.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>To report the work of the Audit and Risk Committee January - May 2021.</td>
</tr>
<tr>
<td>Decision trail</td>
<td>This report was considered by the Committee at its meeting on 12 May and is based on scrutiny and discussion from papers discussed on 28 January, 25 March and 12 May 2021.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>To note the report and the assurance provided by the work of the Committee.</td>
</tr>
</tbody>
</table>
| Annexes         | Annex A: Evaluation of internal audit performance  
Annex B: Head of Internal Audit Annual Report |
| Author contacts | Lindsey Mallors, Assistant Director of Audit and Risk Assurance and Freedom to Speak Up Guardian  
lindsey.mallors@gmc-uk.org, 020 7189 5188 |
| Sponsoring director/Senior Responsible Owner | Charlie Massey, Chief Executive  
charlie.massey@gmc-uk.org |
Background

1. The Audit and Risk Committee (the Committee) provides Council with independent assurance on the effectiveness of arrangements established by the Executive to ensure the:

- integrity of the financial statements
- effectiveness of the systems of internal control, governance and risk management
- adequacy of both the internal and external audit services.

2. The Committee has met remotely three times since its last report to Council, both in seminar and formal session. In January, we welcomed our two new members, Lara Fielden and Professor Suzanne Shale.

3. The meetings have been very much business as usual, with executives, relevant colleagues and observers in attendance. The seminars have focused on corporate social responsibility, value for money and the GMC’s data capability.

Current position on audit activity

4. Seven audit reviews have been completed since December Council meeting. Work continues to progress with the usual consideration of the business peaks and troughs and ongoing impact on colleagues of working remotely. Risk factors include taking account of how the GMC is responding to the pandemic and the potential impact on organisational systems of control.

5. Areas to bring to Council’s attention arising from the Committee’s responsibilities and activities are outlined below.

Risk management

6. Each year, as the trustees of a registered charity, Council is required to make a positive statement in the GMC’s Annual Report, confirming that the major risks to which the charity is exposed, as identified by the trustees, have been reviewed, and that systems have been established to mitigate those risks. The Audit and Risk Committee plays a key role in providing assurance to Council that risk management arrangements are in place and have operated effectively.

7. Last year was an unusual year and as reported previously, the risk landscape changed with the onset of the pandemic. The risk statement in the Annual
Report therefore explains how the focus on risk changed and the Committee’s role in providing scrutiny, support and assurance of the changes the GMC made in responding to new ways of working and the risks emerging. The Committee is able to confirm that the risk statement in the Annual Report is an accurate reflection of the risks that the GMC has been and continues to manage.

8 The Committee is able to fulfil its role with respect to assurance of risk management arrangements to Council by:

- conducting an unscripted, open risk discussion at the start of its meetings
- using risk as the basis for its approach to oversight and scrutiny bringing a balanced consideration of forward-looking risks and issues alongside its backward look at audit work to gain assurance on systems of internal control and risk management
- considering the Corporate Opportunities and Risk Register at each meeting
- overseeing delivery of an internal audit programme of work which is risk driven.

9 At its March meeting, the Committee briefly reflected on the threshold for reporting serious incidents to the Charity Commission, prompted by a discussion on a significant event review involving a European doctor who obtained registration fraudulently. The Commission describes a serious incident as one which results in or risks significant harm to people who come in to contact with the charity, loss of income or assets, damage to property or harm to reputation. Their guidance identifies ‘significant’ as meaning ‘significant in the context of your charity, taking account of its staff, operations, finances and/or reputation.’

10 The GMC has taken the view that to date, there have not been such events occurring which have been outside the context of its normal operations as a regulator of medical healthcare. The Committee asked that the Executive confirm the Commission’s expectations of us in line with our understanding and interpretation of their guidance. As a result, we will be refreshing our Significant Event Review policy to incorporate guidance on thresholds for referrals to the Commission.
Internal audit management arrangements

2020 performance

11 The 2020 annual evaluation of internal audit’s performance was completed in January. The performance review takes account of the views of Committee members, the Executive and auditees and assesses the key performance indicators for the internal audit service. Annex A provides the detailed evaluation.

12 Satisfaction with Internal Audit from all key stakeholders remains good. There is confidence in the Team’s work and contribution to GMC business, and audit continues to have visibility across the organisation. However, there are some warning signs which need to be addressed as performance has dipped in more recent years. A key factor has been the transition from Moore Stephens to BDO and a period of turnover at manager level.

13 Following the discussion at the January meeting, the BDO partner and Assistant Director have met with both the Chair of ARC and separately with the Director Resources. These conversations allowed for a more qualitative discussion and exploration of ideas and a focused quality action plan was shared with the Committee in March which we will monitor over the next 12 months.

14 BDO and the Assistant Director Audit and Risk Assurance, have worked closely to minimise the ongoing impact of the pandemic on ways of working, and maintain the quality and effectiveness of the internal audit service. Discussions are also underway to plan and manage audit work when lockdown restrictions ease and face-to-face contact is permitted.

Review of internal auditor provider contract and co-sourcing arrangement

15 The contract with BDO is due for renewal at the end of 2021. The Director of Resources, in consultation with the Chief Executive and Committee, has agreed to extend this for a further 12 months which is within the terms of the current contract. This will mean a full procurement exercise will need to be undertaken in 2022.

16 The co-sourcing model, introduced in its current format in 2013, has worked well for our context and significantly improved on internal audit arrangements prior to this time. The External Quality assessment conducted by the Institute of Internal Auditors in 2019 benchmarked the GMC’s internal audit function in the top quartile of performers. Extending the BDO contract for a further 12 months affords us the opportunity to consider whether a co-sourcing arrangement
remains the best fit for the GMC. A review of the model is being commissioned by the Director Resources with the Institute of Internal Auditors, and the scope agreed in consultation with the Chair of the Committee. The outcome of the review will be discussed by the Committee in the autumn.

Head of Internal Audit annual report

17 On 25 March, the Committee received the annual report and opinion from the Head of Internal Audit. The opinion is given in accordance with the Institute of Internal Auditors Practice guidance in the context of a risk-based audit programme which the Committee had agreed, and has been delivered with appropriate audit resources and skills.

18 The opinion was given against a backdrop of unprecedented external turbulence and in the context of an organisation testing its resilience in a period of change and uncertainty. The Committee was pleased to see that the opinion awarded substantial assurance on the effectiveness of the GMC’s arrangements in place to ensure delivery of corporate objectives. The full report is provided at Annex B.

Delivery of 2021 Internal audit programme to date

19 To date this year, the Committee has overseen the completion of seven audit reviews in line with the 2021 programme. In all cases, the Committee has scrutinised the audit findings and satisfied itself that the management actions proposed are appropriate.

20 The assurance ratings awarded to reports can range from red to green with red/amber, amber and green/amber in between and the ratings for completed audits are given in the following table.
<table>
<thead>
<tr>
<th>Audit review</th>
<th>Assurance rating</th>
<th>Number of recommendations (high priority)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Curricula approvals</td>
<td>Green amber</td>
<td>3</td>
</tr>
<tr>
<td>2 Anti-fraud arrangements</td>
<td>Green</td>
<td>3</td>
</tr>
<tr>
<td>3 Education quality assurance</td>
<td>Green</td>
<td>3</td>
</tr>
<tr>
<td>4 Procurement</td>
<td>Green amber</td>
<td>4</td>
</tr>
<tr>
<td>5 Legislative reform spot check</td>
<td>Not rated</td>
<td>2 (2)</td>
</tr>
<tr>
<td>6 Raising concerns arrangements</td>
<td>Green</td>
<td>1</td>
</tr>
<tr>
<td>7 Governance Team arrangements</td>
<td>Green amber</td>
<td>7</td>
</tr>
<tr>
<td>8 Payroll system</td>
<td>Green amber</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>29 (2)</strong></td>
</tr>
</tbody>
</table>

21 There were two high priority recommendations from the spot check on legislative reform (now known as regulatory reform). At the time of the fieldwork few formal programme and project management controls were in place and the recommendations relate to ensure these are established along with robust governance arrangements. A significant amount of work was underway and an update to the Committee in March provided some confidence that progress was being made.

22 However, the Committee remains concerned at the scale of the programme of activity needed to support regulatory reform and the continuing uncertainty around timeframes and what exactly will be required by government. A series of spot checks will take place throughout the life cycle of the programme to provide assurance on progress and direction - the next one in June. There are also scheduled updates for discussion at Council meetings.

23 Discussion on regulatory reform and the Committee’s recent focus on value for money, has again raised the question of whether there is sufficient financial scrutiny and oversight at ‘board’ level of the GMC’s strategic finances. The Committee is keen to ensure that this is given appropriate consideration in the emerging agenda on the regulatory reform proposals.
Reporting audit progress

24 At each meeting, the Committee received an audit progress report, including an update on the status of actions arising from internal audit work. At the time of this report there was one overdue action outstanding.

Significant event reviews

25 We have scrutinised one significant event review. Teodora Crisovan was a Romanian national who used fraudulent documentation to gain registration and a licence to practise in the UK. Once concerns were raised, the GMC responded promptly, protecting patient safety with an interim order (and subsequently erasure) and notifying the police of criminal action.

26 Crisovan was registered under a provision in the Medical Act that covers the registration of nationals from any one of the 29 countries in the EEA. Until the end of 2020 EEA nationals with recognised medical qualifications had an automatic entitlement to registration with the GMC. Since 1 January 2021, this is no longer the case and all EEA applicants now need to meet the same requirement as international medical graduates and have their medical qualifications independently verified before they apply for registration.

27 The Committee has also received a short report providing assurance of appropriate follow up of the actions agreed from significant event reviews which have been conducted over the last two years.

Trustees’ Annual Report and Accounts 2020

28 At its meeting on 12 May, the Committee scrutinised the Annual Report and Accounts 2020 and received the Audit Findings report of the external auditor. We are happy to recommend Council approve them. The Committee complimented the teams on the quality of both the financial statements and the Annual Report and noted that a discussion on the level of reserves will be brought to Council in 2022.

Raising concerns

29 In May we received the Freedom to Speak Up Guardian’s Annual Report 2020. This provides us with assurance on the GMC’s development of a safe, inclusive and transparent working environment and providing a confidential route for colleagues who want to raise a concern. The increase in concerns reported in 2020 suggests that colleagues have confidence in the FTSU initiative. We were
also pleased to note the integrated working and future initiatives on cultural development with ED&I, HR, learning and development and the staff networks.

Adding value

Continuing to increase its knowledge of the business and seeking assurance through audit and risk activity, the Committee believes it is improving its own performance and consequent value to the business. Auditees attending the Committee, unprompted, report that audit work have provides useful findings and learning which enables them to continually improve their activities. Observers at meetings also report that the Committee appears robust in conducting its business. Specifically, the Committee adds value through:

- Being clear on its role and purpose and continuing to check that this is still appropriate for the business’s needs.
- Developing agendas and a programme of work which are pertinent to regular business and emerging issues so that meetings are relevant and focused.
- Holding seminars which focus on continual development of the Committee’s knowledge and understanding of the business and specific risk areas.
- Providing scrutiny of the Corporate Opportunities and Risk Register and Corporate Issues Log.
- Holding management to account by calling directors and senior staff to meetings to respond to the findings from audit reviews and following through on the implementation of audit recommendations.
- Meeting internal and external auditors without management present.
- Regular dialogue between the Chair and Assistant Director of Audit and Risk Assurance between meetings.
- Dialogue between the Chair of Council and Chair of the Committee on emerging issues and sharing of key issues from each meeting with Council members.
- Inviting auditors to provide broader insight from global and national risk and audit trends in the financial, political and health environments.
- Providing a significant amount of time on agendas to reflect on broader opportunity/risk issues and horizon scanning.

31 By proactively exploring its remit and testing the level of assurance Council is receiving via the Committee to underpin its decision-making, the Committee is able to tailor its activities to ensure maximum value is achieved. Over the last three months this has included a more specific focus on cost, impact and effectiveness. We will continue to pay attention to these ingredients of ‘value for money’ as our work develops through the rest of the year.

Arrangements to appoint a new co-opted member

32 In July, Liz Butler, will be demitting office after serving two full terms as an independent member of the Committee. We would like to formally record our thanks to Liz who has brought her wisdom and shared experiences to the Committee’s scrutiny and challenge over the last eight years. A recruitment process has been completed, and Council will be asked to approve the appointment of her successor elsewhere in this meeting’s agenda.
Agenda item:

Report title: Review of Internal Audit performance 2020

Report by: Lindsey Mallors, Assistant Director Audit and Risk Assurance
lindsey.mallors@gmc-uk.org, 020 7189 5188

Action: To consider

Executive summary
Satisfaction with Internal Audit from key stakeholders remains good. There is confidence in the team’s work and contribution to GMC business and audit continues to have visibility across the organisation.

However, there are some warning signs which need to be addressed as performance over the last five years shows a downward trend. The Assistant Director Audit and Assurance and Partner, BDO, will be providing an action plan in March on how we plan to address the feedback.

When the pandemic took hold, the Assistant Director, Audit and Risk Assurance, took the decision that support for the work being undertaken at the right time was more important than meeting usual KPI deadlines. Flexibility on elapsed fieldwork schedules, reporting, and management response times were introduced and this has impacted on KPI performance.

Recommendation
The Audit and Risk Committee is asked to consider internal audit’s performance for 2020 and the reflections and learning for 2021.
Approach to review of internal audit performance

1 In line with previous year’s, the 2020 annual review of internal audit performance has been drawn from four sources of information:

- Committee satisfaction survey
- Executive satisfaction survey
- Auditee satisfaction survey
- Analysis of audit key performance indicators.

2 We use these sources to provide a rounded view of our stakeholders and hold ourselves to account against robust KPIs. Collecting the same data year on year allows us to see trends in performance over time identify areas for improvement. Our process was regarded by the External Quality Assurance Assessor who assessed the GMC’s internal audit function in 2019, as robust and of greater depth than the Institute of Internal Auditor’s own internal audit performance survey process.

Summary of findings

3 This is the second year of the second contract with BDO (previously Moore Stephens at the time of our tendering exercise). We have worked with Moore Stephens/BDO for 6 years in our co-sourcing arrangement and over this period have seen a strong and consistent level of satisfaction and performance.

4 This year has been dominated by the pandemic. After a short pause in audit work, as both BDO and the GMC adjusted activities and ways of working to adapt to the uncertainties in the external environment, the audit programme was re-designed to reflect the emerging risks and their impact on operational delivery. The Team believes it was flexible and adaptable in its approach. Whilst this has been acknowledged and appreciated by the Committee, Council and Executive, with hindsight, there was perhaps more consideration needed in explaining the work we were doing, and the timeframes involved with auditee team members below heads of section level.

5 Performance remains good in all forms of satisfaction measurement which perhaps, in part at least, reflects the values and commitment the GMC demonstrates to the audit colleagues it works with. However, there are some warning signals that the audit function needs to pay attention to. An extended analysis of internal audit performance over the last five years shows some areas of downward trend in satisfaction overall. As there is little qualitative data to draw from, it is difficult to pinpoint what the underlying causes of this may be but there is some insight to be gleaned from the comments provided by survey respondents, (particularly auditees)
and in reflecting on the contexts underlying the five years. Some initial observations and more detail are provided in Annex A.

6 Initial discussions have been held with BDO Partner, Sarah Hillary, and the analysis will be discussed in detail at the next contract meeting. BDO will also be offering private meetings with the Chair and separately, Director Resources, to elicit further feedback.

7 The following table summarises overall performance results for 2020.

<table>
<thead>
<tr>
<th>Respondent satisfaction to survey statements 2020</th>
<th>Committee members and Executive</th>
<th>Auditees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree 2019</td>
<td>37%</td>
<td>29%</td>
</tr>
<tr>
<td>Agree 2019</td>
<td>49%</td>
<td>54%</td>
</tr>
<tr>
<td>Neither 2019</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Disagree 2019</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>Strongly disagree 2019</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KPIs 2020 2019 in italics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scoping meeting held two-four weeks in advance 100% (100%)</td>
<td></td>
</tr>
<tr>
<td>Scope approved by sponsor five days in advance 93% (100%)</td>
<td></td>
</tr>
<tr>
<td>Close meeting held 100% (87%)</td>
<td></td>
</tr>
<tr>
<td>First report draft within ten days 93% (80%)</td>
<td></td>
</tr>
<tr>
<td>Management responses within ten days 71% (93%)</td>
<td></td>
</tr>
<tr>
<td>Final report within five days 71% (93%)</td>
<td></td>
</tr>
</tbody>
</table>

8 Learning for 2021

Whilst it has been an unusual year, audit activity moved swiftly and smoothly into a remote working arrangement. Overall, this has worked well in the circumstances, but we recognise that something is lost by not meeting colleagues face-to-face on at least some occasions through an audit, and by not being on site for the period of the fieldwork. Onsite presence provides the opportunity for picking up soft intelligence and getting a sense of the culture and working arrangements of a team. This is something all auditors will need to think about as the pandemic subsides and new ways of working are established on a permanent basis which may not be a direct full
time return to an office. We will need to give this consideration as we move through 2021 if working circumstances change.

9 Whilst overall the comments provided are useful there are areas we need to re-consider:

- earlier planning and scoping to allow auditors time to become more familiar with the GMC’s operations before beginning fieldwork
- better advance planning with teams in programming audit visits – this will require both parties to commit to dates further ahead and not then request them to be moved if dedicated resources have been made available for a fixed period or other things ‘come up’
- a continued search for benchmarking information and comparison with other BDO clients to promote learning and continuous improvement
- ensuring there are no surprises on any review to enable a smooth reporting and management response process.

10 We would also want to maintain all the positives noted this year, including:

- the robustness of scoping and planning discussions which continue to include building in for all visits the ‘value add’ identified by auditees
- the professionalism and conduct noted for audit team members
- the more frequent communication updates during the audit (daily catch ups for 15 minutes) which have been particularly important for effective remote working.

11 Both the Assistant Director Audit and Risk Assurance in their capacity as Head of Internal Audit and senior BDO colleagues, remain focused on delivering a service which is robust, independent, customer focused (recognising the various customer stakeholders) and professional. This is strengthened by a partnership working approach with the business and support for continuous improvement.

12 The next BDO contract meeting will provide an opportunity for us to discuss these results in greater detail and develop an action plan for the year ahead.

Committee and Executive satisfaction

13 There are more respondents to the surveys this year but overall there continues to be a good level of satisfaction with audit seen as adding value to GMC activities. However, there is an increase in the number of responses of ‘neither agree nor
disagree’ from Committee members which is of concern and is discussed in more detail below.

**Committee satisfaction**

14 Seven Committee members responded to the survey giving an 100% response rate (see Annex B). Overall members continue to be satisfied with internal audit performance and there are no areas of the survey where ‘disagree’ or ‘disagree strongly’ were noted. However, there are a considerably higher number of responses ‘neither agree nor disagree’ with at least one for every question except ‘I am confident in the internal audit annual opinion’ and 21 in total. This suggests that internal audit performance has slipped in the last 12 months when only one ‘neither’ response was received in total.

15 Of particular note are questions where there either 2 or 3 ‘neither’ responses:

- Internal audit reports are clear and accurate (Q1, 2 responses. The Curricula Approvals report on this meeting agenda is in a new format as we were already aware of this feedback)

- Internal auditors have the requisite expertise to effectively audit the GMC (Q6, 3 responses)

- Internal audit findings have led to improvements in management of key risk areas (Q12, 2 responses)

- Internal audit has a positive impact on governance, control and risk management (Q13, 2 responses)

- Internal audit has had a positive impact on achievement of GMC objectives (Q15, 3 responses).

16 There is one comment in the open commentary box which provides some helpful insight: ‘I do not think I have enough knowledge of how internal audit does business to answer these questions. I only see their output, not input.’ This suggests that the Assistant Director Audit and Risk Assurance and Partner, BDO, need to provide more general information to the Committee to provide assurance on the robustness of how internal audit functions. With new members joining the Committee, we have an opportunity to re-think how we do this going forward.

17 Notwithstanding the neither responses, the majority of respondents agreed or agreed strongly with every statement. Particularly strong responses, where five members strongly agree with a statement, are:

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[www.gmc-uk.org](http://www.gmc-uk.org)
- Reporting on the execution of the audit plan is clear, concise, reliable and accurate (Q2)

- The Head of Internal Audit has built strong relationships with the Audit and Risk Committee and the Executive (Q9)

- The Audit and Risk Committee and the Executive have an appropriate relationship and access to the audit supplier (Q10).

There is one supplementary comment provided which acknowledges the turbulence of the last ten months and internal audit’s flexibility in addressing the GMC’s assurance needs: ‘This has functioned well at a time of great change and turmoil. Thanks to all concerned.’

**Executive satisfaction**

- Six responses were received from Executive members – an 86% response rate (see Annex C). Overall satisfaction remains high with the majority of responses also being ‘agree’ or ‘agree strongly’. However, as last year, the balance of these is different to the Committee, with more responses being ‘agree’ (68 versus 30 for members) rather than ‘strongly disagree’ (17 versus 54 for members). However, there are no responses of ‘disagree’ or ‘disagree strongly’ and only five responses of ‘neither’ in total for the Executive.

- There is only one comment provided which suggests slight concerns that BDO do not really understand GMC business which caused some challenge during the audit process and subsequent dialogue around recommendations. This comment reinforces the Committee feedback where Q6 had three ‘neither’ responses to the statement regarding internal audit having the requisite expertise. It is not clear which audit review the executive comment refers to. However, inducting new BDO team members and providing sufficient upfront information about the area of audit remains a priority and ongoing challenge to ensure we maximise the benefit of their expertise and scrutiny whilst minimising the resource burden on auditee teams.

**Auditee performance satisfaction**

- Full details of the responses received is at Annex D and reflected under the three themes of planning, communication and conduct, and reporting, in the following table. Bracketed figures refer to 2019.
The results of the questionnaires suggest there continues to be general satisfaction with the knowledge, conduct and communication effort the audit team makes in delivering a customer service focused on providing assurance as well as adding value. However, for the second year running, there is a slight downward trend in terms of numbers of responses giving satisfaction levels of ‘agree’ or ‘strongly agree’.

The comments provide some useful insight. On planning we note the need to better understand the work of MPTS and the need to engage the audit team earlier in reviews in this area to give them the maximum opportunity to get to grips with the auditee’s systems and processes in advance of the fieldwork.

We also note the feedback in relation to the horizon scanning review feeling rushed and needing, from the auditee’s value perspective, to consider more fundamental questions (for example on engaging with key audiences, balancing knowledge dissemination with a role in making recommendations).

It is difficult to draw specific conclusions from the information as the audits and auditees differ from year to year, but, as noted previously, we will be considering the detailed analysis more carefully in the contract meeting.

All of the comments and feedback are useful to the ADA&RA and audit team and in line with our commitment to continuous improvement.

Key performance indicators

This year has been particularly challenging not only to keep audit work that was already underway going to a conclusion, but also in ensuring the timing and approach to the business with the learning work prompted support rather than barriers. We recognise that in many cases the audit focus burden fell disproportionately on those

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who were already extremely busy responding to the pandemic challenges across the business.

28 BDO and the GMC have worked incredibly flexibly to accommodate colleague’s personal situations, working hours and in some cases, limited capacity. We recognised that all of the above would have an impact on our KPIs for the year and the Assistant Director, Audit and Risk Assurance, took the decision that support for the work being undertaken at the right time was more important than meeting usual deadlines. To that end we deliberately introduced flexibility on elapsed fieldwork schedules, reporting, and management response times. This decision was supported by the Committee Chair at the time and regularly discussed with her in fortnightly update meetings as well as being noted at Audit and Risk Committee.

29 The KPI performance for 2020 reflects this flexibility. Whilst review planning and upfront preparations have continued overall to work well, there have been more difficulties with reporting stages. One report missed the 10 day KPI to have a draft report after the fieldwork, five reports needed further clarification and updated drafting, four exceeded the 10 day KPI for management responses to be provided to the recommendations and four missed the five day target to produce a final report.

30 It is clear that responding to the pandemic and working under the current arrangements is going to continue for some time. Whilst maintaining a focus on KPIs, the Assistant Director Audit and Risk Assurance will continue to be flexible, making judgements as to reasonableness of responses on a case by case basis, escalating to senior management and the Committee Chair if necessary.
Head of Internal Audit Annual Report
### Audit and Risk Committee meeting – 12 May 2021

**Agenda item**  
Head of Internal Audit Annual Report

<table>
<thead>
<tr>
<th>Action</th>
<th>To note</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>Each year the Head of Internal Audit provides a statement on the overall adequacy and effectiveness of the GMC’s systems of risk management, control and governance processes.</td>
</tr>
<tr>
<td><strong>Recommendation</strong></td>
<td>The Committee is asked to note the report.</td>
</tr>
<tr>
<td><strong>Annexes</strong></td>
<td>n/a</td>
</tr>
</tbody>
</table>
| **Author contacts** | Lindsey Mallors, Assistant Director Audit and Risk Assurance and Freedom to Speak Up Guardian  
Lindsey.Mallors@gmc-uk.org, 0207 189 5188 |
| **Sponsoring director/Senior Responsible Owner** | Neil Roberts, Director of Resources  
Neil.Roberts@gmc-uk.org, 0161 923 6230 |
Executive summary

The delivery of internal audit services and position within the governance framework

1 The GMC’s internal audit service continues to be delivered through a co-sourcing model. The Head of Internal Audit (HOIA) role is carried out by the Assistant Director of Audit and Risk Assurance (ADA&RA), supported by BDO LLP as the external supplier audit team. Internal audit work has been planned and conducted in accordance with the International Standards for the Professional Practice of Internal Auditing and reflects the ethos of the Public Sector Internal Audit Standards, which include the requirement for an annual report from the ‘Chief Audit Executive’. An external quality assessment conducted by the Institute of Internal Auditors in late 2019 evidenced that the GMC internal audit conforms to the Institute of Internal Auditor’s standards.

2 The Council is responsible for the GMC’s system of internal control, governance and risk management in delivering the organisation’s strategic aims. It has put in place arrangements to provide assurance on the overall effectiveness of delivery of the corporate objectives and the internal audit function supports the assessment and understanding of how well those arrangements are working in practice.

3 Internal audit is also a stimulant for positive change, supporting continuous improvement and providing opportunities for shared learning across the organisation. This independent, objective and evidenced based HOIA opinion contributes to the assurance available to the Chief Executive, Executive, Audit and Risk Committee and Council in making their own assessment of the effectiveness of the arrangements in place.

Head of Internal Audit opinion

4 This opinion is given in accordance with the Institute of Internal Auditors Practice Guide: Formulating and Expressing Internal Audit Opinions. The planned audit programme for 2020, which was approved by the Audit and Risk Committee in November 2019, was based on the risks facing the GMC at that time. Subsequent to the COVID-19 pandemic in March 2020, the audit programme was halted temporarily as the organisation made its immediate response to the government guidance and announcements on national lockdown. This decision was made in conjunction with the Committee Chair. A revised programme of internal audit activity, adapted to focus on the emerging threats created by the pandemic, was subsequently agreed by the Committee and notified to Council.
The revised programme of work focused on addressing risks in relation to the delivery of activities during the pandemic and the organisation’s response to changes in ways of working. The audit approach has adopted two lenses. The first is one of assurance with regard to areas of statutory activity. The second is drawing out the learning from the GMC’s response to the pandemic to capture lessons which might inform future recovery decisions and provide consideration for longer term ways of working. This aligned with the GMC’s commitment to protecting patients, supporting the profession and supporting its own workforce.

The opinion for 2020 is therefore given against a backdrop of unprecedented external turbulence. It is not given on the basis of individual audit review and learning results, but in the context of an organisation testing its resilience in a period of change and uncertainty. Each review took an individual approach and was commissioned using the audit team’s knowledge of the business, risks and management information. Scoping activity involved senior management and auditees in the preparatory stages whilst maintaining independence and control of all audit activity and reporting.

Overall substantial assurance can be given that those systems in operation during 2020 were generally well designed and working effectively to ensure the achievement of the GMC’s objectives. 2020 was an unprecedented year in terms of turbulence, uncertainty and change. The GMC adapted well to meet the risks it faced and has identified areas of opportunity for the future as it recovers from the pandemic and plans its renewal.

Systems of governance, risk management and internal control in operation during 2020 were generally well designed and working effectively to ensure the achievement of the GMC’s objectives. There have been no areas of major failure identified. Risk management systems have been robustly tested. Risk thinking and the ability to adapt systems of governance and operational processes at speed were demonstrated evidencing the organisation’s resilience when faced with unplanned and unexpected external events. There have been no instances during the year which have required reporting to the Charity Commission.

This opinion is based on:

- Outcomes of the audit and learning reviews for 2020.
- Management’s approach to implementation of the recommendations raised in audit reports.
- Outcome and analysis of three significant event reviews undertaken in 2020.

- Insight into the control environment through:
  - Arrangements for setting and monitoring business objectives.
  - Risk management.
  - Information for decision-making.
  - Performance reporting.
  - Financial management and reporting.

10 The full year audit and risk costs were £383,546 (£418,916 in 2019) in the draft accounts against a budget of £391,674 (£406,916). Audit delivery supplier costs were £206,000 against a budget of £205,000.

**Detailed audit activity**

11 The risk-based audit programme comprises operational compliance audits, spot checks for short targeted reviews, and audit work on areas with a clear key strategic impact – for example a major change programme such as the restructure to deliver the Outreach service. All reviews are reported to the Committee as they are completed along with an update on the implementation of previously agreed audit actions at each meeting. In total, internal audit delivered 10 audits, six learning reviews and two pieces of follow up work.

**Analysis of 2020 programmed reviews**

12 The individual reviews are noted in the table below. The audit ratings where given, are based on a five-point scale of green through to red.
### Audit review

<table>
<thead>
<tr>
<th>Audit review</th>
<th>Assurance rating</th>
<th>Number of recommendations (high priority)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  2019 audit recommendations follow up</td>
<td>Green</td>
<td>0</td>
</tr>
<tr>
<td>2  Interim orders tribunals</td>
<td>Green amber</td>
<td>12</td>
</tr>
<tr>
<td>3  Business planning and budgeting spot check</td>
<td>Green amber</td>
<td>3</td>
</tr>
<tr>
<td>4  Outreach implementation</td>
<td>Amber</td>
<td>7</td>
</tr>
<tr>
<td>5  Contract management</td>
<td>Green amber</td>
<td>16</td>
</tr>
<tr>
<td>6  BS10008 (delivered by a separate external supplier)</td>
<td>1 minor non-conformity*</td>
<td>3 opportunities for improvement</td>
</tr>
<tr>
<td>7  Horizon scanning</td>
<td>Amber</td>
<td>2</td>
</tr>
<tr>
<td>8  Strategic Communications and Engagement risk arrangements</td>
<td>Amber</td>
<td>3</td>
</tr>
<tr>
<td>9  Cyber security</td>
<td>Amber</td>
<td>3 (1)</td>
</tr>
<tr>
<td>10 Risk management</td>
<td>Green</td>
<td>0</td>
</tr>
<tr>
<td>11 ISO27001</td>
<td>Green amber</td>
<td>5</td>
</tr>
<tr>
<td>12 Pandemic learning - Temporary registration</td>
<td>Green</td>
<td>7</td>
</tr>
<tr>
<td>13 Pandemic learning - Virtual hearings</td>
<td>Green</td>
<td>0</td>
</tr>
<tr>
<td>14 Pandemic learning - Governance and decision-making</td>
<td>No rating</td>
<td>N/A</td>
</tr>
<tr>
<td>15 Pandemic learning - Planning for recovery and renewal</td>
<td>No rating</td>
<td>N/A</td>
</tr>
<tr>
<td>16 Pandemic learning - Working arrangements</td>
<td>No rating</td>
<td>N/A</td>
</tr>
<tr>
<td>17 Pandemic learning – Summary review</td>
<td>No rating</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>58 (1)</strong></td>
</tr>
</tbody>
</table>

*Relates to a single identified deviation from the documented policy and procedures or the requirement of the standard that in itself is not as a serious issue.

13 In addition to programmed reviews, two additional pieces of follow up work were undertaken. The first was in relation to action agreed following the Infected Blood Inquiry learning review and the second was in relation to actions agreed from significant event reviews over the last two years. In both cases,
appropriate follow up was either completed or in hand in the majority of cases. Actions which are still being implemented related largely to ongoing longer-term policy work following the significant event review about a fraudulent doctor, Zholia Alemi.

14 The work undertaken in 2020 raised 58 recommendations with one high priority recommendation arising in the cyber review. Cyber security penetration testing forms an annual part of the assurance programme. This year the testing by BDO Cyber Security focused exclusively on raising staff awareness through phishing tests – a common tactic used by hackers. To maximise the benefit of the test, unlike previous exercises, IT controls were allowed to be bypassed and there was no IS intervention.

15 This test led to a much higher number of staff clicking on the link within the phishing email than during previous phishing exercises. Management believe that this higher click-rate reflects the fact that the IS controls were allowed to be bypassed. The high priority recommendation which arose from the audit was that a review of the current training was timely and there was a need to remind staff of the incident reporting arrangements.

16 The Assistant Director Audit and Risk Assurance separately commissioned an independent review of the GMC’s BS 10008 (the British Standard for best practice in the implementation and operation of electronic information management systems) to which the GMC became fully accredited in 2016. The GMC is one of only a few organisations to hold BS 10008 accreditation. As in previous years, the independent reviewer was complimentary about the work of the Team concluding that the information management system at the GMC is effective in ensuring the trustworthiness of electronic information. In particular, they noted that the implementation of the Pandemic Business Continuity Plan had not affected the information management systems and demonstrated that change could be made and sustained in a controlled manner.

17 In November 2020 the GMC and MPTS again successfully achieved re-certification to the ISO 27001 standard. ISO 27001 sets out the requirements for a comprehensive set of controls based on best practice in information security management systems. This provides independent assurance of the GMC’s ongoing commitment to the protection of the information it holds.

18 Stepping back and taking an overall view of the results of the audit work completed in 2020 demonstrates that the GMC is a resilient organisation with a core purpose of patient safety which is well understood across the workforce. Evidence shows:
mature risk management arrangements underpin confidence and ability to adapt quickly to external environment challenges

new processes and operationalisation of systems and controls were developed at speed and with flexibility to meet the requirements of temporary registration

the flexibility to switch delivery platforms for MPTS hearings from in person to mostly virtual hearings occurred within three days

a ‘can do’ attitude and culture of continuous learning and improvement. The GMC recognises that it has an opportunity to change the way it works and how it can influence the wider health system and increase efficiency and impact. Examples include:

a continuing virtual hearings in MPTS

b changes in registration ID checks

c revisiting fitness to practise thresholds.

Culturally, the pandemic and the need to make quick decisions has forced the GMC to apply a more pragmatic approach to the level of detail applied to much of its work reserving the priority effort where it is necessary and the risk is highest. It has sharpened the focus on the importance of prioritisation and a more structured and disciplined exercise is now being carried out to embed the learning into a tangible outcome.

Spot checks

One spot check was conducted to consider progress in implementing changes to the business planning and budgeting processes based on recommendations made from previous audit reviews. The spot check concluded that the business planning and budgeting project was in its early stages and a more detailed project plan was needed to meet the 2020 delivery target. A working group had been set up to address this. Since the review was completed, this work has concluded and a three year business plan and budget has been published alongside the new Corporate Strategy 2021-2025. There is also now an established process in place for the scrutiny of new initiative bids or requests for other additional funding.
Significant event reviews

21 A significant event is where an incident did or could have had the potential for a material adverse effect on the organisation. Carrying out a review allows identification of how the incident occurred and the learning from this to strengthen controls for the future where appropriate. The Audit and Risk Assurance function provides guidance, support, challenge and independent quality assurance over significant event reviews (SERs), their findings and action plans.

22 There have been two SERs during 2020 which sadly involved the death of a doctor. The first was in relation to a doctor who died from natural causes and a hearing was held for the doctor after his death. The doctor had notified the GMC that they would not be attending the hearing in person and therefore there was nothing to indicate on the day of the hearing that there may have been a change in circumstances. The second one related to the suicide of a doctor following an interview with the police, suspension by their employer and being referred to the GMC. In both of these cases, appropriate policies and procedures were followed.

23 A third SER related to a Romanian national, who used fraudulent documentation to gain registration and a licence to practise in the UK. Once concerns were raised, the GMC responded promptly, protecting patient safety with an interim order and notifying the police of criminal action.

24 The individual was registered under a provision in the Medical Act that covers the registration of nationals from any one of the 29 countries in the EEA. Until the end of 2020 EEA nationals with recognised medical qualifications had an automatic entitlement to registration with the GMC. Since 1 January 2021, this is no longer the case and all EEA applicants now need to meet the same requirement as international medical graduates and have their medical qualifications independently verified before they apply for registration. The GMC is also able to require EEA doctors to provide evidence of their English language skills upfront before they apply for registration.

25 The internal review concluded that the restrictions in place at the time of the individual’s application which meant the GMC was unable to primary source verify qualifications of EEA applicants, their EEA application information being provided online and the changes in identity check arrangements in place in response to COVID, were a combination of factors which created opportunity for the fraud to go undetected.
26 The frequent phone calls from the individual may also have been a deliberate ploy to pressure staff in to feeling hurried in their assessments of their information. This type of social engineering tactic is increasingly used by criminals to create a sense of urgency which may lead an organisation’s employees to take ‘short cuts’ or make mistakes through feeling pressured and stressed by an insistent caller. One of the outcomes from the review is that refresher fraud awareness training will be run on a more regular basis going forward to keep abreast of the complex and sophisticated techniques fraudsters develop.

27 Staff are trained to identify obvious falsification, but this was a complex fraud and the individual had gone to some lengths to create a complete suite of fabricated documents and references. Having re-reviewed the evidence submitted online with the hindsight of a fraud having been committed, Registration colleagues are reasonably confident that an in-person ID check would have identified the medical qualification document as fraudulent. Pre-registration verification checks by the GMC’s established partner would also have identified that the qualifications submitted were not genuine.

28 The Charity Commission requires the GMC to report serious incidents as defined by their trustee guidance:

- harm to people who come into contact with your charity through its work
- loss of your charity’s money or assets
- damage to your charity’s property
- harm to your charity’s work or reputation.

29 There were no such incidents to report in 2020.

Risk management

30 As evidenced by audit review, risk thinking is inherent in discussions and operations at all levels of the business. There is a mature set of risk management arrangements embedded in day-to-day activities and risk registers are used as a tool for identifying, articulating, monitoring and managing operational and project risks.

31 Risk thinking is also integral to the work of the Audit and Risk Committee. It’s open forum risk discussion at the start of every meeting provides the opportunity to consider both current risks the GMC is facing and emerging areas
in the wider external environment which may impact on its activities and whether these are appropriately captured in the Corporate Opportunities and Risk Register.

32 During 2020, the wider context has been dominated by the pandemic and whilst responding to the pandemic raised some significant challenges, it also brought opportunities to look at how business is managed and ways of working, both as a regulator and an employer. The priority focus for the organisation throughout the year has been to protect patients, support the medical workforce, and the health and wellbeing of its own colleagues. The audit series of independent learning reviews found that the GMC was widely regarded internally and externally as having handled the pandemic crisis well.

33 Alongside managing the response to the pandemic other risk priorities have continued to progress, including:

- driving work forward on Supporting a profession under pressure programme as part of the commitment to becoming a proactive regulator
- managing preparations for the impact of Brexit
- preparing for introduction of the Medical Licensing Assessment in 2023
- responding to a range of important public investigations and inquiries, such as the Independent Neurology Inquiry in Northern Ireland, the Shrewsbury and Telford investigation on maternity care and the Inquiry into the death of Elizabeth Dixon.

34 The ability to handle such diversity of risks and continually scan the wider external horizon for emerging threats and opportunities against the pandemic backdrop, illustrates the maturity of the GMC’s risk handling. It’s clarity of focus as issues have emerged over the last 12 months, the ability to stand back and take stock from an organisational wide perspective and maintain an appetite for learning as it has gone through the year, describe a resilient organisation with well embedded risk management arrangements which support a confidence to act quickly and flexibly in a dynamic world.

Quality management of internal audit

35 The performance of internal audit is kept under ongoing review and is drawn from three sources of information - ARC member and Executive satisfaction questionnaire, auditee satisfaction questionnaires and analysis of audit key performance indicators.
36 Overall, the results of the questionnaires continue to be positive and reflect the effort the audit team makes in delivering a customer service focused on providing assurance as well as adding value. The co-sourcing arrangement works effectively and relationships between the Head of Internal Audit and the Committee and Executive remain strong. Internal audit continues to be visible across the organisation and is seen to have a positive impact on the achievement of GMC outcomes.

37 Whilst it has been an unusual year, audit activity moved swiftly and smoothly into a remote working arrangement. Overall, this has worked well in the circumstances, but something is lost by not meeting face-to-face on at least some occasions through an audit, and by not being on site for the period of the fieldwork. Onsite presence provides the opportunity for picking up soft intelligence and getting a sense of the culture and working arrangements of a team. This is something all auditors will need to think about as the pandemic subsides and new ways of working are established on a permanent basis which may not be a direct full time return to an office. As we move in to 2021, we will be looking at ways to gather some of this softer intelligence, for example, through the use of team-based questionnaires when audits are taking place.

38 A summary of internal audit performance for the year is given in the following table.
<table>
<thead>
<tr>
<th>Respondent satisfaction to survey statements 2020</th>
<th>Committee members and Executive</th>
<th>Auditees</th>
<th>KPIs 2020 2019 in italics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree 2019</td>
<td>37% 48%</td>
<td>29% 41%</td>
<td>Scoping meeting held two-four weeks in advance 100% (100%)</td>
</tr>
<tr>
<td>Agree 2019</td>
<td>49% 50%</td>
<td>54% 44%</td>
<td>Scope approved by sponsor five days in advance 93% (100%)</td>
</tr>
<tr>
<td>Neither 2019</td>
<td>13% 2%</td>
<td>13% 10%</td>
<td>Close meeting held 100% (87%)</td>
</tr>
<tr>
<td>Disagree 2019</td>
<td>0% 1%</td>
<td>4% 4%</td>
<td>First report draft within ten days 93% (80%)</td>
</tr>
<tr>
<td>Strongly disagree 2019</td>
<td>0% 0%</td>
<td>0% 1%</td>
<td>Management responses within ten days 71% (93%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Final report within five days 71% (93%)</td>
</tr>
</tbody>
</table>

Performance remains good in all forms of satisfaction measurement which reflects the values and commitment the GMC demonstrates to audit work. However, there are some warning signals that the audit function needs to pay attention to. An extended analysis of internal audit performance over the last five years shows some areas of downward trend in satisfaction overall. There is little qualitative data to draw from in the survey responses, but further insight has been provided through discussion with the Chair of the Committee and the Director Resources. This suggests that the merger between Moore Stephens and BDO caused some unexpected changes and over a period of 15 months, the lead audit manager changed four times creating some instability in the relationship. A Quality Action Plan has been developed to addresses the feedback. Actions include:

- earlier planning and scoping to allow auditors time to become more familiar with the GMC’s operations before beginning fieldwork
a continued search for benchmarking information and comparison with other BDO clients to promote learning and continuous improvement

the Partner from BDO meeting quarterly with the ARC Chair.

On the positive side, the business continues to recognise the value audit contributes to GMC business and the professionalism and conduct of team members. Internal audit remains focused on delivering a service which is robust, independent and customer focused (recognising the various customer stakeholders). This is strengthened by a partnership working approach with the business and support for continuous improvement.

As part of the ongoing quality assurance of audit work, as well as BDO’s own internal arrangements, the Assistant Director of Audit and Risk Assurance would usually visit BDO offices to review a sample of audit working papers. The proposed visit last March was unable to go ahead as planned. Instead, at the request of the Assistant Director, BDO undertook their own review using the GMC’s framework. The results highlighted the improvements that had been made since the last quality assurance visit and overall, the audit files were in good order with work generally undertaken in line with the audit methodology. A full QA visit will be planned as soon as BDO and GMC offices are re-opened. In the meantime, BDO is currently undergoing their formal five-year External QA review and the results will be shared in due course.

Independence of the Assistant Director Audit and Risk Assurance

It is important that the Assistant Director Audit and Risk Assurance (ADA&RA) is, and is seen to be, independent of management decision making. To facilitate this, the role is accountable to the Chair of the Audit and Risk Committee with audit responsibilities to the Chief Executive and day-to-day line management through the Director Resources.

To maintain independence from the responsibilities for risk which sit with the ADA&RA, the scope and report for the internal audit risk management review were agreed directly with the Chair of the Committee. If the ADA&RA is involved in delivering audit reviews, the Partner from BDO undertakes a review of the report and challenge of the evidence and conclusions drawn.

The ADA&RA is regularly challenged by the Partner, BDO, on safeguards for maintaining independence and the Audit and Risk Committee meets separately with BDO at least once a year without the ADA&RA being present. However, the Partner has free access to the Chair of ARC at any time. The Committee also meets with the external auditor without management or the ADA&RA present.
which provides an opportunity for any concerns that Crowe LLP may have from their regular liaison with internal audit and the ADA&RA.

Activity in 2021

45 Whilst the HOIA opinion for 2020 does not include the period since January 2020, the ADA&RA has continued to observe the ongoing work in responding to the impact of the pandemic and audit will continue to maintain a watching brief, providing advice support and assurance as appropriate.

46 We have also published ‘Internal Audit’s Contribution to Delivering the Corporate Strategy 2021-2025’. This important paper articulates how we will support the Strategy’s four strategic aims but goes further than just to provide assurance on organisational operations to include annual reporting on delivery progress of the Strategy.

47 As the GMC responds to a turbulent and unpredictable external landscape internal audit will be flexible and adapt at speed as events and responses to them develop and unfold. We will keep our contribution under constant review, adding and adapting our direction and approach in line with the threats, opportunities and assurance needs which emerge.
<table>
<thead>
<tr>
<th>Paper withheld from publication</th>
<th>Please note this paper is being withheld from publication prior to going to Parliament.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For further information, please contact the Corporate Governance team via email, <a href="mailto:GovernanceTeamMailbox@gmc-uk.org">GovernanceTeamMailbox@gmc-uk.org</a>.</td>
</tr>
</tbody>
</table>
**Council meeting – 9 June 2021**

**Agenda item M10**
Fitness to Practise Annual Statistics Report 2020

<table>
<thead>
<tr>
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</tr>
</tbody>
</table>
Please note this background paper is being withheld from publication - details of our complaints and compliments are published in our Annual Report.

For further information, please contact the Corporate Governance team via email, GovernanceTeamMailbox@gmc-uk.org.
### Action
To note

### Purpose
This paper is to inform Council about the progress of the Education Reform: Enabling Flexibility programme. The programme is using insights from our pandemic response to enable more flexible, responsive medical education and training. This objective of this is work is to help develop a sustainable workforce who can meet future patient needs; a corporate priority for the organisation.

### Decision trail
This programme will draw from our previous work on the Flexibility Review, and our pandemic response including approving derogations to ensure doctors could continue to progress through their training, where appropriate. The work will link to the review of Good Medical Practice, Regulatory Reform, Lifelong Learning and other work related to supporting the medical workforce.

### Recommendation(s)
To note the approach and scope of the Education Reform: Enabling Flexibility programme.

### Annexes
No

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  paula.roblee@gmc-uk.org, 0207 189 5207
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  Abbie.Pearson1@gmc-uk.org, 0161 240 8398

### Sponsoring director/ Senior Responsible Owner
- **Colin Melville**, Medical Director, Director of Education & Standards, colin.melville@gmc-uk.org, 0161 923 6772
Background

1 Council is being asked to note the scope and approach of the Education Reform: Enabling Flexibility programme.

2 In response to the Covid-19 pandemic, changes to medical education and training have been implemented at a rapid pace. Many of these changes have addressed our long-standing ambitions for more flexibility in training and training which is responsive to patient needs as they emerge.

3 As we progress out of the emergency phase of the pandemic, we will evaluate the impact of these changes and use that intelligence to develop a responsive, sustainable position for the future.

Why are we addressing this subject?

4 The pandemic has demonstrated that medical training must become more resilient to adapt to future pressures, as well as providing the scope to make changes quickly within education and training. Changes brought in over the last 12 months have provided an opportunity to evaluate flexible approaches to assessment, redeployment and FiY1 preparation. We are seeking to embed these changes where they have been shown to improve educational outcomes, maintain standards and ensure patient safety, and which support more responsive education and training over the long term.

5 The mandate for this work is already set out in our Corporate Strategy (2021-2025) and our Business Plan (2021-23) where we have identified making education and training more flexible as essential to developing a sustainable workforce and enabling safe care.

6 We know from engagement with system leaders that stakeholder organisations also recognise the case for change and are committed to working together to find sustainable solutions.

Proposed approach

7 We have agreed with stakeholders on four priority areas for reform. We have also provisionally agreed which organisations are best placed lead on them:

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Aim</th>
<th>Lead organisation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalism</td>
<td>To define and embed generalism through doctors' careers</td>
<td>Academy of Medical Royal Colleges (AoMRC) + GMC</td>
</tr>
</tbody>
</table>
Council meeting, 9 June 2021

M13 – Education Reform: Enabling Flexibility update

<table>
<thead>
<tr>
<th>Progression</th>
<th>To improve progression, through curricular and assessment enhancements</th>
<th>Academy of Medical Royal Colleges (AoMRC) + GMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership</td>
<td>To promote leadership skills and encouraging clinical leaders</td>
<td>Health Education England (HEE) + Health Education &amp; Improvement Wales (HEIW)</td>
</tr>
<tr>
<td>Preparedness for training</td>
<td>To better prepare students moving into the foundation programme.</td>
<td>TBC – we are in discussions with the Statutory Education Bodies about who will lead on this</td>
</tr>
</tbody>
</table>

8 We are currently developing robust problem statements and establishing governance for the programme with our partner organisations. To date, our activity has primarily been focused on the workstreams where we have a lead role (Generalism and Progression).

9 Although we are still in the early stages of this work, we intend that our policy recommendations must meet our five principles:

- Maintain patient safety
- Maintain professional standards
- Prioritise outcomes over time input
- Assess competency not quantity
- Maintain proportionality

10 System leaders (including the 4 Chief Medical Officers of the UK, Postgraduate Deans for the Statutory Education Bodies and NHS Service Leaders) have agreed to act as an oversight board whilst we develop this work.

11 We will ensure Council has a chance to reflect on and feed into this work as it progresses.

Milestones and timeline

12 We are in the scoping stage of the work on the four projects (Q1-Q4). We are pacing the work to fit with the capacity of our partners and key stakeholders as they recover from the impact of the pandemic. Deliverables include:
Council meeting, 9 June 2021
M13 – Education Reform: Enabling Flexibility update

- Commission/evaluate data and research to identify the breadth of issues in each workstream (Q1/Q2).
- Initial engagement activities with colleagues across the GMC and with our partners to develop a straw-person set of ideas (Q2).
- Test initial proposals with critical friends and the leading organisations (Q3/Q4)
- Seek agreement on these proposals and possible actions plans with system leaders (Q4)

13 We anticipate moving towards delivery/implementation in early 2022, subject to the outcomes and feedback gathered in this exploratory stage.

14 It is likely the workstreams will diverge in timing and deliverables as the programme matures.

**Workstream progress**

*Generalism workstream*

15 Problem statements and key points:

- Doctors and health care professionals increasingly work as part of diverse teams, which include colleagues from different specialties.
- Whilst we have introduced the generic professional capabilities into our outcomes for approved training, the majority (76%) of doctors at any given time are not in training, so there is a need to support this agenda for the wider medical community.
- Medical care is evolving, emerging technologies are changing the landscape, and the need for flexibility among healthcare systems and professionals has never been greater.
- During the pandemic workforce planning has been a significant challenge for the wider healthcare system.
- Heavy workloads and pressures on the workforce are compounded by long term issues such as rigid career pathways for doctors and doctors narrowing their practice early in their careers.
- Statutory education and training bodies have evidenced the need for doctors to complement their expert specialist knowledge with broader, generalist skills throughout their careers. Knowledge and skills learnt...
during training should be encourage with opportunities for doctors to enhance these skills throughout their careers

- A system level consensus on the value and definition of generalism is necessary to bring the profession along.

**Progression workstream**

**16 Problem statements and key points:**

- Disruption to postgraduate medical education and training caused by the pandemic required GMC to consider a range of temporary pragmatic changes to curricula and assessment requirements to minimise that disruption for doctors in training.

- It is uncertain how long these temporary changes will remain but when no longer required, the focus then will be on addressing downstream impact of the changes.

- The overall objective is to apply the lessons of the pandemic to effect changes to support more flexible and responsive medical education and training to meet workforce needs.

- There have been particular changes to assessment, which have moved towards more authentic experience, which we believe it would be desirable to learn from and explore the advantages of emphasising more over the long term.

- There is opportunity to capitalise on any long-term benefits of these changes. The focus of this work stream will be on any longer-term proportionate improvements, taking account of any impact on diversity, that might engender a:
  
  - More streamlined and flexible progression process
  - More resilient and adaptable curricula
  - Move towards more authentic evaluation and reducing assessment burden.

**Leadership workstream**

**17 We are working with HEE and HEIW to identify gaps in the breadth of clinical leadership initiative available across the UK. We are also working with colleagues on the Supporting a Profession Under Pressure work programme and the clinical fellows to ensure work in this work stream aligns to and supports our commitments and agreed actions for leadership.**
Discussions so far have indicated:

- All doctors, especially as they move out of training, should have opportunities to develop and maintain their leadership skills. Very often doctors in training will have exposure and experience to leadership opportunities but these are not necessarily supported further as they move through their careers.
- Some groups of doctors, such as SAS doctors, struggle to access leadership roles and opportunities, and the experience that they have can be undervalued.
- Across the UK, there are several interventions to encourage and support doctors and the multi-profession team to develop their leadership skills, roles and responsibilities. But more could be done to spotlight good practice, which fosters and values leadership in the medical profession.
- There is also a need to actively encourage doctors into more specific leadership roles, especially in public and community health in order to shape these contexts and improve population health.

Preparedness workstream

We are reflecting on research that was commissioned to evaluated medical students’ preparedness to enter the Foundation programme as well the outcome of research specifically about the Foundation interim Year One posts that were created in response to the pandemic in spring 2020. These reports will help inform ideas and proposals to better support students as they move into practice and point to some very specific advantages that were gained through this process.

We will accelerate work on this workstream further in Q3/Q4 when stakeholders have more capacity to consider longer term changes for this transition.

Other Implications

Risk

We anticipate that having insufficient resource to support the work (both internal and external resource as this will be a joint programme) is the largest risk to delivery. To mitigate this internally we will be working to secure appropriate resource. Externally we will continue to have close dialogue with our partners to adapt our work programme to their availability.
Links to other GMC work

30 We are liaising with other teams within the organisations to establish where there will be a crossover. We anticipate that this programme will need to link to our review of Good Medical Practice, Regulatory Reform, Lifelong Learning and other work related to supporting the medical workforce.

Engagement

31 Following the Education Summit held with system leaders in November 2020, we have continued to have regular bi-lateral discussions with the Academy and Statutory Education Bodies.

32 We have set up an internal programme board to socialise the work with relevant colleagues and we are currently establishing task and finish groups to support the workstreams.

33 We are working with SC&E colleagues to develop a targeted communication plan in conjunction with partners to ensure we engage effectively with the profession throughout the life of the programme.

Four UK countries

34 We are partnering with the Statutory Education Bodies from across the UK on this programme. We want our recommendations to be supported by the four countries and so part of this programme will involve agreeing a plan for implementation.

Equality, diversity and inclusion

35 To understand if this programme will have a differential impact on protected groups we will be producing an Equality Analysis (EA) as part of our policy development.

36 We will also be incorporating the relevant findings of the EA produced for the changes to assessments in response to the Covid-19 pandemic into this work.