Medical and Dental Recruitment and Selection
Quality and Standards Subgroup Report 2016
Executive Summary

The Medical and Dental Recruitment and Selection (MDRS) Quality and Standards (Q&S) sub group aims to drive improvement in the quality of recruitment and selection processes, and to ensure standards are maintained in all medical and dental specialties across the 4 nations. This year, the sub group has continued to review the quality of current recruitment and selection processes, in order to allow us to focus on areas where we still need to drive improvement, and also to allow us to share areas of good practice.

Quality is defined as the high utility, reliability and validity of recruitment and selection processes, which promote patient safety, professionalism and the NHS values, and ensure equity for trainees.

Planned Areas of Focus for the Last Year

1. Evaluation of selection processes
2. Assessor training and benchmarking of selection.
3. Development of the Specialty Recruitment Assessment (SRA)
4. Implementing standards for externality including the external evaluation of General Practice selection
5. Improved partnership working with colleges
6. Sharing of best practice across healthcare professions, including the learning from dental recruitment.

This paper details the progress with these areas of activity and the outcomes achieved.

Outcomes:

1. Database of current recruitment processes
2. Identification of best practice within a breadth of current processes
3. Identification, action, and improvement in standards in some specialties
4. Definition of minimum standards for inclusion in the Memorandum of Understanding with lead recruiter
5. Completion of an external review of the GP recruitment processes
6. Review of issues to ensure there is learning and any required changes in systems
7. Further development of specialty specific online assessor training tool
8. Additional specialties successfully adopting the use of the Specialty Recruitment Assessment in their selection processes
9. Defined minimum recruitment standards for selection processes
10. Cross specialty use and development of the Specialty Recruitment Assessment
11. General Medical Council (GMC) support with data analysis
12. Clearer college and junior doctor input
13. External academic analysis
1. **Introduction**

The Medical and Dental Recruitment and Selection (MDRS) Quality and Standards subgroup was set up by the Department of Health, to drive improvement in the quality of recruitment and selection processes, and to ensure standards were maintained in all medical and dental specialties across the 4 nations. This function continued when the group transferred to be managed under the new governance arrangements hosted by Health Education England (HEE).

In recent years the MDRS Quality and Standards sub group had been working on improving areas of variable practice in specialty selection and on developing the Specialty Recruitment Assessment.

The Quality and Standards sub group has continued to review the quality of current recruitment and selection processes, in order to allow us to focus on areas where we still need to drive improvement, but also to allow us to share areas of good practice.

For this process, quality is defined as; the high utility, reliability and validity of recruitment and selection processes, which promote patient safety, professionalism and the NHS values, and ensure equity for trainees.

**Key Objectives of the MDRS Quality and Standards Sub Group**

- To bring together stakeholders involved in quality and standards for postgraduate recruitment and selection within individual specialties and across the UK.
- To promote a unified approach to quality and standards between colleges, medical and dental postgraduate local offices and deaneries, regulatory bodies and the 4 UK health departments.
- To promote fairness and transparency during national recruitment, selection and appointment processes.
- To ensure best practice in equality and diversity as it relates to recruitment and selection issues in postgraduate medicine and dentistry.
- To improve the validity and reliability of the selection process.
- To ensure recruitment and selection processes incorporate values based testing.
- To develop national standards for assessors to ensure that all specialties are recruited to a common standard.
- To promote standards for benchmarking of scoring across specialties.
- To promote the availability of accurate, consistent and comparable information about the recruitment and selection process through a standardised evaluation process.
- To promote appropriate externality in the selection processes, including the involvement of trainees and lay members.
- To improve the utility of the selection processes.

**Planned activities for 2015/16**

1. **Evaluation of selection processes**: A common standard of evaluation
2. **Assessor training and benchmarking of selection**: ensuring a common standard.
3. **Development of the Specialty Recruitment Assessment (SRA)**: Results and next steps
4. Implementing standards for externality – learning from the **external evaluation of General Practice selection**: Appropriate externality to ensure transparency
5. Improved partnership working with the royal colleges
6. Sharing of best practice across healthcare professions, including the learning from dental recruitment.
2. Update on Progress

2.1 Evaluation of Selection Processes

Outcomes:

1. Database of current recruitment processes
2. Identification of best practice within a breadth of current processes
3. Identification, action, and improvement in standards in some specialties
4. Definition of minimum standards for inclusion in the Memorandum of Understanding with lead recruiter
5. Completion of an external review of the GP recruitment processes
6. Review of issues to ensure there is learning and any required changes in systems
7. Defining minimum recruitment standards for all selection processes

2.1.1 Evaluation of Specialty Selection

In 2014/15, the MDRS Quality and Standards sub group introduced a common standard for ongoing evaluation of specialty selection. The framework produced allowed all national recruitment leads to report back on their processes in a consistent way, against a list of standard domains:

- Accuracy and effectiveness
- Cost and efficiency
- Implementation issues
- Stakeholder acceptance and feedback
- Operational issues and administration
- Values Based Recruitment

The responses provided were used to create a national database of selection processes and allowed for easy comparison of specialties.

In 2015/16, these specialties have been surveyed again, against specific areas of the selection process, to confirm that the information held centrally is up to date and accurate.
Review of the data collected identified some areas of good practice in use by specialty selection processes. The Quality and Standards sub group have used these to write a number of best practice guides that can be shared with all national recruiters. To date, the following have been written and shared:

- **Trainee involvement in selection processes** – outlining the appropriate use of trainees in recruitment selection, to include involvement in steering groups and selection panels
- **Assessing values in selection processes** – there is a requirement in England to assess the values of the NHS Constitution of all appointees to NHS posts. Although much of the national specialty recruitment processes are UK wide, it was deemed appropriate to assess values of all applicants. This guide gives examples of how values can be assessed and what competences can be used to assess them
- **Lay Representative Report Form** – a nationally agreed form for lay representatives to record issues relating to selection processes that they have attended. This ensures that feedback is captured in consistently.

Review of the data collected has also identified that there is significant variability in portfolio assessment. However, there has been some robust evaluation in some specialties and there is also a lot of good and common practice with regards to assessment of portfolios. Production of a best practice guide for assessment of portfolios is currently in process.

In addition the group is working on a guide for lay representatives at recruitment which will outline roles and responsibilities. The minimum standards identified will inform the Memorandum of Understanding for HEE local office/ Deanery national recruitment leads and the Service Level Agreements with recruiting royal colleges that will be signed with HEE for 2017 recruitment processes. These agreements will ensure a clear understanding of the expectations on delivery and evaluation of processes in order to receive continued funding.

### 2.1.2 Ongoing Review of Problems and Issues

The MDRS Q&S sub group reviews all ongoing issues and problems to ensure there is learning from them and that action is taken to minimise risks for the future.

Each lead recruiter is required to maintain an issues log for the specialty that they manage and provide the national team with an updated version on a monthly basis.

In addition, the national team maintains a log of all issues that have been escalated to them. To date, we have experienced 8 issues, with varying risks, throughout the 2016 recruitment process. These have been managed quickly and none of them have resulted in legal or significant media interest. Should issues occur, it gives us the opportunity to look at how the issue has happened, whether it could have been avoided and what action can be taken to ensure that similar issues do not recur in future recruitment rounds. Most issues are managed and the learning shared at the Recruitment Operational Group, with significant issues escalating to the Quality and Standards sub group and to senior leaders in HEE and the devolved nations.
Issues will continue to be logged and reviewed throughout the recruitment year.

### 2.2 Assessor Training and Benchmarking of Selection

**Outcomes:**

1. Development of a generic online assessor training tool
2. Development of additional specialty specific modules in 8 specialties

A generic online assessor training tool has been developed for use by interviewers for specialty recruitment. This tool will ensure that all selection assessors have access to an online training package that will educate them on the minimum standards expected.

The training package is particularly beneficial for specialty recruitment processes where interviews are delivered at different venues across the country and for assessors who are new to specialty selection. Using the online tool will ensure that all interviewers assessing for the same specialty have been trained to the same standard and are assessing applicants in the same way.

Core Surgery, Core Psychiatry and Core Medicine have all developed specialty specific modules to supplement the generic tool. Development of specialty specific modules further increases the consistency of selection processes.

### 2.3 Development of the Specialty Recruitment Assessment

**Outcomes:**

1. Specialty Recruitment Assessment (SRA) is being used as a key mandatory element of selection
2. Review of the use of the SRA as a selection tool
3. Collaboration across specialties using the SRA
4. Discussions with further interested specialties

The Multi-Specialty Recruitment Assessment Committee was established on the recommendation of the MDRS Quality and Standards sub group to take forwards work on making the Specialty Recruitment Assessment (formally the Specialty Selection Test) a more generic tool that could be used to support selection and recruitment processes across all specialties. The group was established in January 2015 with representatives from a range of stakeholders including royal college representatives for specialties using the SRA, the General Practice National Recruitment Office, Work Psychology Group, BMA Junior Doctors Committee and NHS Education for Scotland.

Core Psychiatry and Ophthalmology joined General Practice in using the SRA in 2015 and Clinical Radiology joined in 2016. Evaluation from these specialties has been very encouraging.
Further work is being undertaken by the Committee with other interested specialties on how they can utilise the SRA for future recruitment rounds. Expressions of interest have been received from Obstetrics and Gynaecology, Histopathology, Community Sexual and Reproductive Health and Neurosurgery.

2.4 External Evaluation of General Practice Evaluation

Outcomes:

1. Recommendations received on potential changes to improve future recruitment processes

In 2015, General Practice recruitment and selection was identified for an in depth review due to the low fill rate combined with a need for clarity about utility of more expensive recruitment processes.

Following a competitive tendering process, the University of Birmingham, in collaboration with the University of Warwick and the University of London were awarded the contract to undertake the evaluation.

The evaluation team produced a report of their findings which included a number of recommendations for future recruitment rounds. These recommendations were reviewed in depth by the Quality and Standards subgroup and a report was provided to and accepted by the MDRS Programme Board on how these should be taken forward.

When reviewing the recommendations, subgroup members were keen to ensure that:

- Only recommendations that they had control over were considered
- Further investment was not put into developing processes that have been shown to be less reliable
- Cost benefit analysis should be undertaken before any investment is made
- Recommendations that further increased the length or cost of the GP selection process would be rejected

The full response to the recommendations can be found in Appendix 1

The suggested next steps are:

- Alterations to the current process in line with the report recommendations
- Further review of the Stage 3 process
- Longer term follow up of applicants, including those who are not recruited
- Collaborative work with medical schools on GP recruitment
- GP experience in foundation.
2.5 Improved Partnership Working with Colleges

The Quality and Standards subgroup has representation from the Academy of Medical Royal Colleges, dentistry and the National School of Healthcare Sciences. Any work undertaken with regards to advising on best practice is done in collaboration, considering input from all groups.

The database of specialty selection processes has allowed the subgroup to identify areas of good practice that can be shared between the different colleges and groups and their associated specialties. A recent example of this is the development of the new, nationally coordinated, cluster delivered recruitment process for Paediatrics for 2017 recruitment. The recruitment model being used is one that has been successfully used in other specialties in recent years; Respiratory Medicine, ACCS Emergency Medicine and General Practice.

3. Future Work

Over the next 12 months the MDRS Quality and Standards sub group will continue to build on the work already undertaken and ensure there continues to be widespread engagement with raising the quality of recruitment and selection processes.

As part of an annual review of recruitment processes, recruitment leads will be expected to provide an evaluation of the previous year’s process, focusing on lessons learnt, analysis of selection methodology and evidence of budget management. Raising the quality of selection processes will be further embedded through the signing of Memorandums of Understanding or Service Level Agreements for all selection processes with each of the recruitment leads. The evaluation of specialty selection has identified a number of areas where inconsistency exists between different specialty processes. We plan to continue to develop minimum standards and guidance on best practice, ensuring this is communicated to recruiters and specialties.

We will work across specialties in developing specialty specific modules for the online assessor training tool.
Evaluation of the use of the Specialty Recruitment Assessment has been positive, showing that the tests are appropriate for selecting individuals into specialty training. In the coming months we will engage with interested specialties to ascertain whether they wish to use the test as a part of their selection processes in future years.

Most national recruitment is currently managed by a lead HEE local office/Deanery on behalf of all regions and the associated royal college for the specialty concerned. Further engagement is planned directly with the royal colleges to ensure that they are fully aware of the work that the MDRS Quality and Standards sub group is undertaking and the implication that this work has on their specialty selection processes.

**Planned Activities for 2015/16**

- Continued evaluation of selection processes with greater in depth analysis to share best practice and set minimum standards
- Reviewing the implementation of standards for externality
- Continued focus on partnership working with royal colleges
- Sharing of best practice across healthcare professions, including learning from dental, pharmacy and healthcare scientist recruitment and from the review of standards from the annual reporting.
### Appendix 1 – GP Evaluation: Response to Recommendations

#### Recommendation 1:
Although not currently being pursued, interpretation of the ‘50%’ target should reflect the percentage of UK graduates who do not go straight from Foundation into Specialty training (currently 48% and rising), and/or who never enter either the GP or Specialist Registers (historically 15% and possibly rising). Similarly, as the ‘3250’ target is for England only, the targets for Scotland, Wales and Northern Ireland should also be published. As GP selection is UK-wide, it would be helpful if such announcements are agreed and coordinated between the 4 countries.

**Response:**
Workforce targets are set by the Department of Health and therefore this recommendation cannot be taken forward.

#### Recommendation 2:
Invest in improving the validity and reliability of GP and specialty selection. In terms of the whole UK healthcare system, this is likely to be highly cost-effective in the long-term.

**Response:**
The GP national recruitment steering group (GP NRSG) would welcome further investment in looking at the process and improving the validity of Stage 3 but others felt that further investment in a stage of the recruitment process that has been shown to not be particularly reliable should not happen.

#### Recommendation 3:
Seek to reduce Stage 1 rejections and encourage those who are rejected to re-apply. In 2016, candidates are being given longer to provide evidence of Foundation competency and for IMGs to complete their application for sponsorship so a move to addressing this recommendation is already underway.

**Response:**
Already happening. Impact of this needs to be evaluated.

#### Recommendation 4:
Use statistical equating of the CPST and SJT scores across years e.g. by Rasch modelling; this makes Stage 2 an absolute form of assessment.

**Response:**
Members felt that there needed to be an understanding across the years with the different cohort. This is work that should be taken forward by the GPNRSG.
<table>
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<tr>
<th>Recommendation 5:</th>
<th>Use continuous Stage 2 scores rather than Bands</th>
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<tr>
<td><strong>Response:</strong></td>
<td>Support to do this as using raw scores will be more discriminatory than using bands</td>
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<tr>
<th>Recommendation 6:</th>
<th>Select to Stage 3 using the total CPST + SJT score rather than a cut-off mark for each; however, we have not investigated this in detail e.g. the optimal way to weight SJT compared with CPST</th>
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<tr>
<td><strong>Response:</strong></td>
<td>This has not been investigated in detail. However, members were supportive of continuing with a cut score for each of the tests as they are measuring different things. It was felt that having a total score across both tests could create a risk to the quality of applicants</td>
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<th>Recommendation 7:</th>
<th>Increase the length of the Stage 2 assessments, particularly SJT, to increase reliability</th>
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<tr>
<td><strong>Response:</strong></td>
<td>There would need to be a cost-benefit in doing this. Members were unsupportive of increasing the length</td>
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<th>Recommendation 8:</th>
<th>In terms of transparency, it would make sense to separate development and administration of the selection system from its evaluation (this also applies to Stage 3)</th>
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<td><strong>Response:</strong></td>
<td>Noted but no action to take</td>
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<th>Recommendation 9:</th>
<th>Use a combination of CPST, SJT and the Stage 3 total scores rather than the algorithm to decide which candidates should be offered places. If this is done, weight the Stage 2 CPST and SJT continuous scores more heavily than the Stage 3 score</th>
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<tr>
<td><strong>Response:</strong></td>
<td>In order to take this forward, the GPNRSG need to model how a raw score could be used and moderation removed</td>
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## Recommendation 10:
Withdraw the moderation procedure. If uncomfortable with this without further evidence, undertake sociolinguistic and additional statistical analyses of moderation to enable a more comprehensive assessment to be made of what it adds, and whether it does so consistently.

**Response:**
In order to take this forward, the GPNRSG need to model how a raw score could be used and moderation removed.

## Recommendation 11:
Investigate the possibility of increasing the number of stations to increase reliability and predictive validity. Removing the moderation session would mean about a third more time is available. There may also be potential to reduce the length of the scenarios. Any such changes would need to be designed carefully.

**Response:**
Members disagreed with this recommendation. Stage 3 is already a costly process and to achieve the desired level of reliability would require many additional stations.

## Recommendation 12:
The generalizability analysis suggests that simulators and cases contribute roughly similar amounts of variance (error) as assessors; so:

a) Consider ways to reduce differences between simulators and cases, as much as between assessors
e.g. more simulator training and feedback on their ‘hawkishness’ or ‘doveishness’; ideally cases would be piloted, but perhaps more realistic is consideration of the difficulty of previous cases when developing new ones (for which Rasch analysis provides a useful methodology).

b) Design the selection centres so that variances due to assessors, simulators and cases can be partitioned (distinguished) i.e. keep careful records of which assessor, simulator and case are seen by each candidate, and ensure each assessor and simulator experiences at least two simulators/assessors and cases e.g. rather than confounding assessors with simulators by always pairing them in the same way.

**Response:**
Members disagreed with this recommendation as it was felt that assessors could be trained in the process.
### Recommendation 13:
Avoid using Cronbach’s alpha as a measure of reliability. Generalisability analyses are well developed and should be used routinely within and between selection centres. Techniques such as the EM algorithm and alternative forms reliability can also be used.

**Response:**
Noted but no further action required.

### Recommendation 14:
Investigate why candidates (particularly those who are graduates of UK medical schools) are failing Stage 3 (and Stage 2) and consider enhancing medical school or Foundation training to help applicants address the areas of weakness identified. Publish the results to help prospective candidates understand what is required of them and consider using videos of poor, acceptable and excellent candidates in example scenarios to help applicants prepare for the Selection Centre.

**Response:**
Members agreed with this recommendation and felt that this should be undertaken in all specialties to see what happens to trainees that do not pass selection.

### Recommendation 15:
Consider whether the greater reliability, validity and cost-effectiveness of abolishing Stage 3 are beneficial, given potential losses in terms of educational impact and acceptability.

**Response:**
Members felt that there is insufficient evidence on the impact of removing Stage 3 to agree to this recommendation. Members agreed that Stage 3 needs to be reviewed to see if it could cost less while delivering the same reliability, or how it could be used to improve recruitment to GP, however, it should not be abolished.
**Recommendation 16:**
Take a long-term strategic approach to obtaining, checking, using and storing data related to recruitment and training. Ideally this is in all specialties from the beginning of medical school to retirement.

This is now underway with UKMED, but it will take many years before it will have sufficient longitudinal data to address many of the issues in this report; consequently, ‘bottom-up’ improvements in data retention are also desirable.

a) Investigate why in 2014, 5% of candidates appeared to pass Stage 2, but were not invited to Stage 3: if due to LETB preferences, should offers elsewhere still be made?

b) Investigate why in 2015, 224 (4%) GP candidates appear to have been deemed appointable, but were not made an offer (even if to a different LETB).

c) Investigate why some doctors have no GP ARCP records despite accepting offers, and others enter the GP register despite being recorded as not accepting offers (they could be via the CEGPR route, but may be due to data errors).

d) Maintain accurate ARCP records, particularly regarding OOP, TOOT and LTFT, so that FTE lengths of training can be calculated precisely

**Response:**
Members agreed to this recommendation

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**Recommendation 17:**
UKMED will also inevitably be limited in the measures it obtains of medical students and their interests and intentions, and separate methods of collecting such data routinely need to be developed

**Response:**
Members agreed to this recommendation

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**Recommendation 18:**
Positive GP experiences at medical school are important influences on applying for GP, particularly as they help students become aware that GP suits their personality. It is possible that improving these experiences and providing positive careers advice towards general practice may increase long-term uptake of GP

**Response:**
Members agreed to this recommendation

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**Recommendation 19:**
Address the problems that hinder Foundation doctors from gaining GP experience in Year 1.

**Response:**
Members agreed to this recommendation

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**Recommendation 20:**
Consider ways to encourage and facilitate applications from those who have been working abroad or in another specialty

**Response:**
Ongoing work