



Selecting for  
Excellence  
Medical Schools Council

End of Year Report  
2013

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# Introduction

In 1944, the Goodenough report stated that “unsuitability for a medical career should be the sole barrier to admission to a medical school”. Although progress has been made since then in widening access, Alan Milburn put a stark challenge to our profession last year:

*...medicine lags behind other professions both in the focus and in the priority it accords to these issues. It has a long way to go when it comes to making access fairer, diversifying its workforce and raising social mobility.*

In response to this, Health Minister Dr Dan Poulter convened a summit on widening participation in medicine, which coincided with emerging plans from the Medical Schools Council to tackle the issue. And at the same time a GMC-commissioned literature review into best practice in the selection of medical students identified linked challenges for medical schools over the different methods which are used across the UK. The Selecting for Excellence project has grown from these sources and aims to improve selection into medicine for many years to come.

The project was launched officially in July 2013. We have established four work streams and with

input from key partners and experts in the field we have set priorities, collected and analysed large amounts of data, consulted with admissions deans and careers guidance professionals and made preparations to widen participation in medicine and assist medical schools in using optimal selection methods. Given the amount of work underway, it is clear that the end product will have a huge weight of experience and consideration behind it.

The benefits of widening participation in medicine are two-fold:

1. a medical profession which reflects the diversity of the population it treats is important for social mobility
2. a medical profession with access to the widest possible talent pool is essential for producing the best possible doctors.

The relationship between medicine and widening participation is changing. Selecting for Excellence is at the forefront of this change and I am committed to seeing it support young people's aspirations. With the help of the people and groups identified in this report, we hope to make the aspiration of the Goodenough report a reality.



Professor Tony Weetman,  
Chair, Selecting for Excellence Executive Group

# About the project

## Background

The Medical Schools Council set up the Selecting for Excellence project in March 2013. It was officially launched by Dr Dan Poulter MP, Parliamentary Under Secretary for Health, in July 2013. The central aims of the project are to look at selection to medicine with particular focus on widening participation and to support medical schools in selecting the candidates most suited to becoming the excellent doctors of the future.

It is well known that medicine is a demanding subject to study, requiring the highest level of intellect as well as other attributes such as exceptional communication skills. The application process is very competitive with many more people applying to enter a course than there are places available. Entry requirements are stringent with medical schools requiring outstanding academic achievement as well as strong performance in other selection methods, such as interviews and aptitude tests.

With such demanding entry criteria, it is important that candidates are selected in the fairest possible way. Concerns have been raised that some people, despite having the talent to study medicine, are being excluded from this career. This is to the detriment of the future medical profession. In particular it is important that the high entry criteria do not exclude potential applicants from lower socio-economic backgrounds who may not have had the educational advantages of their more privileged peers. This was a major concern raised by Alan Milburn in his 2012 progress report on social mobility.

As the demographics in the UK are changing and the aspirations for our health service increase, it is more important than ever to ensure that medical schools are selecting students based on who will be the most effective doctors. A recent literature review commissioned by the GMC and published in November 2012 highlighted the fact that UK medical schools use a variety of different methods to select their students. UK medical schools run a variety of curricula and teach in different ways to achieve the outcome expected by the GMC,

and while there are very good reasons for this diversity of approach, there is also a need to ensure that decisions on entry to the profession are consistent with producing the best doctors of the future.

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## Project work streams

There are four distinct but related work streams to this project:

*Widening participation* – ensuring that excellent candidates are able to access medical courses no matter what their background is. This work stream looks at what steps medical schools can take to widen participation.

*The role of the doctor* - when medical schools are selecting potential students they need to know what they are selecting for. This work stream looks at what makes a good doctor and these attributes can then be tested at admission to medical school.

*Selection methods* – there is diversity in how individual medical schools select their students. This work stream will take an evidence based view on what works best in terms of selection methods.

*Evidence base* – to evaluate whether selection methods work, a longitudinal data set needs to be created so that medical schools can see what happens to the students they select after graduation.

## Selecting for Excellence Executive Group

The Selecting for Excellence project is overseen by an executive group which is known as SEEG. The group is chaired by Professor Tony Weetman, who is the Pro-Vice-Chancellor of the Faculty of Medicine, Dentistry and Health at the University of Sheffield. SEEG makes regular reports to the MSC Council and Executive to keep them updated as to progress.

The group is made up of representatives from the following organisations:

- Brightside Trust
- British Medical Association Medical Students Committee
- Department for Business, Innovation and Skills
- Department for Education
- Department of Health
- General Medical Council
- Health Education England
- Higher Education Funding Council for England
- Medical Schools Council
- NHS Employers
- Office for Fair Access
- Social Mobility and Child Poverty Commission

The biographies of members are available below.

## Professor Tony Weetman Group Chair

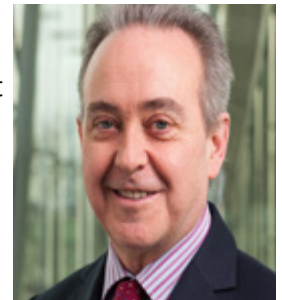
Tony Weetman has been the Sir Arthur Hall Professor of Medicine at the University of Sheffield and Consultant Endocrinologist at the Sheffield Teaching Hospitals Foundation Trust since 1991. He was Dean of the School of Medicine and Biomedical Sciences from 1999-2008 and became Pro-Vice-Chancellor for Medicine in 2008. After graduating from the University of Newcastle-upon-Tyne in 1977, he trained with Professor Reg Hall at the Welsh National School of Medicine, Dr Tony Fauci at the Laboratory of Immunoregulation, National Institutes of Health in Bethesda, USA and Professor Sir Keith Peters at the Royal Postgraduate Medical School, London and the University of Cambridge. His main research interests are the immunoregulation and genetics of autoimmune endocrine disorders, especially those involving the thyroid. He is a Founder Fellow of the Academy of



Medical Sciences (Council member 2002-5), a former editor of *Clinical Endocrinology*, *The British Medical Bulletin* and *Clinical and Experimental Immunology*, and has served as an Associate Editor of *Endocrine Reviews*. He received the Merck Prize of the European Thyroid Association (2002), the Novo Nordisk Jacobeus Prize (2012) and the Paul Starr Award of the American Thyroid Association (2013). He has also given the Royal College of Physicians Goulstonian and Bradshaw Lectures, the Clinical Endocrinology Trust Lecture and the Pitt Rivers Lecture. He has been Chair of the Medical Schools Council, President of the British Thyroid Association and a member of the Executive Committee of the European Thyroid Association and the Council of the Royal College of Physicians of London.

## Paul Buckley

Paul is the longest serving member of staff on the GMC's Senior Management Team, joining as a senior case worker in Fitness to Practise in 1996. In 2004, Paul was made Director of Strategy and Planning and, among other responsibilities, he coordinated the GMC's response to the Shipman Inquiry. Paul went on to lead the work programme following the White Paper, *Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century*, published in 2007.



In 2008, Paul took over responsibility for Education. As Director, he led work on the Patel review of the regulation of medical education and training, the successful merger of PMETB with the GMC and the development of the first Education Strategy. In 2012, he was made Director of Education and Standards.

Prior to joining the GMC, Paul qualified as a teacher and worked for a number of public sector organisations, including the Inland Revenue and the Parliamentary Ombudsman. He has a degree in Modern History and Modern Languages and a postgraduate qualification in Education.



## Professor Les Ebdon

Professor Ebdon has been Director of Fair Access to Higher Education since 1 September 2012. He was previously Vice-Chancellor of the University of Bedfordshire.



That followed an illustrious career in analytical chemistry, including more than 250 publications and several awards.

Professor Ebdon obtained his PhD at Imperial College, London, then lectured at Makerere University in Uganda and Sheffield Hallam University before becoming Reader in Analytical Chemistry at what is now the University of Plymouth. He was promoted to a personal chair in 1986, became Head of Environmental Sciences in 1989 and then, in the same year, Deputy Director. He was promoted to Deputy Vice-Chancellor (Academic) in 1992. He remained in that position until 2003, when he was appointed Vice-Chancellor at the University of Luton and became Vice-Chancellor of the University of Bedfordshire on its creation in 2006.

Professor Ebdon was awarded a CBE in 2009 for services to local and national higher education. He was appointed Deputy Lieutenant of Bedfordshire in 2011.

## Professor Anne Garden

Anne graduated from the University of Aberdeen in 1973 and after house jobs in Aberdeen and Stornoway, settled on a career in Obstetrics and Gynaecology, gaining MRCOG in 1979 and FRCOG in 1992. She worked in Cape Town, South Africa and Toronto, Canada before taking up post as Senior Lecturer in Obstetrics and Gynaecology in Liverpool in 1987. Whilst in Liverpool she developed an interest in Paediatric and Adolescent Gynaecology, setting up a service for the sub-specialty based at Alder Hey Children's Hospital. She has written two books on the subject. She continues her clinical work in Paediatric and Adolescent



Gynaecology at Alder Hey and also at the Royal Lancaster infirmary – as well as carrying out clinical duties at Furness General Hospital.

Her interest in Medical Education began in 1996, becoming Director of Medical Studies at Liverpool in 2001. One of her main areas of interest is Quality Assurance in Medical Education, having served as a QAA Subject Specialist Reviewer for Medicine from 1998 to 2001. She was one of the Team Leaders for the GMC's QABME (Quality Assurance in Basic Medical Education) programme and is a member of Council of the Academy of Medical Educators.

Her main interest in Medical Education is in Professionalism in Medical Education, having led the successful bid for a Centre for Excellence for Learning and Teaching for Developing Professionalism while at Liverpool.

## Sarah Howls

As Head of Student Opportunity at HEFCE, Sarah oversees the broad range of policy development and implementation across the Council's work to promote and protect the collective student interest and widening participation. This includes: developing the Council's approach to the collective student interest, ensuring that all that it does considers the interests of students; that it is able to engage effectively with students, where appropriate, across the broad range of activity; and that it works with its partner bodies (such as the QAA, OIA and NUS) to deliver effective protection and promotion of the collective student interest. Widening participation continues to be a key priority for HEFCE and as such is still a fundamental part of Sarah's role. Sarah continues to lead on the funding policy for widening participation and oversees the development of the widening participation strategic statement process. She has played a significant role in the development, implementation and continued enhancement of the National Scholarship Programme and continues to oversee HEFCE's policy as it relates to disabled students; supporting student success; widening participation research and evaluation;



widening participation to postgraduate study; and with OFFA developing and implementing the national strategy for access and student success.

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### David Johnston

David Johnston is Chief Executive of the Social Mobility Foundation, a charity which helps young people from low-income backgrounds enter universities and professions through programmes of mentoring, internships, university application support and skills development. He has previously been Director of Future, a charity which supports other charities working with young people and sponsors an academy, and the Coordinator of the Oxford Access Scheme, which ran a range of one day and residential programmes to encourage young people from inner city areas to consider higher education.



David is a member of the Social Mobility and Child Poverty Commission, established by Parliament to monitor progress made in improving social mobility and child poverty by government and other key actors such as universities and professions.

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### Professor Gary Mires

Gary Mires is Professor of Obstetrics, Deputy Dean of Medicine and Director of the Medical Education Institute in the School of Medicine, University of Dundee. He is an Honorary Consultant Obstetrician at Ninewells Hospital and Medical School, Dundee.



He obtained his MBChB and MD from the University of Dundee, is a Fellow of the Royal College of Obstetricians and Gynaecologists (RCOG) and a Fellow of the Higher Education Academy. His clinical interest is high risk pregnancy particularly the management of multiple pregnancy and pregnancy complicated by diabetes. His research interests relate to both

Obstetrics and Medical Education.

He is Chair of the Scottish Deans Medical Education Group and Honorary Director of E-learning at the RCOG.

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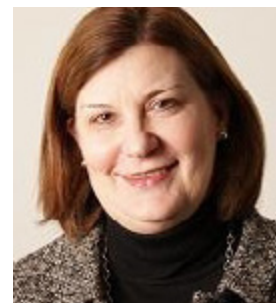
### Sarah Parsons

Sarah is the Medical Workforce Manager in NHS Employers Medical Pay and Workforce.



### Professor Wendy Reid

Professor Reid is Medical Director of HEE. Wendy was previously appointed the Dean of Postgraduate Medicine at London Deanery in 2003. She is a Consultant Gynaecologist and became an Associate Dean in London in 2001, leading on Anaesthetics and Paediatric training and sector development across North Central and North East London. Wendy has collaborated with many organisations developing new ways of working for doctors and was the national lead for the Hospital at Night project for some years. Wendy has recently completed her term as Vice President at the Royal College of Obstetricians and Gynaecologists.



### Alan Robson

Alan Robson is a Senior Civil Servant at the Department of Health. He has worked in the health service throughout his career at local, regional and national level. In his previous role, Alan worked as the Secretary to the Mid Staffordshire NHS Foundation Trust Public Inquiry – supporting Robert Francis QC in his role as Chairman. Alan has held the position of Deputy Director of Workforce Development



Strategy since April 2013.

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## Dr Tessa Stone

Dr Tessa Stone is the Chief Executive of Brightside, the education charity which uses online technology to connect, inform and inspire more young people to achieve their potential through education. Brightside's online mentoring service connects disadvantaged young people with volunteer mentors from universities or professional backgrounds who can support them into further and higher education and employment. Its free online resources – [www.brightknowledge.org](http://www.brightknowledge.org) and [www.studentcalculator.org.uk](http://www.studentcalculator.org.uk) – provide accessible, impartial information about education, money, student life and careers.



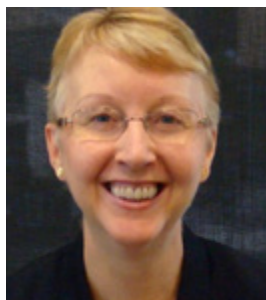
Tessa is also actively involved in national debate about widening participation as founder and chair of the Bridge Group, the independent policy association promoting social mobility through access to Higher Education ([www.thebridgegroup.org.uk](http://www.thebridgegroup.org.uk)). She is a member of the Ministerial Group on Data Sharing, the DBIS Expert Group on Student Finance Communications, and the UK Careers Sector Strategic Forum, and a charity trustee and school governor.

Tessa joined Brightside in 2009 after six years as Director of the Sutton Trust. Before working in the Third Sector she was a historian and an Admissions Tutor at the University of Cambridge.

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## Bev Thomas

Bev Thomas was appointed Deputy Director for Widening Participation and Quality Teaching in Higher Education at the Department for Business, Innovation and Skills in April 2007. Having gained a Bachelor of Education from Goldsmiths, University of London, Bev worked in the private sector designing and delivering

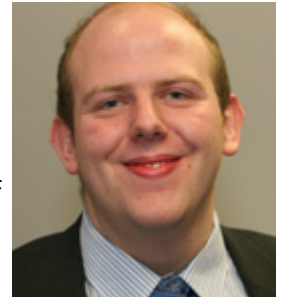


training courses for a number of years. She joined the Employment Department in 1990, with machinery of Government changes leading to the formation of the Department for Business, Innovation and Skills. Within BIS and its predecessors Bev has worked predominantly in post-16 education and training in both Further and Higher Education.

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## Andrew Wilson

Andrew is originally from Northern Ireland and is now a fourth-year medical student at the University of Edinburgh, and is the current national co-chair of the British Medical Association Medical Students' Committee.



The Medical Students Committee is very supportive of widening access to the profession, and believes fervently that the profession should represent the population that it serves. Widening participation has been identified as one of the co-chairs' four main priorities for the year, especially now that university fees are at £9,000 per annum.



# Data analysis

## Summary

This chapter looks at available data on widening participation and medicine. The data are drawn from a variety of public sources including the Higher Education Statistics Agency (HESA), the UK Clinical Aptitude Test (UKCAT<sup>1</sup>), UCAS (University Central Admissions Service) and the General Medical Council (GMC). The report concludes that while progress has been made on representation of women in the profession and increasing ethnic diversity, there remains significant under-representation of mature students, disabled students and students from lower socio-economic groups.

## Approach

Cohorts were selected based on protected characteristics, as defined by the Equality Act 2010<sup>2</sup>, and socio-economic background. Where possible the profile of applicants, students and doctors working in the UK was examined and compared. Caveats to the data presented are referenced.

Data were available for the following areas:

- Gender
- Age
- Ethnicity
- Disability
- Socio-economic background

## Applications to medicine: context

In the academic year 2012–2013, there were 41,422 medical students studying at 32 medical schools in the UK<sup>3</sup>. Each of these students went through a highly competitive process to gain admission.

The number of applicants that medical schools are allowed to accept onto their courses is set nationally through the Health Education National Strategic Exchange (HENSE), which brings together the Department for Business Innovation and Skills (BIS), the Department of Health (DH), Higher Education Funding Council England (HEFCE) and relevant bodies from the devolved administrations. In recent years, numbers have been fixed at a new intake of approximately 8,000 students per academic year.

Demand outstrips supply with a ratio of about 10.6 applications for every 1 place for pre-clinical medicine in 2012<sup>4</sup>. Figure 1 compares this with the sector average and illustrates the scale of competition.

**Figure 1:** Competition ratio for medicine and sector average



1 The UK Clinical Aptitude Test (UKCAT) is used in the selection process by a consortium of UK university Medical and Dental Schools. 26 medical schools currently use this tool. While not all schools use the test, the majority of medical school applicants are likely to have taken the UKCAT. More information about the UKCAT can be found here: [www.ukcat.ac.uk](http://www.ukcat.ac.uk)

2 [www.legislation.gov.uk/ukpga/2010/15/part/2/chapter/1](http://www.legislation.gov.uk/ukpga/2010/15/part/2/chapter/1)

3 GMC (2013) 'The state of medical education and practice in the UK' [www.gmc-uk.org/SOME2013\\_web.pdf](http://www.gmc-uk.org/SOME2013_web.pdf) 53703867.pdf

4 UCAS website (2013) 'Data Files' [www.ucas.com/data-analysis/data-resources/data-tables/subject/2012](http://www.ucas.com/data-analysis/data-resources/data-tables/subject/2012)

Subject (applications)	Ratio
Pre-clinical medicine	10.6: 1
Sector average	5.7: 1

With such a high volume of applications, medical schools have a demanding challenge of selecting those with the aptitude to become the best doctors, and helping to ensure a diverse medical student population that reflects the society that doctors serve.

Data that follow give a snapshot of the progress medicine has made in fulfilling this mission.

## Available data on protected characteristics

The figures below highlight the current profile of medical school applicants and students by age, gender and ethnicity and disability. To give a wider context, a profile of doctors working in

the UK is also, where possible, included. For all groups, sufficient datasets were not available concerning religion and belief, marital status, gender reassignment, pregnancy and maternity, and sexual orientation.

## Gender

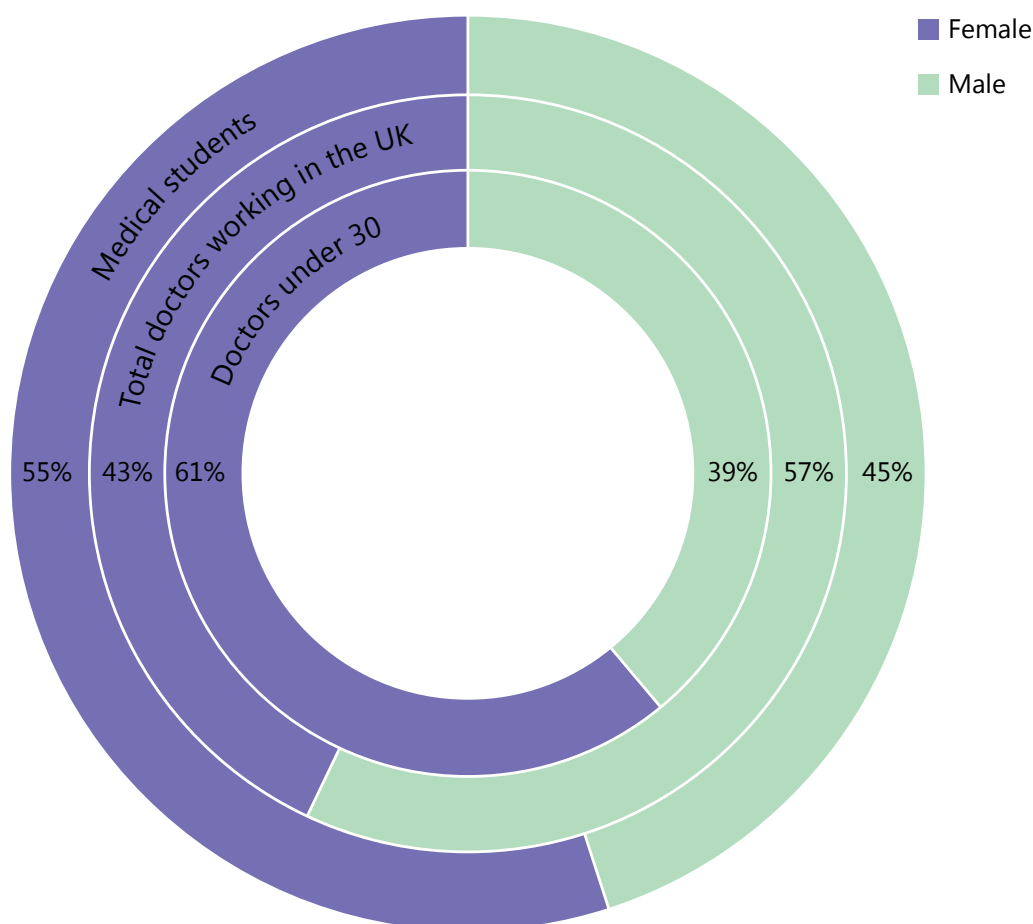
The figure below reflects the proportion of women/men studying medicine and of doctors working in the UK (including the proportion for doctors under 30). The data below are drawn from the GMC<sup>5</sup> and HESA<sup>6</sup>.

Whilst women outnumber men in regards to medical students and for doctors less than 30 years old, when looking at total doctors working

5 GMC (2013) 'The state of medical education and practice in the UK' [www.gmc-uk.org/SOMEPEP\\_2013\\_web.pdf](http://www.gmc-uk.org/SOMEPEP_2013_web.pdf) 53703867.pdf

6 HESA student: First degree, Pre-clinical and clinical student, UK domicile, gender, 2011–2012

**Figure 2:** Gender profile of medical students and doctors working in the UK



in the UK, overall men outnumber women. However, it is predicted that this will change and that women will make up the majority of all doctors by 2017<sup>7</sup>. Significant progress has been made in the representation of women since the 1960s, where the proportion of female medical students remained between 20% and 25% until 1968<sup>8</sup>.

7 Women and medicine: The future Royal College of Physicians (June 2009) <http://pressrelease.rcplondon.ac.uk/Archive/2009/Women-to-become-majority-of-doctors-after-2017>

8 McManus IC, Sproston KA, Women in hospital medicine in the United Kingdom: glass ceiling, preference, prejudice or cohort effect? Epidemiol Community Health 2000 p. 10

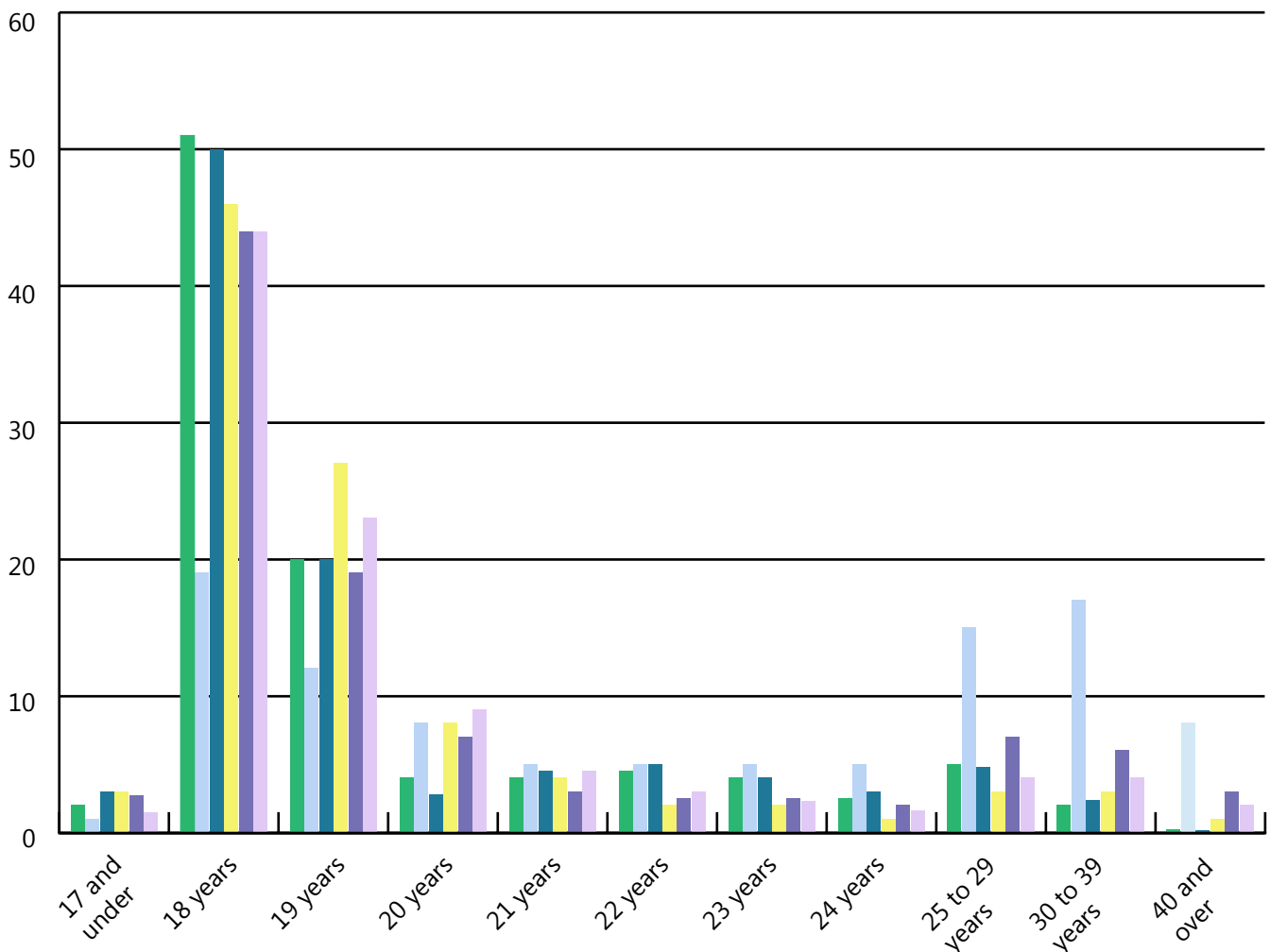
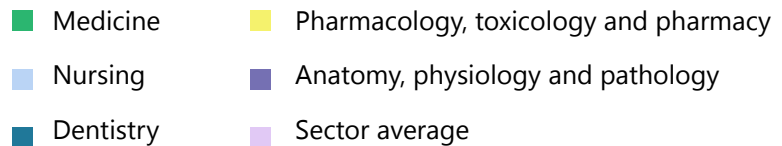
## Age

Figure 3 below, drawn from UCAS data, demonstrates that medical entrants are predominately from the 18-19 year old cohort and is similar to the sector average for all courses. This graph also provides an overview of sector trends in relation to other health subjects<sup>9</sup>.

Nursing is proportionally atypical in terms of mature learners, with 32% of total applicants being between 25 to 39 years old. Features of the nursing career pathway such as bursaries and the potential for part-time courses may partially explain this. The graph also illustrates that the decision to pursue medicine as a career

9 UCAS website [www.ucas.com/data-analysis/data-re-sources](http://www.ucas.com/data-analysis/data-re-sources)

**Figure 3:** Age profile of health course applicants



is made early and this has implications for the way in which medical schools conduct their outreach activities.

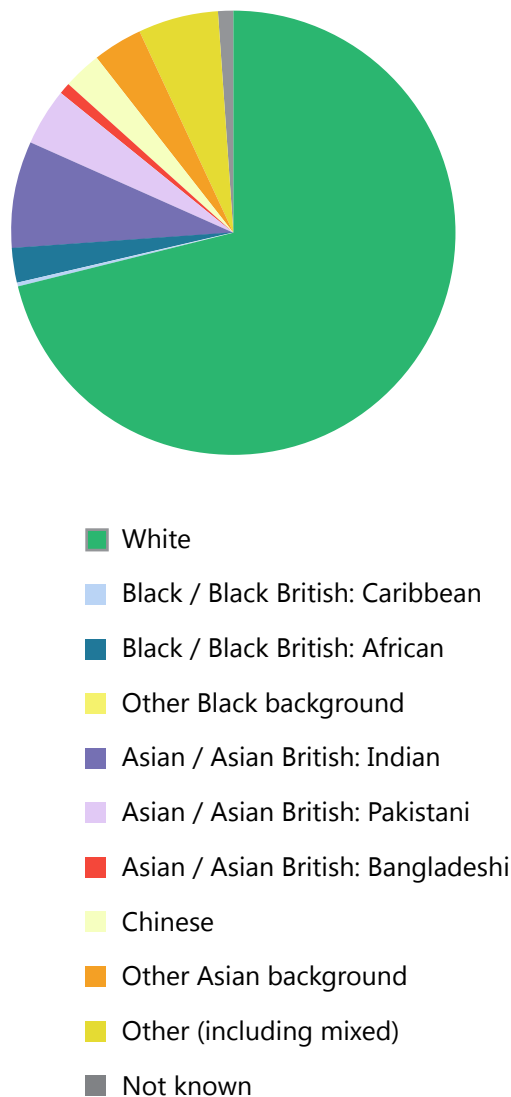
## Ethnicity

Data from HESA reveal that in 2011–2012 around a quarter of UK-domiciled students were from black and minority ethnic backgrounds (Figure 4)<sup>10</sup>. This is a significant increase from the position of the past. For example, the percentage of non-white UK medical graduates was around 2% in 1974<sup>11</sup>. Data on applications by ethnicity are not yet available. These will be sought for the final Selecting for Excellence project report to provide sharper focus on the detail of the relationship between medicine and ethnicity.

In spite of this, the above chart suggests that there is still significant under-representation of students from black African, black Caribbean and Bangladeshi backgrounds. This may be explained by this group’s attainment rate being on average lower nationally than some of the other groups, which can also be observed at GCSE stage and is the result of numerous and complex factors<sup>12</sup>.

For doctors working in the UK, 49% describe their ethnicity as ‘white’, 27% as ‘black and minority ethnic groups’ and ethnicity was unknown for 24%. For the population of England and Wales as a whole in 2011, 86% identified with the white ethnic group and 14% with black and minority ethnic groups<sup>13</sup>. This suggests that there is good representation of black and minority ethnic groups within medicine compared to the proportion of the general population (Figure 5). More detailed data about

Figure 4: Ethnicity profile of UK medical students



10 HESA student: UK-domiciled, undergraduate students studying (A1) Pre-clinical medicine or (A3) Clinical medicine with an expected length of study greater than four years by ethnicity

11 Goldacre M, Country of training and ethnic origin of UK doctors: database and survey studies, *BMJ* 2004;329:597

12 Wright C, Understanding black academic attainment Policy and discourse, educational aspirations and resistance *Education Inquiry* Vol. 4, No. 1, March 2013, pp. 87–102

13 [www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-and-quick-statistics-for-local-authorities-in-the-united-kingdom---part-1/rft-ks201uk.xls](http://www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-and-quick-statistics-for-local-authorities-in-the-united-kingdom---part-1/rft-ks201uk.xls)



the ethnic profile of medicine are not currently available to suggest priority areas. Having said this, it appears that representation of students from black African, black Caribbean and Bangladeshi backgrounds is relatively low.

## Disability

Finally, it is possible to extract information in relation to disability for medical students from HESA. Due to the way in which HESA categorises information it is not possible to extract information on medical students alone and therefore the data sets are combined with students of dentistry and veterinary sciences<sup>14</sup>. Also, at present it is not possible to determine which disabilities students have. Nevertheless, data reveal that the sector average of the number of students in receipt of disabled students' allowances (DSA)<sup>15</sup> is 5.9%. By comparison, 4.8% of the total medicine, dentistry and veterinary science group receive DSA, indicating that this group is slightly under-represented when compared to the sector average.

The data on the following page look at total students from each subject in regards to low DSA. It is worth noting that medicine and dentistry are primarily associated with higher entry tariffs. It is therefore interesting to look at the representation of DSA when looking solely at entrants with tariff points of 421-480 (roughly equivalent to AAA and upwards at A-level). This analysis shows that 4.3% of students at this tariff level from the medicine, dentistry and veterinary science group receive DSA – this is above the sector average at 3.9% at this tariff level.

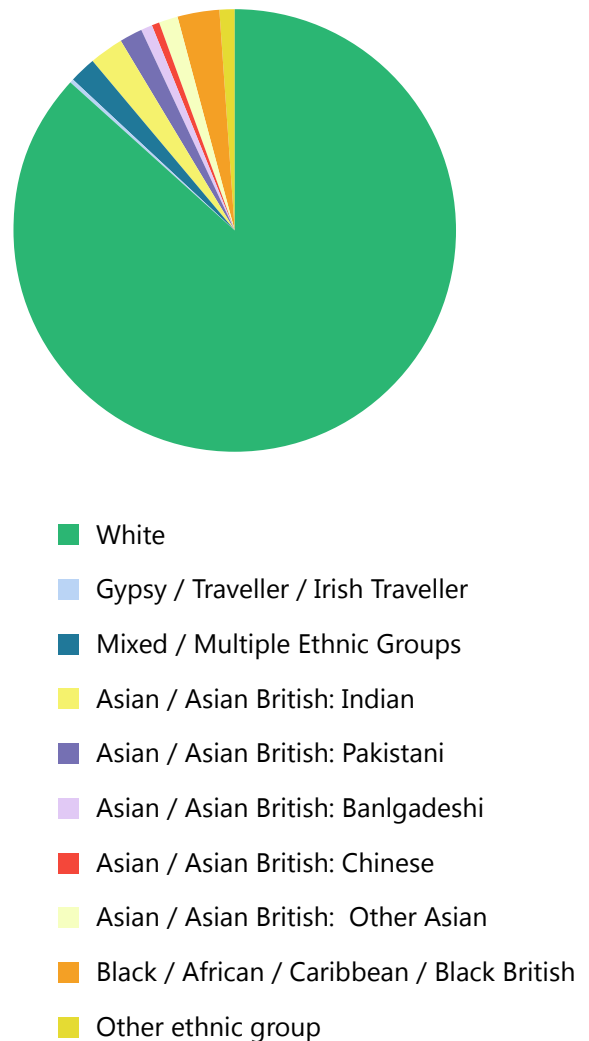
It is important to note that for this group of subjects, medical fitness to train is an important consideration which may affect admissions decisions. For medicine, more detail can be found in *Medical Students – Standards of medical fitness to train*, produced by Higher Education Occupational Physicians/Practitioners<sup>16</sup>.

14 HESA website: [www.hesa.ac.uk/index.php?option=com\\_content&task=view&id=2062&Itemid=141](http://www.hesa.ac.uk/index.php?option=com_content&task=view&id=2062&Itemid=141)

15 More information about DSA here: [www.gov.uk/disabled-students-allowances-dsas](http://www.gov.uk/disabled-students-allowances-dsas)

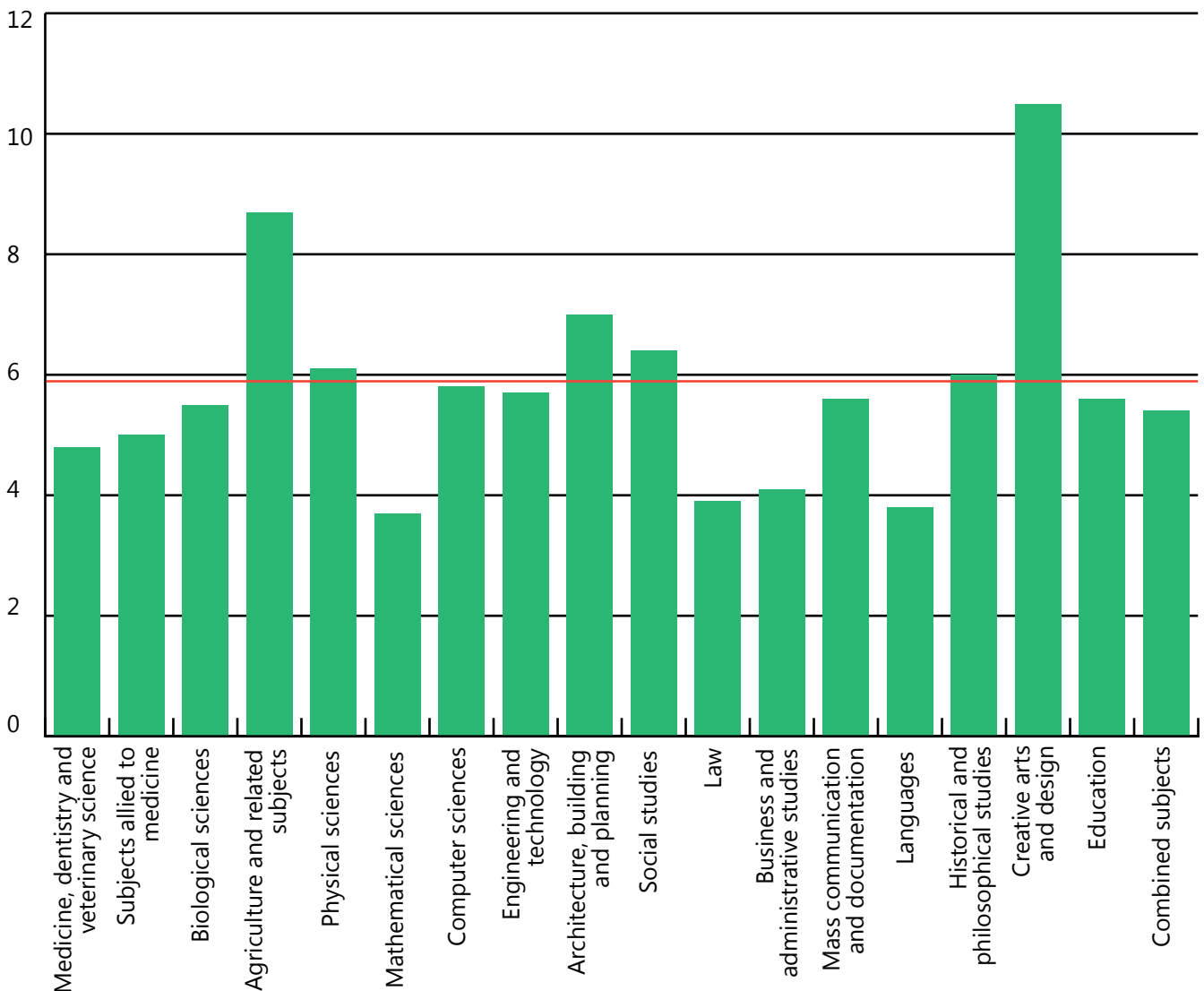
16 [www.heops.org.uk/HEOPS\\_Medical\\_Students\\_fitness\\_standards\\_2013\\_v9.pdf](http://www.heops.org.uk/HEOPS_Medical_Students_fitness_standards_2013_v9.pdf)

Figure 5: Ethnicity profile of the UK population



**Figure 6:** Proportion of students in receipt of DSA by subject

■ Of total subject cohort  
— All subjects



## Socio-economics in focus

A range of measures has been used to capture the socio-economic profile of UK medical school applicants, students and trainee doctors. Each has its limitations, but when triangulated they can provide a picture of whether medicine is currently open to people from all walks of life.

### School type

The first area examined was the type of school attended. The independent school sector educates about 7% of all pupils in the UK, and more

than 18% of pupils over 16 years old<sup>17</sup>.

For medical students, there appears to be a significant divide between those educated privately and via the state school or college system. Despite the information below (Figure 7)<sup>18</sup> not being able to provide us with information concerning 'selective' state-run or -funded schools, the analysis suggests that the private school sector is over-represented in comparison to the general population.

17 Independent Schools Council [www.isc.co.uk/research](http://www.isc.co.uk/research)

18 UK-domiciled, undergraduate students, studying (A1) Pre-clinical medicine or (A3) Clinical medicine on courses of four years of more in length by state school marker

**Figure 7:** Medical student school type

State school marker	Total	Percentage of total
State school or college	21620	68%
Private school	8690	27%
Unknown	1605	5%
Total	31915	100%

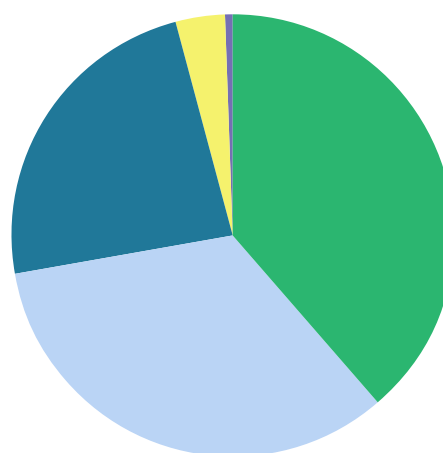
A very similar picture is painted when looking at the educational backgrounds of trainee doctors: 33% of total trainee doctors responding were educated in independent or fee-paying schools (Figure 8). Different types of school are associated with different types of socio-economic status. However, the type of school someone attends does not necessarily relate to their background. Pupils who attend state schools can be from wealthy backgrounds and pupils who attend independent or fee-paying schools can be from less wealthy backgrounds. Nevertheless, for medicine there is an over-representation of those who have been to independent or fee-paying schools which requires further explanation.

### Socio-economic classifications

There are several measures which can be used to measure the socio-economic backgrounds of medical applicants. The National Statistics Socio-Economic Classification (NS-SEC) is the primary social classification used in the United Kingdom. The highest of the applicants' self-reported parental occupational groups is used to assign their NS-SEC category (Figure 9 provides a scale). Although NS-SEC is broadly 'ordered', in that NS-SEC 1 has higher socio-economic status than NS-SEC 5, it is NOT a strictly ordinal scale – own account workers for example are not necessarily lower than 2 or higher than 4. The information on socio-economic background is also self-reported which means that occupation is subject to individual interpretation

Another measure that can be used to analyse the socio-economic background of medical applicants is the Index of Multiple Deprivation (IMD). This measure is used throughout the UK and uses a postcode to assign a person's socio-economic status. However, solely relying on the IMD as a measure of deprivation has met

**Figure 8:** Medical trainees - type of school attended between 11-16 years old (2013)



- Non-selective state-run or state-funded school
- Independent or fee-paying school
- State-run or state-funded school that was selective on academic, faith, or other grounds
- Preferred not to say
- Did not know

**Figure 9:** NS-SEC Description

NS-SEC category	Category Name
Class 1	Managerial and professional occupations
Class 2	Intermediate occupations
Class 3	Small employers and own account workers
Class 4	Lower supervisory and technical occupations
Class 5	Semi-routine and routine occupations

a degree of scepticism as critics argue that an area or postcode is not necessarily a direct or meaningful measure of deprivation (eg a person can be wealthy and live in a deprived area).

The IMD profile and NS-SEC categories of UKCAT applicants was supplied by the UKCAT consortium in 2013<sup>19</sup>. UK domiciled applicants were defined as resident in England, Scotland, Wales or Northern Ireland based on the first two digits of the home address postcode provided. For consistency with the NS-SEC the most

19 Socio-economic status of applicants to UKCAT Consortium Medical Schools 2009–2012 [www.medschools.ac.uk/Publications/Documents/Ex-13-40-UKCAT-socio-economic-analysis-2013.pdf](http://www.medschools.ac.uk/Publications/Documents/Ex-13-40-UKCAT-socio-economic-analysis-2013.pdf)

affluent fifth of postcodes were defined as IMD quintile 1, and the most deprived fifth as IMD quintile 5.

The infographic below illustrates the proportion drawn from each social grouping for both the IMD and NS-SEC in 2012 in England. From this it can be concluded that applicants to medical school are broadly drawn from higher socio-economic groups, but the individual NS-SEC and postcode IMD measures give different impressions of the breadth of access to UKCAT for English applicants<sup>20</sup>:

20 UKCAT, Socio-economic status of applicants to UKCAT Consortium Medical Schools 2009–2012

Figure 10: Socio-economic background of UKCAT applicants (England only)

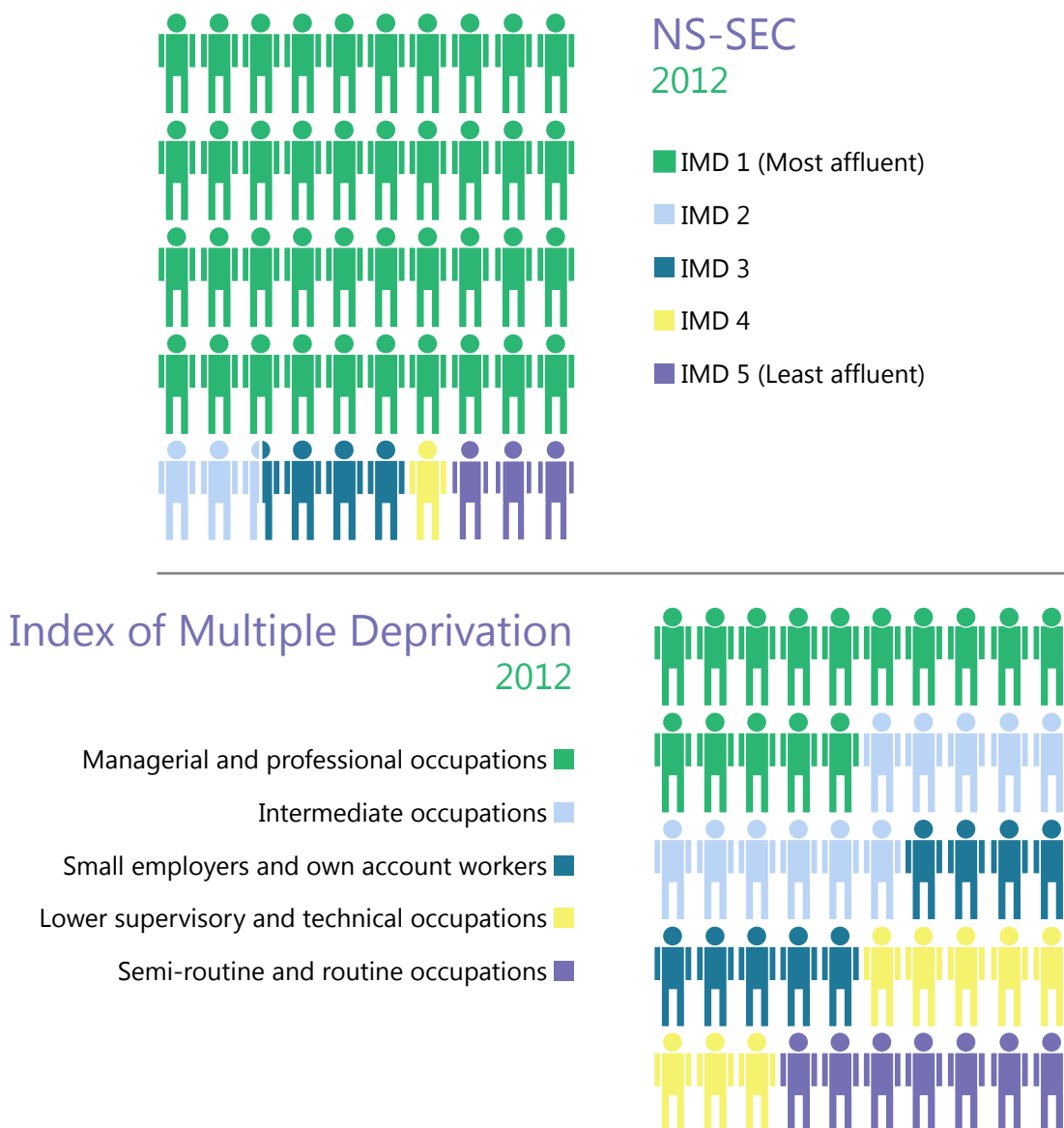
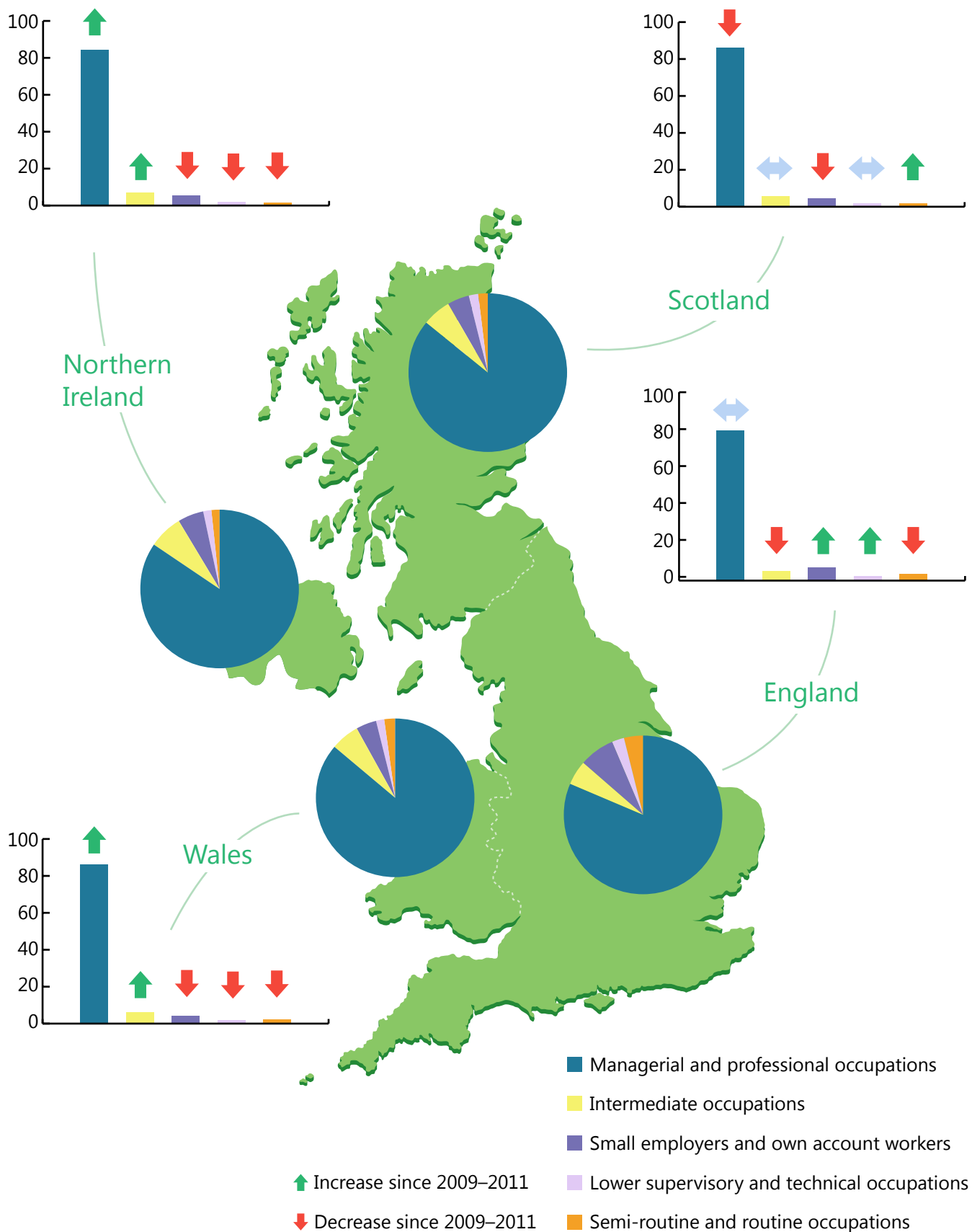




Figure 11 demonstrates that across all four nations of the UK, each with different higher education funding and student support systems, there remains a very strong trend for UKCAT applicants to be from managerial and professional occupations/backgrounds.

**Figure 11:** Applications to UKCAT by socio-economic background, 2011–2013



A final measure of socio-economic status included in this snapshot is Participation of Local Areas (POLAR 3). POLAR 3 is published by the Higher Education Funding Council (HEFCE) as a series of maps and data sets, showing the participation of young people in higher education (HE) for geographical areas ranging from regions to wards<sup>21</sup>.

It is possible to gain a breakdown of UK-domiciled, undergraduate, young entrants to UK

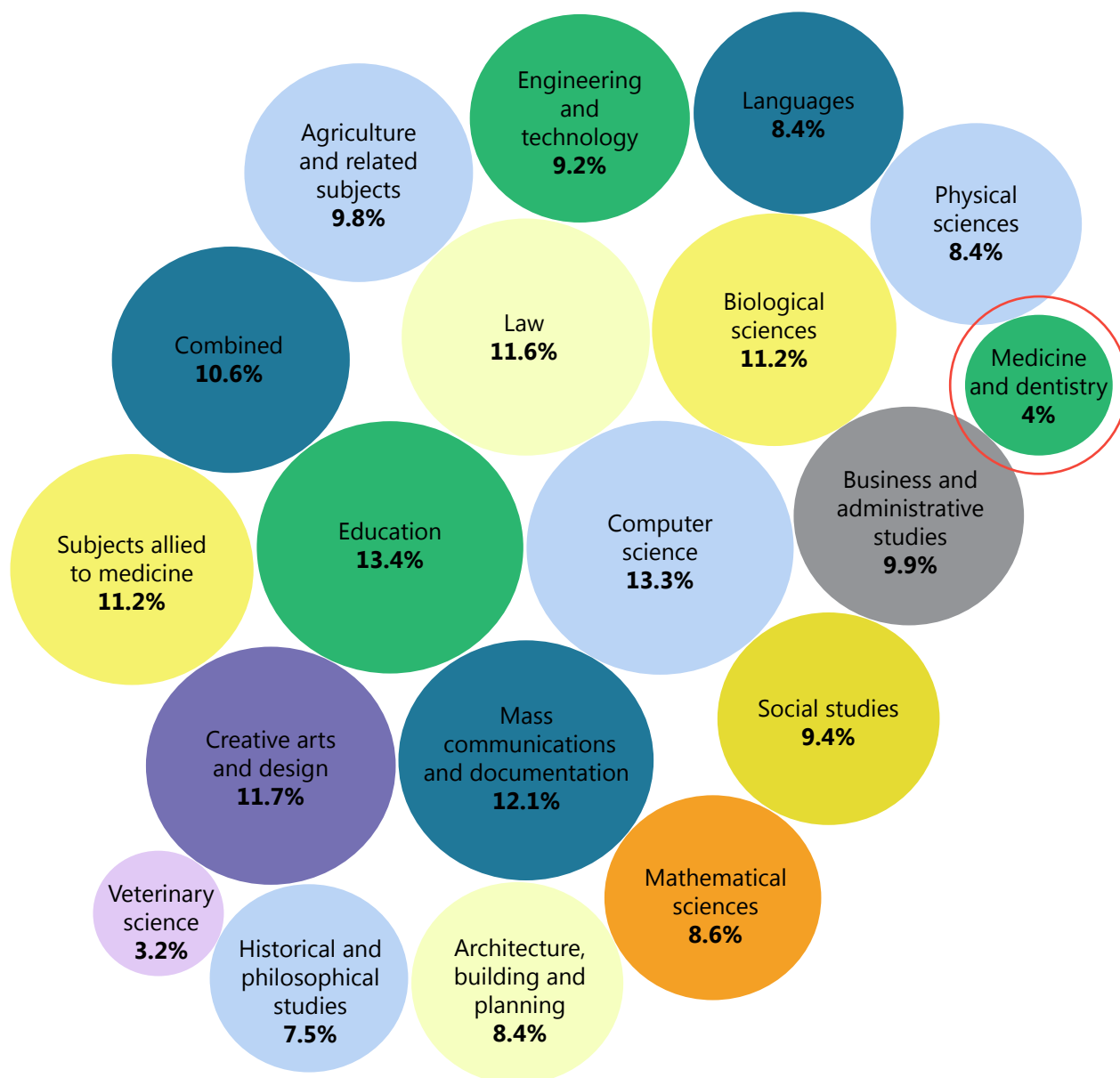
21 [www.hefce.ac.uk/whatwedo/wp/ourresearch/polar](http://www.hefce.ac.uk/whatwedo/wp/ourresearch/polar)

HEIs from low HE participation neighbourhoods (POLAR 3, quintile 1) for 2011–12 by broad subject area<sup>22</sup>. Here it is apparent that medicine and dentistry are below the sector average of 10.3% and only veterinary science ranks lower<sup>23</sup>. Because medicine and dentistry have higher

22 For this analysis the population is 'UK-domiciled, undergraduate, young entrants to UK HEIs from low participation neighbourhoods (POLAR 3, quintile 1) in 2011–2012'

23 Unknowns have been excluded should also be added in a footnote to the table

**Figure 12:** Percentage of low-participation students per subject, 2011–2012 (POLAR3)



entry tariffs, it is relevant to examine the representation of POLAR 3 low participation students in relation to all entrants with grades of at least AAA or Scottish Highers grades of least AAAAA by background. At this tariff level 4.4% of students from medicine and dentistry are from low participation backgrounds – this is much closer to the sector average of 4.9%.

Triangulating these three datasets it is obvious that applicants to medical school are drawn from higher socio-economic groups and this is reinforced when considering trainee doctors' IMD profile. As Figure 11 shows, the majority of trainees were from less deprived areas of the UK.

### Household characteristics

A number of other measures of socio-economic status could be used to identify the profile of medical undergraduates. For example, parental/guardian experience of higher education, receipt of income support and eligibility for free school meals are useful indicators elsewhere but these data are not systematically collected for medical students and applicants. However, data are available for trainee doctors' household characteristics; these are outlined in Figure 13.

These household characteristics provide further evidence that those from financially disadvantaged backgrounds are under-represented in medicine.

Figure 13: Trainee doctors by IMD quintile (2013)

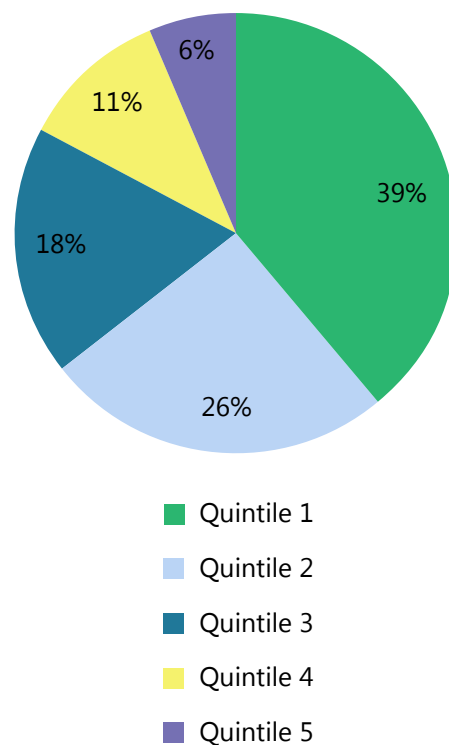
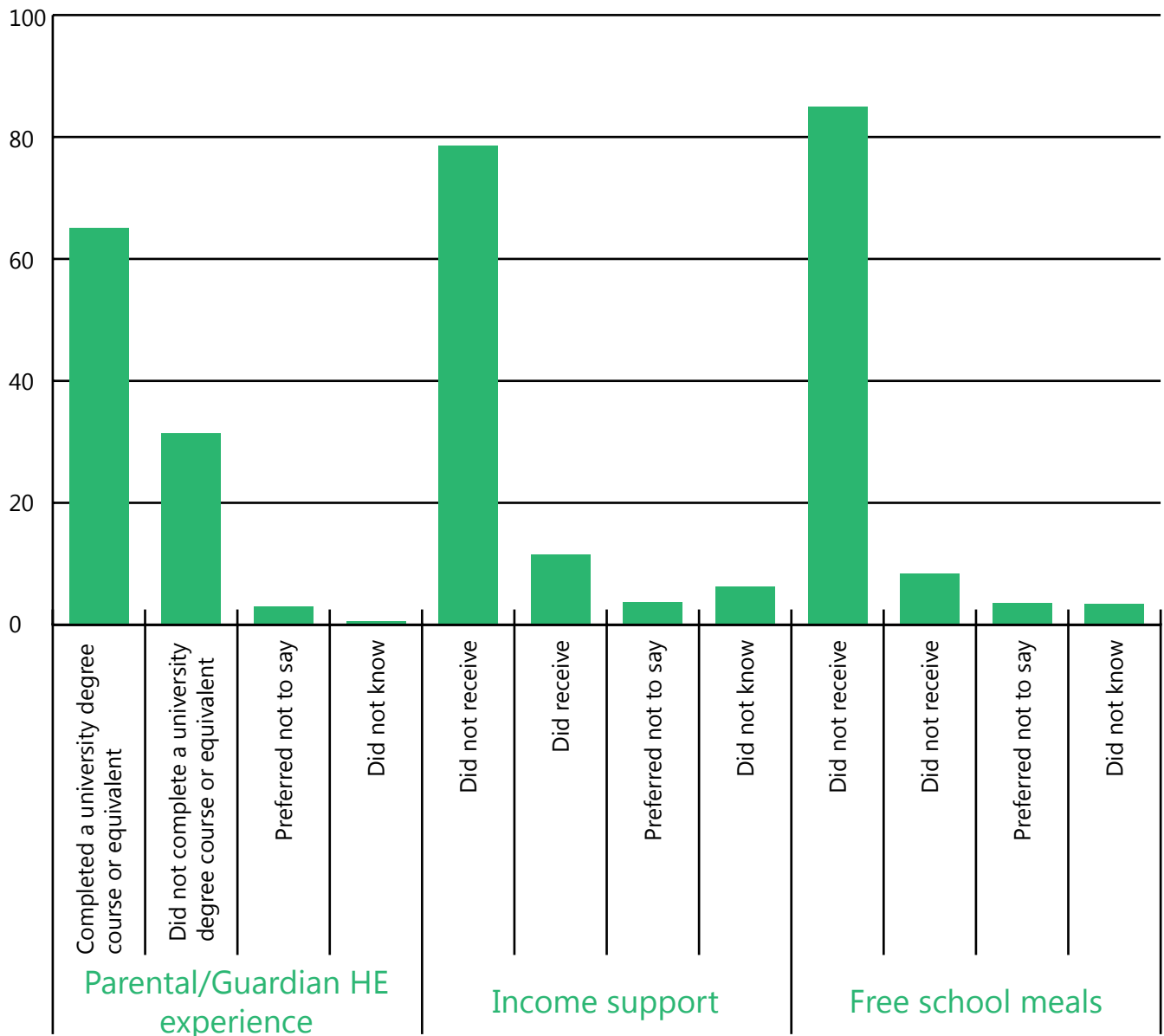


Figure 14: Household characteristics of trainee doctors



## Conclusion

It is possible to build a profile of medical school applicants, students and doctors working in the UK from a range of data sources. There would be great value in rationalising data to produce even clearer future measures of socio-economic profile that could be used for long-term tracking.

The data currently available suggest that medicine does not currently have a socio-economic profile that reflects society. As found in other reports, while good progress has been made on representation of women in the profession

and increased ethnic diversity is apparent, there is an under-representation of people from lower socio-economic groups and of older and disabled applicants. There remain some ethnic groups that are under-represented in medicine; this is particularly true of students from black African, black Caribbean and Bangladeshi backgrounds. Links between ethnicity and socio-economic background are complex and never absolute, but people from black and minority ethnic groups have been found to be more likely to live in low-income households<sup>24</sup>. Indeed this link is also likely to be apparent for other under-represented groups. This suggests that

24 [www.poverty.org.uk/reports/ethnicity.pdf](http://www.poverty.org.uk/reports/ethnicity.pdf)



further action and research on broadening the socio-economic profile of medicine could help to address wider issues of under-representation of certain other groups in the profession.

Finally, it is worth stating the axiom that medical schools cannot solve the issue of under-representation alone. As we have seen above, other subject areas are facing similar challenges that are likely to be driven by wider societal factors.

For example, many of the barriers to attainment and information advice and guidance begin at an early stage in life. However, medical schools can and do play an important role in drawing from a wide pool of talent that includes people from all walks of life.

The sections that follow outline how the Selecting for Excellence project has worked this year to try and take action on these issues.

## Data sources and their limits

### Medical school applicants and students

Classification of medicine by HESA is currently split into 'pre-clinical' and 'clinical' students. This has a historical basis in that medical students were more likely to have clinical contact in later years of study and a more theoretical underpinning earlier in the course. However, medical school curricula have moved on and there is greater integration of clinical experience throughout the course. Therefore, work is ongoing to establish whether a more accurate data label could be produced to cover the full cohort of medical students.

In UCAS and other data, medicine is often reported with other subjects (usually dentistry). This can present a challenge in finding the specific trends for medicine. The Selecting for Excellence Project is in the process of obtaining medicine-only data from UCAS to form a more detailed picture.

### Doctors working in the UK

For 'doctors working in the UK', data reported are relevant to the 252,553 doctors on the medical register in 2012. When a medical student graduates, they enter into a two-year generic training programme which forms the bridge between medical school and specialist/general practice training. After they have successfully completed their postgraduate training, doctors gain entry to either the GMC specialist register or GP register and are able to apply for a senior post as a consultant or a GP principal, respectively. After this, doctors are committed to continual professional development.

The General Medical Council collects information about these doctors in order to provide a picture of the profession. (*The State of Medical Education and Practice in the UK report: 2013* [www.gmc-uk.org/SOMEF\\_2013\\_web.pdf](http://www.gmc-uk.org/SOMEF_2013_web.pdf) 53703867.pdf).

There is no systematic data collection on the socio-economic background of all doctors working in the UK. However, this year, for the first time, the GMC has asked 38,933 doctors in training who completed both their secondary education and medical degree in the UK questions about their socio-economic status. Figures are taken from National Training Survey 2013: socio-economic status questions [www.gmc-uk.org/Report\\_NTS\\_Socioeconomic\\_Status\\_Questions.pdf](http://www.gmc-uk.org/Report_NTS_Socioeconomic_Status_Questions.pdf) 53743451.pdf.

# Progress to date

*This chapter will set out the work done as part of the Selecting for Excellence project in 2013.*

## Widening participation

This work stream looks exclusively at how the number of students from lower socio-economic backgrounds can be increased. From the data analysis in Chapter Two it is clear that this is the central concern for medicine in terms of increasing the diversity of the medical student population.

The Milburn report in 2012, University Challenge: How Higher Education Can Advance Social Mobility, and the State of the Nation 2013 report from the Social Mobility and Child Poverty Commission have had a major influence on the work being undertaken in this strand of the project. In particular, the 2012 report highlighted unequal access to work experience opportunities for students from lower socio-economic backgrounds as being an important issue that medicine needs to address.

## Work experience

Whilst access to work experience is in itself undoubtedly a concern, medical schools also need to clarify why potential applicants should have done work experience and what attributes or behaviours are being assessed through work experience as part of selection processes. Medical school admissions deans have been considering this issue and a consensus statement on the use of work experience in selection processes will be produced in 2014.

## PRACTISE

The PRACTISE scheme is based on a similar programme of work carried out by the legal profession and informed by Sutton Trust expertise to increase work experience opportunities in law for students from a lower socio-economic background.

Under the scheme, work experience providers in the health service will commit to prioritising

work experience opportunities in medicine for pupils from a lower socio-economic background. The commitment they will be asked to sign up to is detailed below.

### The PRACTISE Commitment – widening participation in health and social care work experience

- We agree to prioritise work experience applications from students who:
  - have been eligible for free school meals and/or;
  - are the first generation to be applying to university having been at a school where at least 30% of pupils were eligible for free school meals<sup>1</sup>
- We will advertise work experience opportunities openly.
- We will support students by providing financial assistance to ensure they can attend work experience. As a minimum we will provide refreshments and reimburse reasonable travel expenses.
- We will inform participants about the range of careers available in the medical profession and wider healthcare sector.
- We will support the development of key personal skills and an understanding of the values that are required for entry into the healthcare professions and to optimise the patient experience (eg patient focus, safety, team working, communication, professionalism).
- We agree to provide PRACTISE sponsors with an evaluation of the impact of the scheme. This will be submitted six months after signing up to this commitment.

<sup>1</sup> The Institute for Fiscal Studies has found that the criteria of schools having 30% of pupils eligible for free school meals to be a good predictor of educational disadvantage [www.ifs.org.uk/comms/r79.pdf](http://www.ifs.org.uk/comms/r79.pdf)

These criteria are based on:

- Current medical school practice in work experience widening participation activities
- Those used by the legal profession's PRIME commitment, which were developed with Sutton Trust expertise
- Learning from the Social Mobility Foundation's approach to scheme criteria and the findings of an Institute for Fiscal Studies report into educational disadvantage measures

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## Implementing PRACTISE

In the first instance it is intended that the scheme will be rolled out across NHS Trusts (and the equivalent across the three devolved nations) and that it will be primarily aimed at pupils who wish to become doctors in the future. As the scheme develops, it will be extended to other healthcare providers, such as GP surgeries and care homes, and will be of relevance to other healthcare students.

A website is being developed which will be managed by MSC initially and will contain the details of participating placement providers and further information on the scheme, such as frequently asked questions.

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## Outreach

Outreach has been identified by both the SEEG and the stakeholders we have talked to as being an essential part of widening participation work. The GMC literature review found that although all medical schools undertake outreach work there is little consensus as to what works. The report suggested that further research be carried out to assess what works in terms of outreach and that the results should be shared across UK medical schools.

MSC has commissioned Dr Jen Cleland, Aberdeen Medical School, and Dr Sandra Nicholson, Queen Mary University, to undertake this research. The first report from this project is available at Annex A.

## The role of the doctor

This work stream seeks to highlight what medical schools are selecting for; what are the values, skills and attributes that students will need when they graduate and work as doctors? Medical schools recruit students whom they feel will be able to meet the outcomes set out in the GMC standards in *Tomorrow's Doctors*. However, recent developments in the healthcare sector have placed a greater emphasis on values-based recruitment which this work stream reflects.

Following on from the Francis Report into failings at the Mid-Staffordshire Foundation Trust there is an increased emphasis on values across the healthcare sector. Health Education England (HEE) is specifically looking at how values can be tested at the point of recruitment to the NHS. Our work is designed to supplement the HEE project by further embedding values in selection processes and also by looking at how medical schools can assess at the point of selection the attributes that doctors will need to display in the future.

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## The role of the doctor statement

In 2008 the four CMOs, the GMC, the Academy of Medical Royal Colleges, the BMA, COPMeD, AUKUH, NHS Employers, the King's Fund and the Medical Schools Council agreed a consensus statement on the Role of the Doctor<sup>2</sup>. Consensus was reached following a two day conference and a YouGov survey of a representative sample of the public.

The Selecting for Excellence Executive Group has agreed to update that survey because, five years on, a number of developments may have affected trust in doctors or expectations of them:

- A prolonged economic downturn and financial pressure on public services
- Public scandals focusing on the 'culture' of societal institutions
- The Francis Report and the Keogh Review
- A reorganisation of NHS structures and changing political focus

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<sup>2</sup> [www.medschools.ac.uk/Publications/Pages/Role-of-the-Doctor-Consensus-Statement.aspx](http://www.medschools.ac.uk/Publications/Pages/Role-of-the-Doctor-Consensus-Statement.aspx)

- Proliferation of social media and increased general internet usage
- Use of big and increasingly transparent data sets
- Advances in biomedical science

In light of this, a YouGov survey will investigate whether UK patients and the public have new expectations of doctors. Additionally the original contributors to the development of the statement in 2008 have been asked to suggest any updates they feel should be made to the statement as it currently stands. The comments from stakeholders and the results of the survey will be used to determine whether the consensus statement needs to be amended.

The new consensus statement will be merged with other sources, including the GMC's Good Medical Practice and the statements that medical schools provide to potential applicants, to create a core set of values, skills and attributes that medical schools can use in their selection processes.

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## Good Medical Practice

In 2013 the GMC published an updated version of Good Medical Practice (GMP). The process for reviewing the guidance involved extensive public consultation with over 3,000 doctors, organisations and members of the public responding. Given the weight of public opinion behind this guidance and the fact that these are guidelines that medical students know and will need to work to when they graduate, SEEG feels that GMP should be used in selection to medical school.

SEEG is in discussions with the GMC as to how GMP might be utilised in selection and this will also be discussed with admissions deans. One suggestion is that potential applicants to medicine should be asked to read the guidance as part of their preparation for applying and that selection processes should check whether applicants have read and understood it and are capable of practising in line with it in the future.

## Selection methods

This work stream looks at the methods used by medical schools to select their students.

The GMC recently commissioned a literature review<sup>3</sup> to look at these methods and found that there was considerable variation between medical schools in the methods used in their selection processes. The report did not come to a firm conclusion as to whether this variation was justifiable; instead it recommended that further work and research be done to establish the best ways of selecting medical students. The report did suggest that aptitude tests and multiple mini interviews (MMIs) may be the most valid ways of selecting students, but that further research would need to be undertaken to confirm this view.

In November 2013, MSC brought together admissions deans from medical schools across the UK to discuss the findings of the GMC commissioned literature review. Areas where greater consistency between schools could be achieved were discussed and two areas were identified where quick progress could be made. These two areas were a single statement of the values and skills needed to study medicine and a consensus statement on the purpose of work experience. It was also agreed that further research should be commissioned on selection methods with the aim of ensuring greater consistency between schools in the future. A full report from the meeting is available at Annex D.

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## Evidence base

This work stream looks at both what is currently known about the demographics of students studying medicine and how longitudinal evidence can be gathered to evaluate selection methods and to track what happens to widening participation students once they graduate.

The data that MSC have collected on the current student profile are available in the Data chapter. In order to put these data together it was necessary to use multiple sources and a key conclusion from this work is that there is a need to harmonise data collection across the sector. In particular it will be important to develop (i) a set of criteria to establish which candidates can be judged to be from a lower socio-economic background and (ii) a method for tracking what

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<sup>3</sup> Identifying best practice in the selection of medical students, Cleland et al (2013): [www.gmc-uk.org/Identifying\\_best\\_practice\\_in\\_the\\_selection\\_of\\_medical\\_students.pdf](http://www.gmc-uk.org/Identifying_best_practice_in_the_selection_of_medical_students.pdf) 51119804.pdf

happens to these students through medical school and after graduation.

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## UK Medical Education Database

MSC is leading the development of the UK Medical Education Database (UKMED). This database will link data from undergraduate medical education to data from postgraduate medical education and training. For example, it will take information collected through selection processes such as aptitude tests and link it with performance data in postgraduate assessments including royal college exams and the assessments that form part of selection to the Foundation Programme.

Data will be linked at the individual level, but they will not be reported that way; instead data will be aggregated and anonymised. However, because the data will be linked at an individual level it will be possible to identify students from a lower socio-economic background and track what happens to them as they develop their careers. This is important as it is not enough to encourage these students to apply; they must also be supported after entry to enable them to fulfil their potential.

The database will also be used to evaluate selection methods. It will enable medical schools to see how the students they have selected perform throughout their careers.

# Priorities for 2014

*This chapter sets out the next steps that need to be taken in order to meet the aims of the Selecting for Excellence project.*

## Implementing PRACTISE

The PRACTISE scheme to kitemark work experience providers who give preference to candidates from a lower socio-economic background has been widely welcomed by stakeholders including Health Education England. In order to implement the scheme, further work needs to be undertaken with Local Education and Training Boards (LETBs) and their equivalents in the devolved administrations. LETBs will be asked to quality assure placements and encourage providers in their local area to join the scheme. The target will be to have 100 placement providers signed up to the commitment by 2015.

Further work also needs to be done to ensure that PRACTISE also covers placements within primary care and community-based providers.

## The purpose of work experience

At a meeting of admissions deans held in November 2013 (see report in Annex D) it was agreed that a consensus statement should be produced on the purpose of work experience and how it should be evaluated within selection processes.

This statement will be developed with admissions deans and signed off by the Executive Group in 2014. A common statement will help all applicants to medicine by clearly stating what all medical schools expect by way of work experience so that they can gain this experience and present it in a way acceptable to all the schools they apply to. This will particularly benefit applicants from a lower socio-economic background who may not have the access to the same levels of support in putting together their application that more privileged applicants have.

## Outreach

MSC now has the final report from the research commissioned in 2013 (report available at Annex A). MSC will convert the recommendations contained in the final report into a national framework which schools can use both to plan and evaluate their outreach activities.

To help schools to evaluate the impact of their outreach activities MSC will investigate whether it would be possible to identify applicants who have benefited from outreach schemes and to track which medical school or university ran the scheme they attended and which school they were eventually accepted to.

## Core values and attributes statement for medicine

In 2014 MSC will produce a core values statement which will set out the values, attributes and skills that all medical schools are looking for when they select medical students. Medical schools will be able to add aspects that are specific to their own school's requirements and in line with their vision and mission statements as autonomous institutions. However defining clearly the core values and skills needed for all medical courses will help potential applicants to judge whether medicine is the right career for them.

The contents of the statement will be drawn from three sources; the statements all medical schools currently supply to potential applicants on what they are looking for, the results of the market research with patients and the public on the role of the doctor and the values contained in the GMC's guidance *Good Medical Practice*.

This statement must be easy for potential applicants to understand and should not contain any measures that students from a widening participation background may not be able to attain.



## Contextual data

In 2014, MSC will investigate with medical schools how contextual data can be used in admissions processes. The research report on outreach programmes will also include data on how contextual data are used.

The work done in this area will build on the recent report from Supporting Professionalism in Admissions (SPA) on the use of contextual data across the higher education sector<sup>1</sup>.

It is likely that in order to get a consensus on the use of this type of data in admissions, further research will need to be undertaken. The decision as to whether more research is needed and what form it should take will be made in early 2014 to allow consensus to be reached by the end of the year. In particular this should focus on whether academic attainment can be contextualised to reflect the environment in which it was gained.

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## Selection methods

Whilst consensus statements on the purpose of work experience and the core skills and values needed to study medicine will bring greater clarity for applicants, medical schools continue to select students using a variety of different methods. Whether there are grounds for this degree of variation and which methods are most reliable are questions which have not yet been answered. In 2014 MSC will work with medical schools and in particular with admissions deans to tackle these questions.

Funding will be made available for further research into the validity of different selection methods. The initial findings from the GMC-commissioned literature review suggested that aptitude tests and MMIs may have the most validity as selection methods and it is likely that further research will focus on these areas. Additionally UKCAT has included a situational judgement test (SJT) as a component of the overall aptitude test and SEEG is keen to see how this element of the test performed. SJTs are

a useful tool in testing values and ethical thinking and this work could have implications across the healthcare sector.

SEEG will also investigate whether more radical changes to selection processes across UK medical schools might be desirable. One suggestion has been that applicants to medicine could be assessed in part based on MMIs conducted at regional selection centres. Potential benefits would include pooling of resources and expertise and simplifying the application process. Set against this are the risks that any such system could impact on the autonomy of individual institutions and would make the student body more homogenous rather than diverse. Any radical change to selection processes such as this would take time and work would need to extend past the end of the Selecting for Excellence project in December 2014.

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## Openness and transparency

Throughout our discussions with stakeholders one point has been made consistently to the SEEG: there needs to be more easily understood information about selection processes available to applicants. This is important as applicants from a lower socio-economic background may not have the same support available in deciding which schools to apply for as applicants from a more privileged background. In the absence of this central resource, applicants rely on websites with student-created content and even paid courses to help them with the application process. This can put applicants from lower socio-economic backgrounds at a disadvantage and, because the information provided is not quality checked by medical schools, applicants may be given incorrect information.

In 2014 SEEG will work with medical schools to produce a single resource for potential applicants to medicine to use. This resource should provide advice on applying to medicine including links to useful sites such as UKCAT and BMAT and easy to understand information on the selection criteria and processes used by individual medical schools. One suggestion is that that online resource should sit within

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<sup>1</sup> Contextualised Admissions: examining the evidence, SPA, 2013; [www.spa.ac.uk/documents/ContextualData/SPA\\_ContextualisedAdmissions.July2013.pdf](http://www.spa.ac.uk/documents/ContextualData/SPA_ContextualisedAdmissions.July2013.pdf)

an established website such as the Medical Careers website as this would mean there was one website for careers advice on medicine for individuals at all stages of their training.

SEEG will also investigate whether additional, applicant-focused support could be provided through this resource such as online access to medical students or careers professionals who would be able to answer specific questions from applicants. Systems such as this are in place in the commercial sector but the cost of running such a process would need to be carefully considered and questions would need careful triage.

## Foundation courses

Thirteen medical schools run foundation courses to prepare applicants for the undergraduate medicine course. In some instances these courses are specifically designed to widen participation and in others they are focused on providing applicants who did not study the sciences at A level with the necessary knowledge to complete a medical degree.

In early 2014 SEEG will bring together those responsible for running these foundation courses together to discuss their impact on widening participation.

# Engagement

*Throughout 2013 SEEG has been engaging with key stakeholders about the Selecting for Excellence project. This chapter provides details of the activity that has taken place this year and highlights what work MSC proposes to carry out in 2014.*

## Postgraduate educators

On 27 September 2013 SEEG organised a roundtable meeting for those involved in postgraduate medical education and training. The aim of this meeting was to establish whether those who are responsible for the next stages of training think that medical schools select the right sorts of people to become doctors.

A full report of the meeting is available at Annex B but the following main points were made by attendees:

In order to ensure that the correct values are embedded in the future generation of doctors it is worth considering whether patient safety metrics might be embedded further into the curriculum. It may be that greater use of 360-degree appraisals for medical students (including patient feedback) might be an effective route to explore.

Information, advice and guidance on alternative careers to medicine should be provided in order to allow medics to 'exit' the profession when necessary. Detailed analysis of data on trainee doctors in difficulty would help to identify patterns and routes for support.

More emphasis should be placed on 'non-technical skills', leadership skills and patient safety – this needs to go alongside requirements to have an effective and detailed knowledge base.

Information on bursaries, scholarships and student support needs to be made available under the new tuition fee regime. It may be helpful to compare the funding support available to medical students in the UK compared to the 'offer' provided by other countries.

There needs to be a clearer grasp on how to tackle and use contextual data with the possibility of a national framework being created.

There should be a greater emphasis on the ability of applicants, students and trainees to be 'team players'.

Quotas may prove to be an effective way of incentivising institutional recruitment.

It will be important to develop an evidence-based evaluation of the medical students who had been provided additional support to study medicine despite not having suitable levels of GCSEs.

It is important to consider whether key performance indicators could be developed which might help identify those students who may not be suitable for a career in medicine.

## Careers advisers

In October 2013 SEEG set up a roundtable event for career advisers. This event focused on the purpose, usefulness and resources surrounding careers advice for students aspiring to study medicine. The group was made up of representatives working in careers advice. A medical student was also invited to give their perspective on careers advice and admissions. A full report is available at Annex C.

Some of the main points made at the meeting included:

There is a need to build an evidence base on contextual data to allow its use to be more transparent in the admissions' process. This would aid careers advisers.

Consider supporting medical students to act as mentors through a more centralised resource which could provide advice to potential applicants and careers advisers.

Clarify what the work experience expectations of medical schools are to aid advisers and applicants. Consider how to influence the update of national NHS work experience guidance (eg how to address patient confidentiality).

Make online information on access to medicine more centralised to ensure transparency. The information on this site should include details of different schools' entry requirements and selection processes in a way that is designed to help applicants judge their likelihood of success.

Consideration could also be made to developing an online toolkit with a host of resources for advisers or teachers. This could include

Provision of lesson plans covering medical applications

Summaries of workforce intelligence

Up-to-date information on medical admissions opportunities

Potential to have an FAQ or Q&A (maybe online chat facility which could be staffed by 'experts' from within HE/postgraduate arena.

Links to other resources.

Invest in online peer to peer advice alongside online information portals.

Maximise the use of role models in publicity/marketing/talks/mentoring – particularly of those applicants who have successfully entered medical school through non-traditional routes and/or are from non-stereotypical backgrounds.

Emphasis in careers advice should be more focused on the core values and behaviours needed to be a doctor and what this means in practice.

One potential role for careers advice would be to look at the alternative options from medicine, including non-clinical careers so that trainees who, during their medical studies, feel that medicine is not for them could positively identify other options.

Explore the further development of 'taster' courses for students from under-represented groups. These would have a role to play in providing an opportunity for attendees to decide whether or not the profession is right for them.

## Admissions deans

In November 2013 SEEG brought together admissions deans from across the UK to discuss the Selecting for Excellence project. The full report from this meeting is available at Annex D but the main action points from the meeting were:

SEEG should draft a statement setting out the values, attributes and skills needed to become a doctor.

SEEG should develop a consensus statement on the purpose of work experience.

Further research should be commissioned on selection methods.

Work should be undertaken to establish the long term feasibility of a national selection process for medicine including whether regional selection centres could be developed.

This meeting was only the first of a number of meetings that will be run with admissions deans about the project; there will be further meetings in Spring and Autumn 2014. Additionally a number of admissions deans have volunteered to become part of an Expert Sub-group who will provide advice to the executive group on matters relating to selection.

## Teachers

Individual teachers have an important role in informing career decisions and success in medical school admissions. For example, a recent study has found that medical school admission interview performance was positively related to whether a teacher, tutor or career adviser had provided advice on the interview process. A repeated message at a meeting of admissions deans on 26th November was that the support given at secondary school/college level had a significant impact on applicants' preparedness and aspiration.

Therefore, the Selecting for Excellence project has agreed the importance of engaging with teachers in secondary schools and further education colleges about:

1 Their understanding of medical schools' admissions processes

2 What could be done to support teachers and their pupils through these processes.

To this end, meetings have been held with TeachFirst and a survey for teacher representative organisations has been drafted for circulation in early 2014. The results of the survey will be used to inform the final recommendations of the project.

## Patients and the public

Ensuring that medical schools are selecting the students who will go on to be the doctors that meet patients' and the public's needs is a crucial role of admissions processes. Therefore, using patient and public opinion in the work of the Selecting for Excellence project is vital.

To gather patient and public views, a survey on the role of the doctor has been created. A representative sample will be asked to outline their agreement on a series of questions about the present and future role of the doctor. These results will, in part, be used to update the role of the doctor consensus statement. It is hoped that this will be a first step in ensuring that medical schools have up to date information about what patients and the public want from their doctors. Discussion is under way about how an updated statement could be tested with groups of

patients to ascertain whether the aspirations are being met in reality.

## Plans for engagement in 2014

The engagement plan for the Selecting for Excellence project in 2014 will build on the work done in 2013. SEEG will continue to engage with admissions deans, teachers, careers advisers and those involved in postgraduate education and training. SEEG has also identified a number of other key stakeholder groups which have an interest in the project and with which it will be important to engage with in 2014.

In particular it will be important to engage with students as to their experiences of selection processes and widening participation schemes. As part of the research project on outreach a number of focus groups will be held with students. SEEG will also continue to work with the BMA Medical Student Committee, who are executive group members, on this project. Additionally in 2014 SEEG will look at other bodies that represent students, for example the National Union of Students, to see how they might contribute to this work.

SEEG is aware that many potential applicants to medicine go online to get information about selection processes. The most popular website that applicants use is The Student Room. In 2014 SEEG will look into ways of working with the website to ensure that potential applicants receive the best quality advice on applying to medicine.

A priority for 2014 will be to engage with other healthcare professionals on the work of the Selecting for Excellence project. In 2013 SEEG has informally engaged with the Dental Schools Council, the Pharmacy Schools Council and the Council of Deans of Health but in 2014 this engagement needs to be formalised so that other professions can benefit from the work being done in medicine.

In 2014 MSC will publish quarterly newsletters to ensure that all stakeholders are kept up to date with the work of the Selecting for Excellence project.

# A review of current practice to support Widening Participation in medicine

## A Medical Schools Council (MSC) funded project

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# 1. Introduction

In this report, we provide the rationale for this project, background on the widening participation literature and importance, and the study aims and research questions for this multi-method programme of work.

## 1.1 Background

Increasing the demographic variability of medical students remains a major policy issue in the UK. Widening Participation (WP) refers to the policy that people such as students from disadvantaged backgrounds, mature students, students from ethnic and cultural groups and disabled students should be encouraged into higher education, which in turn relates to improving social mobility. Social mobility can be defined as breaking the transmission of disadvantage from one generation to the next (Fair Access to Professional Careers, 2012). When a society is mobile, individuals have more opportunities of progressing in terms of income or occupation.

A second rationale for WP to medicine is to improve healthcare provision by ensuring “doctors should be as representative as possible of the society they serve in order to provide the best possible care to the UK population” (BMA, 2009). This assumes that increasing the diversity of the medical workforce will improve healthcare, based on the assumption that “like would treat like” (James et al., 2008). Additionally, it may be that students who train in more diverse medical schools gain a greater understanding of other people from different socio-cultural backgrounds, and this increases their ability to provide healthcare to people with backgrounds different from their own (e.g., Cohen-Steinecke et al., 2006; Saha et al., 2008; Whitla et al., 2003).

While the rationales for WA to medicine – social equality and improving healthcare provision – are laudable, data suggest that the efforts to date to minimise the barriers into medicine have had mixed success. Since the 1970s, the UK medical student body has become increasingly diverse when it comes to gender, ethnicity and age. That progress, however, has not been mirrored by a similar change in the socio-economic background of medical students.

*“Medicine... has a long way to go when it comes to making access fairer, diversifying its workforce and raising social mobility... Its success in recruiting more female doctors and doctors from black and minority ethnic backgrounds indicates that with the right level of intentionality the medical profession can also throw open its doors to a far broader social intake than it does at present. ... Overall, medicine has made far too little progress and shown far too little interest in the issue of fair access. It needs a step change in approach”*

Fair Access to Professional Careers (2012, p.3)

That medicine has engaged in considerable activity to remedy this situation, including the establishment of the Selecting for Excellence Executive Group (SEEG) chaired by the MSC, is acknowledged in the 2013 State of the Nation report (p26). However, the same report goes on to state that there remains limited progress to widen participation into the professions, with initiatives still small scale and a focus on school outreach work rather than systematic reform of recruitment practices. This statement is supported by the findings of a literature review commissioned by the General Medical Council (GMC) in 2012 by Cleland, Nicholson and colleagues (<http://www.gmc-uk.org/about/research/14400.asp>) who identified that not only were widening participation initiatives small scale but that there were few, and poor, evaluations of activities; poor data reporting; complex selection processes which impact on socio-economic class bias; differing understandings of WP and “fair”; and ambivalence about the role selection can play in this area.

This report can be considered a follow up to the earlier GMC-funded review.

## 1.2. Aims and research questions

The aim of this work was to conduct an external evaluation of contemporary medical school widening participation (WP) activities in order to address gaps in the WP literature and inform the activities of the SEEG. We aimed to:

- Describe the range of WP activities carried out by UK medical schools, and assess the extent to which these are evaluated.
- Explore the role of work experience in the selection process
- Explore the extent to which contextual data are used in the selection process
- And provide insight into the views of those involved with Medical Admissions as to, in relation to WP what works for whom, and under what circumstances?

This project collates, analyses, and critiques data from four sources (see later), and synthesises these into recommendations for policy and action

## 2. Review 1: Selection and widening participation data available from GMC returns

### 2.1 Data collection

First, we collated existing data on WP from GMC returns from all UK medical schools<sup>1</sup> into one spreadsheet. The aim of this exercise was to clarify what is actually reported in relation to selection and WP to the regulator by medical schools. We looked specifically at Question 10a, b and c:

*Has your process for student selection changed since 2011?*

*What is your school's approach to admissions for students from lower socio-economic groups?*

*What outreach activities does your school take part in?*

We were particularly interested in data referring to admissions processes and the use of contextual data and work experience in selection. We also looked for any data which indicated the success rate of WP activities as measured by offer rates and other outcome markers.

### 2.2 Main messages

Note that we are reporting only on the data provided by medical schools to Question 10 in the GMC returns. Schools with no changes to their selection processes since 2011 were not obliged to provide data. Hence, we cannot report on processes already in place by 2011 unless schools chose to provide an historical overview or additional specific data under 10b or c. While the data reported varied widely in terms of focus and amount of detail, we were able to identify some trends.

#### Selection methods

Twenty one of thirty two (21/32) medical schools reported changes in their student selection processes. Seven schools reported moving from traditional interviews to multiple mini interviews (MMIs) or "OSCE format" which we interpreted as more or less the same process. One school had piloted MMIs. Some schools had clearly introduced MMIs before 2011.

There seems to be a move towards less weighting being given to the personal statement in the selection process. Formal selection tests such as UKCAT, BMAT and GAMSAT feature widely in the selection

<sup>1</sup> Our thanks to the GMC for granting permission and providing access to this data.

processes. While used by the majority of schools, how these selection tests are used, and weighted, differed by school.

### Use of contextual data

Thirteen out of thirty-two schools reported the use of contextual data in their admissions process. However how and what contextual data were taken into consideration differed across schools - from that relating to average school performance/low progression rates into higher education to personal or individual contextual data such as socio-economic markers of class, to no clear detail of what contextual data are used. Five medical schools stated that they would consider reducing either the entry tariff/grades or selection test scores on the basis of contextual data. One school specifically stated that they ring-fenced places, two schools used contextual data to guarantee an interview, and two further schools described how selectors should use contextual data to understand the context of an applicant's achievements. However, overall it was often unclear how medical schools used contextual data in the selection process.

### The role of work experience

While a number of schools made reference to the personal statement still having a role in selection, only two schools specifically mentioned work experience. One stated that applicants must offer work experience in the healthcare sector while, in contrast, another had made changes to how they score the personal statement so not to put as much emphasis on health-related work experience.

### Widening Participation

Engagement with formal WP schemes, medical school initiatives and a variety of out-reach/in-reach was clearly stated by most schools. Medical schools gave details of their connections with initiatives such as "Realising Opportunities", the Sutton Trust and, in Scotland, "REACH". Three medical schools described summer schools that involved local hospitals. Five schools specifically outlined student-led activities: two e-mentoring, but also student ambassadors. Further details were provided during the admissions deans' interviews (see later).

Two medical schools specifically stated they visited schools early (from year 5 and in year 9). Often sparse information was given as to how schools or participants were chosen or invited to take part. This means that sometimes it was hard to evaluate whether the initiatives are truly targeting those most in need.

There were three references to tracking successful applicants from WP backgrounds. One medical school is formally reviewing student admission and progression data to recommend changes in the way that it collects and uses contextual data. Two further examples of good practice are detailed below:

*The Sheffield Outreach and Access to Medicine Scheme (SOAMS) run by the Medical School at the University of Sheffield takes 100 pupils from Year 9 each year. Approximately 360-400 school pupils are engaged with the programme at any one time. Both parents and the secondary schools are very much part of the programme. The programme is well supported by the University and medical students themselves who volunteer to support the pupils. The latest figures show that approximately 60% of all those who participate in the scheme end up entering some form of healthcare education. Not all become doctors but we believe that this overall conversion rate reflects well on the impact of SOAMS as a whole.*

*Medical Aspirations Programme: this is a widening access, residential programme that targets students from Norfolk and Suffolk who attend schools where students achieve lower than average levels of participation in Higher Education; have no tradition of family in higher education; and/or a household income less than £25,000. These criteria are scored to shortlist participants. Our programme runs during the spring half term week and the aim is to give 25 students an insight into University*

*life. We have approximately 30-40 applicants per year. Students attend seminars and workshops on medically-related topics, take part in team building activities and learn how to best support their applications to Medical School. Two students who attended in 2010 are now in receipt of a full scholarship at our medical school, and five who attended in 2011 and registered at UEA this year are receiving a full scholarship – funded by an alumnus donor.*

## 2.3 Summary

There seems a trend towards using more robust methods of selection (e.g., MMIs rather than interviews, less emphasis on the personal statement). However, many of the descriptions of selection processes suggest local culture/systems continue to exert a stronger influence on practices than the evidence base. Medical schools have responded to the request to provide more information concerning WP, but how this is reported is variable. A more systematic approach to concluding what works would be facilitated if returns were structured so all schools provided the same data. This may be achieved by clear guidance as to what must be reported. We suggest such guidance should ask for data on WP engagement and tracking, how schools specifically use contextual data, and how individual selection methods are used and weighted.

## 3. Review 2: Widening participation data available from school websites

### 3.1 Data collection

We searched the websites of all medical schools for information referring to widening participation (WP) initiatives and systems. We collated this information in a spreadsheet (Appendix B) and analysed it for themes and patterns. As before, we looked for reference to the use, or role, of contextual data and work experience in relation to WP. We also looked for any data which indicated the success rate of WP activities as measured by offer rates and other outcome markers.

Our reporting is based on the data available from medical schools' webpages, in Sept/Oct 2013. Medical schools may well do more than is reported but if the data were not accessible to us via the webpages, neither were they accessible to potential applicants.

### 3.2 Main messages

All schools had information about WP on their webpages. The extent of this information varied widely, from merely reference to, and a link to, the MSC guidance on WP to the purely descriptive ("we take part in [WP scheme]...") to providing detailed guidance on eligibility criteria and process). We felt only a small number of schools provided sufficient information for a prospective applicant to know if they were eligible for a WP pathway.

Case Study 1 is an example of unambiguous guidance for applicants.

#### **Case Study 1: Clear and useful guidance from the University of Southampton**

"(The aim of the) BM6 programme is to widen access into the medical profession. The course has achieved national recognition as an example of good practice. It involves studying for an extra year on a specially-designed year zero course before joining students on the BM5 and BMedSc programme. Guaranteed place on BM5 and BMedSci (conditional on satisfactory completion of year zero). A small-group setting with 30 students. Eligibility criteria: applicants need to satisfy three of the following criteria:

- first generation applicant to higher education

- parents, guardian or self in receipt of a means-tested benefit
- young people looked after by a Local Authority
- in receipt of a 16-19 bursary or similar grant
- in receipt of free school meals in Years 10-13
- living in an area with a postcode which falls within the lowest 20 per cent of the Index of Multiple Deprivation, or a member of a travelling family"

We felt that reference to, for example, "attracting non-traditional students" or "those from lower socio-economic classes" to medicine could be relatively meaningless to potential applicants, who may not define themselves as "non-traditional" or lower class, and hence may not realise that they are eligible for WP initiatives.

There seemed a fairly even split between schools reporting that they engaged with university-wide WP initiatives and those describing medicine-specific activities. Some schools clearly took part in both types. As expected given the outcomes of the recent GMC review (Cleland et al., 2012), most schools offered a number of short WP initiatives and a combination of in-reach and out-reach activities. Many focused their widening participation efforts on local engagement. The level of engagement (school or individual) was sometimes unclear. Some schools indicated good practice in terms of initiatives targeted at Year 9 school pupils and above, rather than just older pupils, but often the age range of those targeted in WP activities was not stated. Ring fenced places for WP applicants who met certain contextual and academic criteria were indicated by six schools.

Only two websites gave an indication of the success of their WP schemes in terms of admissions. A number of schools reported 6-year programmes aimed at WP. Foundation or Access to Medicine courses were also referred to by a number of schools. We felt that the quality of Foundation and Access courses may be a concern as most schools who mentioned these routes were very specific about which courses they would consider. Some of these were run in house while other schools had clearly partnered up with particular courses. One school specifically stated that applications from Access to Medicine courses would not be considered.

## 3.2 Summary

Medical school webpages indicate that the majority of schools engage with WP although some seem more actively engaged than others. The information provided indicates a variety of initiatives, most limited by their small scale and restriction to an individual institution. There was little indication of the success of these initiatives.

Only a few websites were "applicant friendly". It was rare to find sufficient information for a potential applicant to know if they were eligible for a WP initiative and, if so, how to go about finding out more information.

## 4. Admissions deans' survey

### 4.1 Background

After obtaining the necessary ethics permissions, JC emailed all UK admissions deans and asked if they would be willing to share data on WP and other aspects of selection. The responses were overwhelmingly positive. Participants were then sent details of the questions by email so they could collate local data before the interview (see Appendix A). These questions were developed in collaboration with the MSC.

Within the time frame available, we spoke to (n=11), or receive detailed information by email (n=7),



from 18 admissions deans or their representatives. The findings are presented in the form of the frequency and percentages of the respondents' answers, quotations quotes from the interview text and case studies.

## 4.2 Main messages

### Socio-economic data

Table 1 shows that the most common forms of socio-economic data of applicants held by medical schools are either UCAS or postcode details. A surprisingly small number of medical schools hold information on whether the applicant is part of a WP programme. The other data refer to information including the SIMD, NS-SEC 4-7 and specifically whether the applicant has been in care for more than three months. There seemed remarkably little data held given that this information is essential in determining the success of WP.

**Table 1:** Socio-Economic Data held for Applicants

Types of Data Held	Percentage %
UCAS data	56
Postcode/Geographical Area	56
School Code or Type A/B	22
Self-Apply for/part of WP programme	22
Self-declared Information – ethnicity, parental occupation, etc.	22
Socio-economic Class	11
ACORN/Polar	28
Does Not Receive Data Directly	6
Other*	33

### Widening Participation initiatives

All 18 schools interviewed were involved in WP initiatives. These initiatives varied widely in terms of format and intensity, aims and objectives, and goal clarity. Tables 2 and 3 provide summaries of the activities engaged in with regard to out-reach (those that occur out with the medical school or university) and in-reach (those that occur within the medical school or university) as well as an approximate percentage of the activities that medical schools reported that they took part in or ran. Where it was possible to provide an indicator of intensity of an activity this was also provided (note this is an approximation).

**Table 2:** A summary of "in-reach" WP activities

In-reach Activities:	Intensity	Percentage %
Summer schools	1-2 weeks, from 20 to 350 attendees	28
Residential placements	1-5 days, from 20 to 150 attendees	33
Workshops	Day long for both small and large groups up to 66 times a year	44
Open days	Dependent on university provision – up to 5 times a year	33
Taster sessions	Ranging from 20 to 500 attendees on up 12 occasions in year	28

In-reach Activities:	Intensity	Percentage %
Mentoring programmes	Up to approx. 100 mentors	33
Ring-fenced places	See Case Study 2	6
Study skills modules	-	6
Practise mock mini-multiple interviews	-	22

Table 3. A summary of “out-reach” WP activities

Out-reach Activities	Intensity	Percentage %
Talks with schools/working with schools	From up to 2 hour talks to student placement with schools.	78
Career days and career fairs	Not held frequently	28
Reach/Access initiatives	-	33
Teachers talks and conferences	-	11
Shadowing days	-	6

Most commonly, interviewees described the activities shown in Tables 2 and 3 in terms of providing potential applicants with “hands on” experience of medicine. The activities were also considered to be aspirational, encouraging those who had not previously considered this as a prospective career. For illustration a more detailed, in-depth case study of the types of activities participated in and ran by one medical school is also given below.

### Case Study 1

The following outlines the range of WP activities conducted by one medical school.

Clinical Skills Workshops run by medical students as part of a summer school that is attended by the top 10-12 students from 9 schools in the local area.

Online Mentoring programme for those who attend the summer school

Medicine Workshops aimed at enhancing work placement options in ‘access’ priority schools with the follow up option of a Medicine Shadowing Day.

Medicine Shadowing Days for S5/S6 pupils from ‘access’ related backgrounds interested in studying Medicine.

Identifying ‘Access’ priority students through summer schools for both the full and Pre Med course in Medicine.

Teachers Conference for state/‘access’ school teachers to gain more insight into Medicine to advise their students more effectively.

Tracking and contextualising applications from ‘access’ backgrounds with regular meetings between the recruitment department and medical admissions.

REACH Officer working with local schools employed by the university.

#### **‘Access’ routes to Medicine:**

Pre Med Year in Science in which successful completion of the Year leads directly to Medicine.

Applicants include those are from non-standard backgrounds whose academic performance does not match minimum entry requirements for Medicine but who show strong potential.

Applicants from ‘access’ backgrounds who meet the minimum entry requirements but whose applications are not as competitive as that of others, continue to be considered for DIRECT entry to

Medicine.

The 'Pathway' to Medicine which through the HNC Applied Sciences course gives a direct route to Medicine for mature students or for those who may have left school with few formal qualifications or who pursued employment rather than going to university.

WP activities often focused on knowledge provision - information about the UKCAT, the medical profession as a career – and/or skills development - practising mock mini-multiple interviews and personal statement writing. A number of schools involved students (e.g., mentoring programmes, going out to talk to schools). Student involvement was seen as very positive role modelling – *“Actually, it's the mentoring programme that I think helped hand-hold them into medicine and we know that by looking at the socio-economic demographics of that, that actually we are getting to some of the people that wouldn't otherwise get an opportunity to come into medicine.”*

We found that some Deans/Deans' representatives were very clear on what they were and were not doing in terms of WP whereas others seemed less informed or involved. Similarly, some schools seemed to be making good attempts to evaluate the success of local WP initiatives while others were less critical (see below).

### Success Rates of WP Schemes

There was considerable variation in the amount and type of WP scheme evaluation. Of the 18 medical schools interviewed, 12 reported that they evaluated the success rate of their WP schemes whilst six either specifically did not evaluate them or did not have access to the data at that point. A number of interviewees stated that WP and traditional applicants did equivalently well in terms of offer rate or better, indicating that students from WP backgrounds who enter the admissions process do relatively well.

*“We compared the success rate at interview for people coming in through widening participation schemes and the standard applicants and there was no difference in the offer rate.”*

*“What we've said this year is: if the Reach pupils who apply to medicine get the minimum academic requirement, and they're in the top 75% of the UKCAT scores, we will guarantee them an interview. Because when you get them to interview, a lot of them are just fantastic, and they may not have got there otherwise. So, I think that's the best bit – if you can actually guarantee that you get them to interview, and you give them, then, the chance to sell themselves.”*

However, these are not formal evaluations but anecdotal reports and there was awareness that the evaluations are limited (“whether it's achieved what we set out to do, it's difficult to know whether that is the case”). While we were surprised at how few schools were routinely evaluating WP initiatives, Case study 2 presents an example of good practice in terms of evaluation and data reporting.

### Case Study 2 – Success Rates

Below are the success rates in terms of offer and admissions numbers of one medical school.

#### Offer rates

The proportion of students on WP programmes or with contextual data flags who receive an offer with the proportion of non-WP applicants receiving an offer are compared. For 2013 entry, 13% of non-WP applicants received an offer; 24% of care-leavers and students with two WP flags received an offer; 31% of participants in the Access 2 Medicine programme (the forerunner to Medicine) received an offer.

#### Numbers of admissions

For 2013 entry, 6.5% of non-WP applicants entered the course; 10% of care-leavers/WP-flagged applicants entered the course; 23% of Access 2 Medicine participants entered the course.

Approximately half of those interviewed (56%) reported tracking successful applicants once they start the course. Little detail was provided as to the nature of this tracking.

## Resources

Of concern was the variation in WP resources. A number of participants reported difficulty adhering to expected practice in the face of central (institutional) budget cuts. Moreover, some of the activities proposed as WP seemed more to advertise the medical school rather than open it up to more disadvantaged students. For example, workshops and residential courses are a good way of getting a taste of medicine but it may be that they are less accessible to WP students due to associated costs. There seemed to be little financial support for potential applicants from WP background to attend events.

Table 4 shows that our interviewees felt that targeting particular schools, careers and guidance teachers were the most effective use of resources.

**Table 4:** WP methods perceived to be effective uses of resources

Method	Percentage %
Targeting particular schools	78
Guidance and careers teachers	50
Communicating with parents	11
Grade concession	11
Including contextual data in admissions	11

Our interviewees were, however, quite critical of schools and teachers who they perceived “put off” potential applicants by telling pupils they are not “right” for medicine, on the basis of an inaccurate understanding of what medical schools are looking for.

*“We found, generally, that a lot of colleges, and even parents, are gatekeepers, with regard to widening access. That they can actively discourage some students, so I believe that the colleges themselves really need to be targeted - to let them know what type of students, and what requirements there are for applications to widening access. Because I don’t think that a lot of them know. We still get students coming in saying, oh, our teachers told us not to bother, we wouldn’t get in as we’re not the right type of student.”*

The interviews indicated that helping non-traditional school pupils aspire to medicine remains an issue. Medical schools seems quite dependent on third parties (schools and teachers) to do this, and the quote above indicates that the level of understanding and/or engagement from schools/teachers may not dovetail with medical school WP aims and objectives.

The need to target pupils at a younger age was also frequently mentioned as “likely to raise aspiration and motivate raised attainment”.

Resources were also alluded to in terms of supporting successful WP applicants. These students tended not to receive any additional support (unless on a formal WP programme) and a number of interviewees felt this was less than ideal.

## Use of Contextual Data in Admissions Decision Making

In total, 13 out of the 18 medical schools involved in the interview survey said they use contextual data in admissions decision making. This tended to be lower grade criteria and/or provision of an interview where the applicant did not meet the standard threshold for interview. Getting WP applicants to inter-

view was seen as crucial: “having face-to-face contact is seen as valuable, particularly for interviews as there is often a “disparity between the statement and what we see when we get them for interview”. On the other hand, there was awareness that consideration also needs to be given to WP applicants at interview as they tend to have less experience of, and less coaching in, interviews. Group exercises were seen as potentially problematic as WP applicants may be less confident, and thus be less able to show their potential in such settings.

Table 5 shows the types of contextual data used in the admissions decision making process and the percentages of medical schools that use these data. These may not be exhaustive but are those specifically mentioned by interviewees.

**Table 5.** Types of Contextual Data used by the 13 medical schools in admissions decision making

Contextual Data	Percentage %
Postcode/SIMD	38
School attended	62
Socio-economic class	31
Parental income	31
WP activities/Flag	46
POLAR/ACORN	23
In care	38
Parental access to higher education	23

Grade boundary change and contextualising grades were frequently described as being an effective means of supporting WP as they are quick, less prone to manipulation and relatively easy “way of giving a boost to those people who have attended poorly performing schools”.

Whilst contextual data are perceived as important there are concerns with how reliable the indicators are such as post-codes, POLAR and NS-SEC, particularly if the data are self-reported as they can be prone to error and open to manipulation. Mature students and those just on the boundaries of WP access can fall through the gaps due to the limitations of existing indicators.

## Overall impressions

Many of those interviewed showed considerable passion for WP. Several of the deans discussed WP in terms of the right and moral response, social accountability and engagement as well as the excitement of finding individuals who have untapped potential. Others were more sceptical about WP, particularly with respect to the criteria and boundaries used, and about the role of medical selection in “social engineering” or as one interviewee put it, “social re-engineering” to level the playing field for those who did not receive an expensive education. The position of the Dean towards WP seemed to have a knock-on impact on how committed the school was to WP activities – although it is difficult here to tease out cause and effect. In other words, do medical schools who are committed to WP ensure that those selected for the position of Admissions Dean espouse the views of the school, and vice-versa?

There was a desire to ensure that boundaries and criteria were robust and fair to all applicants. Concerns over those who were in the “middle” spectrum of abilities who tended not to get places were highlighted. “But there’s an awful lot in the middle, where these are people who are at ordinary schools and doing ordinary subjects and probably don’t necessarily have the specialist help and support that those that go to a selective education get. And I think they’re probably the group that we’ve probably got the most potential to do anything with.”

### 4.3 Summary

All medical schools interviewed reported engaging in WP activities. A variety of approaches were used by medical schools that reflected both in-reach and out-reach activities. However, some activities described to us as supporting WP seemed quite routine and not designed to be specific to any particular group of applicants.

Furthermore despite this range of activity few schools systematically track the progression of WP students. Contextual data are used widely but what contextual data are used and how they are used differs widely often without any obvious rationale for any particular approach. The impact or success of WP activities and the use of contextual data are poorly evaluated, with mostly anecdotal reports of their success provided.

Overall there seemed remarkably little data held or readily available to admissions staff concerning the socio-demographic details of applicants, including those who attend widening participation initiatives. This would seem a priority in ameliorating the similar paucity of data relating to determining the success of WP.

There is an awareness that targeting WP activities towards younger pupils (senior school, but before selecting subjects) is ideal. However, there is often a tension between schools and medical schools in terms of supporting WP, with schools/teachers not supporting pupils to aspire to medicine, possibly because they do not understand the nature of medicine and the profession's desire to be more inclusive.

## 5. Student focus groups

### 5.1 Background

The rationale for this aspect of the enquiry was to further explore the range of issues that medical applicants from disadvantaged backgrounds face, and in so doing be able to gauge what initiatives they find useful in overcoming any perceived barriers in gaining a place to study medicine. This approach is required because we know that many medical schools have not fully evaluated their widening participation initiatives and so it is speculative what applicants find useful.

### 5.2 Data collection

Three focus groups were convened; two at Barts and The London and one at Southampton medical school. The participants from Barts and the London were year 12 students from local secondary schools situated in areas of high deprivation currently attending a student-assisted medical and dental outreach programme. The participants from Southampton meet several widening participation markers as requisites for their current enrolment on the BM6 pre-entry to medicine programme based at Southampton Medical School.

Each focus group had six or seven participants and lasted for approximately 45 minutes. Each group was facilitated, and used a series of prompts to stimulate discussion around participants' experience of applying for medicine, any specific difficulties they perceived due to their social background, and what help, if any, formal or otherwise, they found useful. Field notes were taken and the discussions recorded and later transcribed. Thematic analysis using a modified grounded theory approach categorised the issues arising from the participants' discussion into two areas: themes associated with perceived disadvantage and the benefits gained from engaging with widening participation initiatives.



## 5.3 Main Findings

### Perceived issues for medical applicants from disadvantaged backgrounds

Unsurprisingly applicants to medicine from deprived backgrounds describe a process of application and application preparation that is made more difficult by a significant relational lack of social capital<sup>2</sup> as perceived in comparison to their more well connected peers. This is further demonstrated by participants' descriptions of their lack of inside knowledge and ignorance about perceived accepted ways of going about things as this participant explains:

*"There are certainly opportunities I have heard about and I have done research into 'what can I go to?' but literally it is the first time I have heard about it and it sounds like something that would have really benefited me if I had heard about it or gone to it back in the past, but what has happened has happened" (p. 19 int 1).*

This disparity participants largely believed was due to a lack of medical contacts which they consider significantly disadvantages them. Participants gave examples where they felt they had no-one to ask for specific help particularly if their school had little experience of medical school applications:

*"I remember when I was applying as a volunteer and on the application form, it said, do you have relatives working at this hospital? If so, we will arrange for you to be with them. Like to sit in with your relative or your family friend or whoever. And I was thinking, no I don't have any. And then I remember when I was trying to get work experience, I sent out e mails to... I went on to the hospital website and I got a list of all the surgeons and their e-mails and their details. And I sent out this mass e mail, just changed their name and changed the Dear Whoever, and then sent it to every single surgeon" (p.13 int 3).*

However, having no medical contacts and so expertise to call upon was seen by some participants as strongly motivational:

*"I think you could always sort of get up there yourself but you have to be self-determined and that is part of being a doctor so I think it is important that you do get there yourself and kind of be self-determined enough to actually push yourself through, provide as much as you can, make sure that you do put yourself on the same level as everyone else without the classes" (p.10 int 1).*

When participants had secured external help or attended courses they sometimes felt these experiences undermined their self confidence primarily because they then recognised the competition they were up against:

*"But those courses, they are bad as well because you meet a lot of scary people. You talk to people, you sit next to and everything. Oh, my grandfather pioneered this operation. You are just like, how am I going to compete against some of these people?" (p.11 int 3).*

*"So, I went to the summer school and everyone there is really... Not that I want to generalise and so on, but everyone was really middle class. Most of them went to private schools. One of the girls that was with us on the summer school, I think two of the girls, actually. Their fathers were surgeons and they were professors and so on. You think, wow. You really see yourself in relation to other people. But ultimately I thought, I want to do medicine and my reasons are genuine and I hope that's all I can do" (p.12 int 3).*

However, participants did clearly articulate how they felt the advantages some applicants had because of their backgrounds as seen by their schooling or family contacts created a sense of "unfairness". This

<sup>2</sup> Social capital (Bourdieu and Passeron, 1964) is determined by an individual's "sphere of contacts" (Grenfell and James, 1998, p.21) and the social contacts that they may call upon to facilitate social movement but also increase their capital in other ways.

perceived disparity highlighted participants' anxiety concerning how medical schools could fairly judge applicants, as these participants explain:

*"Students from Eton would definitely have a lot more preparation for certain entry requirements, to pass the UKCAT, to pass the BMAT, to definitely get the grades, than a student from a normal sixth form college. I don't think we get half as much support as they would, they might have a guaranteed spot already, who knows" (p.8 int 1).*

*"The only thing that gets me is the fact that all of us have put in a lot of hard work on our own and it is how the university would differentiate between a student who has tried to do as much as they can individually and a student whose parents are doctors or his father is a teacher at the school and so everything is in place for him. On paper he has everything that is needed to apply for Medicine, I am not sure if this is making a lot of sense, but yes it is how university would differentiate between a student who has been spoon-fed more or less or a student who like us, had to do quite a bit on your own" (p.16 int 1).*

Money, or lack of money, was a persistent feature:

*"I felt kind of pressured from... You get all these advertisers who advertise these courses, they give you all this information. And when you don't do it you feel like, am I going to be alright, am I going to be disadvantaged because I didn't go to this course. I said, I'm not paying £200 to sit in a room where they can do it. I guess if I did have that money available to me, I probably would. Yeah. If I had that money, I would have just taken it and gone. Because any advantage is an advantage, at the end of the day" (p.10 int 3).*

Participants described how their own schools sometimes presented a disadvantage by not being in an experienced or knowledgeable position to help medical applicants as stated by the participant below:

*"I think maybe schools don't really know that much about what Medicine entails. I think they just assume it is like everything else so they can't really help you that much" (p.4 int 2)*

This includes help with all aspects of the application process from writing personal statements because the number of candidates is higher than schools can cope with, to specific help with aptitude or entrance tests, as these 4 participants describe:

PAR1: *"The UKCAT was quite a big barrier.*

PAR2: *Yes UKCAT and no support from the school.*

PAR3: *Whatsoever.*

PAR6: *Regarding the UKCAT, I don't think they are that experienced with the UKCAT, like if you ask some of the teachers they don't even know what it is" (p.12 int 2).*

A somewhat unexpected finding, which is corroborated with the admissions deans' interviews, is the evidence and views expressed by participants that some of their teachers actively tried to dissuade medical applications:

*"I just think they should stop being so pessimistic about it and so conform to the idea of the perfect student and the perfect this and the perfect that, I mean we don't have all the opportunities of these perfect students who come from obviously much better backgrounds than we do and I feel like because of that they are trying to convince us that we are not going to get into Medicine so why are you trying? I don't think they do it on purpose"*

And in some cases blocked a participant's application as stated below:

*"Literally, we have a Head of medical applications. Because they like the statistics to say, oh, out of*

*everyone who applied, 60% got in. So if it looked like you didn't have the grades, she'd just say, I'm not sending off your application, sorry. Cool. Lots of arguing. We were like, oh, you are. So yeah. I would just say that's the biggest deterrent" (p.16 int 3).*

## Benefits gained from engaging with widening participation initiatives

Participants were clear that they felt disadvantaged in not having personal medical contacts. They felt this disadvantage reduced their immediate and pertinent, otherwise known as "hot", knowledge of how best to make a successful application. This was partially ameliorated by coming into contact with authentic knowledgeable medical people, such as medical students, taking part in local school initiatives and a variety of in-reach activities, as explained:

*"I think current medical students and past medical students are the biggest help really because they have been through it before, they can tell you what to expect, what to do and if they got through then they can help you get through as well" (p. 11 int 1).*

Medical students were felt to be able to better relate to the medical student participants, more so than teachers or medical faculty, who were perceived as not being so approachable, as the participants below explain:

PAR3: *Yes and also the students that, especially xxxxxxxx, they are not quite as patronising as you said. They are very nice and friendly and you can talk to them and communicate with them.*

PAR2: *They get what you are going through.*

PAR3: *Yes they understand the pressures whereas I don't think teachers do because it has been such a long time since they have actually done it themselves (p.8-9 int 2).*

The most beneficial support received by participants mirrors aspects of mentoring where personal support is provided on an individual basis as two of the participants comment:

*"Our school like they have linked with the xxxxxx so if you apply to that, it is quite similar to xxxxx. They do quite a lot of things and they are constantly checking up on you, you are given a mentor in the field who is possibly currently at medical school, who is continually going to be, that you can ask them any questions you have" (p.6 int 2).*

*"I like it when you have someone that knows about like Medicine that is actually supporting you in the process but not actually being patronising about it. So it will vary with different people but the mentor that I have I know he is really supportive, he goes through everything really well. Yes I think that just helps, having someone who is with you constantly telling you what to do for each step" (p. 8 int 2).*

Medical contacts and mentors, alongside other resources, such as student chat rooms, provide information concerning how to write personal statements, prepare for interviews and gain medical work experience.

*"I found the interview practice the most useful. Because it's good going to a personal tutor and whatnot, but going to actual medical students, going through that and later you went, oh, I don't need that. I don't need this. That's actually, I think, better. Yeah. I found more helpful" (p.7 int 3).*

Participants found accessing relevant work experience both stressful and difficult. They made several suggestions that they felt would help applicants in their positions, such as having a list of possible placements to approach and linking placements with specific schools. However, the overriding advice was that such information should be published and available much earlier.

*"I went trawling through the student room and I found this golden nugget. It was this list, it was on some random thread. And it was this list of all of the people in London hospitals that were willing to give work experience to Year 12 students. Amazing. It had all of the hospitals on it and the numbers and the e mails. I thought I was in heaven" (P.14 int 3).*

*"I commend the person who was able to get off to a good start very, very early because a lot of the entry requirements don't just stem from when you start A Levels, they stem from GCSEs, it maybe onward so it all gets taken into consideration, so early help would be essential" (p.14 int 1).*

### 5.3 Summary

*"At the interview for some of the other medical schools that I went to. Most of them were middle class... Well, I don't know if they were middle class. They came across to me as middle class. I'm assuming, I don't know. They may not be. But sometimes it feels like they have links that you don't. They've been to all these different things, they've met all these different people. Sometimes it feels like medicine is like this game, where if you have links to enough people, you have an advantage. Because you can get work experience with this person or you can get an advantage in that way. I know it sounds as though I'm playing the smallest violin. It does make a difference who you know" (p.12 int 3).*

The above quotation epitomises what participants from widening participation backgrounds said about their experiences concerning their medical applications. Such medical applicants feel disadvantaged by their lack of medical contacts and the perceived advantages that are associated with possessing such social capital. Participants valued most the help they received through a variety of widening participation initiatives that facilitated their UCAS applications, personal statement writing, interview preparation and gaining vital work experience. Assistance in the form of mentoring by medical students appeared to be most valued. However participants were clear that all this information was required earlier (GCSE year) and should be more publicly disseminated.

## 6. Overall Summary and Recommendations

This project aimed to describe the range of WP activities carried out by UK medical schools, and assess the extent to which these are evaluated. Drawing together themes from all four sources of information (GMC returns, website, admissions deans' interviews and student focus groups) indicates that a robust and consistent approach to the process and evaluation of WP to medicine continues to be lacking, and this, in turn, continues to disadvantage potential applicants from so-called "non-traditional" backgrounds.

Medical Schools are not consistent in their approach to WP and indeed seem to differ in their commitment to WP. Publicly available information is often not presented in such a way as to be useful to potential applicants. There remains inadequate evaluation and publication of widening participation initiatives by schools. Initiatives are evaluated as successful in the main by anecdotal evidence without sufficient quantitative longitudinal or qualitative follow up of participants. Priorities would be to derive a consensus on which markers define widening participation, ensure these are made appropriately available to applicants, and consider how widening participation initiatives may be meaningfully evaluated.

Further aims were to explore the role of work experience in the selection process and the extent to which contextual data are used. The importance of clear and readily available information for medical applicants, and those from a widening participation background in particular, is critical. Clear information detailing how medical schools select, particularly how contextual data and work experience contribute to decision making is required. A national UK Medical School consensus on these issues would seem the most appropriate way forward.

Much of the described work into raising aspiration and widening participation is admirable. Participants clearly value initiatives that provide personable assistance and relevant advice concerning all aspects of application, including personal statement writing, interview practice and gaining work experience. However there is a clear directive from applicants that medical schools should aim to work with aspiring medical applicants as early as possible and have schemes in place for at least out-reach activity from the GCSE year.

The relationships between secondary schools and their disadvantaged pupils, and medical schools and the teachers from such secondary schools, were sometimes a source of friction, mixed agendas and unrealistic expectations. It would appear that the best opportunity for increased student social mobility is for school teachers and medical schools to work together. Shared activities such as joint teacher/pupil open days, named liaison teachers and conferences are suggested. Further research to examine the costs of WP and how non-traditional students with medical aspirations can be best supported in times of limited resources is required.

The GMC returns are an important opportunity to gather consistent data and allow comparison across schools. The authors encourage schemes that would reward good practice in widening participation and lament that current markers contributing to medical school and university league tables ignore such activities. This study confirms that Medicine wishes to respond to the challenge to open its doors to under-represented socio-economic groups, but realistically for this to happen the appropriate research, resource and expertise is urgently required.

## 7. Contributions, acknowledgements, ethics, conflicts of interest

### Contributors

Cleland and Nicholson designed the programme of work and secured its funding. Cleland secured ethics permission for the admissions deans' interviews and contacted the Deans. Roberts conducted these interviews under the supervision of Cleland. Nicholson secured ethics permission for the focus groups. Zhou conducted these groups under the supervision of Nicholson. Westwood conducted the website searches, supervised by Nicholson. The GMC, medical schools' websites and interview data were analysed by Cleland, the focus group data by Nicholson. Cleland and Nicholson wrote this report. Cleland had primary responsibility for the work programme. Aberdeen acted as the lead contractor for administrative purposes.

### Acknowledgements

We thank all the admissions deans and students who participated in this study, and the MSC for funding this work. We also thank Dr Sally Curtis, BM6 Programme Director, University of Southampton, for facilitating focus groups with Southampton students, and for her insights into WP issues.

### Ethics

This study was approved by the relevant ethics committees within each site, and additional site-specific approvals were secured where necessary. Informed consent was obtained from all participants, along with their right to withdraw from the study at any time without penalty.

### Conflicts of interest

This research was carried out independently of the study sponsor, who had no input to the collection, analysis, and interpretation of data; and writing the report. Both authors had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

The study team have expertise already produced well-received reports for the GMC which have

informed policy. The collaboration proposed brings together researchers with expertise in all of the different aspects of this project to provide a unique knowledge mix. The team already have strong formal and informal collaborative links through previous research and teaching collaborations.

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## Appendix A: Admission Deans' interview questions

Are you responsible for undergraduate, post-graduate or both?

1. What data do you hold on the socio-economic background of applicants?
2. In what widening access (WA) schemes and activities does your medical school participate or run?
  - c. Can you describe these in terms of outreach and inreach, and give us some idea of intensity (e.g., a week summer school vs a 30 mins talk to a school assembly).
  - d. Do you run any work experience schemes specifically for WA applicants/potential applicants? And/or is there any prioritization of work experience places for those from lower socio-economic backgrounds?
  - e. How do you use work experience in the admissions process (e.g., Is there a points system? As a hurdle that must be crossed?)
  - f. What does your institution consider the purpose of work experience to be?
7. What is the success rate of your WA schemes? Please describe how you evaluate them? This might include, for example,
  - h. Offer rates
  - i. Numbers of admissions
  - j. Are these data broken down per scheme or per school, or in any way?
11. Usually medical schools target particular schools for WA activities. Is this the most effective use of resources? What about targeting parents? Careers guidance teachers or organisations? Other potential agencies or partners?
12. Do you use contextual data in admissions decision making?
  - m. If so, what and how?
  - n. Any analysis that has been done at a local level as to its impact?
15. In your view, what selection methods support WA and which do not? Are there any methods which could be/should be dropped, and others which could/should be used more intensively?
16. Do you track successful WA applicants once they commence the course?
17. What are your views on WA activities – for example, what WA activity works for whom, in what circumstances?
18. Does your medical school have a specific course code that defines those applying and entering via a WA route? If so, what is it, and when did it commence?

## Report

# Junior doctors: How can we meet commitments to improve service and widen participation?

10.30–13.00pm

Friday 27th September 2013

Woburn House Conference Centre, Boardroom

**Executive Summary:** This report provides a summary of the *Junior doctors: How can we meet commitments to improve service and widen participation?* roundtable hosted by the Medical Schools Council (MSC) as part of the Selecting for Excellence Executive Group (SEEG).

**Rationale:** This roundtable focused particularly on junior doctors' ability to meet service priorities and how to widen participation. The group was made up of representatives of postgraduate medical education and employers in order to ensure as open as possible discussion. Further groups, ie students and trainees will partake in future activity through the wider SEEG research programme and the results will be triangulated to form overall recommendations by the end of 2014.

**Impact/next steps:** This roundtable report shall inform the SEEG working group of which will make recommendations late next year. The roundtable forms part of a wider research programme that is currently being carried out to collect a wide range of opinions on the issues of widening access and improving selection to medical education.

## Attendance

**Chair:** *Tony Weetman Pro-Vice-Chancellor – Medicine, Dentistry & Health, University of Sheffield*

### Speakers:

*Jamie Rentoul, Director of Workforce Development, Department of Health*

*Stephen Powis, The Association of UK University Hospitals*

*Sandra Nicholson, Lead, Academic Unit for Community-Based Medical Education*

### Attendees:

*Clare van Hamel, Foundation School Director, Health Education South West*

*Clare Owen, Policy Adviser, Medical Schools Council*

*Daghni Rajasingam, Consultant Obstetrician, Faculty of Medical Leadership and Management*

*Derek Gallen, National Director, The Foundation Programme*

*Katie Petty-Saphon, Executive Director, Medical Schools Council*

*Martin Hart, Assistant Director, Education and Standards Directorate, General Medical Council*

*Naomi Drinkwater, Senior Policy Officer, Medical Schools Council*

*Oliver Watson, Senior Policy Officer, Medical Schools Council*

*Sarah Parsons, Medical Workforce Manager, NHS employers*

# Agenda

**Introduction:** Professor Tony Weetman, Chair, Medical Schools Council and Pro-Vice-Chancellor - Medicine, Dentistry & Health, University of Sheffield

## Speaker presentations

**Medical Schools Perspective:** Professor Tony Weetman

**Workforce Planning Perspective:** Jamie Rentoul, Director of Workforce Development, Department of Health

**Service perspective:** Professor Stephen Powis, Royal Free London NHS Foundation Trust

**Academic Perspective:** Dr Sandra Nicholson, Lead, Academic Unit for Community-Based Medical Education

## Q+A

## Refreshments

**Discussion:** *How can we meet commitments to improve service and widen participation?*

- What makes a 'good' trainee doctor?
- Are the 'right' trainees being selected to study medicine?
- What more could be done by both medical schools and NHS services to widen participation to medicine?
- What needs to be done to ensure that students become 'good' doctors?
- What role does your organisation play in early engagement with potential students and out-reach activities?

## Closing comments

## Roundtable minutes

### Medical Perspective:

*Tony Weetman Pro-Vice-Chancellor - Medicine, Dentistry & Health, University of Sheffield*

The Chair introduced all to the table outlining the work of SEEG.

Attendees were reminded that the first session would focus on speaking slots with a move towards a more focused discussion attempting to answer the following questions:

- What makes a 'good' trainee doctor?
- Are the 'right' trainees being selected to study medicine?
- What more could be done by both medical schools and NHS services to widen participation to medicine?
- What needs to be done to ensure that students become 'good' doctors?
- What role does/could your organisation play in early engagement with potential students and outreach activities?

The group was reminded that medical schools all run outreach programmes designed to widen participation. Reports such as Milburn had reminded us, however, that medicine still has a reasonable way to go in terms of improving participation for lower socio-economic groups. Statistics were cited which revealed that in 2011–2012 57% of accepted medical school applicants came from the top three socio-economic classes, but only 7% from the bottom three socio-economic classes. This represented only minor improvements from eight years earlier, when the proportions were 62% and 7% respectively.

The group was also reminded that one of the biggest barriers remains prior attainment of under-represented groups – ie only 21% of the poorest fifth (measured by parental socio-economic position; SEP) manage to gain five good GCSEs (grades A\*-C, including English and maths), compared to 75% of the top quintile, and just 16% of those eligible for free school meals. Any significant barriers to participation therefore need to be tackled and approached in partnership with schools in order to provide the correct advice and guidance.

### Workforce Planning Perspective:

*Jamie Rentoul, Director of Workforce Development, Department of Health*

- The medical profession needs to reflect the values of the society it serves.
- Further clarity needs to be reached about what elements of widening participation need to be achieved in medicine and what a 'good' doctor looks like.
- Admissions tutors were in a very powerful position to decide on the next generation of doctors. 18 is extremely young to be making these judgements and there may need to be flexibility to receive more mature entrants into the profession.

### Service Provider Perspective:

*Stephen Powis, The Association of UK University Hospitals*

- The right values need to be tested for in trainee doctors – eg there is a huge emphasis on physiology and anatomy, but seemingly less on the patient experience and safety.

- Needs to be the correct balance reflected in terms of specialisation and flexibility.
- There are few patient experience metrics in the NHS and the focus is high on financial security metrics.
- Graduates need to have the necessary knowledge to be able to diagnose correctly and provide effective treatment. Good clinical care is essential for achieving good levels of patient safety and experience.

## Academic Perspective:

*Sandra Nicholson, Lead, Academic Unit for Community-Based Medical Education*

- If widening access was to become a serious agenda that we need to be clear about what value would be added to medical practice and why.
- Widening Participation is not just about admission but also about outreach to potential applicants, retention and what happens to people further on in their careers.

A number of recommendations from the GMC commissioned research project on selection ([www.gmc-uk.org/about/research/14400.asp](http://www.gmc-uk.org/about/research/14400.asp)) were presented including that the GMC should work with the MSC and medical schools to further explore and define good practice on selection into medical school, considering the following:

- an aptitude test and academic record are used conjointly in selection, as this may positively impact on socio-economic class biases in selection (Tiffin et al, 2011)
- personal statements and references lack validity and reliability, and impact on socio-economic class bias
- SJTs should be considered as a selection tool for non-academic attributes of medical selection as these are among the best and most valid methods in medical school selection.
- that structured interviews are used as part of the selection process
- that an agreed, national framework for the use and transfer of contextual data such as applicant school or social circumstances is created and validated
- To explore the utility of a (supplementary) league table which includes selected other indices pertinent to medicine, such as effective WA schemes or student support

## Discussion

There was a wider discussion about the academic level of students entering on to medical courses and how tariffs have increased over the past 20 years. This has not necessarily resulted in a decrease of applicants. One medical school has reported that increasing entry tariffs had resulted in an increase of applicants.

There was discussion that the 24/7 working culture that was previously embedded into junior doctors had been altered as a result of the Working Time Directive (which limits the time that a junior doctor is able to spend on the ward). There was discussion that this may have altered the 'culture' of education and training slightly. Within this discussion several comments were made concerning the fact that it is important to ensure that the foundation year is more supportive and evaluative for trainees.

There was considerable discussion around the fact that patient safety and non-technical skills need to be incentivised within the curriculum and during training via the assessment programmes at both undergraduate and postgraduate level. This would not, however, replace the requirements for a

detailed knowledge base or academic capability.

A number of comments were made that medicine is a very hard profession to 'get out of' should a student or trainee doctor wish to pursue an alternative career. It was commented that this could be improved and that alternative routes should also be available should a candidate feel as though the profession is not quite correct for them. There may also be the need to introduce improved mechanisms for removing students who were not displaying the values required to be a doctor early into their undergraduate degree.

There was some general discussion that widening participation had been improved as a result of the emergence of graduate entry programmes. A number of comments, however, were made that graduate entry programmes were not necessarily a means to increase quality of entrants as high attrition rates can occur.

A number of members commented that there is currently no national framework for the use and transfer of contextual data in medicine. It was recommended that a framework concerning applicant schools and social circumstances be created and validated.

The discussion then concluded to reflect on the power of effective advice and information. It was commented that in light of the new tuition fee arrangements that clearer information needs to be brought together regarding financial support for potential medical students. Innovative new ways of funding undergraduate medical education were also discussed: could students receive grants for their training in return for a reduced salary after graduation? Clearer advice on bursaries, scholarships and details about financial support could potentially be developed.

## Key conclusions

- In order to ensure that the correct values are embedded in the future generation of doctors it is worth considering whether patient safety metrics might be embedded further into the curriculum. It may be that greater use of 360-degree appraisals for medical students (including patient feedback) might be an effective route to explore.
- Information, advice and guidance on alternative careers to medicine should be provided in order to allow medics to 'exit' the profession when suitable. Detailed analysis of data on trainee doctors in difficulty would help to identify patterns and routes for support.
- More emphasis should be placed on 'non-technical skills', leadership skills and patient safety - this needs to go alongside requirements to have an effective and detailed knowledge base.
- Information on bursaries scholarships and student support needs to be made available under the new tuition fee regime. It may be helpful to compare the funding support available to medical students in the UK compared to the 'offer' provided by other countries.
- There needs to be a clearer grasp on how to tackle and use contextual data with the possibility of a national framework being created.
- There should be a greater emphasis on the ability of applicants, students and trainees to be 'team players'.
- Quotas may prove to be an effective way of incentivising institutional recruitment.
- Important to develop an evidence base evaluation of the medical students who had been supported despite not having suitable levels of GCSEs.
- Important to consider the identification key performance indicators which might help identify those students who may not be suitable.



# Report

## Careers advice focus group

### Selecting for Excellence

10.30–12.30

Thursday 31st October 2013

Woburn House Conference Centre, Boardroom

**Executive Summary:** *This report provides a summary of the careers focus group discussion hosted by the Medical Schools Council (MSC) as part of the Selecting for Excellence project.*

## Key conclusions

- Build an evidence base on contextual data to allow its use to be more transparent in the admissions process. This would aid careers advisers.
- Consider supporting medical students to act as mentors through a more centralised resource which could provide advice to potential applicants and careers advisers.
- Clarify what the work experience expectations of medical schools are to aid advisers and applicants. Consider how to influence the update of national NHS work experience guidance (eg how to address patient confidentiality).
- Make online information on access to medicine more centralised to ensure transparency. The information on this site should include details of different schools' entry requirements and selection processes in a way that is designed to help applicants judge their likelihood of success.
- Consideration could also be made to developing an online toolkit with a host of resources for advisers or teachers. This could include
  - » Provision of lesson plans covering medical applications
  - » Summaries of workforce intelligence
  - » Up-to-date information on medical admissions opportunities
  - » Potential to have an FAQ or Q&A (maybe online chat facility which could be staffed by 'experts' from within HE/postgraduate arena.
  - » Links to other resources.
- Invest in online peer-to-peer advice alongside online information portals.
- Need to maximise use of role models in publicity/marketing/talks/mentoring – particularly of those applicants who have successfully entered medical school through non-traditional routes and/or are from non-stereotypical backgrounds.
- Emphasis in careers advice should be more focused on the core values and behaviours needed to be a doctor and what this means in practice.
- One potential role for careers advice about medical degrees would be to look at the alternative options from medicine, including non-clinical careers so that trainees who, during their medical studies, feel that medical training is not for them, could look to identify other positive options.
- Explore the further development of 'taster' courses for under-represented groups to potential applicants by universities/medical schools. These would have a role to play in providing an opportunity for attendees to decide whether or not the profession is right for them.

## Report

**Rationale:** This roundtable focused on the purpose, usefulness and resources surrounding careers advice for students aspiring to study medicine. The group was made up of representatives working in careers advice. A medical student was also invited to give their perspective on careers advice and admissions.

**Impact/next steps:** This focus group report shall inform the SEEG working group of which will make recommendations late next year. The focus group forms part of a wider research programme that is currently being carried out to make sure a wide range of opinions on the issues of widening access and improving selection to medical education is gathered.

## Attendance

Facilitator: Dr Johnathan Dowell, Reader in General Practice and Admissions Convenor at Dundee Medical School (Facilitator)

- Alan Simmons, Careers Specialist, NHS Careers
- Andy Gardner, Careers and Higher Education Adviser
- Clare Owen, Policy Adviser, Medical Schools Council
- Dr Tessa Stone, Chief Executive, Brightside.
- Laurie McLoughlin, National Careers Service in London
- Lisa Stone, Senior Careers Adviser - Medicine, Health Education England
- Mike Wilson, Careers Lead, Health Education North East
- Naomi Drinkwater, Senior Policy Officer, Medical Schools Council
- Paul Teulon, Higher Education Liaison Officers' Association Sam Dolan, Education Chair of the Medical Students Committee, British Medical Association

**Questions:** Members were provided with a brief literature review prior to the discussion and asked to consider the following questions.

- What is the purpose of careers advice?
- What is the purpose of work experience?
- What careers advice is available and is it sufficient?
- Do careers advisers understand the entry requirements and application process for medicine enough?
- What sort of resources would be helpful for careers advisers in supporting potential applicants?
- Building on the literature review is there any further research that needs to be conducted to enhance the evidence base?
- Any other evidence you are aware of?
- Key missing evidence?
- How could we obtain adequate evidence, if needed?

## Minutes

The facilitator opened the group by asking members if they thought that any key evidence was missing from the literature review. It was reflected that there might be an opportunity to build on evidence concerning the usefulness of contextual data and to make the use of it more transparent in the admissions process. In particular from the university admissions perspective it was identified that it would be useful to understand better how to contextualise admissions and how to identify particular candidates. Furthermore it was reflected that the evidence base supporting the use of contextual data should be developed further.

The discussion then evolved to discuss how difficult it is to reach schools as there is no longer a central careers service and the majority of state schools do not employ careers advisers. Careers advisers also reflected that they at times need help navigating the admissions process to medicine as it remains a relatively complicated process and that many careers advisers or teachers (unless from a medical background) do not specialise in this area. It was reflected that there might be an opportunity for medical school students to further help with advice and mentoring as they would have recently gone through the process themselves.

The facilitator then asked the group whether work experience in medicine admissions served an important purpose. It was reflected by the group that – medical schools evaluate work experience differently in selection processes and ask for different types of experience. Furthermore it was especially hard for those from WP backgrounds to access medical work experience. The Medical Schools Council (MSC) reflected that a scheme would be introduced shortly which aimed to badge trusts who were giving priority to those from WP backgrounds. WP backgrounds in the first instance would be defined by whether the student was eligible for free school meals and/or if they are part of the first generation of their family to apply for higher education. It was also reflected that the medical insight courses such as that used in Coventry might be useful to emulate or the Scottish equivalent. It was also reflected by one member of the group that it would be useful to bust a number of myths about work experience.

It was reflected that the Student Room was a popular resource for many students trying to get careers advice and that the online revolution needed to be embraced. One member recommended that the NHS Medical Careers website was a good resource and that a single information point should be created. Currently it was felt that the admissions criteria available on each medical schools' website was fragmented and that there might be an opportunity to centralise resource so that information is more transparent. One member commented that the careers service had undergone a number of significant changes last September and that the effects of this were yet to be seen on the student population.

Finally, it was reflected that the use of mentoring alongside access to online information should not be underestimated and that the two were not mutually exclusive. It was discussed that an online virtual tool should be developed to allow peer to peer advice.

## Enclosure A:

### Comments offered by participants post the focus group:

Any imagery around candidates/case studies used in hard copy or digital formats needs to reflect the breadth of society – race, gender, disability, etc.

- Need to maximise use of role models in publicity/marketing/talks/mentoring – particularly of those applicants who have successfully entered medical school through non-traditional routes and/or are from non-stereotypical backgrounds.
- Issue is more around what medical schools deem acceptable/preferable for work experience. What are the expectations? Experience gained in a caring role is perhaps more achievable than working alongside a doctor and could be gained in a variety of settings, including the NHS, private healthcare providers, charities, through volunteering etc.
- A small number of medical schools/universities (eg Nottingham) run 'taster'/insight type activi-

ties for potential applicants. These have a role to play in providing an opportunity for attendees to decide whether or not the profession is right for them. It would be interesting to know what the make-up is of students attending these activities. Do they reach students outside the private sector? How do the medical schools/universities advertise/market these? How common are these activities? A central source of information about these could be a useful step forward.

- In the context of medical school admissions, careers advice is often aimed at negotiating the application process. So support is generally orientated at coaching for UCAS application forms and for admissions interviews. There is a recognition that advice about suitability to medicine should be provided, but this is increasingly disparate given the fragmented nature of careers advisory services in the compulsory education sector.

Consideration should be given to whether this is sufficient. Areas which may need to be explored would be:

- Suitability to medicine as a **career**. Often candidates have an unrealistic view of medicine as a career and the triggers for applications can be external, eg parents, schools, etc. Misconceptions of the role of a doctor, or indeed the perception of the social class of medicine has led to stereotyping, which has been identified in various publications since the 2000s. Emphasis needs to be placed on the core values and behaviours that make up a doctor and what this actually means in practice.
- **Career** options – more advice and guidance needs to be provided on the realities of medical careers. Often medical students have unrealistic career goals as they are unaware of labour market information and service pressures within the NHS. Careers advice should have a role in demonstrating what are realistic career goals so that applicants to medicine understand their chances.
- **Alternatives** – it has been recognised that medical graduates may progress into Foundation Programme training because it is the 'done' thing and are unaware of the alternatives. MSC has already identified a need for medical schools to provide this advice, but it can often be patchy. One potential role for careers advice about medical degrees would be to look at the alternative options from medicine, including non-clinical careers so that trainees who, during their medical studies, feel that medical training is not for them, could look to positively identify options.

## What is the purpose of work experience?

This was an area that needs clarification. Too many applicants consider work experience as a rite of passage, and therefore approach it as a 'tick box' exercise. Guidance should be provided on the nature of work experience expected and why this is required. Consideration should also be given to whether medical schools should emphasise that work experience is not mandatory but is advised to get an idea of the job of caring for others and to be able to reflect on this.

## What careers advice is available and is it sufficient?

Was discussed widely in the focus group but the consensus nationally is that careers education and careers guidance is fragmented, potentially partial and therefore not of a recognised quality within the compulsory education sector. Whilst universities and postgraduate training organisations and generally well-resourced with careers advice, they often have a limited 'pre-entry' offer and therefore there is a definite gap in the provision of accurate information and advice.

There was some discussion in the group about peer support which is an excellent idea. However, there would need to be some element of training these ambassadors to ensure they are not providing disinformation. Clinical colleagues are seen as a source of information. However, research on supervisors in postgraduate training has found this to be unsatisfactory – due to changes in training structures, often partial about their own specialty, and not trained in giving advice in an appropriate way. Whilst this is being addressed in the postgraduate arena with the proposed standards for trainers, this is not

common across the range of clinicians who will work with medical students or potential medical students. Would some form of development for medical school staff be appropriate, perhaps as a toolkit (See resources)

## What sort of resources would be helpful for careers advisers in supporting potential applicants?

As well as 'beefing up' the Medical Careers website and trying to standardise information from medical schools there is a need to provide contextual data on labour market information. Individuals providing advice to potential medical and dental applicants should have access to Centre for Workforce Intelligence data, although this would need to be diluted into high level statements rather than the level of detail produced by CfWI.

Consideration could be made to developing an online toolkit with a host of resources for advisers or teachers. This could include

- Provision of lesson plans covering medical applications
- Summaries of workforce intelligence
- Up-to-date information on medical admissions opportunities
- Potential to have an FAQ or Q&A (maybe online chat facility which could be staffed by 'experts' from within HE/postgraduate arena?)
- Links to other resources

## Report

### Admissions Deans Symposium

10:00-16:00, Tuesday 26 November 2013  
Herschel Room, Mary Ward House, 5-7 Tavistock Place, London WC1H 9SN

The Admissions Deans Symposium was convened in order to provide an opportunity for medical schools to come together to consider the issue of consistency within selection processes. Chaired by Dr Paul Garrud, the event also reflected on available research on selection methods along with the work of the Selecting for Excellence project.

#### Session 1: Introduction to the Selecting for Excellence Project

Professor Tony Weetman, Chair of the Selecting for Excellence Executive Group, provided an introduction to the Selecting for Excellence project, facilitated by the Medical Schools Council, and further established the drivers behind this area of work. It was noted that the *Fair Access to Professional Careers, A Progress Report* (2012) was critical of widening access within the medical profession, particularly in relation to access to work experience for pupils from lower socio-economic groups. Furthermore, it was reinforced that Dr Dan Poulter MP, Minister of Health, has a particular interest in this topic and has publicly endorsed the project. Research commissioned by the General Medical Council (GMC) *Identifying Best Practice in the Selection of Medical Students* (2012) identified challenges for medical schools around selection.

It was noted that there are four work streams within the Selecting for Excellence project, intended to respond to these drivers:

- Widening participation: with a particular focus on increasing the number of students from lower socio-economic backgrounds studying medicine.
- The role of the doctor: considering the skills, attitudes and values required by current and future doctors.
- Selection methods: exploring the possible convergence of selection methods and the progression of openness and transparency in the selection process.
- Developing the evidence base: exploring and developing a response to identified data needs.

One of the identified risks within the Selecting for Excellence project was indicated to be the difficulty of lowering tariff points, which are often seen to be an indicator of a 'prestige' institution. It was noted that adjusting tariff points can have an effect on medical schools' position within league tables which could potentially lead to resistance from institutions' Vice-Chancellors.

#### Session 2: Achieving transparency for applicants and greater consistency between schools on selection

The aim of this session was to explore further the extent to which convergence of selection methods can be progressed. It was indicated that medical schools hold differentiated goals as to what they are looking for from a medical student, often as a result of local priorities and the history of institutions. Acknowledgement was made that while these differences are justified, there are a number of shared goals held by medical schools which provide a focus for the potential convergence of selection methods.

Attendees were informed that the admissions deans meeting in 2012 had considered this issue, with



attendees being asked to consider the similarities and differences between schools' approaches in order to ascertain the opportunities and advantages in the convergence of admissions processes and principles. It was summarised that attendees suggested a high level of priority and feasibility of convergence within the following areas of selection: occupational health checks, measures of Fitness to Practise, as well as secondary educational qualifications. It was noted that selection is controlled by a number of drivers, including: external policy and guidance, applicant facing policy and processes such as application deadlines, as well as internal policy and processes decided by schools and their institutions.

Delegates were asked to consider the specific areas of the selection process which would lend itself to greater consistency as well as considering whether diversity in the student body can be maintained if greater consistency is pursued.

In response, delegates raised the lack of agreed definition of widening participation and noted that this has created difficulties in understanding the effects of widening access activities. It was also noted that consideration should be made as to whether consistency of goals, consistency of processes, or consistency of both goals and processes, should be pursued.

While it was acknowledged that schools will score aspects of the selection process differently, the weighting placed on various stages of the selection process was seen to have a greater effect. Consequently, it was suggested that this is likely to be of greater relevance were consistency to be pursued.

In relation, it was also acknowledged that *Aim Higher* supported widening access activities and that its closure had had a negative effect on the co-ordination of school widening access activities. Consequently, it was noted that there is a risk of schools not collaborating in the facilitation of widening access activities. In addition, it was suggested that widening participation should be considered not just in terms of supporting people to enter a medical degree, but that there is also a need to consider how the retention of widening participation candidates can be enhanced.

In relation to the transparency and availability of information, it was highlighted that students need to apply to those medical schools to which they are suited and will allow them to assert their strengths. This was suggested to further indicate the need for clear communication to applicants as to the expectations of schools. It was suggested that one way to aid communication would be to have an agreed format in which information is presented to applicants in order to facilitate comparisons between schools. Some schools suggested that openness regarding admissions processes may increase the likelihood of 'game-playing' by parents and schools, potentially to the detriment of those applicants from a widening participation background.

Delegates also questioned whether more radical changes to selection processes across UK medical schools might be feasible and/or desirable. It was suggested that potential applicants to medicine could be selected via a single national process that could include attendance at regional selection centres. It was noted that a single system would make applying to medicine easier for applicants and that all applicants with the right grades would be considered for selection. In relation, it was also suggested that a national system could negatively impact on the autonomy of individual institutions and would make the student body more homogenous rather than diverse. It was confirmed that radical changes to selection processes such as those suggested would take time and work would need to extend past the December 2014 deadline of the Selecting for Excellence project.

When asked to consider the values and attributes schools required from applicants, delegates noted that the majority of schools' selection processes were informed by the following common essential qualities:

- Academic ability (defined as attainment, aptitude and potential)
- Critical thinking; problem solving (often comprising part of aptitude tests)
- Integrity (defined as honesty and probity)

- Communication (seen to be an essential component of people skills)
- Empathy (ie perspective taking)
- Insight and reflection (defined as self-awareness)
- Motivation and commitment
- Teamwork (including leadership roles)
- Personal organisation (defined through proxy measures such as meeting deadlines)

It was noted that some, rather than all, schools believed that the following were essential qualities.

- Resilience
- Conscientiousness
- Understanding of doctors' role and work

Delegates highlighted that all schools were preparing medical students to meet the same learning outcomes and that this shared aim should support consistency in the values perceived to be essential to selection to medical school. It was highlighted that the General Medical Council's planned review of guidance on Student Fitness to Practise should also consider the selection of students considered fit to practise. A further area identified as requiring consideration was the effect of reform to the Disclosure and Barring Service checks in England and Wales and the decision to no longer report isolated cautions.

## Session 3: Overview of research on selection methods

### Medical selection and widening participation – an academic perspective

Dr Sandra Nicholson provided an overview of the main recommendation and findings on selection methods as reported in *Identifying best practice in the selection of medical students* (Cleland et. al, 2012). It was noted that research suggests there is, at present, no direct indication that widening participation improves patient care and that, consequently, the benefits of widening participation should be viewed as helping to advance social justice, as well as improving education for undergraduates through increasing diversity within the student body.

It was highlighted that the GMC-commissioned research had the following objectives:

- To identify the evidence on the effectiveness of student selection methods, and different combinations of methods, currently used.
- To identify if there is evidence to suggest that different selection methods have differential impacts in terms of who is selected.
- To identify the evidence in terms of how practical considerations influence medical schools in their design of student selection methods.
- To make recommendations for future actions on the part of the GMC with regard to selection and widening access initiatives.

It was noted that there is evidence to suggest that some selection methods support widening participation in comparison to others. However, the recommendation for the GMC and the Medical Schools Council to further explore and define good practice in selection was acknowledged. The opportunity for medical schools to provide clarification to the GMC and the public on the use and weighting of particular selection tools was also highlighted as a further recommendation, as was the need to further consider longitudinal research in order to provide evidence which would improve and further inform selection processes.

Delegates were also provided with an update of research that will help to inform the Selecting for Excellence project. It was noted that work is being progressed to develop a reporting tool in which data collected through the UK Clinical Aptitude Test (UKCAT) are being matched with UCAS data in order to follow the progression of a medical student. Delegates were informed that the data are stored within the Health Informatics Centre based at the University of Dundee. Furthermore, it was noted that appropriate legal advice had been sought in order to ensure that appropriate safe conditions have been developed which ensures the work meets the requirements of the Data Protection Act.

The intention to develop a UK Medical Education Database, from the current UKCAT and other databases, was highlighted and it was noted that this would provide a ring-fenced environment in which individual schools could track their graduates. It was noted that a pilot exercise had matched more than 80% of records from the Foundation Programme Application System (FPAS) of the 2013 graduating cohort to data gathered through the administration of the UKCAT. External stakeholders had, in principle, agreed to the further development of the database and had been challenged to identify the funding for this work.

Delegates were informed that there is the potential for the Selecting for Excellence project to commission research in the area of widening participation. It was noted that there is the opportunity for delegates to feed into suggested research questions which will help inform the evidence base for specific selection processes. The following areas were suggested as possible areas which would benefit from further research.

## General

- How should widening participation be defined and how is it measured?
- Are the same people rejected from medical schools (ie how diverse are the intakes)?
- Does local outreach activity support people accessing medical degrees elsewhere in the UK?

## Multiple-mini interviews

- What lessons could the facilitation of multiple-mini interviews (MMIs) learn from the administration of Objective Structured Clinical Examinations (OSCEs)?
- Is there a practice effect within MMIs?
- Is there the opportunity to devise a natural experiment to further understand whether candidates with shared characteristics perform well on certain MMI stations?

## Session 4: Work experience

Delegates noted that the 2012 Milburn report challenged the medical profession on the lack of work experience opportunities for applicants from lower socio-economic backgrounds. It was noted that a variety of online resources contribute to maintain a perception that applicants require specific types of work experience, despite some schools reporting that this is not the case.

In order to further consider how schools respond to work experience, delegates were asked to consider how work experience is evaluated by schools, as well as consider the purpose of work experience and whether this has to be undertaken within a clinical setting.

It was stated that work experience can have dual purposes for both medical schools and the applicant. One identified purpose of work experience was to allow the candidate to develop social awareness, while also potentially providing the opportunity for an individual to further develop their insight and understanding about what is required by a medical career.

Delegates provided a range of opinion as to whether work experience has to be undertaken within a clinical setting. While some acknowledged the importance of work experience occurring in a clinical setting, others stated that relevant work experience is that which has allowed the applicant the opportunity to interact with a variety of people, as well as helping to develop self-awareness and understand the realities of working in a caring profession. It was noted that a distinction could be made by referring to 'patient-focused experience'.

Delegates suggested that graduate-entry candidates are likely to have had more opportunity to access work experience opportunities as they have not come straight from school and may have worked in other fields before deciding on a career in medicine and so it is important that any declared work experience is recent.

It was noted that schools take a range of approaches to the evaluation of work experience within selection processes; however it was acknowledged that interviews offered the opportunity for applicants to expand on what they have gained through work experience.

Some delegates expressed concern regarding the actions of a minority of applicants who choose to pay to access work experience in another country, suggesting that there may be ethical concerns surrounding the exposure of candidates to inappropriate procedures. Nevertheless, caution was expressed that a public statement against such an approach may act to discriminate against international candidates.

In addition, delegates highlighted that Health Education England's mandate suggests the intention for 50% of medical graduates to work in primary care, consequently the accessibility of work experience opportunities in primary care was considered crucial. In response, it was noted that Leeds Medical School has been involving General Practitioners within its widening access activities and that there is an opportunity to engage with the Royal College of General Practitioners (RCGP) to explore whether guidance on facilitating work experience can be reinstated on the RCGP website.

**ACTION:** Work in partnership with Leeds medical school in order to consider whether guidance on work experience can be reinstated on the RCGP website.

## Session 5: Summary and action points

The final session of the day provided an opportunity for delegates to consider the main outcomes and actions decided during the course of the meeting. The degree of consensus as to the essential qualities required by a medical school was highlighted, along with the intention to draft a document outlining the qualities required by medical schools.

**ACTION:** The Medical Schools Council to draft a statement on the essential qualities required by medical schools for comment. This statement will be developed using the feedback from admissions deans received at this meeting and the results of the Role of the Doctor survey. Further consideration will also be given to how the GMC's Good Medical Practice guidance might be embedded within the statement.

Following discussions on the evidence base informing selection processes, the opportunity for the Selecting for Excellence project to commission further research was highlighted. Delegates were invited to submit one-page proposals exploring research questions which could help to inform the evidence base on widening participation.

**ACTION:** An invitation for delegates to submit proposals to undertake further research on widening participation to be distributed to attendees.

In order to maintain momentum and progress the execution of these actions, delegates were invited to form a working group. It was noted that the working group is likely to be administered until January

2015.

**ACTION:** Medical Schools Council to establish and facilitate an expert sub-group made up of admissions deans to further consider issues around selection methods and to provide expert advice to the Selecting for Excellence Executive Group.