

Meeting of the Board of Trustees

Friday 3 February 2023

Assessment Strategy Review

Executive summary

The Assessment Strategy Review was implemented following Council's approval in July 2021 after the successful migration of the College's examinations online in 2020. The aim of the group was to evaluate the best delivery method for the CASC, align the new curricula to College assessments, and review the current WPBA system.

Following this review, the paper is presented to Trustees to approve the following decisions:

- Continuing to run written papers A and B online via Pearson Test Centres
- From September 2023, moving to a face to face delivery model for CASC with some digital elements like iPad marking and the possibility of digital stations.
- Creation of a new Assessment Oversight Committee to have strategic oversight of educational assessments, and report to the ETC.
- Creation of a formative assessment working group to create a recommendations report by the end of 2023.

Action:

- For decision

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Assessment Strategy Review

Final Report

January 2023

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1. Context and drivers for change

In 2020, the Royal College of Psychiatrists responded to the global COVID-19 pandemic by taking the courageous decision to move its face-to-face OSCE (Objective Structured Clinical Examination), as well written papers A and B, online.

The written papers A and B form the first two components of the MRCPsych qualification. The CASC (Clinical Assessment of Skills and Competencies) is the third and final component of the MRCPsych and is made up of 16 OSCE stations which assess the specific skills required of a psychiatrist including history taking, examination (both physical and mental state) and patient management. Each of these stations consists of a clinical scenario with a professional role player acting as a simulated patient (or other health professional), with the examiner in the station marking the candidate's performance against the agreed criteria on the mark sheet.

This bold move to move the MRCPsych examinations online, enabled thousands of trainee psychiatrists to complete Core training and progress to their new placements. In turn, this ensured that the flow of newly qualified psychiatrists into the workplace would not be interrupted.

The transition to online examinations had its challenges but was accomplished successfully. It enabled candidates to take the exams from wherever they were located, overcoming the international barriers to travel imposed by the pandemic.

In 2021, after several diets of online examinations which had delivered results comparable in terms of reliability, and with a new Dean, the College began to evaluate whether the online delivery of the College's OSCE exams should continue. The movement of written papers to an online format had been planned pre-pandemic and was in line with the actions of many other professional awarding bodies, so the delivery of the written exams was not in scope.

However, coinciding as this did with the complete revision of all ten of the RCPsych curricula, it immediately became apparent that a more complete strategic review of assessment throughout training, both formative and summative, would be beneficial and the Assessment Strategy Review (ASR) was proposed to Council in June 2021, approved and instituted.

The ASR task and finish group, chaired by the Dean, brought highly experienced RCPsych members involved in many aspects of exams, workplace training, curricula and differential attainment together with educationalists from other academic institutions and psychometric consultants. They were tasked with delivering a holistic approach to formative and summative assessment that evaluated the key skills and knowledge needed by trainee psychiatrists during their journey through core and higher training and beyond in their roles as consultants.

The four drivers for change were:

1. New curricula, to be implemented from 2022, aligned with the GMC's Excellence by design standards which now provide a link between assessment and the curricula key capabilities.
2. Limitations of the existing workplace-based assessment (WPBA) system: inconsistent gradings, feedback and supervision.

3. Consideration of the benefits brought by the introduction of a digital CASC exam and the extent to which it was desirable to retain this digital delivery model.
4. Re-evaluating assessment methods in order to help meet the GMC's ambitious target to address differential attainment (DA)

2. Assessment Strategy Review objectives

The aim of reviewing the College's assessment strategy and examination blueprint is to improve patient care, maintain the highest professional standards and support psychiatrists to achieve their professional potential by:

- Reviewing the educational methodology behind all assessments, including WPBAs and the MRCPsych examination in order to improve learning outcomes.
- Considering alternative assessment methods like log books, consultation recordings and others.
- Establishing the best delivery method for the CASC examination.
- Reducing the differential attainment gap in training and in particular addressing any perceived bias/disadvantage of different assessment systems for particular cohorts of trainees.
- Standardising and improving WPBAs, engaging and training trainers and ensuring these are robust and effective assessment tools.
- Demonstrating that assessment methods are fair, reliable and valid.

Above all, the intention was to ensure that assessment methods offer assurance to key stakeholders (the public, regulators, employers, trainers and trainees) that trainees have satisfactorily demonstrated their accomplishment of the key capabilities – specifically those set out in the core curriculum.

Also to be taken into account was the renewed focus in the new curricula on holistic, person-centred care and the biopsychosocial model.

3. Current assessment strategy and new curricula

The Silver Guide is the repository of the College's rules and guidance on Psychiatry training. The current assessment strategy is set out in the Silver Guide, Section 13.

In 2022, the College introduced new core, specialty and sub-specialty curricula, in response to the GMC's Generic Professional Capabilities framework.

Each curriculum now corresponds to the generic professional capabilities, enabling skills to be more readily transferable across medical specialties.

The curriculum is split into nine high level outcomes (HLOs), some of these subdivided into one or more themes. Within each theme are key capabilities: a trainee should show that during their three (whole time equivalent) years of training they have met most of the key capability requirements – sufficient for their supervisor to confirm that they have met the standard required for each specific year, or phase, of training.

The curriculum framework is structured around:

- [The Silver Guide](#)
- [The curricula](#) core, specialty and sub-specialty
- [Personal development plans](#)
- [End of year standards guidance](#)
- Assessment (formative and summative).

The use of workplace-based assessments has been linked to the HLOs by requiring supervisors to evaluate their trainee's performance against the standard expected of each HLO by the end of the training year.

To assist with this evaluation, the End of year standards guidance have been produced – these provide examples of the sorts of behaviours that should be exhibited by trainees working at the expected standard.

In this strategic review, we have looked at assessment throughout training, from the start of CTI to the final ARCP (Annual Review of Competency Progression) that confers progress to specialist registration in order to be appointed as a consultant. It is important that assessment is seen as a continuum, a blend of standardised summative and less formal formative assessment that together ensure professional consultant psychiatrists have the knowledge and skills to make a real clinical difference.

4. Stakeholder engagement and consultations

The ASR identified groups of key stakeholders whose views it would be critical to capture. These groups are shown here.

Stakeholder Mapping



Led by Subodh Dave, the Dean of the College, the ASR committee drew together viewpoints from this range of stakeholder groups - with input also from the Chief and Deputy Chief Examiners, Chair of the CASC Panel, Associate Deans for Curriculum and Trainee Support, Psychiatric Trainee Committee (PTC) current and past chairs, trainee representatives, and a patient representative. Specialist input was also sought from leading experts in medical education and assessments.

We used quantitative and qualitative methods of evaluation to establish the views of key stakeholders on the College's approach to assessment.

Qualitative and quantitative surveys

In order to gain a more nuanced perspective on our approach to assessment and to inform our quantitative surveys, we ran an extensive series of focus groups, facilitated by an independent research team. College staff were not part of these groups and the findings were collated and reported by the research company.

These panel discussions sought the views from the following six discrete groups, all of which were UK-based:

- trainees in core and specialty training
- supervisors in core and specialty training
- examiners
- CASC panel and Education Standards Committee members
- patient and carer representatives
- Medical Directors representing employers

Survey and focus group participants were asked a range of questions about the College's current approach to assessment to elicit an informed understanding of what it did well and where there was scope for improvement.

Surveys and focus groups addressed all aspects of summative and formative assessment.

There were common areas of enquiry and common themes that emerged from all forms of stakeholder evaluation.

The detailed survey responses are available via the following links; we would encourage you to review them:

[Trainee survey - quantitative](#)

This survey of UK trainees received 420 responses. 47% were core trainees and 53% higher trainees. Trainees' personal preference regarding CASC delivery were 45% preferred face-to-face, 24% remote delivery, 19% combination, and 12% not sure.

[Supervisor survey - quantitative](#)

This survey of UK supervisors received 305 responses. Supervisors' personal preferences regarding CASC delivery methods were 67% preferred face-to-face, 4% remote delivery, 25% combination, and 5% not sure.

[Examiner survey – quantitative](#)

This survey of CASC examiners received 123 respondents. 76% of respondents had examined for more than 3 years. 74% had experiencing of examining in both face-to-face and online exams. Examiners' personal preference in terms CASC delivery method were 50% preferred face-to-face, 18% online, 21% a combination, and 11% not sure.

[International medical graduates - quantitative](#)

This survey of international medical graduates received 800 responses. 73% of respondents did not use English as their first language. The survey explored the motivations for international candidates taking MRCPsych qualifications. The majority of candidates responded they were better able to demonstrate clinical skills in the CASC through face-to-face delivery, and that GMC approval of the MRCPsych was key to their decision to take the exams. Further details are provided below.

[AoMRC – EDI and online exams quantitative survey](#)

This survey of UK trainees was developed by the Academy of Medical Royal Colleges (AoMRC). It was distributed to trainees by all Medical Royal Colleges to examine the impact of equality, diversity and inclusion (EDI) as a result of the move to online exams during the pandemic. The survey received 281 responses. Detailed analysis of the results are included in the EDI section of this paper.

[Combined report on qualitative surveys](#)

This is a summary of the results from the qualitative research. A summary of the results is included in the key themes below.

As reviews were being undertaken, the Chief Examiner presented early findings at conferences and other meetings to ensure that members were being kept abreast of developments. It was reassuring that the informal feedback gathered at such events reflected the formal feedback from the quantitative and qualitative surveys.

Key themes

The high-level results from all forms of stakeholder engagement are set out below.

There was strong feeling across all groups that face-to-face exams got as close to replicating a clinical setting as was possible, given the artificiality of it being an exam using simulated patients.

Of all the criteria to consider when deciding about format, all groups were clear that reliability and validity were the most important. They were also clear that a face-to-face clinical exam was superior to an online clinical exam for assessing the main clinical skills particularly communication skills. A key ask from all respondents (UK and International, on CASC, Paper A and Paper B) is the desire to be able to complete the exam with as little stress and worry as possible. This leads them to conclude that either face-to-face (for CASC) or at an exam centre (for Papers A and B) works best.

Some skills were felt to be less suitable for a digital examination: physical examination, cognitive testing and non-verbal communication were most frequently mentioned. Those developing stations would confirm that they found it difficult to develop stations for the video consultation format that fully assess some important aspects of cognitive function, and physical examination is limited in the online format. We will give this further consideration as part of the WPBA review which is continuing.

However, many respondents acknowledged the very significant reductions in anxiety, time and cost arising from being able to sit the exams at home / at a test centre closer to their home. One respondent noted that in her country it was perceived to be less safe for women to travel on their own and that they therefore had to be accompanied by a male relative, which added significantly to their costs. Some examiners reported being better able to focus on candidates online rather than in a noisy exam hall.

Predictably, most of the anxieties about the online exams related to the challenges of internet connectivity, having good enough hardware to run the exam and maintaining a quiet environment conducive to concentration. Remote proctoring of online written paper exams taken from home was highly prescriptive and induced anxiety, as well as challenges in not being able to behave naturally.

Many respondents felt that with video and online consultations becoming much more commonplace, a mechanism for examining skills in this area should be found and thus supported a hybrid model exam, or inclusion of a video consultation element in a predominantly face to face exam.

A significant number of respondents raised queries about the quality of the questions within the written papers and CASC. Some referenced the widespread availability and use by trainees of commercial exam preparation offerings which claimed to have RCPsych questions and stations.

The IMG survey helped our understanding of the value carried by the MRCPsych qualification, particularly the recognition by the GMC as a qualification accepted for registration. Many respondents indicated reluctance to travel to sit the MRCPsych exams in future. It is not only IMGs intending to come to the UK to work who desire the qualification, it is also beneficial for roles in other countries and for recognition in local healthcare systems.

Areas where our current summative assessments are not presently assessing skills were examined in the quantitative surveys and we have a long list of skills to consider (formulation, written communications, for example) to determine whether formative or summative assessment is most appropriate.

There was comment on the duration of CASC stations, with trainees querying whether they could appropriately demonstrate their clinical skills in seven-minute stations.

Trainees also commented in the focus groups that they would like to have more feedback from the CASC exam so they could improve their performance. We followed this up in the quantitative surveys and asked all stakeholders what sort of feedback we should provide. All stakeholders ranked free text personalised feedback as their first preference, followed by actual scores achieved on individual stations.

Formative assessments are recognised to be useful to evaluate trainee performance in the workplace. Respondents identified issues which have regularly been reported of WPBAs in research into their effectiveness:

- challenges of variability in grades awarded by different supervisors, combined with lack of clarity in use of Likert scale grading
- difficulties of getting supervisors to provide personalised, specific feedback – especially where performance is not meeting an expected standard
- supervisors not allocating the full hour of psychiatric supervision to trainees and not completing feedback on WPBAs in a timely manner.

The need for training emerged strongly from all survey formats – for different groups:

- supervisors, in providing formative feedback
- trainees, in seeking and effectively using formative feedback
- everyone, about the format, structure and principles of the summative assessments.

The patient and carer survey made suggestions about how to include the patient and carer voice and experience in the creation of assessments, instructions for role-players and workplace-based assessments and these will be pursued. The many themes arising from the various surveys are followed up more closely in the areas of enquiry, outcomes and recommendations that follow.

5. Areas of enquiry

Validity

High stakes examinations must reassure the public that those passing have met an acceptable standard to assess and treat patients. In order to do this, they must be valid: that is, they must assess what they are supposed to assess - the knowledge, skills and attitudes to be a psychiatrist as set out in the curriculum.

We investigated the validity of the MRCPsych exams through widespread consultation to establish whether:

- the programme of assessment enables candidates to demonstrate that they have the key skills required
- examiners can assess candidates effectively
- supervisors, Medical Directors and patients believe that the exams deliver the key skills and capabilities currently required by consultant psychiatrists.

Assessment strategy and blueprint

For examinations to be valid, they need to appropriately test the different areas of the syllabus. We reviewed the assessment blueprint and assessment methodology and conducted a mapping exercise to evaluate whether the key capabilities are assessed appropriately. Stakeholders were consulted on appropriateness of formative and summative assessment and were asked to consider whether there were any gaps in the assessment of key capabilities.

A [new syllabus and blueprint was developed for the CASC exam](#), closely correlated with the high level outcomes (HLOs) and key capabilities of the 2022 core psychiatry curriculum and in response to stakeholder feedback.

This new syllabus retains the four key clinical skills of history, examination, clinical management and communication, but provides much more detail about those skills specifically to be assessed.

Reliability

Our examinations need to be reliable, that is to say that the results are reproducible, and they must be fair. This means they should only discriminate between candidates on the areas to be tested, not in any other way; reasonable adjustments should be made to accommodate candidates with disabilities.

To determine the reliability of summative assessments, data for Papers A, B and the CASC exam from 2018-2022 have been compiled and analysed to benchmark the reliability of all exams. Further analysis has been done on the CASC exam to explore any differences between face-to-face and online examination delivery. Additionally, we explored what the impact on reliability would be if the number of stations in the CASC exam were to be reduced.

Differential attainment

To help us understand more about the attainment levels of groups with different protected characteristics, we analysed the pass rates for the Paper A, B and CASC examinations between 2017 and 2022.

The different cohorts were analysed by gender, ethnicity and age, candidates holding a UK primary qualification compared to candidates with an overseas primary qualification, candidates working in the UK compared to candidates working overseas.

Equality, diversity, inclusion and accessibility

As part of our stakeholder consultations, we have conducted an impact assessment on the shift to digital exams and how changes have affected trainees in the context of equality, diversity and inclusion.

The Academy of Medical Royal Colleges (AoMRC) developed a common set of questions for all Colleges and Faculties to use, and our analysis draws on the output from this research and the significant amount of work the College has undertaken to ensure we offer a fair exam for all candidates.

International candidates

Between 2018 and 2021, there was a 48% increase in overall candidate exam entries (from 3363 in 2018 to 4985 in 2021).

MRCPsych is now an international examination with global relevance, confirmed by the fact that over this period, entries from international candidates have increased by 84%.

We surveyed international candidates to get more detailed insight into the international recognition of MRCPsych qualifications, the motivation for taking our qualifications and the appetite for specialty qualifications. We also conducted analysis to get a deeper insight into the most popular international destination for candidates achieving the MRCPsych qualification, at the same time seeking feedback from candidates on their perception of face-to-face versus digital exam delivery and their willingness to travel internationally to take the CASC exam.

Sustainability

Sustainability is a priority for the College, which has committed to reduce its impact on the environment to net zero by 2040. We have analysed the carbon footprint from delivering examinations in 2019, before exams were delivered digitally. This includes accommodation, shipping and travel emissions. We have explored the impact of returning to face-to-face delivery for the CASC exam and the impact of moving to computer-based delivery for the written papers.

We have considered how we can align our assessment strategy with our sustainability targets and commitments and included feedback from our stakeholder consultations.

Formulation skills

Formulation skills were previously examined by the long case assessment, before the CASC exam was introduced. The exam blueprint assesses a broad range of skills, but it has the effect of disaggregating different aspects of a patient's context. Formulation, which relies on synthesising information from a range of contexts to provide a cohesive reason for the patient's mental ill-health, is difficult to evaluate in the present CASC format.

We considered a range of options, addressing some of the limitations of WPBAs along the way, and have proposed a way to give formulation skills the emphasis that they deserve.

Workplace-based assessments

The College has been considering the introduction of entrustable professional activities (EPAs) and changing its terminology to refer to WPBAs as supervised learning events (SLEs) in line with that used by the GMC for some time.

The quantitative and qualitative feedback echoed research into WPBAs in identifying common challenges. It also examined areas in which assessment could be introduced, such as collaborative working.

We researched extensively and communicated with educationalists and other institutions such as the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to establish current thinking and will summarise our findings.

Operational feasibility

We need to have assessments that are operationally feasible to deliver, and do not place an undue financial burden on candidates or on employing bodies needing to release examiners to conduct exams.

As part of our stakeholder consultations, we gathered feedback on what each stakeholder group considered to be the most important factors when considering exam delivery and their personal preferences in terms of the future delivery methods for College exams.

We conducted a cost comparison analysing the financial implications of face-to-face versus digital delivery. We have also considered the impact on examiners and our exam panels. Several innovations were introduced to the CASC exam as a consequence of online delivery during the pandemic, so we have also considered which innovations should be retained as part of the future assessment strategy.

6. Outcomes and analysis

Validity

The clinical component of the MRCPsych examination has been based on an objective structured clinical examination (OSCE) for over a decade. It is known as the Clinical Assessment of Skills and Competencies (CASC). The examination is structured around 16 stations that test the core psychiatric clinical skills of:

- History taking (examined in five stations)
- Examination (examined in five stations)
- Clinical management (examined in six stations)
- Communication (examined in all stations).

Until January 2020, CASC was delivered in a face-to-face consultation format. With the onset of the pandemic a decision was made to move to a digital format: since September 2020 CASC has been delivered remotely in a format using four-way live video consultation.

In our consultation with trainees, we asked how well they thought that they could demonstrate the key clinical skills through the different exam delivery methods (See Table 1). The feedback from candidates was clear that for examination and communication skills, the face-to-face format is better.

For history taking, face-to-face performs slightly better and for clinical management the highest proportion of respondents felt that face-to-face and digital delivery formats were similar.

Table 1. How well trainees think they can demonstrate the key clinical skills through different exam delivery methods

	Face-To-Face Is Better	Same/Similar	Digital Is Better	Don't Know / N/A
History Taking	37.9%	34.5%	9.4%	18.1%
Examination	66.2%	12.7%	5.5%	15.6%
Clinical Management	28.5%	44.8%	10.3%	16.5%
Communication Skills	55.6%	20.3%	7.8%	16.3%

Supervisors and examiners were asked how well they think clinical skills can be assessed through the different exam delivery methods (see Tables 2 and 3). The profile of the examiner results was identical with examination at 73% and communication at 74% preferring face-to-face assessment, 47% preferring history taking face-to-face and 51% considering clinical management same/similar (see Table 3).

Table 2. How well supervisors think clinical skills can be assessed through different exam delivery methods

	Face-To-Face Is Better	Same/Similar	Digital Is Better	Don't Know / N/A
History Taking	69.2%	24.6%	2.3%	3.9%
Examination	87.9%	6.7%	2%	3.4%
Clinical Management	41.4%	50.7%	4.3%	3.6%
Communication Skills	81.5%	13.5%	1.3%	3.7%

Table 3. How well examiners think clinical skills can be assessed through different exam delivery methods

	Face-To-Face Is Better	Same/Similar	Digital Is Better	Don't Know / N/A
History Taking	47.2%	47.2%	2.4%	3.3%
Examination	72.7%	21.5%	1.7%	4.1%
Clinical Management	43.8%	50.4%	3.3%	2.5%
Communication Skills	73.8%	22.1%	1.6%	2.5%

Similar feedback was received from the focus groups conducted with Medical Directors, patient and carers, core and high-level trainees and the exam panels.

Examiners have provided feedback that it is very hard to assess advanced communication skills in the video consultation format, for example empathy, and picking up cues from non-verbal communication.

Trainees have also reflected the same concern – citing difficulties in demonstrating critical skills in the video consultation format. The quality of history-taking and mental state examination is also affected by the video consultation format, especially where role-players are simulating patients with major mental illness or with neurodevelopmental conditions.

Within the recommendations section we have suggested compiling the evidence that is available to demonstrate the validity of the written paper A and B. Following this we will explore whether further work is required.

Assessment strategy and blueprint

A mapping exercise was undertaken to evaluate whether the high level outcomes (HLOs) and key capabilities of the 2022 Core Psychiatry Curriculum are assessed appropriately through the programme of summative assessment. The mapping exercise shows the key capabilities being tested by summative assessment (Paper A, Paper B, CASC) across the core curriculum. Where there were gaps, this led to consideration of whether the capability would best be assessed in future by formative or summative assessment.

[Core Psychiatry Curriculum Mapping document](#)

The mapping exercise demonstrated good coverage of the HLOs and key capabilities across the programme of summative assessment.

Mapping was also undertaken for workplace-based assessments, but this proved unhelpful as aside from the specific medical psychotherapy assessments all of the others could be deployed on all key capabilities. The WPBA research has identified the use of specified WBPAs for specified clinical activities, possibly as part of the introduction of entrustable professional activities (EPAs), as an area for further exploration.

As part of our stakeholder consultation, we asked trainees, examiners and supervisors which areas of the curriculum should be assessed by only summative or formative assessment or by a combination or both. In every curriculum area, the majority of respondents (+60%) thought that both formative and summative assessment should be used.

In respect of physical examination, 43% of trainees, 28% of supervisors and 23% of examiners who responded believed this should be assessed only by formative assessment; similarly, developing a personalised holistic management plan, taking a collateral history and legal and ethical management also scored relatively highly (+20%) in terms of the number of respondents who felt these skills should be assessed by formative assessment only.

42% of supervisors responding thought there were gaps in the capabilities and knowledge currently evaluated by formative and summative assessment, suggesting that we also needed to assess:

- clinical decision-making skills
 - advanced communication skills
 - formation of complex management plans
- collaborative working across disciplines and teams was mentioned most frequently as a gap in the capabilities being assessed.

CASC syllabus

We have developed a new syllabus to clarify those key capabilities in the new core curriculum that the exam will assess. The new curriculum places importance on values, personalisation and seeing psychiatry as a holistic, biopsychosocial discipline and gives physical health an important focus.

As a consequence of this, and in response to feedback from stakeholders, there is a new focus on:

1. **personalisation of the consultation** (for example adapting it to someone's cultural background, or to a neurodiverse condition or in tailoring medication or psychosocial treatment regimes to individual context)
2. **prevention strategies** including primary and secondary prevention (public mental health) and
3. on the **interaction between physical and mental health**.

The syllabus is updated to include all the relevant conditions from the 11th revision of the *International Classification of Diseases* (ICD-11), and to ensure that all the specialties of psychiatry are represented in the exam's blueprint.

Those developing stations have found it difficult to develop stations for the video consultation format that fully assess some important aspects of cognitive function, and physical examination is very limited in this format.

[New CASC syllabus](#)

Reliability

The reliability of our exams was cited as the most important factor by trainees and the second most important (after ability to assess clinical skills/validity) by examiners and supervisors.

Reliability is a measure of the extent to which the exam produces consistent results. In clinical examinations we should aim for reliability values between 0.8 and 0.9. In multiple choice examinations the expected standard lies between 0.8 and 0.95.

Our psychometric analysis also considers:

- standard error of measurement, which is an indicator of the precision of a test, and
- candidate scaled scores, which should indicate comparable levels of performance that a candidate may see on alternative administrations of the same exams.

The data set analysed includes Paper A, B and CASC between 2018 and 2022.

[ASR Psychometrics report](#)

The data indicates a very high level of reliability for Paper A exams. Between 2018 and 2021 reliability for all eight exam diets in this period was >0.90 (for all candidates) well within the target range of 0.8 to 0.95 for multiple choice exams.

There were nine exam diets between 2018 and 2022 for Paper B. All Paper B exams within the period were above the acceptable threshold >0.80 for multiple choice exams.

For the CASC there were ten diets within the period analysed: five face-to-face exams between January 2018. As the exam took place across multiple days, a reliability range has been provided in the report. The data shows that the face-to-face and digital exams produce similar reliability figures.

On most days, the reliability value is at an acceptable level above the threshold of 0.8. The estimated reliability of the CASC over the full period, using Cronbach's alpha, is 0.83.

In summary, we can conclude that in terms of reliability, all College summative assessments are reliable instruments to assess candidates' skills and competencies.

In addition to measuring the reliability of current CASC exams, we also investigated the implication of testing candidates across fewer stations in the future. Currently candidates sit 16 stations in the CASC and must achieve a score above the pass standard and must pass 12 or more of the 16 stations. While the estimated reliability of the CASC is 0.83, the estimated reliability for UK trainees is 0.74. Our analysis suggests that reducing the number of stations by more than two would be inadvisable psychometrically, as this may reduce the reliability of the exam for UK trainees which could adversely impact the overall reliability of the exam. A reduction in number of stations would also reduce the blueprint coverage and remove a margin in terms of reliability if we had to remove a poorly performing station.

[CASC fewer stations – Final report](#)

Differential attainment

To help us understand more about the attainment levels of groups with different protected characteristics, we analysed the pass rates and scaled candidate scores for eight Paper A diets, nine Paper B diets and ten CASC diets between 2018 and 2022.

The following differential attainment trends have been repeatedly identified through pass rate data in this period and the analysis of the scaled candidate scores identified a similar pattern:

- Female candidates perform better than male candidates
- UK Primary Medical Qualification (PMQ) candidates perform better than international PMQ candidates
- Candidates in training perform better than candidates not in training
- Candidates working in the UK perform better than candidates working overseas
- Candidates from White ethnic backgrounds perform better than candidates with Black, Asian, Mixed and Other ethnic backgrounds.

In Paper A there has been an increase in the pass rate of candidates since converting to digital exams. The difference in performance between White ethnic background candidates and candidates from Black, Asian, Mixed and Other ethnic backgrounds, who have a UK Primary Medical Qualification (PMQ), has decreased since moving to digital exams, with the difference in pass rates reducing in the last two diets analysed. The pass rates of international PMQ candidates have also moved closer to UK PMQ candidates in the period studied.

In Paper B, the overall pass rate has not changed over the period and there is no variation in the pass rate between paper-based and digital exams. Similarly, there is no clear change in trend in any group following the move to digital exams. UK PMQ White candidates perform better than UK PMQ candidates from ethnic minority groups and UK PMQ candidates perform better than international PMQ candidates.

In the CASC exam there has been a significant increase in the overall pass rate of candidates since moving to digital exam delivery. UK PMQ White candidates outperform UK PMQ candidates from ethnic minority groups in all diets, but there has been a steady improvement in performance of UK PMQ candidates from ethnic minority groups which has decreased the difference in performance. Similarly, there has been a steady decrease in the difference between UK PMQ and international PMQ.

[Report on Differential Attainment 2018-2022](#)

A huge amount of work was undertaken to ensure the exams are fair to all candidates through the 'A fair exam' project. This appears to be having an impact on Paper A and the CASC in terms of reducing differential attainment. This involved a suite of measures including increasing reading time, avoiding items/stations relevant to a specific geographical region, unconscious bias training, and ensuring a diversity of examiners, question writers and simulated patients. The CASC masterclasses have also proved to be effective at improving the performance of candidates. In the recommendations we will highlight other opportunities to address differential attainment.

Accessibility, equality, diversity and inclusion

Through the 'Fair exam project' the College also reviewed equality, diversity, inclusion and accessibility to ensure that we offer a fair exam for all candidates, this includes making reasonable adjustments for candidates with disabilities or other needs.

With the move to digital delivery during the pandemic, we evaluated the type of adjustments that the College was making pre-pandemic and considered opportunities for how we could match or improve the accessibility of all our exams.

As part of our stakeholder consultations, we conducted an impact assessment on the shift to digital exams and how changes have affected trainees in the context of equality, diversity and inclusion.

In total, 281 trainees responded to the survey which used a common set of questions developed by the AoMRC short life working group. The survey was only sent to candidates who said they sat exams during the pandemic.

For Paper A, which was delivered either via a Pearson Professional test centre or at home with invigilation by remote proctoring, 94% of respondents commented that they thought the test location was suitable.

Trainees were asked to comment on a range of factors asking them to compare their experience during the pandemic in this location with previous experience of exam delivery. 76% thought accessibility during the pandemic was better in this location and 12% responded it was same / similar.

Trainees were asked to comment on whether the delivery method had affected their performance positively, negatively or had had no difference. For all protected characteristics, most respondents commented that the delivery method either had no difference or positively impacted their performance. For example, for candidates with disabilities, 25% responded it had a positive impact, 2% a negative impact and 73% that it had made no difference. Age, gender, pregnancy, socio-economic and migrant status scored similarly highly in terms of having a positive impact (+20% positive, less than 5% negative). Race and religion or belief scored +14% positive, less than 2% negative. In terms of reasonable adjustments, the College was able to partially meet 5%, and fully meet 81%, of candidates' reasonable adjustment requests in respect of remote exam delivery.

For Paper B, which was delivered either via Pearson Professional test centre or at home with invigilation by remote proctoring, 91% of respondents commented that they thought the test location was suitable. 72% thought accessibility during the pandemic was better in this location and 18% responded that it was same / similar. For all protected characteristics most respondents commented that the delivery method had either made no difference or positively impacted, their performance. The pattern of responses closely matched the pattern for paper A. In terms of reasonable adjustments, the College was able to partially meet 11%, and fully meet 73%, of candidates' reasonable adjustment requests in respect of remote exam delivery.

For CASC, 91% of respondents sat the exam at home. The remaining 9% sat at their workplace, college or a hybrid location. 86% responded that they thought the test location was suitable.

The 14% who did not think the test location was suitable cited poor internet or connectivity problems as the problem for the location. 82% thought accessibility during the pandemic was better in this location and 7% responded it was same / similar.

The pattern of responses regarding protected characteristics, and whether the change in delivery method may have impacted performance positively or negatively, was quite different to the Paper A and B results. 10% of respondents thought race and ethnicity had had a negative impact, 6% a positive impact and 84% thought it made no difference. The reasons cited for those who felt negatively impacted were 'bias in the exam' and the perception that the online exam was better for those whose first language was English. Potential solutions proposed were the return to face-to-face exams and running more localised exams with simulated patients and examiners of the same nationality.

Pregnancy, disability and age scored highly in terms of the positive impact experienced:

- age 16.5% positive, 10% negative
- pregnancy 14% positive, 2% negative
- disability 17% positive, 10% negative.

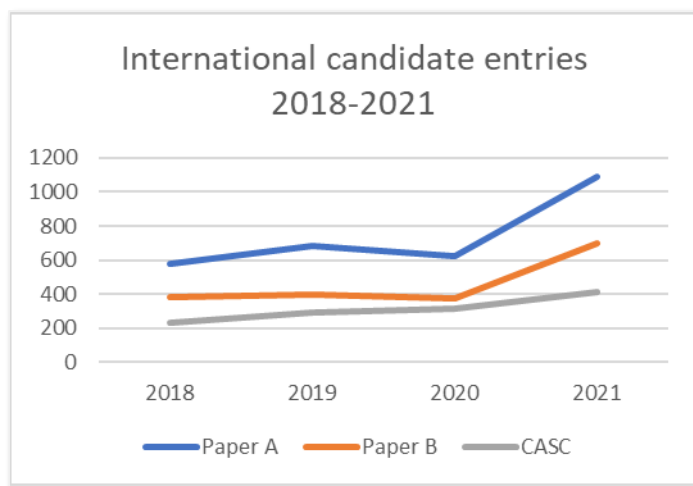
We received feedback from a candidate who, as a result of a stroke in 2019, suffers with mobility issues, fatigue and dysarthria. They reported that being able to sit their exams from home, particularly the CASC, was of significant benefit in meeting their additional needs and they highlighted the difficulties they would experience in a face to face CASC. However we have experience of supporting candidates with significant disabilities with reasonable adjustments in the face to face CASC, such as the candidate sitting in one room and the examiners and role players rotating to them, and will continue to tailor support to each individual candidate's needs.

In terms of reasonable adjustments, the College was able to meet 67% of reasonable adjustment requests fully during the remote exam delivery and 23% partially.

[EDI CASC survey](#)

International candidates

The graph below shows the total number of international candidates that sat each exam between 2018 and 2021. Between 2018 and 2021 all exams experienced a significant increase in international candidate entries. Paper A was up 88%, Paper B up 83% and CASC up 77%. This growth is continuing in 2022.



In 2021, 49% of Paper A entries were from international candidates. Outside the UK, Malaysia was the most popular location with 229 entries, overtaking Ireland for the first time with 224 entries. India was the third most popular international destination with 210 entries (up from 114 entries in 2020).

For Paper B, 42% of entries were from international candidates. India became the most popular location outside the UK with 180 entries, followed by Ireland with 161 and Malaysia with 75.

For CASC, 40% of entries were from international candidates. This was a jump of 10% from 2020. Outside the UK, India was the most popular location with 95 entries, followed by Ireland with 86 and Hong Kong with 43.

We surveyed international candidates to get more detailed insight into their reasons for taking MRCPsych qualifications.

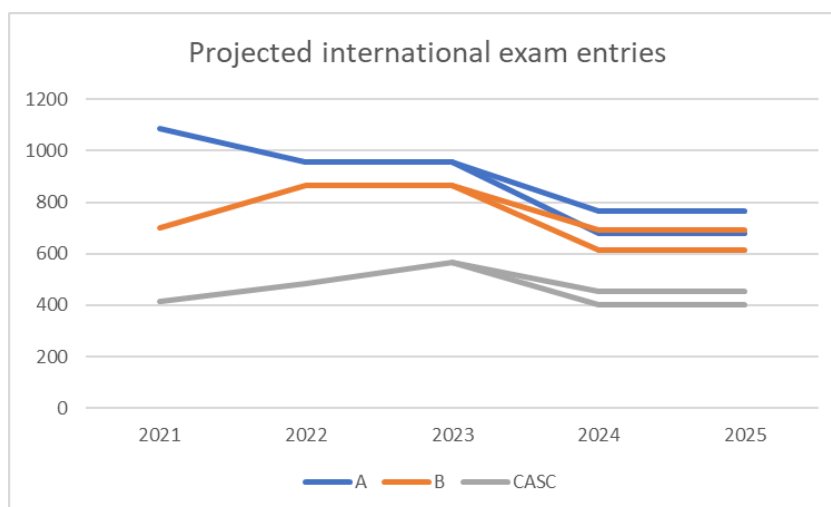
Out of 800 respondents, 65% of candidates said that our qualifications were recognised by their country's regulator. 'Improving skills and experience' was the most important motivation for taking our qualifications, with 93% of respondents saying this was important or very important. 76% rated as important or very important 'to improve job prospects', 64% 'to work in the UK', 60% 'to work in own country', 57% 'to move to the next stage in training' and 54% 'to work in another country'.

Outside of the UK, the top seven countries in which candidates were planning to work were Ireland (115), Australia (107), Malaysia (92), UAE (50), Singapore (35), India (33), Canada (24).

Candidates were asked if they would be willing to travel internationally to take the CASC exam. 40% said yes, 32% not sure, 29% no. Candidates who said they were not willing to travel were predominantly based in India (54), Ireland (34), Malaysia (34). Cost was cited as the main reason not to travel.

Projected international exam entries

The graph below shows projected international exam entries. It shows actual exam entries in 2022, which have declined for paper A, but increased for Paper B and CASC. In 2023, we are forecasting that Paper A and B entries will remain static, but CASC entries will continue to increase due to the volume of eligible candidates to the CASC.



In 2024, as a result of moving to face-to-face exams we are forecasting a drop of between 20 to 29%. This decrease would remain static in 2025. The line chart shows the 20-29% range for each exam between 2024 and 2025.

For those willing to travel internationally, 35% would travel to or within South East Asia, 30% to Europe, 26% South Asia and 15% within the Middle East and North Africa. Recognition by the GMC, by their local regulator and in other countries is very important to international candidates. 80-90% of respondents stated each of these categories of recognition was important or very important. 96% of candidates were interested in post graduate subspecialty qualifications.

[International MRCPsych candidate results](#)

Consideration has been given to the possibility of creating a separate international qualification as an alternative to the CASC, however based on the importance placed on GMC recognition by international candidates this does not seem to be a sensible approach to follow.

Therefore, in deciding to move back to face-to-face delivery for the CASC exam, careful consideration will need to be given to how and where it should be delivered internationally. Previously, the CASC was delivered internationally twice a year, with test centres in Hong Kong and Singapore. Given the profile of candidate entries and the willingness of candidates to travel, to sustain the level of demand for the qualification built up over the last three years it would be advisable to explore offering exam opportunities in the Indian subcontinent, South East Asia and Middle East or North Africa. Consideration would need to be given to existing partnerships in these regions, recruitment of local examiners, role players and invigilators. This will be covered further in the recommendations section of the paper.

Sustainability

The College is dedicated to ensuring that sustainability remains at the forefront of its strategic priorities and is actively completing projects that aim to reduce its carbon output. We have committed to achieving net-zero by 2040 to coincide with agreed NHS targets.

In our stakeholder surveys, 82% of examiners, 78% of trainees and 64% of supervisors responded that sustainability was an important or very important factor in terms of our exam delivery. The majority of respondents in all stakeholder groups also commented that digital exam delivery was better for sustainability.

For the CASC exam we are aware that any decision to move back to face-to-face delivery would increase the carbon footprint because of the need to travel to conduct and take examinations. The tables below show the total carbon emissions in 2019 resulting from the delivery of the face-to-face exams.

Environmental Consultant, Green Element, were instructed to complete data analysis into the carbon output of both CASC and Paper A and B examinations as part of the College's 2019 carbon footprint. This aligns with works being conducted to establish the College's journey towards carbon net-zero. 2019 has been established as the baseline year as it is considered the last fully operational year prior to the pandemic. Green Element follow the Green House Gas (GHG) Protocol when calculating carbon emissions. The following page shows the results of the report.

CASC - 2019

	Emissions (tCO2e)	Notes / assumptions
Venue Consumption	11.37	Used capacity of UK badminton court and m2 per person to estimate remaining rooms, based on capacity. Apportioned consumption for UK CASC exams, based on number of candidates, for overseas CASC exams. No gas consumption was assumed for Hong Kong and Singapore.
Food	5.54	Assumed 1 coffee, 1 tea, 3 biscuits and 1 meal per person, per day, for CASC exams. Assumed 25% opted for vegetarian meals and 75% opted for meat meals.
Marking Sheets	0.69	Marking sheets includes distribution and end of life.
Air Travel	155.14	This includes staff and examiners
Hotel Stay	28.09	Figures taken from corporate travel bookings and reimbursements managed by the College
Road Travel	12.78	Figures taken from corporate travel bookings and reimbursements managed by the College
Rail Travel	2.02	Figures taken from corporate travel bookings and reimbursements managed by the College
Total	215.63	

Digital CASC emissions in 2022

The table below shows the estimated carbon emissions for the digital CASC exam in 2022. The participant emissions are based on [a recent study by Oxford University](#) indicating typical emissions from desktop and screen generating 70g CO2e with continuous use over 8-hour period. The server emissions are based on [Teads AWS emissions calculator](#).

Participant emissions	25.608	Based on 194Kg emissions per circuit with 34 participants connected for 8 hours at 0.070 CO2g per person. 132 exam circuits in 2022.
Server emissions	1.670	Based on total of 18 exam days. 0.116 gCO2e per hour per exam day. M5.12x large server located in eu-west-2 London.
Total (tCO2e)	27.278	

*Green Element did not conduct analysis into the 2022 digital emissions and the figures above are based on estimations provided via the disclosed services.

Paper A and B exam emissions summary

A decision has been taken that we will continue to deliver our Paper A and B exams by computer-based testing. Previously, the Paper A and B exams were delivered via paper and pen in a choice of eleven locations (44 exam centre locations per year).

The table below shows the emissions in 2019 delivering Paper A and B exams.

	Emissions (tCO ₂ e)	Notes / Assumptions
Venue Consumption	9.69	Used floorspace figures to create a m ² per candidate. Applied this figure to remaining venues. Assumed no gas supply in India, Hong Kong, Singapore, Oman, and Malta.
Exam Collection	2.54	Calculated from data provided by Stephen Austin.
Exam Distribution	2.54	Calculated from data provided by Stephen Austin.
Business Travel	2.15	Figures taken from corporate travel bookings and reimbursements managed by the College
Exam Stationery	1.09	-
Printing of Exams	0.99	Calculated from data provided by Stephen Austin.
Written Exam Food	0.45	Assumed 1 coffee, 1 tea, and 3 biscuits per person for written exams.
Exam End of Life	0.02	Assumed the same number of exams were administer 5 years ago and would have been disposed of in 2019.
Total	19.47	

For the written exams significant emissions were generated as a result of printing and shipping of exam papers to 44 global test centres. The energy consumption of global test centres was also calculated. By moving to a computer-based global test centre delivery model we have eliminated shipping costs associated with the written exams and significantly reduced the need for candidates to travel internationally or long distances to take these exams.

The table below shows the estimated carbon emissions through delivering the Paper A and B exams via computer-based delivery. The participant emissions are based the same study used to calculate the digital CASC emissions (Oxford University) and the server emissions are based on [Teads AWS emissions calculator](#).

Participant emissions	10.62	Based on 0.0265 emissions per candidate per exam, 3833 candidates in 2022.
Server emissions	0.278	Based on total of 8 exam days. 0.348 gCO ₂ e per 3-hour exam. M5.12xlarge server located in eu-west-2 London.
Total	10.898	

*Green Element did not conduct analysis into the 2022 digital emissions and the figures above are based on estimations provided via the disclosed services.

The total emissions generated via College exams in 2019 is at 235.09 (tCO₂e).

The sum of 2019 CASC emissions and the emissions from the computer-based delivery of Paper A and B provides us with an estimate of the total annual emissions from exam delivery moving forward. This is 95.828 (tCO₂e).

By returning to face-to-face delivery of the CASC and moving to computer-based testing for the written exams we will be generating 59% less carbon per year than 2019.

2019 total emissions	235.09 (tCO ₂ e)
2019 CASC emissions + computer-based delivery of Paper A and B (estimated)	95.828 (tCO ₂ e)
% Decrease	59%

We plan to further decrease emissions by encouraging stakeholders and candidates to use train to travel to exams where possible. Train travel emits approximately 70% less emissions than car journeys. Other measures we are planning to implement include:

- Sourcing invigilators and role players close to exam venues
- Primarily working with suppliers that adhere to our sustainability policy
- Retaining online marking, reducing printing and distribution costs
- Strategically positioning and increasing global exam centres to minimise travel for international candidates and examiners.
- Reducing the number of staff and CASC panels members attending international exams

The College continues to implement initiatives to reduce its carbon output and will continue to review the operational aspects of examinations to promote sustainability as part the ongoing project to achieve net zero by 2040, linked to the 'NHS Carbon footprint plus' initiative.

Operational feasibility

Operationally, almost twice the number of examiner days are required to deliver the digital CASC exam compared to the face-to-face CASC. It has only proved possible for examiners to examine nine candidates in the morning session and nine in the afternoon in the digital CASC, whereas they would examine 16 in each session in the face-to-face CASC.

This means a digital CASC requires more than 500 additional examiner days per year compared to a face-to-face CASC.

A huge amount of work has gone into recruiting new examiners. 120 new examiners were appointed in 2021 and 170 new examiners were appointed in 2022. This has brought the total number of examiners up to over 700. However, at the same time as recruiting more examiners we have also experienced a significant increase in demand from candidates wishing to take the exam. For the September 2022 exam we received 747 candidate entries, which was a 50% increase in candidate entries compared to September 2021.

This has meant that we have not been able to fully meet candidate demand, which has led to having to run additional diets of the exam or postpone candidates wishing to take the exam. The impact of this has been that a small number of candidates have not been able to progress through into ST4 National Recruitment within the timeline they had originally planned.

Due to the increase in the number of exam days, we have significantly increased the days we require the CASC panel to support the delivery of the exams. The CASC panel support through supervising the standardisation meetings, clinical invigilation and acting as super reserve examiners that can examine on any station if an examiner needs to be replaced. The increase in their workload on exam days has had a knock-on effect with regards to station writing, consequently a very limited number of new CASC stations have been written since the pandemic. This and the increase in the number of times stations are sat has increased exposure to the stations. A significant amount of work is now required by the CASC panel to update and build up the bank of CASC stations.

In addition, although we would typically run eight or nine parallel circuits in the face-to-face CASC, operationally this is challenging in the digital CASC.

While we have run up to twelve parallel circuits on some days in the digital CASC, it has proved challenging to scale up, onboard and train the number of staff required to deliver the digital exam. The digital exam requires a much larger number of invigilators, circuit leads and IT support staff than the face-to-face exam.

Several innovations have been introduced to the CASC exam during the pandemic for which there is a strong argument to retain.

Electronic marking is more reliable than scanning marksheets, and allows for quicker processing of results, and more options to develop feedback to candidates.

The introduction of pre-populated standardisation forms to the standardisation meetings has helped to focus the meetings so that the examiners can have a detailed discussion of what would meet the passing standard whilst maintaining continuity across diets.

Consideration has also been given to the creation of more videos as part of the station development process to help simulated patients with the presentation of the role, for example emotional tone and to support examiners with understanding the passing standard. This is something that should be explored further, especially as it would provide an opportunity for patients and carers' perceptions and lived experience to be used to guide the role-players' delivery – resulting in greater fidelity.

Financial implications

The table below shows the comparison of costs for the face-to-face and digital CASC. These figures have been calculated assuming 1,000 candidates per year.

The face-to-face costs are based on holding two diets per year in Sheffield. Indirect costs including payroll, psychometrics, exam development and legal fees will be identical for both options and are not included in the financials.

CASC operations	Face-to-face	Digital
Papers and materials	£5,000	£0
Exam hall and catering	£181,500	£4,000
Hire of CASC equipment	£27,500	£0
Photocopying and courier	£1,000	£0
Invigilator staff fees	£85,000	£205,800
Actor fees	£190,000	£360,000
Travel and subsistence	£270,000	£10,000
Practique OSCE	£73,428	£78,428
Additional staff	£0	£100,000
Examiner vouchers	£0	£75,000
Miscellaneous costs	£20,000	£20,000
Total direct costs	£853,428	£853,228

Figures have not been calculated for internationally held face-to-face CASC exam diets. Internationally held exams have always been self-financing from exam fees. This ensures that there is no financial burden or increase in exam fees for UK trainees.

The costs associated with extending the number of international exam centres and running international exams will be explored further – this is referenced in the international recommendations section of this report.

Financial implications for candidates

In the surveys of UK trainees and international medical graduates' candidates were asked to comment on their perception and experience of digital and face-to-face exam delivery. Both UK and international medical graduates rated digital delivery more favourably in terms of cost. 87% of international candidates commented digital was better in terms of exam costs (7% face-to-face is better, 5% same/similar, 7% don't know). 45.8% of UK trainees rated digital better in terms of cost (30.9% don't know, 14.6% same/similar, 8.7% face-to-face).

Despite the high percentage of candidates that said digital was better in terms of cost, face to face was the highest ranked delivery method in terms of personal preference of UK trainees. UK trainees' personal preference regarding CASC delivery were 45% preferred face-to-face, 24% remote delivery, 19% combination, 12% not sure. International candidates were not asked to comment on their personal preferences but were asked to comment on how well they are able to demonstrate each clinical skill through the different exam delivery methods and face-to-face ranked the highest in terms of candidates being able to demonstrate communication skills, examination skills and history taking. Management skills ranked as same/similar in terms of delivery methods.

7. Formulation skills

Background

Although formulation skills form part of the formative assessment review, we have addressed them separately because of their critical importance to psychiatric clinical practice. When the CASC examination replaced the long form case as the College's approach to clinical summative assessment, much was gained in standardisation, reliability and validity.

However, CASC evaluates skills in four domains across sixteen individual stations, each consultation lasting only seven minutes. Whilst this permits the blueprint to evaluate skills across many syllabus areas, it by necessity fragments those skills. Missing is the important skill of being able to synthesise information

The introduction of new curricula has re-emphasised the requirement for psychiatry training to reflect the holistic, person centred, biopsychosocial model of psychiatry. In turn, this need to ensure that psychiatrists are well prepared and able to deliver person-centred care has re-emphasised the importance of evaluating formulation skills.

Definition

Formulation can be defined as:

'... an attempt to explain how a situation is developed, maintained or resolved, or an attempt to make sense of what has happened. This is clearly distinct from diagnosis, which in psychiatry is generally descriptive rather than explanatory in nature...'

RCPsych OP103: Using formulation in general psychiatric care: good practice

Formulation contextualises the patient's experience: it requires the psychiatrist or psychotherapist to synthesise all the information that they have gathered about the patient from the various psycho, bio and social contexts into a cohesive explanation of how they came to be in need of care. Having done this, it enables care to be much more personalised and specific to the patient's needs – and ultimately to be more effective in addressing the mental ill-health which has brought the patient to the clinician.

2022 Core and specialty curricula

The new Core curriculum HLO 2.2 requires trainee psychiatrists to:

Demonstrate skill in the psychiatric assessment, formulation, diagnosis and person-centred holistic management of an appropriate range of presentations in a variety of clinical and non-clinical settings.

It also specifies a key capability, within the same HLO, that by the end of core training trainees should be able to:

Use an appropriate formulation framework to devise a safe, systemic, effective, collaborative and co-productive management plan to ensure continuity of care in the immediate, short and longer term.

The specialty curricula use a very similar wording in HLO 2.2, although they refer to 'advanced skills'.

The new curricula map very closely to the GMC's Generic Professional Capabilities.

Work-place based assessments (WPBAs)

At present, the assessment of formulation skills is addressed only in a limited way in the CASC. WPBAs evaluate a trainee's performance in key areas of their clinical practice, and in discussion with their supervisor and reflective practice – formulation skills should be picked up and assessed within WPBAs and should be addressed regularly within supervision.

However, the need to assess formulation skills is implied by the range of WPBAs used in training, but there is no requirement for a WPBA to focus specifically and exclusively on formulation skills.

The assessments tools used for the psychotherapy components of core and higher training do refer to formulation, but it is important this is assessed as a key skill across all psychiatry specialisms. The WPBAs used for these assessments provide descriptor statements to guide the assessors and support consistency in the assessment gradings.

Workplace-based assessments have their own challenges – there can be significant variation between supervisors assessing to the same standard, exacerbated by the reluctance to give negative feedback to trainees but specifically to trainees with whom supervisors have to continue to work. There are separate recommendations relating to WPBAs elsewhere in this report.

While training supervisors can go some way to addressing these issues in WPBAs generally, formulation skills are critical to psychiatric practice and therefore a different approach is required.

8. Formative assessment

Core and specialty training and new curricula

Formative assessment is central to training to be a consultant psychiatrist. While summative assessment provides a standardised, objective view of a trainee's ability to perform within a structured, blueprinted framework, formative assessment is the main tool used to evaluate trainee development and progress over the six+ years of core and specialty training. It is as valid as it can be, being based on encounters with real patients/colleagues in the clinical environment.

Formative assessment in psychiatry uses a variety of workplace-based assessments to collect evidence of trainee performance in a range of situations. Assessors can be the trainee's supervisor or other professional colleagues. Reflective practice and discussions in supervision are also collated in an ePortfolio and all are used to triangulate performance.

With the introduction of the new curricula in August 2022, the College has made the relationship between workplace-based assessments and the curricula overt. When a WPBA is completed, the assessor is asked to indicate the trainee's current level of performance (whether that is working towards the expected standard, meeting the standard or exceeding it) against as many of the HLO themes as it is possible to comment.

A Likert scale is provided so that assessors can use their professional judgment and the use of free text feedback boxes with prompts is also encouraged.

The Silver Guide specifies the minimum numbers of WPBAs of each type to be completed in each year of training, but otherwise the use of WPBAs is left to the discretion of the trainee and their supervisor.

Again, with the introduction of the new curricula, the College has taken the opportunity to link the key capabilities that trainees should show they have by the end of core/specialty training to the activities they plan to undertake during each placement and to the evidence that they provide. We have recommended a conversation between trainee and supervisor at the start of each placement to plan out in principle the curriculum capabilities that could be met in the placement.

By reinforcing the link between training and the curricula we hope that more consultants will be aware of the key capabilities expected of them (and to some extent by the GMC Generic professional capabilities framework to which the new curricula are mapped). With the link to the key capabilities in the core curriculum now being overt in the newly created CASC syllabus, it is hoped that work-place based assessments such as ACE, mini-ACE, CBD, etc., will offer opportunities for trainees to obtain formative feedback for the discrete skills that would be assessed in the CASC examination.

Issues with current workplace-based assessment system

Workplace based assessments were recognised as being effective ways to identify trainees who were struggling and acknowledged to provide a more accurate reflection of real-world practice than CASC – it is seen as crucial for the development journey.

Formative assessment in the workplace permits observation of the way in which trainees interact with patients and provide patient-centred care – it is also the most appropriate context in which to seek the thoughts of patients/carers on trainees.

However, if patients are involved it is critical that the trainee remains focused on the care being provided and not on the assessment.

However, respondents still had reservations. In the focus groups and quantitative surveys, they consistently noted that formative assessment is not standardised and that the output is very dependent on the assessor chosen.

The tendency of some trainees to cherry pick assessors whom they know will mark generously was recognised, as well as the tensions between supervising and line managing a trainee and the adverse impact that negative feedback can have on that relationship.

A reluctance to provide feedback on areas of perceived deficiency in current performance was mentioned frequently.

Supervisors not being available to observe assessments, not committing sufficient time to supervision or completing assessment forms in good time were also referenced as issues.

It was frequently observed that formative feedback is much more helpful for trainees than a ticked box on a scale, but the challenge of obtaining quality, individual feedback from supervisors was acknowledged.

Training was recommended as a way of addressing many of these issues, together with some redesign of WPBA forms.

Modern approaches to formative assessment in medical training

In exploring this area for the Assessment Strategy Review, we also researched formative assessment, the provision of impactful feedback, the use of entrustable professional activities, the ways in which other Colleges used workplace-based assessments and guidance from the GMC and AoMRC.

The GMC's [Excellence by Design framework](#) and [Designing and maintaining postgraduate assessment programmes](#) documents contain principles to which a thorough review of formative assessment should adhere.

The guidance emphasises the importance and centrality of professional judgment in making sure that trainees have met the key capabilities and high learning outcomes (HLOs) in the core and specialty curricula, commenting that:

'Assessors must use their professional expertise and experience. Through their understanding of expected levels of performance, they must make accountable professional judgments as part of a valid programme of assessment.'

This last is an important point: we should consider how to emphasise that supervisors appreciate the gravity of their role in making professional judgements and are accountable for the decisions that they make about trainee performance.

Similarly, the guidance in these two AoMRC documents: [Improving assessment](#) and [Improving assessment: further guidance and recommendations](#) provide a useful pointer towards improvements that we can make.

Some we have already implemented, such as linking feedback to learning goals (key capabilities) but there is more that we can do.

- The main purpose is to help trainees to identify areas for improvement – formative, not summative.
- Individual formative WPBA outcomes should not be used to influence progress though training.
- If a WPBA is to be used summatively, its purpose must be clearly defined
- ARCPs should use a range of outcomes from WPBAs as one component of evidence to be used to determine progress.
- Not all key capabilities should be formally assessed at every stage of training
- Adequate time to complete assessments effectively should be written into job plans, with Clinical/Psychiatric Supervisor and Education Supervisor receiving 0.25 PAs per trainee.
- It should be possible to recognise training excellence.
- We should encourage deaneries to put in place measures to support supervisors dealing with poorly performing trainees.
- WPBAs should be consistent across specialties although some variation in skills/capabilities assessed may be necessary.
- Assessments should be based on a trainee's proximity to the standard expected at the end of a period of training or for independent practice.
- There is a strong argument for moving away from numerical scales toward more specific text descriptors. WPBAs should be subjective judgments of professional behaviour by competent experts.

- There is a need for longitudinal and continuous approach to assessments, using a number of different assessment tools over a period of time with a variety of scenarios.
- It is important to assess trainees in the clinical environment as clinical performance is contextual. Assessment should be done while they are conducting their daily activities.
- WPBAs should only be used to assess capabilities that are relevant to clinical practice.
- Feedback should be linked to learning goals (key capabilities).
- Named clinical and educational supervisors should be trained for their roles.
- Trainers and trainees should be provided with the appropriate guidance and training in providing and responding to effective feedback and producing action plans.
- Benefits of direct observation, effective feedback and action plans should be clearly demonstrated and reinforced.
- Trainees should be encouraged to actively seek feedback from their trainers while the trainers should be advised to encourage trainees to do so.
- There should be deliberate structured planning between trainee and trainer.
- Specific goals identified during feedback should be handed on to the trainee's next Educational Supervisor to ensure a consistent training programme that is as far as possible tailored to the trainee's learning needs.

9. Recommendations: educational/assessment methodology

The College's educational and assessment framework has been designed around the GMC Excellence by Design principles.

Design

The GMC has approved the core, specialty and sub-specialty curricula, which conform to its design requirements by including purpose statements explaining the context in which each curriculum sits and why it is needed. The Silver Guide sets out the rules that apply to training, on all curricula, for all trainees.

Each curriculum is structured around nine high level outcomes which map directly to the nine generic professional capabilities required by the GMC. Within the HLOs are themes: for example, HLO1 splits into 1.1: Professional relationships and 1.2: Professional standards.

Within each HLO, key capabilities articulate the behaviours required of a trainee who has met the standard by the end of either core or higher training.

These standards are further explained in the *End of year standards guidance*, which identifies behaviours that may be observable, as exemplars, in trainees who are meeting the expected standards at the end of each year of training.

Development

Wide representation on the Curricula Review Working Group ensured that all stakeholder views (including those of trainees and patients/carers) were considered in the development of the curricula, which were endorsed by all devolved nations. The guidance is even-handed and applies across all four nations of the UK.

With a view to inclusion, the curricula also abstained from mandating activities where feasible, in acknowledgement of the fact that not all trainees are afforded the same opportunities, purely as a consequence of the placement or employing body in which they are working. This should no longer be an impediment to completing training.

And indeed in some cases, trainees' previous experience may provide evidence for the acquisition of a particular key capability. Our curricula, therefore, advocate an individualised approach to helping trainees plan to meet their learning needs. The curricula have been designed to be fair and to support equality and diversity – our surveys of the pilot roll-outs to new CTI and ST4 starters in February 2022 revealed no concerns about unfairness or inherent bias.

Deployment

The guidance given to trainees and supervisors has been altered with the implementation of the new curricula. There is a new emphasis on linking activities done in each placement to the key capabilities and HLOs, with a recommendation that the first few supervision sessions should focus on conversation about what the trainee wants to get out of their training placement, as well as what their supervisor believes the placement can offer them. Activities and the workplace-based assessments completed to evidence them are directly mapped to key capabilities and to HLOs.

We have developed many examples of personal development plans which can be used as guides for trainees and trainers as to the kind of activities and evidence that it might be appropriate to try to achieve in a placement.

At the end of the placement, or training year, it is clear to both parties how much progress has been made to achieving the key capabilities required by the end of training. This process then repeats at the start of the next placement or year, so that by the end of their third year (WTE), most of the key capabilities have been evidenced and (hopefully) the trainee has been signed off by their supervisor as having met all nine HLOs to the expected standard or exceeded that standard. The professional judgment of the supervisor, who can observe the trainee in the clinical environment and in their interactions with patients and colleagues is critical to this.

Where trainees are in difficulty, their supervisor is the best placed person to offer them support and guidance as to how they can bring their development back on track.

Assessment

Supervisors are encouraged to provide formative feedback to trainees on every workplace-based assessment completed, as well as rating their performance to show whether they are yet meeting the standard expected for that year of training.

During Core training, in addition to formative assessment, trainees are expected to complete the summative assessments – written papers and CASC of the MRCPsych qualification – in order to demonstrate that they are ready to progress to specialty training. The new syllabus devised for the CASC exam maps the blueprint to the key capabilities and HLOs of the core curriculum, making the link to that curriculum overt.

The syllabus, blueprint, stations and exam organisation have been reviewed to ensure that all exams are valid, fair, acceptable, feasible to achieve and effective in differentiating performance at different standards, each station is carefully standardised, and examiners are extensively trained.

In addition to the guidance in the Silver Guide and the psychiatric and education supervisors reports, ARCP decision aids give guidance to ARCP panels on the evidenced required to support their decisions.

Training for key stakeholders

We developed comprehensive learning and information resources for the implementation of the new curricula, all easily accessible from the College's website.

We recognise that more training would be valuable, for trainees, supervisors and assessors and refer to this in the recommendations that follow.

Differential attainment

The College has been undertaking a lot of work on differential attainment – this is described elsewhere in this document. More work needs to be done across the training pathway and this is also referenced in the recommendations that follow.

Burden of assessment

Delivering the digital CASC exam requires twice the number of examiner days compared to the face-to-face CASC exam. Employers have found it increasingly difficult to release doctors to examine, so delivering face-to-face exams will reduce the number of examiners required to deliver the exam.

As part of our review of assessment across core and higher psychiatry training, we have considered the skills that should be assessed by summative and formative assessment, or by both. Our stakeholder feedback, which included focus groups with Medical Directors and supervisors, was conclusive that both assessment types were required, and identified additional skills that need to be assessed. These have been highlighted in the recommendations.

We have looked at the number of stations that form part of the CASC exam, in order to relieve the burden of assessment, but concluded that we would only achieve a reduction at the cost of reliability – we therefore did not make this change.

As part of the formative recommendations below, we will consider the challenges faced by supervisors in observing workplace-based assessments and will explore what should be feasible within the dedicated hour set aside for psychiatric supervision each week.

Equality, diversity and inclusion

We have found no evidence in any of our areas of enquiry to suggest that the training and assessment programme provided by the College is not aligned with our values and aims of equality, diversity and inclusion. The College prides itself on the actions that it has taken to become a values-led organisation, living its own values and referencing values for psychiatrists in all curricula. There is always more to do, and we have made some further recommendations below.

10. Governance: recommendations

We recommend the creation of an Assessment Oversight Committee that will meet twice a year. The composition of the committee will primarily include the Dean, Chief Examiner, Associate Dean for Curricula, Director of Professional Standards, Head of Training and Workforce and Head of Examinations.

The aims and objectives of the committee will be to:

- have strategic oversight of assessment systems in UK-wide psychiatric training and education
- develop holistic strategy for formative and summative assessment
- align formative and summative assessment approaches with clinical best practice
- monitor efficacy of the programme of assessment and its effectiveness in developing outstanding psychiatrists
- ensure robust governance
- review the performance of operational committees to identify opportunities to improve effectiveness
- analyse progression data and trainee/candidate performance in both formative and summative assessment to inform interventions intended to tackle differential attainment and support for progression.

It is envisioned that this group would report into ETC and would have links with ESC and the Curricula and Assessment Committee.

11. Summative assessment: recommendations

*** Subject to scoping and the approval of a business case to demonstrate self-funding or secure internal or external funding.**

CASC syllabus and blueprint

- Publish new syllabus and highlight changes and the areas that have been given more emphasis.
- Complete mapping of all CASC stations and identify where new stations need to be created to ensure the whole syllabus and blueprint are covered.
- Following this mapping, explore extent to which CASC is able to assess skills that are not believed to be well examined/currently addressed in CASC, or whether these should be assessed in knowledge papers or in workplace, for example teamwork and video consultation skills.
- Streamline station writing, piloting and quality assurance (QA) process for the CASC.
- Establish the additional stations that are required to cover the new syllabus and blueprint, sufficiently sample the curriculum and achieve psychometric standards. Implement plan and timetable to meet this target question bank size.
- Quality assure all existing questions for CASC.
- Retain 16 station examination.
- Review the conjunctive standard required to pass the CASC.

CASC operations: all candidates

- Develop communication plan to ensure all potential candidates are aware of the outcomes of this review and the timeline to implement changes. Retain the ability to run online examinations should another emergency need arise *
- Review key roles and processes for face-to-face exams to identify possible areas of innovation or efficiency.
- Complete work on data cleansing to address anomalies in historical data identified during the station analysis work.
- Embed data capture and management as a standard part for the exam process following each exam, so data can be mined effectively rather than requiring large cleansing.
- Invest in additional data analysis resource.*
- Improve feedback to trainees on exam performance. Start sharing individual station scores and explore operational feasibility of providing personalised feedback to trainees (AoMRC Principle 4). *
- Review published exam support and guidance to ensure this is inclusive and meets the needs of all learners including non-UK PMQ trainees. (AoMRC Principle 1). *
- Explore potential to create a self-assessment tool for trainees to assess their readiness to sit (See MRCCP self-assessment) (AoMRC Principle 2). *
- Retain electronic marking.
- Evaluate continued use of Practique in respect of required functionality for digital marking, especially management information on examiner performance.
- Continue use of pre-populated standardisation forms and review approach to revising agreed marking schedule.
- Create a secure location for examiners for the digital distribution of stations and marking schemes and standardisation forms ahead of day of exam. *
- Explore new roles for existing newly recruited examiners– e.g. contributing to question development – if we need significantly fewer of them for face-to-face exams.
- Pilot the use of pre-created videos as part of standardisation and role player preparation – to show accurately how a borderline candidate would perform and guide role players on calibrating their role. Could draw on patient/carer input in recording, and used in international centres to maintain accurate standardisation. *
- Consider including patient/carer voices in creation of role player instructions/videos, to ensure greater authenticity.
- Develop exam preparation resources for candidates and trainees (in UK this varies significantly between employing bodies/deaneries.) – initially to explain the rationale, structure and operation of the exams. (For example, to explain the reasoning behind the use of seven-minute stations for the assessment of discrete clinical skills, with the assessment of the trainee's ability to synthesise or aggregate clinical skills taking place in the workplace through the use of WPBAs.). *
- Consider development of MRCPsych preparation courses. *
- Explore use of video consultation station(s) to replicate modern working practices. *

CASC operations: UK candidates

- Deliver enhanced face-to-face exams in the UK from September 2023.
- Explore feasibility of single vs multiple UK exam centres and outsourced or permanent OSCE facilities *
- Continue work to prevent unauthorised distribution of CASC stations.

CASC operations: international

- Produce fully costed plan and timeline for launch of international face-to-face CASC in 2024.
- Evaluate candidate numbers emanating from different locations, scope the development of further international centres in places of highest demand (likely to be India, the Middle East, and South East Asia), proposal to include start-up costs, training costs, travel costs, venue costs, role player recruitment / costs, examiner costs, invigilator costs, exams team and CASC costs.
- Develop and deliver training for local examiners, invigilators and role players.*
- To maximise sustainability and minimise cost, aim to work in partnership with an appropriate local medical organisation that can provide infrastructure and psychiatrists to train as examiners (we have successfully used this model previously in Hong Kong and Singapore).
- Implement additional online diet in Summer 2023 to meet international demand.
- Consider electronic marking implications for international exams.

Written Papers A and B

- Review written paper exam development processes and put forward recommendations paper on best practice for item bank writing, item bank size, item re-use, quality assurance and psychometric analysis of items.
- Establish the additional questions that are required to cover the blueprint, sufficiently sample the curriculum and achieve psychometric standards. Implement plan and timetable to meet this target question bank size.
- Continue to quality assure questions in existing question banks.
- Conduct research on the validity of the blueprint, test specifications, coverage of the syllabus, use of different item types, standard setting process.
- Set target date for implementation of very short answer questions (VSAQs) and give consideration to alternative question formats.

Differential attainment

- Produce a strategy and action plan to address differential attainment (including a policy on offering enhanced support) (GMC Principle 3).*
- Conduct further research into the concerns expressed regarding bias in the exam and measures that can be taken to address these concerns, for example pass performance and comparisons, differential item and exam functions.
- Improve support and guidance for MRCPsych Course Organisers on ways to address differential attainment (GMC Principle 5).*
- Scope feasibility of expanding CASC masterclasses/CASC preparation support to help more candidates to succeed and progress in training, consider eligibility criteria.*
- Continue to consider impact of the phrasing of written paper questions on differential attainment and requirement for cultural awareness.

Accessibility, equality, diversity and inclusion

- Conduct an accessibility audit for the face-to-face CASC and explore opportunities to improve the face-to-face experience, focusing particularly in those areas where candidates with protected characteristics expressed that the online CASC positively impacted their performance. For example, disability and pregnancy. *
- Ensure that presentation in any online platform meets W3C accessibility standards to at least level AA.
- Build on and enhance any accessibility recommendations that arose from previous face-to-face diets.

Sustainability

- Encourage use of public transport (especially train transport) for travelling to exam venues.
- Source invigilators and role players close to exam venues.
- Primarily work with suppliers that adhere to our sustainability policy.
- Retain digital marking, minimise printing and distribution costs.
- Strategically position global exam centres to minimise travel for international candidates and also address candidate concerns about costs, anxiety, safety and wellbeing.

12. Formulation skills: options for consideration

Formulation skills are critical for all consultant psychiatrists. To ensure that they are assessed during training we are proposing that the formative working group to be set up (see below) will have formulation skills as a key workstream and that, among other things, it should consider the feasibility of:

- Creating a specific WPBA for formulation skills, based on a case-based discussion template.
- Developing a range of descriptor statements that can be referred to by the assessor to indicate whether a core or higher trainee is operating at the standard expected at the end of core or higher training.
- Providing training for assessors, similar to that for examiners, on how to evaluate, how to give feedback, how to address possible bias, equality and diversity. *
- Creating an online training course that provides comprehensive training with opportunities to evaluate assessment practice. *
- Introducing a recommendation (short of making it mandatory) that all trainees must demonstrate the acquisition of formulation skills in core training (most likely by using a formulation skills WPBA). In higher training, trainees will be expected to demonstrate the application of advanced formulation skills in their practice – again, most commonly via a specific WPBA, but occasionally other forms of evidence might be more appropriate. *
- Incorporating this requirement into the core and higher training ARCP decision aids.
- Creating a list of accredited assessors and encourage schools to match trainees and accredited assessors with each other. This will provide independence and encourage more objective feedback to be provided.
- Setting up peer group meetings in schools where assessors can compare practice.
- Using data analytics from portfolio platform to evaluate relative marking standards of different assessors.

13. Formative assessment: recommendations

The quantitative and qualitative surveys, together with the research that we have done into formative assessment and previous work undertaken but not implemented by the College raise a number of areas where we feel that it is possible to revise and improve our current approach.

Because of the central importance of formative assessment to psychiatry training, expert input from experienced practitioners is needed before we can make decisions. Therefore, we are proposing to put in place a new working group, with formative assessment as its sole focus, to report by the end of 2023.

The working group will be asked to consider, reach agreement and make recommendations on the areas proposed below, after pilot evaluations where required.

Formulation skills

See section above for options to be considered.

Feedback

- How can we encourage formative feedback?
- Should leaving free text comments be made mandatory in WPBAs? If so, how?
- How to identify doctors in difficulty early so that support can be provided.
- Should we encourage trainees to self-evaluate before finding out supervisor's thoughts?
- How can we include the patient / carer perspective in feedback?
- How can we ensure that feedback focuses on topics that are useful and is not simply praise?

Naming

- Should we follow the approach of other medical royal colleges and the GMC and refer to WPBAs as Supervised Learning Events (SLEs)?
- Should we change the names of our WPBAs to bring them into line with those that other Medical Royal College's/the GMC use?

Entrustability

- Should we introduce a system of Entrustable Professional Activities (EPAs) along the lines of those introduced by RANZCP?
- Should we link specific WPBAs to specific EPAs as RANZCP do?
- Would EPAs be a better confirmation that trainees are acquiring the skills needed to be a consultant psychiatrist?
- What would it take to put them in place?
- How would we pilot their use?

Rating scales

- Should there be any summative evaluation within these formative tools?
- If so, should it be a Likert scale? Or a binary choice, at standard/not at standard?
- Should the scale be anchor statements describing the expected standard not positions on a Likert scale?
- If we retain the Likert scale, should we more clearly indicate to what each position on it refers?
- How do we acknowledge and encourage excellence?

WPBAs used

- Should we reconsider the use of all the currently used WPBAs and variants such as Med Psych, Addiction, Forensic?
- Should we link specific WPBAs with specific clinical activities?
- Is there merit in having Core WPBAs and Higher WPBAs?
- Can we replace some WPBAs with reflection or use other forms of evidence for some HLOs?

Evidence for progression decisions

- How many pieces of evidence do there need to be for confidence that the trainee is ready to progress?
- Who should be able to see the evidence?
- In what format does it need to be produced?

Standards expected

- Does the End of Year standards guidance sufficiently articulate the expected standards?

Assessors

- How do we ensure that assessors can observe WPBAs in order to be able to provide feedback?
- Should we accredit some assessors – e.g. for a specific independently assessed WPBA that could be used for formulation skills?
- What would accreditation process look like?
- Should we consider a single assessor who assesses all local trainees on one single WPBA rather than same person doing all WPBAs for one trainee? More objective outcomes.
- How do we make assessors / supervisors accountable for their professional judgments?

Assessment

- Are we confident in the continuum of assessment from the first WPBA in CT1 to the last ARCP in ST6?

Training for supervisors and educational supervisors

What training could we provide for supervisors that would improve WPBA use?

Suggestions – most of the supervisor and examiner respondents to our surveys said 'Feedback':

- personal skills: empathy, compassion, communication, leadership, time management
- purpose of formative and summative assessments
- how to give feedback that is meaningful, timely, sometimes negative, constructive, personalised, specific – hollowness of praise alone
- applying consistent standards across trainees, expected standards at each point in training, trainees should not be exceeding standard at start of placements
- critical role of supervisor in training, importance of observation, purpose and use of psychiatric supervision hour – obligations, protecting time, managing conflicts of interest between supervisor and line manager roles
- cultural barriers, helping people to adjust who have just come to UK, neurodiverse/disabled trainees, unconscious bias, equality, diversity and inclusion
- evaluating and helping trainees to develop clinical and formulation skills, report writing
- the curriculum and syllabus, particularly how it maps onto the programme of assessment to ensure that supervision is also helping trainees to track their progress towards the skills assessed in CASC
- MRCPsych exams and what trainees must achieve, CASC exam skills
- how to engage trainees with their training, mentoring, coaching, how to train trainees to know what to ask for, how to seek feedback, pastoral care, dealing with difficult/ bullying trainees, helping with career planning
- supporting trainees in difficulty or with attitudinal difficulties, how to sensitively address deficits in skills e.g. language/non-verbal communication when English is not a first language
- curriculum, planning for placements
- helping trainees to create their electronic portfolio.

Training for assessors

What training could we provide for (non-supervisor) assessors that would improve WPBA use? Suggestions:

- purpose of formative assessments
- how to give feedback that is meaningful, timely, sometimes negative, constructive, personalised, specific – hollowness of praise alone
- applying consistent standards across trainees, expected standards at each point in training, trainees should not be exceeding standard at start of placements
- importance of observation and timely completion of forms.

Training for trainees

What training could we provide for trainees that would improve the formative value of WPBAs? Suggestions:

- purpose of formative and summative assessments
- how to get the most out of feedback that could be perceived to be negative
- importance of timely feedback
- standards
- importance of observation
- critical role of supervisor in training
- clinical skills

- formulation skills
- help with portfolio – expectations of WPBAs
- how to find WPBA assessors, how to choose assessors
- MRCPsych exams, relationship to curricula
- ARCP process, outcomes, what to expect
- **Note:** it would also be beneficial to review the local MRCPsych courses being offered to trainees, to ensure that these are educationally sound and making use of the most modern tools and techniques.

WPBA models used elsewhere

- What can we learn from the approach to WPBAs adopted by other Medical Royal Colleges?

Burden of assessment

- How do we encourage more consultants to become willing to assess WPBAs?
- How do we make sure that proper observation and timely feedback can occur?

ARCP process

- Can we provide guidance on the College's perspective on ARCP processes to all employing bodies / Deaneries / Schools?
- Can we make the ARCP decision aids more useable?
- Can we streamline the process in an ePortfolio platform?

Skills presently not well covered by summative or formative assessment

When we asked what skills were not presently assessed by either formative or summative assessment, but should be assessed, the skills below were identified.

The working group will review the existing assessment of these skills and consider how any additional assessment could be introduced:

- addressing health inequalities
- case-load based discussion (applying evidence-based care to communities of practice)
- clinical decision-making
- communication, verbal and particularly written skills, communication at appropriate developmental level
- complexity and uncertainty, deviating from guidelines – nuanced care, managing cases with multiple co-morbidities, no NICE or other recognised guidelines and no absolute answers, managing ethical and societal issues,
- conflict – dealing with and resolving
- cultural context - help needed for non-UK candidates/candidates making significant moves, to acclimatise to local terminology, etc.
- digital literacy
- educational skills, motivational skills
- emotional literacy, interpersonal skills, empathy, compassionate working, establishing therapeutic rapport, trust, honesty and integrity, listening, showing respect
- formulation skills – synthesis of skills in taking a comprehensive clinical history and developing diagnostic and management plans
- medico-legal reports, Mental Health legislation and framework

- patient management plans, from entry into hospital to discharge
- physical health and risks, e.g. patient suffering from anorexia nervosa
- psychodynamic formulation skills – trauma induced care / practice
- psychopharmacology
- phenomenology
- rehabilitation
- religion and mental health
- research
- safeguarding
- systems literacy
- teamwork and collaboration, liaison, chairing meetings, working in a multi-disciplinary team, time management.

14. Approvals

Throughout the lifetime of this project, the GMC have been engaged with the progress of the review and have met with the College on multiple occasions to help us understand their perspective on different delivery methods of examination.

A draft version of the ASR report was taken to the Education and Training Committee of Council and was approved in October 2022. Shortly after, it was brought to the ASR group for final review and sign-off of the recommendations.

The headline recommendations to be approved are:

- Continuing to run written papers A and B online via Pearson Test Centres
- From September 2023. moving to a face to face delivery model for CASC with some digital elements like iPad marking and the possibility of digital stations.
- Creation of a new Assessment Oversight Committee to have strategic oversight of educational assessments, and report to the ETC.
- Creation of a formative assessment working group to create a recommendations report by the end of 2023.

15. Conclusion

The Assessment Strategy Review has garnered the views of all key stakeholders on the present use of formative and summative assessment within psychiatry training and the recommendations of this paper will enhance all assessments to ensure they are reliable, fair, valid and demonstrate that candidates meet the key capabilities as outlined in the new curriculum.

More work will be undertaken immediately by the College to implement the summative recommendations.

The formative recommendations and those relating to formulation skills will be taken forward by the ASR Formative Working Group, to be constituted as soon as possible.

A further report, with recommendations for changes to be made to formative assessment will be produced before the end of 2023.

16. Authors and acknowledgments

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17. Documents referred to within report

- [AoMRC – EDI and online exams quantitative survey](#)
- [AoMRC Improving assessment](#)
- [AoMRC Improving assessment: further guidance and recommendations](#)
- [ASR Psychometrics report on reliability of CASC](#)
- [Core Psychiatry Curriculum Mapping document](#)
- [Core Training Curriculum \(CT1-CT3\)](#)
- [End of year standards guidance – Core curriculum](#)
- [Examiner survey results – quantitative](#)
- [GMC Designing and maintaining postgraduate assessment programmes](#)
- [GMC Excellence by Design: standards for postgraduate curricula](#)
- [International medical graduate survey results - quantitative](#)
- [MRCPsych CASC Syllabus and Blueprint](#)
- [Placement-specific personal development plan – Core Psychiatry exemplar](#)
- [RCPsych CASC: The implications of fewer stations – Final report](#)
- [Report on Differential Attainment 2018-2022](#)
- [Research by Design combined report on qualitative surveys](#)
- [Supervisor survey results - quantitative](#)
- [The Psychiatry Silver Guide](#)
- [Trainee survey results - quantitative](#)