AKT Board Report 2024-25 – Common FAQs

Medical Schools Council

Exam Development & Governance

1. How are AKT exam questions developed, reviewed, and approved?
Questions are written by trained academics from across UK medical schools. They go through multiple rounds of review for accuracy, clarity and fairness. The Item Development Group (IDG) oversees the growth and quality of the item bank, while the Exam Construction Group (ECG) oversees the construction of the exams according to a national sampling grid that is aligned to the GMC content map.

Refer to pages 15–17.

2. What groups are involved in AKT governance, and what are their roles?
Key governance groups include:

- AKT Exam Board: Oversees all operational groups, ratifies results, and ensures national consistency.
- Item Development Group (IDG): Maintains and grows the question bank.
- Exam Construction Group (ECG): Constructs the exams and ensures alignment with the GMC Content Map.
- Standard Setting Group (SSG): Sets the pass mark using a standardised process.
- Policy Group: Develops and maintains the policy framework, including EDI guidance and student support.

Refer to pages 6–7.

3. How is the exam aligned to the GMC Content Map?
Exams are constructed to reflect the knowledge, skills, and clinical areas defined by the GMC Content Map. While the Content Map list is not exhaustive, it identifies core conditions. This ensures that all exams fairly assess the knowledge required to safely enter the UK Foundation Programme.

Refer to pages 18–19.

4. How does the Exam Construction Group ensure comparability across multiple exam sittings?
The ECG uses a standardised sampling grid and automated construction algorithm to create the exams which are then reviewed manually to confirm alignment. This ensures all exams cover the same topics in similar proportions, maintaining fairness and consistency.

Refer to pages 18–19.

5. What quality assurance processes exist to check exam items?
Each item undergoes multiple layers of peer review before it is available for use in exams and is then reviewed using psychometric data post exam. Items can be flagged, revised or retired if necessary.

Refer to pages 15–17.

6. How are psychometric analyses used in exam construction and post-hoc review?
Psychometric data help check the reliability, difficulty and discrimination of items. Analyses using Classical Test Theory and Item Response Theory inform decisions about pass marks and any potential item revisions.

Refer to pages 20–21.

7. How is the national pass mark for each AKT determined?
The Standard Setting Group uses a Modified Angoff method, a criterion-referenced approach, where expert panels estimate the performance of a minimally competent candidate. Pass marks are reviewed for consistency across exams.

Refer to pages 20–21.

Student preparation & support

8. What practice materials are available to students?
Students have access to a 200-item practice exam (blueprinted to the Content Map) and shorter practice papers. These materials help students become familiar with question styles and the online platform.

Refer to pages 9–11.

9. How are reasonable adjustments handled?
Medical schools, guided by a national policy framework, handle requests for reasonable adjustments (e.g., extra time, assistive technology). Decisions are made on a case-by-case basis, in line with equalities legislation.

Refer to pages 12–14.

10. Are mitigating circumstances allowed for this exam?
Yes, individual medical schools apply their own mitigating circumstances policy to the exam guided by the AKT Policy Framework.

Refer to pages 12–14.

11. How are students informed about AKT policies and procedures?
The AKT is centrally constructed and developed, with medical schools responsible for the local delivery of the AKT. Whilst there is a national policy framework, schools manage the delivery within the context of their university regulations and so each school is responsible for providing appropriate information to their students.

Refer to pages 9–11 and 12–14.

Performance & metrics

12. What do Cronbach alpha values indicate about exam reliability?
Cronbach's alpha measures internal consistency. All AKT "main sit" exams had alpha values above 0.8, showing the exams are highly reliable and measure knowledge consistently.

Refer to pages and 21–22.

13. How should the national pass rate be interpreted?
The AKT is designed as a minimum competence standard exam, so most students are expected to pass if they meet required knowledge levels. The high pass rate reflects that the exam reliably identifies those meeting this threshold.

Refer to pages and 21–22.

14. How consistent are AKT results across schools, exam dates, and panels?
Results are highly consistent. Standard-setting panels show strong alignment with previous pilot data and performance across different schools and exam dates is comparable.

Small differences between schools are expected and reflect normal variation and differences in student cohorts. Everyone who passes the AKT meets the same national standard for safe medical practice.

Refer to pages 20–24.

15. How does the Modified Angoff standard-setting process ensure fairness?
Expert panels independently judge each item against a minimally competent candidate. This method reduces bias and ensures a national standard.

Refer to pages 20–21.

16. Were any items removed following post-exam analysis?
No items were removed in 2024–25 following post-exam review. Feedback on individual items is shared with the IDG to help inform the way those items are written in the future.

Refer to page 20.

17. How does performance in penultimate-year AKTs compare to final-year AKTs?
Performance is very similar, with pass rates of 96.4% in penultimate-year sittings and 98.3% in final-year sittings, showing consistent standards across cohorts.

Refer to pages 22–24.

Equity, Diversity & Inclusion (EDI)

18. What awarding gaps were identified in the first AKT?
Small gaps were observed between groups sharing protected characteristics. For example:

- Students with disabilities had a 3.1% lower pass rate than those without.
- Black British students had ~3% lower pass rates than White British peers.
- Asian British students had 2–2.3% lower pass rates, with British Bangladeshi students at 96.9% vs 99.2% for White peers.
- Students eligible for free school meals had a 0.9% lower pass rate.

The gaps are consistent with longstanding patterns seen in undergraduate and postgraduate medical assessments. The AKT does not appear to create new structural disadvantages but reveals existing patterns of disadvantage and provides a benchmark for schools to monitor and address awarding gaps.

Refer to pages 25–34.

19. How does the MSC use AKT demographic data to support intersectional analysis?
The demographic data collected as part of the running of the AKT can allow analysis of how multiple characteristics (e.g., ethnicity and socio-economic background) may combine to affect outcomes, helping to identify and address compounded disadvantage. This analysis will not be part of the annual reporting of the AKT but will be carried out and published by research teams in due course.

Refer to page 41.

20. What steps are being taken to use AKT data to reduce disadvantage?
Schools receive benchmarking data to monitor awarding gaps and take targeted action. MSC supports best practice in assessment design and EDI across schools to reduce disadvantage. The MSC EDI Alliance, which includes membership from across every UK medical school, works to improve inclusivity and address inequity in medical education.

Refer to pages 25–30.

21. How can medical schools use national AKT benchmarking data?
Schools can compare their students' performance with national trends, track awarding gaps over time and develop strategies to support underperforming groups.

Refer to page 41.

Operational insights

22. What is the role of the Rapid Response Team during exam delivery?
The Rapid Response Team monitors live exams, provides immediate advice to schools and the MSC team, and ensures timely resolution of issues on exam days. Any problems are logged in real-time, decisions are communicated to schools, and feedback is used to improve future processes.

Refer to pages 23–24.

23. How does the AKT maintain consistency when multiple exam dates occur?
Automated exam construction, manual review and psychometric oversight ensure that all exam sittings are equivalent in content, coverage, and difficulty.

Refer to pages 18–21.

24. How is feedback from exam boards fed back into item development?
Post-exam analysis, including comments on item performance, is shared with the IDG to improve the question bank and inform future exams.

Refer to page 20.

Future & research applications

25. How will AKT data support research into socio-economic and linguistic factors?
The AKT demographic survey collects novel data such as language proficiency and socio-economic background, enabling research into factors influencing performance.

Refer to pages 28–32 and 41.

26. How might intersectional analyses help identify compounded disadvantage?
By analysing combinations of characteristics (e.g., ethnicity + socio-economic status), researchers and schools can identify groups at higher risk of disadvantage and develop targeted support.

Refer to page 41.

27. How will AKT results and annual reports inform future exam improvements?
Annual reports highlight trends, award gaps, and operational insights, guiding updates to exam content, policies, and student support to ensure fairness and reliability.

Refer to pages 25–30 and 41.

28. Should AKT or MLA results be used to rank medical schools?
No. The purpose of the MLA is to ensure consistency, fairness and safety for patients, not to rank universities or their students. AKT and MLA results are a benchmark for competence, not a measure of institutional performance, and should not be used to judge or compare medical schools.

The AKT measures whether each student meets a national threshold for safe practice, not the overall quality of teaching at a medical school. Slight differences in pass rates between schools reflect normal variation in student cohorts, course timing and local assessment methods, not “better” or “worse” schools. The exam is pass/fail only, so using results to create national league tables would be misleading and uninformative.