RACGP

RACGP Education

Exam report 2023.1 CCE

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Introduction to the Clinical Competency Exam

The Clinical Competency Exam (CCE) is the final general practice Fellowship examination for The Royal Australian College of General Practitioners (RACGP). The examination is blueprinted to both the RACGP Curriculum and the clinical competency rubric. It is designed to assess clinical competence and readiness for independent practice as a specialist general practitioner (GP) at the point of Fellowship.

The CCE was introduced in 2021 to replace the Remote Clinical Exam (RCE) and the Objective Structured Clinical Examination (OSCE). In 2023.1, the CCE was delivered remotely to all candidates via videoconferencing technology. The CCE reflects contemporary assessment principles and standards. A significant amount of academic research, combined with local and international external consultation, informed the development of the CCE.

The CCE consists of nine clinical cases.

The 2023.1 CCE was delivered in two streams on non-consecutive days as follows:

- **Day 1A:** Saturday 17 June 2023, cases 1A–4A
- **Day 1B:** Sunday 18 June 2023, cases 1B–4B
- **Day 2A:** Saturday 24 June 2023, cases 5A–9A
- **Day 2B:** Sunday 25 June 2023, cases 5B–9B.

Exam psychometrics

The 2023.1 CCE proved to be reliable and valid. Table 1 shows the psychometrics for the entire cohort that sat the exam. These values can vary between exams. The reliability calculated using Cronbach's alpha is a measurement of the consistency of the exam, with values between 0 and 1. Each case had high internal reliability. There were two streams in the 2023.1 CCE, each independently reliable and valid.

The 'pass rate' is the percentage of candidates who achieved a pass mark. A candidate must achieve a score equal to or higher than the pass mark (or cut score) to pass the exam. The CCE pass mark is determined by the borderline regression method.

The RACGP has no quotas on pass rates; there is not a set number or percentage of people who pass the exam. Candidates are not required to achieve a pass in a minimum number of cases to achieve an overall pass. There is no negative scoring in the CCE. Table 2 shows the pass rate by number of attempts.

Table 1. 2023.1 CCE psychometrics

Average reliability	0.68
Pass rate (%)	88.84%
Number passed	629
Number sat	708

Table 2. 2023.1 CCE pass rate by number of attempts

Attempts	Pass rate
First attempt	93.45%
Second attempt	79.75%
Third attempt	46.35%
Fourth and subsequent attempts	47.25%

Exam banding

Table 3 provides a percentage breakdown of candidates into bandings.

Table 3. 2023.1 CCE candidates in each banding

Banding	Candidates (%)
P4	32.49%
P3	24.15%
P2	20.62%
P1	11.58%
F1	6.78%
F2	3.81%
F3	0.42%
F4	0.14%

P1 is the first band above the pass mark, and P4 is the highest band.
F1 is the first band below the pass mark, and F4 is the lowest band.

Figure 1 provides an overview of the number of candidates in each band.

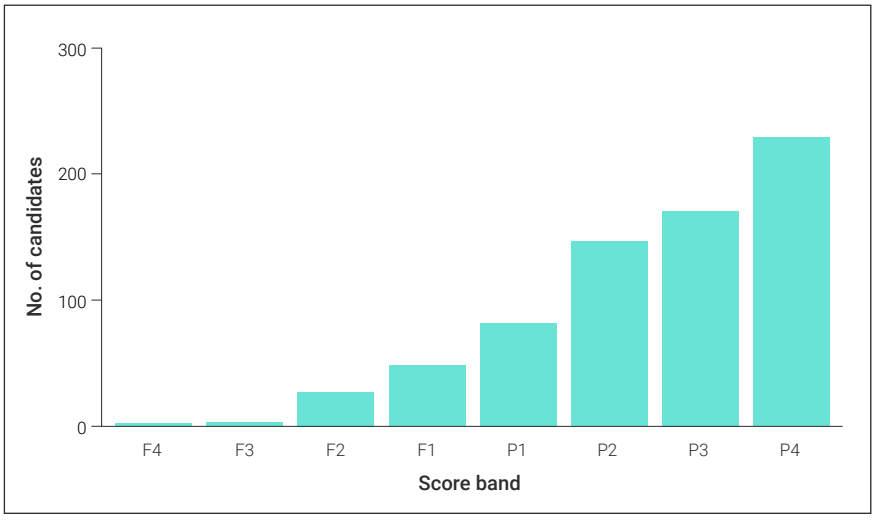

Figure 1. 2023.1 CCE banding distribution

Figure 2 shows the average performance of the cohort of passing candidates across clinical competency areas in the 2023.1 CCE.

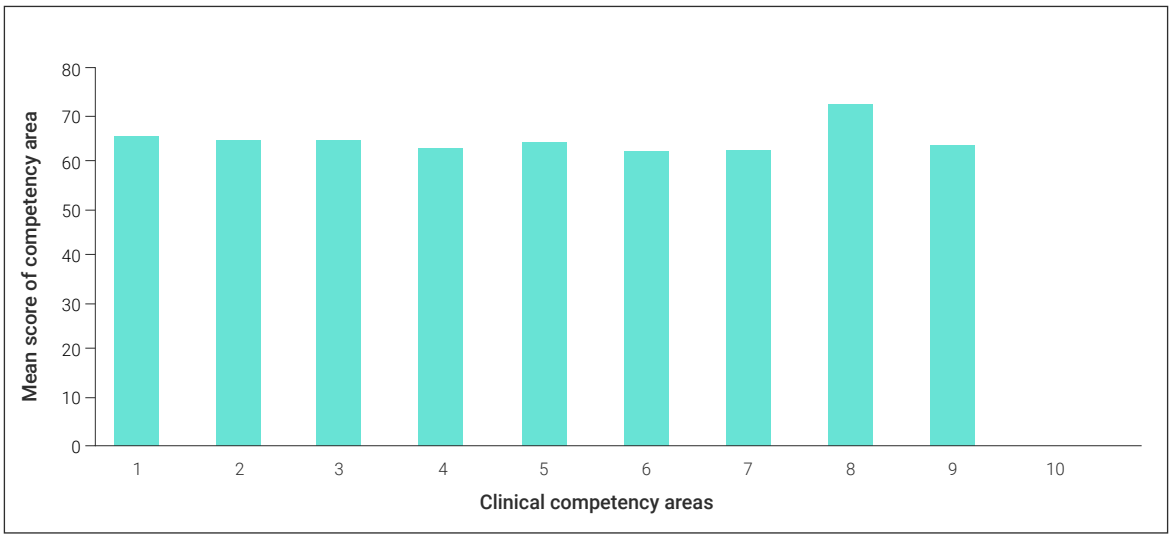

Figure 2. Average performance of CCE – by competency area

1. Communication and consultation skills; 2. Clinical information gathering and interpretation; 3. Diagnosis, decision-making and reasoning; 4. Clinical management and therapeutic reasoning; 5. Preventive and population health; 6. Professionalism; 7. General practice systems and regulatory requirements; 8. Procedural skills; 9. Managing uncertainty; 10. Identifying and managing the patient with significant illness.

For candidates who sat the 2023.1 CCE, refer to your candidate portal to see how your personal performance in each competency compares to that of the passing cohort. Some competency areas are examined more extensively than others in the CCE.

The list below provides a breakdown of the assessed criteria within each competency area. In the 2023.1 CCE, 107 individual competency criteria were assessed.

Breakdown of criteria within competency area for 2023.1 CCE

1. **Communication and consultation skills** (30/107) 28%
2. **Clinical information gathering and interpretation** (10/107) 9%
3. **Diagnosis, decision-making and reasoning** (16/107) 15%
4. **Clinical management and therapeutic reasoning** (22/107) 21%
5. **Preventive and population health** (13/107) 12%
6. **Professionalism** (7/107) 7%
7. **General practice systems and regulatory requirements** (6/107) 6%
8. **Procedural skills** (1/107) 1%
9. **Managing uncertainty** (2/107) 1%
10. **Identifying and managing the patient with significant illness** (0/107) 0%

Preparation for the CCE

Preparation for the CCE primarily involves working in and reflecting on comprehensive general practice. It is useful to practise case-based discussions with supervisors and colleagues, and it is important to understand and apply the clinical competencies, as outlined in the clinical competency rubric.

A two-part CCE preparation course is available on *gplearning*. The first module, 'Introduction to the RACGP Clinical Competency Exam for candidates', includes information on the competencies being assessed and how they can be demonstrated by candidates. The second module, 'Preparing for the CCE case discussions and clinical encounters', is a guided exam preparation activity that includes cases, marking grids and video examples.

Frequently asked questions, tips, technical resources and multiple additional practice cases are available on the CCE resources website, available to all RACGP members. This includes the clinical competency rubric with the criteria and performance lists against which candidates are being assessed.

The online delivery via Zoom requires candidates to have the ability to use Zoom's basic functions. A technical guide is available on the CCE resources website. The RACGP encourages all CCE candidates to practise in the online environment as much as possible to best prepare themselves for the exam-day experience.

2023.1 CCE cases

All candidates are under strict confidentiality obligations, and must not disclose, distribute or reproduce any part of the exam without the RACGP's prior written consent.

This feedback report is published following each CCE in conjunction with candidate results. It is helpful to consider your personal graph of performance in each of the competency areas when reflecting on the item feedback. All cases within the CCE are written and quality assured by experienced GPs who currently work in clinical practice, and are based on clinical presentations typically seen in an Australian general practice setting.

The CCE assesses how a candidate applies their knowledge and clinical reasoning skills when presented with a range of common clinical scenarios. It allows a candidate to demonstrate their competence over a range of clinical situations and contexts.

Each case assesses multiple competencies, each of which comprises multiple criteria describing the performance expected at the point of Fellowship.

Examiners rate each candidate's performance in relation to the competencies being assessed in the context of each case. Ratings are recorded on a four-point Likert scale, ranging from 'competency not demonstrated' to 'competency fully demonstrated'.

This assessment is designed as a summative measure of competency. It is not designed to give feedback to candidates, and as such, we do not ask examiners to comment on individual candidate performance; we ask examiners to rate performance based on the demonstration of competencies.

The feedback report is provided so that all candidates can reflect on their own performance in each case. It is also being provided so prospective candidates, as well as those assisting them in their preparation, can see the breadth of content in the exam.

Specific case details are outlined below (Saturday: Stream A, Sunday: Stream B). Equivalent competencies are assessed over both streams, and each clinical case provides a framework in which those competencies are assessed.

Each case assessed an average of 12 criteria. Competencies are assessed multiple times over the exam. Some competencies are assessed more frequently over the exam. Examiners were surveyed on exam day to identify candidate performance characteristics that demonstrated competency and common pitfalls observed.

Cases 1A and 1B

These case discussions presented scenarios where candidates were asked to undertake a child health check within an Aboriginal medical service environment. Both the A and B cases explored different examples of children in out-of-home care. The A case presented a kinship care scenario and the B case a foster care example. Each scenario had different medical and social complexities to consider. Candidates were expected to demonstrate a trauma-informed approach to the patients and their carers along with the capacity to consider the cultural needs of the children. Information on how to engage in a trauma-informed approach can be found at https://humanrights.gov.au/sites/default/files/ahrc_sr_2021_8_trauma-informed_approach_a4_r2_0.pdf

Competency was achieved for candidates who demonstrated the ability to reflect on their own skills and knowledge and identify where to seek assistance in developing their own cultural understanding. A competent candidate required self-reflection and self-awareness to avoid harmful biases, assumptions, stereotyping and rote-learned responses that did not consider the individual patient context.

A collection of resources and learning modules on Aboriginal and Torres Strait Islander health can be found in the 2022 RACGP Curriculum and syllabus for Australian general practice and on the RACGP Aboriginal and Torres Strait Islander Health website. Information on cultural awareness training is also available on gplearning . Further information on cultural considerations in out-of-home care can be found at https://earlytraumagrief.anu.edu.au/files/rb8.pdf

Many examiners commented that, in this case, the medical aspects were well managed; however, many candidates did not address cultural aspects, or the social situation for the patient and their out-of-home carer.

Examiners commented that candidates demonstrated competency by:

- demonstrating the ability to be specific and considerate of the issues pertaining to this particular case, rather than simply giving general statements about child health or Aboriginal health
- meaningfully engaging with the specifics of the complex social history
- considering both carer and child needs
- demonstrating an awareness of the barriers to care that may exist for this family unit
- understanding culturally informed care beyond offering an Aboriginal health worker
- demonstrating practical examples of a team-based approach, including the carer, the GP, child services, allied health, culturally appropriate education services, and culturally appropriate parenting programs for carers as needed
- considering comprehensive and holistic management, following a biopsychosocial framework
- being open about their knowledge limitations and experience, and being willing to seek help.

Examiners commented that common pitfalls in these cases included:

- listing engagement of an Aboriginal health worker as the solution to any and all cultural aspects of the case, and demonstrating no real understanding of the actual role or scope of the Aboriginal health worker
- ignoring the cultural and historical context of the Stolen Generation or the potential trauma on a child in out-of-home care being separated from their land, family, community, cultural practices and language
- treating the case only in medical terms and not linking to the cultural background or a trauma-informed framework
- not realising that in the question the candidate is working in an Aboriginal medical service, thus not framing responses appropriately
- omitting crucial basic examination components of the Aboriginal Health Check – for example, hearing assessment and aural examination
- not demonstrating an understanding of the difference between culture and other concepts related to Aboriginal health – for example listing high rates of chronic disease or equity measures like the Closing the Gap (CTG) – PBS Co-Payment program as 'cultural'
- stereotyping or judgemental approaches, using generalisations and not approaching lack of knowledge and understanding with humility and curiosity.

Cases 2A and 2B

In these case discussions, candidates were presented with a practice incident to manage. A needlestick injury or a breach of patient confidentiality by a practice member were explored with questions from the examiner designed to assess competency in diagnostic and therapeutic reasoning in addition to professionalism, population health and general practice systems.

Resources freely available on the RACGP website that may assist learning in this area include A guide to manage clinical risks, errors, near-misses and adverse events and Helping you manage the business side of general practice.

Examiners commented that candidates demonstrated competency by:

- describing an appropriate history and examination to assess the patient and identify key features of the assessment
- providing reasoning for the investigations selected
- having a sensitive discussion around ethical dilemmas
- showing appropriate professionalism
- describing general practice systems and how they can be used to track incidents and near-misses for quality and systems improvement
- considering population health and contact tracing
- recognising the need for learning from a breach of confidentiality and strengthening practice policies and procedures as a response
- appropriately recognising that it is the responsibility of every GP to identify, report and manage any breaches of confidentiality regardless of their employment or management status within the practice
- recognising the importance of training, protocols and procedures in the practice environment.

Examiners commented that common pitfalls in these cases included:

- covering the clinical aspects adequately and not attending to the ethical and professional issues in the case
- not adequately considering the patient's confidentiality
- not using prompts as an opportunity to elaborate on the answers given to the assessor
- a disorganised, scattergun approach with no safety-netting or follow-up
- lack of structure, not reading or following the case instructions
- placing blame on an individual staff member for the workplace incident rather than looking at the systems in place to support staff.

Cases 3A and 3B

In these clinical encounters, a patient presented with a forest plot summarising a systematic meta-analysis and asked the candidate to help interpret the data to help with their decision making. In each of the different clinical scenarios, candidates were asked to take a history, apply the information in the forest plot to the patient, and consider their management options and preventive care. Research is an important driver of clinical change in the general practice setting; interpretation and understanding of statistics remains a vital skill for all GPs.

Examiners commented that candidates demonstrated competency by:

- not only understanding the overall study findings, but also quantifying the magnitude of the results and communicating this information to the patient in a relatable, patient-centred way
- taking an adequate biopsychosocial history to demonstrate an understanding of the impact of pain on the patient and ascertain management thus far
- discussing the study with the patient and applying the findings to their specific case, using the findings to guide management decisions
- following the case instructions, forming rapport with the patient, taking a history, discussing therapeutic options and covering preventive health for the patient.

Examiners commented that common pitfalls in these cases included:

- not reading the case instructions properly, and therefore not undertaking the prescribed tasks
- dismissing the case instruction ('You have judged the paper to be of sufficient quality to rely on the results') and dismissing the article as having any significance for the patient
- poor time management, either spending too long collating a history or explaining the article, not leaving sufficient time to cover preventive activities
- not demonstrating active listening skills, repetitively asking questions the patient had already answered
- taking a paternalistic approach to management without exploring the patient's preferences
- using too much jargon and not using patient-centred language
- addressing preventive health as an afterthought and not tailoring to the patient and their needs
- lack of consultation structure leading to omissions or running out of time to address the prescribed tasks
- failing to explore the patient's ideas, concerns and expectations with open-ended questions
- not allowing the patient to provide scripted information by interrupting.

Cases 4A and 4B

In these clinical encounters, post-discharge care in the setting of ischaemic heart disease was presented to candidates. Candidates were required to take a history, educate and manage the patient, and advise on preventive care. The expectation was for candidates to consider the psychosocial impact of the cardiac event as well as the medical impact.

Examiners commented that candidates demonstrated competency by:

- reading the instructions for the case and undertaking the prescribed tasks
- using active listening and taking a full social history
- exploring the impact on the patient, work confidence and their mood
- assessing patient concerns and addressing cardiovascular risk factors and lifestyle change to reduce the risk of a secondary cardiovascular event
- using a team approach with services locally
- offering medical certification and a return-to-work plan
- tailoring management and prevention to this patient based on their ideas and concerns.

Examiners commented that common pitfalls by candidates in these cases included:

- not taking a psychosocial history
- missing the opportunity to safety-net for the patient, particularly about how to manage symptoms if they recurred
- overfocusing on medications and not approaching the patient as a whole
- being overly directive and paternalistic in the approach to management rather than asking the patient about their goals
- taking a scattergun approach to history and management rather than an orderly approach
- using jargon and complex language
- dismissing the emotional impact for the patient and minimising symptoms such as anxiety and nightmares
- poor prioritisation within the consultation – spending too much time on history at the expense of educating and managing the patient
- an overreliance on a checklist approach – vaguely mentioning multiple health providers and care plans.

Cases 5A and 5B

In these case discussions, candidates were asked to assess a new skin lesion, advise what clinical history and examination features would help them to come to a diagnosis, and then explain how their management would alter with different histology repots. The case also considered preventive health for the patient and asked candidates how practice systems might be used to assist preventive care.

Examiners commented that candidates demonstrated competency by:

- approaching the case holistically, considering the risk factors and key features of both the history and examination
- a systematic approach to the history and examination
- considering prevention beyond skin cancer prevention and follow-up
- considering family situation, other medications and risk factors for the patient
- considering practice systems such as recalls and audits to assist with preventive care.

Examiners commented that common pitfalls by candidates in these cases included:

- failing to consider prevention more broadly, for example not considering family stressors
- a disordered approach to examination – not considering the positive and negative findings
- not interpreting the findings in front of them – rather, speaking in generalities instead of interpreting what they could see in the case material
- uncertainty regarding margins for biopsy and excisions
- failing to refer for specialist care when appropriate
- being non-specific with the probability diagnosis.

Cases 6A and 6B

In these case discussions, candidates were presented with a case of diarrhoea and worsening diabetes control. Initially, candidates were asked to outline the case representation, differential diagnosis and approach to investigation. The cases then developed into managing different malignancies and palliative care. As the cases were set in a rural area, this context needed to be addressed.

Examiners commented that candidates demonstrated competency by:

- considering the rural context of the case. Even if the exact service availability was not known, it was important to acknowledge the network that would be needed, consider telehealth, consider the additional role a GP plays in supporting a rural patient with end-of-life care – for example considering home visits, considering weekend, out of hours and emergency care – and considering the patient's wishes regarding at-home or in-hospital care
- recognising what the patient initially presented with – a diabetes check-up – and addressing this
- summarising the information given in the stem and showing reasoning by collating an appropriate problem list and rational differential diagnosis
- being organised and presenting information logically

- rationally choosing investigations that clarified the differentials to rule in or rule out diagnoses
- recognising the significance of weight loss for the patient and considering a serious or sinister cause
- recognising and describing how to break bad news
- being able to discuss legal and ethical aspects of end-of-life care and thinking broadly about the patient, their family and their needs in the context of a rural setting
- having knowledge about using a syringe driver, including pre-ordering medication supply, having equipment available, seeking advice as needed from palliative care, community nursing involvement and potentially family education in use and adjustment
- considering what impact the patient's illness would have on the rural community and the treating team in terms of knowing the patient.

Examiners commented that common pitfalls by candidates in these cases included:

- neglecting to discuss communicating a serious diagnosis
- a scattergun approach to differential diagnosis and investigation
- considering malignancy on the differential, then not investigating for it
- not recognising the significance of weight loss in the patient
- ordering tests that had already been done for the patient within the last week for which the result was provided
- using faecal occult blood test (FOBT) as an investigative/diagnostic tool
- omitting to consider symptomatic relief from symptoms
- advising they would break bad news using the SPIKES method, but not being able to elaborate on what this meant
- not demonstrating an understanding of the rural context, the possible gaps in care and the role of the GP in managing those gaps
- identifying difficulties or challenges of rurality but not suggesting solutions to these challenges
- using keywords such as 'We will work as a team' and not elaborating on who, how or what that meant
- not identifying the need as a GP to coordinate/liaise/link with services in the rural context, instead only referring the patient away to a regional or capital city for treatment
- not appreciating the context of a terminal illness, encouraging the patient to only seek active, curative treatment
- giving inappropriate advice such as 'weight loss' in a patient with a terminal malignancy, or 'moderate intensity exercise for 30 minutes five days a week', or 'General Practice Management Plan (GPMP) for podiatry and optician'
- failing to take into account patient wishes or address patient needs
- deferring the initiation or use of a syringe driver to another person
- thinking that a syringe driver was for use in voluntary assisted dying only.

Cases 7A and 7B

These clinical encounters gave candidates the opportunity to demonstrate competencies in communication, gathering history, exploring and addressing patient concerns, and providing appropriate patient education and advice. The scenarios depicted a mother wanting to discuss her child's gender. There was no expectation for the candidate to be expert in this area; rather, the expectation was that candidates would demonstrate a non-judgemental and supportive approach and direct the patient to sources of information for the development of their understanding. This encounter might have been a new or unfamiliar presentation for some candidates; however, uncertainty is a normal part of general practice and the ability to manage an unfamiliar scenario, support this family's journey and coordinate community resources is an appropriate skill to examine.

Examiners commented that candidates demonstrated competency by:

- following the instructions for the case
- actively listening and taking a history, identifying the patient's agenda, concerns, ideas, fears and expectations
- using clear, succinct non-judgemental communication, checking in with patient understanding, and demonstrating empathy and a genuine interest in the patient's situation
- using appropriate, patient-centred language to explain terms like 'sex', 'gender' and 'genetics'
- checking in with the patient on how they were coping with their child's situation
- maintaining professional boundaries and confidentiality.

Examiners commented that common pitfalls by candidates in these cases included:

- not listening to the patient and her concerns about her child, instead following their own, doctor-centric agenda
- using incorrect pronouns for the patient's child
- failing to respond to the patient's verbal and non-verbal cues
- giving advice prematurely, based on incorrect assumptions
- assuming/telling the parent what emotions they had rather than listening to or exploring their feelings
- confusing sex and gender
- not considering that fertility concerns may require a framework for breaking bad news.

Cases 8A and 8B

In these clinical encounters, candidates were required to take a collateral history, formulate a differential diagnosis for the patient's symptoms of cognitive decline, in two different aged care settings. They were then asked to outline an appropriate investigation and management plan to the patient's child. This case assessed managing uncertainty and explored two different ethical dilemmas commonly presenting in aged care. This is extensively explored in the RACGP Silver Book, Part B.

Examiners commented that candidates demonstrated competency by:

- showing empathy and good communications skills with the family member
- taking an appropriate biopsychosocial history
- explaining a reasonable differential
- taking a rational approach to investigation with a reason for each investigation
- offering the family member education and resources on dementia
- addressing safety concerns
- involving a team of other health professionals in patient management – for example, pharmacist to undertake a medication review, occupational therapist, physiotherapist
- acknowledging the uncertainty and putting appropriate safety-netting in place.

Examiners commented that common pitfalls by candidates in these cases included:

- lack of attention to the task instructions
- lack of empathy towards the relative and their concerns
- poor listening – asking information that the family member had already given
- minimal exploration of collateral history
- premature closure of diagnosis – not considering reversible causes of cognitive decline
- not considering the safety of the patient
- giving an inadequate list of possible diagnoses
- failing to give reasons for investigations, or not being specific with investigations – for example 'blood tests' or 'urine screen'
- lack of structure to manage common concerns in the elderly patient
- lack of specific multidisciplinary team approach
- referring for geriatrician review and pharmacy review without discussing their own plan to deprescribe or manage symptoms themselves
- spending too much time on history at the expense of explaining management.

Cases 9A and 9B

In these clinical encounters, candidates were asked to assess a patient with a fever, headache and lethargy. Candidates were required to take a history, consider what could be causing the patient's symptoms, and appropriately investigate and manage. This case was more about communication and the diagnostic reasoning process rather than each of the different diagnoses. Uncertainty when presented with the cluster of undifferentiated symptoms was also assessed in these cases.

Examiners commented that candidates demonstrated competency by:

- taking a structured and yet targeted history demonstrating a hypothetical–deductive approach
- active listening and attending to both the patient's and doctor's agenda
- considering the problem definition and synthesising an appropriate differential list based on the key features in the history
- creating a defensible investigations list that was well explained to the patient
- recognising the diagnostic uncertainty and approaching this with honesty
- considering appropriate safety-netting and follow-up planning and consultation with appropriate support from other clinicians – for example, infectious disease.

Examiners commented that common pitfalls by candidates in these cases included:

- a disorganised approach to the consultation, with a poorly structured history
- omitting the psychological impact of the illness
- prioritising the doctor's agenda over the patient's agenda
- not listening to the patient, asking closed questions from very early in the consultation
- focusing on only one aspect of the presentation – for example, headache
- failing to undertake a systems review
- poor problem definition and subsequent limited differential listing
- lack of confidence in dealing with uncertainty and lack of a structured approach to investigation
- over-investigation and referral to hospital despite limited rationale for this in the presentation
- limiting differential to infective causes only
- not safety-netting or organising follow-up
- disregarding the fever as insignificant
- considering infections that did not fit with the history of exposure – for example, Lyme disease.

Feedback on candidate performance

Candidate clinical performance: General comments

Successful candidates were able to demonstrate an empathic and non-biased approach to patient management, taking into consideration the patient's context.

General stereotyping and making assumptions are not appropriate and demonstrate a lack of understanding of patient context. Competent candidates should demonstrate a non-judgemental approach to all patients.

Other common pitfalls included formulaic responses that used a scattergun approach in answering the question. This does not demonstrate clinical reasoning ability or understanding of individual patient context and needs. Assumptions and formulaic responses to specific cultural groups, for example, without considering individual circumstance, might lead to incorrect conclusions.

Reflecting on areas of practice with which a candidate might be less familiar, and addressing these gaps, is helpful in exam preparation. In some stations, it was obvious to examiners that candidates had not previously managed a certain type of presentation in practice. This leads to a formulaic, rather than patient-centred, approach.

A structured and systematic approach will assist candidates to encompass important potential diagnoses that guide their history, examination, investigations and management.

Process: General comments

Most candidates engaged well with the process and had a smooth examination experience. However, a small number of candidates had not tested their technology and arrived at the exam without adequate audio and camera functionality. The RACGP information technology team, administrators and examiners supported those candidates to progress through the examination, but pre-exam preparation would have ensured a better experience for them.

A reminder that, if needed, candidates should use the 'ask for help' (NOT the raise hand function) button in Zoom to alert the administrator to a problem, and not leave the exam until speaking with an administrator if you have encountered a technology-related problem.

A small number of candidates appeared to be unfamiliar with the functionality of the Zoom platform, and were therefore less prepared to manage on-screen documents. Candidates should practise resizing documents and obtaining a gallery view in Zoom, allowing for resizing of the shared document and face tiles.

Additionally, some candidates experienced slow internet connections that affected their connectivity to the exam. The likelihood of this occurring can be reduced by testing internet speed prior to the exam. Refer to the CCE candidate technical guidelines for more information.

Preparation is key to a smooth experience. We encourage all candidates to optimise their examination environment and tools when preparing to sit the CCE.

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