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Values Based Recruitment: What works, for whom, why, and in what circumstances?

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DISCLAIMER

The views expressed in this report are those of the authors and not necessarily those of the NHS, the National Institute for Health Research or the Department of Health and Social Care.

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PLAIN ENGLISH SUMMARY

The National Health Service (NHS) employs over a million people, and the vast majority of these staff provide front-line patient care. Failures in care, particularly in Mid Staffordshire NHS Hospital Trust as detailed in the Francis Report in 2014, raised concerns about the values underpinning working practices in the NHS. One policy response to these concerns was to encourage recruitment of undergraduate health professional students, trainees and employees whose personal values are consistent with the overall values of the NHS Constitution: 'values-based recruitment' (VBR). This report presents findings from the evaluation of VBR commissioned by the Policy Research Programme. This addressed the question: *How have education and service providers implemented VBR approaches and what are the impacts on service delivery and care?*

There were four stages to the evaluation (conducted between 2015 - 2020). In the first stage, we analysed policy documents and published literature, and interviewed a sample of individuals who were responsible for developing VBR. Following this (Stage 2), we examined the implementation of VBR in four organisations: two universities that educate student health care professionals, and two NHS organisations, one acute hospital and one provider of mental health services. We analysed documents and other organisational data, and interviewed people involved in recruiting health care professionals and students, as the candidates for professional roles or university courses. Using all this information we developed theories of VBR in terms of what works, for whom, and in what circumstances (Stage 3). Finally, Stage 4 evaluated the longer-term impact of VBR in universities. We conducted a national survey of universities, analysed national data on the characteristics, profile and continuation of students recruited to healthcare programmes, and undertook follow-up interviews with participants from the Stage 2 university case sites. We secured the necessary ethics approvals for the study. The research team was guided by a project advisory group.

We learnt that since VBR was launched, there have been considerable efforts to promote the recruitment of health care professionals and students based on their values. We found wide variations in approaches and processes used when recruiting

for values. However, the effect of VBR is not clear: on the basis of our study we cannot support the assumption that VBR has led to improving the recruitment of individuals whose values are better aligned with those of the NHS. Nor have we established whether VBR enhances the quality of healthcare provision. Recruitment was perceived as an initial, but not the only source of influence on the values of individuals. NHS workplace practices and organisational cultures were seen as more influential in shaping individual values. VBR did not, on its own, lead to changes in the values of the NHS workforce.

Healthcare professionals are employed to meet the needs of patients (and the public) for care and support. Therefore, recruiting healthcare professionals and student healthcare professionals with the appropriate values is important. But we heard from study participants that recruiting for values had been undertaken in some form in universities and NHS organisations before introduction of the VBR policy. Nonetheless, VBR was generally thought to have increased the focus on patient-centred values and promoted greater structure and transparency to recruitment processes. The methods used for assessing values may not be sufficiently sensitive: almost all candidates were assessed as possessing the appropriate values. Moreover, the longer-term benefits of embedding VBR in recruitment processes were difficult to assess with any confidence.

In conclusion, VBR on its own will not change the values of the healthcare workforce and ensure quality of care and service provision for the public. However, it may help signify to new recruits the expected values of organisations and provide a means by which those unwilling to subscribe to these values can opt out. VBR has an important formative role but it needs to be embedded within cultures that are *already* compassionate and caring if these values are to grow and be sustained in the wider workforce.

EXECUTIVE SUMMARY

BACKGROUND AND AIMS

Independent and public inquiries of quality of care provided by the National Health Service (NHS), including the investigation of Mid Staffordshire NHS Foundation Trust (the Francis Inquiry), highlighted significant deficiencies in service delivery and organisation, and the need for cultural changes to ensure staff promoted quality of care and patient safety. The Francis Inquiry highlighted the key role that values play in promoting and ensuring high quality, safe and compassionate care. In 2014, the Government mandated Health Education England (HEE) to develop an agenda focused on improving staff values in the NHS. Values-based recruitment (VBR) was an important policy response to these concerns. The VBR framework was developed to align the values and behaviours of staff with the expectations of the NHS and the public. VBR is one element in a broader values-based employment model aimed at combining recruitment strategies with systems and environments to ensure the delivery of high-quality services and care.

VBR was mandated by HEE for Higher Education Institutions (HEIs) when recruiting health care students to NHS funded training courses. It was not mandated for NHS organisations: there was variable uptake of VBR for the recruitment of registered health care professionals by NHS organisations. The contribution of VBR to promoting, sustaining, and developing values and behaviours in NHS staff merited investigation. This report presents findings from the evaluation of the implementation of VBR commissioned by the Policy Research Programme. This addressed the question: *How have education and service providers implemented VBR approaches and what are the impacts on service delivery and care?*

To answer this question, the study addressed the following aims**,** to:

1. understand and conceptualise VBR in the context of healthcare education and service delivery in order to unpack what works, for whom, why, and under what conditions;
2. identify the ‘active’ components of models of VBR and create a typology of VBR models according to their constituent parts;

3. understand the longitudinal impacts of VBR for HEIs recruited through the 'first cycle' of VBR; and
4. propose successful models of VBR to inform practice and policy.

RESEARCH APPROACH AND METHODS

Realist methods were used to understand the different ways in which VBR was enacted by education and health service providers, and to generate explanatory accounts of how and why it might work, for whom and in which circumstances? Normalisation Process Theory (NPT) provided a middle -range theoretical lens for our evaluation. Specifically, it helped to frame and make sense of how VBR was routinely operationalised, embedded, and sustained as 'normal' recruitment practice within the case studies. We used NPT as a 'sensitising' device to structure our evaluation and to sharpen our analytical focus for testing and refining our programme theories.

The evaluation comprised four separate but inter-linked stages (conducted during 2015 to 2020).

Stage 1 generated a 'working' theory of VBR by (i) involving analysis of policy documents and a rapid review of the VBR literature; and (ii) interviews with policy architects to explore the intended advantages and any disadvantages, contextual influences, mechanisms/processes behind outcomes, and ways that VBR differs from previous recruitment models. This stage culminated with the formulation of five initial theories for VBR: generative explanations of the mechanisms and contexts associated with outcomes.

In Stage 2 we tested these theories in four case studies: two HEIs and two NHS organisations (one acute and one mental health trust). Data comprised: (i) case site documents; (ii) organisational measures of performance; (iii) explorations of the potential costs and consequences of VBR; and (iv) interviews and focus groups with stakeholders.

Cross-case analyses of case study findings in Stage 3 enabled refinement of theories of VBR in terms of what works, for whom, and in what circumstances.

Finally, Stage 4 evaluated the longer-term impact of VBR in HEIs through a national longitudinal survey of HEIs, analyses of secondary data of the characteristics, profile and continuation of students recruited to healthcare programmes nationally and follow-up interviews in the HEI case sites.

Ethics and governance approvals were secured for each stage.

The research team was guided by a project advisory group (including patient and public involvement representatives).

FINDINGS

The summary of findings revisits the ambitions of the study.

Understanding and conceptualising VBR in the context of healthcare education and service delivery

We addressed this aim to better understand and conceptualise VBR to help structure our data collection and analysis. Stage 1 (presented in Chapter 3) informed the development of initial theories of VBR which we tested in four case studies (Stage 2: presented in Chapters 4 and 5), representing both education and health service providers. Based on these findings we developed and refined our theories of VBR (Stage 3: presented in Chapter 6).

Our study revealed the considerable investment made by education and service providers in assessing patient-focused values of healthcare professionals and students applying for a healthcare programme of study. Investment was not dependent on a VBR mandate. Case studies demonstrated wide variations in approaches and processes for assessing values. The personal investment of operational staff was an important driver for shaping the development of locally relevant VBR, implementing and embedding it in everyday recruitment. The VBR policy promoted standardised (i.e. inclusion of patient-focused values) but

contextualised (i.e. tailored to the organisation) recruitment. Whilst our refined programme theories explain circumstances under which VBR may work, for whom and why, it should be borne in mind that VBR was an important initially necessary - but not sufficient - process for embedding values in healthcare service delivery.

Identifying the 'active' components of models of VBR

In Stages 1 to 3 (presented in Chapters 3 to 6), we developed in-depth understanding of how and why key resources for VBR - or the reasoning (cognitive or emotional) of the people involved with VBR (*mechanisms*) – might trigger change or effects (*outcome*), and those *contexts* necessary to sustain these. Active components can be considered mechanisms and contexts that generate intended and unintended consequences (outcomes) of VBR. Key mechanisms included:

- Operationalising standardised and transparent processes for the assessment of a candidate's values, tailored to the local context
- Resources (such as clear management commitment and support, and appropriate infrastructure) supporting staff to implement VBR
- Engaging staff involved in local recruitment with the development and implementation of VBR to enhance its meaning and relevance
- Recruitment processes that reduce interviewers' unconscious bias and subjectivity when assessing candidates
- Interviewers collaborating in new ways with confidence in each other's abilities and contribution to the recruitment processes
- Recruitment processes promoting two-way conversations between candidate and interviewer and increasing candidate engagement

These mechanisms enhanced individual and collective engagement and commitment to VBR. They promoted equity of opportunity for candidates to influence individual and organisational outcomes. Determining the impact on individual (patient or staff) and organisational outcomes was not feasible. This is because a variety of workforce policies were implemented simultaneously in sites and the challenges of isolating the impact of VBR, as well as a lack of available organisational outcomes data, rendered causal inference invalid. The contextual conditions required for these mechanisms to be triggered included factors such as: leaders who actively

embraced VBR; meaningful engagement of local opinion leaders and operational staff; a rich mix of interviewers reflecting diverse backgrounds; recruitment training; systematic evaluation of recruitment processes; and experience-based transparency and honesty about the challenging nature of healthcare work built into recruitment processes.

The extensive variation in processes and approaches that national VBR policy prompted at local level meant it was not feasible (or relevant) to develop a typology of VBR. The active components we have identified in our study will be useful for informing education and health service providers implementing VBR. The lack of a typology does not diminish the contribution of this work.

Understanding the longitudinal impacts of VBR for higher education institutions

Stage 4 (presented in Chapter 7), illustrates the longitudinal impacts of VBR for HEIs. This was addressed successfully through: (i) a national survey of HEIs; (ii) analyses of national secondary data sets; and (iii) follow-up interviews with participants from HEI case studies (Stage 2).

The national survey, building on Stage 2 findings, reinforced the varied approaches and mix of interviewers used to assess values of candidates for healthcare programmes of study. Respondents, on the whole, positively appraised the VBR policy and its implementation in their organisation but were largely uncertain of the optimal process to be aimed for and the impact of the new way of recruiting.

There were no significant changes in the characteristics, profile or continuation of students recruited to healthcare programmes in England following the introduction of VBR. Our descriptive analyses revealed the biggest changes in student characteristics and profile followed the removal of NHS bursaries, and not the introduction of VBR. Following the removal of NHS bursaries, the number of applications to nursing courses decreased; the proportion of applications from 18/19-year olds increased, with a corresponding decrease in applications from older students.

Follow-up interviews with Stage 2 participants from universities highlighted their continued commitment to VBR – albeit often with adaptions to the original approach and process. They described the impact of the bursary removal on the number and age profile of applicants. They also described the broader healthcare contexts that graduates may choose to work in and whether this should be considered in the values that students were recruited for. Participants defended their adopted approaches and highlighted the unintended and negative consequences (for those involved in the recruitment process and candidates) of those they rejected. Determining the longer-term impacts of VBR remains problematic given the poor quality and relative paucity of data.

Proposing successful models of VBR to inform practice and policy

VBR was implemented in varied ways by education and service providers. The active components (as described above) offer an indication of what needs to occur for the successful implementation of VBR - regardless of the approach or processes deployed - and the contextual factors that will support this. Judging 'success' in the context of this national policy intervention is challenging. If success means staff engagement and commitment to VBR, and the standardisation and transparency of processes which promote equity of opportunity of candidates, then our evaluation highlights those mechanisms and circumstances that will enhance the chances of success along these lines. We are less confident of the impact of VBR on individual and organisational outcomes. We were unable to gather evidence of the success of VBR on these, as such evidence was lacking. Proposing successful models for VBR shaping quality of care through the values of a more diverse biographical and demographic mix of candidates is not appropriate or feasible based on our evaluation.

REFINED PROGRAMME THEORIES

Considering these findings, we developed and refined the initial theories of VBR into these four programme theories:

A strong policy argument and/ or mandate for VBR appreciated and embraced by key leaders in an organisation, who can meaningfully engage colleagues and/ or "opinion leaders" (context) to operationalise the assessment of patient-focused values in everyday recruitment practices (mechanism – resource) in ways that resonate and are considered to have relevance by education and service providers (mechanism -reasoning), supported by adequate resources and clear management commitment (mechanism - resource), will promote collective responsibility and increased engagement and commitment to embed VBR by staff in the organisation (outcome).

People with diverse backgrounds (which includes patients and public), who are adequately trained in recruitment processes for assessing values and mutually support each other in its operationalisation (context) will be open to working together in new ways (mechanism – resource) and will have confidence in each other's abilities and unique contribution (mechanism - reasoning) to promote an approach for recruitment that is transparent about the assessment of values by individuals (regardless of background) and who are committed to continue to support VBR (outcome).

Locally developed and well-led approaches for assessing values, that are designed with operational level staff and systematically evaluated (context) will support relevant, standardised and transparent recruitment approaches that are valued and adopted by staff across the organisation (mechanism – resource) and that minimise interviewer unconscious bias and subjectivity when assessing candidates (mechanism – reasoning) to promote equity of opportunity for candidates so they can demonstrate they possess the required values for a health care professional role or programme of study (outcome).

Attraction and selection stages of recruitment need opportunities for people with experience to be transparent and honest about the challenging nature of healthcare work and study (context) so that an individual candidate and staff at the recruiting organisation can have a two-way conversation to assess values (mechanism – resource) and increase candidate engagement with the role so that they can consider their own suitability (mechanism – reasoning) and an informed choice is made about the alignment of an individual's values with the system in which they will work or study and that may influence individual and organisational outcomes (outcome).

DISCUSSION

To the best of our knowledge, this is the first theoretically informed, mixed methods, evaluation of VBR. The architects of VBR made the assumption that recruiting individuals for their values, and then maintaining and encouraging these values in the workplace, would lead to the desired improvements in quality of healthcare provision. Since the policy framework was launched, and mandated for HEIs, there have been considerable efforts by staff (with a remit for recruitment in HEIs and NHS organisations) to develop VBR. Based on our study findings, we cannot support the assumption that VBR leads to the recruitment of individuals whose values are better aligned with those of the NHS. Nor have we established whether VBR enhances the quality of healthcare provision. Recruitment was perceived as an initial, but not only, source of influence on the values of individuals. NHS workplace practices and cultures were seen as more influential forces for socialising people into core NHS values. Student healthcare professionals also identified workplace cultures (and especially clinical placements) as important influences on the sustainability of 'values' of those working in the NHS. The Francis Inquiry highlighted the need for cultural values in the NHS to change, and VBR was considered an important policy for addressing this. However, our findings suggest that VBR alone has not changed the values of the NHS workforce.

It is difficult, if not impossible, to argue against the importance of recruiting healthcare professionals and student healthcare professionals for their values. Healthcare professionals are employed to meet the needs of patients (and the

public) for care and support. Addressing those needs and working in ways which value them is both pertinent and desirable. VBR was perceived as increasing the focus on patient-centred values and promoting structure and transparency to the processes used to achieve this. We did not find evidence of the discriminatory power of VBR for recruiting people with the right values or for rejecting those who did not possess the required values. The extremely low rejection rate of applicants for healthcare programmes of study revealed that almost *everyone* was assessed as possessing these values. The longer-term benefits of embedding VBR in recruitment processes were difficult to assess with any confidence.

The VBR policy was permissive. It promoted principles that organisations could consider when developing approaches tailored to the local context. This created wide variations in recruitment approaches and processes. In addition, VBR was often introduced alongside a range of workforce initiatives. This adds complexity when trying to disentangle impact and to isolate which intervention is having impact.

VBR needs to be understood within the broader context and influence of the cultures in which individuals learn and work. As a single policy intervention VBR will not change the values of the healthcare workforce and ensure quality of care and service provision for the public. However, it can help signify to new recruits the expected values of organisations and provide a means by which those unwilling to subscribe to these can opt out. VBR has an important formative role but it needs to be embedded within cultures that are *already* compassionate and caring if these values are to be sustained by the workforce.

The strengths and limitations of this study are detailed in the full report.

IMPLICATIONS

Issues identified by our research that merit further consideration by policymakers, providers, and researchers.

Implications for policy

- Securing bottom-up buy-in and the co-design of VBR with education and service providers supports the principles for good policy making
- Our study focused on education and service providers who had implemented VBR and the varied ways in which the policy had been interpreted in the recruitment approaches and processes. However, there are many NHS organisations that have not implemented VBR. Understanding the implementation of VBR across different contexts (acute, mental health and community trusts) and considering the implications for patient care and experience is an important area for future policy
- The lack of evidence of impact of VBR on areas that we could analyse for university healthcare programmes (such as student profiles and characteristics pre- and post-VBR, or MMIs as a filter for university offers) suggests that further investment in this area should be scrutinised
- Understanding workplace practices and cultures and how these nurture and support values is key for realising VBR in the broader context of values-based learning and employment and future workforce policies and requires attention by policy
- Supporting organisations to establish systems for monitoring and evaluating workforce policy initiatives is vital. This could usefully establish organisational data sets for comparative evaluation purposes, as well as standardising audit and monitoring by organisations

Implications for education and service provision

- There is a need for education and service providers to reconsider the usefulness of VBR for their local context (including its costs and benefits) and to consider how, when combined with the organisational culture in which individuals work or learn, values will be nurtured
- Efforts to align individual values with those of an organisation require well designed organisational policy and human resource management which supports values-based employment or learning, including a commitment to address poor workplace practices and cultures directly and justly when necessary

- Clear management engagement and commitment to recruit healthcare professionals or students to programmes of study for their values is important and will engender individual and collective responsibility of staff to embed VBR in everyday practices. Health profession education programmes are delivered in partnership with health (and social care) employers. A commitment to recruit individuals for their values is therefore appropriate across the system and to bring about mutual responsibility
- Operationalising standardised and transparent VBR processes for the local context is key for promoting meaning and relevance of values assessment in recruitment processes for staff in the organisation
- Ensuring adequate resources and systems are in place is a prerequisite for the development and implementation of VBR and crucial for it becoming part of everyday work
- Systematising processes to evaluate and review VBR is important for staff to appreciate VBR as a distinct approach for recruitment and to grasp the potential value, benefits and importance of it for their own work and for the work of the organisation of which they are part

Implications for research

- Given the variation in approaches and processes for VBR there is scope to undertake a longitudinal natural experiment to assess impact over time for different approaches
- Researchers should explore with education and service providers possibilities for co-designing a core set of standardised process and outcome measures that could be used for comparative workforce policy studies
- Understanding how values are created, nurtured and sustained by the organisations in which individuals work or study merits further investigation: VBR needs to be understood within the broader context of values-based employment or learning which should be included in any further research

Further research is needed in the following areas, to:

1. Evaluate patient/ service user perspectives, as well as the views of a wider range of interested stakeholders (such as Royal Colleges, or Unions)

2. Explore a range of competing values and their respective impact on improving care to determine: What are the most important values? Do some values, such as effectiveness and efficiency, compromise other values, such as compassion?
3. Explore whether academic qualifications are more important in some areas than values, and where/when does the 'trade off' occur?
4. Understand if different healthcare professions have different values and when and how do these harmonise or clash in the organisation and delivery of patient care. This could include exploration of the role of the professional bodies (for example the Royal College of Nursing) in promoting the right values.
5. Evaluate whether poor patient care (when it occurs) is the result of poor individual values (bad apples) or the culture of the organisation (bad barrels), the profession (bad cellars) or the wider NHS (bad orchards)

CONCLUDING REMARKS

Current policy prescriptions that seek to nurture values-based cultures are in need of a more secure evidential base. We have drawn on a mixed method study to sharpen thinking about the implementation of VBR. There is still much to learn regarding the implementation of this key policy and to this end we have highlighted a number of important gaps in knowledge that are in need of sustained research-based evolutionary development.

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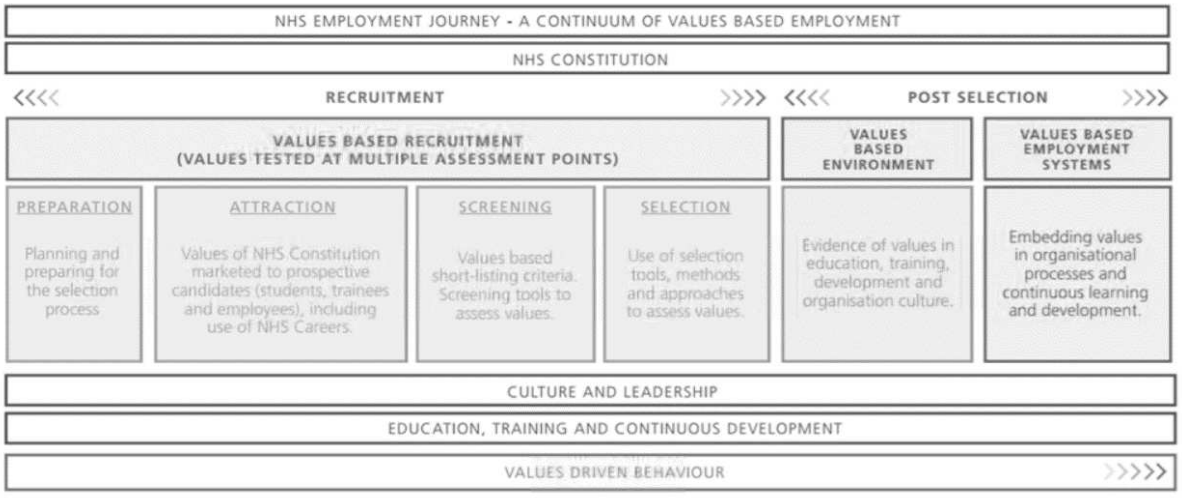
CCA	Cost Consequence Analysis
HEE	Health Education England
HEI	Higher Education Institution
HESA	Higher Education Statistics Agency
MMI	Multiple Mini Interview
NHS	National Health Service
SBR	Strengths-Based Recruitment
SJT	Social Judgement Test
UCAS	University and Colleges Admissions Service
VBR	Values-Based Recruitment

CHAPTER 1: INTRODUCTION

The National Health Service (NHS) employs 1.3m staff (headcount), with almost one million employed in direct patient care activities (602929 professionally qualified clinical staff, supported by 345,248 support staff) (NHS Digital, 2020). It is staff that overwhelmingly determine how patients experience healthcare. High profile reports have highlighted deficiencies in healthcare services delivery and organisation (Francis, 2013; Keogh, 2013) and the need for cultural change to ensure staff promote quality of care and patient safety (Department of Health, 2012; Berwick, 2013; Cavendish, 2013).

The promotion and adoption of a values-based recruitment (VBR) approach to attract and select health care students, trainees or employees *'on the basis that their individual values and behaviours align with the values of the NHS Constitution'* (Health Education England, 2013) was a high-profile policy response to these concerns. VBR is one element in a broader values-based employment model (Health Education England, 2013), which aims to combine recruitment strategies with systems and environments for effective work by individuals and teams to ensure the delivery of high quality services and care (Figure 1).

Figure 1: Health Education England's values-based recruitment framework



VBR was mandated by Health Education England (HEE) for Higher Education Institutions (HEIs) when recruiting health care students for NHS funded training courses[1]. NHS organisations vary in their implementation of VBR (Health Education England, 2013). Despite nuanced differences, VBR's core includes: explicitly weighting values (such as compassion) over and above applicants' training and experience; a formal and structured approach to identifying and matching applicants' values to those of the NHS Constitution (Department of Health, 2013); 'stages' in managing values in recruitment through pre-application expectation management ('what sort of people do we want?'); explicitly referencing values at screening and interview; and values-reinforcing activity once in employment and as part of continuing professional development.

VBR assumes that recruiting for values and behaviours and then maintaining and encouraging these, will improve healthcare quality. Whilst intuitively appealing, there is only unsystematic and anecdotal evidence to support this assumption (Connolly, 2013; Strachan-Hall, 2013; Groothuizen et al., 2017). Evaluations of the impact of VBR on aspects of care such as 'compassion' or variables such as staff retention rates or indicators of organisational health (such as staff sickness and absence rates) have not been undertaken. Moreover, the costs (from both the organisational and the macro-NHS systemic perspectives) of implementing VBR are unknown. Consequently, we have very little evidence to inform decisions about investing in VBR. There is a need to broaden understanding of organisational processes and cultures which sustain (or erode) health care professional values and behaviours (Maben et al., 2007; Mannion, 2014).

This research project focuses on the components of VBR across education and service providers. We sought to map the 'active' components of models of VBR, and propose successful models of VBR for education, practice, and policy. The study examines the values and behaviours expected of health care professionals (including nurses and allied health professionals) from a range of perspectives, including the public, NHS staff, student health care professionals, education and

[1] During the evaluation period the NHS bursary for nursing, midwifery and allied health students was withdrawn (https://www.gov.uk/government/publications/nhs-bursary-reform/nhs-bursary-reform). This change in policy context, and as perceived by case study participants, is considered in Chapter 5.

service providers, as well as education and service commissioners. We also explore the potential benefits, costs and consequences of different models of VBR; examining VBR within a broader context to explore what works, for whom, how, why and in what circumstances.

The contribution of VBR to promoting, sustaining, and developing values and behaviours in NHS staff merits investigation. Levels of employee engagement can correlate with both performance (MacLeod and Clarke, 2009) and improved patient care and patient satisfaction (Glen et al., 2014; NHS Employers, 2014). However, we do not know whether individuals recruited using VBR are better able to enact and sustain their values when engaging in day-to-day health care work and when engaging with health care teams. Our study explores and models the 'ingredients' required for interventions that will best support NHS organisations recruiting, selecting, managing and supporting health care professionals and students to deliver services and care in line with the aspirations of the NHS Constitution (Department of Health, 2013) and the expectations of the public which the NHS serves. A better understanding of the contexts within which different approaches are effective will allow for more selective development of support systems and interventions (Davies and Mannion, 2013; Mannion, 2014).

Given the lack of evidence for implementing VBR across education and service providers, we asked the question:

> *How have education and service providers implemented VBR approaches and what are the impacts on service delivery and care?*

To answer this question, the study addressed the following **aims,** to:

1. understand and conceptualise VBR in the context of healthcare education and service delivery in order to unpack what works, for whom, why, and under what conditions;
2. identify the 'active' components of models of VBR and create a typology of VBR models according to their constituent parts;
3. understand the longitudinal impacts of VBR for HEIs recruited through the 'first cycle' of VBR; and
4. propose successful models of VBR to inform practice and policy.

We used quantitative and qualitative methods and various data to address study aims through four connected stages. In this report, we present the findings of each stage of this study, detail our theoretical propositions of VBR (what works, for whom, why and in what circumstances), identify key cross-cutting issues related to implementation of VBR in different settings, and highlighting the implications and areas for consideration by policymakers and individuals and teams involved in recruitment processes in both HEIs and the NHS.

In Chapter 2, we explain our research design and methods. This includes the ethical considerations for this study, alongside methodological and practical challenges of conducting this research. Chapter 3 represents our findings from Stage one's formulation of initial theories of VBR (using policy analysis, a literature review and interviews with policy 'architects'). We test these theories in four case sites (Stage 2) using a multiple case site embedded design (Yin, 2009) (Stage two), presented in Chapters 4 and 5. First, we present findings from two HEIs and their implementation of VBR for healthcare students (including nursing and allied health care professionals) to programmes of study (Chapter 4). We then present findings of implementation of recruiting for values in two NHS organisations - one acute NHS Trust using strengths-based recruitment (SBR) and one mental health NHS Trust using VBR - particularly for newly registered health care professionals (Chapter 5). Chapter 6 provides our subsequent cross-case analyses and refined theoretical propositions for VBR (Stage three). Chapter 7 looks at the longitudinal impact of VBR in HEIs (Stage four) using a national survey of HEIs, analyses of secondary data of the characteristics, profile and continuation of students recruited to healthcare programmes nationally, and follow-up interviews with stakeholders in the HEI case sites. The final chapter highlights key issues related to implementation of VBR in different settings, and the implications and areas for consideration by policymakers and individuals and teams involved in recruitment processes in both HEIs and the NHS and consider our study's strengths and limitations. To encourage transparency, we have included a comprehensive set of appendices.

CHAPTER 2: RESEARCH APPROACH AND METHODS

To explain why and how policy interventions (such as VBR) work, realist methods identify the underlying mechanisms driving different outcomes and the ways context influences these (Pawson and Tilley, 1997; Pawson et al., 2011; Greenhalgh and Manzano, 2021). VBR is a complex [policy] intervention, involving multiple stakeholders and contexts over a period of time. Making sense of VBR in this way enables us to consider the different ways in which VBR is enacted, and to provide an explanatory account of how a particular version may work, when, and for whom.

The active ingredients of VBR can be articulated as *programme theories;* outlining how components (*mechanisms*) trigger changes and effects (*outcome*), and which contextual conditions/resources (*context*) are needed to sustain these. We used Dalkin et al.'s (2015) adapted version of Pawson and Tilley's (1997) original C+M=O formula:

$$\text{M (resources)} + \text{C} \longrightarrow \text{M (reasoning)} = \text{O}$$

Further separating mechanisms into resources and reasoning helps understand VBR in different contexts. Box 1 describes our working definitions of realism's "building blocks" (Pawson et al., 2005; Wong et al., 2012).

Box 1: Definition of context, mechanism, outcomes and programme theory

Context
Any condition that triggers and/or modifies the behaviour of a mechanism.

Mechanism
Our unit of analysis and the generative force that leads to outcomes. This can be separated into resources that are made available within the context or the reasoning (cognitive or emotional) of the various 'actors'.

Outcome
Occur at organisational and/or individual levels and are intended or unintended consequences of the intervention.

Programme theory
Specification of the mechanisms associated with which outcomes and what features of context affect whether or not mechanisms operate.

EVALUATION STAGES

Evaluation was a four-stage design.

Stage 1 generated a 'working' theory of VBR by (i) analysing policy documents and a rapid review of VBR literature; and (ii) interviews with national stakeholders to explore the intended advantages and disadvantages, contextual influences, mechanisms/processes behind outcomes, and ways that VBR differs from previous recruitment models. This stage culminated with the formulation of initial theories for VBR: generative explanations of the mechanisms and contexts associated with outcomes. In Stage 2 we tested these theories in four case studies: two HEIs and two NHS organisations (one acute and one mental health trust). Data comprised: (i) case site documents; (ii) organisational measures of performance; (iii) explorations of the potential costs and consequences of VBR; and (iv) interviews and focus groups with stakeholders. Cross-case analyses of case study findings in Stage 3 enabled refinement of theories of VBR in terms of what works, for who, and in what circumstances. Finally, Stage 4 evaluated the longer-term impact of VBR in HEIs through a national longitudinal survey of HEIs, analyses of secondary data of the characteristics, profile and continuation of students recruited to healthcare programmes nationally and follow-up interviews in the HEI case sites.

Further details of each stage are provided below.

STAGE 1: FORMULATING INITIAL THEORIES FOR VBR

In this stage we focused on identifying those ideas and assumptions underpinning and explaining how VBR is intended to work and in what circumstances. This involved the development of initial *programme theories* (Pawson et al., 2005). Programme theories articulate the ideas and thoughts of practitioners and policy makers about how and why an intervention works. Articulating theory promotes relevance and meaning for practitioners and policy makers – as well as intellectual transparency.

Effective theories in realist evaluations typically combine stakeholders' theories – often derived from their experiences - with substantive, formal, theories (Davidoff et al., 2015).

Developing these initial programme theories involved:

a) a documentary analysis (Bowen, 2009) of VBR national policy (including Health Education England and NHS Employers' resources and tools) to establish the 'official' theory of VBR;
b) a rapid review of literature (Khangura et al., 2014) to synthesise current knowledge of the composition, assumptions and impacts associated with VBR models; and
c) stakeholder (or policy 'architect') interviews to identify implicit and/or explicit beliefs about VBR and the 'active ingredients' in the approach according to education and service providers.

These initial programme theories were tested and further refined in subsequent stages of the evaluation.

The project advisory group (see Appendix 1 for membership) helped identify key policy documents and literature, introduced us to key informants for the stakeholder interviews, and commented on the emergent programme theories (presented at the end of Chapter 3).

Review of VBR policy and literature

To provide our preliminary understanding of the underlying assumptions and theories of VBR we first analysed Health Education England's VBR framework (2014) and NHS Employers' (2014) toolkit. An important analytic starting point was considering the mechanisms by which VBR is supposed to work in particular contexts and leading to outcomes, both intended and unintended (Pawson and Tilley, 1997). We started by scoping the range of theories and conceptual frameworks underpinning the various aspects of this document. Next, we examined a broader range of literature to gain insight into implementation of VBR in practice, what is intended to happen and what is reported to happen in specific contexts.

Searching for documents and literature

Our search aimed to identify the range of documents and literature in which stakeholders wrote about VBR. We included policy documents, editorials, comments, letters, and news articles. As it was a "new" policy, we did not anticipate finding research evaluations specific to VBR.

We searched a range of electronic databases (including CINAHL, MEDLINE, Embase, Google Scholar, Business Source Premier, Health Management Information Consortium, and Social Policy and Practice) using the search term and truncation operator "values based recruit*" in the title or abstract to retrieve 'recruitment' and 'recruiting'. A total of 21 references were identified through this search following deduplication. The websites of relevant organisations (for example Health Education England, NHS Employers, Council of Deans of Health, Skills for Health, Skills for Care) were also searched. Reference lists of identified policy and literature were examined to identify further relevant literature.

Selection and appraisal of documents and literature

The selection and appraisal of identified policy and literature were based on relevance to the review question: reflecting established realist review methods for theory elicitation (Pawson et al., 2005). All retrieved records were screened based on title and abstract using the following criteria: (1) is this about VBR and (2) does it potentially contain ideas about how VBR works, for whom and in what circumstances? We did not exclude studies on the basis validity (for example, how well they predicted or explained VBR outcomes) Full text copies of potentially relevant documents and literature were retrieved and read. The relevance criteria is detailed in Box 2. In summary, we sought to include policy and literature that offered insights about how VBR is introduced in practice and how it affects recruitment practices (the mechanisms), the contexts in which this happens and/ or the consequences of this (the outcomes).

Box 2: Determining the relevance of policy and literature for the review

Does the policy document or literature: - contain ideas about how VBR is introduced in practice (education or service)? - describe contexts in which VBR is introduced? - explain consequences (or outcomes) associated with introduction of VBR (for education or service or staff or patients)?

Having begun to understand the mechanisms underpinning VBR, the next stage of our evaluation turned to focused on understanding and explaining which mechanisms were influencing which outcomes in different contexts.

Stakeholder interviews

A stakeholder was defined as someone with the experience, knowledge and ability to express the view of the group or organisation they represented (Brugha and Varvasovszky, 2000). We identified, approached, and recruited eight stakeholders working at a policy level for in depth qualitative interviewing. These stakeholders had been involved with the development of the VBR policy and represented the Department of Health and its arms-length bodies, higher education, and public and patients.

Stage one's interview plans were reviewed and supported by the University of Leeds (School of Healthcare) Research Ethics Committee (reference number SHREC/RP/526). Appendix 2 provides evidence of this approval. The ethical considerations for all stages (1, 2 and 4) are considered below on pages 51-52.

Potential participants were initially emailed to introduce the study and the team (Appendix 3). They were provided with a participant information sheet (Appendix 4) and asked to reply to the research team within 3 days. Two further reminders were sent on days 4 and 10 after the first email if needed. All potential participants responded and accepted the invite or nominated a colleague. Once participation was secured, a telephone interview was scheduled. Consent was obtained in writing prior to the interview (Appendix 5) and verbal consent secured and recorded at the beginning of the recorded interview.

Participants were asked to use their experience and expertise at policy level (rather than in an "individual" capacity) to guide their question responses. The interviews explored contextual influences, mechanisms and processes by which VBR achieves desired outcomes, *intended and unintended* advantages, disadvantages and consequences of VBR, and how VBR differs from previous recruitment models. The interview topic guide is detailed in Appendix 6. All interviews were recorded with permission and transcribed word-for-word.

Interview data were thematically analysed (Braun and Clarke, 2006). First, data was segmented into categories that were close to how participants described the issues. We then compared within and between categories and identified emphases and differences in participants, which were themed. These themes were then used in conjunction with the policy and literature review to develop initial theories of how VBR 'should' work and why.

Stage 1's findings are presented in Chapter 3 alongside the initial programme theories generated.

STAGES 2 AND 3: TESTING AND REFINING VBR THEORIES

Stage 2 of the evaluation focused on collecting and analysing data to test the initial theories for VBR developed in Stage 1. Four case studies were conducted to examine recruiting for values in higher education (n=2) and health service providers (n=2).

Case studies are ideally suited to researching social action for detailed insights (Ferlie, 2001; Yin, 2009). We examined the relationship between 'planned' formal policy (espoused strategy) and 'actual' informal negotiation of the implementation of VBR policy by staff in practice (emergent strategy) (Lipsky, 1980; Ferlie, 2001). This stage involved developing understanding of a variety of important aspects of implementing complex policy initiatives at organisational and individual levels:

- individual and professional ownership of VBR,
- system complexity and levels of change required for introduction of VBR,

- the influence of external bodies on any internal reforms,
- leadership (transactional versus transformational),
- cultural diversity (domination or integration of sub-groups in the organisation), constructive versus unintended or dysfunctional consequences of introducing VBR.

Stage 2 of this evaluation was reviewed and supported by the NHS Health Research Authority (reference number HREC15-041, Appendix 7), and approved by the University of Leeds (Appendix 8). Both HEIs provided their approval for the study to progress based on confirmation of governance approval by the University of Leeds: South University on 23 March 2016 and North University on 13 May 2016. Confirmation of capacity and capability was provided by the Acute NHS Hospital Trust on 6 February 2017 and by the Mental Health NHS Trust on 1 May 2017.

Normalisation Process Theory in Realist Evaluation

Recruitment is not a new intervention; but VBR as a policy and mandating this for higher education was. It represented a change in practice to be embedded within everyday recruitment practices. Whilst not mandated in the NHS, our scoping review in Stage 1 highlighted a potential shift in recruitment approaches to values-based (or similar) approaches was happening in various NHS organisations.

Normalisation Process Theory (NPT) (May and Finch, 2009) provided a theoretical lens for our evaluation. Specifically, it helps explain and make sense of how VBR as a "technology" (in the broadest sense) was routinely operationalised, embedded, and sustained as 'normal' recruitment practice within each case study. We used NPT as a 'sensitising' device to structure the approach to our evaluation and to sharpen our analytical focus for testing and refining our programme theories.

There are three formal propositions behind NPT (May and Finch, 2009, p.540):

1. Material practices become routinely embedded in social contexts as the result of people working, individually and collectively, to implement them;
2. The work of implementation is operationalised through four generative mechanisms or constructs – coherence (the ways that people make sense of

the work entailed in implementing and integrating VBR), cognitive participation (how they engage with this work), collective action (how they enact it), and reflexive monitoring how they appraise its effects and modify it) (see Box 3 for further detail of these constructs and their core components); and

3. The production and reproduction of a material practice requires continuous investment by agents in ensembles of action that carry forward in time and space.

Box 3: Core constructs of NPT and their components

1. COHERENCE: The sense-making work that people do together and individually to operationalise a set of practices (intervention). It has four components:
(i) Differentiation: Understanding how a set of practices and their objects are different from each other.
(ii) Communal specification: Building a shared understanding of expected benefits, aims, objectives.
(iii) Individual specification: Understanding own responsibilities and specific tasks around the set of practices.
(iv) Internalisation: Understanding benefits, value and importance of set of practices.

2. COGNITIVE PARTICIPATION: Relational work done to build and sustain community of practice around complex intervention. It has four components:
(i) Initiation: Understanding how key participants work to drive practices forward.
(ii) Enrolment: Organising selves and colleagues to contribute to work involved in new practices, and more complex rethinking of individual and group relationships may be required.
(iii) Legitimation: Work that builds on ensuring other participants believe the intervention is right for their involvement, and they can make a valid contribution.
(iv) Activation: Collectively defining procedures that help sustain the intervention and maintain involvement.

3. COLLECTIVE ACTION: The operational work people do to enact the intervention/set of practices. It has four components:
(i) Interactional Workability: Interactional work that people do with others, artefacts, and other elements of a set of practices to put them to use in everyday settings.
(ii) Relational Integration: Knowledge work people do to develop and build accountability and maintain confidence in each other and the sets of practices as they use them.
(iii) Skill set Workability: Who the work is allocated to, in terms of the division of labour and skill sets built up around a set of practices.
(iv) Contextual Integration: Managing sets of practices by allocating different types of resources, and executing protocols, policies and procedures.

4. REFLEXIVE MONITORING: Appraisal work, done to assess the new sets of practices, and the affects they have on people and/or surroundings. It has three components:
(i) Systematization: Involves the work of collecting information in different ways to find out how effective and useful sets of practices are.
(ii) Communal Appraisal: The work involved in evaluating the worth of a set of practices, using systematised and experiential information.
(iii) Individual Appraisal: Individuals express their personal relationships to complex interventions by appraising its effects on themselves, their other tasks, and the contexts in which they are set.

http://www.normalizationprocess.org/what-is-npt/npt-core-constructs/

Sampling case sites

To test our programme theories we purposively sampled and recruited four case sites: two HEIs educating trainee health care professionals undertaking a 3-year programme of study (focusing on nursing, midwifery and allied health professionals) and two NHS organisations (one acute and one mental health NHS Trust). We agreed our case site selection with the project advisory group. The co-operation and support of local key stakeholders in each case site (higher education and NHS) was secured and critical for undertaking the evaluation.

We consulted survey data collected by Health Education England in 2015 from higher education institutions in England. These data provided insight into the breadth of programmes delivered by each institution and the approaches adopted for implementing VBR. Our two case sites were sampled based on the following criteria:

- geographical area: an institution was selected from the North and South of England;
- health care programmes (of 3-year duration) offered in the institutions: for comparative purposes we selected institutions offering similar programmes; and
- interview methods to assess candidate values: to represent institutions where (i) there was one approach *across* all programmes or (ii) there were variations in approach across programmes *within* the institution.

Our intention was to recruit an NHS site partnered with each HEI. Our rationale being that reciprocal arrangements are usually in place between partner organisations for recruitment: staff from NHS sites often participate in recruitment activities with their higher education partner. We successfully recruited an acute NHS site partnered with the higher education case site in the South. However, we were unable to replicate this in the North. The partner mental health NHS Trust for the higher education site in the North declined to participate – citing Trust "pressures". Our project advisory group were keen for a mental health Trust to participate and so two more Northern mental health Trusts were contacted; both Trusts declined: one was not using VBR and the other (again) stated that due to pressures within the Trust they did not have capacity to support the evaluation. After

long negotiations, and following advice from our project advisory group, we secured a mental health Trust in the South of England.

Some description of methods used for assessing candidate values are presented within case study findings in Chapters 4 and 5.

Data collection methods and data analysis

Case study data collection used both quantitative and qualitative methods and included: document analysis; routine organisational data; non-participant observation, interviews and focus groups.

Organisational approach to VBR: Document analysis

In case studies, documents are used to corroborate and augment data from other sources (Yin, 2009). Documents detailing the organisational approach to VBR were collected; either by a key contact in each case study site or retrieved directly if publicly available. Documents related to attraction, screening, and selection stages of VBR were collected. No site offered documents associated with candidate "preparation" for recruitment.

Documents analysed included: organisational web pages (NHS or University health care programmes of study); job adverts and descriptions of role (NHS); electronic and paper copies of promotional materials for programmes of study (University); protocols for recruitment process, including shortlisting documents (NHS and University), and documents used in the interview process (NHS and University) – see Table 1. We designed a document analysis form to determine whether - and how - 'NHS Constitution values' (or where these were mapped to organisational values), '6 Cs' (Department of Health, 2012) or 'values-based recruitment' were explicitly stated within documents. We aimed to retrieve a range of documents (described above and detailed in Table 1) to ensure comprehensiveness of the documentary analysis.

Table 1: Document analysis for University and NHS case sites

Document type	North University	South University	South Acute Trust	South Mental Health Trust
Website	✓	✓	✓	✓
Programme guide	✓	✓		
International/ EU prospectus	✓			
Interviewer training materials			✓	
Recruitment and retention policy				✓
Job advert			✓	✓
Job description/ person specification			✓	✓
Candidate pack				✓
Application screening documents	✓	✓		
Candidate self-assessment questionnaire			✓	
Interview questions	✓		✓	✓
Multiple Mini Interview guidance notes/ station information	✓	✓		
Multiple Mini Interview questions	✓	✓		
Situational Judgement Test	✓			
Group activity question	✓			
Interview scoring sheets	✓	✓	✓	

Exploring routine sources of organisational data on outcomes and costs of VBR

Organisational data were provided by the two HEIs for five years, for students enrolling onto health care programmes in (i) 2012/13, (ii) 2013/14, (iii) 2014/15, (iv) 2015/16 and (v) 2016/17 entry. VBR was introduced for students enrolling in 2016/17. We used these five years of data for analysis to explore any effects of VBR

on the characteristics of students recruited. Data were provided by Senior Admissions Officers from each University and included, demographics (age, gender, and ethnicity) and two deprivation measures, IMD decile[2] and POLAR 3 score[3]. The University North case site provided applicants' tariff points (unavailable from the University South case site).

Just five time points precluded a formal time series analysis, so we used descriptive statistics to examine data and look for potential changes. In addition, the removal of bursaries and introduction of tuition fees and loans in 2017 is a severe confounder, very likely to affect the characteristics of students who apply for nursing and other programmes; in reality VBR was in place for only one application/entry year (2016) before any effects would have likely been substantially affected by replacement of bursaries with tuition fees. Data were summarised by applicants, those invited to interview, those offered places and those who enrolled. For those invited to interview, a comparison was made between those rejected and those offered places to explore how VBR impacted on this part of the recruitment process. This was done by course, by institution. Heterogeneity between the two institutions prevented a joint analysis for the courses they had in common.

In HEIs, as well as looking at the organisational effects of the policy, we also aimed to consider the opportunity costs and any potential cost savings over time. Data limitations and lack of a single clear outcome measure preclude cost-utility or cost-benefit analysis. Instead we proposed a cost consequence analysis (CCA) (Kaufman, Watkins and Simms, 1997). CCA offers a 'course grained estimate of what one puts into a system and what one gets out of it' and has the advantage of providing a rapid picture, at a reasonable cost, of the important variables decision

[2] The **Index of Multiple Deprivation (IMD Decile)** is a measure of relative deprivation for small areas. Deciles are calculated by ranking the 32,844 small areas in England from most deprived to least deprived and dividing them into 10 equal groups. These range from the most deprived 10 per cent of small areas nationally to the least deprived 10 per cent of small areas nationally.

[3] The **POLAR classification** looks at how likely young people are to participate in Higher Education across the UK and shows how this varies by area. POLAR classifies local areas or 'wards' into five groups, based on the proportion of 18 year olds who enter HE aged 18 or 19 years old. These groups range from quintile 1 areas, with the lowest young participation (most disadvantaged), up to quintile 5 areas with the highest rates (most advantaged).

makers require to decide whether the return on investment in VBR is worthwhile. VBR could result in additional short-term recruitment costs, particularly in the time of staff involved in shortlisting and interviewing using more detailed methods. Over a longer time period, however, cost savings could accrue (e.g. via reducing student attrition and staff turnover). We explored the potential costs and cost savings of VBR to inform decision making in HEIs, while recognising the constraints (e.g. data limitations) and confounders (e.g. removal of bursaries) that influenced the measurement of both costs and outcomes over the time period of this study, and precluded any real possibility of attributing any observed changes to VBR *per se*.

Unlike HEIs, NHS employers were *encouraged* rather than mandated to use VBR. NHS Employers suggested that VBR be delivered in a number of ways: pre-screening assessments, values based interviewing techniques (role play, written responses to scenarios) and assessment centre approaches.[4] This is likely to vary considerably across sites and between occupations, and even those organisations who implemented it in full would only have a small proportion of their staff recruited in this way. In combination with this being encouraged not mandated, routinely available data on potential consequences – e.g. adverse events, serious untoward incidents or patient complaints – could not be attributed to VBR. It was therefore not possible to meaningfully analyse quantitative data, either from national sources or from our NHS case sites, to evaluate the impact of VBR.

Understanding implementation and impact of VBR: interviews, focus groups and non-participant observation

We used qualitative methods to understand how VBR was implemented and its perceived impact. We sampled stakeholders, ensuring that a range of participants with differing roles in VBR were represented.

Initial study contact (Appendix 9) and study information (Appendix 10) was shared by email with staff members (and potential study participants) by our key contact in each case study site: for NHS sites this was a member of the senior executive team

[4] https://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/values-based-recruitment

and for the HEIs this was the Admissions Lead for each of the health care programmes. Key contacts at our University sites ensured that study information was shared with clinicians outside the University who helped with recruitment events (Appendix 10) and patient and public representatives (Appendix 11). Students were recruited by research team members via lectures or recruitment days - following an invite from University staff. This enabled the research team to share study information with students and candidates (Appendix 10). Students and candidates either volunteered on the day that they met the researcher or later after follow up contact from researchers. Our attempts to recruit via focus groups (see (Appendix 12 for Participant Information Sheet) with students and staff was variably effective in both University and NHS contexts. It proved impossible to host focus group discussions with staff (including clinicians) and patient and public representatives. Written informed consent was obtained from every participant for either an interview or focus group discussion (Appendices 13 to 16). Verbal consent was also secured at the beginning of the recorded interview or focus group. All interviews were recorded and fully transcribed.

A total of 102 participants were included in the qualitative interviews and focus groups in Stage 2: 87 interview participants and 5 focus groups with 15 participants. Table 2 provides a breakdown of participants and Table 3 details the stakeholders by case site. Interviews were conducted either face-to-face or by telephone, according to participant preferences. Focus groups were face-to-face. The interviews and focus groups explored contextual influences, mechanisms, and processes by which VBR achieves desired outcomes, *intended and unintended* advantages, disadvantages and consequences of VBR, and how VBR differs from previous recruitment models.

We used the 'teacher–learner cycle' interviews (Manzano, 2016) in the interviews with stakeholders with experience of VBR to refine and test Stage 1's programme theories. In teacher–learner cycle interviews, the researcher's theory is the subject matter: the researcher first teaches the interviewee about the theories they want to explore within the interview; the researcher then invites the interviewee to use their experience of the intervention to reflect on these theories, refining and adding to them. Effectively, the interviewee is using their experience to *teach* the researcher.

An example of a semi-structured topic guide to facilitate these teacher-learner interviews is provided in Appendix 17.

Table 2: Interview and focus group participants by case site

Case site	Number of interviews	Number of focus groups (participants)	Total participants
South University	33	1 (3)	36
North University	18	4 (12)	30
South NHS Acute Trust	19	-	19
South NHS Mental Health Trust	17	-	17
Totals	87	5 (15)	102

Table 3: Participants by stakeholder group by case site

Case site	Staff	External clinicians	Students	Patient & public	Total participants
South University	17	7	9	3	36
North University	11	3	12	4	30
South NHS Acute Trust	19	-	-	-	19
South NHS Mental Health Trust	17	-	-	-	17
Totals	64	10	21	7	102

We used non-participant observation methods to understand differences in behaviours related to VBR in each site – an approach usefully employed by other realist evaluation teams to test and refine theory (Greenhalgh et al., 2009; Rycroft-Malone et al., 2010). Familiarisation with VBR operationalisation in each case site enhanced understanding of participants' interview and focus group descriptions.

Observations focused on recruitment training days (South Acute NHS Trust) and methods used (both university case sites and South Acute NHS Trust). In line with realist recommended practice, interviews took place in the early phases of the study and were scheduled *after* observations. Interviews were thus, guided and informed by incidents arising from the observations; contributing to further theory testing and consolidation (Manzano, 2016). We were unable to undertake any observations in the South Mental Health Trust because we were not given permission.

Interview, focus group and observation data were thematically analysed at case site level. First, by segmenting data into categories representing how participants

described issues and that enhanced understanding of underpinning contexts, mechanisms, and outcomes. We then compared within and between categories and identified preoccupations or differences by participants. These were themed in a process similar to analysis of interviews in Stage 1.

We then undertook pattern matching and building for each of our initial programme theories using the range of case site data (qualitative, documents and organisational data) to consider what might work, for who and in what circumstances. This cross-case analysis (Stage 3 of our study) is presented in Chapter 6.

STAGE 4: LONGITUDINAL IMPACT OF VBR IN HEIS

Stage 4 was added in response to policy customers' wishes to see the longitudinal impact of VBR in HEIs. We undertook a national survey of HEIs, analysed secondary data about the characteristics, profile and continuation of students recruited to health care programmes nationally, and conducted follow-up interviews with participants of the Stage 2 HEI case sites (North University and South University).

We discussed with the project advisory group ways to determine impact arising from the VBR policy mandate and subsequent changes in recruitment on characteristics and profile of students recruited to health care programmes. We agreed with the advisory group to use routinely collected data by the universities, to cover the period pre- and post- introduction of VBR processes in the universities. These secondary data sources included student demographics (age at entry, gender, student specified ethnicity), and measures of deprivations (POLAR classification[5] and Index of Multiple Deprivation (IMD)[6]). In addition, Tariff Points were analysed at North University.[7]

[5] The POLAR classification looks at how likely young people are to participate in HE across the UK and shows how this varies by area. POLAR classifies local areas or 'wards' into five groups, based on the proportion of 18-year olds who enter Higher Education aged 18 or 19 years old. These groups range from quintile 1 areas, with the lowest young participation (most disadvantaged), up to quintile 5 areas with the highest rates (most advantaged).

[6] The Index of Multiple Deprivation (IMD) is a measure of relative deprivation for small areas.

[7] University and Colleges Admissions Service (UCAS) Tariff points are allocated to qualifications generally studied between the ages of 16 to 18. Universities use these Tariff Points to report to Government bodies but may also use these in their entry requirements (https://www.ucas.com/ucas/tariff-calculator)

Stage 4 of this evaluation was reviewed and supported by the University of Leeds (School of Healthcare) Research Ethics Committee (reference number HREC 18-027). Appendix 18 provides evidence of this approval.

National survey of HEIs

To explore the national implementation of VBR in HEIs for the recruitment of students to health care programmes (including nursing, midwifery and allied health professionals), and staff perceptions of the impact of VBR, we conducted a cross sectional survey (September to November 2019) using questionnaires.

Data collection and analysis

We designed a questionnaire (see Appendix 19) based on Stage 2 case study findings for academic staff with a role in leading admissions in their universities for these programmes. Section one captured participants' employing university, the undergraduate degree programme(s) worked on, the methods used to screen and select students, whether (and how) values were promoted in marketing materials, and the contribution of patients or public or clinicians to recruitment processes in their organisation. Section two had 12 items, each using a 5-point Likert scale (strongly agree, agree, neither agree or disagree, disagree, or strongly disagree) to measure attitudes towards VBR (3 items), perception of impact of VBR (4 items), perceptions of colleague attitudes towards VBR (2 items), and perceptions about how well VBR was implemented within their organisation (3 items). All 12 statements were phrased positively, a lower score (i.e. a score of 1) indicated a stronger level of agreement, and a higher score (i.e. a score of 5) indicated a stronger level of disagreement. The final section (three) was optional and comprised one open text question to capture experiences of VBR and its impact on undergraduate health care programme(s).

The questionnaire was distributed by email with a link to an online form to every university in England providing nursing, midwifery, or allied health professional health care programmes (n=62). We purposively sampled participants working in admissions roles. Study invites were sent direct to these staff (if identified on University web pages) or to the Head of Department who were asked to forward to

academic staff with a lead role for admissions for health care programme(s) (Appendix 20). Participant recruitment was carried out over a 3-month period, with monthly email reminders sent to non-responders - 3 reminders in total.
Data were analysed using the Statistical Package for Social Sciences (IBM SPSS Statistics 26.0). Categorical variables were reported as frequencies, and percentages. The 12 items measured using a 5-point Likert scale generated ordinal data which in line with recommended practice was treated as interval data (Sullivan and Artino, 2013). The data generated from each of the 12 Likert scale items generated non-normally distributed data, and for this reason the median (inter-quartile range) values for each individual item were reported. Open text responses were analysed thematically (Braun and Clarke, 2006) to understand closed-question response findings. Open text data were treated both inductively and deductively, to identify data providing detail on questionnaire topics and allowing new topics emerge. Data were coded, codes merged into themes and sub-themes. See Chapter 7 for responses and results.

National secondary data analysis

We analysed national secondary data sets to examine the characteristics of students recruited to health care programmes before and after VBR implementation and to determine if their characteristics changed.

Characteristics examined included age, gender, ethnicity and qualifications across seven health care programmes: midwifery, physiotherapy, radiography, occupational therapy, mental health nursing, adult nursing and children's nursing. Analyses focused on first year undergraduate students beginning courses between 2012 and 2017. VBR was implemented for students commencing their programme of study in 2016/17. We examined drop-out rates during the first year of study.

Data collection and analysis

Student data was provided by Higher Education Statistics Agency (HESA) and included demographic data and continuation data from 81 HEIs. Demographic data was provided for six years (2012-18) and continuation data for five years - 2017/18

data was not released at the time of our analyses. In addition to HESA data we used publicly available data and reports from UCAS (UCAS, 2019).

Descriptive statistics and regression models were used to summarise the data and explore any apparent changes in trends over the time period 2012/13 to 2017/18.

HESA data from each HEI was modelled. The dependent variable was the characteristic of interest (e.g. average age, proportion of female students). We also included variables that represented year: the time before and after the VBR intervention and the intervention point. Analyses were adjusted for the number of students enrolled on each course and each course analysed separately.

National-level UCAS data was unsuitable for formal ITS and so was limited to descriptive statistics.

HEI case site follow-up interviews

Follow-up interviews with a sample of the Stage 2 HEI case study participants (in 2019) were conducted to promote (i) reflection on the ways in which VBR had been operationalised and any adaptations to recruitment since their first interview (conducted 2016-2017); (ii) re-appraisal of VBR and its purpose; as well as (iii) consideration of potential impacts, including longer-term impacts.

Data collection and analysis

We approached individuals (staff and students) who participated in Stage 2 HEI case studies and who provided consent for us to contact them again. This approach was by email (Appendix 21) and included a participant information sheet (Appendix 22 and Appendix 23). We sent reminder emails at 1 and 2 weeks after the initial email (2 reminders). We approached 38 individuals: 19 from North University and 19 from South University. Seven had left their previous position at the university or NHS organisation and so were not available for follow-up interview. Of the remaining 31 potential participants, we arranged telephone interviews with 13 people: South University (n=7) and North University (n=6); academics (n=5), clinicians (n=2), students (n=4) and service users (n=2) (Table 4).

Table 4: Stage 4 participants by stakeholder group and university case site

Case site	Staff	External clinicians	Students	Patient & public	Total participants
South University	3	1	2	1	**7**
North University	2	1	2	1	**6**
Totals	**5**	**2**	**4**	**2**	**13**

Interviews were conducted by telephone and lasted ~30-minutes. All participants provided written consent (Appendix 24 and Appendix 25). Interviews explored: developments and changes in VBR in their university; perceived advantages and/ or disadvantages of VBR; contextual factors at individual and/ or organisational levels that had influenced use of VBR; mechanisms and processes through which VBR outcomes were achieved; potential costs and consequences of VBR; future development of VBR and how this linked with other key policies and strategies. Interviews allowed participants to raise experiences or perspectives they considered important for the longitudinal study of VBR. The topic guide used for these interviews is in Appendix 26. Interviews were recorded and transcribed.

These interview data were thematically analysed using the same processes previously described. Interviews were compared to Stage 2's analysis to evaluate longitudinal impact.

ETHICAL CONSIDERATIONS

The ethics and governance approvals secured for each stage were described above (Stage 1, page 35; Stage 2, page 37; and Stage 4, page 48). For all stages, six main challenges were addressed:

1. Informed consent: potential participants were given information about the research in a form that they could understand. Written material was complemented by discussion and explanation - where requested. Participation was voluntary.
2. Handling and storing personally identifiable data: Details of case sites and participants were stored electronically on a password protected database, only accessed by, and accessible to, the research team. Paper copies of consent forms were stored in a locked filing cabinet in a secure locked office

separate from study data. Case sites and participants were given a unique (to them) study identification (ID) number.

3. Patient safety: We were mindful of and planned the possibility of a participant disclosing information that could compromise patient safety. Participant information sheets and consent forms explicitly stated that further action would arise should the team have any concerns about patient safety.
4. Disclosing sensitive or upsetting information: A contact name of someone participants could discuss any issue following the data collection was provided to all participants.
5. Anonymity: Direct quotations have been anonymised to protect the identity of participants. Audio recordings of interviews were uploaded on to password protected University computers and immediately erased from local digital devices. Transcribed data were anonymised and stored on password protected university computers, available only to the study's researchers.
6. Secondary data were anonymised and stored electronically on a password protected database, accessibly only the study's analysts.

SUMMARY

This study was a response to the Department of Health and Social Care Policy Research Programme's invitation to tender. Plans were peer reviewed and revised to accommodate the comments of reviewers and the funding body. The evaluation design and methods used have been detailed in this chapter. The chapters that follow report our findings.

CHAPTER 3: STAGE 1 - UNDERSTANDING VALUES-BASED RECRUITMENT AND DEVELOPING THEORIES OF HOW IT MIGHT WORK, FOR WHO AND IN WHAT CIRCUMSTANCES

> *"There was clear support for student recruitment processes that made values-based assessments and explored academic achievement and ability, experience in care settings, and the motivation for choosing nursing. Recruitment should balance academic excellence and values."*
> (Willis Commission, 2012, p. 25)

Quality in health care is influenced by more than what staff do - it's also about *how* they do it (Bridges et al., 2013). The Francis Inquiry highlighted the key role values play in ensuring safe, compassionate care. Post Francis, the VBR framework was developed to align the values and behaviours of staff with the expectations of the NHS and the public. VBR was an important policy response for assessing the personal characteristics, values and beliefs of staff and students - the future health care professional workforce. Against this policy background, the contribution of VBR to promote, sustain and develop desired values and behaviours among NHS employees in practice was not known. The starting point for this evaluation was understanding how VBR *might* work, for who and in what circumstances.

VBR ACCORDING TO POLICY AND LITERATURE

To understand the "official" theory of VBR we examined national policy documents, alongside HEE and NHS Employers' resources and tools.

Our narrative synthesis of the findings of the documentary analysis and rapid literature review undertaken was structured into three areas to develop our initial theories of VBR and how it might work: (i) context; (ii) mechanisms; and (iii) outcomes.

Context

In 2014, the Government mandated HEE to develop an agenda focused on improving staff values in the NHS (Department of Health, 2014). Based on the assertion that there was no place for poor culture, poor behaviour, lack of care or lack of compassion in the NHS (Colqhon, 2014). Literature discussing the development of VBR, highlighted high-profile reports outlining deficiencies in the delivery and organisation of care: the Francis (QC) Inquiry into failings at Mid-Staffordshire Hospitals NHS Trust (Francis, 2013), and the Keogh review (2013) into the poor quality of care provided by hospital trusts in England with persistently high mortality rates. Other reports informing the development of VBR talked of the need for cultural change in the NHS, including a focus on: compassionate care (Department of Health, 2012); quality and safety (Berwick, 2013); and the unregistered health care workforce (Cavendish, 2013). VBR was one response by the Government to address 'caring behaviours' in health care trainees, professionals and staff (Carter, 2013). This backdrop was always likely to influence the adoption of VBR in different settings.

The manifest failings and poor-quality care at Mid-Staffordshire Hospitals NHS Trust revealed by Francis (2013) showed how employing staff without the right qualifications and experience and that express values mis-aligned with the service could be so detrimental. The NHS Constitution's core values are (2013): working together for patients; respect and dignity; commitment to quality of care; compassion; improving lives; and everyone counts. These NHS-wide values are intended to strengthen local values in individual organisations and guide the behaviours of staff.

For undergraduate pre-registration health care students, the focus of VBR was on the 'practical' aspects of caring and the candidate's ability to demonstrate caring behaviours in readiness for a future role in health care (Carter, 2013; Hunt, 2013; Lyth, 2015; Sprinks and Duffin, 2015). VBR's focus was extended to NHS health care professionals and staff employed in direct patient care activities (Miller, 2015). And whilst some NHS organisations recruited staff for values *prior* to the Francis report, this form of recruitment intent was catalysed by the introduction of VBR policy (Torjesen, 2014). VBR and associated approaches were seen as "superior" to

previous recruitment approaches (Miller and Bird, 2014) by supporting the assessment of candidates' values, drivers and motivators, not just experience and qualifications as in "traditional" approaches.

Within nursing, polarised views on HEE's VBR Framework (2014) and its intended purpose emerged. For some, testing prospective nursing students for compassion at recruitment was futile, as a lack of compassion was principally a defensive response to working in difficult environments not part of an individual's intrinsic values (Osborne, 2015). Beagan and Ells (2009) revealed the values that mattered most to a small sample of nurses (n=20): helping others; caring and compassion; making a difference; patient-centredness; advocating for patients; personal and professional integrity; holistic care; and sharing knowledge for patient empowerment. The contexts these nurses worked in meant they often perceived an inability to enact values and make a difference to patients. They cited barriers such as inter- and intra-professional hierarchies, or poor workplace policies and resources. Others have argued that a focus on contextual, rather than individual, factors excuses dysfunctional behaviours. Mid-Staffordshire Trust nurses were considered to have ignored patients in distress, rather than fail to notice their distress (Osborne, 2015). Accordingly, tests to identify suitable candidates for the profession at the recruitment stage were welcomed by only a proportion of the profession.

A statement by the Council of Deans reported that the majority of universities (96%) already recruited potential health care students for their values and there was no evidence that recent graduates were of concern in terms of their values (Dean, 2014). They emphasised that more important foci should be the health care environment and organisational cultures in which students were learning in practice. Delivering compassionate care is complex; it is likely influenced by both resources available and the organisational environments in which nurses work, as well as the individual and their values (Sawbridge and Needham, 2014).

A key acontextual aspect shaping the public's perception of the nursing profession and work in contemporary health care was the growing gap between how nursing thinks about itself, how it describes its practice, and how nursing is perceived by the public (Allen 2015). A gap appears between professional ideals and practice and has

two important consequences: misplaced public expectations of nursing and dissatisfaction with the nursing role and work – leading to burn out, diminished commitment, or leaving the profession. The lack of published discussion and evaluation of VBR for other health care professions suggests that critical focus is concentrated heavily on nursing.

Mechanisms

The literature described the ways in which HEIs and NHS organisations reflected VBR policy in their recruitment strategies. This highlighted variability in the adoption of VBR in the NHS. Heterogenous accounts of pre-screening assessments, individual interviews, group interviews, situational judgement tests, role play and written responses to scenarios were all evident. Most literature on VBR approaches focused on recruitment of nurses and/ or midwives to undergraduate programmes, their first position as a registered professional, or when changing jobs (Kendall-Raynor, 2013; Miller, 2015).

Multiple mini interviews were advocated as a reliable alternative to individual interviews to inform selection decisions in pre-registration student midwives (Callwood et al., 2014). Ellis et al. (2015) described one university's development and testing of an instrument to measure professional identity and core values in nurses. Taylor et al. (2014) reported on a study evaluating selection processes for recruiting student nurses and midwives. They argued that: (i) there is a lack of agreement on the requirements for entry to nursing courses, particularly in relation to attributes and characteristics; (ii) psychological profiling may have a contribution to a multifaceted approach to student selection, but should not be an exclusive approach to decision-making; and (iii) selection processes should address expectations to reduce the mismatch between these and the reality of programmes of study.

Assessing values and behavioural competence of applicants for NHS jobs was seen as important as assessment of technical or work-based competence (Colqhon, 2014). Personal statements in applications for health-related positions were criticised as lacking validity for assessing values and that in-person selection processes were key (Torjesen, 2014). It was suggested that, as a minimum, VBR should involve at

least a face-to-face interview with an applicant (Latham, 2014). The use of assessment centres was advocated; as was involving service users (Colqhon, 2014; Duffin, 2014; Torjesen, 2014; Miller and Bird, 2014). Situational judgement tests were highlighted as useful for assessing candidates and informing effective selection decision making (Kendall-Raynor, 2013). This was despite the lack of evidence to support these claims.

VBR approaches focused on the applicant's attitudes and behaviours and whether they were a good 'fit' for the organisation (Trueland, 2014): getting the 'right' person into post (based on alignment of the personal values with those of the employing organisation) was considered most important because once in post the individual could develop their clinical competence through training. Conversely, influencing and changing personal values was considered difficult. Trueland (2014) described the VBR approach at the Birmingham Women's NHS Foundation Trust. Applicants for nursing and midwifery posts at this organisation were informed they would be assessed on their values and that the assessment process could take up to three days. The first stage involved screening for values via a questionnaire. Successful candidates were then asked to spend some time in the trust, perhaps chairing a meeting, going on a ward round, or delivering a teaching session. Only then were they invited for interview. At interview, they were asked to demonstrate how they put their values into practice. No data was available on how many candidates were rejected for not having the right values.

Beyond nursing and midwifery, Colqhon (2014) reported that some universities and NHS organisations were recruiting pharmacists for values, with limited detail on how this was being enacted. Within mental health services, there were examples of NHS organisations who had commissioned the National Society for the Prevention of Cruelty to Children (NSPCC) to 'overhaul' recruitment methods and to place greater emphasis on a candidate's values (Duffin, 2014). Again, detailed examples of mechanisms used were not provided. The most detailed report at this time described three different types of NHS organisations' approaches to VBR: ambulance service, a health care trust and blood and transplant services (Anon. 2014). Each described the core values of *the organisation* as forming the basis for recruitment and assessment of values. Thus, variability in the degree to which NHS core values were

represented in recruitment were, in effect, hard-wired into local recruitment. Figure 2 summarises the VBR approaches used. This revealed that an emergency call handler was subjected to a series of assessments. Once passed, they were then invited to a one-day assessment. The other organisations referred to an "interview", with little detail about the assessment of values.

Figure 2: Values based recruitment in three NHS organisations (Torjesen, 2014a)

Organisation	Core values	Behaviours	Recruitment approach
Ambulance	Committed, professional and accountable; working together; delivering consistently; shaping the future; and showing we care	Empathy; ability to question appropriately; to control the call; to listen and interpret responses correctly; to work quickly and accurately to meet response times	For emergency call handlers: (i) Remote situational judgement test (SJT); (ii) If pass SJT, online assessment of skills; (iii) personality assessment and response to computer generated call; (iv) one-day assessment including interview and behavioural role play
Healthcare Trust	Patients first; safe and high-quality care; responsibility and accountability; everybody's contribution counts; and respect.	Assessment of behavioural competencies that make up each value	All staff types and levels interviewed to assess values and technical ability – 'give an example of when you have shown compassion or sensitivity towards another person.' Behaviours to score the response provided for the interviewer include: listen, act, comfort, patient consent.
Blood and transplant	Not stated	Not stated	On application form, values and behaviours assessed – 'please give example of when you have provided good customer care skills.' At interview, values-based questions asked

Our rapid review illustrates the varied landscape of VBR implementation. But also the absence of deep understanding of the recruitment approaches used, how they enabled assessment of candidates' values, or whether an approach worked better in

some settings (NHS or HEI) or for particular groups (students, newly registered professionals, experienced professionals, or different professions).

Outcomes

At the time of our review, there was no research evidence linking VBR to outcomes. Despite this, wide ranging and bold claims were espoused in policy documents and literature on the positive difference that VBR would make to patients' experiences of care and the health care workforce's experiences at work. VBR was to ensure the principles and values of the NHS, *'[breathing] … new life into the NHS Constitution'* (Latham, 2014). Policy documents and literature directly linked alignment of individual and organisational values in health care (through VBR) to positive impacts and outcomes.

Staff employed using VBR approaches would be happier, more engaged, and more productive (Torjesen, 2014). A claim made on the basis of on an NHS Employers' report stating organisations were reporting *'a significant reduction in staff turnover'* as well as *'reduced sickness absence levels'* and *'increased job satisfaction'* following introduction of VBR. No data were provided to substantiate these claims. In a report detailing recruitment of health care assistants for their values (rather than qualifications) by one NHS Trust (Anon, 2013), turnover fell from 17% in 2010 to 9.9% in 2013, and sickness absence among assistants by 20% in 3 years. Given the plethora of human resource strategies and policies introduced during the same time period, it was simply not possible (or sensible) to attribute these outcomes solely to VBR.

In higher education, recruitment to a programme of study using VBR was intended to create a *'shift in the focus'* of undergraduate pre-registration nursing students when on clinical practice placements (Miller and Bird, 2014). The nature of this shift in focus by students was not articulated, beyond a list of desirable behaviours: work efficiently in teams to achieve shared goals; enhance patient experience and care; experience greater job satisfaction. This same article (Miller and Bird, 2014) reported several organisations' claims of less requirement of agency staff; less staff turnover; higher staff morale; more positive work environments; staff reporting feeling more

valued; lower sickness and absence rates; staff reporting greater job satisfaction; better care as reported by patients – all seemingly attributable to VBR but not based on empirical evidence. As well as benefits, Miller and Bird (2014) noted some unintended and dysfunctional consequences of using VBR. Including, failure to recruit individuals unable to communicate values effectively at interview (underperform) or, conversely, over-recruiting students who rehearse the main [expression of] values required at interview. The sensitivity and specificity of VBR as a *test* of values was unquestioned. Colqhon (2014) cautioned VBR would not necessarily produce 'good' professionals at the end of their programme of study; it would only be 'effective' in picking out oddities or characteristics undocumented in a candidate's personal statement. How well it did this, was not known. The Council of Deans recognised that VBR alone would not create cultures to prevent another failing in health care delivery akin to Mid-Staffordshire (Dean, 2014).

SUMMARY

Limited published evidence related to VBR existed to develop a uniform approach to VBR on. Our analysis included policy documents and resources, small-scale evaluations or research and opinion articles. Each provided useful context and discourse that shaped the development of VBR in HEIs and the NHS. The main headlines:

- Recruiting organisations (HEIs and NHS) varied enormously in the clarity of articulated values and embedding these across recruitment and selection procedures.
- There is wide variation in VBR approaches adopted by the NHS and HEIs to assess an individual's values. Approaches advocated included situational judgement tests (SJTs), structured interviews and MMIs. Approaches considered inappropriate included personal statements, references and unstructured interviews.
- Assessing an individual's values for "suitability" for health care was seen as intrinsically complex – for unclear reasons.
- Understanding candidates' expectations of professions was considered an important aspect of recruitment by HEIs to minimise the mismatch between these and the reality of programmes of study.

- A sole focus on recruitment for character and values at inception ignores the ongoing support needed for *sustaining* values throughout the programme of study and beyond, when employed.
- There was no evidence to support claims that VBR leads to improved care for patients, or improved outcomes for staff or organisations.
- VBR's costs were not addressed.

Our analysis of policy and literature lacked the depth to generate theories about VBR: in particular, what might work for who, why and in what circumstances. Interviews with VBR policy 'architects' in 2016 explored *intended* advantages and disadvantages, contextual influences, mechanisms, and processes by which outcomes were expected to be achieved, and how VBR differed from previous approaches to recruitment – providing some of the requisite depth for theory generation.

VBR AS ESPOUSED BY 'ARCHITECTS'

The implementation of a national policy, such as VBR, is complex, fraught with challenges and shaped by local contexts: what works well in one setting may work differently, or less well, in another setting. VBR was mandatory for HEIs but only recommended for the NHS.

"One size doesn't fit all": Developing VBR

Participants described the context within which VBR was developed. HEE, as an arms-length body (ALB), were mandated by Government to deliver VBR for HEIs. This involved broad "engagement" with other ALBs, such as NHS England, the Care Quality Commission, the Council of Deans and Healthwatch, to promote a "whole system" (sic.) approach and "partnership" (sic.) working:

> *"We wanted to ensure that we engaged across the system, because however complicated our NHS had been made from moving it from one organisation to I suppose seven key arms-length organisations, seven bodies, we wanted to ensure that we were doing this across the system, because we knew that we couldn't do it on our own."* (Stage 1: Policy architect: 2)

NHS Employers were commissioned to work with NHS organisations to implement VBR. The work was wide in scope, aiming to understand how values were introduced into the everyday business of the organisation – policies, procedures and ways of working – and then how they were being implemented in recruitment processes:

> *"We knew from work that had been done on values before – particularly work on staff engagement - that if we didn't have a whole-systems approach to looking at how the organisation worked with its values and the staff worked with its values then the recruitment piece on its own would fail… So, we've just tried to bust some myths around it doesn't really matter where you start with this, you just need to find a way in and then expand beyond there."* (Stage 1: Policy architect: 4)

Participants described their involvement with the development of VBR. In some situations, there was reluctant engagement but recognition that, politically or publicly, it would not be appropriate for an organisation to (actively) *oppose* recruiting for values:

> *"I think in our policy domain, politicians – and to a greater or lesser extent, sometimes officials from Health Education England – create problems that they want to solve. So, they had decided… that there was a problem in getting the right people onto courses. And I just fundamentally disagree with that. I don't think there's any evidence that the problems in care are linked to who we recruit, and I don't think there's any evidence that the people we recruit are the wrong people, in broad terms."* (Stage 1: Policy architect: 3)

The development of VBR involved a shift from the original Government focus on an automated tool for VBR, to the development of a looser framework with six core requirements, providing some flexibility for HEIs:

> *"A conceptual framework and giving some flexibility and variability to each HEI instead of saying 'right, you must do this' and it feeling a very top-down piece*

of work. It was ensuring that they had their own flexibility about how they did that. Because most HEIs were doing something in this field anyway, so we just needed to make sure that we tried to sort of pipe all of that together." (Stage 1: Policy architect: 2)

The framework was to offer "standardisation" and promote "transparency" of the NHS Constitution values in recruitment. It also necessitated face-to-face structured interviews with formal assessment of values. A key requirement of the framework was involvement of patients and the public in different stages of the recruitment process. Architects saw this as well-received across the system and as politically important post-Francis:

"And the way in which you use patients on the educational journey is totally undervalued by most organisations. And that's from when you recruit, so using scenarios with real patients, creating scenarios based on patient journeys and patient stories." (Stage 1: Policy architect: 6)

Through the eyes of policy architects, implementation of the framework was to support HEIs in reviewing their recruitment processes; including reconsidering the methods and resources required – including cost saving opportunities. For those working closely with universities there was a perception that students had always been recruited (at least in part) based on values expressed. But the inevitable variability in achievement was also recognised. Participants cautioned that previous approaches to recruitment had relied too much on "instincts" or "gut reactions" to candidates. The question of proportionality in response to this variability was raised by some:

"And I think one of the interesting policy discussions that we have a lot is the kind of 'are you using a hammer to crack a nut?' type of thing. So, if you've got a couple, or a handful, of Universities who are clearly not doing this and you've got evidence of serious concerns. Why are you trying to impose a national framework on everybody, rather than just looking for the exceptions? And if you can show evidence that they're not doing it, you're the commissioner, so stop commissioning!" (Stage 1: Policy architect: 3)

Participants also commented that despite wide-ranging challenges (dispersed physical locations, geographically spread out services, VBR to be implemented within existing resources) there was some perceived utility in VBR as a framework for NHS recruitment. This seemed to be borne of a semi-forced reconsideration of *how* they assessed for values:

> *"I think once people got into actually doing it, it provided a framework which some people said where there had been things they'd found it really difficult to put a measure next to before, now they were more easily able to do that. So, when people say how can you assess whether someone is caring or somebody is honest, it's not just having the values but they're then going to have some measures underneath it."* (Stage 1: Policy architect: 4)

The organisational context in which VBR was being implemented was important. In universities, the health care programme size and scope, internal systems of support for recruitment, existing relationships with NHS partners and the university's financial health were all cited as mitigating factors on implementation. Both university and NHS staff raised 'buy-in' among staff as also influencing implementation:

> *"Some people are signed up to that and some people don't think it's possible. And if you don't think it's possible then it's really hard to kind of persuade yourself that these hoops are worth jumping through."* (Stage 1: Policy architect: 3)

VBR's mandate in HEIs but not NHS trusts was considered a missed opportunity to promote values beyond recruitment and into employment:

> *"We were really committed in the framework to ensure that it was a Values Based Recruitment journey and you didn't see it in isolation from recruitment to when they go through to working in the Trusts. So, for me I think that is a disadvantage, we don't have that lever over the Trusts to say, like we have with the Universities, 'we need you to do this.' We can't do that with Trusts,*

and I think that's quite difficult when we want to look at the continuum of values-based employment." (Stage 1: Policy architect: 2)

"No, there isn't a statutory requirement, but I suppose you could argue – and the ones who have done this say - that they see the value of having values run through their business… We know that the whole values piece from leadership through to all aspects of employment practice makes a difference to the staff who are working in those organisations." (Stage 1: Policy architect: 4)

Participants also indicated that the VBR framework should be reviewed and able to evolve based on reflection and feedback by those using it.

Reality check: Being open and honest about the rewards, challenges and pressured nature of health care roles and work

Participants were keen to highlight that individuals embarking on a programme of study as a health care professional needed to understand the challenging and pressured nature of health care work

"Because it is a challenging job and its hard graft isn't it? And I do think people need to understand what they're getting into before they actually get too deep into the programme, if you like." (Stage 1: Policy architect: 1)

Concerns were expressed about the portrayal of health care work in the media and in particular on programmes such as *Casualty* or *Holby City* that glamourised health care work and the professionals delivering it. Participants acknowledged positive aspects, such as a sense of doing "rewarding" work, but also the physically and emotionally tiring work of health care professionals. For some, this needed to be an important part of the messaging for attraction and recruitment; something best done by ensuring existing health care professionals and students were involved in recruitment activities and openly discussed the realities of roles and work.

Working in a pressured environment was linked to the importance of personal values. It was suggested suitable individuals would find ways to cope with work pressures and challenges and work in ways that maintained their values. Alternatively, they might employ "workarounds" or work in ways where personal values were compromised. Individuals' confidence in their personal values and consistent behaviours as the vehicle for upholding these values were important for work as a health care professional and using that work to promote quality of care – all the while:

> *"Just assuming that an individual is going to be able to care day in, day out because they are a caring person, without any understanding of what it takes to do that and what you need to do to support them to do that is missing the point. I don't think it'll work."* (Stage 1: Policy architect: 7)

The need for a whole system approach was also emphasised. Tensions in the system were identified with NHS employers reporting that students were not prepared adequately during their programme of study for a role as a health care professional. Working together to resolve this was considered to be an important aspect of promoting VBR and values-based practice:

> *"When [employers] say 'the students, that [universities] tip up, I've got to spend bloody months and weeks bloody getting them up to the standards that I need, the Universities are not getting me the right people.' To which I say 'well, you know, I thought your people were involved in the recruitment?'"* (Stage 1: Policy architect: 1)

Recruiting for values and promoting values-based practice

An important element of VBR was the need to align the values of the individual with those of the team and the employing organisation. This was articulated as a two-way process and informal social contract with two key elements. First, assessing the individual's values and whether they will 'buy-in' to programme/team/university/NHS organisation values. Second, what the programme/team/university/NHS organisation

will provide for that person to enable them to enact their values and flourish in their educational preparation for a role in health care:

> *"I see it as sort of opening the front door to people and actually giving them a full view, flavour, to allow them to make an informed decision. But also, as well, us being a bit more ruthless, us being a bit more clear-cut in the type of people we want to bring in."* (Stage 1: Policy architect: 1)

This was not a one-hit, one-off, chance to consider values. Rather, it was an ongoing process throughout education, appointment to first professional role and each change in role or promotion through a career. There was a call for university and NHS staff involved with recruitment and career progression to review values at each stage:

> *"What we are rubbish at, when they get to, say, year three, is saying 'your interpersonal skills with patients is such that you're not cut out to be a [health care professional], have you thought of a job in research?' In the labs, is what I mean by that. We're never, ever prepared to second-guess our judgement later down the line. And that's where I think that values-based recruitment is different because it's not just about one point at the beginning, it's through the whole of the process."* (Stage 1: Policy architect: 1)

Such a process requires investment in people once recruited and ensuring they worked in supportive cultures where they were able to behave in ways that represented their values. Work to understand VBR in NHS organisations had taken this broader approach to considering values enactment in everyday business *and then* considering how recruitment could further support the organisation's values ambition. The success of VBR was closely linked to values enactment as "everyday business" in organisations:

> *"It's no good doing all of this if someone then comes into the environment which doesn't demonstrate any of those values in practice. Because you either end up with people leaving very quickly so your turnover rates are higher than they were before, or the toxic environment wears people down so*

then they just get to the point of thinking, well, I'll just stick it and I'll just cocoon myself. And that then starts to drive a different culture and unhealthy behaviours." (Stage 1: Policy architect: 4)

"And that is what's happening with students, they get recruited, they then go on a placement and the values of that particular placement are totally different to what their University is, or what they've been led to believe. And suddenly we have a real crisis." (Stage 1: Policy architect: 6)

"It just becomes a bit of hypocrisy to train nurses in this way, expect those values, for them then to go into organisations that don't respect the values at all." (Stage 1: Policy architect: 6)

An overwhelming objection to VBR by some participants focused on the underlying assumption of "static values". The educational process was considered to have an important role in shaping values and attitudes: education is transformative, and values evolve. This also linked with the environment:

"But the idea that this is the individual without their external environment and that the environment doesn't change the way that people's values and their behaviours and all of that interact, is just not right. It's just not true, is it?" (Stage 1: Policy architect: 3)

The sole focus on the values of an individual was perceived to distract from the organisational context in which individuals' practice. This was considered problematic and perpetuating unhelpful assumptions and discourse that poor care was because the wrong people were being accepted to study as health care professionals and that if the right people were recruited then poor care would not happen.

Participants also suggested that recruitment processes should be frequently reviewed so that the processes or approaches used to assess values could be developed and enhanced.

Privileging values rather than background or qualifications

Participants discussed the importance of VBR for promoting equality of opportunity for applicants to a university health care programme of study or an NHS job. Recruitment processes needed to be about more than qualifications, opportunities to engage with volunteering roles, ability to access coaching for applications and interviews:

> *"So, if you don't get [recruitment] right you'll just continually get this cadre of people coming through, maybe some of the pushy white middle classes."*
> (Stage 1: Policy architect: 1)

Participants highlighted the challenges of equity in opportunity for applicants to health care programmes when being assessed for values. Younger applicants were highlighted as often unable to articulate their values. More mature applicants, or those with previous health or care experience, may be better able to articulate their values – in context - at interview. Using experience or the sense made of previous employment, obviously does not *de facto* translate into how a student will learn or their intellectual openness/criticality or potential for personal growth during their studies:

> *"I think that some of them would have really struggled to pass this kind of test. Partly because they're just young and, you know, they can't necessarily articulate all of those things. I think the other interesting thing is, and I don't have evidence for this, but what I hear from members is that the real struggle around values that they often face is with students who've worked in the Health Service, or in care homes. And, actually, kind of changing and rooting out those attitudes, trying to change and transform them into thinking differently in their education is a real job of work for those people who've experienced burn-out or negative behaviours, particularly as care assistants."*
> (Stage 1: Policy architect: 3)

Privileging "values" was viewed negatively by some participants. Values needed to be considered alongside the individual's ability to work with others and their

resilience to cope with the demands of their professional role and pressurised work environments:

> *"How an individual operates as a registrant in that complex environment. And are there elements of that that you can look for as people come onto programmes?"* (Stage 1: Policy architect: 3)

> *"It doesn't matter if you're compassionate if you can't handle the environment that you are in."* (Stage 1: Policy architect: 3)

What difference will VBR make?

Overwhelmingly, and despite general enthusiasm for VBR, questions were raised by participants about the benefits of the approach and, simply, whether VBR, "would make any difference?" Mandatory HEI VBR was considered meaningless by some if there was no evidence of its impact or the difference it made. The areas raised included whether NHS employers and staff noticed any difference in the students or newly registered professionals recruited for their values when compared to previous cohorts:

> *"Are they any different to what you had previously? Are they more robust? Are they stronger? Are they more resilient? Are they showing the right belief systems?"* (Stage 1: Policy architect: 1)

Participants made connections between VBR and the following outcomes: improved patient care, experience and outcomes, decreased attrition of students, increased retention of staff and decreased fitness to practice cases (staff and students). Other general outcomes were voiced, such as recruiting the 'right' people with the 'right' type of values and skills:

> *"So, we have to find ways of getting the right people and people who will stay in that post. Now if we make sure that we're recruiting the right people, the turnover is likely to be lower. And I think it's certainly not going to be the sole answer to this problem but it's one of the pieces of the jigsaw that will help to*

solve the problem. I think it's vitally important, actually." (Stage 1: Policy architect: 5)

The most important test for VBR was considered to be whether patients noticed any difference and had confidence in the health care professionals providing care and services to meet their needs. Many participants were advocates for VBR and highlighted how this would translate into improved patient care and outcomes:

> *"They are more motivated at work and are more likely to advocate in their own place of work that the impact that they have on delivering patient care is improved and we see really clear results then between staff experience and patient experience and patient outcome."* (Stage 1: Policy architect: 4)

VBR was considered by some participants as a mechanism for minimising attrition from programmes of study and linked to reducing financial waste:

> *"It would save them money in the long term to not waste their money on training people who aren't going to last the course out because they find that actually they're not suited for this role."* (Stage 1: Policy architect: 5)

> *"When it costs us £78,000 to train a nurse and a lot of them are leaving before they've been fully trained - we should be asking just purely as a treasury question 'why is that happening?'"* (Stage 1: Policy architect: 6)

A view not universally shared:

> *"Are you spending a disproportionate amount of resource on this bit of the picture and then it's not going to have the impact because there's all this other stuff to do that I would argue is more important."* (Stage 1: Policy architect: 7)

Participants made sense of the limited evidence base underpinning VBR. For those who supported the introduction of VBR, growing an evidence base at the same time as implementing it was pragmatic and would support the rationale behind the policy's introduction and its continued use. However, a few participants were sceptical and

reported that it was the lack of an evidence-base that was key to their reservations about VBR and its widespread implementation:

> *"And I'm just very sceptical at this end … because I think it's barking up the wrong tree. But even if it was barking up the right tree, there needs to be some evidence." (Stage 1: Policy architect: 7)*

VBR's implementation costs were highlighted by participants. For the unconvinced, recruiting for values could be resource-intensive and expensive, and this would impact differently according to the size of the organisation or the programme of study. For some NHS organisations, this was a barrier - the lack of mandate meant some organisations would not prioritise VBR.

Wider HEI funding context was raised by some participants. Interviews were conducted at a time when consideration was being given to changing the commissioning of health care programmes by HEE as part of the 2017 Spending Review. Some participants suggested values would continue to be part of the recruitment process, regardless of the outcome of the Spending Review. However, if the contract between HEE and universities disappeared then HEE's ability to "police" VBR implementation by universities would no longer exist. This issue was explored further in the next stage of the study and when this outcome was known.

SUMMARY

Interviews with the architects of VBR included:

- The need for a strong policy argument/leadership/mandate to underpin VBR.
- Partnership working - including patients and the public - is key for implementation of VBR.
- A framework for standardising and promoting transparency of values assessment in the recruitment process is most useful for HEIs and the NHS.
- Promoting flexibility for assessing values in recruitment is preferable to a structured tool.
- Recruiting for values should promote equality of opportunity for *all* applicants.

- There should be ongoing evaluation and development of approaches used by organisations when recruiting for values.
- Individual expectations of a health care programme or role need to align with the organisational 'offer'.
- Applicants need to understand the realities of health care work, its rewards, challenges, and pressures.
- Values need to be embedded in the everyday business of organisations.
- If successfully implemented, then VBR will positively influence a range of outcomes for patients, health care staff and students.
- Costs of implementing VBR will be outweighed by the benefits.

INITIAL THEORIES OF VBR

What was generated from this phase of the evaluation were five initial theories of VBR. These were underlying assumptions about how the intervention (VBR) is meant to work and the impact that it is meant to have (Figure 3). These theories considered context, mechanisms, and outcomes[8].

The next stage was to test these initial theories through empirical study of VBR in different settings: case studies of HEIs and the NHS.

[8] ***Context*** refers to the conditions of the setting for the intervention (VBR) and context influences the way resources are perceived to generate outcomes. ***Mechanism*** refers to the resource the intervention (VBR) provides and the impact it has on the reasoning of staff. ***Outcome*** refers to expected or unexpected results of the intervention (VBR).

Figure 3: Initial theories of VBR

CONTEXT	MECHANISM	OUTCOME
If a strong policy argument and/ or mandate is made for values based recruitment…	…then this will resonate and be considered to have relevance by education and service providers…	…and there will be increased engagement and commitment to embed a values based recruitment approach in the organisation
If the optimal mix of people (including patients and public) are engaged in values based recruitment…	…this prompts partnership working and a collective view about values and methods for how these should be assessed…	…and leads to an approach that is transparent and meaningful and ensures recruitment of individuals with these values
If there is a planned approach in design, implementation and evaluation of values based recruitment…	…this prompts a more systematic, standardised and transparent approach…	…and leads to greater objectivity, sensitivity and specificity when assessing values of candidates
If values based recruitment is developed to recognise the challenging nature of healthcare work…	…this prompts alignment between the values of the individual being recruited and the system in which they will work…	…and leads to increased awareness of the role and improved satisfaction in the role by the individual, improved standards of care for patients, and reduced turnover of staff for the organisation
If values based recruitment pays attention to an individual's personal and role expectations…	…this prompts increased engagement of the individual with the recruitment process, which leads to…	… personal/ individual benefits (e.g. perceived self-efficacy) and potentially organisational impacts (e.g. commitment to role)

CHAPTER 4: STAGE 2 - UNIVERSITY CASE STUDIES

This chapter presents findings from two university case sites: South University and North University. In conducting this research, it is important to highlight the distinction in language used by study participants: 'selecting for values' related specifically to the VBR policy and its intended purpose, whilst the 'VBR process' was concerned with the methods and approaches used for recruiting students.

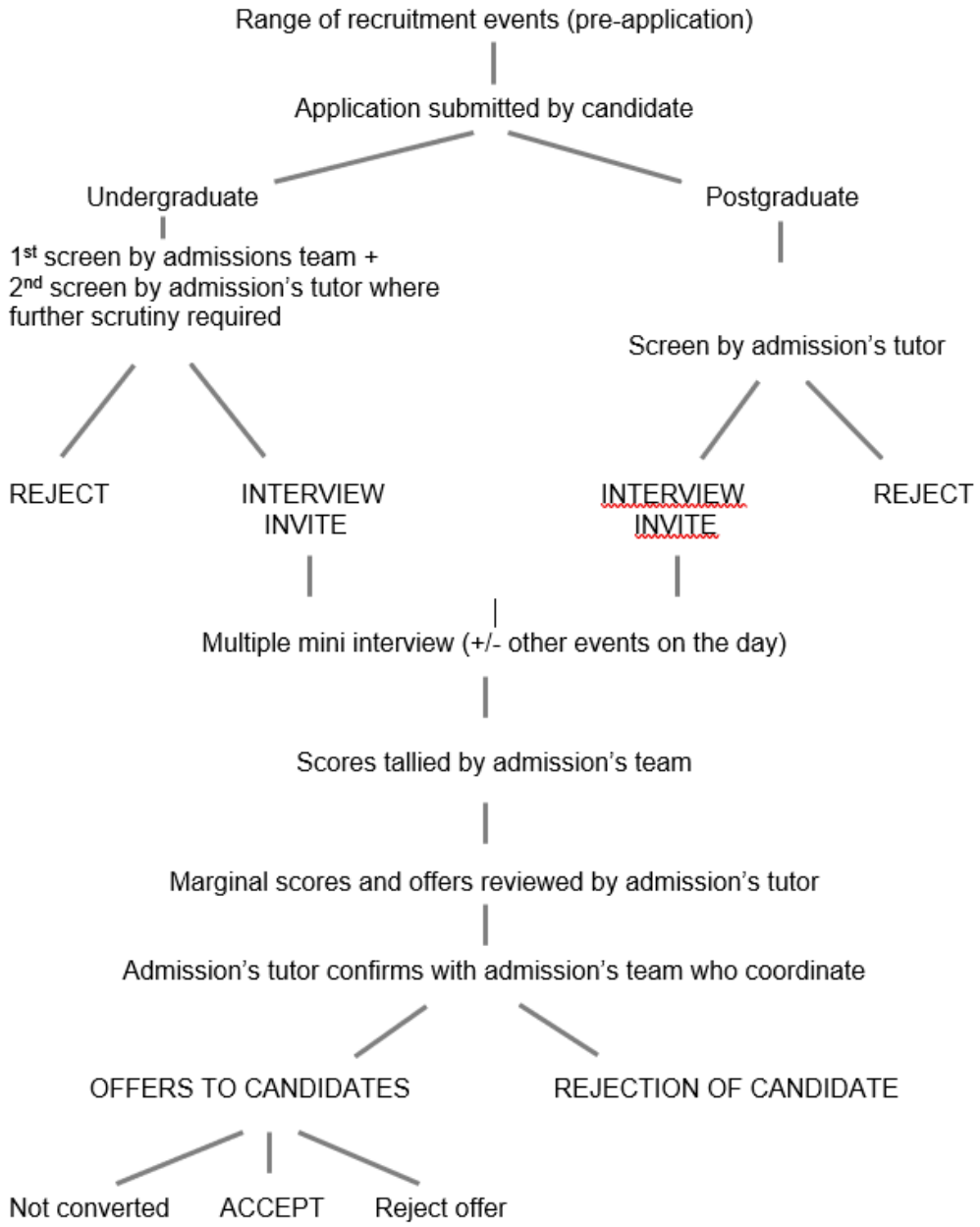
In this chapter we first provide some contextual detail to orientate the reader to each university's implementation of VBR. Then we present these findings from both case sites in a combined narrative, presenting analytic conversion and diversion across the sites.

DESCRIPTION OF VALUES-BASED RECRUITMENT AT THE UNIVERSITY CASE SITES

South University

South University is a large university with nine academic faculties. There are over 26,500 students at this university, coming from more than 150 countries. It has an international reputation for its research and teaching, including health care education. It delivers the following pre-registration health care programmes: Physiotherapy (BSc and MSc), Dietetics and Nutrition (BSc and MSc), Nursing (BSc and MSc) in field of Adult, Children or Mental Health, and Midwifery (BSc). The university mandated that all health care programmes (at undergraduate and postgraduate level) used MMIs as the method for assessing candidate values. The recruitment process is shown schematically in Figure 4. All programmes at this university used multiple-mini interviews (MMIs) for student selection. The MMI consists of a series of short, structured interview stations used to assess a candidate. The candidate rotates (with other candidates) through this series of interview stations where they will have a short exchange on a focused question with the interviewer. A MMI circuit varies in terms of the number of stations used and the time spent at each station. The VBR approach (i.e. MMI stations) used for each health care programme is summarised in Box 4 and further information provided below.

Figure 4: Overview of recruitment process at South University (all health-related programmes)



Box 4: Assessment of values used for each health care programme at South University

Physiotherapy
MMI: six stations (with four explicitly about NHS values)

Dietetics and Nutrition
MMI: five stations (with one explicitly about NHS values)

Nursing (all programmes)
MMI: six stations (with all six explicitly about NHS values)

Midwifery
MMI: six stations (with all six explicitly about NHS values)

Whilst some variation existed across MMI processes for different health care programmes (see Box 4), the structure and format of the MMI followed a similar pattern. Candidates (up to 15) gathered in a pre-interview room where they were given a briefing and shown a video clip (twice). This would form the basis for one of the questions in the interview. No further instruction was given on this clip, but candidates were informed they could take notes which they may find to be helpful. Candidates were then escorted to the interview room which was partitioned into separate cubicles. An interviewer was seated in each cubicle and candidates were instructed to take a seat outside of a cubicle. Clear instructions followed and, upon the bell, candidates entered the cubicle for 5 minutes, answered the question posed by the interviewer and, upon the bell, were instructed to move to the next cubicle. A 90 second interval punctuated each station. Candidates did not interact with each other, only the interviewers at each station. Following the MMI, candidates were escorted to a debriefing room and had the opportunity to comment on the experience and ask any questions: they were informed they were no longer being assessed. The formality/informality of this debriefing varied across the programmes (discussed further below).

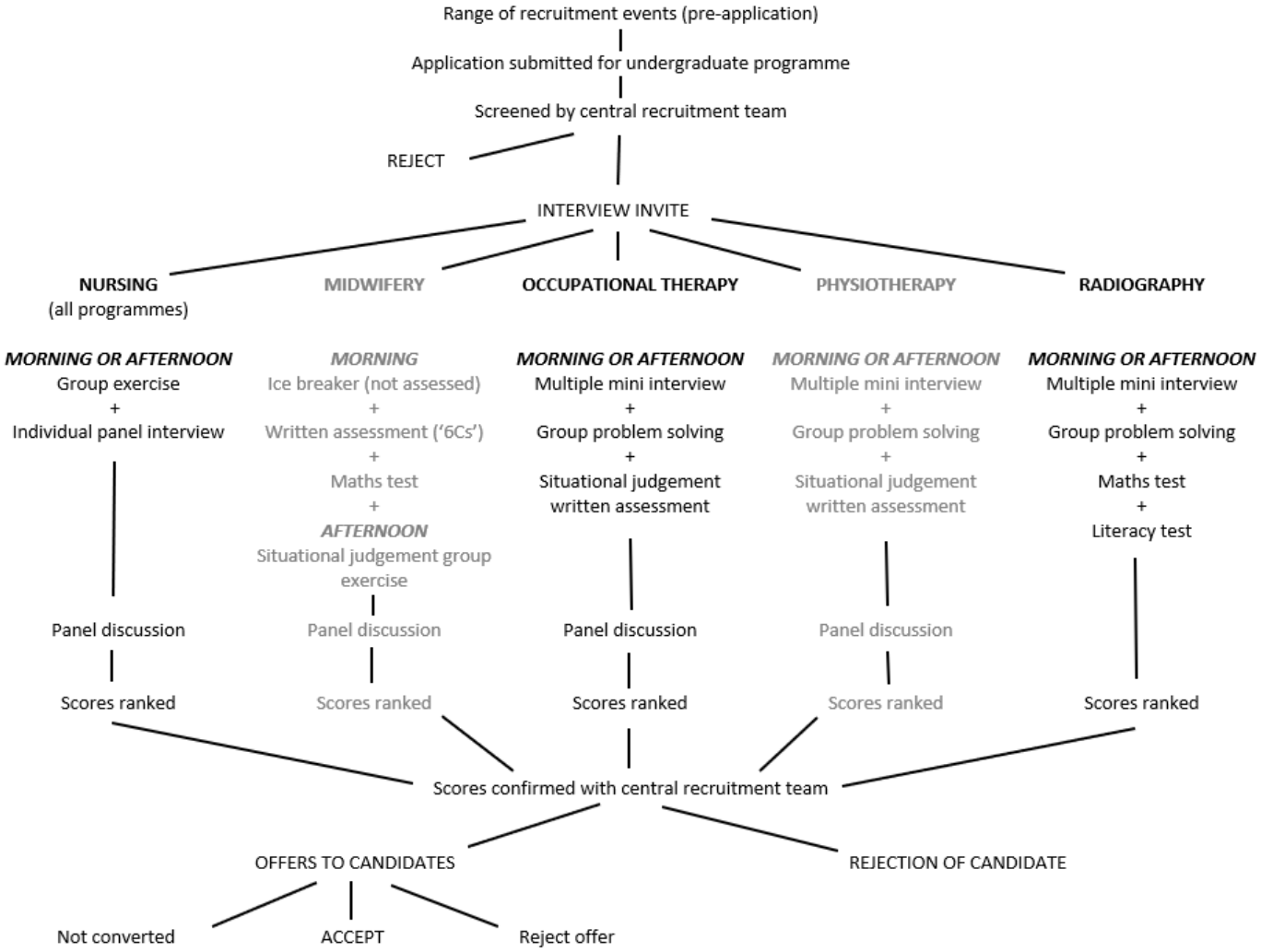
MMIs were not used with candidates that were resident abroad. These were interviewed by videocall by two academic staff members using similar questions used in the MMIs.

Candidates for the Nursing and Midwifery programmes were also required to take a numeracy and literacy test: this was not required on the other programmes of study. These tests occurred on the same or an alternate day to the MMI depending on the distance travelled by a candidate, i.e. local candidates were invited on a different day, while candidates from further afield were able to take the tests on the same day of the interview to minimise demands on their time and travel.

North University

North University is a public research university, which has four academic faculties. There are about 9,500 students at this university, coming from over 110 different countries. It has a strong reputation for research and knowledge transfer. Health Studies became part of the University in the mid-1990s. It delivers the following undergraduate pre-registration health care programmes: Physiotherapy (BSc), Occupational Therapy (BSc), Nursing (BSc) in field of Adult, Children or Mental Health, Midwifery (BSc), and Diagnostic Radiography (BSc). No postgraduate programmes were offered for these programmes. There was no universal approach mandated by this university for the assessment of candidate' values. Academic staff led the processes for VBR and emphasised a concern to establish this for the recruitment of future health care professionals and for patient care. Physiotherapy, Occupational Therapy and Diagnostic Radiography programmes had adopted MMIs: indeed, Radiography had introduced MMIs prior to the national VBR policy and mandate. The Midwifery recruitment process involved multi-stage assessment of candidates, with a group activity and situational judgement tests. The Nursing programmes used group discussions about a video clip, followed by an individual panel interview. The recruitment process is represented in Figure 5. The VBR approach used for each health care programme is summarised in Box 5.

Figure 5: Overview of recruitment process (all health-related programmes at North University)



Box 5: Assessment of values for each health care programme at North University

Nursing (all programmes)
Group activity: a 3-minute DVD which the group are asked to discuss. Candidates scored based on contribution to group discussion and interpersonal skills rather than content
+
Individual panel interview: 3 questions all NHS values focused

Midwifery
Written assessment: candidate asked to write on a values-based topic
+
Maths test
+
Situational judgement group exercise: group of candidates presented with a situation to discuss and offer individual perspective in the context of the discussion

Occupational therapy
Situational judgement written assessment: presents a situation and then asks candidate to address a series of questions
+
Group problem solving: a task that requires the group to work together and demonstrate problem solving skills
+
MMI: six stations (with four explicitly about NHS values)

Physiotherapy
Situational judgement written assessment: presents a situation and then asks candidate to address a series of questions
+
Group problem solving: a task that requires the group to work together and demonstrate problem solving skills
+
MMI: six stations (with three explicitly about NHS values)

Diagnostic radiography
Maths test
+
Literacy test
+
Group problem solving: a task that requires the group to work together and demonstrate problem solving skills
+
MMI: seven stations (with five explicitly about NHS values)

FINDINGS

Recruiting for values not novel

VBR was acknowledged by academic staff across health-related programmes at both universities (north and south) as a national initiative from HEE. Many participants recognised the influence of national inquiries into poor care - Winterbourne View (Bubb, 2014) and mid-Staffordshire NHS Foundation Trust Francis, 2013) on the introduction of VBR:

> *'I think it's as a consequence of the fallout from Mid-Staffs and the Francis [Report] and the recommendation that we need to be somehow screening or recruiting people for compassion and their qualities in that way. And that values-based recruitment is a step towards that.'* (Stage 2: South University: Academic Adult Nursing 14)

However, the strong policy argument and rationale for the mandate by HEE were not apparent in many academic staff accounts and not discussed at all by participants such as NHS staff, students or service users. Academics did not consider the mandate a proportionate response or that the focus on recruitment was the best way of addressing 'the problem' of poor care in services. Indeed, they were concerned the VBR mandate was introducing an unnecessary 'measure' for processes already part of recruitment procedures for programmes of study for health care professionals:

> *'Well, oh dear, we have always done VBR, and so that's a really difficult question for me, because the fact that we were mandated to start doing this, with all due respect, was irrelevant to me because we here, think that our graduates should have the right values to be a health professional, and nothing that HEE have ever said, has ever made me think that even more.'* (Stage 2: South University: Academic Dietetics 22)

> '*I think as professionals, and the other health care professions are probably the same, I think we would probably argue that those values are what we've always been looking for because as the nature of the profession they're what*

you want to see in people.' (Stage 2: North University: Academic Midwifery 10)

Regardless of the policy mandate VBR not seen as novel amongst academics. At the North University, academic staff described their commitment to supporting their NHS partners and promoting consistency of values when recruiting to programmes of study to reflect the NHS values. Senior clinicians helping with recruitment in the NHS and universities described the challenges of recruiting and retaining health hcare professionals and the need for a different approach that promotes the alignment of values from health care student to health care professional:

> *"There's so many challenges around nurse recruitment and retention that we do have to do something differently and we do need some evidence to support the different methodologies really. I think it's really important that we understand better the longer-term impact of values-based or strength-based recruitment. Well I think it's totally crucial because, you know, I think for anybody in nursing at the moment, recruitment and retention is probably the biggest challenge, but not just in terms of numbers, in terms of the quality of our candidates."* (Stage 2: South University: Clinician 27)

Academic staff felt that assessing candidates for values had always been part of the recruitment for health care programmes, and that the mandate simply encouraged that this be more demonstrable and transparent. This task was considered straightforward and largely positively by academic staff (and the wider participants) responsible for recruitment of students to programmes of study. The unintended consequence of the mandating of VBR by HEE, often unacknowledged by academic staff, was that the policy had encouraged staff to think more deeply about values and how to ensure these were incorporated into recruitment.

While the policy mandate for VBR did not resonate with academic staff, the organisational mandate of a change in recruitment processes to MMIs for all health-related programmes at South University had more relevance. Mainly because it came with more resources for recruitment processes. The North University's mix of approaches to VBR across the health care programmes (as described above) meant

no universally shared experience of mandated organisational change at this site. However, academic staff at North University acknowledged the commitment (described as 'buy-in') of the Dean of the Health Faculty to VBR and their commitment to work with the Dean to ensure VBR was embedded in all health care programmes of study.

Individual motivations for academics to engage with the change in approach to recruitment at South University, particularly for postgraduate programmes, was the additional support offered by the central admissions team with the process. Centralisation of recruitment was also a feature of North University. However, there were unintended consequences associated with the wider range of individuals involved in the recruitment process as a whole: there was variability in terms of whether and how these teams were collaborating and shared responsibilities across different departments related to different aspects of the recruitment process created tensions for some academic members of staff. The risk being misalignment of values across the different departments involved in recruitment. Whilst recognising the substantial task of screening applications and personal statements, academic staff indicated that 'non-professionals' (i.e. the Admissions Team administrative staff) may not appreciate fully the values they should be assessing and that they may miss important information or criteria:

> *"We're losing our dedicated recruitment people in this building, and they're all going to one big central team. And, there's a lot of hoops that needed to be jumped through with health admissions, with regards, like DBS [Disclosure and Barring Service], and second reference, and interviews. It's not the same as a history course, where you apply, you put in your personal statement, they read it and make you an offer or not. We've got to see ID, we've got to see qualifications, so I do have some worries that things are going to be missed."* (Stage 2: North University: Academic Mental Health Nursing 10)

The quest for intelligent, competent and able individuals *with* values

Both case sites emphasised the need for VBR to encompass those 'values' most important for caring for patients. HEE refers to the NHS Constitution (Department of

Health, 2013) values as most relevant for this purpose and many programmes considered the ways in which these NHS Constitution values, and the 6Cs outlined by the Chief Nurse for England (Department of Health, 2012), could be 'mapped' onto recruitment processes and interview questions. VBR varied across the two universities: South University implemented an organisation-wide approach: MMIs. Northern University used a mix of MMIs, group interviews, situational judgement tests (SJTs) and individual interviews or a combination of these for different programmes. Despite the differences, programmes across the universities could demonstrate how *values* were incorporated into recruitment.

There was agreement on a 'core' set of patient focused values considered important by participants for recruitment. Academic staff and clinicians (particularly on the more competitive (oversubscribed) programmes at the South University) also highlighted the importance of professional attributes and academic abilities, and the importance of assessing these in candidates:

> *'I think what's difficult about it is that while you're assessing for values you're also assessing for a lot of other things and that's something that we've always discussed is that in the quest for assessing values we mustn't lose sight of the fact that we need people who are academically very able, we need people who communicate very well. We need a bit of passion and enthusiasm and we mustn't kind of lose sight of the whole picture.'* (Stage 2: South University: Academic Dietetics 23)

> *"I think it's quite important that we're not just looking for values in the recruitment process. I know they're telling us that we have to look for values but there's still other things."* (Stage 2: North University: Academic Midwifery 10)

> '*And someone who is intellectual, like knows their science, but also relatable. That it's one thing knowing the facts but being able to put that across and for the other person to understand it is useful.'* (Stage 2: South University: Clinician 59)

At the North University, the tension between VBR and the institution's ambition to recruit the most able academic students was evidenced in the higher grades of those accepted to study at the University:

> *"One of the university's key strategies is to increase [the UCAS] tariff. So, I know that from speaking to colleagues in the [health faculty] they feel a bit under pressure to continually increase tariff, but actually the tariff score isn't the full picture here. However, there is a balance between pushing up the tariff too high and actually still getting people who show the correct values."* (Stage 2: North University: Central Administrator 20)

> "*So, we could have a really good applicant, who really impresses everybody at interview, but if they narrowly miss out on their grade, if they ended up with, let's say, 2As and a B, they wouldn't be accepted; the last couple of years, they would not be accepted."* (Stage 2: North University: Academic Radiography 4)

Recruitment then was a balance between values, competencies for the profession, motivation, academic ability and communication skills. This was experienced by candidates who identified the importance of values alongside other qualities brought to a programme:

Student 1: *"I think what it is, if you're applying for this type of course or applying for a job in the NHS I think there's certain key words that are engrained in your head anyway, even if you've not been working in the health service. If I had ten pounds on me now I'd put ten pound on every one of us applicants saying the word empathy.*

Student 3: *And compassion.*

Student 5: *Definitely.*

Student 1: *And I know my ten pound would be safe, because I think there's just certain words, maybe three or four, sympathy, empathy, compassion, I bet every one of us in here said them three words in our interview."*

(Stage 2: North University: Student focus group Radiography)

"I was very much aware that they weren't just testing subject knowledge, they were looking for behaviours, attitudes, aptitudes, competencies." (Stage 2: South University: Student Dietetics 49)

Academic staff revealed professional attributes were open to interpretation and influenced by the professional agendas of programmes. An 'insider' understanding of the characteristics of a 'good' candidate for study of a professional programme was advocated by academic staff at South University:

"But yeah, I would prefer people from their respective disciplines to [interview], because it's those little nuances of why exactly someone wants to. You know, if we have a student who comes in and doesn't talk about women at all, talks consistently about patients and medical issues, and doesn't have any understanding of the idea of woman-centred care, or doesn't have any understanding of normality, you get quite a lot of applicants who come in and talk about how traumatic birth always is, and that's why women need midwives and you kind of think, mm, okay, alright. And I'm not suggesting that a colleague from mental health nursing or whatever would necessarily go along with that, but I think I would definitely want to draw out, like, where that's coming from." (Stage 2: South University: Academic Midwifery 15)

However, the 'insider' perspective was recognised as a challenge by service users on the interview panel as it was thought that this could create a sense of 'them' and 'us' that was not always conducive to a fair and transparent interview process:

"I mean the obvious example is those interviewing for midwives and, presumably, lecturers on the midwifery course have occasionally been a little bit snooty about general nursing intake and, 'well those candidates don't have to reach such a high standard do they' and 'we're only going to take the best of the pool' and so on.' (Stage 2: South University: Service user 36)

"The assumption was, service user, doesn't know anything, they're thick. But unfortunately, that might be a common misconception. These people should

be aware that they shouldn't be stereotyping." (Stage 2: North University: Service user 29)

At South University, interviews for a programme of study (regardless of method) were only undertaken by academic staff from that profession. So for example, whilst there was a nursing recruitment team comprised of an academic from mental health, children and adult's nursing to design the nursing interview format and structure, only academics from the field of nursing would interview candidates for the field-specific programme of study. This tension about who was best placed to assess professional attributes was also raised at the North University.

A consensus around a 'good' candidate across programmes (and universities) was broader than the values advocated by the HEE mandate. Tensions were apparent between members of the interview panel (academics, clinicians and service-users) with regard to who was best placed to assess candidates and which approach worked best.

There was only limited discussion by academic staff of the relevance of resources developed by HEE to support the introduction of VBR within their programmes or institution and to support recruitment processes. When discussed, academic staff raised concerns about the lack of available training, resources, and guidance from HEE in terms of how to implement VBR and, to ensure that the questions used for recruitment related to values:

"I think the downside I would still think is the question, the questions themselves. I know there is some sort of guideline as to how to set the questions but there needs to be better guidelines so that the questions are such that it's actually picking up the values. I know it's a challenging thing to do so, but I think Health Education England is to guide more in terms of having some guidelines, possible questions, possible scenarios, and things like that." (Stage 2: South University: Academic Physiotherapy 26)

"*[HEE training materials] it was just basically people talking about their perception of values-based recruitment. Like I say, I don't think there was anything. There are different packages and different things but nothing's really telling you. I don't know what it actually is that they're looking for and how to score it, which values and how you actually assess those values. I don't think there's anything really out there that tells us that. That's why we make our own."* (Stage 2: North University: Academic Midwifery 8)

HEE resources were rarely used instrumentally in the design of the recruitment approaches. There was also confusion about VBR policy and the tools that could be used, for example MMIs:

"What it [VBR policy] didn't do was acknowledge that they're all only tools and any one of the tools is flawed. [I went to an event and] I was talking to a colleague that I think trains paramedics and has a very small number of people. And they said, we just can't do this, we just can't. I said, what are you doing at the moment? And they were saying, well, we do one to one interview with two of us. And I said, what is it you assess the interview? And it was on values. We assess their motivation to work, their view of other people, you know, some sense of altruism. I said, but that is a values-based recruitment, the MMI is just a tool. And I really think that a lot of people didn't separate those two out. They saw the tool as being the values-based recruitment." (Stage 2: South University: Academic Mental Health Nursing 13)

Participant descriptions of the personal and organisational investment in the processes and tools used in each of the universities to recruit for values provided deeper understanding about how VBR had been implemented (and embedded). This resonated more than the policy argument or mandate with participants. It is to these processes and tools that we now turn. In particular, we consider their design, implementation and evaluation to promote standardised and transparent recruitment for values.

Operationalising VBR: How to assess for candidates' core values

Finding ways to assess candidates' core values was a key concern for academics, clinicians, and service users. This core set of values was viewed as an important foundation for professional study and development. Service users and clinicians highlighted the importance of assessing whether the candidates (and future health care professionals) demonstrated these values, particularly compassion. VBR processes were considered appropriate and sensitive by service users for determining compassion in candidates. Or as one student expressed it, distinguishing between candidates with values or "faking" it:

> *'You can't teach them compassion. And so, you know, when you feel that [compassion], the rest of the things can be learned. And they will develop according to their personality, their ability to withstand - but that's the same in any job, in any area of work that you do. So, you know, what I'm looking for, principally, is people who really care, and who will really work hard to do whatever they need to do, to put that care into place.'* (Stage 2: South University: Service user 38)

> *"The service users were involved because they would be the best people to tell from it, they can tell a fake from a real. For someone who's experienced health care, and that, they can tell who's genuine… and who isn't and who's saying what they need to."* (Stage 2: North University: Student OT 12)

Others were more sceptical of whether approaches for VBR enhanced interviewers' ability to assess values such as compassion. Concerns about a number of factors were expressed, including difficulties for candidates to express their values depending on prior exposure (or not) to health and care and their educational route which may offer advantages for some particular groups over others (such as school leavers compared to candidates applying after a break in study):

> "*And it's always very apparent how the different routes that people come, how much it influences their performance at interview. [I: Yeah. And that, I mean, that's a really interesting point that you raise, [VBR] is meant to offer equitable opportunity for people to be able to express themselves and their values, but I*

think actually, what you're identifying is…] No, it doesn't. The ones that have been in, had a good education, shine. And the ones that have had to sort of struggle through, and it's difficult for them." (Stage 2: North University: Clinician 44)

Concerns were also raised about 'rigidity' in assessing values that might result in the rejection of some candidates who may have developed these values through the education programme:

"And again, maybe it raises the whole question of can you actually ascertain the potential for compassion in someone who hasn't learnt the right words to say it yet? Because sometimes I'd rather someone came raw and working through some of these issues in their head and maybe said some of the wrong things, but for the right reason, than someone who just quotes the six Cs at you, because they've been in health care and they know that's what we want to hear. I think the first is more genuine. But I don't know actually we all appreciate that to the same extent and that worries me." (Stage 2: South University: Academic Adult Nursing 14)

"*Yeah, and the other thing is that, I've come across this before in another context, is, these aren't the finished professionals… It's about attitudes and values at the end of the programme, not necessarily what they come in with."* (Stage 2: North University: Academic Radiography 4)

These reservations were not held by students. They considered attempts to assess values at the outset as important as they helped to provide a candidate with the opportunity to reflect on their suitability for a future role as a health care professional:

"I think if you want people who think in a certain way or behave in a certain way it's good to make that explicit so that people can self-select initially and think, is this right for me? But also, they can be aware that those are the properties that they need to cultivate, and they need to showcase when they're being recruited. And I think it's good that, for example, in my interview I wasn't simply asked, do you have quality X? There was actually questions in

order to assess whether I had that quality rather than me just self-reporting it." (Stage 2: South University: Student Dietetics 49)

Methods of assessment were acknowledged by participants as challenging. Despite these challenges, MMIs were advocated by academic staff at the South University, and for some programmes at the North University. The delineating factor for academic at North University was the ability to choose other approaches – particularly for ruling *out* those who may *not* possess the required values:

"Generally, we're looking for good people, and good people are not actually that hard to find. It's weeding out the not so good people, who are not doing it for the right reasons, who genuinely don't care." (Stage 2: North University: Academic Mental Health Nursing 10)

Academic staff described the processes used to design questions for assessing values. This involved a process of mapping the interview questions to the NHS Constitution values, as well as looking to other programmes in the organisation for ideas that could be adapted for a programme. An important aspect of any of the VBR processes, but particularly MMIs, was the encouragement for candidates to engage in discussion. Sometimes using scenarios, photographs, video resources or news articles as prompts. The (not always realised) intention was to assess spontaneous or 'non-rehearsed' responses from candidates, which could reveal insights into their values and how these aligned with the values sought in future health care professionals.

"It will be the way they talk about working with patients and families, you know. Or there's a scenario, there's a couple of stations, not necessarily on the same circuit, but we have a couple of stations that have either a scenario that's somebody in a wheelchair or there's a picture, one of the picture ones is somebody in a wheelchair, you know. And it's not difficult, because they might say, well, you know, people in a wheelchair are different. It can be really quite obvious what people's values are." (Stage 2: South University: Academic Adult Nursing 1)

Whilst individual academics often suggested their professional programme had always recruited candidates/health care professionals on the basis of values, the process of designing questions for the range of methods used refocused the ways in which this could be assessed. Academics - with experience of the 'old' and 'new' approaches - perceived these processes as sharpening the focus on values that matter to patients:

> *"But no, definitely, the MMI questions are very, very clearly focused on the NHS values, in a way that the previous interviews weren't, in the same way. I think you pick up some of the same stuff, but definitely the focus is more specifically on the values."* (Stage 2: South University: Academic Midwifery 15)

> "*I think that we've, in physio, always tried to recruit in a similar way. I think we're just being much more overt about the words that we're using and how we're doing it now."* (Stage 2: North University: Academic Physiotherapy 5)

> *"So, I think I've been around, and been in the health service, long enough to see lots of things come and go in fashion. And I think it's [VBR policy] provided a structure, it's probably made it a little bit easier for candidates, because most people are asking the same question now."* (Stage 2: North University: Academic Mental Health Nursing 10)

Any assessment is only as good as the questions or scenarios used; sometimes, this was found wanting:

> *'If the scenarios are not right then it's a bit mickey mouse and doesn't work and it just doesn't test the values, and I think they, I would suggest that there are at least a couple of scenarios [name university] should go back and look at again, to rewrite the scenario to test the values that they are looking at, because there's no reason why they shouldn't look at that every recruitment round to be honest and just refresh them.'* (Stage 2: South University: Service user 36)

The introduction of VBR and the response of universities was perceived to have forced academics to consider more fully and be more openly transparent about the interview process and mechanisms used for assessing values. However, there were differing views among academic staff over the sensitivity of the recruitment process for assessing values:

> *'So, you have some text in an application that you've got to read, and then you've got an interview, and in our processes, we've got five minutes dedicated to values and it's threaded through some other things. It's very difficult to say that 100 per cent of the time that will result in a student who has all of those right values, getting in, or preventing someone who doesn't have them, from getting in, because in any selection process, there are always strengths and limitations of the processes, and so it's very difficult… There are always surprises, there are always times when, half-way through first term, you're like, gosh, that person's being very demanding, and not demonstrating the sort of behaviours that I would imagine a health care student should. And then they get to placement, and things arise on placement, related to values, or have values threaded through as an issue. So it's not 100 per cent fail safe.'* (Stage 2: South University: Academic Dietetics 22)

The VBR tool or process and the quality of the questions or prompts used for assessing values in candidates appeared more influential in terms of supporting the relevance of VBR for participants than the policy argument or mandate. The composition of the interview panel was considered important for sense-checking alignment of values that matter to patients and the institutions.

Enhancing the collective view about values through optimal interviewer mix

Programme interviewers across both universities and regardless of the tool or method used to assess values were a mix of academic and clinical staff and service users (aka "patient public representatives"). At North University, students on the programme were also involved in selection events for the physiotherapy and radiography programmes. Some programmes at South University hosted informal

events for candidates, allowing them to meet existing students on the programmes. At both universities, clinicians had been involved with recruitment prior to VBR, and at North University service users were also on interview panels prior to VBR. Partnership working was not entirely new but the more explicit focus on values was.

Academic staff acknowledged the HEE mandate meant service users being involved in some stage of the recruitment process of future health care professionals. At both universities, this involvement largely occurred in selection events. At North University, service users had the opportunity to engage in a range of activities associated with VBR, including open days and interview question construction. An approach supported by a member of academic staff:

> *"I think, it's having that involvement in all layers of it, not just in certain aspects. So, we can say they [service users] are involved in the open days, constructing the questions. They've certainly been really influential in evolving the process. So, they've commented on whether they think the mini interviews work better, and the impact seems to have worked really well, in terms of refining the process and having a voice in it."* (Stage 2: North University: Academic Service User 21)

There was a view among academic staff at South University that it was only possible logistically to engage the broader group of interviewers (clinicians and services users) with the interview day, rather than involve them in all aspects of the recruitment process. As such, this mixed group's knowledge and skills in interview panels were under-utilised. There was a view that the selection event content (all MMIs) was determined largely by academic staff:

> *"I guess in the ideal world we would have a whole team of people involved in the recruitment process and we'd try to come to some sort of shared understanding of what it is we're looking for. But the reality is the amount of time any person can give to that activity is limited and so, you know, other than a fairly modest briefing at the beginning of the session and perhaps a few lines in the information that we send out to potential interviewers, we just*

kind of assume that they know roughly what it is that will make a successful nutrition and dietetics student, you know. And then we ask them very much to work to the written guidance that, please use the wording the question is written, you know, or try and apply these criteria to score. Yeah, so that's, so it's very much, you know, they're trying to work to my view of what is the right, the sort of people we're looking for. And when I say my view, again it's something that [name academic colleague] and [name academic colleague] and I have kind of agreed on." (Stage 2: South University: Academic Dietetics 24)

Service users and clinicians at South University described themselves as "only involved" in selection events. They were able to offer feedback on the selection events through informal mechanisms, such as at the end of selection days to the academic staff or by email to the admissions lead for a programme. One programme at this case site convened a formal stakeholder meeting to discuss the interview questions and to review the interview process with the mix of people involved in the recruitment. Service users and clinicians did not always attend these formal meetings, preferring to use informal feedback mechanisms:

"But there is opportunity to say what you want, how you want, during the sessions, and afterwards. You do have access to the people, so it doesn't have to be something that you would comment upon immediately." (Stage 2: South University: Service user 38)

This picture was contrasted in North University where there was an appointed academic lead for service user involvement on health care programmes, including involvement in the recruitment process. Service users at this university were involved in formal meetings to review the recruitment cycles and contribute to the question or scenario development in order to refine the recruitment processes for subsequent cycles.

Regardless of level of involvement in the recruitment process, service users reported that they felt valued by academic staff for their contribution. They also highlighted the importance of their role in asking questions about core values and in 'scoring' the

candidates. This was a departure from previous interview formats at both universities:

> *"[Service users] talk a lot about feeling very valued in the recruitment process and feeling that they do have an influence on the shape of future practice really, because they're able to contribute to the selection of future practitioners. So, overall, and I think I'd be speaking strongly for the group, yes, I think it has worked well, for this particular facet of the activity, definitely."* (Stage 2: North University: Academic Service User 21)

> *"We were, you know, I was made to feel very valued and how our input was important, but I guess because we're not supposed to give, our station feedback is not academic, it is purely on how they made us feel as a patient and our patient experience."* (Stage 2: South University: Service user 64)

There was a general held view across participants' groups that having this mix (including a service user) added a *'richness to the assessment process'* (Stage 2: South University: Academic Dietetics 23) and MMIs and also provided a *'safer'* mechanism for recruiting individuals with the right values to study as health care professionals:

> *"Safer in terms that we're getting more likely to get the right people and screen out those who aren't. I feel this is better in that way because I think it's more intensive, it's more focused on the individual. People can't just go under the radar by neither being terribly bad or terribly good. But in a group [interview] they could I guess because they didn't say a lot. What they said was vaguely okay, but they actually didn't say anything that really raised alarm bells. But that could be pure chance. While this feels much more robust. If somebody genuinely was not cut out working in the health profession, you'd pick it up because of that intensive one-to-one conversation, multiple times for different people."* (Stage 2: South University: Academic Adult Nursing 14)

Service users were unanimous in the view that patient involvement in the mix of interviewers was crucial for selection of future health care professionals:

> *"I think, the multiple disciplines, collectively, in the main space, they're all looking at each candidate from a different point of view. All of it, all of the approaches are based on their own life experience, be it academic, or actual practical nursing, or whatever. And I think that the collection of thoughts, you know, collective thoughts, and distilling them into an overall mark, is a very fair way of doing things."* (Stage 2: South University: Service user 38)

The mix of interviewers for the MMIs was advocated as promoting the importance of partnership working and demonstrating this to the candidates. Most candidates positively appraised the MMI process and the mix of interviewers:

> *"I thought it was quite nice, because you get five chances, like, maybe I'm going to like you better, maybe you're going to like me better. Rather than just one…Like, if you don't get on with that one person, you know, but five, you have five chances. That's what I was thinking in my head, I was like, it's fine, just move onto the next one."* (Stage 2: South University: Student Dietetics 41)

Other VBR approaches were also considered important for 'showcasing' the health care programme, but these approaches were often part of a series of activities associated with recruitment. For example, at North University, academic midwives described the benefits for candidates of spending the day at the University which allowed candidates the opportunity and time to assess whether the programme and University were the right place for them to study.

Problems associated with maintaining the same interview panel (regardless of interviewer mix) were evident in individual panel interviews at North University. It was thought different interviewers could reduce consistency of values assessment. Despite the challenges, the recruitment team tried to ensure the same panel members were used where possible – although there was no formal evaluation of "consistency" in group judgements:

"And also from an academic's point of view we have a core group that actually interview, and we started that up about two years ago because I was finding that if anybody within nursing interviewed we wasn't getting core values, with everyone looking for different things. So, it helped to have a core group, so everybody was coming from the same song sheet in that concern." (Stage 2: North University: Academic Adult Nursing 6)

Service users had a range of motives for involvement in the recruitment process. All were patients wishing to ensure their perspective was incorporated into the selection of future health care professionals, as well as wanting to contribute to ongoing education and development. Many of the service users involved in the recruitment processes were recruited from a 'professional' pool of service users and were engaged in recruitment, education and continuing professional development across university and NHS sites. This was considered a strength by service users. Some academics though were sceptical of the value of 'professional' service users and questioned if these were the right group to be involved in recruitment; without offering any alternative to current arrangements:

"So, they are patients, they are service users, they have got health experience but they're almost all professional service users. I don't know if that's the case somewhere else, but their service user status is part of almost their employment and I don't know, are they the right people?" (Stage 2: South University: Academic Dietetics 23)

Clinical staff were engaged to assess the motivations of candidates for a role as a health care professional. Engagement of clinicians was viewed as key because of their important role in the support of students in practice and because they also possess current experience of working in the NHS; something many academics lacked:

"I think it gives a really nice perspective on whether it's someone they would want to train, whether it's someone they would want to work with, whether it's somebody who can demonstrate the qualities that we're looking for in

dieticians; I think that works brilliantly." (Stage 2: South University: Academic Dietetics 60)

"And the question was, why do you want to become a dietician and what, I think it actually even said, this is not word for word, it's something like, "what values or skills do you have that make you think that would be useful to be a dietician?" [I: Was that a good question for you to be given, do you think?] I think it was because I understand what you need to be a dietician because I've been a dietician for about eight years now so I do have a deep understanding as to what sort of skills and things that you need to be a dietician so I think, yes, definitely that's a relevant question for me to be asking." (Stage 2: South University: Clinician 68)

An unintended benefit of the introduction of MMIs for one of the academic departments at South University was enabling non-professional members of academic staff to engage with recruitment. Something considered difficult in the previous interview-based recruitment formats.

A mix of interviewers was seen as important for recruitment processes. We explored how this had been measured and its potential influence or impact. Our analysis of mean scores of students interviewed at different MMI stations (n=5) by different types of interviewers – including academics (n=12), clinicians (n=7), service users (n=4) and a clinical academic (n=1) - revealed little discernible effect on mean scores of student values (Figure 6). This analysis was conducted for one programme (with small numbers) at the South University but does suggest the possibility that a mix of interviewers may not be as crucial as perceived cannot be ruled out.

Figure 6: Summary of stations for one programme's MMI by interviewer role (*mean score ranges from 0-10 with 10 being the highest possible score)

Station	Interviewer role			
	Academic (n=12)	Clinician (n=7)	Service user (n=4)	Clinical academic (n=1)
	Mean* (SD)	Mean (SD)	Mean (SD)	Mean (SD)
1 content	7.15 (.27)	7.05 (.34)	7.17 (.27)	6.92 (-)
1 communication	7.43 (.51)	7.54 (.54)	7.57 (.29)	8.08 (-)
2 content	6.02 (.54)	6.02 (.66)	6.02 (.41)	5.00 (-)
3 content	6.13 (.49)	6.05 (.60)	6.08 (.16)	5.92 (-)
4 content	6.91 (.49)	6.80 (.73)	6.95 (.33)	7.92 (-)
5 content	8.07 (.89)	8.25 (.90)	8.18 (1.14)	8.00 (-)
5 communication	7.98 (.98)	8.25 (.98)	8.09 (1.19)	8.50 (-)

The challenges of mixing interviewers

Academic staff raised concerns about service user contributions to selection events. This was particular to South University and the use of MMIs, where service users were considered to not always to keep to the brief for the interview question. Some academics indicated there was a need for checking of scores provided by service users because this "deviation from the brief" could influence scoring. Service users also noted this as an issue and raised their lack of training to prepare them for their role in interviewing. Some clinicians expressed concerns about their confidence in conducting the MMIs:

> *"Inexperienced or incompetent interviewers, in a panel situation, can be carried and can learn from other panel members. Where if you're thrown in at the deep end, on your own [MMI], you're struggling... I don't know what experience, or training they'd had but the organisation seemed to have missed a trick in defining a sort of standard or expectation of its interviewers. Because it's the MMI process the interviewer can get away with that, not get away, well yes, get away with it or remain at that low level without being picked up."* (Stage 2: South University: Service user 36)

> *"I think at the beginning, one of the ladies that was interviewing said, oh, you know, they're really very nervous, so give them a couple of seconds to kind of*

get their breath. And I thought I'm really nervous, I'm probably more nervous than they are. Because obviously, I wasn't sure what to expect and all I kept thinking was, gosh, these girls' careers are hanging in the balance of my hand, and I just want to make sure that obviously you do give people a good chance." (Stage 2: South University: Clinician 65)

There was wide variation in the ways in which external staff were prepared for their role on the interview day. Academics recognised the importance of ensuring all interviewers were prepared and trained for their role on recruitment panels to: (i) promote consistency and transparency of the process; (ii) enhance the student experience; and (iii) fulfil any legal requirements for documenting the interview process to comply with any request under the Freedom of Information Act.[9] However, it was also recognised that the requirements of the university had to be balanced with reasonable expectations of time commitment for these external interviewers and costs for individuals and organisations. Differences in training of external partners were apparent at South and North Universities:

"I mean now of course training people has implications in terms of, are you able to get everybody together to train them? What's the cost implication of that to the department running the interviews, and not only to the university, to the individual who's coming?" (Stage 2: South University: Academic Physiotherapy 26)

"Yeah, once we've devised and worked out the questions and the process of the interview then there will be some training sessions set up for the service users and for the clinicians that are coming in from practice, recognising that they don't do it as much as we do so we want to give the candidates the best shot we can by making sure everybody's as au fait with the process as possible really." (Stage 2: North University: Academic Child Nursing 3)

At South University, external interviewers were briefed in writing and supplied with an information pack prior to the interview date. Some clinicians indicated that they

[9] https://www.legislation.gov.uk/ukpga/2000/36/contents

found the volume of information too much to digest before the interviews given clinical commitments. A briefing meeting was held on the day with the admissions tutor for the programme – an opportunity valued by external interviewers. Some clinicians requested the opportunity to observe some of the interviews prior to taking on the interviewer role. This ensured support for the role of the external interviewers for the recruitment processes. But the lack of preparation for the role was a concern, in particular when assessing candidates alone at an MMI station. Some clinicians raised concerns about their lack of preparation for and understanding of the recruitment process, highlighting that VBR was not commonplace in the NHS:

> *"To be perfectly honest, I didn't know that this was values-based recruitment. It was just information that I got from my colleague who said, "oh, they're interviewing for the undergrads, do you want to go?" I went in blind almost, so I didn't know what to expect. And I think even when we were there it wasn't really emphasised that it was a values-based recruitment process. I've not really used that; I've not really heard that terminology before and not in the clinical interviews that I've been involved in either."* (Stage 2: South University: Clinician 63)

Academic raised challenges to mixed engagement included funding, the logistics and organisation of interviews and training for external interviewers. Service users were paid for the time on interviews. This was an additional cost for academic departments laid squarely on the HEE mandate. Clinical staff often became involved as part of their role (supporting students when on clinical placement) and contractual obligation, or personal interest and motivation:

> *"Well I, for many years have volunteered really to help with the interviews just because from a sort of ongoing professional aspect of my role I suppose I feel it's important to invest some time and energy into the pre-registration workforce and over that time they've changed the way that they do the interviewing at the university."* (Stage 2: South University: Clinician 27)

Many clinical staff at South University engaged with the recruitment process in their own time. At North University engaging clinicians, with MMIs in particular, was

difficult. Lack of payment of clinicians for their time, and a lesser emphasis on contractual obligations, created problems for the running of the selection days and MMIs when clinical staff withdrew at the last minute due to competing priorities:

> *"People who help us do the recruitment are doing us a favour. As I said, those are the clinicians who come and interview for us, are either doing it because they're interested. Very few, I think many of them, are doing it in their own time. Though you would hope, in an ideal world, the Trusts might think that us recruiting good people to come on the course to ultimately be their employees and be something that they might invest in. But that isn't how it is anymore. I think everybody is really strapped for cash. So, we have a teaching contract with one of the Trusts, and they do provide some staff through that teaching contract."* (Stage 2: South University: Academic Physiotherapy 18)

> *"We would like to involve clinical service more, but they're a little unreliable, so often they'll say they're coming, and then you'll get a phone call in the morning, or an email, to say, sorry we're too busy, we can't make it. And then that leaves you an interviewer short, and you can't really run it with being an interviewer short. So that's problems in some management of it [the MMI].*" (Stage 2: North University: Academic Radiography 4)

While admissions teams supported the organisation of the interview days, academic staff expressed their anxieties related to the running of the day. Failure of one panel member to not make the interview day could create problems, particularly for MMIs as these required a minimum number of individuals to be in place at each station. Involvement of service users was considered crucial but there was also concern when these members of the interview panel had to withdraw at short notice:

> *"There is a rolling burden of organisation, so you're working with service users, they're not academic members of staff, they get poorly, they tell you at the last minute, that they can't come to this interview session, and that sort of thing. So, there are challenges with involving service users in the interview process itself, and that's difficult to overcome. But I think that's a small cost to*

pay, to involve service users in the process." (Stage 2: South University: Academic Dietetics 22)

Strategies for managing the lack of patient representation were described but these 'back-up plans' often meant that an academic or administrative member of staff would stand-in for a missing clinician or service user which limited the 'optimal mix' on the interview panel.

A myriad of tools and processes to assess values

A range of tools and processes had been developed across health care programmes for assessing values. The format and overall structure of the tools and processes used for VBR at the two university case sites varied: at South University there was universal use of MMIs but at North University different tools and approaches were used across the programmes (described in detail above). Academic staff raised concerns about how best to measure and score values as well as questioning whether everyone involved in the interview process had the same understanding of the preferred values. Service users also raised concerns about the range of approaches used for VBR at North University:

"Some of the feedback we've had from service users is, why doesn't everybody use the same process. If you're looking for the same values, why can't you do the same process, but I think, what's happened is, people will align them to the process they feel most comfortable with." (Stage 2: North University: Academic Service User 21)

Where a standardised tool such as MMI was used (for example across programmes at South University and for some programmes at North University), there remained variations in implementation across different programmes. The number of stations used for MMIs was typically 5. At each station, a different question was asked, not all questions were focused on values and not all programmes had a consistent first question. For example, at South University, the MMI format for physiotherapy interviews had a consistent first question at station 1 (of 6). This it was believed would put candidates 'at ease'. Candidates then rotated across 5 stations, returning

to the first station for the final question. However, the MMI structure for dietetics did not have the warm-up question, so depending on the station the candidate started at, they could be faced with *either* a scientific question or a question about their values:

> *"I wasn't there when we had the debates of how to do it [MMI structure], but my understanding is because we want to have the same interviewer for each question, we decided that it would be just done in rotation. So, if you start at station four you have question four first."* (Stage 2: South University: Academic Dietetics 62)

Some concerns were also raised by academic staff that this was inequitable for the candidates: depending on whether the first question was scientific (i.e. "harder") or "softer" in focus may have had the unintended consequence of disadvantaging some candidates.

Criteria used for scoring candidates also varied across health-related programmes (and MMIs) at the South University. For nursing and midwifery programmes, candidates were assessed on the content of their responses. For allied health programmes (including physiotherapy and dietetics), candidates were scored on both the content of their response to a question and some questions assessing values were also scored separately for candidate communication skills. The rationale being to distinguish the quality of the response to a question from the articulacy of the candidate and to assess confidence in communications skills:

> *"I think if [a candidate's] very good at talking, and they're likeable, then [interviewer's] could end up giving them a fantastic score. So, I thought if you gave [interviewers] the opportunity to think, content this [score], but they were fantastic at communicating, that might slightly stop that sort of nonsense."* (Stage 2: South University: Academic Physiotherapy 18)

> *"So, there was two [scores], one was for communication and one was for content. So, one is the whole, yeah, body language and how they answered the question with their verbal communication skills, and then the other was the actual content of what they answered. And some, yeah, I'd say there was*

differences between the two actually; that some people could answer very well but the actual content wasn't there, or vice versa, that they were struggling maybe with English or putting the sentences together, but the content, they'd clearly done a lot of reading and extra work." (Stage 2: South University: Clinician 59)

As well as the split between content and communication, there was discussion (mostly among academics) about scoring used within MMIs; again, this varied between different programmes within the South University. The allied health programmes scored "out of ten" for each MMI question; a range considered to enhance the process for ranking candidates and offer-related decision making. Other programmes (nursing and midwifery) used a smaller number of four categories and a binary distinction between a candidate being "good" or "poor". An unintended consequence was that some interviewers created a "mid-range" score, ticking between the boxes:

"I want the MMIs to discriminate between the right and wrong candidates. I mean, an assessment process should be discriminatory. It shouldn't be prejudiced but it should discriminate against, discriminate according to the criteria we're asking you to discriminate. So, are their communication skills poor or good? Is the demonstration of their value poor or good? I don't want okay. I think okay's meaningless in a way. And then you find some people who will mark on the line rather than either box, or they'll put 2.5 and make up their own criteria, even if you've asked them to follow a particular pattern." (Stage 2: South University: Academic Mental Health Nursing 13)

Service users had mixed views about the smaller number of options to score candidates for the nursing and midwifery programmes. However, they frequently made use of the open comments box to clarify or justify their score:

"Even when I put an outstanding sometimes there's that bit more you want to add and just think, you know what, this is someone that I'd want to nurse me. Other times an outstanding candidate is an outstanding candidate and you don't necessarily feel the need to give more. However, I think certainly if

you're giving a poor or a satisfactory you need to explain why for the admissions team because, you know, it's a fair process and I'm sure they don't just disregard everybody that's got a poor or satisfactory, I'm sure they look at them in detail. So, it's nice to explain what my reason was." (Stage 2: South University: Service user 64)

Variation of scoring was highlighted not only as a problem at South University: similar problems were also noted at North University and across the different approaches for recruiting for values. Scoring values was considered inherently difficult, without a wider range of scores there were concerns that this diminished the process and its purpose:

"*I think we need to broaden the range of scoring, at the moment I don't think it allows for enough difference between what is an average answer, and what is a really good answer.*" (Stage 2: North University: Academic Mental Health Nursing 10)

"One of the things that did come up on the evaluation, that I do remember without having gone through a lot of the information recently, was that they felt any scoring system could perhaps be a little bit more expansive. That, perhaps, there weren't enough categories to accommodate the different levels of responses, so that it wasn't sensitive enough. I think that's basically what they were saying." (Stage 2: North University: Academic Service User 21)

Prompts (regardless of process used across programmes and universities) were provided to guide the interviewer when asking their question and when scoring the candidate's response. This was to promote consistency and transparency within the process but there were varied views on whether this was achieved:

"Yes, it is more standardised, I think. Purely from a basis of, it's very standardised about the questions that we ask, the way we ask it, the prompts that we give. On paper, at least, that's standardised. They're not recorded. So, we never know, I don't know, what so and so in the next booth is actually really saying, whether they're sticking to the question, or whether they're

going off on a bit of a tangent. I'm aware of situations where interviewers have gone off on a bit of a tangent with students. That's been dealt with. So, I think it is more standardised, definitely, but you're still dealing with that subjective thing of, that's two people having a conversation, and you can't standardise their answer." (Stage 2: South University: Academic Midwifery 15)

"They do give you prompts, which I think initially was really helpful because, if I'm honest, when I first got the question, because I was quite nervous as well, I'd never done it before, I kind of looked at the question and just blanked in terms of what I would be giving as an answer, as a dietician. But obviously once you then looked at the prompts and you realised. So, I think having the prompts there really helped in terms of prompting the people you were interviewing, as well as obviously yourself, in terms of what was a good and not a good answer." (Stage 2: South University: Clinician 65)

It was generally perceived that the use of prompts encouraged interviewers to be reflective and more responsive to answers given by candidates. Where an interviewer considered the candidate's response appropriate but not covered by the prompts there was an opportunity to discuss this with the admissions tutor during the break between interview sessions. This enabled a process of 'moderation' to occur (between interviewers and the admission tutor) and helped to ensure that a candidate was not scored low simply because their answer did not adhere to the prompts:

"And there's a bit of guidance about how students should be marked, based on written, indicative content. But it's very much along the lines of, this is what we would expect, so if somebody says something that you didn't expect, but you thought was a fantastic answer, a brilliant piece, then appropriately and vice versa, if they need a lot of prompting, and they don't mention any of the points on here, and you don't think it's relevant, then you need to reflect that in your mark of the candidate as well." (Stage 2: South University: Academic Physiotherapy 25)

In these circumstances, interviewers were requested to provide written notes for the underlying rationale for their score and the responses of the student that they considered good but not within the list of prompts. Further examples were given about the importance of written notes as these could prove helpful when trying to make decisions about offers to candidates:

> *"So, for example, we had the student today who really struggled, so the comments on her box would be then linked very much to her specific situation, which is going to be really important to me when I'm looking through the 'in between' [candidates], the ones that we're not sure about. Because there's somebody we would consider, and somebody that perhaps you wouldn't consider, based on those comments."* (Stage 2: South University: Academic Dietetics 60)

All programmes made their decision to offer a place of study to candidates on the basis of performance and ranking on the interview day, including performance on numeracy and literacy test scores (where used) in combination with interview performance. Any information provided at application stage was not considered for most of the offer decisions. The only exception was where the number of remaining places were limited, and choices had to be made about which candidates should be offered a place. In these circumstances, various strategies were deployed by admissions tutors to make decisions in (quite often) pressured time scales to comply with UCAS deadlines. In some departments this involved consideration of whether there were any questions where candidates had scored particularly poorly and changing the weight associated with these questions. Alternatively, the admissions tutor referred to the application form to make a decision based on criteria that could be used to 'weight' the applications (but these criteria were not necessarily about values):

> *"The only time that their past experience might impact on selection would be if we had seven people on the same score, and only one or two places left. At that point we would go back and look for things that we would consider positive. And that usually is people who've worked as a health care assistant, paid employment as a health care assistant, would be one of our ways of*

trying to open up access, that sort of thing"' (Stage 2: South University: Academic Physiotherapy 18)

When asked to compare scores and rankings generated by the varied VBR interviews with previous panel interviews, some academic staff reported that the process had not enhanced or made decision making easier. However, from the processes described, the MMI appeared to minimise the manipulation of scores by panel members and arguably saved time for the admissions tutor.

A systematic and standardised approach for screening and selection

VBR requires consistent and systematic screening and selection of candidates based on their values for a programme of study. The variations in approaches between programmes within universities (including variations for undergraduate and postgraduate programmes) and between universities means this was not achieved.

Whilst values formed part of the screening process for "competitive" programmes (such as Midwifery, Children's Nursing or Dietetics), this was not the case for all. It was clear that there were a wide range of other factors, other than values, influencing which applicants passed the first screening prior to being invited for interview. Application screening at both universities was undertaken by the central admissions team for undergraduate programmes. Criteria were developed by academic staff to support the admissions team with this process, of which values may or may not be included. For example, at South University criteria for assessing the personal statement of physiotherapy applicants explicitly listed some NHS values (such as compassion) and others closely aligned with NHS values (including teamworking, or interpersonal skills). These criteria enabled the ranking of applications which informed decisions about whether or not to invite the candidate for interview. An important criterion related to 'widening participation' as well as offering an opportunity for these candidates to be interviewed:

"Well, I mean generally, if the values are absent or poor, we still wouldn't take them, but what does sometimes happen, and has happened in the past, has happened this year in fact, that students have been marked as Widening

Participation students, and we have said, actually we don't think those students are suitable and it's gone up to Widening Participation, and they've come back and said, can you reconsider? Can you have another look at this, and see whether there's a way of getting the student onto the course?" (Stage 2: South University: Academic Midwifery 15)

Working with the admissions team was viewed positively, although academic staff commented on turnover within the teams and therefore the need to ensure admissions staff were sufficiently briefed regarding their specific programmes each year. Systems were in place to support the admissions team to liaise with the admissions tutor about any applications they were unsure of; particularly related to students from differing educational backgrounds and not possessing A Level qualification. Applications were scored and ranked in order and the number of places for interview offered for those scoring most highly and then in descending order:

"But we, you know, we believe that we have enough interview places that most of the people who are likely to be suitable will get an interview place and then we'll just weed them down from there. So, we aim to interview 90 undergraduate applicants and we made about 55 offers this year to get the, you know, the 24 or 25." (Stage 2: South University: Academic Dietetics 24)

Further scrutiny occurred once A Level results were available. Some programmes (especially those that were highly competitive for available places) avoided the UCAS clearing system. Other programmes (such as adult nursing) recruited via the clearing system with candidates subjected to the same recruitment process and tests.

For postgraduate programmes at South University, application screening was undertaken by the admissions tutor. An academic raised concern that this process for screening post graduate applications meant that 'good' candidates were not always offered an interview:

"…some slip through the net by not even getting shortlisted for interview. And I find it very hard doing the shortlisting, especially when I'm running out of spaces and there's a few really quite good candidates and I've only got a certain number of spaces left. But it's very difficult really. [I: Are there any key things that tip someone into the pile of being interviewed?] Well, I suppose if you've got someone who's outstanding academically who's also got a really good personal statement then, yes. But, to be honest with you, I believe even with that huge number of candidates not ever so many fit into that really oh yes, they're obviously going to be shortlisted. There's quite a few who it's actually really hard to distinguish, as in they're all good, but which one is better." (Stage 2: South University: Academic Dietetics 62)

Academics highlighted ways in which candidates could 'influence' shortlisting of their application. Criteria were used to score academic achievement (including completion of a research module for the postgraduate programme), personal statement and references. The scores were used to rank applicants and then either offer an interview or decline the progression of the application. This was at the discretion of the admissions tutor:

"When we get to the interview, how many people we choose for interview, so we have their profile and then we have a score for references and a score for personal statement. You can add those scores together, I think we weight the references slightly less than the personal statement, and people who are very, very bright, are the first usually. If they've scored very well, they will get an interview." (Stage 2: South University: Academic Physiotherapy 18)

"But I think we just have to accept that it's essentially a screening process, and essentially you're going to get false positives, and invite some people for interview, and think, actually they're terrible, we shouldn't have invited them, and we're going to lose people." (Stage 2: North University: Academic Radiography 4)

At interview, the sensitivity and specificity of MMI as a "test" for the "right" candidates for clinical roles were not evidenced. The perception among participants was that

MMI would identify candidates unsuited to a health care professional role and prompt their rejection. Analyses of data from nursing programmes at one case site did not substantiate this. The proportion of candidates rejected was very small and of those rejected only a few (1% or less) were on the basis of the MMI score alone (see Table 5).

Table 5: Probability of rejection based on MMI performance at South University

		Reason for rejection			
Programme	**Interviewed n**	**Literacy & MMI n (%)**	**Numeracy & MMI n (%)**	**Numeracy & Literacy & MMI n (%)**	**MMI n (%)**
Adult Nursing (BSc)	955	3 (0.3%)	5 (0.5%)	4 (0.4%)	7 (0.7%)
Child Nursing (BSc)	298	2 (0.67%)	0	0	0
Mental Health Nursing (BSc)	181	0	0	1 (1%)	1 (1%)
Midwifery (BSc)	348	3 (0.86%)	1 (0.29%)	3 (0.86%)	2 (0.57%)
Nursing (PG Dip)		0	0	0	0

Alignment and engagement

Attracting potential applicants was a minimal part of VBR-based processes described. When mentioned, a perceived lack of national initiatives supporting recruitment and unsympathetic university marketing processes meant opportunities to promote alignment of potential applicant and organisational values were lost. There was scepticism among academics of allied health programmes of the added value of amending materials for attracting students to these programmes due to their existing [high] reputation and desirability:

> *"We're such a small discipline, if you've done a degree in nutrition, you're going to apply to [name] to do your dietetics, so it's absolutely not changed. I don't think anyone's looked at it [programme materials], and thought, you know, I don't have good values, so I'm not going to apply. I don't think that's had any difference whatsoever, in terms of who we attract."* (Stage 2: South University: Academic Dietetics 22)

We reviewed promotional materials for the health care programmes across the two universities. Each health care programme had a webpage, programme guides or specification documents. There were wide variations in the presentation of values in these promotional materials. Most were not always explicitly linked to NHS values. Academic staff highlighted the importance of values in programme brochures – even though our documentary analysis revealed this was limited - and at recruitment events:

> *"So, it's not just about, you know, having a job, it's about having a job that suits you, that suits your personality, that suits the kind of, your temperament, you know, and that kind of a thing. So, we make them [values], we make it abundantly clear to them through that."* (Stage 2: South University: Academic Physiotherapy 26)

Events such as open days were viewed as important for outlining the realities of being on a programme leading to registration as a health care professional. This included registered students being available to speak at open days, highlighting the importance of clinical practice hours and shift work, the extended study periods compared to other degree courses (because of clinical placements) and having a realistic understanding of clinical work.

Academic staff raised concerns that centralising recruitment processes was limiting their involvement in promotional events. Consequently, it was also limiting opportunities for them to credibly highlight the importance of values in the future health care workforce. Potential recruits with no health care experience were perceived as acquiring early ideas of the realities of the profession through social media, particularly younger candidates.

Recruitment provided an opportunity for candidates to express and discuss perceptions and motivations for enrolling in a health care programme – as well as a chance for candidates to self-select out of the process:

"So, values-based recruitment isn't just about trying to assess the values in others, but say this is something we care about, we're inviting you to also care about it. And hopefully, if people come along and think what on earth is this, or why are you asking me this, this doesn't relate to me, then they might not choose nursing as well. But I think the idea is about trying to get the best fit for people. And the idea of assessing values to do that, it's hoped, will rule out those folks who aren't suited to sustaining a delivery of nursing." (Stage 2: South University: Academic Mental Health Nursing 13)

"*We know it's a tough course and we know it's a tough profession. We don't want to lose students, so we are very clear, and I try to make it as clear as possible. I always say, I don't want to put anybody off, however you've got to think about the fact that you might be travelling, you're going to be working 12 hour shifts, you're going to be working weekends and it is tough. So, yes, we get that in as well and what it's like doing the job and sometimes it's nice fluffy bits but for us it's not all about birth. You've got your antenatal and your postnatal. It's not about cuddling babies. It's very often that you don't cuddle babies. So, we do try and say it as it is, but we do try and get these values in as well.*" (Stage 2: North University: Academic Midwifery 10)

The two-way social interaction between interviewer and candidate – particularly in MMIs - was valued by academics as means of showcasing the programme and importance of partnership:

"And it comes back to that thing that values-based recruitment, if we want to get it right, to my mind, is more about how we demonstrate our values in recruitment, not how we assess them in others." (Stage 2: South University: Academic Mental Health Nursing 13)

"I was just thinking there as well it was really important about our recruitment processes in particularly the MMI day is that it is a two-way process. I think that's something that's very important is it's not about them just coming and being assessed by us, it's a real opportunity for us to give those candidates a lot more information about the programme and our expectations of being a

student on that programme and I think that's really important." (Stage 2: South University: Academic Dietetics 23)

Interview panel composition was seen as a way of demonstrating the values of programmes and institutions. Involving lay people and clinicians was perceived as an important mechanism for candidates to recognise the commitment of programmes and institutions to collaborative working in health care. The promotional effects of the interview process were perceived as influencing a candidate's decision over whether they decide to study at the institution:

"But what I think works, what's really good about the MMIs that we run here at [name] I think is that it showcases our values to the applicants as well. So it's about how we welcome them and greet them, but also it's the things, like, the fact that they will be interviewed by service providers and they will be interviewed by a service user as well, so they can really see that it is a partnership working… So, an opportunity to get a flavour of the university." (Stage 2: South University: Academic Adult Nursing 1)

The involvement of service users was appraised positively by candidates:

"You know, 'cos the person who's been a patient, they might not focus so much on the academic side of things but they'll pick up have you got the compassion, the way you speak, do you sound like someone who's reasonable, you know." (Stage 2: South University: Student Nursing 58)

It is important to highlight however that this was not considered important by candidates when describing choices. Candidates applying to a range of health care programmes explained their motivations for a range of reasons: the international research profile of the university and its staff; varied programmes of study in health and medicine; links with large teaching hospitals; good employment record for graduates; student satisfaction; the facilities and age mix of the cohort:

Student 1: *They're supposed to be one of the top [universities], especially with dietetics. A lot of people that I know, and end up working in similar industries, if you go to [names university], you know, you're not going to struggle finding a job, and things like that.*

Interviewer: *So, it has a good reputation, and that sort of fitted with the practical side of it?*

Student 2: *Yeah.*

Interviewer: *How about you two, do you agree, was it its reputation, or were there practical sides?*

Student 3: *A bit of both, the reputation and the fact that it's got such a huge medical community as well, so I thought, well, coming to do dietetics in such a big medical based university, we might get some advantages through that somehow.*

Student 2: *With the research and stuff.*

Student 3: *Yeah…*

Student 1: *But then, I was thinking, if someone said, I went to [other university], and then someone else said, I went to [name university], I would be like, oh [X], not [Y].*

Student 2: *You see [name university] all the time in the newspapers.*

Student 1: *And the lecturers as well, if you look at the lecturers here, they're like, research, research, research.*

Student 3: *They're all doctors.*

Student 1: *But, if you look at the other places, no, they've done like maybe two papers, or something. So, you're thinking, I want people with good knowledge that's up to date. So that's why.*

(Stage 2: South University: Student focus group Dietetics)

For other candidates, the choice of university related to their personal circumstances:

> *"I chose [name university] because I'm from [name city] originally, and for me to move out, it's just to do with finances really. My job is here, I work here, and if I was to go away to [name another] University, I won't have stability with my finances."* (Stage 2: North University: Student Midwifery 32)

Interview day formality varied across programmes. Whilst MMI processes were structured, run in almost exam-like conditions, variation was very apparent. Some programmes hosted 'ice breaker' or 'open' events prior to the MMI as an opportunity for candidates to meet staff and current students as well as tour campuses. These provided reassurance for candidates on how MMI process would be conducted. Other programmes focused on ensuring sufficient time post-MMI for candidates to look around and meet people. At North University, where a range of VBR processes were deployed, these informal events were staggered around the formal interview process.

Promoting 'fairness', 'objectivity' and 'equity of opportunity' for candidates

Participants identified that VBR processes should promote fairness, objectivity and equity of opportunity in assessment. These were key motivational factors for individuals involved in these processes. Participants recognised that any interview has a degree of subjectivity; and that interviewers often rated candidates they 'liked' or judged 'like us' more highly. However, MMIs mitigated these biasing effects by involving multiple interviewers and (relatively) transparent processes:

> *"Because I think every recruitment process where you have people making decisions, there's an element of subjectivity, even when you have very clear criteria. It's still about human beings making decisions, and it just makes it more objective if you have clear criteria, clear prep and clear briefing amongst the people doing it."* (Stage 2: South University: Academic Adult Nursing 14)

> *"It seems to me to be fair and quite balanced because you've got chances to shine in different areas and you've got different people viewing you in all those... That's the beauty of it, I think. Because then I think it's fair because when all those are added up, you know, they'll, you've got a better rounded understanding, or may, you know, because maybe the person I thought was outstanding and I would have maybe let through if I'd had an hour interview maybe it wouldn't be great, or the person that I thought they were poor was not very fair, you know."* (Stage 2: South University: Service user 64)

Previous interview panel formats used by programmes at South University (candidates assessed by single academic and clinician for 20 minutes) gave prior sight of candidates' application forms. Panel members had information about individuals assessed in advance of the interview – something that could disadvantage some candidates. Interviewers at MMI stations were not provided with information about candidates. They were asked to assess solely on their answers (and performance) at each station:

> *"So, once they have been selected for interview, everything that's gone beforehand doesn't count anymore. So, we literally then score them on their interview."* (Stage 2: South University: Academic Physiotherapy 18)

> *"You know, with the MMIs, we don't have any type of information how old the people are, what have they studied before, do they have family or kids, or anything about their private background. You don't know nothing. And that's quite good because you judge what you get on the day."* (Stage 2: South University: Clinician 66)

Individual panel interviews at North University for nursing consisted of three values-based questions with the panel not accessing the application form. Ignoring application forms at interview was valued by candidates at both HEIs:

> *"So, once you're there [at interview], it's literally you as a person, and it's not about like your history and what you've done. I think it's very good because they sort of, they still obviously want to know your experiences and what you've learned and stuff, but they're not just interested in what you've done. I think that when you get to that interview process, you've got just as good a chance as someone who's from one of the top, top unis and who's got four A stars and stuff, because they're looking at other things."* (Stage 2: South University: Student Physiotherapy 79)

The change in the recruitment process addressed inequalities arising from previous recruitment methods:

"*Permit me to say it's white, middle class girls that are in the cohort* "
(Stage 2: South University: Academic Physiotherapy 26).

A service user explained:

> *"I really think the, I don't think there're groups of people that would be disadvantaged. I think that's the beauty of each station or, you know, each having five different viewpoints because I think it's probably impossible to discriminate, whereas one person interviewing for an hour can quite easily do that… I think, yeah, you've got five heads and we're all different. We're different races, we're different religions, we're different genders. So, I think it's very diverse and, therefore, promotes, for me, diversity"'* (Stage 2: South University: Service user 64)

Assessment by a range and mix of individuals was seen as reducing 'unconscious bias' and promoting fairness compared with the previous format (an interview panel):

> *"On the MMIs, I mean there are definitely pluses and minuses. I like the system very much because it forces each interviewer to come to a decision about a candidate in front of them. Occasionally at panel interviews one or, you will get influenced by your other panel members kind of thing and you think oh maybe I didn't, I think I drew the wrong conclusion about that candidate."* (Stage 2: South University: Service user 36)

> *"What happened was that almost always, no matter how many times you'd ask people to score them independently, they agreed the scores, and quite clearly what was happening, was that people [candidates] were walking in through the door, and they were thinking, oh they look lovely, we'll have them, and just giving them high enough scores to make sure they got a place."*
> (Stage 2: South University: Academic Physiotherapy 18)

Discussion of candidates following MMIs was not a feature of South University; in contrast to North University, where two programmes discussed candidates post-MMI and group exercise to "review scores":

> *"How it worked was we would just go through each individual prospective student, so we'd all get out our sheets for that particular person and then we'd just go round the circle basically and just talk about how they answered the question, what we felt was positive, what maybe they struggled with, what marks we'd given them."* (Stage 2: North University: Clinician 47)

Academic staff described subjectivity creeping into MMI process: interviewers 'inflating' the score they gave to a candidate because they considered them a 'lovely person' or 'thought they would do well on the course'; even candidates may not have responded well to a question at the MMI station. Academics said this 'rogue scoring' could be easily spotted within the range of scores and its impact was limited as it constituted only one of five scores for each candidate. Academics and service users, putting themselves in candidates' position, suggested the opportunity to move between interviewers following a 'difficult' question and presenting themselves to a mix of interviewers was a positive facet of MMIs. A perspective reinforced by students:

Student 1: *I thought it was quite nice, because you get five chances, like, maybe I'm going to like you better, maybe you're going to like me better.*
Student 3: *Yeah.*
Student 1: *Rather than just one.*
Interviewer: *Right.*
Student 1: *Like, if you don't get on with that one person, you know, but five, you have five chances. That's what I was thinking in my head, I was like, it's fine, just move onto the next one. It will be better next time…*
Student 3: *I quite liked it as well. The same sort of thing, that you're going in to see different people, and you might not get on so well with someone, or if you've gone off on a tangent, or done really badly in one question,*

you can sort of almost go and start again with someone else and a whole new question, and you can do really well in that one.

Interviewer: *Okay.*

Student 2: *Yeah, and you had a minute in between to just get your breath back.*

(Stage 2: South University: Student focus group Dietetics)

> *"The feedback from the applicants is good. They like it. They like the process, that they report feeling they could represent themselves well, it was good to meet lots of people."* (Stage 2: South University: Academic Mental Health Nursing 13)

> *"I felt like I could show my personality quite a lot, I felt like there wasn't…they weren't trying to trick you, they were just sort of…just trying to see the kind of person that you are, which was nice."* (Stage 2: South University: Student Physiotherapy 79)

Unintended consequences arose from MMI processes; specifically in relation to equity of opportunity. Academics suggested VBR may unfairly advantage candidates with sufficient life experience to draw on and provide examples of values enactment. At North University, academics emphasised the importance of 'transferable' skills for younger candidates:

> *"And we always say to them, so, if you're working in [retail], what skills have you got that you can bring into nursing, and how are you going to tell me about those? And half of the time, they don't get it. And you say, well do you not talk to your customers - oh, yeah! And they think it's something very extravagant, something very detailed, that they have to have. And it's not, it's the simple things, but as long as they can explain it."* (Stage 2: North University: Academic Child Nursing 7)

Differing views existed between VBR interviewers about relevant experience for demonstrating values. Academics felt NHS colleagues often struggled with what was reasonable of a 17-year-old candidate compared to those with more life experience. The language used in interview questions and levels of understanding and

interpretation by younger candidates also created a focus for tension: younger candidates may have encountered and used language which served to disadvantage them compared to older candidates or those with experience in health care:

> *"So, we know what that word means, and we immediately think about dignity in all sorts of health care settings that we're incredibly familiar with, and the threat to dignity in any health care setting. But why would somebody who's not had that experience know that?"* (Stage 2: South University: Academic Adult Nursing 14)

> "*The privacy and dignity [question] that we use. I can't remember the question off the top of my head. But it talks about, oh, how would you maintain dignity and respect in a children's nursing setting. Well, I could answer that, very easily, being a children's nurse, and a lot of my colleagues could. But somebody coming out of school, 18 years old, they really struggle*." (Stage 2: North University: Academic Child Nursing 7)

Participants recognised that MMI processes may not suit every candidate. For example, the introverted or those needing time to develop rapport may be less able to themselves effectively. Conversely, one-to-one stations may (or may not) allow candidates to express themselves in ways they might find more difficult in groups:

> *"I think they found that group interviews were sort of very much based not so much on people's skills or ability to demonstrate those skills but offers just came down a lot to personalities. When you sit a bunch of nervous students in a group I guess, the ultimate challenge is to make yourself heard and it's just so much up to chance about what the group dynamic is like. I mean you might have someone very quiet and very skilled who could easily sort of get overshadowed by someone who's maybe more assertive but not as skilled."* (Stage 2: South University: Central Administrator 25)

> *"I never felt quite comfortable with that. I felt some students were very vocal and always quick to come in with the answers, very good, eloquent answers, but other students were more reticent and shy, or by the time they got round*

to saying [something], everybody else in the group had already said what they were going to say. So, I wasn't convinced about the group interview. But I don't know, that, to be honest, the multi-mini interview gives us any more information. Maybe I'm being cynical about it, maybe I'm just trying to look for Utopia and maybe there's no selection process that gives the definitive right answer, because maybe there isn't one." (Stage 2: North University: Academic Radiography 4)

North University group interviews were conducted alongside individual panel interviews for nursing. Academics and administrative staff reported this combination enabled candidates to demonstrate their communication, teamworking and values-in-action; meaning fairer assessment:

"So, we have changed our interview processes over the years from group interviews to individual interviews. I think, as I mentioned earlier, it's very difficult to have a style of selection that suits everybody and I think in some of the group interviews we saw that particularly some of the younger students found that it was quite a daunting process. They might not have been for an interview before or may only have had one experience of that. So we introduced individual interviews so we could actually try and get a bit closer to the person themselves." (Stage 2: North University: Central Administrator 20)

Academics suggested limited time at MMI stations facilitated assessment of how quickly candidates could develop dialogue and rapport. Skills key for any future health care professional for developing relationships with patients and their families. Some academics and clinicians considered MMI processes as hindering interviewer understanding of the candidate "as a person". Participants suggested MMI processes could be 'de-humanising' and 'conveyor-belt':

"[The MMI is] quite slick. Mind you, it may feel conveyor belt… You know, I'm looking at it from my point of view and saying, you know, I think it's all this positivity, but maybe it's a bit conveyor belt like. Thinking about it as I'm talking to you, I guess that's a negative that it may be viewed that it's a bit of a conveyor belt." (Stage 2: South University: Service user 64)

Despite candidates perhaps having multi institutional experiences of interviews, MMI was viewed as promoting equity of opportunity. Academics held to the belief that it would be difficult for candidates to 'rehearse' answers. Whilst some questions were "stock" – 'why would you like to study as a physiotherapist?' – and academics recognised that guidance or coaching was possible, other questions (often in response to audio visual props/prompts) would be hard to prepare for. This diversity in question format was an asset:

> *"I don't want people who come and have learned the answers to the questions and discuss it on the student room, or whatever those forums are, where they all kind of talk about what you need to say to demonstrate compassion or words you must make sure you put in your interview."* (Stage 2: South University: Academic Dietetics 23)

> *"They [candidate] definitely would be able to prepare. But I think there's enough in there [the MMI] that puts them on the spot a little bit and can hopefully assess how they'd really be in that situation."* (Stage 2: North University: Clinician 47)

Candidates confirmed the view that MMI questions were harder to prepare for than standard interview questions:

> "*I was expecting more direct questions, whereas they were quite open to interpretation I felt... probably the whole point of it, in that they want to see what you're like and anybody I suppose can repeat the right answer. So, I do see why they are the way they are. But I did find that quite difficult."* (Stage 2: South University: Student Nursing 48)

Interviewers recognised candidates may have had an interview elsewhere or previously and could become proficient at managing themselves and formulating their answers. This perceived advantage (confirmed by candidates) was not considered problematic by academics.

Impact of VBR

All participants said it was too soon to determine if VBR (however it was implemented) was having an impact:

> *"I think we haven't had maybe, long enough to know whether our processes have resulted in students, and therefore, professionals, who have better values, so we just haven't had long enough of doing this new style approach, to doing it, in order for me to assess whether it's improved the values that our students have."* (Stage 2: South University: Academic Dietetics 22)

> *"We've only been doing it for a couple of years, you're a couple of cohorts through. I mean there's been nothing obvious; I don't think the students I'm meeting are really that profoundly different to the ones we had before, except they tend to be younger. But that's because we've changed the old degree. I think that overall there's a change but I'm not sure it's been because of MMIs. I think it's because of the change in the programme and the entry criteria. So, I think our cohorts are different and have changed over the last five years to be much younger than they were before."* (Stage 2: South University: Academic Adult Nursing 14)

No change in the characteristics and profile of students recruited to the health care programmes arising from VBR was identified from our longitudinal analysis. Boxes 6 to 13 summarise our analyses of these data: these are presented for each health care programme and (where relevant) the programmes at each case site are presented side by side.

Box 6: Nursing (Adult)

South University	North University
Age • Those offered places after interview were younger than those rejected, these were significant differences. The age of applicants had remained relatively constant	**Age** • The age of applicants has increased significantly over time, those invited to interview have on average been younger than those not invited • Those applicants who were offered a place after interview were significantly older than those who were not offered a place, this has not changed over time • Those enrolled were significantly older than those who were not enrolled, this has not changed over time
Gender • The proportion of female offered a place after interview varied a little over the five years	**Gender** • The percentage of places offered to female over the five years has varied • The percentage of females interview, offered and enrolling is higher than those applying indicating the females are more successful than males
Ethnicity • The proportion of white applicants applying and offered a place after interview had decreased since 2014/15 from 76.2% to 60.8%	**Ethnicity** • The number of white applicants, those invited and those offered places has varied over the five years with no clear pattern
POLAR Score • The POLAR score has remained constant for applicants • The POLAR score is significantly higher for those offered places across all years	**POLAR Score** • In 2012/13 and 2013/14 there was a much bigger difference between those offered places and those not than in later years. • Between 2014/15 and 2016/17, overall the POLAR score of all applying and those invited to interview was decreasing
IMD • IMD scores were higher for those offered a place, it has not changed over the five years for those applying	**IMD** • These data were not well collected for 2012/13 (19%) and 2013/14 • IMD scores decreased slightly from 2014/15 to 2016/17 • There were no significant differences between those offered and those not from 2014/15
	Tariff Points • These data were not recorded/eligible for all 1489/3776 (39%), this varied from year to year (2012/13, 43.9%, 2013/14,

	38.4%, 2014/15, 36.9%, 2015/16, 40.8%, 35.9%) • Over time the tariff points for applicants has significantly increased, those invited to interview have significantly higher tariff points • Those offered places did not have significantly different tariff points than those rejected. Those invited for interview in 2016/17 had higher tariff points, those offered places had lower tariff point than those not offered • Those enrolled did not have significantly different tariff points

Box 7: Nursing (Child)

South University	North University
Age • Prior to 2014 those offered places were significantly younger than those rejected, this changed in 2014 and the following years where there were no significant differences in age between those accepted and those rejected	**Age** • Those offered places after interview are older than those rejected, these were significant differences except in 2016/17
Gender • The proportion of females offered a place after interview varied over the five years	**Gender** • Applicants for this course are mostly female • The proportion of female offered a place after interview varied over the five years
Ethnicity • The proportion of white applicants applying and offered a place after interview had decreased since 2013/14 from 85.2% to 73.6%	**Ethnicity** • The proportion of white applicants applying and offered a place after interview varied over the five years
POLAR Score • The POLAR score has remained constant for applicants • The POLAR core is significantly higher for those offered places across all years	**POLAR Score** • The POLAR score varies over time
IMD • IMD scores were higher for those offered a place, it has not changed over the five years for those applying	**IMD** • Data were poorly collected in 2012/13 and 2013/14 • There was no significant change between 2014/15 and 2016/17, those offered places had higher IMD scores than those not offered a place
	Tariff Points • There were no significant differences between those rejected after interview and those offered places • Overall, the tariff points for those applying had increased since 2012/13

Box 8: Nursing (Mental Health)

South University	North University
Age • Those offered places were significantly younger than those rejected	**Age** • Age varied across the years with no obvious pattern
Gender • The proportion of females offered a place after interview varied over the five years	**Gender** • There was a higher proportion of female that were offered places and enrolling than applying indicating than females were more successful
Ethnicity • The proportion of white applicants applying and offered a place after interview varied between 77.44 in 2012/13 to 73.6% in 2015/16 but fell to 61.2% in 2016/17	**Ethnicity** • White applicants were more likely to be successful, however the proportion of white applicants and those offered places was decreasing each year, indicating a more diverse population
POLAR Score • The POLAR score has remained constant for applicants • The POLAR core is significantly higher for those offered places across most years	**POLAR Score** • With the exception of 2015/16 there were no significant differences between those offered places and those rejected after interview. • POLAR scores are higher for those interviewed and offered places than those rejected at any stage
IMD • IMD scores were higher for those offered a place,(except 2013). These were significant differences	**IMD** • This was not well competed for 2012/13 and 2013/14 • With the exception of 2015/16 there were no significant differences between those offered places and those rejected after interview **Tariff Points** • There were no significant differences between those offered a place following interview and those rejected

Box 9: Midwifery

South University	North University
Age • There were no significant differences between the age of those offered places and those rejected. Those interviewed from 2014/15 were younger than those interviewed for places in 2012/13 2013/14	**Age** • Age of applicants remained constant across the years and there were no significant differences between those offered places and those rejected after interview
Gender • The vast majority of students on this course were female	**Gender** • This course was entirely female, although there were some male applicants who were unsuccessful
Ethnicity • The proportion of white applicants applying and offered a place after had started to decrease from 2013/14	**Ethnicity** • White applicants were more likely to be successful as the proportion offered a place was higher the proportion applying. However, the proportion varies from year to year
POLAR Score • The POLAR score has remained constant for applicants • The POLAR score for those interviewed varied across the years with significant differences seen between those accepted and rejected in 2015/16 and 2016/17is significantly higher for those offered places across most years	**POLAR Score** • POLAR scores are higher for those interviewed and offered places than those rejected • There appeared to be no change in the pattern across the five years
IMD • IMD scores were higher for those offered a place. These were significant differences in 2015/16 and 2016/17	**IMD** • This was not well completed for 2012/13 and 2013/14 • From 2014/15 the gap between those offered places and those rejected was widening slightly with those offered places having a higher IMD score **Tariff Points** • Tariff points varied across the years with no obvious pattern

Box 10: Physiotherapy

South University	North University
Age • Age had remained relatively constant across the five years	**Age** • Age of applicants remained relatively constant across the years (20.7 to 23.2 for applicants) and there were no significant differences between those offered places and those rejected after interview
Gender • The proportion of female offered places varied across the 5 years	**Gender** • Female applicants were more likely to be successful as the proportion offered a place was higher the proportion applying. However, the proportion varies from year to year
Ethnicity • The proportion of white applicants applying and offered a place had remained fairly constant (excluding peak in 2013/14)	**Ethnicity** • White applicants were more likely to be successful as the proportion offered a place was higher the proportion applying. However, the proportion varies from year to year
POLAR Score • The POLAR score has remained constant for applicants and for those offered places	**POLAR Score** • No difference in POLAR scores for those interviewed and offered places than those rejected except in 2013/14. • There appeared to be no change in the pattern across the five years
IMD • IMD scores were generally higher those offered a place (except 2013/14). These were significant differences in 2015/16 and 2016/17	**IMD** • This was not well completed for 2012/13 and 2013/14 • From 2014/15 there was no significant difference between those offered places and those rejected **Tariff Points** • Tariff points increased from 2014/15 to 2016/17 • Those offered places had slightly higher tariff points than those rejected

Box 11: Radiography (North University only)

North University

Age

- Age of applicants remained relatively constant across the years (23.9 to 24.4 for applicants) and there were no significant differences between those offered places and those rejected after interview

Gender

- Female applicants were more likely to be successful as the proportion offered a place was higher the proportion applying. However, the proportion varies from year to year, with the highest proportions in 2016/17

Ethnicity

- White applicants were more likely to be successful as the proportion offered a place was higher the proportion applying. However, the proportion varies from year to year

POLAR Score

- No difference in POLAR scores for those interviewed and offered places than those rejected except in 2016/17, where those offered places were significantly higher than those rejected.
- There appeared to be no change in the pattern across the five years

IMD

- This was not well completed for 2012/13 and 2013/14
- From 2014/15 the gap between those offered places and those rejected was widening slightly with those offered places having a significantly higher IMD score

Tariff Points

- Tariff points increased from 2012/13 to 2014/15 but then remained relatively constant.
- Those offered places had slightly higher tariff points than those rejected

Box 12: Occupational Therapy (North University only)

North University

Age

- Age of applicants remained relatively constant across the years. Those offered places were on average older than those rejected after interview

Gender

- From 2014/15 female applicants were more likely to be successful as the proportion offered a place was higher the proportion applying.

Ethnicity

- Despite there being more applications from non-white applicants, white applicants were more likely to be successful as the proportion offered a place was higher the proportion applying

POLAR Score

- No difference in POLAR scores for those interviewed and offered places than those rejected except in 2013/14
- There appeared to be no change in the pattern across the five years

IMD

- This was not well completed for 2012/13 and 2013/14
- From 2014/15 there was no significant difference between those offered places and those rejected

Tariff Points

- Tariff points varied over the five years.
- There were no significant differences in tariff points between those rejected and those offered places

Box 13: Dietetics and Nutrition (South University only)

South University

Age

- Age for those offered places had varied across the five years

Gender

- The proportion of females offered places varied across the years

Ethnicity

- The proportion of white applicants applying and offered a place had reduced from 75% in 2014/15 to 66.7% in 2016/17

POLAR Score

- The POLAR score for those offered places was significantly higher than those rejected in 2015/16 and 2016/17

IMD

- IMD scores were higher those offered a place. These were significant differences in 2013/14, 2014/15 and 2016/17

Recruiting for values would not reduce student attrition according to academics, because students often left a programme of study for personal reasons: increased caring responsibilities or pregnancy; deciding a career as a health care professional was not what they wanted; they were unable to manage the demands of study; they were homesick; or had a relationship breakdown. Academics were keen to recruit individuals who would stay on programmes – something that was a target for commissioners. North University academics did not consider attrition a 'problem' for their courses. They highlighted that recruiting for values helped them to identify students suited to their teaching style (problem-based learning) and so VBR supported retention. We study attrition in our longitudinal evaluation (see Chapter 7). Some academics planned to review course outcome against performance at interview (Stage 2: North University: Academic Radiography 4); to the best of our knowledge this has not been done.

There was also little confidence that VBR would ensure maintenance of values of candidates once "in role". Recruitment was one of a range of influences on the values of individuals. NHS Workplace cultures were viewed as a more powerful force, reinforced by workplace socialisation. Students themselves identified that workplace cultures and clinical placements as bigger influences:

> *"But I think the risk is when you actually go into your workplace, the culture there, actually carrying those values on and sometimes being in the minority about how things should be done or how care should be given. I think that is where standards might start to drop*." (Stage 2: South University: Student Nursing 48)

MMIs were seen as efficient. Academics and administrative staff highlighted that after an initial investment of time and money setting up processes and establishing MMI questions it felt a more streamlined way to manage human resources for the recruitment process in a 'condensed' time period. The burden associated with the changes was not seen as a deterrent, and the outcome worthwhile. Previous recruitment formats were in part perceived as placing too many demands on staff, prompting a change in approach.:

"So, whilst I would say it is resource intensive, and I would say also that the intensity is probably condensed into a couple of weeks, you know, the weeks leading up to interview. So, it's not like we're having to do the same sort of collation of scores the entire year, I think it's a very short, intense period of time. But even in that condensed time I think the process is definitely worth the outcome, because from what I've seen and the experiences I've heard other people say, it's just a better process in terms of administration." (Stage 2: South University: Central Administrator 25)

"I think it's more labour intensive in terms of the number of people that actually have to participate in the delivery of the interview. So you would need to have more individuals on the stations, you might need to have students who participate as well, current students, and I think that has been the challenge, to get enough participation, because people are doing other things, have got other responsibilities, and because of the volume of applicants it's not a one-off activity, it's something that you have to repeat, maybe every week, and it's quite a commitment. But it is important to put that commitment in to get it right." (Stage 2: North University: Central Administrator 20)

Whilst service were users were reimbursed for their time the front-line clinical staff involved generally saw this as part of their role and "obligation" to the NHS Trust and University:

'So, I am working as the clinical practice educator, so to speak, in one of the Trusts in [name city] and I am supporting pre-registration nursing students. So one of the things I have to do for the trust is be involved in recruitment of nursing students. [I: Okay, that's interesting. So as part of your actual clinical role, you are required by your organisation to be involved in the recruitment process?] Yeah. And not only by the organisation, also by the university, because nursing education is academic and in the clinical setting.' (Stage 2: South University: Clinician 66)

During case study data collection (2016-2017), the Government announced removal of the NHS bursary managed through HEE for students undertaking a health-related programme leading to professional registration. We asked participants whether they considered the removal of the bursary would have any impact on the approach to recruitment (currently mandated by HEE). Most academics suggested values would continue to feature in recruitment processes. The impact was more likely to be felt in increased revenue from broader programmes that prepared professionals for roles outside the NHS and increased numbers of international students. Concerns were raised that lack of funding may change the characteristics of applicants:

> *"I think we'll get far fewer mature students, we'll get far fewer students who have actual work experience, who have life experience, we'll get lots more students who are 17, straight out of school. Don't get me wrong, they are mostly completely fabulous, but I think it's a shame that we'll, inevitably, I think we will lose some of that mixture of experience and understanding and knowledge."* (Stage 2: South University: Academic Midwifery 15)

> *"I think we're going to lose a wealth of experience… the people that we interviewed this week were 17, 18, 19 years old and there wasn't the 30, 40 year olds mums that have been doing part-time support work and things like that… Unfortunately, there'll be a lot of people that can't get into it because they can't then afford the student loans or they can't afford to give up work or they wouldn't be able to have the childcare and all those things that come with, giving up a life to actually going back to being a student."* (Stage 2: North University: Clinician 46)

At the point of data collection at the university case sites, the demographic and revenue impacts of the VBR policy mandate and the subsequent changes in recruitment processes was not being felt.

SUMMARY

This chapter presented findings of the implementation of VBR policy and processes for assessing values of health care students for programmes in two university case

sites. We have highlighted the variations that existed in how VBR was introduced into these organisations and the factors promoting and inhibiting its adoption. Our evaluation focused on the work that individuals and groups have done to enable VBR in HEIs, and the appraisal of VBR in terms of its intended and unintended consequences. We considered the organisational and 'real-world' contexts and how this influenced implementation.

CHAPTER 5: STAGE 2 - NHS CASE STUDIES

This chapter presents findings from two NHS organisations case sites: an Acute NHS Trust and a Mental Health NHS Trust. VBR was not mandated for NHS organisations. Unsurprisingly, its interpretation and implementation was variable in these very different NHS organisations. Therefore, we have presented the findings of these case sites separately.

For each case site, we provide contextual detail to orientate the reader to how the NHS organisation had addressed recruiting for values and then present the findings. These case sites are reported separately. Our cross-case analysis (of all case sites) and the refined theories of VBR are presented in Chapter 6.

ACUTE NHS TRUST

This case site is a large NHS Foundation Trust (based in a number of geographically dispersed hospital sites) providing acute care and services to a local inner-city population, as well as providing specialist services to people from throughout the UK. Services include: (i) urgent care, planned care and allied critical services (including Acute and emergency care, Dental, Planned surgery, ophthalmology and optometry, Post-acute, planned medicine and outpatients, Theatres and anaesthetics, Therapy, rehabilitation and allied clinical services, Women's health) and (ii) networked care (including Cancer; Cardiovascular sciences; Critical care, radiology and MEP (medical engineering and physics); Haematology and precision medicine; Liver and renal; Neurosciences; Paediatrics). The hospital is part of the Shelford Group: a collaboration formed in 2011 between ten of the largest teaching and research NHS hospital trusts in England.

We evaluated the approach, implementation and perceived impact of recruitment in this case site which was transitioning to a strength-based approach for the recruitment of Registered Nurses (RNs) at Bands 7 and 5 (and Health Care Assistants (HCAs) at Band 2, but non-registered staff were not the focus for our study). The organisation employs approximately 4,500 registered nurses and reported a 14% vacancy rate in RN posts (a vacancy rate that was, over time, constantly at this rate). The Trust was experiencing pressures around recruiting

sufficient numbers of RNs to meet demand and, following the publication of the Francis Report (2013), wanted to explore different ways to ensure the recruitment of the 'right' people into nursing roles to improve quality of patient care, improve patient outcomes and reduce staff turnover, and to restore public faith in the nursing profession (Fenton, 2014). The Shelford Group started working with the strength's consultancy firm *Engaging Minds*. At the time of the study, there was no standardisation, or mandating, of VBR in NHS organisations. Given that a large number of NHS trusts were adopting the strength-based approach, we agreed with our project advisory group to understand this approach as part of our evaluation of VBR. It is important to outline the ideas underpinning strength-based recruitment (SBR) and why we considered this relevant for the evaluation of VBR.

Understanding strengths-based recruitment

SBR focuses on assessing an individual's strengths and 'fit' for a particular role. This approach shifts the focus from what people can do (competency-based recruitment) to what they are naturally good at – a strengths-based approach. A strength is defined as something that someone is: (1) good at; (2) enjoys doing; and (3) is energised by (Bibb, 2016). The strengths-based approach recognises the person and their individual strengths (which includes their values) and that their motivation at work comes from these strengths. Identifying the right people who will excel in their work because they are a natural fit is at the core of strength-based recruitment. When recruited to the 'right' role, then the right work environment, the right team, and the right supportive manager has the potential to help an individual thrive in their role and at their work. SBR therefore aims to assess the values that individuals who are great at the job possess.

Participants in our study were asked about differences between values-based and strengths-based recruitment approaches. This was a difficult question to answer for many. The majority focused on distinguishing values as what people think are important (such as compassion) whereas strengths are what people do with "appropriate" attitude and based on skills, knowledge and beliefs (such as, demonstrating commitment through hard work):

"A strength is how you operate, maybe, it's that bit more. It's how you apply yourself and what resources you've got within you. Whereas a value, to me, is what you believe in, what's precious to you, and how you treat others and how you expect to be treated." (Stage 2: Acute: Service 75)

"My understanding would probably be, the strengths-based will probably be, you know, people's skills, knowledge, their whole personalities. It's just putting all that together and bringing it out in that person. I think values will probably be people's make-up, you know; what they believe, what they understand, who they are, and what values they base their lives on; whether people can connect to [name organisation] values, connect to their own values, and see how they can combine those two together, to be able to, you know, perform the caring jobs that we've got. The strength is not just about whether I can do this job. It's whether I can do this job with the right attitude." (Stage 2: Acute: Service 77)

Our review of the process indicated that within the strengths-based approach there was some assessment of values and how this influenced individuals' strengths: people's strengths include their values. For this reason, coupled with its widespread adoption in a number of large organisations (i.e. the most consistent approach in NHS sites) we considered it an important and appropriate approach to include in our evaluation.

An important starting point for the participating organisation (with Shelford Group colleagues and Engaging Minds) was to create Strengths and Motivator Profiles[10] for nursing roles: Band 7 Charge Nurse (or Ward Sister) and Band 5 Registered Nurse. The Band 7 profile has 4 domains: integrity, ownership, delivery and relating. The Band 5 role has 3 domains: integrity, delivery and caring. Figures 6 and 7 provide indication of what needs to be considered in these domains to determine if an individual possesses the right strengths and motivation for these roles.

[10] The Strengths and Motivator Profiles are the intellectual property of Engaging Minds. We have permission to share only the Strengths and Motivator Profiles summary of strengths and not the full profiles or other related materials.

The role profiles were developed by observing and interviewing exemplars in a role to discover what strengths, values, and motivations they shared, alongside interviewing the people who knew them well (usually, but not always, their managers). The role profiles were the result of studying exemplars in all ten Shelford Group Trusts, in all clinical areas (except midwifery):

> *"But I do think, and it's not magic or anything, it's been designed by people who have interviewed Sisters for years, who know what it is that they're looking for. So, it's not magic, it's been designed by people who know what they're doing, and have done it."* (Stage 2: Acute: Executive 61)

There was a sequence of filters for the candidate interviews aimed at ensuring a candidate demonstrated the necessary strengths for the role and that only the 'right' person was recruited. First, candidates scored themselves against a range of statements profiled for their role by indicating whether the statement was 'very much', 'a bit' or 'not very much' like them. This took about 5 minutes. The interview (45 minutes) focused on asking questions based on these responses – 'tell us about that?', 'can you provide an example?' and 'what's that like?' The interview panel focused on validation (or otherwise) of these responses. They looked for evidence of the strengths by considering what they heard (such as words used or the tone of the candidate) and non-verbal cues of the candidate. This shifted the interview focus on to strengths – something someone is good at, enjoys doing and is energised by - rather than questions of the 'old' style of interviews, which focused on scenarios and competencies. The strengths-based interview aimed to reveal whether someone was the right type of person for the role. Assessment of whether the candidate had the right clinical experience was established by reviewing their curriculum vitae.

Engaging Minds and The Shelford Group hospitals' Chief Nurses agreed that only NHS staff who had completed strengths-based interviewer training delivered by Engaging Minds or Trust staff who had been trained by Engaging Minds to train others should undertake interviews.

Figure 7: Strengths and Motivator Summary Profile for Band 5 Registered Nurse

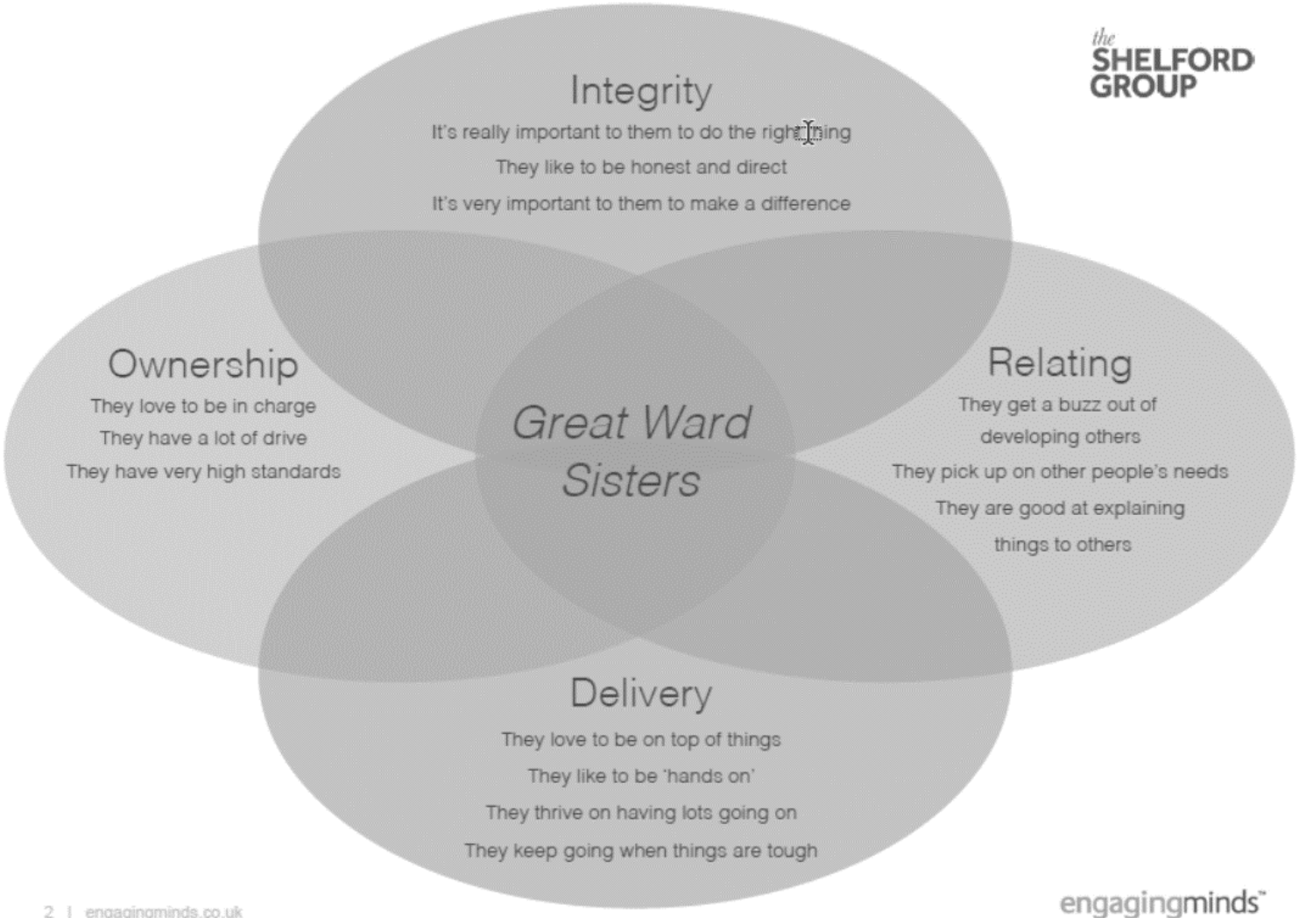
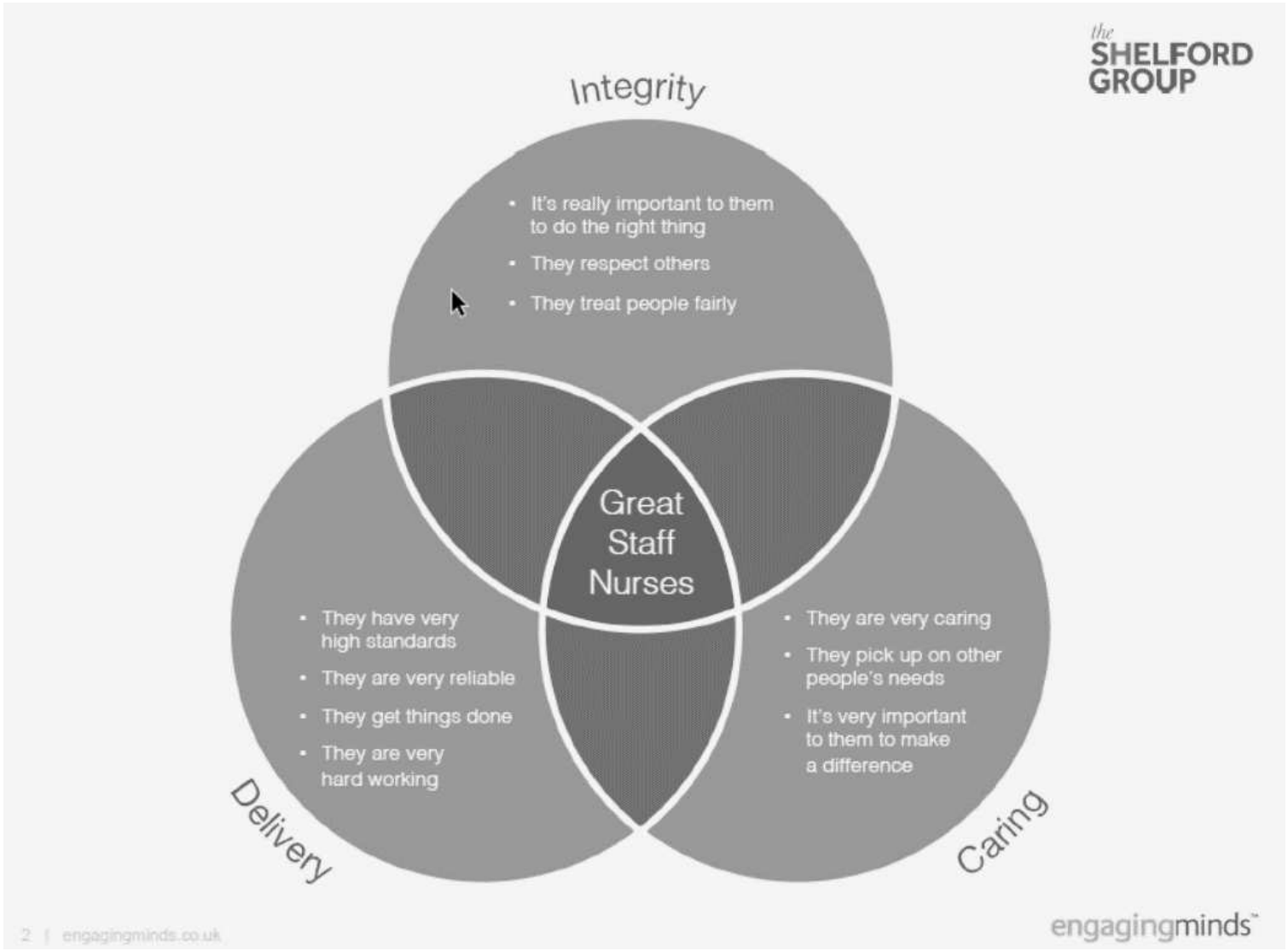


Figure 8: Strengths and Motivator Summary Profile for Band 5 Registered Nurse



Data collection

Interview participants

We interviewed 19 people involved in SBR. Our sampling strategy aimed to ensure a mix of participants from across the organisation with varied experience of SBR. We recruited staff with a strategic executive role (n=2), service level clinical and management role (n=11), ward or team level clinical and management role (n=4), which included 2 staff recruited through SBR, and clinical staff interviewed for a Band 5 role in the Trust and exposed to a strengths-based interview (n=2). These 19 participants also represented: staff using strengths-based interviews for recruiting staff (n=11) and of these 5 were SBR trainers; staff trained but who had not yet used the approach (n=2); one staff member not trained to use the approach (n=1); candidates who had experienced the strengths-based interview (n=2) as well as staff who had experience as both an interviewer and candidate or interviewee (n=3). Our approach ensured the sample was representative of key individuals across the organisation involved with recruiting using strengths-based interviews, training other colleagues about the approach and/or recruited to the organisation using this approach, as well as staff who were not using SBR (Table 6). Members of the public were not involved with the recruitment processes in this organisation and so were not interviewed. We approached staff in the Human Resources Department to participate in the study: no staff agreed to participate (no reason offered).

Table 6: Acute NHS Trust interview participants

	Executive	**Service**	**Ward/ team**	**Clinician**	***Total***
Use SBR (and trained)	2	4			***6***
Use SBR (trained) and a trainer		5			***5***
Not using SBR (not trained)			1		***1***
Not using SBR (but trained)		2			***2***
Use SBR & recruited by SBR			3		***3***
Recruited by SBR				2	***2***
Total	***2***	***11***	***4***	***2***	***19***

Documents

Organisational documents analysed included:

- job adverts and associated job description (n=6)
- website review (n=1)
- train the trainer manual (n=1)
- SBR profiles and statements (n=2)
- policy on use of SBR and profiles in NHS (n=1)

Observations

We observed

- interviews for Band 5 registered nurses (1-day equivalent)
- a train the trainer course (1.5 days)

FINDINGS

SBR as strategic solution for recruitment and retention

At an organisational level, and with other Shelford Group Chief Nurses, executive nurses had appraised the current situation for nursing recruitment and retention post-Francis Inquiry. They were concerned about ensuring the right people were recruited into Ward Sister/ Charge Nurse positions and to restore public faith in the nursing profession. Coupled with the high vacancy and turnover rates in nursing posts in these organisations and concerns about managing poor performance of staff when in post, prompted the perceived need for a different approach when recruiting nursing staff among the Shelford Group Chief Nurses:

> *"[Q: When you say they knew you needed to do something different what was the basis for that?] Well, our general workforce data, our vacancies and our turnover especially, because I think you can't look at recruitment and retention separately. Like a lot of organisations, particularly in [name city], we were carrying, and still are in some areas, carrying a high vacancy level, and we've got a high turnover, so we need to understand why that is. And the whole basis around strengths-based recruitment is that you have the right people doing the right jobs, and you've got a round peg going into a round hole rather than a round peg trying to fit into a square hole… And obviously to reduce our*

turnover or vacancy we want people to come into roles that they feel fits with their skill set and that they're comfortable and enjoy, because we know, and nursing research supports it, that happiness means happy patients, good patient outcomes. So that was the premise really." (Stage 2: Acute: Executive 52)

"We're recruiting lots of people and, or we were recruiting lots of people and the quality wasn't great. So, we're, we spend a lot of time managing, supporting, you know, performance managing. You know, the time spent is just unquantifiable on staff who are really not fit for the roles that we expect them to do. So, by recruiting using the strengths-based method, you know, we at least have an idea of the, it's not about the competency, you know, you can teach people skills but you can't teach them, you know, to be, to love doing what they do. You just can't do it. You know, if they like it they like it, if they don't then they're not going to take an interest in it." (Stage 2: Acute: Service 69)

"Turnover in this trust is incredibly high, that's because of pressures. However, I think also because they had the wrong people in the wrong jobs with, I think NHS comes to a point where they get to an attitude where almost it's bums on seats and actually that's far more detrimental to your establishment." (Stage 2: Acute: Service 72)

At executive level, strengths-based approach for recruitment to Band 7 and Band 5 posts was advocated. Work was undertaken in the organisation to establish shared beliefs about its purpose and its value for recruiting nurses. Interviews revealed varied perspectives on the value of SBR and its appeal for recruitment to different nursing posts (i.e. of different levels).

There was general consensus that this approach was important for nursing leadership roles at Band 7 (for example charge nurse or clinical team leader positions). Participants reflected on historical promotion processes: senior staff were often appointed to leadership roles based on "time served" rather than demonstrable leadership skills and abilities. There was support for the strategic and executive

vision of recruiting individuals demonstrating suitability by having the requisite strengths for leadership positions. The appointment process was seen as ready for change because of the pivotal and influential nature of nursing leadership roles. When the "right" leaders were in post the view was that this would create the environment for staff and quality of care to flourish:

> *"…we really did have wrong nurses in the wrong jobs and that people had been promoted just based on the fact that they had been here for a certain length of time. With nursing recruitment as well, and I've heard it happen, you know, throughout the whole of my career, that if you've done your time in a department then you deserve to get the next promotion. I think people get promoted incorrectly and wrong and then they were going into these jobs and they were failing and they were sinking because actually they didn't have the right skills or the right strengths to carry out those jobs."* (Stage 2: Acute: Service 72)

There was greater uncertainty regarding the value of SBR among clinical and managerial participants (i.e. ward/service level staff), particularly when recruiting to Band 5 registered nursing posts. Many participants argued that because these staff have only just gained their registration then it inappropriate to deny them their first clinical position based on assessment of strengths. Staff should be able to consolidate their learning and have some time to develop in post:

> *"I find that very tricky. I think some of those girls are young and there are some of the strengths, I feel, they might perhaps over time, with a bit more maturity, get the strength."* (Stage 2: Acute: Service 74)

When making sense of this new approach, staff often contrasted the value of the approach between these different positions:

> *"Band 5, you just want them to develop and grow and enjoy and experience. So it's about the character and the values they have. And then they will develop in the role, I think. Band 7s, you sort of want them hitting the ground running.*

There's no room for developing and growing in the job." (Stage 2: Acute: Service 70)

There was a tension between executive and clinical nurses, which manifested in the perceived value of SBR for nurses at different levels (Band 7 and Band 5): there was minimal support of the approach among clinical nurses for recruiting Band 5 registered nurses.

Championing a new approach for recruitment and retention

The executive team and selected individuals in clinical and management roles at the service or team level actively championed SBR. Working with *Engaging Minds* was perceived as important for staff engagement with SBR principles and ensuring they were trained - and could therefore recruit, interview and sustain the approach.

Staff differed in their experiences of introducing the change in recruitment. Executives asked services to "nominate" a member of their team to be trained in the strengths-based approach. The experience of this for senior clinical and managerial staff was varied, and not always positive:

"We just got an email saying the trust was moving to this system and they want as many people trained and we are all moving to this system of training and recruitment and you have to have, you won't be able to recruit unless you have the training, basically." (Stage 2: Acute: Service 70)

There was a perception that some areas of the organisation were better supported and trained than others. Accompanied by a perception that 'pockets' of services in the organisation existed that had not engaged with the approach. This created resentment due to perceived unequal contribution of senior nurses and an over reliance on a small number of SBR champions:

"Obviously, the strengths-based training is a challenge at the moment, because everybody is so super busy and nobody wants to go out [of practice]. You know, we've been trained, so we're expected to deliver the training. But, it's quite

difficult … to be able to leave your area of work, to go out and do the training." (Stage 2: Acute: Service 77)

"So, I've done a lot in the Trust, compared to some people." (Stage 2: Acute: Service 76)

The challenge for the organisation was in rolling out and embedding the strengths-based approach as a replacement for other forms of interview. Our evaluation revealed that this had not happened.

Working to embed new approaches for recruitment

The senior executive team and champions were working to embed SBR in the organisation and for this to be used for all nursing posts at Band 5 and 7. Senior staff suggested resource constraints hindered adoption:

"It's been a case of introduce [SBR], get on with it, let's hope for the best almost. Which is unfortunate because it's, you know, the process of change cannot really be successful if you don't manage it closely but, again, I understand the restrictions to that. You know, there is no extra money and there are all these extra things to do." (Stage 2: Acute: Service 69)

Participants raised concerns about the length of time it was taking to roll the approach out across the organisation: *"it's been work in progress for a long time"* (Stage 2: Acute: Service 76). The pace at which staff were trained in the approach was considered too slow, with concerns that the "train the trainer" approach had increased pressure on individuals to shoulder the responsibility for embedding this approach when investment and strategic direction was needed:

"I mean I think, you know, strengths-based recruitment in its current format is just a starting point. I, you know, and I say that, it's the longest starting point ever, it's been three years, hasn't it, and it's never really got past the, you know, as we discussed earlier, we struggle with trainers, you know, people

don't necessarily engage with it because although they believe in it they don't have the time to do it." (Stage 2: Acute: Service 69)

The number of people trained to interview using this approach was too low to enable systematic use of the approach for all interviews. Despite SBR guidance suggesting only two interviewers were needed, the trust held onto a received view that each interview needed three panel members. This misunderstanding contributed to accusations of overengineering and wastefulness – especially for recruiting Band 5 registered nurses:

"I just think to train a few people, to rely on staff to train each other, I think it's, you know, we've kind of launched it but half the people aren't trained... When I was saying about being fully engaged with this and having people to do it, you cannot get three on a panel for a Band 5. You try but, you know, it's a waste of three senior nurses' time, quite frankly, and you can't get them anyway. You can just about get three for a [Band] 7, and you should have three, I think, for that. But, to get three on a panel for Band 5 interviews? You're doing so many all the time, is not a useful use of people's time." (Stage 2: Acute: Service 76)

"I would say it's only about 20 per cent from the time that we recruit, the time that it started that we recruited band five it's already like a proportion. [Q: So why only 20 per cent?] A. Not everyone has been trained. B. There is some resistance with some of the managers or they say it's a long process and especially when you're interviewing at least 10 in a day." (Stage 2: Acute: Service 78)

This was exacerbated by the centralisation of the recruitment of Band 5 (and Band 6) posts to the organisation's Human Resources recruitment team: managing job adverts and role profiles. Participants perceived that the strengths-based approach was separated out to the interview process. Our analyses of job adverts and role profiles reinforced this perception; with no reference to values or strengths in these materials, and only an implicit mention in some of the role profiles (see underlined [our emphasis]):

"*We are looking for motivated, innovative nurses with strong clinical knowledge, excellent communication, management and leadership skills who are able to demonstrate suitability and experience for the position. You will need to be flexible, enthusiastic and passionate about emergency care and you need to be committed to improving service delivery, able to sustain new ways of working and develop nursing practice."* (Team leader/ Senior Sister/Charge Nurse Emergency Department role profile)

The trust's web pages revealed 5 "values" that were clearly stated on the front and other pages: 'About us', 'Our people', 'Careers' and 'Appraisal'. A free text search for 'values' identified other documents where the organisation's values were mentioned, suggesting the values were well embedded in the organisation's policy, strategy and meeting documents, as well as press releases and newsletters (Box 14). A free text search for 'strengths' did not generate any hits. The section related to recruitment had no details about values or strengths; this absence was particularly noted on the pages about preparing for interview.

Box 14: Organisation documents citing Trust values

- Introduction to the Trust and Guide to the Profile of Learning Opportunities for nursing and midwifery students in practice
- Strategy 2014-19 Our Vision for the new [NAME] Council of Governors – Public Session Minutes of the meeting held on [DATE, 2015]
- Mandatory and statutory training
- Trust magazine
- [NAME] Preceptorship Programme
- [NAME] Board of Directors - Minutes of the meeting of the Board of Directors held [DATE, 2009]
- Engagement and Experience Strategy 2012-2015
- Press releases
- Annual report and Accounts 2014/15

Centralisation of scheduling of interviews led to challenges for clinical teams in ensuring staff trained in the approach could work on 'management' (rather than clinical) duties for the dates of the interviews. It was apparent there was work to be done to promote interactions between recruitment teams to promote the operationalisation of SBR in the organisation:

"What we have a problem with is actually getting people off the shop floor to get the panel together, especially now the recruitment team has taken over the Band 5s and we don't have responsibility for it. So, they lead on the Band 5s and Band 6s, so they do all of our recruitment for us and because they're set interview days that's what we struggle with. However, when we lead it internally ourselves we manage it very, very well because we know what dates we're going to be interviewing on, we know who can be arranged and you can pre-populate the rota to order to ensure that actually you have people around to do those interviews with you." (Stage 2: Acute: Service 72)

Lack of interactivity between teams to promote planning for recruitment days, alongside perceived pressure among senior nurses to use this approach when recruiting, created variations in recruitment panel composition. Resulting in deviations from trust recruitment policy:

"[Name of colleague] will have three people, they'll have people who are properly trained [in SBR] and into it and doing it properly and well. Whereas we'll have whoever's on the day with a pulse, with at least one person in the room who's done the training." (Stage 2: Acute: Service 85)

When embedding new recruitment processes who gets to do the work (i.e. the division of labour) will affect it's operationalisation in the real world. Allocating work to staff untrained in the approach will likely impact on interview and decision-making processes – or at least fidelity with the policy architect's vision. The impact of this deviation is difficult to quantify, but the perception of influence was something voiced by interviewers and candidates:

"I just think, it [SBR] could be great. But you need to let the people (a) out of the shop floor to do it, (b) make sure the right people are on the panel, and that the right people are doing the training." (Stage 2: Acute: Service 85)

Interviews were not always carried out with all Band 5 recruitment. Only those applying through NHS jobs would be interviewed, with only some of these

interviewed using SBR. Interviews were not conducted for undergraduate student nurses transitioning into their first clinical post as a registered nurse: there was an agreement between the HEIs and Trust that these students were guaranteed a clinical post. Participants argued that SBR should also be used by HEIs when recruiting students to an undergraduate programme of study to promote consistency in reinforcing workforce strengths required to be a registered nurse:

> *"They've been a student nurse with us maybe, or somewhere else, for three years and they've got through their nurse training and then these are basic strengths that we expect them to have and then you would question if they don't have those strengths, how have they got through their nurse training. How do you suddenly develop them? So actually, this is about the basic requirement to be a nurse. So those strengths to me need to be when you're applying as a student."* (Stage 2: Acute: Service 75)

> *"I find it quite disempowering that I'm just given someone and I haven't interviewed them, I don't know who they are, I don't know what their references are, I don't know what areas they've worked in, I don't know why they want to come and work in [name ward], I don't know why they want to work at [name organisation]. I find that quite disempowering as a manager."* (Stage 2: Acute: Ward 80)

Participants described registered nurses transferring across clinical services in the organisation were not interviewed. This created differences in approach for how staff were recruited to Band 5 nursing roles in the organisation and contributed to the unsystematic and disparate use of the strengths-based approach:

> *"I guess it's difficult for me to say that it's embedded, because, like I say, if I interviewed this nurse who came to me through NHS jobs, she would come through with SBR. If I get a newly qualified nurse from [names HEI], I've never interviewed them. I know they're guaranteed jobs. If someone comes to me from the transfer window, they might have been in medicine for five years or surgery for five years or neuro for five years. But now they're coming into my team and is this the right person in the right role? I don't know, because I've*

never necessarily met them in my life. So, I think it's difficult to say that it's embedded." (Stage 2: Acute: Ward 80)

In some clinical areas, strengths-based profiles were also being used to recruit to Band 6 posts. This deviated from the recommendation that profiles are used only for the intended level (Band 5 or 7). It revealed the challenge faced by the organisation to systematically embed the approach as detailed in the recruitment policy:

"So, we have two different Band 6s. They all come under a Band 6 budget, but we split our Band 6s into junior sisters and senior staff nurses. So, that's why the senior staff nurses can use the Band 5 profiles and the junior sisters, because they are sisters or charges nurses, they can use the Band 7, the profile, because our expectations and strengths are exactly the same. I think people just need to think outside the box. Like you're looking at exactly the same strengths for a junior sister and a junior charge nurse as you would be for a Band 7 senior sister and senior charge nurse because the only difference between the two bandings would be their qualifications and what your expectations of them are as their desirable or their essential qualifications." (Stage 2: Acute: Service 72)

The challenges of embedding the approach across recruitment for all Band 5 and 7 nursing posts undermined SBR overtime. The patchy adoption meant not all participants were willing to commit to it. Consequently, the "new" recruitment approach was not always used nor was it connecting the necessary people sufficiently to sustain it. Participants described the ways they had adapted and reconfigured recruitment processes to make the new approach more "workable":

"None of the ward managers are, none of my ward managers in medicine are trained for strengths-based. So, we have a pro forma of questions that we ask that have some values-type questions in them, but it's not a pure strength-based interview." (Stage 2: Acute: Service 84)

"So, what we've done now, with traditional questions, is kind of putting a little of the strengths-based in there. So, we would say, where people are struggling

with a question, can you think of an example. But we don't use the whole strengths-based profile, but we just base some of the questions and tweak it a little bit." (Stage 2: Acute: Service 77)

Experiences of strengths-based interview approach

The strengths-based approach was not explicit for applicants for jobs in this organisation. Job adverts, role profiles and application forms completed by applicants did not explicitly reference SBR. This provided opportunity for a hybrid approach to recruitment. It also hindered the ambition to embed SBR in the organisation. The proportion of candidates interviewed using SBR meant service managers had *some* experience of conducting the strengths-based interview - but also the real time comparator of "traditional" approaches to reflect on.

At interview, candidates were asked to complete a role profile (5 minutes), which would then form the basis for the interview (45 minutes). Statements in the profile (13 statements for Band 7 and 10 statements for Band 5) encouraged candidates to indicate whether statements were 'very much', 'a bit' or 'not very much' like them. Interviewers went through the statements, asking candidates: (i) tell me about that; (ii) give me an example; and (iii) what's that like for you? Interview were described by participants (interviewers and interviewees) as "very different" to other forms of interview for a nursing post.

Interview experiences came across as deeply personal. Candidates felt interview panel members wanted to know them as a 'person' and cared about getting to know them and their fit for the post:

"I guess they try to find out if what you're saying is actually who you are. It's not just saying always that, I don't know if it makes sense what I'm saying it's hard to express myself, but yeah, because anybody can say that they are something, but then it was this other question that you had to answer, maybe they wanted to find out if that's really a fact, or if that's really true. I feel like you can maybe, what do you call it, take out the bad apples, I guess, and just

really find the good people who are actually perfect for the job." (Stage 2: Acute: Clinician 82)

Interviewers – despite sometimes finding strengths-based interviews repetitive – acknowledged it helped them better understand the person they were interviewing. Interviewers had to engage with the process and carefully listen:

"It's [old style interview] boring, because it always comes to the same thing, especially when you have so many to interview. At the end, you don't feel you're listening properly anymore because it's just going over your head, if it comes. Then, it's unfair, it feels. But, with this one, with the SBR, you can't do that." (Stage 2: Acute: Service 74)

"I always thought the old process was a pile of rubbish anyway, so what can you tell me about safeguarding. I mean, you might as well read a textbook, come in here and regurgitate it. [SBR] is a much better way of really getting to grips with who that person is that you're interviewing." (Stage 2: Acute: Service 75)

"I was really apprehensive about it because I was like, what on earth can you get out of nurses in this type of interview process? So, I was really, really scared about it but actually the more interviews you've done and the more like confidence you have in the interview style you're absolutely amazed with how much information you get out of the candidates. What I learnt to realise quite quickly is that you can revise, almost, as a nurse to do competency-based interviews. The more senior you become the more of an idea you have of what people expect from you at that level and what questions they may or may not ask you. So, you almost parrot fashion it off, whereas actually you can't revise for strengths-based assessment and you can't parrot fashion off. It's about your strengths, and you can't lie about your strengths and weaknesses." (Stage 2: Acute: Service 72)

Interviewers required practice to gain confidence. In the early days this impacted on some managers' ability to engage with candidates because they were concerned

with the process. However, anxiety decreased over time and with experience. Even though some maintained concern about the style of questioning:

> *"With Strengths-Based Recruitment, some of it is just, doesn't grammatically read right, let alone make sense."* (Stage 2: Acute: Service 76)

This different approach often surprised candidates. Managers noted that candidates were not able to fully prepare for the interview. Candidates recognised that any pre interview preparation for an interview was not relevant in this new context:

> *"I had so many ideas of things that I wanted to say and things that I felt like I wanted to use to sell why I think I would be good at this job. I had all of these things and I had spent a lot of time talking to other people, not about the interview but more about like, well what would I do when I'm in that role, what changes would I make, you know, who are the key people? I was like, oh God, all this thinking has gone out the window. I felt, oh my God, you know, it's, none of this is relevant anymore, they just want to talk about me."* (Stage 2: Acute: Ward 81)

> *"So it seemed quite alien doing it I guess because it was so different, especially the self-rating, because, probably sounds stupid, but it's like everything else when they say 'what's your strengths?', you're generally not that good at always putting across your strengths."* (Stage 2: Acute: Ward 80)

Managers suggested this element of 'surprise' (or difference) promoted equity of opportunity for all candidates: no candidate could prepare for the interview and so had to just "be themselves". Others viewed it less charitably, feeling the interview process meant some individuals struggled with the style of the interview process and internal candidates were advantaged:

> *"I think with the internals [candidates], who may be (a) are expecting it, because it's been all over the Trust about what it is, and (b) I'm not saying they know the questions, everything about it, some people, you know, but they're aware of it. They're, to a certain extent, you could argue slightly more, relaxed might not be*

the right word, but prepared, and it's not as bad. So, I think if we did look at what candidates genuinely thought of it, I think you'd need to consider internal and external maybe slightly separately." (Stage 2: Acute: Service 76)

Generally though, participants felt SBR was a "fairer" form of recruitment. Interviews were recognised as inherently subjective and prone to unconscious (and conscious) bias. Standardised strengths-based approaches mitigated these risks for some:

"I've always thought we probably promote and hire a bit in our own eye. We can't help ourselves. We're human beings. And there are probably people types that I'm not very sympathetic to, do you know? And that's not very fair, it's just how it is. So, I think, a standardisation of approach, is bound to make it a bit fairer." (Stage 2: Acute: Executive 61)

"So, I'm still a strong believer that strengths-based is fair and it's obviously set in stone, how you ask the questions. Whereas the other questions can easily be tweaked and twisted to suit the recruiter's, you know." (Stage 2: Acute: Service 77)

For some though, SBR as a systematic check and balance on subjectivity and unconscious bias fell short:

"[Q: Does SBR promote a fairer system for recruitment?] Gun to head! No! Because of all the examples I have given about people, the decision being made outside of, when I wasn't involved, that it was just, get a bum on a seat. I don't think it's unfair to externals over internals, because there's a natural foot in the door there anyway. You can't take that away from the situation. So, I don't think it's unfair to externals in that sense. I think because it's still too, what's the word, subjective? Is that the right word? It's still down to the interviewers what they think is a strength, do they agree, do they bump people up, do they move people down, can they justify their decision based on body language and note-taking and all that sort of thing? Fair, is that the word you used, sorry? [Q: Fairer. Does it promote a fairer system?] No, I don't think it's a fairer system because there's still too many variables." (Stage 2: Acute: Service 76)

And SBR judgements could be overridden:

> *"So you'll often have internal applicants where you know they could do the job, but put them in a strengths-based interview, so it's like the girl that I said that my colleague didn't think I should appoint based on the strengths-based interview, but I knew that she could do the job."* (Stage 2: Acute: Service 84)

Senior managers held mixed views on the relative advantage (over previous formats) of SBR in assessing competence:

> *"You see I don't know whether it's because I haven't received training in strengths-based that I'm not comfortable with this and I'm more comfortable with the more traditional style of interviewing. That's what I've always done is that type of scenario-based interview, practical questions, and that's what I'm used to doing, that's what I've always done since I've been interviewing for years. And then all of a sudden there's this strengths-based and it's a complete change of style in interviewing, and if you're not familiar with something and you're not doing it on a regular basis and you haven't had full training for it, then there is a bit of a kind of like, oh, is this going to work, I don't know whether I trust this or not."* (Stage 2: Acute: Service 84)

> *"We always did that, yes. I think we're just not brave enough to leave it. But, to be honest, I think what you get out of SBR shows you actually if someone is competent in a way, because they come with good examples. It's the quality of the examples comes through as well, when you do SBR. [Q: So, how confident would you be in dropping the organisational task?] It's a habit which is hard to change, to be brave enough to do that, I think, to be honest, I think what would be worth doing is, looking how they did in the interview and how they did in the competency."* (Stage 2: Acute: Service 74)

Candidates appreciated time taken conducting interviews; comparing this with interviews at other organisations where they felt they were on a 'conveyor belt'. The

downside of the intensity though was candidates who described feeling, "interrogated", "stressed", and "exhausted" by the process:

> *"I've spoken to two or three people that have been through it and they found it stressful and exhausting. They were exhausted at the end of the process. And that's worrying. I think they'll be stressed and thinking I'm coming to a stressful organisation, and I'm worried it'll put people off. Because you ask a question and it's almost as though you ask things over and over again, which is what some people say, why are you asking the same thing over and over again."* (Stage 2: Acute: Service 70)

> *"So, then the most extreme counselling session of all time. So, I was there for, I think, about an hour and a half, but I also talk quite a lot. So, it wasn't just about the interviewers, it was about me talking a huge amount. I have to be honest; I came out and I just did not know what had just happened in there. Like I felt like really, I felt like it was like an extreme counselling session. I felt, not in a negative way but it felt it was, I think, just so far from what I expected. That was why it was so, I found it so, not challenging, that's why I found it so different."* (Stage 2: Acute: Ward 81)

Regardless of a positive interview experience, not all candidates accepted job offers. Factors such as career opportunities were often more influential in their decision making. Senior managers recognised that evidence that SBR influenced candidates' decision-making or increased the organisation's appeal as a place to work was missing. One manager stated: *"we're all fishing the same pond for the nurses"* (Stage 2: Acute: Executive 52).

Appraisal of SBR

There was universal agreement that recruiting the right person to a nursing post was important for quality of care and promoting team working and caring cultures – also necessary conditions for quality care in the heads of participants:

"The strengths-based thing, gives you an understanding of their personality and how they interact with people and, you know, how you can see them fit in in the team. You know, it just gives us a much more balanced view of the person that we're trying to recruit to work for us, ultimately so we can improve patient care, that's what we want to do. It's not about anything else, it's about giving good care." (Stage 2: Acute: Service 69)

"I think it's a bit too short that we have done it, and the long-term outcome is a bit hard to see, I would think. But I think the perception of what type of people we want makes it very clear with SBR." (Stage 2: Acute: Service 74)

SBR offered the opportunity to assess the suitability of an individual for a nursing post by gaining a better understanding of the 'person' and not just 'competence'. Competence was perceived as important, but participants largely felt skills and competence could be taught but attitudes and/or values were more difficult (sometimes impossible) to alter. Recruiting on these aspects was considered important and appropriate for nursing:

"I've always kind of been a firm believer that like within nursing, or within any job, you know, we, you can teach people to do a job but you can never give them the softer skills that they'll excel in that job. So, I think that that's what made it [SBR] quite interesting." (Stage 2: Acute: Ward 81)

"My role as a matron, basically, is making sure, you know, obviously maintain standards and hopefully we recruit the staff that will able to help us to do that. So, staff that are passionate about nursing, want to be a nurse, and also want to do the work that we vouch for in the first place. So, I've always been a strong believer that I can teach someone a skill, but I can't teach them an attitude. With the traditional way of recruitment, we obviously can't, you can't pick that up in a normal interview and obviously with strengths-based you can." (Stage 2: Acute: Service 77)

Aside from the appeal of SBR in targeting the 'right' people, participants shared the counterfactual view that care and teams could be damaged when the 'wrong' people

were appointed to roles. Participants described difficulties in managing staff members who were not “in the right role”, the negative impact on patient care and the pressures it created for the team:

> *“We're recruiting lots of people and, or we were recruiting lots of people and the quality wasn't great. So, we're, we spend a lot of time managing, supporting, you know, performance managing, you know. The time spent is just unquantifiable on staff who are really not fit for the roles that we expect them to do. So, by recruiting using the strengths-based method, you know, we at least have an idea of the, it's not about the competency, you know, you can teach people skills but you can't teach them, you know, to be, to love doing what they do. You just can't do it, you know. If they like it, they like it. If they don’t, then they're not going to take an interest in it.”* (Stage 2: Acute: Service 69)

> *“Whereas actually if you’ve got the wrong person into that job who's not picking up the workload, is not up to speed, doesn’t have the knowledge. If you’ve got other staff picking up that person’s workload that makes them unhappy. That disgruntles them because they're getting paid either the same amount of money or they're getting paid less money. You know, if a Band 5 is picking up a Band 6’s workload that Band 6 does earn more money than them and that makes an unhappy establishment and an unhappy workforce because they start to resent their team because people aren't picking up the work that they're meant to be doing. So, it causes a massive effect.”* (Stage 2: Acute: Service 72)

Despite broadly positive appraisal of SBR, for some service and clinical managers there was widespread scepticism about whether SBR *actually* impacted on the types of people appointed to Band 5 nursing posts. No data were collected within the organisation about numbers of people interviewed and appointed using SBR and so it was not possible to measure potential impact. Informal communal appraisal of SBR (i.e. appraisal between colleagues) rather than the collection of formal data impacted on the perceived acceptability and usefulness of the approach. In addition, individual appraisal focused on the worth of the approach and its impact on other work:

"I don't know how many people have been interviewed using this technique, how many were successful, of those that were successful, how are they doing, are they still in the Trust? I don't know that. From my perspective, it's just what I see going on out there and what I hear, this is going back to your original question: I don't personally know or hear of any difference between when we do use SBR or don't, in terms of who we're recruiting for Band 5s." (Stage 2: Acute: Service 76)

"If we get all the strengths that we're supposed to have of an individual then they fit. [Q: Do they not now?] I don't believe that they don't now, to be honest." (Stage 2: Acute: Service 70)

The change of approach was perceived by some as disproportionate, given the work involved for marginal or no gains:

"I think my biggest gripe is that the, is how much resource is consumed. But more importantly it's the fact that you are taking three people to interview one person and it does take a long time. If you do it properly it takes a long time and that's very challenging because you're taking three very senior staff members, you know, sometimes 45 minutes to an hour of interviewing somebody. [Q: So, do you know how long a traditional interview would have taken for a Band 5?] We'd usually tap it at a half an hour. Yeah, so, it's now looking at twice the length of time." (Stage 2: Acute: Ward 81)

"We invest a lot of time in them. You know, an hour's a lot of time, you know, for a panel of three people. It's three work hours essentially, plus or minus preparation." (Stage 2: Acute: Service 69)

For recruitment to some clinical areas, the interview process continued to incorporate an assessment of the candidate's competency and so this also increased the amount of time required for the interview. Mixed views were provided on this issue; some participants emphasised the importance of including competency assessments whilst others stated they developed personal confidence of the

strengths-based interview process over time and to solely use it for informing their decision-making:

> *"You could have the most compassionate nurse in the world, but if she's not very good at critical care and add up the sort of drugs we're using because he or she has not got enough experience, then no, I struggle with that… One thing we test is that they can look at an observation chart, pick up on problems straight away and escalate them."* (Stage 2: Acute: Service 76)

> *"It made the interview process incredibly long because I would do the strengths-based assessment for the Band 7s and I would ask them competency-based questions and I would give them a clinical scenario. So, I actually was making the interview really, really long and actually the more confident I became with this style of interview [SBR] I then scrapped the competency-based and the clinical scenario and now purely for Band 7s we just use strengths-based and nothing else."* (Stage 2: Acute: Service 72)

Participants emphasised the changing context for recruitment: fewer staff applying for advertised posts and shortages of staff within teams. This created pressures to secure staff to deliver services and challenges for using the strengths-based approach:

> *"Sometimes, you know, they're desperate to get staff and they just ignore the profiles going through them. They're so desperate, just because the person's got the right attitude, has a little bit of skill, and they think, okay I can work with you, you know."* (Stage 2: Acute: Service 77)

> *"In Band 5, it's definitely something where we are so desperate to have staff, to be honest, so everyone who has a nursing qualification and is registered with the NMC, you know, we would always shortlist, because you need to see every candidate these days because, yes it's really hard to recruit. That's always that kind of balance where, you know, can you say no to someone when you're very desperate for nurses, but equally you want only the good nurses, you know."* (Stage 2: Acute: Service 74)

"I'm just not convinced of the use of it in the current climate, just because they are so short staffed that I can't see that they would, you know, that they would be turning anyone away based on that." (Stage 2: Acute: Clinician 83)

"Also, it depends on the motivation of the interviewer as well, some people want bums on seats, other people are prepared to have spaces and wait for the right people. It really depends what pressure is on them." (Stage 2: Acute: Service 85)

For some, consistently applied SBR was a positive force, reducing vacancy rates and increasing stability:

"By employing these three people it's just gone from zero to hero really in a year, you know, and it's because they demonstrated that, at interview, that they understood that all these things are important. They gave examples of why they thought they were important and how they would improve them and so they literally talked the talk and then walked the walk. So, yeah, so that's why I believe it works." (Stage 2: Acute: Service 69)

"Personally, in the department everyone that I have recruited in the three years that I have been here have not resigned, they have all stayed, and that is all on the strengths-based assessment. The people that have left were recruited historically prior to me starting and actually some of them, when I first started here, I felt very much were in the wrong jobs and should never have been in those positions anyway. However, whether that is based on the recruitment strategy of them or whether that's based on the strengths-based I couldn't comment, but certainly that's been the case that I kind of have witnessed." (Stage 2: Acute: Service 72)

The convinced, attributed positive effects to greater discriminatory ability and supporting decision-making about the 'right' person; interviewers were more likely to reject a candidate rather than 'give them a go':

"With that attitude, I don't want her on my team. You can have her on your team, but I'm not having her, not with that attitude, because half the staff will go. Half the staff will feel intimidated by her attitude, you know. You need to have that nurturing kind of nature, to be a ward manager, because you want your staff to stay and you want them to feel cared for and valued. But with the strengths-based, because of the profiles about the caring and about giving examples, about how you care for people, and also examples about when you were in a difficult situation, you know. There's all various types of questions that brings out, you know, how people perceive it. It's so unconsciously done, that people don't realise they're doing it. But, because it makes people feel comfortable, after a few of the profiles, it makes them feel relaxed and they get comfortable, then they just come out of their shell and they just reveal whatever is the person inside." (Stage 2: Acute: Service 77)

These views were inconsistent. We heard examples of people performing well in the strengths-based interview but badly in post. As well as professionals appointed to a post after performing badly in a strengths-based interview:

"And I said to the [name position], who'd appointed him? I'm just interested, 'cause I haven't seen him really, as a leader. What made you? He got through the strengths-based recruitment. All right, did he? And she kind of went a bit red. And I said, what happened? And she said, we interviewed him twice with strengths-based, and he didn't get through it. And I said, so, but you appointed him anyway? And she said, yeah, and it was a mistake." (Stage 2: Acute: Executive 61)

Staff differed in their appraisal of the impact of SBR on retaining staff. Many felt other organisational factors were more influential for retention than getting the right person in post. It was hard to disentangle claimed effects from other contextual factors:

"SBR is getting them in the door. Keeping them in is a totally different thing, and it's a lot more money than SBR. Local inductions, mentoring courses, training tools to do the job, and that is a whole ballgame, because even if you've got

the right people in they will actually leave quickly because you haven't given them the resources to do what they want to do." (Stage 2: Acute: Service 70)

"I mean, if you go to some specialist areas, they won't take newly qualified nurses because you've got to have some sort of medical background. So, people come to medicine just as a stepping-stone and then they move on to more specialist areas." (Stage 2: Acute: Ward 73)

Some believed SBR encouraged the appointment of ambitious staff who inevitably would move posts or leave to progress their career:

"I think one of the biggest strengths of this SBR is that you want nurses that are passionate about their profession and passionate about their career and that they'll keep going and that they'll have, you know, aspirations to be a Band 6 and to be a Band 7 or to go into a clinical nurse role. That it's not that they're just getting a job to sort of stay there forever, that they actually will have aspirations to push the limits. So, I guess in some ways having those kind of people and having, recruiting with those strengths they're the kind of people that you'd like to have on your team and that they move on would be your indicator of success." (Stage 2: Acute: Ward 81)

When participants appraised SBR they were determining how effective and useful it was for them and for others. In the absence of systematic data collection by the organisation this involved staff collecting information in varied ways at an individual and collective level and often informally. The collection of anecdotes was an important source of systemising the collection of information for this appraisal. Our evaluation highlighted the varied subjective appraisals that existed and the challenges this created for embedding this approach in the organisation.

SBR was introduced in all The Shelford Group Hospital Trusts[11]. Sally Bibb, Director of Engaging Minds, led this introduction She has kindly provided her reflections on

[11] https://shelfordgroup.org/

our findings and considered the lessons that can be learned from this work. This response is provided in Appendix 27.

MENTAL HEALTH NHS TRUST

The final case site is a large NHS Foundation Trust providing mental health, learning disability, social care and community health services to adults, children and adolescents. The health and social care services provided by this Trust are delivered across a large geographical area. The Trust employs 6,000 staff. The Trust had undergone significant reorganisation (six months prior to commencement of data collection), bringing together two large mental health organisations. A merger of this scale demanded consideration of organisational policies, including approaches for recruitment:

> *"Their recruitment process was really, really different to ours, really, really different. So, as part of due diligence, preparation work for the merger, we had identified a number of policies that we wanted harmonised from day one of the new organisation. One of those was recruitment and selection." (Stage 2: Mental Health: Executive 88)*

This case study evaluates the approach, implementation and perceived impact of VBR in this case site. The merger of the organisations also offers an opportunity to examine the challenges of implementing policy (such as VBR) within a context that is undergoing significant structural and cultural reorganisation and change.

Data collection

Participants

Our sampling strategy aimed to ensure a mix of participants ranging from staff with a strategic executive role, service and ward or team level management role, as well as clinical staff newly appointed to their role in the Trust and so exposed to the values-based approach to recruitment being used in the merged organisation. Strategic, service and ward level participants were also recruited to offer their perspective on how the Trust (as a merged organisation) was developing values-based recruitment approaches when compared with their previous organisation's approach. This was

not asked of newly appointed staff as they did not have this prior experience and understanding. It was not possible to achieve representation of participants at the executive level from individuals who had been formerly employed by Trust 2. These staff were approached about the study (and follow up contacts were made) but they did not respond or were unwilling to participate in the study. In part, this may be attributed to executive positions in the merged organisations being predominantly awarded to executives originally employed by Trust 1. A total of 17 participants were interviewed (Table 7), they represented key individuals involved with VBR.

Table 7: Mental Health NHS Trust interview participants

	Trust 1*	**Trust 2***	**Not relevant**	**Total (merged organisation)**
Executive level	3	-	-	3
Service level	4	4	-	8
Ward or team level	2	1	-	3
Clinical level (new appointees)	-	-	3	3
Total	9	5	3	**17**

*prior to merger

Documents

We analysed a range of organisational documents to evaluate the ways in which values are embedded within recruitment processes in this case site:

- Recruitment and retention procedure (April 2017)
- Trust website
- Job adverts (n=2)
- Job descriptions and person specifications for Band 5 and 6 staff (n=5)
- Candidate pack (November 2015 – for Trust 1 rather than merged organisations as new candidate pack not produced at time of data collection)
- Values-based questions for interviews resource pack
- Interview record form
- Appraisal document

FINDINGS

Defining the organisational values which underpin VBR

As a newly merged organisation, the organisational values and recruitment processes were under "review and development". This was considered important work by some managers (with a stake in VBR) at strategic and service levels.

Initially, the executive team organised a consultation using an external consultancy firm to facilitate decisions on shared organisational values for the merged organisation. This consultation was considered important by the executive team to promote breadth in engagement and commitment from staff to organisational values. However, the final decision about the organisational values was made by the executive team. It was unclear how the consultation process had influenced this decision making:

> *"…we went round, we did loads of staff briefing sessions, saying to the staff, 'what are our values?' No one, hardly anyone, could recite six values. So, what we came up with was, six is too many… Then the Executive Team came up with three values. They were compassionate, empowering and, err, open."* (Stage 2: Mental Health: Executive 88)

> *"I think that the first thing is that three are easier to remember."* (Stage 2: Mental Health: Executive 90)

> *"…one of the values that was suggested was honest, and we thought that that could be negatively charged as well, that the opposite of that was dishonest. So, we plumped for openness because, A, that's an NHS constitution value but also I think it's wider than just being honest."* (Stage 2: Mental Health: Executive 86)

It was apparent these three values were not always recalled by participants across the organisation. Only a few "front-line" participants were aware of the consultation process:

> *"It's compassion, caring and something else. The third one alludes me. I can't think what it is. It's about being open and honest, isn't it? [I: Yes, it's…you're right, it's Open, Compassionate and Empowering]."* (Stage 2: Mental Health: Service 95)

The executive team's intention of engaging and committing staff in work to develop the organisational values was not realised: not all staff groups had participated in the consultation. Staff reported struggling to make sense of the organisational values and the recruitment approaches being developed to align the assessment of individual values with those of the organisation.

Making sense of VBR

The organisation's recruitment and retention procedure document outlined 6 competencies candidates were to be assessed against at interview: leadership and management, service improvement and quality, service user focus, solutions focus, communication, and teamwork.

Assessing alignment of a candidate's values with those of the organisation was *in addition* to the assessment of these competencies. Recruiting for values was s sub-element of the recruitment approach in the organisation, alongside assessing competence for role. There was no consensus among case site participants about the value, benefits, and importance of recruiting for values.

How VBR differs to previous recruitment approaches

An important element of sense making was for staff to appreciate how VBR might promote the recruitment of staff "better suited" to a role in health care and what VBR added to the assessment of candidates compared to previous recruitment approaches. For many participants, differentiating between VBR and previous approaches for recruitment was difficult. Many participants argued that some form of assessment of an individual's values had always been part of recruitment for caring roles.

Service level clinicians emphasised the importance of values due to the nature of clinical work and patient populations being served. They recognised the benefits of separately assessing individual values in recruitment processes:

> *"I wouldn't want to recruit someone who's values, I felt, weren't right either, because, especially, you know, with this job, because you've got to have the right set of values to work in this field. You've got to be non-judgemental; you've got to be able to show empathy and understanding, because of the difficult nature of what you're dealing with on a daily basis."* (Stage 2: Mental Health: Service 95)

> *"Having recruited a variety of staff at different grades the values that people bring are probably a lot more important, in my mind, than any experience*." (Stage 2: Mental Health: Ward 87)

For others, competence was the most important consideration:

> *"If I'm honest I would probably prioritise competency and that's just through past experience of actually having somebody who has been incompetent in their job and having to go through a really difficult process… You can measure somebody's competency far better than you can measure them against values of a Trust; unless it's bloody obvious, you know, that they're putting people at risk or something terrible like that. Or have been abusive to a patient or for whatever reason. But certainly, in terms of competence you really want somebody competent in the role and I would prioritise that. I know it's probably not right… I guess you get a sense of that person and you get a sense about is that person in the right position, in the right job as well as can they do the job… I think what we want to assess is first of all can the person do the job that you're going to ask of them? Can they do it well and can they do it in the best interests of the team and the patients that they're serving?"* (Stage 2: Mental Health: Service 91)

Some differentiation between previous practices and VBR was possible when considering the questions asked at interview. However, many participants stated that

assessing the values of individuals for a role in caring had always been part of the recruitment process. This difficulty in differentiating between VBR and former recruitment processes therefore hampered engagement and participation for a proportion of staff in the organisation. Participants observed that the best candidates often demonstrated all desirable attributes for a post, including skills, competence, and values. The value, benefit, and importance of recruiting for values was, therefore, considered an important, but not sufficient, aspect of staff recruitment. It is therefore worth considering further the shared understanding being established between individuals within the organisation with regard to the perceived benefits of VBR.

The perceived benefits of VBR

A strategic priority for this newly formed organisation was to agree organisational values and to use these values for the recruitment of individual staff. Study participants, working at different levels in the organisation, considered this important for staff (regardless of role) to enhance the quality and standard of patient care:

> *"For me, it's around, when we're interviewing anybody, whether it's face to face [patient care] or sitting in a back office, like me, no matter what I do, what I'm doing, everything I do, ultimately, is for a patient."* (Stage 2: Mental Health: Executive 88)

> *"Because, it doesn't matter whether you are, say, cleaning in an organisation, it's still about how you treat other people. And, you know, we work with vulnerable people, like I said. And I think that you need to hold those values whatever level you are at, even if you are the Chief Executive, you still need to hold those values because you are making decisions about patient care, you are making decisions about staffing. So, yeah, I don't think it makes any difference what level you are at."* (Stage 2: Mental Health: Service 92)

Despite making links between organisational and individual values and quality of patient care, only a minority of participants (n=2), linked VBR with broader national policies and the Francis inquiry:

> *"After the Stafford [Francis] inquiry they wanted to make sure that people showed compassion, empathy, understanding, that they were caring and has all the right qualities to be a nurse and they weren't just being, you know, flippant and not worrying about, or not having any feelings around anyone that they were looking after and not doing stuff that they weren't supposed. That was the upshot of it all, from my understanding. That it was all to do with, you know, the big national inquiry."* (Stage 2: Mental Health: Service 95)

The drivers for VBR were recognised at the organisation and service level, rather than national, level. At a service level, some participants identified VBR as an opportunity for employment decisions based on individuals' demonstrating (at interview) their values, and how they aligned with organisational values:

> *"I believe that people come to work to do a very good job, I don't believe people come to work to be nasty or horrible, or I don't believe people come to work to provide, to go out of their way in the morning, when they come to work, oh, I'm going to provide a really rubbish level of care today. I don't believe people do that. I just think sometimes people need to be reminded about the reasons why they are coming to work. And I think values-based questions is part of that, and it's made much more aware for the recruitment part, to make sure that we're asking these pertinent questions, to make sure that the person is able to demonstrate they believe in our values."* (Stage 2: Mental Health: Service 94)

For some, incorporating assessment of a candidate's values (using VBR questions) alongside knowledge skills and competence for a role held the possibility of indicating how an individual might perform in role, influence care and service delivery and impact on the team.

Integrating a policy initiative into everyday practices

Implementing and embedding VBR required work by a range of individuals in the organisation. Executive staff, working with human resources staff, were responsible for initiating the policies and procedures for VBR in the organisation and engaging staff from across the organisation to implement and embed it in everyday recruitment

practices. Executive staff recognised the efforts made to embed the approach in the organisation through policies and procedures:

> *"Now what happens is, we've got three values and we now do, so all, we changed our template job description and person specification. The job description has got a big section in it all about our values and what the behaviours are that we expect from them. Then in the person spec, it's got something about the values and that that's an essential criteria for the role. [I: Right, okay]. Then, obviously, we've re-done our values-based questions that are available for managers to download from our intranet."* (Stage 2: Mental Health: Executive 88)

Analysis of a sample of job adverts for this organisation revealed explicit reference to values.[12] The organisation's Human Resources department had template text for job descriptions and person specifications (Box 15). Our analysis of a sample of job descriptions and person specifications revealed trust values were often unreferenced when prepared by the hiring service manager. When the Trust values were not included in the job description then there was often reference instead to the values of the NHS Constitution. At a service level, participants reinforced that organisational values were not always included or considered in job descriptions:

> *"I don't think [Trust values are] something that we consciously think about when we're designing a job description or doing a person specification. I don't think it's something that we think about, if I'm honest."* (Stage 2: Mental Health: Service 99)

> *"[I: Is the values assessment only at the interview stage or is there, does it start when, I guess, the job's advertised or it's in the, what do you call them, the job specification? What is in those stages, in terms of the values?] I don't think it really, how do I say it? I think it's probably only at interview stage. That said, I would hope that the values are things that you would be screening for anyway, if you get what I mean. Because they are so broad, that if you weren't meeting*

[12] To ensure anonymity for the organisation we have not provided this explicit statement here.

those values, I don't think you would be, I'm pretty sure that would be picked up earlier on anyway, if you get what I mean. There's no science to it, before the interview." (Stage 2: Mental Health: Service 89)

Box 15: Our Trust values (as detailed in template for Person Specification)

You are responsible for ensuring that the below Trust values are adhered to daily in your work and whilst providing services to patients and their families.

Open – *We expect our colleagues:*
-To be honest, accessible and responsive.
-To work collaboratively with colleagues and all stakeholders and be open to new perspectives and ways of working.
-To actively listen and have confidence to speak up to improve services.
-To professionally challenge and take ownership to improve safety and change things for the better.
Compassionate - *We expect our colleagues:*
-To understand different perspectives and take responsibility to respond to patients, carers and colleagues.
-To be friendly and courteous and show a caring and empathetic approach in transactions with others.
-To value inclusiveness and respect individual and team differences.
-To strive to provide the highest possible standards of care and support.
Empowering - *We expect our colleagues:*
-To go the extra mile and help others achieve their goals,
-To encourage and embrace change and be proud to share their ideas,
-To embrace continuous learning and self-development,
-To celebrate successes and have the courage to learn from mistakes

Executives responsible for implementing VBR in the organisation recognised these disparities and the need for a collective approach to engaging staff with VBR. A management development programme was being developed in the organisation to support recruiting managers. This was training in VBR and how to utilise the Trust's resources to support recruitment. Executive staff were committed to promoting a universal approach across the merged organisations for recruitment. This approach was being driven from the 'top-down' and there were concerns expressed at the senior executive level that there were differences across the merged organisation based on historical structures:

"…if [Trust 2] are not embracing it, then we need to take action for them to embrace it. We have in [Trust 1] and so it isn't something that we can allow to be different. We have to be consistent in our processes. So, you know, we've got to make sure it's being embraced across the whole [merged] Trust… So, you know, we've got to make sure, as big as we are, geographically, we all have to be doing the same, no matter what it is. Whether it's values=based recruitment, whether it's reporting serious incidents, it's all got to be the same. We can't have people operating differently." (Stage 2: Mental Health: Executive 88)

The origins of this top-down policy impacted on the perceptions and 'buy-in' of some staff about the usefulness of an approach when they did not feel they had been consulted about it:

"I mean, I think, you know, it felt a little bit of a tick box exercise and this was, oh, we'll put the trust values on the recruitment sheet so it kind of almost feels as if we're value basing recruitment. But it didn't kind of work and there was no consultation with those that were actually doing interviews on a regular basis as to whether actually how would you draw out core values from people rather than just writing them, because all they are is they've just written the core values of the trust on a scoring sheet." (Stage 2: Mental Health: Service 91)

There was a view that recruiting for values was an organisational expectation and minimal investment in 'selling' the approach and its importance as well as supporting its implementation was hindering its adoption:

"So, they [another organisation] really, really embraced it, whereas here, we've just got like a template that works for our questions, our interview questions. And you need to follow what the Trust values are, so you know for your questioning, you need to have a question around empowering, because that's one of our Trust values. You have to have one, I guess, 'open', which is another one of our Trust values. And so that's all we do here. Whereas in the other

Trust, they were, it was much more embracing of the values I think, because they sold it better." (Stage 2: Mental Health: Service 89)

"I think we all use them because we've been told we have to... rather than the reason we're doing this is to make the organisation more compassionate, so we want to look at people, at their compassion blah, blah, blah. We're just told we need to ask these questions. So maybe it's just me and I've missed that memo, but it's...but that's what it feels like, is that oh God we just have to ask these questions. Nobody's actually gone the reason we're doing this is." (Stage 2: Mental Health: Service 99)

The Human Resources department had developed an extensive list/'suite' (sic.) of values-based questions that could be used and adapted by recruitment panels to assess candidate's values. For the three Trust values, there were 24 questions presented to assess the value 'open', 28 questions for 'compassionate' and 31 questions for 'empowering', as well as potential follow-up questions and criteria. There was resistance among service managers to the use of the 'suite' of values-based questions; they were not always considered relevant for the clinical setting or service contexts. Our review of the suite of questions suggested these were a valuable resource for hiring managers. The recruitment team guided staff to adapt the questions to promote relevance:

"I think it was just about, I think it was just giving, making sure that they had the support and guidance from the team, because, you know, we always, I think the girls always used to get rung, oh, this question doesn't make sense, you know. They said, yes, but it's just about how you change it to what you need to ask. We're not saying you've got to ask that question specifically as we've written it, but you can ask the question, but in a different way. So, it's just about guiding them that way." (Stage 2: Mental Health: Executive 88)

However, there was reluctance among service managers to use the questions. The questions were seen as overly restrictive and requiring tailoring for the care environment; which was supported by the Trust (as explained above) but often not recognised:

"We have some values-based questions given, that we can use, from the organisation. That's very important, but for me, it's also important about making sure that it's the questions that I need to ask, that are local to the area that I manage. So, for example, some of the values based questions, might be relating to your personal aptitude towards, I don't know, mental health, something like that, which is fine, that's very important, but I also need to get for where I work, which is predominantly older adults, I need to get the person's knowledge or experience or skills, or some reasons, to say, yes, this is the right person to come and work for us, because actually, your drive and remit, everybody has a personal preference where they want to work, and sometimes it might not be older adults, and the values based questions are so standardised, which is fine, I don't actually have a problem with standardisation, but we also need to have a sensibility of asking, the questions, or I need to ask them, or the ward manager needs to ask the questions, that are relevant to the local area. And that is, for me, older adults. So, it's just trying to get a balance between standardisation without losing the local feel of it… I do need to know that they have the right traits and qualities for people that we need to be working for." (Stage 2: Mental Health: Service 94)

"I actually find them really restrictive. I don't like them at all. They're very based on the values, but they're not based on what you want to ask about experience and team experience. So, we tend to do three or four of those [central values questions], and then three or four of our own questions that are pertinent to the role… Because if you're interviewing properly you will find out about those values, and others, and it just seems a bit restrictive going right, okay, well these are the values we're looking at, rather than, you know, honesty. Why is honesty not in there? Right, do you know what I mean? It's, it just feels a bit restrictive." (Stage 2: Mental Health: Service 99)

There was not collective enrolment and engagement with the policies and procedures for VBR in this organisation. There was a split between the 'espoused' vision for VBR by staff at an executive level and its enactment in practice by service and hiring managers. The reluctance and at times resistance of service managers to engage with

these policies and procedures diminished possibilities for effectively embedding VBR across the organisation and its services. This was further hampered by the perception that interviews were not the best approach for establishing an individual's values and competence for a role:

> *"I think if you can truly recruit people who have got the values that our organisation has put out then, yeah, absolutely. I guess my cynicism is you have 45 minutes to an hour to assess whether they have those values. [I: Yeah. Well, it's interesting because my next question relates exactly to that. How confident are you that the process you've got enables you to recruit people with their right values?] I'm not 100 per cent confident. I think you get a feel for people. Don't get me wrong, you get a feel for people and you can see bits in people that you like or that you might – not dislike – but you might think, mm, I'm a bit unsure about you. But I think, yeah, there's no certainty around it at all."* (Stage 2: Mental Health: Service 91)

The interview was considered problematic when recruiting staff whose first language was not English. It was also caused problems assessing candidates who re-apply for posts in the organisation as these candidates gain familiarity with the values questions and rehearse answers (rather than this being a snap assessment of "actual" values):

> *"I suppose the problem with the values-based is that people can get used to it, can't they? So, where you've got the people that keep re-applying…they might think, oh well I know what the questions will be."* (Stage 2: Mental Health: Executive 88)

Participants also revealed the challenge of promoting an objective interview process, describing acting on a 'gut feeling' towards a candidate:

> *"But, I mean, at the end of the day, it's about finding the right person for the post that you're advertising. And you get a feel for them, don't you? Well I think I've done it for so many years, so I get a feel for people at interview, and I think you can tell pretty early on, if they come across as the person that's the right personality for the role you're looking for. [I: Yeah, I've heard that before*

actually, and how do you, do you know what it is that enables you to do that?] It's a gut feeling… I'm a nurse by background, and obviously people is my job, and I think I'm pretty good at sussing people out fairly quickly. You do get hoodwinked on occasions. [I: I'm sure]. And it is about that feeling, it really is, much more so if I had the right feeling about someone, I'd be possibly a lot more, kind of dig much deeper with them at the interview, to really challenge their values, and morals and standards. Just to ensure that, I think you're right, I just want to check for myself." (Stage 2: Mental Health: Service 96)

Such gut feelings (as decision making heuristics/shortcuts) decreased the objectivity of the VBR approach. The appraisal of interviews by service level participants as a mechanism for recruiting the right person alongside assessing values in those interviews impacted on their commitment to and confidence in VBR.

VBR and the 'very real' recruitment and retention challenge

Many participants discussed the ongoing national challenges of recruiting and retaining staff in health care roles, particularly within mental health care and services:

"…it's been an ongoing process. Such is the nature of health care; such is the nature of dementia work. I don't think I've ever been part of team where there hasn't been one vacancy. It's something that's constantly happening, recruitment wise." (Stage 2: Mental Health: Ward 87)

The Trust's investment in VBR was perceived as important for highlighting the organisation's commitment to recruiting and retaining staff of a certain standard, with the right values. The extent to which this ambition was realised varied amongst participants. Participants reported some candidates were shortlisted for interview even when (i) their values were not clearly articulated in the application or (ii) when the candidate may have already been rejected for a previous post because they did not demonstrate values that aligned with those being assessed for a role in the Trust:

"Shortlist them, yes. They [managers] probably would. I don't know if that's because of how desperate we are for nurses, or it's because they think, oh

perhaps they've [candidate] gone away and reflected [on their values]." (Stage 2: Mental Health: Executive 88)

Many participants at executive and service level indicated that candidates unable to demonstrate values at interview would not be offered a position, despite the staffing shortage:

"One, it's, there's a message to the applicant, that these are the kind of people we're looking for. And two, I think it does help us to screen out those people that we think are not holding the Trust values, which are essentials really, for the people we're looking after. So, I think it is important actually." (Stage 2: Mental Health: Service 89)

"I'm still a firm believer, even when you're desperate, and maybe five people applying out of that five, only one might turn up on the day, I think you've really got to be true to yourself, and think, well we need the right person for this role, for our patients. 'Cause if you have the wrong person, the disruption that they can bring is just not worth it. [I: Yeah, sure]. I certainly try and stay true to that. It is very challenging, and you do look at people and think, could I, could I? But I still think that gut feeling has got to be the winner all the way." (Stage 2: Mental Health: Service 96)

These may have been 'ideal' or 'espoused' views; alternative views were certainly expressed. A service manager who continually struggled to recruit staff, and had a large number of staff vacancies, reported their priority was recruiting people *'with a pulse and legs'* (Fieldnotes) to ensure the continued delivery of their service. VBR was not positively appraised by all staff and in all contexts. There was no universal commitment to VBR. There were tensions between espoused organisational recruitment policy and its enactment in services.

Trust recruitment policy stated that service user, carer or BME (Black and Minority Ethnic) representatives should be members of each recruitment panel. The composition of recruitment panels in the trust varied widely; ranging from entirely senior staff, to staff with a service user or patient involved:

"I would possibly ask carers to come onto the panel… It's much more powerful I think for a junior member of staff to ask a prospective manager how are you going to deal with this in our team? [I: And as it is at the minute who's on the panel with you?] More senior staff." (Stage 2: Mental Health: Service 91)

"We have a patient, we have a service user, on our interview panel. [I: Ah, that's interesting. You're the first person who's told me that]. And our service users have had some training to undertake interview skills. They do ask a couple of the questions; before we do the interviews we've got all our packs made up for us, so we will ask the service user what questions they'd like to ask, and if they've got any ideas is there anything they want to change before we start the interviews, because obviously we ask the same questions to all the candidates and stuff. And then there's always two members of staff and a service user, and when there is, say, somebody says, yes, they'd be good, somebody else has got concerns, we ask the service user what they think, could they relate to that person, if they were in crisis could they talk to that person, if they were in recovery could they go through their recovery with that person, and what help do you think they would be, how could they do it. And so obviously the service user has quite a big say for us as well." (Stage 2: Mental Health: Service 98)

The composition of the interview panel was considered essential for maintaining standards in the recruitment process. When the panel included members who may know the candidate then this could create challenges that required careful management by the Chair of the recruitment panel to ensure fairness of process and that candidates were assessed on interview performance only:

"…if I was to sit on a panel with someone and someone says, oh gosh she [candidate] didn't answer that, I know that she knows this, I know. And I go, well I'm sorry, you might know what she knows, but you can only score her for what she said." (Stage 2: Mental Health: Executive 88)

Enactment of VBR in the organisation was limited because policies and procedures were not being fully adopted or executed across the organisation. Attempts were being

made (as discussed above) to engage staff participation and realisation of the benefits of VBR for individuals, teams, and the organisation when organisational and individual values were aligned.

Alignment of organisational and individual values

Candidates recognised that recruitment was focusing on how individual values aligned with those of the organisation. They understood this was important for patient care, particularly in the context of mental health care:

> *"Because you're working, you know, you've got to have a good rapport with the patient, you know, you're quite often dealing with complex situations from a patient and with their family and, I mean, you've got to be quite reliable, because you're going to be in this patient's home from hospital too."* (Stage 2: Mental Health: Candidate 100)

> *"…principles and values of the NHS and trusts you're working in to meet the needs of the client, so hopefully you embody the values that the NHS and my trust would have really, whatever they are. To provide the best service and to ensure that the clients' needs are at the core of everything we do and have an empowering approach, yes, and to respect people and value everyone as individual."* (Stage 2: Mental Health: Candidate 102)

Staff working in executive or service lead roles considering this alignment meant they were, in turn, more likely to consider the consequences of appointing a member of staff *without* these values. When the values of an individual did not align then this was considered as having potential to significantly impact on services and teams due to management time likely to be invested in individuals' performance and capability:

> *"…we believe that if you ask these questions, you'll get the right candidate and then hopefully you won't have the performance and the capability and all of that goes with it. So, in terms of…you know, once they're here, they won't be so resource intensive as someone might be, if we weren't assessing if*

they've got the values that we want them to have." (Stage 2: Mental Health: Executive 88)

"I have been very careful about ensuring that the right people are employed and I would rather have vacancies than have the wrong people in them." (Stage 2: Mental Health: Service 92)

Values 'set the tone' of the organisation

There was recognition that for staff to enact organisational values that they had to experience these values in their day-to-day work. In particular, as exhibited by their line manager and senior management team:

"I think it just shows we care about each other; in the same way we care about our patients. And in challenging times, staff really do need to be nurtured and looked after. And, I think if they feel valued, as well, that really supports them at work. And, just being open and honest with each other is so important, 'cause there's often things you can sort out with your staff member, whereas maybe traditionally, they may have just gone off sick." (Stage 2: Mental Health: Service 96)

"I think it may have a positive impact on that because if you work in a team where people have good values generally the team is happier or want to stay together. Could you say that's a definite? Could you have done values-based recruitment? I don't know if you can… I think it's about staff not just having the same values as each other and as the organisation. I think it's to do with work pressures from the organisation itself and it's no good having a group of staff that have the same values if the organisation doesn't." (Stage 2: Mental Health: Service 91)

Leaders in the organisation were considered key for setting this tone and role modelling the values of the organisation in their everyday individual practices and interactions:

> *"I have a strong sense that, you know, the stronger the leadership team clearly the better the organisation will ultimately be but that the behaviour of the leadership team particularly at a senior level set the tone for the organisation standards, the level of I guess, you know, standards being set at a particularly high level being the benchmark."* (Stage 2: Mental Health: Executive 90)

It was also recognised that values had to be embedded beyond initial recruitment and into post-recruitment processes such as supervision and appraisal. By building in values into ongoing supervision, opportunities for addressing working practices that may not fit the organisational values were created. This was considered particularly important as there was recognition that the clinical roles in the Trust were challenging. As such they were likely to impact on an individual and their values:

> *"But, I think sometimes, you know, once you've been in a job like this for such a long time, that your compassion can slip because it's something that you deal with on a daily basis."* (Stage 2: Mental Health: Service 95)

This highlighted that staff had internalised the potential value, benefits, and importance of values, even without full commitment to VBR. Evidence based commitment would have been challenging for most, given the lack of empirical evidence of the impact of VBR on individuals and organisations.

Perceived impact of VBR

The organisation had not considered gathering data to demonstrate impact of VBR. In part, this was due to the merger of two organisations with differing pre-existing recruitment approaches. There was also an acknowledgement that implementation of the VBR approach would take time to embed and recognition of the varied recruitment practices across the organisation. Indeed, not all organisational policy documents had been amended at time of data collection. For example, the candidate pack still made reference to organisational values of Trust 1. Nonetheless, at the perceptual level, impact was a strong part of peoples' narratives; even if that impact was not always positive.

A small number of potential impacts of recruiting staff for values were identified, including improved staff and patient survey results, lower turnover and improved staff retention:

> *"I suspect that some of the reasons [why people leave] are because people don't feel valued and that's possibly because we're not living the values we have."* (Stage 2: Mental Health: Executive 86)

Some participants acknowledged a link between patients' experiences of care and services and staff working in ways that demonstrated the values of the organisation. This indicated that there was partial perceived worth for individual participants that the recruitment interview needed to include an assessment of a candidate's individual values and how these aligned with the values of the organisation.

At a service and ward level, participants were more sceptical about potential impacts of VBR. Especially when considered in isolation from broader policies and working conditions and the substantial demands and pressures described:

> *"I don't know really, obviously, if you are employing the right sort of people then, you know, you are going to have a better team. But I just don't think that would influence sickness and retention, because I think the teams are so stretched that I don't think anything like that would make a difference."* (Stage 2: Mental Health: Service 92)

> *"And I think if it's the organisation and the pressures of time on people, the pressures of caseloads, all those types of pressures impact on people wanting to remain in the position and I think at the moment in terms of recruitment it's a buyers' market for those who are registered staff or anybody, because you can pick and choose where you go."* (Stage 2: Mental Health: Service 91)

> *"Also, I think there's elements of, certainly in my profession, people becoming quite either disillusioned or burnt out, and wanting to leave."* (Stage 2: Mental Health: Ward 93)

At a service level, participants argued VBR would ensure staff were employed at a threshold to promote patient focused care:

> *"I think it's more enhanced. I think it gives us quite an in-depth process to actually assess people to meet that criteria, if I'm honest, it's a lot clearer, yeah… I don't know whether I'd say it would enhance it. I would say I think it's set very clear boundaries as to what we're looking for."* (Stage 2: Mental Health: Ward 97)

Existing staff who had worked in the organisation were an ongoing challenge for performance management and at ward level. Managers were placing new staff under mentorship of staff employed using VBR:

> *"I think some of the issues with recruitment if you're wanting to change the culture or the team is you're going to have, you know, a large proportion of old or existing staff in there anyway, so it's really difficult I think. I think you can bring some new people in et cetera and that's always a good start, but you've also got your residual potential of just challenging difficult members of staff within that team anyway, if you see what I mean… We've got some staff here that's been here since the eighties."* (Stage 2: Mental Health: Service 91)

> *"Yeah, I would say probably because a couple of the ones that I've recently recruited based on more values than their experience in working in dementia care while the older ones have all the knowledge actually the values and the ways the people work and you can just see it in the standard of work, it's probably a lot higher. [I: In the more recent appointees?] Yes, the more recent employees."* (Stage 2: Mental Health: Ward 87)

VBR was an important "starting point" but that values had to be embraced in the spirit of the wider organisation and through ongoing values-based employment initiatives to promote impact. An important consideration for this case site is ensuring fit between the VBR policies and procedures and how different levels of staff defined their contribution to these policies. Individual and collective 'buy in' to VBR and building practices to support it are essential to promote engagement with, and contribution to,

VBR by staff across the organisation. There is ongoing work required to embed VBR in this organisation, to sustain it and to maintain staff involvement with it.

SUMMARY

This chapter presented findings of the implementation of approaches to assess values of health care professionals employed in two NHS Hospital Trusts. Recruiting for values was not mandated for NHS organisations and there was wide variation across NHS Trusts of their stage in engaging with VBR. Two very different approaches were used in the two NHS case sites. In the Acute NHS Hospital Trust, a strengths-based approach was being (partially) used. This approach recognises the person and their individual strengths (which includes their values) and that their motivation at work comes from these strengths. In the Mental Health Hospital Trust, a newly merged organisation, the Trust had reviewed their values and established mechanisms for these values to be assessed during recruitment of new staff. We presented the findings of these case sites separately due to the very different approaches being deployed.

Our evaluation focused on the implementation of these approaches and the factors that promoted and inhibited the incorporation of values into recruitment practices. Specifically, we focused on the work that individuals and groups have done to enable recruitment for values or strengths (which includes values) in NHS organisation. We have been able to explore how individuals and groups have made sense of values in their recruitment, their engagement with values, work ‘done’ to embed values in recruitment and perceived impacts.

CHAPTER 6: STAGE 3 - REFINED THEORIES OF VBR

In Stage 3 we refined the initial theories of VBR developed from our policy and literature reviews and interviews (Stage 1) and tested in Stage 2.

In Stage 1, we generated five initial theories of VBR (see Chapter 3, Figure 3, Page 74), containing 5 key mechanisms:

i. resonance and relevance of the VBR policy for education and service providers to promote values;
ii. partnership working and a collective view about values and how these should be assessed;
iii. systematic and standardised approaches for assessing individual values;
iv. alignment of an individual's values with the system in which they will work; and
v. an increase in individual engagement with the role for which they will be recruited (programme of study or health care position).

This chapter develops these theories, drawing on the case study empirical work and NPT. We considered the five mechanisms listed above, alongside the contexts (conditions that trigger or modify the mechanisms) and associated outcomes (both intended and unintended consequences at organisational and individual levels). This cross-case scrutiny led us to remove the initial programme theory focused on increased engagement of the individual with the role for which they will be recruited (v). This has been incorporated into the fourth theory focused on values alignment.

In each section we detail the initial VBR theory, summarise key findings from across the case sites relating to this theory and then present a refined theory of VBR based on the empirical work.

RESONANCE AND RELEVANCE

> ***Initial theory:*** *If a strong policy argument and/ or mandate is made for VBR (context) then this will resonate and be considered to have relevance by education and service providers (mechanism) and there will be increased engagement and commitment to embed a VBR approach in the organisation (outcome)*.

VBR was mandated for HEIs but not for NHS organisations; an important contextual backdrop for understanding the variable resonance and relevance of this policy amongst staff and service users involved with recruitment in the two sectors.

Regardless of context (HEI or NHS), case study participants did not consider VBR 'novel'. For many, there had always been an element of values assessment in individuals when recruiting for a programme of study or health care professional role. Differentiating between old and new style recruitment was challenging for many participants. The mandate and policy argument for VBR did not resonate with many of the education and service staff involved with recruitment. Despite the reported lack of relevance and resonance of the VBR policy amongst many participants, the policy prompted two important areas of differentiation. First, it refocused the attention of education and service providers on those *patient-focused values* needed for health care professional practice. Second, it led to consideration of the approaches and processes that should be used to assess these values.

VBR promoted greater transparency in recruitment procedures. The case studies revealed the detailed and varied processes used for assessing values. Whilst participants expressed frustration with the lack of national guidance on 'how' to recruit for values, for others this offered flexibility for local adaptation.

The benefits of investing in VBR and its processes were not fully realised – at least as perceived by participants. There was resentment and scepticism among participants attributed to the time and resources invested in "new" recruitment approaches and processes. With doubt over whether any difference in decision-making when selecting health care professionals and students had resulted. With no organisational reports about the impact of the changes in recruitment to inform staff

about effects - both intended and unintended – then such scepticism was sustained. This lack of individual and staff recognition of the value of VBR impeded the internalisation of VBR into everyday practices and communal appraisal that change was worthwhile. In the mandated environment of HEIs, staff developed a shared understanding of the *purpose* of VBR, even though different views on its *usefulness* were expressed. For staff in NHS organisations, where VBR was not mandated, this collective sense-making was more limited. There was a split between staff who could see the potential value of VBR and those who failed to see value for their work. This disaffection impacted on engagement. In the NHS, universal engagement with the new recruitment procedures was not universal.

Senior leadership and management 'buy-in' to drive VBR policy in the organisation was important. Leaders needed to secure the involvement of other key people ("opinion leaders") to develop recruitment approaches and process. Once these were engaged, other staff could be enrolled from across the organisation to embed VBR into everyday recruitment practices; something that required sufficient resourcing. South University's "organisational commitment" to MMIs, and North University's personal involvement of the Dean of the Health Faculty, both provided resources and offered managerial commitment to operationalising VBR. In the NHS, resource constraints hampered the development and embedding of values-based approaches. The change process was not closely managed and variability and loss of fidelity from original blueprints ensued; limiting the integration of VBR into everyday work. The personal and organisational investment in the processes and tools used in each case site that provided the depth and spread of understanding about VBR's implementation and fostered ensured that VBR resonated with participants.

Refined theory: *A strong policy argument and/ or mandate for VBR appreciated and embraced by key leaders in an organisation, who can meaningfully engage colleagues and/ or "opinion leaders" (context) to operationalise the assessment of patient-focused values in everyday recruitment practices (mechanism – resource) in ways that resonate and are considered to have relevance by education and service providers (mechanism -reasoning), supported by adequate resources and clear management commitment (mechanism - resource), will promote collective responsibility and increased engagement and commitment to embed VBR by staff in the organisation (outcome).*

PARTNERSHIP WORKING

Initial theory: *If the optimal mix of people (including patients and public) are engaged in VBR (context) then this prompts partnership working and a collective view about values and methods for how these should be assessed (mechanism) and this leads to an approach that is transparent and meaningful and ensures recruitment of individuals with these values (outcome).*

VBR provided an opportunity for recruiting organisations to reconsider their approaches and processes for recruiting for values. The VBR Framework highlighted partnership working, and the importance of patients and public being involved in stages of recruitment.

Patients and public/service users were engaged with VBR in both HEIs and in some recruitment activities in the Mental Health Trust studied. Health care professionals were engaged with many of the HEI selection events – albeit to varying degrees, due to clinical pressures and competing service priorities (health care professionals were not paid for their involvement in HEI recruitment). Students were engaged with selection events for some programmes at North University. In both universities they informally supported recruitment events in the attraction phase (open days), and selection (site tours, Q&A sessions, candidate debriefing sessions). Service users were engaged with selection interviews at the Mental Health Trust, but only in recruitment for some services and at the discretion of the appointing manager.

Health care professionals and service users were primarily involved with selection events in the universities. Whilst North University's service user engagement felt broader (encompassing design and review of recruitment processes) and supported by an academic lead, it was not possible to determine the impact of this on candidate selection.

The diverse mix of people – academics, service users, health care professionals and current students - enhanced recruitment processes, at least in the narratives of the participants. Limiting involvement in selection events was defended due to the time that people may be unable to commit to recruitment activities. Several reasons for the mix of people in recruitment were offered:

- academics were able to assess the academic capability of the candidates and potential for development;
- service users were better able to assess "softer" (sic.) skills such as compassion or empathy;
- health care professionals were crucial because of their experience of the clinical role and support roles for students during periods of assessed clinical practice;
- student health care professionals could provide their experience of the realities of studying as a health care professional and the academic and clinical demands.

This diversity of people involved in recruitment processes also served to showcase the health care programmes and highlight partnership working.

The mix of assumed skills and experience created tensions and questioning of fitness-for-purpose. Not paying health care professionals for their time on a university interview panel and service users falling ill led to last-minute cancellations by panel members. This created logistical problems (particularly for MMIs) and compromised a sense of an optimal mix. Perceptions of the roles occupied by different members of the interview panel also varied. Academics often questioned whether the "right" service users were in place. Often these were portrayed as 'professional patients'. The competence and capabilities of users for assessing

candidates was questioned by some. Service users questioned whether interview panels comprised the “right” academics and clinical staff. Professional snobbery, its impact on the professions in the future, and recruitment perpetuating snobbery were all raised as concerns. Finally, adequate support for external panel members was considered important, but sometimes provided with insufficient depth to equip external panel members for their role; begging the question, whether a mix of panel members makes any difference to the interview process or outcome. Panel members and candidates positively appraised this mix but our analyses of candidates’ scores and interview outcomes suggests interviewer mix is not as important or impactful as was often assumed.

Refined theory: *People with diverse backgrounds (which includes patients and public), who are adequately trained in recruitment processes for assessing values and mutually support each other in its operationalisation (context) will be open to working together in new ways (mechanism – resource) and will have confidence in each other’s abilities and unique contribution (mechanism - reasoning) to promote an approach for recruitment that is transparent about the assessment of values by individuals (regardless of background) and who are committed to continue to support VBR (outcome).*

SYSTEMATIC AND STANDARDISED APPROACHES

Initial theory: *If there is a planned approach in design, implementation and evaluation of VBR (context) then this prompts a more systematic and standardised and transparent approach (mechanism) and leads to greater objectivity, sensitivity and specificity when assessing values of candidates (outcome).*

Staff had clearly invested heavily in developing approaches and processes for assessing values in potential health care professional students and staff. Despite this investment, mixed views were present regarding whether values can be assessed at all. Service users portrayed VBR as able to assess the presence (or not) of values such as compassion, but scepticism was more prevalent amongst academics and clinicians.

The VBR Framework itself is not prescriptive. It promotes principles that organisations should consider when recruiting for values and encouraged local approaches appropriate for local contexts. This led to wide variation in approaches deployed. But common to all case studies and regardless of the approach or processes deployed (including structure, content, and scoring) were the attempts by staff to promote systematic, standardised, and transparent approaches for recruitment for values at the selection stage. Despite these efforts (including additional prompts to accompany interview questions) there were variations and inconsistencies between individual interviewers. In addition, academics suggested selection could still be manipulated to accommodate individual candidate preferences, particularly by patient or clinical panel members.

Less attention was given to values in the attraction stages of recruitment - particularly in the NHS. Job descriptions and person specifications for NHS roles often failed to draw on promotional materials developed by the same organisation to embed values (or strengths) into recruitment. Values-based assessments were not adopted in all clinical areas and/or services within these NHS case sites. For example, in the Acute NHS Hospital site SBR was used in ~1 in 5 interviews and in the Mental Health NHS Hospital site participants reported use of VBR as “sporadic”. Resistance was attributable to perceptions of “top-down” implementation of VBR. Rather than compulsion, the net result was variable staff engagement and staff that largely failed to integrate the approach into their existing. Insufficient commitment of resources and limited management support compounded this disjointed adoption.

None of the sites had formally evaluated changes to their recruitment process and so appraising and publicising its impact based on empirical evidence – as opposed to enthusiastic rhetoric - was not possible within the organisations. Feedback on selection events for university health care programmes was informal; for example, free text or verbal comments at the end of the selection day or by email to the lead for admissions. Sometimes experiences were discussed at recruitment cycle review meetings; which only included those involved with recruitment (at North University only). Aside from the possibilities of well-established closed-group biases (Mannion and Thompson, 2014), individuals tended to appraise VBR with reference to the

effects that VBR had on *their own* work. These individual personal evaluations were aggregated into communal appraisal where groups of staff judged VBR as worthwhile, or not. They also provided the opportunity for recruitment teams to consider ways of improving future recruitment cycle processes and for individuals to consider their role in VBR. There were no systems in place for feedback in the NHS sites. Our study was the first opportunity for many participants to appraise VBR. The lack of organisational level data on VBR limited the exploration of impact (beyond perceptions) in this study. Many participants considered it too early to determine if VBR was achieving its intended effects.

For some, VBR promoted equity of opportunity for every candidate. Conversely, amongst university participants the possibility that VBR advantages certain groups over others (mature students with life experience or candidates with experience of health care work) could not be discounted. In the main, VBR was seen as a "fair" assessment of candidates. Approaches such as MMIs offered a check and balance on unconscious bias when assessing candidates because of the number of interviewers involved in the process. Candidates viewed the experience of MMIs positively. Despite efforts to promote a systematic, standardised, and transparent approach for assessing values, interviews remain a very subjective experience and so it was difficult to see how this could be mitigated entirely.

The sensitivity[13] and specificity[14] of values-based approaches was (and is) untested. Diverse question formats in values-based interviews were seen as important for better understanding candidates and their values. Scrutiny of MMIs in one programme at South University suggests they performed badly as a filter for selection. The proportion of candidates rejected was very small. Of those rejected, very few were on the basis of MMI scores alone (Chapter 4, Table 5, page 113). Changes to recruitment processes to incorporate values assessment did not impact on the characteristics and profiles of students at the two universities in the study.

[13] The ability of the selection event to correctly identify candidates with values
[14] The ability of the selection event to designate individual candidates who do not have values

Refined theory: *Locally developed and well-led approaches for assessing values, that are designed with operational level staff and systematically evaluated (context) will support relevant, standardised and transparent recruitment approaches that are valued and adopted by staff across the organisation (mechanism – resource) and that minimise interviewer unconscious bias and subjectivity when assessing candidates (mechanism – reasoning) to promote equity of opportunity for candidates so they can demonstrate they possess the required values for a health care professional role or programme of study (outcome).*

ALIGNMENT OF VALUES OF THE INDIVIDUAL WITH THE SYSTEM

Initial theory: *If VBR is developed to recognise the challenging nature of health care work (context) then this prompts alignment between the values of the individual being recruited and the system in which they will work (mechanism) and leads to increased awareness of the role and improved satisfaction in the role by the individual, improved standards of care for patients, and reduced turnover of staff for the organisation (outcome).*

The importance of promoting awareness of the challenging nature of health care work, particularly in students, was a strong theme in accounts. HEIs hosted attraction events, such as open days, outreach to schools, and widening participation events. They drew on registered students to speak at these events, highlight the importance of clinical practice hours and shift work, the extended study periods compared to other degree courses (because of clinical placements) and being realistic in understanding clinical work. Concerns were expressed that centralisation of recruitment was limiting student involvement in these promotional events and opportunities to highlight the importance of values in the future health care workforce. Social media, something largely outside the control of the organisations studied, was a key vehicle for shaping perceptions of work - particularly for younger candidates.

Interviews (regardless of structure) were a key process, creating the opportunity for two-way conversation between candidate and interviewer(s). Interviews were as much about assessing the candidate and their values as it was about the candidate

determining if the university or NHS organisation met their personal expectations and ambitions. Selection events provided an opportunity for candidates to self-select out. It was apparent that candidates had a range of reasons for selecting a particular programme of study, university, or employer. The interview was only one component informing candidate decision-making.

Explaining the impact of VBR at the level of outcomes generated by health care professionals, students or organisations was not possible. VBR was, for many, an important starting point, but "values" were part of a wider cultural milieux and 'tone' in organisations. The lack of individual and organisational level data collection by participating organisations created challenges for us as evaluators and for participants seeking empirical confirmation of return on investment. Data we were able to analyse indicated no changes to the personal characteristics and profile of students recruited to health care programmes of study pre-and post- VBR. Participant accounts suggested that solely focusing on recruiting for values, and ignoring the contexts that people work or study in, was unlikely to reduce student attrition or staff turnover. There was also little confidence among participants that VBR would contribute to sustaining positive values in staff or students. The wider culture of the environment was considered more influential for the development and maintenance of values.

Refined theory: *Attraction and selection stages of recruitment need opportunities for people with experience to be transparent and honest about the challenging nature of health care work and study (context) so that an individual candidate and staff at the recruiting organisation can have a two-way conversation to assess values (mechanism – resource) and increase candidate engagement with the role so that they can consider their own suitability (mechanism – reasoning) and an informed choice is made about the alignment of an individual's values with the system in which they will work or study and that may influence individual and organisational outcomes (outcome).*

SUMMARY

We started the Stage 2 case studies with a series of five tentative theories of VBR drawn from the policy and literature reviews and interviews in Stage 1. By testing our initial theories in the four case studies, we were able to better understand how and in what contexts VBR might work. This understanding is represented by the refined and expanded theories presented in this chapter.

CHAPTER 7: STAGE 3 - LONGITUDINAL EVALUATION OF VBR

In the commissioning phase, the funder requested we include a longitudinal evaluation of the VBR policy in English HEIs. This chapter presents our longitudinal evaluation to help understand the longer-term implementation of VBR and impacts.

NATIONAL IMPLEMENTATION OF VBR IN HIGHER EDUCATION INSTITUTIONS IN ENGLAND: PERCEIVED IMPACT

Our national survey explored how VBR was implemented by HEIs in England recruiting students to degree programmes of study for nursing, midwifery and allied health professions. Stage 2's findings (Chapter 4) were used to inform the development of the survey for between method triangulation of findings and determining transferability from our local contexts. As well as gathering novel understanding from a broader group of participants involved with VBR in HEIs.

A total of 90 institutional questionnaires were returned, of which 85 provided useable data. Five responses were discarded because: the survey was not completed by the lead for admission (n=3); the university was not stated (n=1); or was a university outside England (n=1). Thirteen of these 85 responses were not included in our analyses describing VBR in the health care programmes. This was to avoid double-counting as respondents replicated information provided by the admissions tutor for health care programmes at the same university. However, we did include these extra responses when analysing individual academic staff perceptions of VBR and its impact.

First, we provide a description of the universities and programmes included in the national survey analyses. We then detail our survey findings in: (i) the processes for attracting, screening and selecting candidates; and (ii) perceptions of VBR amongst academic staff.

Description of survey sample

Analysis of the health care programmes is based on the responses of 72 academic staff with a leadership role for admissions at 37 universities in England (60%

response rate). These represent all geographical areas of England (Table 8). Some of the respondents had responsibility for admissions for more than one health care programme at a university. For example, admissions tutor for Nursing with four separate fields (Adult, Children, Mental Health, and Learning Disability). These responses provided insights into 111 health care degree programmes of study, representing circa one-third (~33%) of England's programmes. Respondents represented a range of programmes, including Nursing (Adult, Mental Health, Children's and Learning Disability), Midwifery, and Allied Health Professions (including Physiotherapy, Occupational Therapy, Radiography (therapeutic and diagnostic), Speech and Language Therapy, Dietetics and Nutrition, and Podiatry).

Table 8: Representation of HEIs by geographical area

Geographical location of HEI	Number of HEIs (n=37)	Percentage of sample (%)
Yorkshire and Humber	7	19.0%
Midlands	6	16.2%
North East	1	2.7%
North West	6	16.2%
London	7	18.9%
East of England	3	8.1%
South East	6	16.2%
South West	1	2.7%

FINDINGS

VBR: Attracting, screening and selecting candidates

Respondents reported explicit promotion of values in marketing materials in 79.3% (n=88/111) of the health care programmes; a fifth (20%) were therefore not promoting values in marketing health care programmes. Further description of the ways in which values were promoted by the universities to attract candidates were provided by respondents for 61 of these programmes. Table 9 presents the methods promoting values used. University websites were used by the majority, in combination with other written materials (such as a prospectus or programme information) or at recruitment events, including as open days.

Table 9: Promotion of values in marketing materials to attract candidates to health care programmes

Marketing material	Number (total n=61)	(%)
Website only	20	32.6
Website, student communications, open days, and other recruitment events	10	16.3
Website and open days	3	4.9
Website and prospectus	13	21.3
Website, prospectus, and open days	4	6.5
Website and specific information about recruitment*	2	3.8
Specific information about recruitment	6	9.7
Open day and course information (e.g. course fact file)	3	4.9

*Specific information about recruitment referred to description of values to be assessed in personal statements/ application and at interview

The majority of respondents reported applicants were screened solely for suitability for a health care programme (n=111) using the application only (n=100; 90%). A smaller number of respondents described using the application alongside the candidate's personal statement when screening (n=8: 7.2%), or the application and a social judgement test (n=3; 2.7%). The in-depth case studies with HEIs (Stage 2) revealed that not all health care programmes assessed and scored candidates' personal statements as part of the screening process prior to interview. However, it is possible that some respondents of this survey may not have explicitly made this distinction between the application and the personal statement for screening.

Respondents reported the most commonly used approaches for selection events for the health care programmes (n=111) were: structured individual panel interview (n=38; 34.2%); group interview based on task plus a structured individual panel interview (n=27; 24.3%); or MMI (n=19; 17.1%). Some selection events for health care programmes used these approaches in combination with another form of assessment (as detailed in Table 10).

Table 10: Methods used to select potential students across health care programmes

Methods used for selection	Number (total n=111)	(%)
Group interview (task)	6	5.4
MMI	19	17.1
Structured interview	38	34.2
Group interview (task) and MMI	4	3.6
Group interview (task) and structured interview	27	24.3
Group interview (task) and test	3	2.7
Group interview (task), structured interview, and test	4	3.6
Group interview (task), structured interview and MMI	1	0.9
Group interview (task), structured interview, and phone interview	1	0.9
Structured interview and test	5	4.6
Structured interview, test, and MMI	2	1.8
Semi structured interview and test	1	0.9

The VBR policy was designed to promote the engagement of a mix of stakeholders with the recruitment process, particularly service users. Service users (patients and or members of the public) were involved with student recruitment processes in some form in 91/ of 111 health care degree programmes (82%). Almost one-fifth of programmes failed to include service users with recruitment. Service user involvement was mainly limited to selection events (or interviews) (n=64; 70.3%). For a small number of health care programmes, service user involvement with the selection event was combined with other recruitment activities, including designing interview questions or screening applications. For 15% (n=14) of health care programmes, service users were not involved with the selection event or interview. Table 11 provides respondent details of service user involvement with the recruitment processes for the health care programmes.

Table 11: Service user involvement in recruitment process for health care programmes

Service user involvement in recruitment processes	Number (total n=91)	(%)
Selection event	64	70.3
Screening applications + selection event	3	3.3
Designing interview questions + selection event	9	9.9
Screening applications + designing interview questions + selection event	1	1.1
Designing interview questions (individual or group interview)	10	11.0
Designing interview questions + assessment materials + open day events	4	4.4

Health care professionals (or clinicians) were involved with student recruitment processes in 104 of 111 health care degree programmes (94%). The majority of health care professionals were involved with selection events (or interviews) (n=96; 92%). Table 12 provides respondent details of health care professional involvement with the recruitment processes for the health care programmes.

Table 12: Health care professional involvement in recruitment process for health care programmes

Healthcare Professional involvement in recruitment	**Number (total n=104)**	**(%)**
Selection event	96	92.3
Screening applicants	3	2.9
Designing interview questions	2	1.9
Screening applications + selection events	1	1.0
Selection events + designing interview questions	2	1.9

The survey's picture of involvement of service users and health care professionals in recruitment processes for health care programmes corresponds with the HEI case study findings (Stage 2): service users and clinicians in these case sites were also involved predominantly with selection events rather than contributing to the recruitment process as a whole.

The perception of VBR among academic staff with a lead role for VBR in HEIs

Academics (n=85) recruiting to health care programmes responded to 12 statements capturing their perceptions of: (i) the VBR policy and its aims (5 questions); (ii) the implementation of VBR within their university (3 questions); and (iii) the impact of VBR (4 questions). The questions were phrased positively and built on Stage 2 case study findings. Table 13 summarises the responses of academic staff to the statements listed in the survey. Of these 85 respondents, over half (n=43) provided additional comments related to their perceptions and experiences of the VBR policy, its implementation and impact.

The VBR policy was positively appraised. It was considered relevant (Q7) and capable of measuring candidate's values (Q8). Recruitment processes were seen as facilitating assessment of the alignment of individual candidates' values with the

systems in which they were to work (Q16). Colleagues involved with recruitment were committed to engaging with VBR (Q17) and organisations were seen as committed to VBR (Q13). Generally, recruitment processes were well designed and implemented (Q15) and there was a shared understanding about how values should be assessed (Q18). However, respondents considered that students recruited to health care programmes needed to be assessed for more than solely their values (Q14). Respondents had positive perceptions of the impact of VBR (Q9-12).

Table 13: Perceptions of academic staff

Statement aim	Survey question number and statement	Median (inter-quartile range)*
VBR policy	*7. I consider VBR to have relevance when recruiting potential students*	1 (1)
VBR policy	*8. I believe it is possible to measure values in potential students*	2 (1)
VBR impact	*9. Recruiting students based on their values has a positive impact on the programme*	2 (1)
VBR impact	*10. Recruiting students based on their values has a positive impact on their first professional post*	2 (2)
VBR impact	*11. VBR leads to a positive impact for patients*	2 (2)
VBR impact	*12. VBR leads to a positive impact on the health care system*	2 (1)
VBR implementation	*13. I believe there is a commitment in my organisation to embed VBR in our recruitment of students*	2 (1)
VBR policy	*14. I believe it is sufficient to recruit students for a health care programme of study solely on their values*	4 (1)
VBR implementation	*15. Our approach to VBR is well designed and implemented when recruiting potential students*	2 (2)
VBR policy	*16. When assessing potential students, we ensure they understand the challenging nature of health care work to align the values of the individual with the system in which they will work*	2 (1)
VBR policy	*17. I believe my colleagues are committed to engaging with VBR when recruiting potential students*	2 (1)
VBR implementation	*18. Among my colleagues there is a consistent view about how values should be assessed when recruiting students*	2 (2)

* A 5-point Likert scale (strongly agree, agree, neither agree or disagree, degree, or strongly disagree) was used. A lower score (i.e. a score of 1) indicated a stronger level of agreement, and a higher score (i.e. a score of 5) indicated a stronger level of disagreement.

The open comments of respondents shone a light on new and unanticipated views of academics leading recruitment to health care programmes. Whilst survey responses to the statements were generally positive, the open comments revealed uncertainties related to VBR processes, implementation and impact.

Uncertainty regarding the processes and measures used for VBR and whether these accurately captured candidate values (Box 16) was a feature of responses. Interview processes did not always facilitate assessment of the candidate: what candidates say in an interview may not accurately reflect who they are or how they behave in the 'real' (sic.) world (Box 17). In many circumstances, candidates were perceived to have rehearsed responses for questions, focused on values and how best to present themselves at interview as possessing these values (Box 18). Forming an accurate assessment of the 'authenticity' of the candidate and their values was fraught with difficulties – according to some admissions staff. Concerns were raised that younger candidates may find it difficult to express, or may not yet possess, the values being assessed. The possibility of (erroneously) rejecting a younger candidate was highlighted: values change and are dynamic, they develop during a health care programme of study (Box 19). Whilst the open comments contradicted many of the structured survey responses, they resonate with Stage 2's case study findings. Participants in Stage 2 also expressed concern about VBR processes performance in assessing candidates' values and the challenges of the selection event context for assessing candidates' values. The open comments expanded upon the survey responses that students recruited to health care programmes needed to be assessed on more than just values. Recruitment needed to assess candidates' academic abilities, their understanding of the profession for which they have applied, and their appreciation of the academic and clinical demands of the programme (Box 20). All findings that reinforce the views of Stage 2's case study participants.

Open comments revealed concerns about variable implementation of VBR. First, implementation was perceived as influenced by role and experience. In particular, involving administrative staff with recruitment decisions created tensions for some academics (Box 21). Second, organisational processes for standardising recruitment did not always align with VBR principles and the processes implemented at programme level (Box 22). Concerns regarding centralisation of recruitment and

increasing involvement of administrative staff in recruitment processes were also highlighted by academics in the case study of Stage 2.

Respondents were generally positive about the impacts of VBR. Examples of this impact were provided, including reporting reduced student attrition and positive feedback from clinical mentors (Box 23). However, some respondents noted an *increase* in student attrition and an *increase* in fitness to practice numbers and scope. Whether VBR was linked to these trends was impossible to unpack given the systemic changes impacting on HEIs, such as lowering the UCAS tariff for a programme (Box 23). Respondents raised the lack of evidence underpinning VBR (Box 24).

Box 16: Uncertainties about process and measures

There are issues with validity of assessment, with none of our measures having undergone rigorous psychometric testing to ensure reliability or validity. (Respondent 56, South West)

I do believe values are important, I just do not know the best way to assess and record them! (Respondent 63, South West)

We have always selected students based on knowledge of the profession, personal skills and attributes and values but how best to do this remains unclear. (Respondent 76, North West)

Additionally, although we ask candidates to articulate their understanding of the values and also to give examples of when they have used them this is not enough to tell whether people really hold these values. (Respondent 55, South West)

Box 17: The interview – 'real' world divide

I get tired of hearing the same 6C-based answers - not because they're wrong but because often they're superficial. (Respondent 37, University in Yorkshire and Humber region)

Values seem to be contingent on a number of factors and portraying certain values in interviews (even if they can be measured) does not necessarily mean they are enacted outside of these interview situations. Claiming otherwise I feel is a fallacy. (Respondent 29, Yorkshire and Humber)

I would also suggest the NHS values are not actually values but rather behaviours. (Respondent 33, Midlands)

I am not confident that we assess values accurately as an interview/group activity is a very false environment and candidates are aware they are being assessed. (Respondent 39, Yorkshire and Humber)

In my experience this is not always reflective in their practice and behaviour once on the course. (Respondent 13, North West)

Also with the best will, what people say and do at interview and how they act in real life are not always in alignment. We do the best we can in the short interview time that we have to assess suitability of applicants but this is not fool proof. (Respondent 30, Yorkshire and Humber)

The real challenge ... must like any short assessment process ... is that students can 'appear' to have great values, which they express in interview ... yet these values are not always upheld for 3 years during training. (Respondent 56, South West)

Box 18: Authenticity of the candidate

As with any other recruitment exercise the individual will model themselves on what they think the recruiter wants. This is not always an honest opinion. There must be more than one way to assess appropriate values and suitability. (Respondent 12, South East)

Assessing a person's values via an application form or an interview is extremely difficult. The person is aware that those are things that are being assessed and so can quite easily adapt their answers to suit. (Respondent 17, North West)

However, over the years I have become aware that how a candidate answers at interview may be different to their presentation during the course. Well schooled candidate can speak what they expect the interviewer wants to hear. (Respondent 75, Midlands)

We sometimes find that applicants want to give the perfect answers, often they are prepped by Schools and Colleges with 'the right answers' and I think it's harder to assess the values of those applicants than the ones that just come and be themselves. (Respondent 37, Yorkshire and Humber)

Our ongoing challenge is to try and keep our scenarios/ stations confidential and not rehearsable. (Respondent 19, Midlands)

Box 19: Values are not static

I wonder how many 18-year olds would understand what values meant to them. Sometimes I struggle to understand how we expect an 18-year old straight from school to understand the type of values we are looking for in a caring HCP. (Respondent 65, London)

Part of the education process is to challenge attitudes and values. At 17 years of age some of the young people are still developing in these areas. (Respondent 75, Midlands)

There are also issues around the number of students we need to recruit and also that often these are young people who have the capacity to grow and change so their views and values at interview may not reflect the adult they grow into. (Respondent 39, Yorkshire and Humber)

Box 20: Values is one component of the assessment of suitability of candidates

Following a year in which, for the very first time, we have lost almost half our first-year students due to academic weakness and unrealistic work expectations, there is so much more to consider than simply student values. (Respondent 4, South West)

Academic values are also important, such as adult learners understanding their learning needs and adapting accordingly: this is another key element within our interviews alongside knowledge of the profession. (Respondent 32, Yorkshire and Humber)

Values alone do not make the student. Academic ability is essential to degree programmes too. We see many caring students fail academically. (Respondent 56, South West)

Some applicants describe themselves as caring but do not demonstrate an understanding of the professional aspects or the role of a nurse or midwife. (Respondent 47, London)

Our recruitment has incorporated VBR but also balances looking for academic elements - not all want to complete a degree and enter direct patient care - some want to enhance care by looking to develop a career in health research. I feel maybe the promotional elements for VBR forget that and need updating to incorporate some thought to that. (Respondent 31, Yorkshire and Humber)

Box 21: Tensions between academic and administrative staff

We are governed by decisions made by junior, inexperienced administrative admissions staff as to who is selected for interview, which are not always within criteria provided to them by academic staff. (Respondent 4, South West)

I think the academic staff who are qualified health professionals fully understand and engage with the VBR agenda. Unfortunately, many of our admissions staff working in central University departments, do not understand VBR and cannot see why this is more important than academic attainment, which causes many heated discussions over why we are rejecting applicants. (Respondent 26, South East)

Box 22: Conflict between organisation and health care programme processes for recruitment

Unfortunately, as the University aims to become more standardised across programmes admission, we are losing the ability to screen for values at interview. (Respondent 6, South West)

Whilst we as a team have a consistent approach unfortunately the University's processes don't always align with what we ordinarily do (i.e. when having to recruit through clearing). (Respondent 60, South West)

Box 23: Perceived impact or lack of impact of VBR

We have halved attrition since implementing the MMI and increasing our academic entry requirements. We have received positive feedback from clinicians about the quality of our student midwives. (Respondent 19, Midlands)

I have discussed this with our programme lead, we have found that the number of fitness to practice issues has not reduced as a result of VBR, which might be one measure. Attrition has increased, but we have also had to lower our tariff due to recruitment pressures and attrition seems to be more closely correlated to tariff than values. (Respondent 55, South West)

Box 24: Lack of evidence underpinning VBR

When we set up our current system for recruiting students, we looked at ways of assessing values but there was no evidence in the literature that this could be done successfully or that it made any difference to attrition. (Respondent 39, Yorkshire and Humber)

I am not sure of the evidence available to support the use of VBR at selection and how it impacts on the quality of students transitioning from student to graduate and beyond. (Respondent 63, South West

There seems to be limited evidence both of the impact of values-based recruitment. (Respondent 33, Midlands)

In summary, the VBR policy mandated by HEE was implemented in some form in HEIs. The majority (~80%) of programmes were explicit with applicants that values would form part of the recruitment process. The survey reinforced the heterogeneity of ways of assessing for values: group interviews, individual interviews or MMIs were the most frequently adopted. Service users and clinicians were involved in recruitment processes in many health care programmes; albeit with a limited role and scope.

Respondents saw VBR as relevant and feasible to implement. Individual and collective commitment to VBR processes was evident, as was shared understanding about how values should be assessed. There were concerns about whether questions or measures accurately assessed values.

Unintended consequences of VBR processes included process components that disadvantage some groups, tensions between different recruitment stakeholders

(academic and admissions staff) or between organisational demands (recruiting a full complement of students to a programme) and VBR's principles: only accept candidates who demonstrate values.

Respondents felt assessment should focus on more than values: academic ability; understanding of the profession applied for, and appreciation of the academic and clinical demands of the programme.

CHARACTERISTICS, PROFILE AND CONTINUATION OF STUDENTS RECRUITED TO HEALTH CARE PROGRAMMES IN ENGLAND

We analysed the characteristics, profile and continuation of students recruited to health care programmes nationally to determine if these had changed following the implementation of VBR and associated changes in recruitment processes across English higher education institutions (HEI).

Six years of data for seven different courses: Adult Nursing, Mental Health Nursing, Children's Nursing, Midwifery, Physiotherapy, Occupational Therapy, and Diagnostic Radiography were analysed. Key findings included:

- Numbers of applications to nursing courses fell between 2016 and 2017 and again between 2017 and 2018 (Figure 8). The proportion of older students applying decreased since 2016 and the proportion of those aged 18/19 years has increased (Figures 9 and 10).
- The number of Physiotherapy and Children's Nursing students increased each year from 2013/14 to 2017/18. Adult Nursing and Mental Health Nursing also increased from 2013/14 but then numbers dropped between 2016/17 and 2017/18. For midwifery, with the exception of 2013/14, the number of students remained fairly constant. The number of Diagnostic Radiography students increased each year. The number of Occupational Therapy students increased in 2016/17 but then fell again in 2017/18. (See Table 14).

- The proportion of students from low participation neighbourhoods (POLAR Classification[15]) varied between health care programmes: a higher proportion studied Mental Health and Adult Nursing, and a lower percentage studied Physiotherapy (Figure 11). We found no evidence of a change in the proportion of students recruited from low participation areas after the introduction of VBR.
- The percentage of female students varied between health care programmes: all courses are majority female. Midwifery, Adult and Children's Nursing programmes have the highest proportion (over 90%) of female students. The male/female split has remained fairly constant for all the health care programmes over time (Figure12). We found no evidence of any change after the introduction of VBR.
- The age of the students recruited to health care programmes varied by programme (Figure 13). Over time, the age of students decreased for Midwifery and Children's Nursing (Figure 14). There were no significant changes in age of students after the introduction of VBR for any of these health care programmes.
- The number of students with a higher qualification varied between health care programmes: the highest proportion were for Midwifery and Mental Health Nursing students (Figure 15). There were no significant changes to this profile following the introduction of VBR.
- For students with A Levels, the tariff[16] had increased year on year with a higher proportion gaining more than 360 points (equivalent to 3 A's or higher) on each programme (Table 15). The tariff changed for 2017/18 so these have been omitted.
- There was a decrease in the proportion of white students enrolled on each programme (Figure 16). There were no significant changes following the introduction of VBR.

[15] The POLAR classification looks at how likely young people are to participate in HE across the UK and shows how this varies by area. POLAR classifies local areas or 'wards' into five groups, based on the proportion of 18-year olds who enter Higher Education aged 18 or 19 years old. These groups range from quintile 1 areas, with the lowest young participation (most disadvantaged), up to quintile 5 areas with the highest rates (most advantaged).
[16] University and Colleges Admissions Service (UCAS) Tariff points are allocated to qualifications generally studied between the ages of 16 to 18. Universities use these Tariff Points to report to Government bodies but may also use these in their entry requirements (https://www.ucas.com/ucas/tariff-calculator)

- The majority of students (approximately 99%) completed the first year for each health care programme and continued their studies (Table 16). First-year completion data for students admitted during the academic year 2017/18 had not been released by HESA at the time of our analyses.

In summary, the data did not demonstrate any significant changes in the characteristics, profile or continuation of students recruited to health care programmes in England after the introduction of VBR. The descriptive analyses clearly showed that the biggest changes occurred following the removal of bursaries[17] as opposed to after the introduction of VBR. From 1 August 2017, new nursing, midwifery and most allied health students no longer received bursaries. This affected the health care programmes we evaluated. Nursing (adult, child, mental health), Midwifery, Occupational therapy, Physiotherapy and Diagnostic Radiography. This change applied to students starting in 2017/18. UCAS data showed the number of applications to nursing courses decreased following the removal of the bursaries, the proportion of 18/19 year olds increased, whilst older students fell.

[17] https://www.gov.uk/government/publications/nhs-bursary-reform/nhs-bursary-reform

Figure 9: Number of applicants for Nursing programmes in England

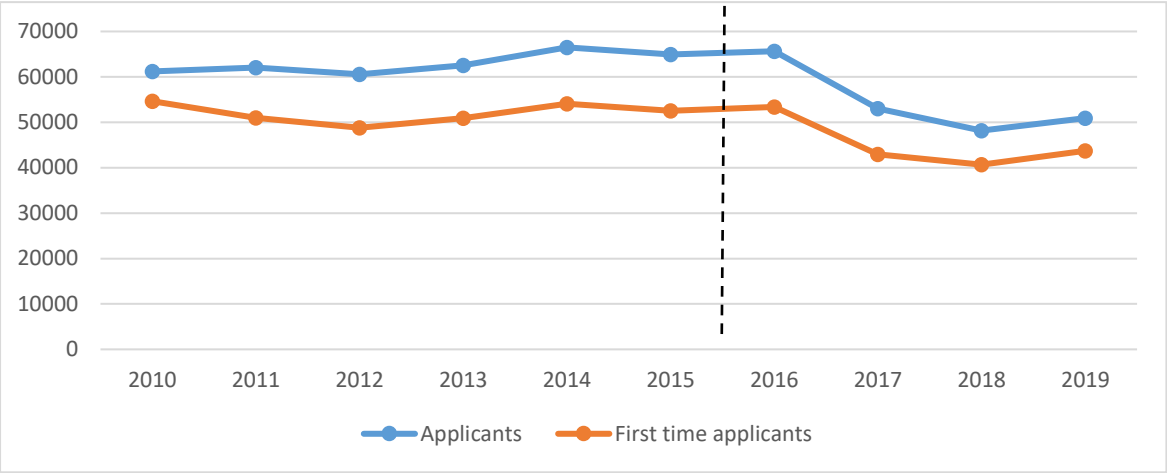


Figure 10: Number of applicants for Nursing programmes in England by Age

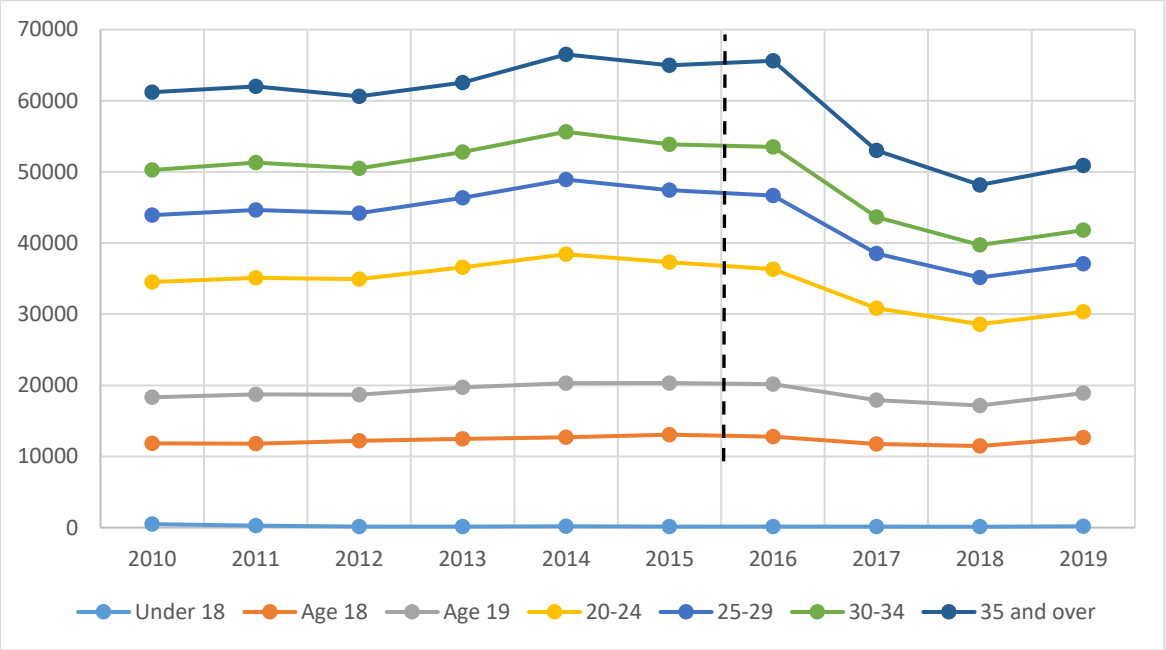


Figure 11: Percentage of applications for Nursing programmes in England from students aged 18/19 years

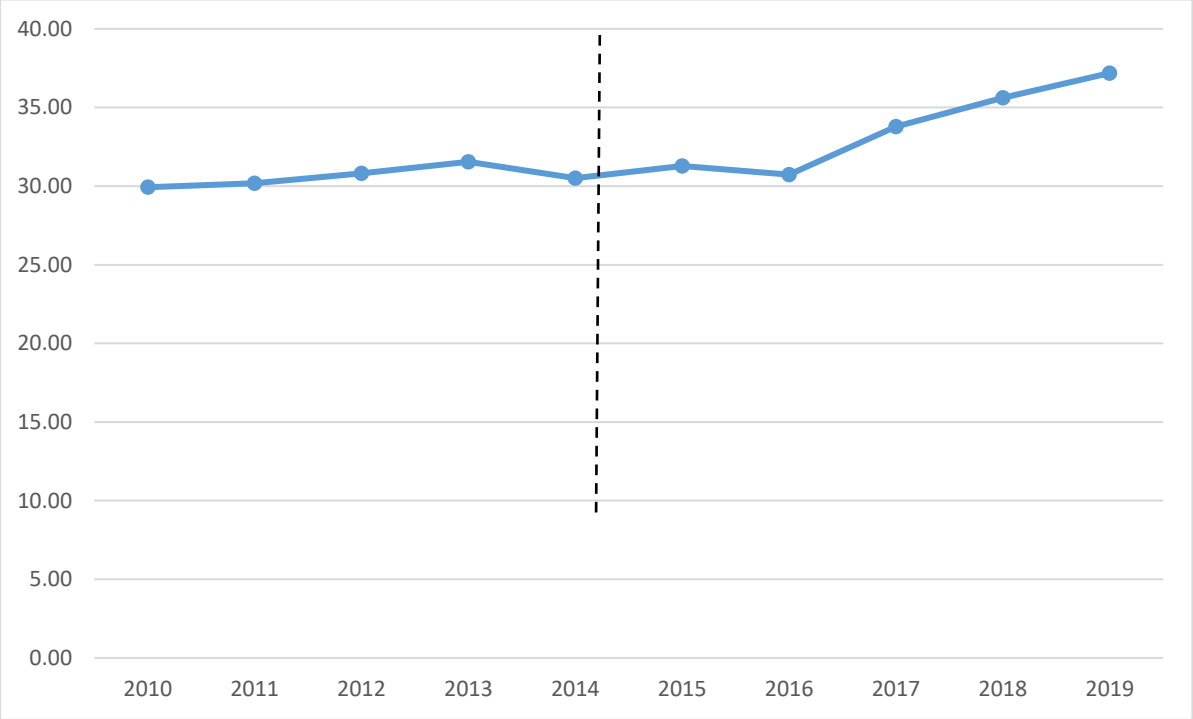


Table 14: Number of students enrolled (Year 1) on health care programmes in England

	Academic year					
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Physiotherapy	1961	1757	1795	1851	1894	2172
Midwifery	3463	3737	3483	3561	3552	3532
Children's nursing	2528	2484	2515	2675	2708	2820
Adult nursing	13446	14392	15509	16231	17397	15279
Mental health nursing	4343	3917	3893	3974	4299	3918
Radiography, diagnostic	1276	1234	1311	1344	1463	1519
Occupational therapy	1724	1736	1728	1774	1802	1661

Figure 12: Percentage of students recruited to health care programmes in England from low participation neighbourhoods

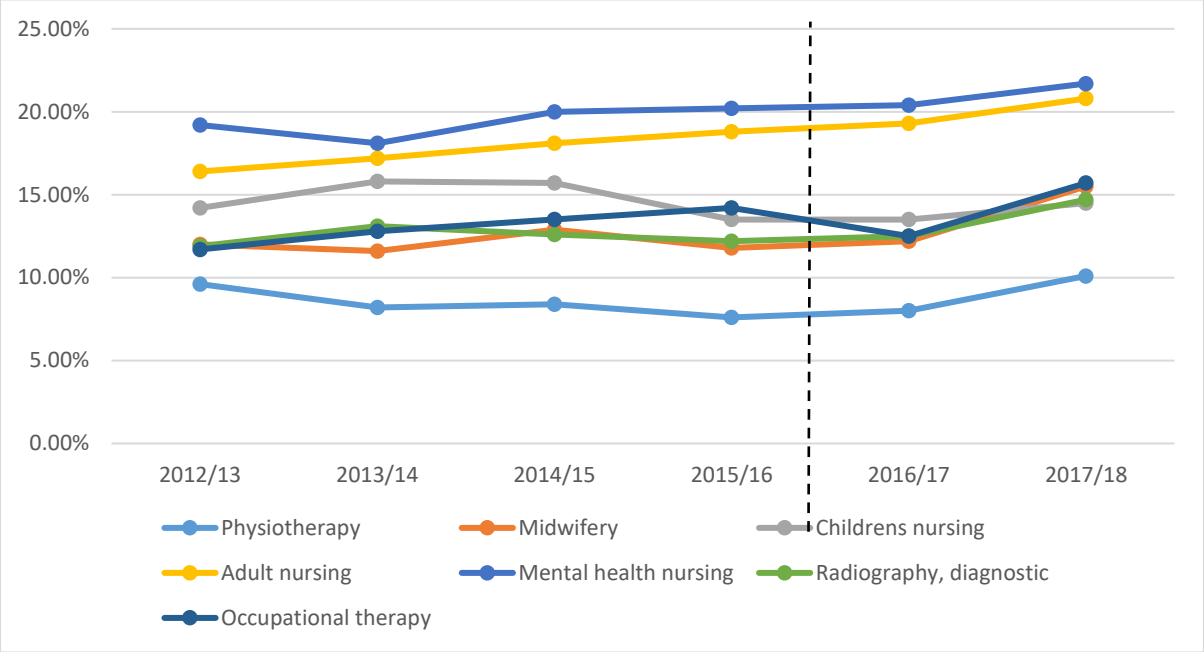


Figure 13: Percentage of female students recruited to health care programmes in England

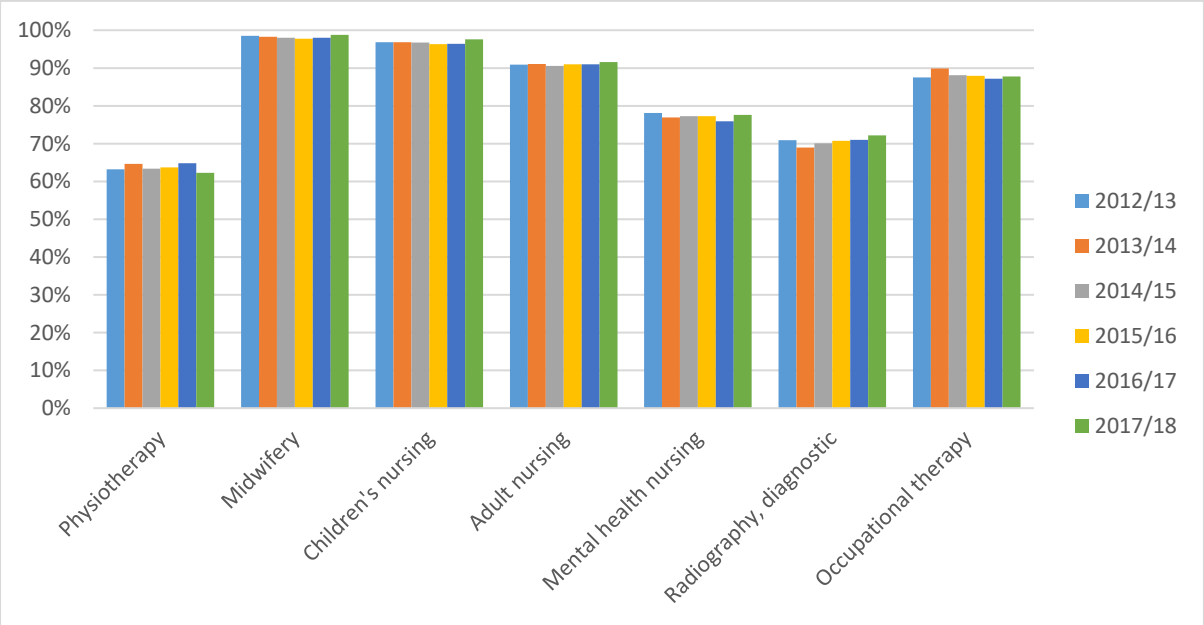


Figure 14: Age of students recruited to health care programmes in England

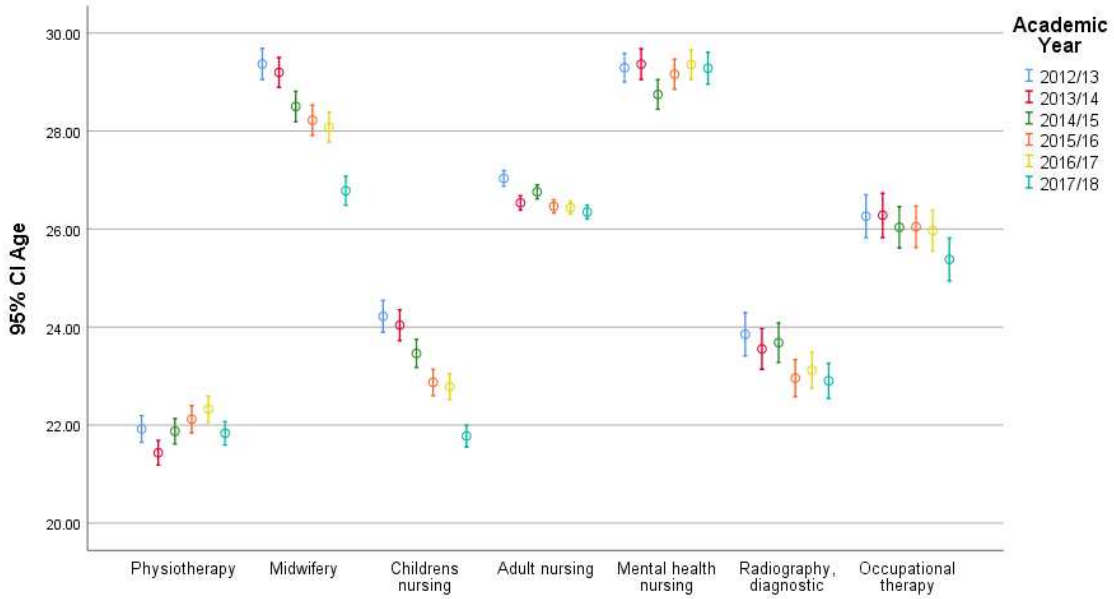


Figure 15: Proportion of students aged 18 or 19 years recruited to health care programmes in England

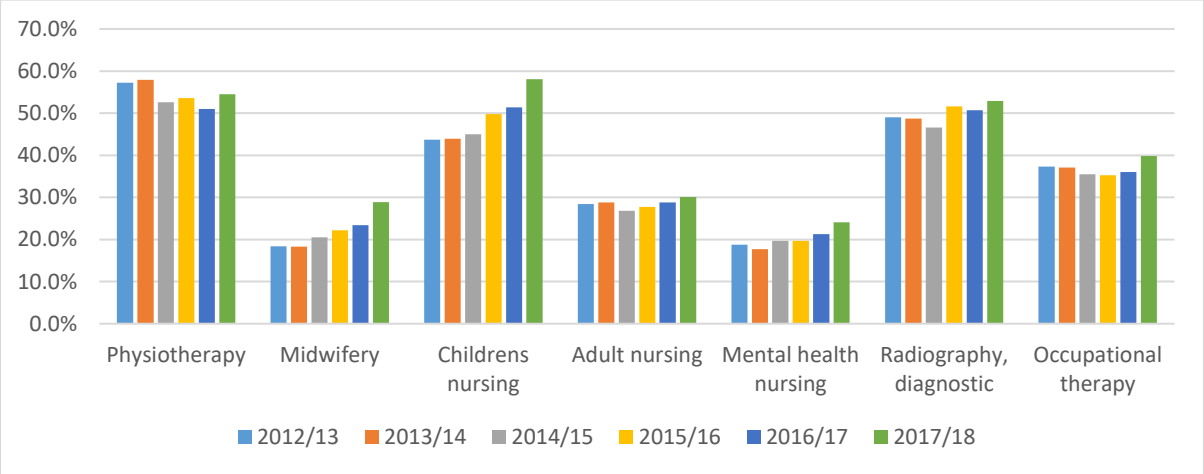


Figure 16: Percentage of students with higher qualifications (first degree/PGCE/postgraduate/ other undergraduate) when enrolled on a health care programme in England

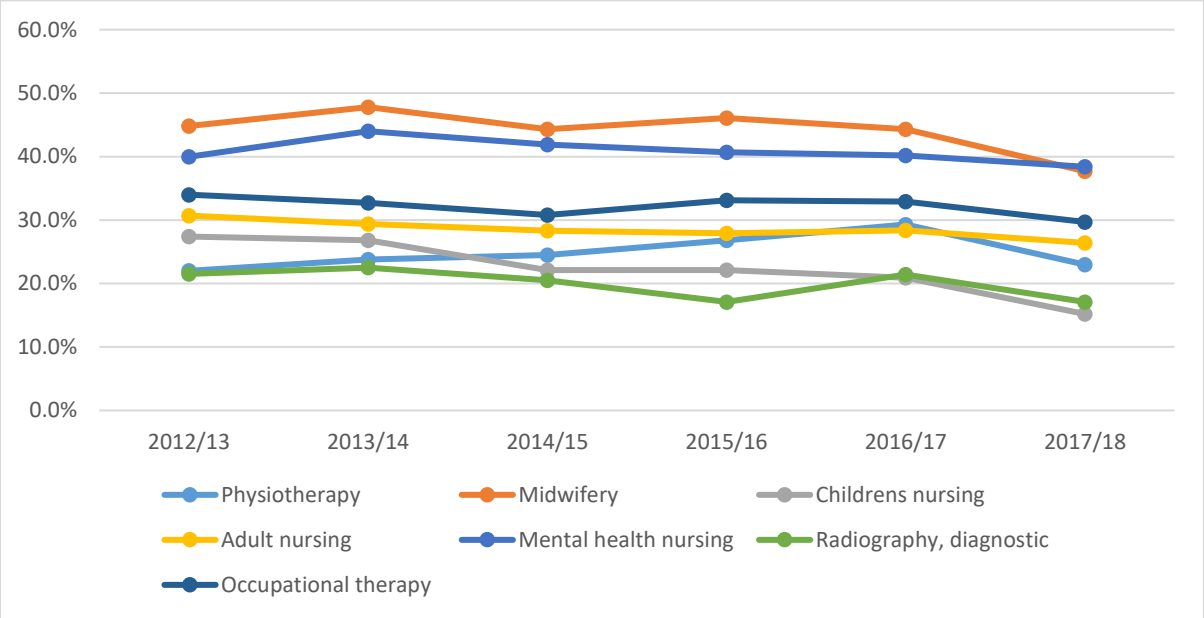


Figure 17: Percentage of students of white ethnic group enrolled on a health care programme in England

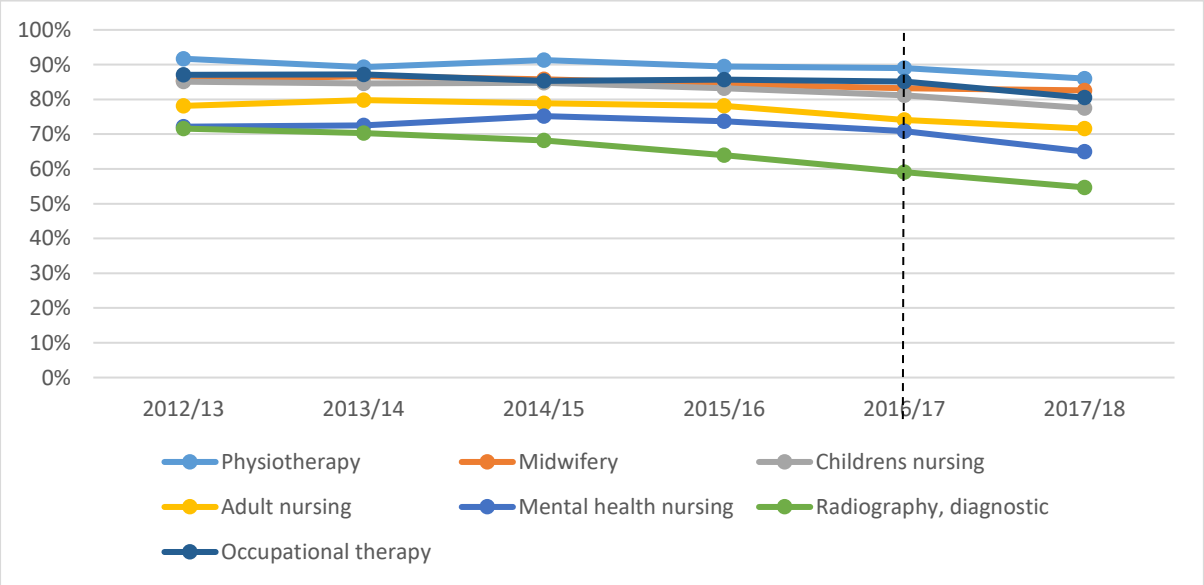


Table 15: UCAS tariff points[18] for students (A Level/ higher only) enrolled on health care programmes in England

	Tariff points	2012/13		2013/14		2014/15		2015/16		2016/17	
		N	%	N	%	N	%	N	%	N	%
Physiotherapy	Less than 300 points	104	8.6%	87	7.8%	107	9.9%	91	8.6%	93	9.1%
	300 - 359 points	220	18.2%	245	22.2%	220	20.4%	236	22.1%	215	21.0%
	More than 359	883	73.1%	775	70.0%	751	69.7%	738	69.3%	715	69.9%
Midwifery	Less than 300 points	287	31.1%	287	28.4%	254	25.1%	215	19.9%	196	17.9%
	300 - 359 points	218	23.5%	232	22.9%	220	21.7%	260	24.0%	246	22.5%
	More than 359	419	45.4%	492	48.7%	539	53.2%	607	56.1%	651	59.6%
Children's nursing	Less than 300 points	519	38.8%	457	34.5%	394	28.2%	401	25.9%	381	23.8%
	300 - 359 points	320	23.9%	290	21.9%	325	23.2%	364	23.5%	393	24.5%
	More than 359	497	37.2%	577	43.6%	680	48.6%	784	50.6%	828	51.7%
Adult nursing	Less than 300 points	2362	48.5%	2351	42.5%	2115	37.7%	2229	35.6%	2258	33.7%
	300 - 359 points	974	20.0%	1142	20.6%	1183	21.1%	1288	20.6%	1392	20.7%
	More than 359	1533	31.5%	2041	36.9%	2316	41.3%	2739	43.8%	3059	45.6%
Mental health nursing	Less than 300 points	594	47.8%	494	45.9%	433	39.5%	425	37.2%	430	34.4%
	300 - 359 points	245	19.7%	241	22.5%	233	21.3%	258	22.6%	298	23.8%
	More than 359	404	32.5%	339	31.6%	429	39.2%	458	40.2%	522	41.8%
Radiography, diagnostic	Less than 300 points	170	23.0%	113	16.2%	159	21.5%	163	20.5%	152	18.2%
	300 - 359 points	212	28.7%	220	31.6%	214	28.9%	228	28.6%	242	28.9%
	More than 359	356	48.2%	364	52.2%	367	49.6%	406	50.9%	442	52.9%
Occupational therapy	Less than 300 points	225	29.3%	216	27.5%	179	23.6%	144	19.0%	162	20.5%
	300 - 359 points	202	26.2%	198	25.2%	197	26.0%	204	26.9%	204	25.8%
	More than 359	342	44.5%	370	47.2%	381	50.3%	409	54.0%	426	53.8%

[18] UCAS tariff points pre 2017/18: A* = 140, A=120, B = 100. The tariff changed for 2017/18 so these have been omitted from this Table.

Table 16: Students leaving without an award at end of first year of health care programme (in England)[19]

	Left without award		2012/13	2013/14	2014/15	2015/16	2016/17
Physiotherapy	No	N	1943	1744	1774	1840	1877
		%	99.1%	99.3%	98.9%	99.4%	99.1%
	Yes	N	18	13	21	11	17
		%	0.9%	0.7%	1.1%	0.6%	0.9%
Midwifery	No	N	3016	3320	3089	3145	3147
		%	98.5%	98.7%	98.9%	98.7%	98.6%
	Yes	N	47	44	35	40	45
		%	1.5%	1.3%	1.1%	1.3%	1.4%
Children's nursing	No	N	2425	2445	2451	2611	2664
		%	99.2%	99.1%	98.1%	98.0%	98.7%
	Yes	N	20	23	48	54	36
		%	0.8%	0.9%	1.9%	2.0%	1.3%
Adult nursing	No	N	11840	14065	15269	15894	17147
		%	98.6%	98.9%	99.1%	98.8%	99.0%
	Yes	N	165	158	144	197	177
		%	1.4%	1.1%	0.9%	1.2%	1.0%
Mental health nursing	No	N	4144	3812	3765	3889	4225
		%	98.7%	98.9%	98.8%	98.7%	99.0%
	Yes	N	55	41	46	50	42
		%	1.3%	1.1%	1.2%	1.3%	1.0%
Radiography, diagnostic	No	N	1260	1227	1291	1330	1443
		%	98.7%	99.4%	98.5%	99.0%	98.6%
	Yes	N	16	7	20	14	20
		%	1.3%	0.6%	1.5%	1.0%	1.4%
Occupational therapy	No	N	1707	1717	1699	1750	1770
		%	99.0%	98.9%	98.3%	98.6%	98.4%
	Yes	N	17	19	29	24	28
		%	1.0%	1.1%	1.7%	1.4%	1.6%

[19] Data for 2017/18 year had not been released by HESA at the time of our analyses

EXPLORING POTENTIAL COSTS OF IMPLEMENTING VBR IN HEIS IN ENGLAND

From 1 April 2015 HEIs were *expected* to use VBR methods for nurses and other health professionals. It is important to consider not only the consequences of this in terms of student outcomes, but also the resources used in the process of screening and selection.

Between April and June 2014, Health Education England conducted an online survey off all HEIs offering funded health care programmes about their screening and selection processes and their progress in implementing VBR.[20]

The findings from this survey provide information on the processes used before VBR was widely implemented (see tables 17 and 18); in comparison with more recent data from the survey conducted in this study, this can potentially be used to identify any *additional* resources used in VBR, and estimate their implied cost.

The HEE survey found that a structured interview was the most common selection method. The survey provided a breakdown by course. To compare this with the national survey conducted as part of the longitudinal evaluation in our study, we used a sample of relevant education programmes: midwifery, nursing, allied health care, specialist nursing and pharmacy. Sixty-seven per cent of respondents reporting from this sample conducted interviews, most commonly by two interviewers and lasting between 16 and 30 minutes. NHS staff were involved in the majority of structured interviews (91.6%), with service users involved in 36.4% of interviews. Group interviews or tasks were the second most common selection method, 47% reported conducting group interviews. The number of candidates in a group varied

20 https://healtheducationengland.sharepoint.com/Comms/Digital/Shared%20Documents/Forms/AllItems.aspx?originalPath=aHR0cHM6Ly9oZWFsdGhlZHVjYXRpb25lbmdsYW5kLnNoYXJlcG9pbnQuY29tLzpmOi9nL0NvbW1zL0RpZ2l0YWwvRXZXTEtocHhTalZPc25rbVFhNG5sRWdCaGk1d0FVaEZJampLU3JVUnB5ZTZadz9ydGltZT14NEJvbTJfdjJFZw&id=%2FComms%2FDigital%2FShared%20Documents%2Fhee%2Enhs%2Euk%20documents%2FWebsite%20files%2FValues%20Based%20Recruitment%2F2%2E%20Evidence%2F4%2E%20VBR%20HEI%20survey%20results%2Epdf&parent=%2FComms%2FDigital%2FShared%20Documents%2Fhee%2Enhs%2Euk%20documents%2FWebsite%20files%2FValues%20Based%20Recruitment%2F2%2E%20Evidence

with the most common number of candidates being six, eight or ten. A typical interview/task was assessed by two interviewers/assessors and lasted between 16 and 30 minutes.

MMIs were much less common than group exercises or structured interviews in the selection process, the majority of MMIs were 5 minutes or less and candidates met on average 5.6 interviewers.

Table 17: Summary of screening processes, 2014

Course	Application form (%)	Situational Judgement Test (SJT) (%)
Midwifery (N=44)	95.5	4.5
Nursing (N=182)	95.0	7.7
Allied Health (N= 157)	91.1	4.5
Specialist Nurse (N=63)	90.5	15.9
Pharmacy (N=22)	63.6	0
Total (N=468)	91.7	7.1

Source: Health Education England Survey 2014

Table 18: Summary of selection processes, 2014

Course	Structured interview (%)	Group (%)	Multiple mini interviews (%)	Situational Judgement Test (SJT) (%)
Midwifery (N=44)	75.0	54.5	15.9	11.4
Nursing (N=182)	69.2	53.3	9.9	12.6
Allied Health (N= 157)	59.0	43.3	8.3	4.5
Specialist Nurse (N=63)	82.5	36.5	9.5	19.0
Pharmacy (N=22)	40.9	27.3	4.5	0
Total (N=468)	66.9	46.6	9.6	10.0

Source: Health Education England Survey 2014

The national survey of HEIs at Stage 4 of our study was conducted in 2019. One hundred and eleven health care degree programme leads responded to this survey (Table 19).

Table 19: Reported selection processes, 2019

Course	Structured interview (%)	Group interview / task	MMI
Single method	34.2	5.4	17.1
With additional method	36.1	36.0	6.3
Total (N=111)	70.3	41.4	23.4

Comparing these results with the 2014 HEE survey, it appears that overall the proportion of structured interviews and group interviews changed very little. There was, however, a statistically significant increase in the number of MMIs conducted (see Table 20).

In 2014 HEE reported that the involvement of service users in a structured interview was 36.4%. In our 2019 survey a service user was involved in 84.6% of selection events.

The results from both the 2014 and 2019 surveys show that the methods for selection varied between courses. This can also be seen in the two cases sites where recruitment processes differed between institutions and courses. There are many possible ways to incorporate VBR into the student admissions process.

Table 20: Changes in recruitment processes, 2014 to 2019

	2014 HEE Survey N=468	2019 Survey N=111	Difference (95% CI)
Screening Application Form	91.7%	90%	-1.7% (-7.8 to 4.4%)
Selection process			
Structured interview	66.9%	70.3%	3.4% (-6% to 12%)
Group activity	46.6%	41.4%	-5.2% (-15% to 5%)
MMI	9.6%	23.4%	13.8% (5% to 22%)
SJT	10.0%	-	
Involvement of a service user	36.4%	84.6%	48.2% (40% to 56%)

Comparing the data from the 2014 and 2019 surveys suggests an increase in the use of MMI and an increased involvement of service users. However these findings should be treated with caution as the surveys differ in their inclusion criteria and

although the HEE results in some cases are broken down by course, the information regarding, interviewers, time of interview and service user involvement is for all courses, including dentistry and medicine.

Resource use and costs of changes in recruitment processes

Approaches to VBR vary substantially, as illustrated in our survey responses and the case studies. Group interviews, individual interviews or MMIs were the most frequently adopted processes. Service users and clinicians were involved in recruitment processes for many of the health care programmes as well as University staff. The main potential for additional resource use from VBR might be from the creation of MMIs and the inclusion of service users.

Collecting detailed data about staff time, use of space, observer expenses and other resources devoted to VBR was outside the scope of this study, and in any case would provide potentially biased data given that i) we were unable to collect baseline pre-VBR data, and ii) during the transition phase, there are additional set-up costs (e.g. creation of a bank of MMI questions and resources) which would be potentially time-consuming but not recurrent.

There are a number of published sources of evidence focused on MMIs. A 2019 review (Yusoff 2019) synthesised international evidence on MMIs, including 64 studies of which ten were from the UK. Most of the studies in this review report medical school processes; a few included dentists and pharmacists, one midwifery, one nursing and one a health sciences faculty. UK papers in the review were published between 2008 and 2014, 5 reported medical recruitment, two dental, one medical and dental, one midwifery and one nursing programme. Overall, the review reports that most MMI stations ranged from seven to 12 with a duration of 10 minutes per station. All the UK studies which provided this information reported five minutes at each MMI station, and between 3 and 10 MMI stations overall.

The number of stations, length of time at each, and numbers of interviewers all potentially affect the costs of this process. A Canadian study (Rosenfeld et al 2008) explored the ‘cost efficiency’ of MMIs compared with traditional interviews over a

five-year period. They included the costs of generating interview material, staff time, infrastructure and other expenses such as lunch for the observers. These authors concluded that MMIs, compared with traditional panel-based interviews, require greater preparatory work, and more rooms in which to carry out the interviews. Nevertheless, these are offset entirely by the MMIs requiring fewer person-hours of effort. The authors (reporting processes at McMaster Medical School) demonstrate that MMI is considerably more efficient in terms of hours taken to evaluate a cohort of candidates and makes much better use of observer time. They found that relative to their traditional interviews, MMIs require 67% of the observer hours per applicant and 16% as much assessor time. It seems, therefore, unlikely that the use of MMIs as part of overall VBR, would add to costs overall. This is particularly the case once a bank of scenarios is created.

The involvement of service users will, however, add to the costs of recruitment. NIHR recommends payment of £150 for involvement in an all-day meeting without advance preparation, which may be a guide to the reimbursement of service users as VBR observers.[21] There is however a more general trend towards involving service users in all aspects of health professional recruitment, regardless of formal VBR processes, so it may be inappropriate to attribute this as a direct cost of VBR *per se*.

CASE STUDY FOLLOW UP INTERVIEWS

Stage 2 reported on our in-depth case studies of two HEIs where changes to recruitment processes had been implemented during 2016/17. We conducted follow-up interviews with participants (n=13) from these universities in 2019: South University (n=7) and North University (n=6). Participants included academics (n=5), clinicians (n=2), students (n=4) and service users (n=2). The interviews offered an opportunity for participants to: (i) reflect on the ways in which VBR had been operationalised and any adaptations to recruitment since their first interview; (ii) appraise VBR and its purpose; as well as (iii) consider its potential impacts.

[21] https://www.nihr.ac.uk/documents/payment-guidance-for-researchers-and-professionals/27392

Operationalising VBR: Changes to the process

Participants were asked to reflect on the ways in which VBR had been operationalised within their programmes and university. Two of the health care programmes at North University had altered their selection methods. The admissions team for the Children's Nursing programme trialled a MMI format to evaluate whether this enhanced opportunities for assessing candidates' values. However, after one cycle of MMIs, they reverted back to undertaking individual panel interviews, with panel members comprised of an academic, clinician and service user. They considered the MMI process did not offer depth of understanding about a candidate - it was described as *"rushed and superficial"* (Stage 4: North University: Academic Child Nursing 7), and preferred the panel interview when assessing the suitability of candidates for the programme:

> *"But when you're doing a panel interview, even if it's not your question you're going to pick up things that the person asking the question doesn't. So, it's about that discussion afterwards and making a group judgement, rather than an individual judgement."* (Stage 4: North University: Academic Child Nursing 7)

The Admissions Team for the Occupational Therapy programme had also changed their processes: moving from MMIs plus a group task to an individual panel interview plus group task. The rationale for this was based on the difficulties for this programme team in resourcing the MMIs (the team is comprised of 7 academic staff of which 4 are part-time): they initially reduced the number of MMI stations from 5 to 4 prior to moving to the panel interview. The panel represents the mix of academic, clinical, and public representatives, and the 10-minute interview asks the candidate about their motivation to be an occupational therapist and then asks them questions about the group task and their role in it. The group task is considered an important part of the assessment:

> *"It [the group task] also gives us the opportunity as well, to observe whether there's any kind of red flags. You know, if they [the candidate] kind of do anything or say anything that we would think would be inappropriate from someone who's going to train as a health professional. [I: Okay, what sort of*

things is that, that you're on the lookout for?] I guess, people demonstrating that, you know, they maybe have some particular prejudice or view, who, I don't know, demonstrate a particular way of thinking that wouldn't be conducive to working as a health professional." (Stage 4: North University: Academic OT 11)

At South University, all health care programmes (and the University) continued to be committed to MMIs for their selection events. However, an important change had occurred in the composition of the interview panel for the nursing programmes since the first round of interviews: service users were no longer members of the MMI panels. Academic staff offered explanation for this, focusing on the lack of competence of service users for scoring candidates – *"they hadn't quite got what they were supposed to be doing"* (Stage 4: South University: Academic Adult Nursing 1), and inappropriate, or "rogue", scoring of candidates – *"either they scored everyone as poor or they were the other end and scored everybody as excellent"* (Stage 4: South University: Academic Child Nursing 16). There were additional costs associated with involving service users with VBR. Paying them for their involvement in selection events and also preparing them for this role incurred additional expense. Academic staff had concerns that there was not the time or resources to adequately train service users for their role in recruitment:

"So, I think, there's always that tension between the practicalities, you know, getting people who come and perhaps do it once or twice a year, versus then the quality of what they actually do." (Stage 4: South University: Academic Adult Nursing 1)

Academics reported patient voice as now incorporated into the MMIs using a film about a patient's experience of discharge. A service user reported their disappointment at this decision and the lack of explanation for this decision by the admissions team:

"A little while ago, was it two years, they decided to stop having members of the public in on those interviews. I never quite got to the bottom of whether it was an issue with the perceived competence of interviewers, or whether it

was an issue of funding. They did give us a small amount of money to participate, so I don't know whether it was cost or competence. But whatever it was, they decided they didn't really need the input of Joe Public, which was disappointing and a bit surprising, but that's the decision they took." (Stage 4: South University: Service user 36)

In summary, the follow-up interviews demonstrated that admissions teams were still refining and rationalising the processes being used to assess candidates' values. An important reported change was removing service users from MMIs for some of the health care programmes at South University, particularly given the mandate from HEE that service users should be involved at some stage of the recruitment process and given other programmes at South University and North University continued with service user engagement in the selection events, which used varied approaches.

Appraisal of VBR

Participants perceived there was a continued individual and collective commitment to, and investment in, VBR across the health care programmes and universities to try and recruit candidates who demonstrated the required values:

"I think we still are committed to having people who demonstrated those values coming on the programme and doing our best to try and measure those." (Stage 4: South University: Academic Dietetics 23)

"I think they are because there's an investment in the people that we're going to offer places to and those are the people that we are then going to be teaching for the next three years and guiding and supporting and there's a big investment for staff to make sure we offer to the right people." (Stage 4: South University: Academic Child Nursing 16)

Stage two's findings demonstrated varied approaches (or nuances within approaches) to assessing candidates' values. At follow-up, participants endorsed the approaches that they were involved in. MMIs were still considered as supporting a fairer, more consistent, assessment process and increasing objectivity in the

assessment of candidates. This was because the score was based on more than one interviewer's opinion and or dominance:

> *"I think what works well, is that there's a consistency to the approach, that every applicant very much has a similar experience… Everybody will be asked a question and get to meet a service user as part of their interview. Everybody will see a dietitian from practice."* (Stage 4: South University: Academic Dietetics 23)

Participants using other approaches defended those. For example, the use of a group task with an individual panel interview was considered to offer a more rounded perspective of the candidate in terms of their communication and teamworking, as well as personal values. It also enabled their performance to be assessed in both a group and individual situation:

> *"We score them on how much they put in, whether it's relevant, and whether they don't say anything. Some people just sit there and because they don't know anything about the actual content of the question they just don't talk. But then sometimes they turn out to be the best candidates when we do the face to face questions."* (Stage 4: North University: Clinician 46)

> *"When we're talking about values based, I suppose I would be thinking about things, like the group, because you know that demonstrates things like communication, it demonstrates things like respect, kind of caring attitudes, problem solving, those kinds of things that we would be looking for in an occupational therapist."* (Stage 4: North University: Academic OT 11)

Concerns were raised that each recruitment process had generated a range of unintended consequences. MMIs were perceived to disadvantage certain candidates, for example younger candidates. Conversely, concerns were raised that group interviews might disadvantage quieter or more introverted candidates, or those from cultures where it was discouraged to voice an opinion in a group setting. These concerns were also raised in Stage 2 findings.

Regardless of the approach used to assess candidates' values, there were several common appraisal points about VBR raised by participants in these follow-up interviews. The VBR policy had increased the focus on values as part of the assessment of candidate suitability for studying a health care programme, as well as promoting structure and transparency of the processes used to achieve this assessment. There was recognition that this may have influenced the student cohort on particular programmes, in terms of widening access (this perception is substantiated by Stage 2 findings (see also Chapter 4, Box 7, page 129):

> *"And the other thing is we've had a huge shift in diversity in our cohort as well within children's nursing. You know, children's nursing traditionally was very white middle-class type of recruit and now over 50 per cent of our students are from a Muslim background. We've had a big shift in the diverse nature of our children's nursing cohort here at (name University). [I: Okay, and have you been able to work out why that is?] I think it's a mixture of having more places and I think. children's nursing, because it is competitive, it's being seen as attractive. And also because the values based recruitment doesn't privilege any type of entry, we have a wide entry gate in terms of what qualifications we will accept to meet our entry requirement but that has meant that we have a very, much more, diverse cohort now."* (Stage 4: South University: Academic Child Nursing 16)

Participants recognised the challenge of assessing values and the need for varied approaches to assess spontaneous and 'non-rehearsed' responses from candidates:

> *"You can tell, but quite a lot of candidates have been prepared to say these are the values of the NHS 'da da da da da'. You have to have questions that don't allow them to give a standardised answer, that they demonstrate the values in different ways."* (Stage 4: South University: Academic Child Nursing 16)

> *"So, I think, it's probably too easy just to say, oh well I am an empathetic person and then give an example why but, I think, it's hard, isn't it, to find out*

whether someone does actually have those values." (Stage 4: North University: Student OT 12)

"As far as the values are concerned, they should know them, or at least they should know the one I ask about, and can beyond just parrot fashion telling me what a particular value is, that they can show that they actually believe in it, and have done something to prove that they have lived the value. And that's what I'm looking for during an interview in connection with the values, that it's not just words, that the candidate can demonstrate that they have lived the values." (Stage 4: South University: Service user 36)

Participants appraised the importance of the mix of interviewers involved in the assessment process. Achieving the optimal mix on panels was an important feature of Stage 2 findings. While appreciating that service users were no longer members of the selection panels for the nursing programmes at South University, other participants discussed the continued important contribution of service users for the selection of candidates and valuing this contribution. Service users and clinicians described themselves as integral members of the recruitment teams and offering a different perspective on candidates that is important for the future of health care and services:

"Often we're very similar, service users, the clinicians and the lecturers but sometimes we're not and just talking it over as a service user or patient, or whatever you call us, might have got a better feeling, you might have thought, yes they [the candidate] might not have had all the technical answers but actually their demeanour and how they spoke about patients I felt I'd like them to nurse me or look after me. And I think when you're debating it you can come over and they do have some value on who you're going to recruit into the health service." (Stage 4: North University: Service user 30)

"I think they [candidates] get a more grounded experience because they're getting people [interviewers] from all different areas. So, the clinical side, the educational side, from a service user led experience. So yeah, I think it's not just a person sat in a white coat that's doing the interviews. They're getting

real people that have done training, that are working with people, that are either receiving or giving care, so they get a better, rounded experience before they even get accepted." (Stage 4: North University: Clinician 46)

Participants appraised whether the changes in recruitment processes, and the focus on values, had led to any changes in the people enrolled on healthcare programmes. There was a general consensus and "gut feeling" (a phrase often used by academic staff) that there had not been any substantial changes: this is supported by our longitudinal analyses of the characteristics and profile of students before and after the introduction of VBR (see pages 215-217). Our longitudinal analyses also clearly showed that the biggest changes in characteristics and profile of students occurred after the removal of bursaries, rather than directly after the introduction of VBR. Participants in the follow-up study offered perspectives of the impact of this for their programmes:

"Also, a very big change in the profile of applicants. So whereas historically we would have attracted people who were, probably about half of our cohort, year on year, would have been people who maybe had done another degree, or had a different career, or coming back to education after having families. We had a half mature cohort, and half school leaver cohort. Since the funding reforms have happened, the majority of our applicants are school leavers. So, there's a very different profile of students." (Stage 4: South University: Academic Dietetics 23)

In addition, academic participants highlighted that the programmes were attracting candidates who may wish to work in settings beyond the NHS. VBR focused on NHS values. Academic staff revealed that the removal of the bursaries had not influenced them with regard to whether or not they should still recruit for values. However, they were considering the values that best represented the diversity of settings that candidates might choose and how to attract such candidates by broadening the appeal of the health care programmes that they were responsible for.

Other participants (including clinicians, service users and students) noted that, intuitively, candidates being assessed for values was important and worthwhile.

Students also suggested that the process allowed some candidates to de-select. This was perceived as important for patients and care delivery, alongside benefits for the individual and university:

> *"I think is better for everyone. So, the students don't waste their time or go in to do a degree that they are not going to enjoy or are not well suited to. And, I guess, maybe the same for the universities is that if people understand, I don't know if they are matched better value wise in what they believe in, then they might be less likely to drop out of the course. I don't know, but maybe."* (Stage 4: South University: Student Dietetics 41)

We now turn to the perceived impacts of VBR. Participants discussed impacts of VBR in relation to alignment of personal values with NHS values, programme completion, and its potential influence on teamwork and patient care.

Perceived impact of VBR

Academic staff expressed some uncertainties that VBR processes always supported the alignment of an individual candidate's values with those of the NHS. The consequences of this lack of alignment were perceived in the impact for the student and their lack of progression (or attrition), and the wider impact of another candidate having been rejected due to limited capacity of the programme. Getting this process right was therefore an important priority for academic participants.

Examples were also provided by participants of circumstances when first year students (so those candidates recruited to a health care programme of study) did not demonstrate values. Value alignment was considered a process of development that extended beyond the recruitment or selection event:

> *"I mean, you know, we find that even if there might be some difficulties in the first year, generally, you know, when they qualify in the third year, they do seem to, have all the attributes, or most of the attributes they need to go out into practice as clinicians. We kind of laugh about it, because it almost seems to be a process when they get into the third year, they suddenly change, and*

they become quite, much more mature and more responsible. So, I think that the majority of them do turn out well." (Stage 4: North University: Academic OT 11)

"So yeah, so anecdotally, we have students who have come through our admissions processes, who have gone into the practice environment, and demonstrated behaviours that are not consistent with the values. Very small numbers, and very complex as to why that might be the case… I think then that's possibly a change we've seen as we've got younger students. Their understanding of those values is perhaps not as developed across the board, and what work we have to do, to try and develop those values as they progress through the programme." (Stage 4: South University: Academic Dietetics 23)

Participants recognised students development through their programme of study and that the health care professional that finally graduated from a programme was a product of their recruitment and initial values, their learning and development, and the assessment processes in place to ensure they graduated as knowledgeable, skilled and competent practitioners with values. One service user suggested the importance of *"values-based learning"* (Stage 4: North University: Service user 30)), a process that extends beyond recruitment and throughout the programme of study. Critical to this was the practice learning environment. An academic raised the issue of an expectation gap and whether students recruited to a programme of study for their values then experienced these values when undertaking a clinical placement:

"I don't know, a thought that has occurred to me, and I'm not sure to what extent it's true, is that by raising the bar on what values we expect from students, I think we can get a bit of an expectation gap, if they don't see those values when they're in the workplace… If people are not behaving in that way towards them, and valuing them and respecting them, and involving them in the team, or treating them compassionately in terms of giving feedback, I think that can be quite difficult." (Stage 4: South University: Academic Dietetics 23)

One student nurse raised the importance of teamwork and values demonstrated towards colleagues:

> *"There needs to be more focus on how people treat each other within the profession."* (Stage 4: South University: Student Nursing 48)

A connection was made between the ways in which health care professionals work together and their respect for each other as influencing patients' experiences of care and services. Whilst many participants implied that VBR was likely to have an influence on patients, they also highlighted the lack of evidence for this assertion. However, a service user highlighted the root causes of many patients' complaints:

> *"And I always say to them [students] if you look at the complaints for the NHS and boil them down, it often, the basic thing is bad communication. It's not a bad NHS, we have a marvellous NHS. It's the communication of the staff."* (Stage 4: North University: Service user 30))

It was not known whether VBR had the potential to influence (longer-term) how a health care professional performed in their role:

> *"I suppose, is there any evidence that recruits that don't go through Values-Based are any worse or better at their jobs, than those who do go through Values-Based Recruitment? I don't know if there is any evidence that that's the case."* (Stage 4: South University: Service user 36)

In summary, the follow-up interviews provided evidence of the continued individual and collective commitment of key stakeholders (academic staff, clinicians, service users and students) implementing VBR to recruit candidates to health care programmes based on their values. Getting the right candidate, with personal values aligned with NHS values, was important to these stakeholders. Following the introduction of VBR there had been increased focus on values by admissions teams and it had promoted structure and transparency in recruitment processes. In addition, participants highlighted the importance of mix of interviewers (academic staff, clinicians, service users) being involved with recruitment. It was reported that

service users were no longer involved with recruitment for some health care programmes.

Varied approaches continued to be used by different health care programmes and universities. Changes to the approaches used had occurred for some programmes since first interview: refining and rationalising of VBR processes were evident. Participants defended the processes they themselves had adopted, sunk costs into and reported the unintended negative consequences of the approaches they had rejected: further supporting the continued rationalisation of approaches. Assessing for values was recognised as challenging. There was also concern expressed about an expectation gap for students who having been recruited for values were then exposed to clinical environments where health care professionals may not demonstrate and actively live these values. Determining the impacts of VBR continued to be problematic for participants: student characteristics and profiles had not significantly changed as a result of VBR but the removal of NHS bursaries was considered to have impacted on number and age profile of applications. Participants voiced continued commitment to promote values for health care students beyond recruitment and throughout their learning, development, and assessment processes. Participants revealed that they were considering the broader contexts that students may work in when they graduated. This was also informing discussion about the values that these candidates need to possess when being recruited to health care programmes in the future. Not all graduates and future health care professionals may choose to work for the NHS.

SUMMARY

This chapter presented findings of the longitudinal evaluation of the VBR policy in English HEIs and reinforced the heterogeneity of approaches being used to assess values. VBR was appraised as relevant and feasible to implement. Individual and collective commitment to VBR processes was reported, as was shared understanding about how values could be assessed. We did not determine any significant changes in the characteristics, profile or continuation of students recruited to health care programmes in England after the introduction of VBR. The biggest changes occurred following the removal of NHS bursaries, rather than VBR.

Unintended consequences of VBR processes included process components that disadvantage some groups, tensions between different recruitment stakeholders (academic and admissions staff or academics and service users) or between organisational demands (recruiting a full complement of students to a programme) and VBR's principles.

There were concerns about whether questions or measures accurately assessed values. Academic staff believe the assessment of future health care professional should focus on more than values: academic ability; understanding of the profession applied for, and appreciation of the academic and clinical demands of the programme.

CHAPTER 8: CONCLUSIONS AND IMPLICATIONS

In this final chapter we revisit the research aims and summarise our findings, noting the strengths and limitations of our evaluation. Finally, we highlight some of the implications of the study, including areas for consideration for policy makers, universities, NHS providers and researchers.

STUDY AMBITIONS

Our overarching research question was: *How have education and service providers implemented VBR and what are the impacts on service delivery and care?* This was addressed by the following **aims**:

1. to better understand and conceptualise VBR in the context of health care education and service delivery in order to unpack what works, for whom, why, and under what conditions;
2. to identify the 'active' components of models of VBR and create a typology of VBR models according to their constituent parts;
3. to understand the longitudinal impacts of VBR for HEIs recruited through the 'first cycle' of VBR; and
4. to propose successful models of VBR to inform practice and policy.

Understanding and conceptualising VBR in the context of health care education and service delivery

We addressed this aim to better understand and conceptualise VBR throughout our research. Stage 1 (Chapter 3) informed the development of initial theories of VBR which we tested in four case studies (Stage 2: Chapters 4 and 5), representing both education and service providers. Based on these findings we developed and refined our theories of VBR (Stage 3: Chapter 6).

Our study revealed the considerable investment made by education and service providers in assessing patient-focused values of health care professionals and students applying for a health care programme of study. Investment was not dependent on a VBR mandate. Case studies demonstrated wide variations in

approaches and processes for assessing values. The personal investment of operational staff was an important driver for shaping the development of locally-relevant VBR, implementing and embedding it in everyday recruitment. The VBR policy promoted standardised (i.e. inclusion of patient-focused values) but contextualised (i.e. tailored to the organisation) recruitment. Whilst our refined programme theories explain circumstances under which VBR may work, for whom and why, it should be borne in mind that VBR was an important initially necessary - but not sufficient - process for embedding values in health care service delivery.

Identifying the 'active' components of models of VBR

In Stages 1 to 3 (presented in Chapters 3 to 6), we developed in-depth understanding of how and why key resources for VBR - or the reasoning (cognitive or emotional) of the people involved with VBR (*mechanisms*) – might trigger change or effects (*outcome*), and those *contexts* necessary to sustain these. Active components can be considered mechanisms and contexts that generate intended and unintended consequences (outcomes) of VBR. Key mechanisms included:

- Operationalising standardised and transparent processes for the assessment of a candidate's values, tailored to the local context
- Resources (such as clear management commitment and support, and appropriate infrastructure) supporting staff to implement VBR
- Engaging staff involved in local recruitment with the development and implementation of VBR to enhance its meaning and relevance
- Recruitment processes that reduce interviewers' unconscious bias and subjectivity when assessing candidates
- Interviewers collaborating in new ways with confidence in each other's abilities and contribution to the recruitment processes
- Recruitment processes promoting two-way conversations between candidate and interviewer and increasing candidate engagement

These mechanisms enhanced individual and collective engagement and commitment to VBR. They promoted equity of opportunity for candidates to influence individual and organisational outcomes. Determining the impact on individual (patient or staff) and organisational outcomes was not feasible. This is because a variety of

workforce policies were implemented simultaneously in sites and the challenges of isolating the impact of VBR, as well as a lack of available organisational outcomes data rendered causal inference invalid. The contextual conditions required for these mechanisms to be triggered included factors such as: leaders who actively embraced VBR; meaningful engagement of local opinion leaders and operational staff; a rich mix of interviewers reflecting diverse backgrounds; recruitment training; systematic evaluation of recruitment processes; and experience based transparency and honesty about the challenging nature of health care work built into recruitment processes.

The extensive variation in processes and approaches that national VBR policy prompted at local level meant it was not feasible (or relevant) to develop a typology of VBR. The active components we have identified in our study will be useful for informing education and service providers implementing VBR. The lack of a typology does not diminish the contribution of this work.

Understanding the longitudinal impacts of VBR for higher education institutions

Stage 4 (Chapter 7), illustrates the longitudinal impacts of VBR for HEIs. This was addressed successfully through: (i) a national survey of HEIs; (ii) analyses of national secondary data sets; and (iii) follow-up interviews with participants from HEI case studies (Stage 2).

The national survey, building on Stage 2 findings, reinforced the varied approaches and mix of interviewers used to assess values of candidates for health care programmes of study. Respondents, on the whole, positively appraised the VBR policy and its implementation in their organisation but were largely uncertain of the optimal process to be aimed for and the impact of the new way of recruiting.

There were no significant changes in the characteristics, profile or continuation of students recruited to health care programmes in England following the introduction of VBR. Our descriptive analyses revealed the biggest changes in student characteristics and profile followed the removal of NHS bursaries and not the

introduction of VBR. Following the removal of NHS bursaries, the number of applications to nursing courses decreased; the proportion of applications from 18/19-year olds increased, with a decrease in applications from older students.

Follow-up interviews with Stage 2 staff participants from universities highlighted their continued commitment to VBR - regardless of the removal of NHS bursaries. They described the impact of the bursary removal on the number and age profile of applicants. They also described the broader health care contexts that graduates may choose to work in and whether this should be considered in the values that students were recruited for. Participants defended their adopted approaches and highlighted the unintended and negative consequences of those they rejected. Determining the longer-term impacts of VBR remains problematic given the poor quality and relative paucity of data.

Proposing successful models of VBR to inform practice and policy

VBR was implemented in varied ways by education and service providers. The active components (as described above) offer an indication of what needs to occur for the successful implementation of VBR - regardless of the approach or processes deployed - and the contextual factors that will support this. Judging 'success' in the context of this national policy intervention is challenging. If success means staff engagement and commitment to VBR, and the standardisation and transparency of processes which promote equity of opportunity of candidates, then our evaluation highlights those mechanisms and circumstances that will enhance the chances of success along these lines. We are less confident of the impact of VBR on individual and organisational outcomes. We were unable to gather evidence of the success of VBR on these. Proposing successful models for VBR shaping quality of care through the values of a more diverse biographical and demographic mix of candidates is not appropriate or feasible based on our evaluation.

STRENGTHS AND LIMITATIONS OF THE STUDY

As with all research, we must acknowledge the strengths and limitations of the study. A key strength of this study was the use of mixed methods and their integration, guided by robust middle-range theoretical frameworks - realist evaluation (Pawson

and Tilley, 1997) and NPT (May and Finch, 2009). Our initial theories of VBR were used to frame the main study and ensured the study directly built on what was already known and what was intended. This enabled us to refine the programme theories and offer explanations of the active components of VBR as an intervention and the contextual factors required for its successful implementation. Our study also includes a longitudinal evaluation. We adopted robust and established approaches in our design, sampling, data collection, and analyses. Our work was enhanced through discussion with our project advisory group, which included patient and public involvement representatives. Their expertise and experience helped to guide our study, and ensured we were able to take into account ongoing developments in practice and policy. Alongside these strengths, there were some notable study limitations.

Firstly, the work is observational and focuses on associations rather than causal relationships. Our findings should be understood accordingly. Our analyses - guided by realist methods - sought to identify plausible mechanisms by which VBR was realised, the contextual factors that enhance its successful deployment and subsequent consequences. NPT usefully framed our explanations of the work that individuals and organisations had to carry out in order to embed and normalise VBR into routine practice. But with limited organisational data to draw on, prospectively and empirically validating these explanations was not possible.

Secondly, and by design, our study was limited to education and service providers in England. We used mixed methods and aimed to gain representation of participants who would contribute to understanding and insights regarding the implementation of VBR. This depth limited the number of case studies and participants in the study. There may be important contextual factors we were unable to select for. This may limit the transferability of our findings. We included a diverse range of participants (policy makers, academic staff, health care professionals, service users, and student health care professionals) but we were unable to recruit applicants for health care programmes rejected for a programme or job. We did include individuals who accepted or rejected the offer of a university or NHS organisation in our student and health care professional samples. The individuals who turned down a place offered perspectives on why they selected to study or work at a different university of NHS

Trust. We also did not include patients; working with service users involved in recruitment to gather experiences and perspectives of VBR from an alternative position.

Finally, it should be acknowledged that the study was conducted in a dynamic organisational context with a range of workforce policies implemented during the period of the study. It was not possible to disentangle the impact of VBR from that of other policies implemented contemporaneously. The relevance of VBR in these changing contexts was not known. For example, following the removal of NHS bursaries there were concerns that VBR would lose its relevance, particularly for universities. There was no indication in our findings that this occurred. The removal of bursaries had impacted on the applicant profile, but staff maintained their commitment to recruiting for values.

CONCLUSION

To the best of our knowledge, this is the first theoretically informed, mixed methods, evaluation of VBR. The architects of VBR made the assumption that recruiting individuals for their values, and then maintaining and encouraging these values in the workplace, would lead to the desired improvements in quality of health care provision. Since the policy framework was launched, and mandated for HEIs, there have been considerable efforts by staff (with a remit for recruitment in HEIs and NHS organisations) to develop VBR. Based on our findings, we cannot support the assumption that VBR leads to the recruitment of individuals whose values are better aligned with those of the NHS. Nor have we established whether VBR enhances the quality of health care provision. Recruitment was perceived as an initial, but not only, source of influence on the values of individuals. NHS workplace practices and cultures were seen as more influential forces for socialising people into core NHS values. Student health care professionals also identified workplace cultures (and especially clinical placements) as important influences on the sustainability of 'values' of those working in the NHS. The Francis Inquiry (Francis, 2013) highlighted the need for cultural values in the NHS to change. VBR was considered an important policy for addressing this. Our findings suggest that VBR did not change the values of the NHS workforce.

It is difficult, if not impossible, to argue against the importance of recruiting health care professionals and student health care professionals for their values. Health care professionals are employed to meet the needs of patients (and the public) for care and support. Addressing those needs and working in ways which value them is both pertinent and desirable. This was an observation of many of the study participants who reported that recruiting for values had always been undertaken in some shape or form because of the importance and centrality of patients in health care provision. VBR was perceived as increasing the focus on patient-centred values and promoting structure and transparency of the processes used to achieve this. We did not find evidence of the discriminatory power of VBR for recruiting people with the right values or for rejecting those who did not possess the required values. The extremely low rejection rate of applicants for health care programmes of study revealed that almost *everyone* was assessed as possessing these values. The longer-term benefits of embedding VBR in recruitment processes were difficult to assess with any confidence.

The VBR policy was permissive. It promoted principles that organisations could consider when developing approaches tailored to the local context. This created wide variations in recruitment approaches and processes. In addition, VBR was often introduced alongside a range of workforce initiatives. This adds complexity when trying to disentangle impact and to isolate which intervention is having impact.

VBR needs to be understood within the broader context and influence of the cultures in which individuals learn and work. As a singular policy intervention VBR will not change the values of the health care workforce and ensure quality of care and service provision for the public. However, it can help signify to new recruits the expected values of organisations and provide a means by which those unwilling to subscribe to these can opt out. VBR has an important formative role but it needs to be embedded within cultures that are *already* compassionate and caring if these values are to be sustained by the workforce.

IMPLICATIONS

It is beyond the remit of this report to offer policy recommendations. However, there are issues identified by our research that merit further consideration by policymakers, providers, and researchers.

Implications for policy

- Securing bottom-up buy-in and the co-design of VBR with education and service providers supports the principles for good policy making (Rutter and Hallsworth, 2011)
- Our study focused on education and service providers who had implemented VBR and the varied ways in which the policy had been interpreted in recruitment approaches and processes. However, there are many NHS organisations that have not implemented VBR. Understanding the implementation of VBR across different contexts (acute, mental health and community trusts) and considering the implications for patient care and experience is an important area for future policy
- The lack of evidence of impact of VBR on areas that we could analyse for university health care programmes (such as student profiles and characteristics pre- and post-VBR, or MMIs as a filter for university offers) suggests that further investment in this area should be scrutinised.
- Understanding workplace practices and cultures and how these nurture and support values is key for realising VBR in the broader context of values-based learning and employment and future workforce policies and requires attention by policy
- Supporting organisations to establish systems for monitoring and evaluating workforce policy initiatives is vital. This could usefully establish organisational data sets for comparative evaluation purposes, as well as standardising audit and monitoring by organisations

Implications for education and service provision

- There is a need for education and service providers to reconsider the usefulness of VBR for their local context (including its costs and benefits) and to consider

how, when combined with the organisational culture in which individuals work or learn, values will be nurtured

- Efforts to align individual values with those of an organisation require well designed organisational policy and human resource management which supports values-based employment or learning, including a commitment to address poor workplace practices and cultures directly and justly when necessary
- Clear management engagement and commitment to recruit health care professionals or students to programmes of study for their values is important and will engender individual and collective responsibility of staff to embed VBR in everyday practices. Health profession education programmes are delivered in partnership with health (and social care) employers. A commitment to recruit individuals for their values is therefore appropriate across the system and to bring about mutual responsibility
- Operationalising standardised and transparent VBR processes for the local context is key for promoting meaning and relevance of values assessment in recruitment processes for staff in the organisation
- Ensuring adequate resources and systems are in place is a prerequisite for the development and implementation of VBR and crucial for it becoming part of everyday work
- Systematising processes to evaluate and review VBR is important for staff to appreciate VBR as a distinct approach for recruitment and to grasp the potential value, benefits and importance of it for their own work and for the work of the organisation of which they are part

Implications for research

- Given the variation in approaches and processes for VBR there is scope to undertake a longitudinal natural experiment to assess impact over time for different approaches
- Researchers should explore with education and service providers possibilities for co-designing a core set of standardised process and outcome measures that could be used for comparative workforce policy studies
- Understanding how values are created, nurtured and sustained by the organisations in which individuals work or study merits further investigation: VBR

needs to be understood within the broader context of values-based employment or learning which should be included in any further research

Further research is needed in the following areas, to:

6. Evaluate of patient/ service user perspectives, as well as the views of a wider range of stakeholders (such as Royal Colleges, or Unions)
7. Explore a range of competing values and their respective impact on improving care to determine: What are the most important values? Do some values, such as effectiveness and efficiency, compromise other values, such as compassion?
8. Explore whether academic qualifications are more important in some areas than values, and where/when does the 'trade off' occur?
9. Understand if different health care professions have different values and when and how do these harmonise or clash in patient care This could include exploration of the role of the professional bodies (for example the Royal College of Nursing) in promoting the right values.
10. Evaluate whether poor patient care (when it occurs) is the result of poor individual values (bad apples) or the culture of the organisation (bad barrels), the profession (bad cellars) or the wider NHS (bad orchards) (Mannion et al., 2018).

CONCLUDING REMARKS

Current policy prescriptions that seek to nurture values-based cultures are in need of a more secure evidential base. We have drawn on a mixed method study to sharpen thinking about the implementation of VBR. Whilst we identify a wide range of issues that need further consideration in implementing VBR style policies, it is beyond the remit of this research to convert these concerns into specific recommendations of the ways in which VBR can be improved. We hope others will use our evidence summary, and in full partnership with services, to do this. There is still much to learn regarding the implementation of this key policy and to this end we have highlighted a number of important gaps in knowledge that are in need of sustained research-based evolutionary development.

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APPENDIX 1: Project advisory group members

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APPENDIX 2: Ethics approval letter for Stage 1 interviews

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UNIVERSITY OF LEEDS

23rd July 2015

Professor Karen Spilsbury
Investment Chair in Nursing Research
School of Healthcare
Faculty of Medicine and Health
Baines Wing
University of Leeds
LEEDS LS2 9JT

Dear Professor Spilsbury

Ref no: SHREC/RP/526

Title: Values based recruitment: what works, for whom, why, and in what circumstances?

Thank you for submitting your documentation for the above project. Following review by the School of Healthcare Research Ethics Committee (SHREC), I can confirm a favourable ethical opinion based on the documentation received at date of this letter.

Document	*Version*	*Date Submitted*
Ethical_Review_Form	1.0	15/06/2015
VBR email text	1.0	15/06/2015
VBR Topic Guide	1.0	15/06/2015
VBR Consent-Form	2.0	15/07/2015
VBR Information-Sheet	2.0	15/07/2015
DoH email re data repository choice	1.0	18/06/2015

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval. This includes recruitment methodology and all changes must be ethically approved prior to implementation. Please contact the Faculty Research Ethics Administrator for further information FMHUniEthics@leeds.ac.uk

Ethical approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The SHREC takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, and may be subject to an audit inspection. If your project is to be audited, you will be given at least 2 weeks notice.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

The committee wishes you every success with your project.

Yours sincerely

Kuldip Kaur Bharj

Dr Kuldip Bharj, OBE
Chair, School of Healthcare Research Ethics Committee

APPENDIX 3: Stage 1 participant invite by email

Email text

Values based recruitment: What works, for whom, why, and in what circumstances?

Initial contact

Dear Colleague

An invitation to take part in a study about values based recruitment: *Values based recruitment: What works, for whom, why, and in what circumstances?*

Values based recruitment (VBR) is a strategy being used to align the values and behaviours of NHS staff and students - the future health care professional workforce - with the expectations of the NHS and the public. Researchers at the University of Leeds have been funded by the Department of Health Policy Research Programme to carry out a study to evaluate the impact of this strategy. As an individual who has played a key role in the development of this strategy and policy, we would like to hear your views and perceptions of VBR - including what you consider to be the advantages and disadvantages of VBR, contextual influences (individual and organisational) on its implementation, mechanisms and processes through which VBR outcomes will be achieved, and how VBR differs from 'previous' recruitment initiatives.

Further information about the study is attached to this email (Participant Information Sheet and Consent form). If you are potentially interested in contributing to this study, then please reply to this email and a member of the research team will get back to you to arrange a suitable time to respond to any queries you may have and/ or to arrange a suitable time for the telephone interview (lasting no more than 40 minutes). If you are not interested in taking part in an interview (and do not want reminders sent to you) then please let me know. You do not need to provide a reason, simply state in the email subject header – VBR INTERVIEW DECLINED.

We appreciate that you will be very busy and thank you for taking the time to read this email.

Kind regards

Professor Karen Spilsbury (Principal Investigator)
School of Healthcare, Faculty of Medicine and Health, University of Leeds
Tel: 0113 343 1329
Email: k.spilsbury@leeds.ac.uk
Further information about VBR project is available at [insert project web page]

APPENDIX 4: Stage 1 Participant Information Sheet (PIS)

UNIVERSITY OF LEEDS

School of Healthcare
Faculty of Medicine and Health

Participant Information Sheet
Values based recruitment: What works, for whom, why, and in what circumstances?

You are being invited to take part in the above named study. Before you decide whether or not to take part it is important to understand what this research study is about and what will be involved if you decide you would like to take part. Read this information sheet carefully and if there is anything you want to discuss in more detail or that is unclear please contact the person named at the end of this information sheet. Take as much time as you need to decide whether or not to take part. Your involvement is entirely voluntary.

What is the purpose of this study?
The National Health Service (NHS) employs over a million people and it is important to ensure the 'right' people are recruited to NHS caring positions and to the educational programmes that train them in universities. Values based recruitment (VBR) is an approach being used in the expectation that it will align the values and behaviours of NHS staff and students with the values of the NHS and expectation of the public. VBR assumes that recruiting for values and behaviours, and then maintaining and encouraging these, will improve the quality of healthcare provision. Whilst intuitively appealing, there is no evidence to support this assumption. This research study aims to evaluate the effects of VBR, in particular to explore its implementation, how people respond, what is working well and what lessons can be learned.

Who is doing the study?
This study is being carried out by a research team from the Universities of Leeds, York and Birmingham, alongside researchers from Firefly Research and Evaluation. The study is being led by a Professor of Nursing (Karen Spilsbury), employed in the School of Healthcare at the University of Leeds, and the team includes other clinicians, and experts on the culture of organisations and on evaluating health policy change. Our study is funded by the Department of Health's Policy Research Programme.

Why have I been asked to participate?
You are being approached to take part in this study because you were involved in the development of VBR strategy and policy. We identified you through our analysis of literature and policy documents on VBR.

What will be involved if I take part in this study?
The study involves four stages. For this stage (stage one) we are conducting telephone interviews with senior staff from national organisations involved in the development of VBR strategy and policy. We are inviting you to take part in one telephone interview which will last no more than 40 minutes. The interview will be scheduled for a date and time that best suits you (in the next couple of weeks. The interview will focus on your perceptions of VBR, including advantages and disadvantages, contextual influences (individual and organisational), mechanisms and processes through which VBR outcomes will be achieved, and how VBR differs from 'previous' recruitment initiatives. If you would like to take part, you will be asked to sign a consent form. With your permission, the interview will be audio recorded and transcribed word for word so that we can identify the main issues that you raise. We may use some anonymised direct quotations that you provide in our study reporting.

If you have decided you do not wish to take part in the interview, we would like to take this opportunity to thank you for reading this information sheet and for giving this matter your consideration.

What are the advantages and disadvantages of taking part?
We do not consider there to be any personal advantages to you for taking part. However, your contribution will be greatly valued. The study is important for understanding the key issues in relation to the national implementation of VBR - what works, for whom, how, and in what circumstances. The findings will be

important to patients and their relatives, the health care workforce and its students and trainees, education and service providers, commissioners and regulators. Ultimately, this study aims to model the 'ingredients' required for interventions that will best support NHS organisations recruiting, selecting, managing and supporting health care professionals and students to deliver services and care in line with the aspirations of the NHS Constitution and the expectations of the public which the NHS serves.

Can I withdraw from the study at any time?

Even if you initially agree to take part, you are free to withdraw before or during the interview without giving a reason for your withdrawal. If you choose to withdraw then we will destroy any recordings. At the end of the interview we will check that we can progress to transcribe your interview. You can withdraw from the study up to one week post interview, without having to give a reason. Any data collected will be destroyed and not used for the purposes of the study if you withdraw within one week. After this time period, we will transcribe your interview and analyse the data and we we would like your consent to be able to use the anonymised data.

Will the information I give be kept confidential?

Your interview is confidential: only the research team (based in Leeds) will have access to the full audio recording of your interview. When we have transcribed your interview (word for word) we will destroy the audio recording. We will use unique study identification (ID) number for you, rather than your name. In the report, we may use some of your words but any report will not allow identification of you – we will use your study ID and ensure no information is reported that may lead to your identification. We will keep all audio recordings and interview notes on a password protected computer. We will store consent forms in a separate electronic folder or in a locked filing cabinet (hard copies). We will comply with the Data Protection Act 1998.

With your permission we would like to deposit your anonymised interview transcript in a data repository to support data sharing with researchers studying similar policy areas. We will share a copy of the anonymised transcript with you (if you would like it). It is entirely up to you as to whether you provide this permission and you can withdraw permission at any stage up to it being deposited (at the end of the study: 30 September 2019). You decision related to this matter does not affect whether you can contribute to this study. This is a separate decision.

What will happen to the results of the study?

We consider this research to be an important nationally study. The interview study you are being asked to take part in is one part of the overall study. We will publish articles, produce reports and this work at national conferences. We have created a project web page and blog (http://medhealth.leeds.ac.uk/VBR) which will share headlines from different parts of the study and encourage engagement, discussion and debate about the findings amongst interested parties. You are invited to keep up to date with the study and join the blog discussion.

Who has reviewed this study?

Ethical approval has been granted by the School of Healthcare Research Ethics Committee *(state project reference number and date)*.[1]

If you agree to take part, would like more information or have any questions or concerns about the study please contact

Prof Karen Spilsbury - Telephone 0113 343 1329 or email k.spilsbury@leeds.ac.uk

Thank you for taking the time to read this information sheet.

[1]All projects carried out in the School of Healthcare must be reviewed and approved by the School's Research Ethics Committee before it goes ahead. Approval means that the Committee is satisfied that your rights will be respected, that any risks have been reduced to a minimum and balanced against possible benefits, and that you have been given sufficient information on which to make an informed decision about whether to take part or not.

APPENDIX 5: Stage 1 Consent form

VBR Stage One: Version 2 (15-07-15)
GHREC/RP/S26

UNIVERSITY OF LEEDS

Participant Consent Form

Name of Centre: School of Healthcare, Faculty of Medicine and Health

Title of Study: Values based recruitment: What works, for whom, why, and in what circumstances?

	Please confirm agreement to the statements by putting your initials in the box below
I have read and understood the participant information sheet (Stage One, V.2, 15-07-15)	
I have had the opportunity to ask questions and discuss this study	
I have received satisfactory answers to all of my questions	
I have received enough information about the study	
I understand that I am free to withdraw from the study:- 1 At any time/up to one week post-interview; 2 Without having to give a reason for withdrawing; and 3 That data collected will be destroyed and not used for the purposes of the study if I withdraw within one week	
I understand that my interview will be audio-recorded with my permission	
I understand that any information I provide, including personal details, will be kept confidential, stored securely and only accessed by those carrying out the study	
I understand that any information I give may be included in published documents but all information will be anonymised	
I agree to take part in this study	
I agree to an anonymised transcript of my interview being deposited in a data sharing repository	
I understand a copy of this anonymised transcript will be shared with me and that I can withdraw this consent at any time up until it is deposited (at the end of the study: 30 September 2019)	
Participant Signature ..... Date	
Name of Participant	
Researcher Signature ..... Date	
Name of Researcher	

Thank you for agreeing to take part in this study.

APPENDIX 6: Topic guide for Stage 1 stakeholder interviews

ABOUT YOU:

- What has been your personal involvement or interest in the development of VBR strategy and policy? *(Asking this preliminary question gives us the context for your views)*

PERCEPTIONS OF VBR:

- How do you see VBR as different from previous practices in NHS recruitment?
- What do you see as advantages of VBR?
- What do you see as disadvantages of VBR?

CONTEXT, MECHANISMS & PROCESSES:

- What factors do you see as likely to affect the extent to which VBR becomes embedded in practice? *(we're seeking to understand the context in which VBR is being implemented, so wish to identify factors – whether at the level of organisations or individuals - which might help or hinder its implementation)*
- What mechanisms and processes are you aware of being used in practice to deliver VBR outcomes?

PROGRESS TO DATE:

- How well do you think VBR is progressing? *(this might be progress by HEIs, by NHS Trusts and/or the partnership between HEIs & NHS Trusts, depending on your personal knowledge)*
- Do you have any examples of how aspects of VBR are being implemented that you think might be of interest to the research team? *(the project will be using a case study approach, working in 2 HEIs and 2 NHS Trusts)*

FUTURE/VISION:

- Looking to the future, how do you envisage VBR developing?
- How does the development of VBR link with other key policies and strategies?

ANYTHING ELSE?

Are there any other aspects of VBR which you think important for us to consider?

APPENDIX 7: HRA approval letter for Stage 2

NHS
Health Research Authority

Professor K Spilsbury
Investment Chair in Nursing
University of Leeds
School of Healthcare, Faculty of Medicine and Health
Baines Wing
LS2 9JT
k.spilsbury@leeds.ac.uk

Email: hra.approval@nhs.net

14 April 2016

Dear Professor Spilsbury

Letter of HRA Approval

Study title:	**Values Based Recruitment: What works, for whom, why, and in what circumstances?**
IRAS project ID:	**197167**
Protocol number:	**HREC15-041**
Sponsor	**University of Leeds**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

IRAS project ID	197167

Your IRAS project ID is **197167**. Please quote this on all correspondence.

Yours sincerely

Miss Lauren Allen
Assessor

Email: hra.approval@nhs.net

Copy to: *Dr Carole Wright, (Key Investigator/collaborator), C.I.Wright@leeds.ac.uk*
Claire Skinner, (Sponsor contact), governance-ethics@leeds.ac.uk
Dr Jane Dennison, Bradford Teaching Hospitals, (Lead NHS R&D contact), bradfordresearch.applications@bthft.nhs.uk

NIHR CRN Portfolio Applications Team

Participating NHS organisations in England

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

Document	*Version*	*Date*
Contract/Study Agreement [DH Research Contract Version 5A/12]	5A/12	
Evidence of Sponsor Insurance or Indemnity (non NHS Sponsors only)		22 September 2015
Interview schedules or topic guides for participants		10 December 2015
IRAS Application Form [IRAS_Form_21032016]		21 March 2016
Letter from funder		05 November 2014
Letter from sponsor	HREC15-041 Updated	15 March 2016
Letters of invitation to participant [Contact Form email or letter]		10 December 2015
Other [Fieldwork Risk Assessment]		09 February 2016
Other [Statement of Activities]	2	
Other [Schedule of Events]	2	
Other [Collaboration Agreement]		17 September 2015
Participant consent form [Public & Patient Reps Intvws]	2	23 March 2016
Participant consent form [Staff & Trainee Health Professionals FGs]	2	23 March 2016
Participant consent form [Staff & Trainee Health Professionals Intvws]	2	23 March 2016
Participant consent form [Public & Patient Reps FGs]	2	23 March 2016
Participant Information sheet (PIS) [PIS Staff & Trainee Health Professionals]	2	23 March 2016
Participant Information sheet (PIS) [PIS Focus Groups]	2	23 March 2016
Participant Information sheet (PIS) [PIS Public/Patient Reps]	2	23 March 2016
Research protocol or project proposal [Revised Proposal Jan 15]		
Summary CV for Chief Investigator (CI) [CV K Spilsbury]		

IRAS project ID	197167

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations, capacity and capability* and *Allocation of responsibilities and rights* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Claire Skinner (Telephone: 01133437587, Email: governance-ethics@leeds.ac.uk)

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	It has been clarified that a 'key-person' will be identified at participating organisations through existing contacts that the University has with the organisations. Potential participants' contact details will be accessed through this 'key-person'. The research team also have existing contacts from stage 1 of the research who may be invited to participate.
3.1	Protocol assessment	Yes	It has been confirmed that the focus group topics will be guided by the individual interviews and will contain the same content as the interviews.
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The Statement of Activities will act as the only agreement between the sponsor and participating organisations and to confirm capacity and capability.

Section	HRA Assessment Criteria	Compliant with Standards	Comments
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	No comments.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Not Applicable	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There is one site-type. Interviews and focus groups will take place at participating organisations. Some participants may also be recruited outside the NHS. HRA approval does not cover activity outside the NHS. Before recruiting outside the NHS the research team must follow the procedures and governance arrangements of responsible organisations.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

Participating NHS organisations in England that are **will be expected to formally confirm their capacity and capability to host this research**. Staff will be invited to take part in an interview or focus group. Participating organisations will also be asked to provide aggregate or anonymised data sets to the research team for secondary analysis.

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capacity will be confirmed is detailed in the *Agreement* section of this appendix.
- The Assessing, Arranging, and Confirming document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Local Collaborator is required where central study staff will be present at the NHS organisation to undertake research procedures. The sponsor has confirmed no formal training will be required.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

A Letter of Access will be required for the researcher to carry out research activities for this study if the research activity is being carried out within a care setting on the premises of participating NHS organisations. No Disclosure and Barring Service or Occupational Health checks will be needed where a letter of access is required.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

- The applicant has indicated that they intend to apply for inclusion on the NIHR CRN Portfolio.
- The research is in 4 stages, HRA Approval is for stages 2 and 3 of the project only.

APPENDIX 8: University of Leeds governance approval letter for Stage 2

Faculty of Medicine and Health
Research Office

University of Leeds
Worsley Building
Clarendon Way
Leeds LS2 9NL
United Kingdom

✆ +44 (0) 113 343 1642

UNIVERSITY OF LEEDS

26 February 2016

Prof Karen Spilsbury
Chair in Nursing Research
Baines Wing
School of Healthcare
University of Leeds
LEEDS LS2 9JT

Dear Professor Spilsbury

Ref no: HREC15-041

Title: VBR: What works, for whom, why, and in what circumstances?

Thank you for submitting your documentation for the above project. Following review by the School of Healthcare Research Ethics Committee (SHREC), I can confirm a favourable ethical opinion based on the documentation received at date of this letter and granted subject to the following condition(s):

- **Evidence of Trust R&D approval must be obtained and sent to this committee prior to commencement of the research**

Document	*Version*	*Date Submitted*
IRASFormVBR9 2 16 ethics app	1.0	11/02/2016
Fieldwork signature page	1.0	12/02/2016
Fieldwork_Assessment_Form_low_risk_final_protected_nov_15	1.0	12/02/2016
Spilsbury_VBR_Revised proposal_January 2015_FINAL_9-1-15	1.0	11/02/2016
VBR Consent-Form STAGE2	1.0	11/02/2016
VBR Contact text	1.0	11/02/2016
VBR Information-Sheet STAGE2 staff	1.0	11/02/2016
VBR Information-Sheet STAGE2FOCUSGROUPS	1.0	11/02/2016
VBR Topic Guide	1.0	11/02/2016

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval. This includes recruitment methodology and all changes must be ethically approved prior to implementation. Please contact the Faculty Research Ethics Administrator for further information FMHUniEthics@leeds.ac.uk

Ethical approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The SHREC takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, and may be subject to an audit inspection. If your project is to be audited, you will be given at least 2 weeks notice.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

The committee wishes you every success with your project.

Yours sincerely

Dr Kuldip Bhatj, UBL
Chair, School of Healthcare Research Ethics Committee

APPENDIX 9: Stage 2 email contact

Values based recruitment: What works, for whom, why, and in what circumstances?

Initial contact by email or letter

[University of Leeds letter head]

[Date]

Dear [Name]

An invitation to take part in a study about values based recruitment: ***Values based recruitment: What works, for whom, why, and in what circumstances?***

Values based recruitment (VBR) is a strategy being used to align the values and behaviours of NHS staff and students - the future health care professional workforce - with the expectations of the NHS and the public. Researchers at the University of Leeds have been funded by the Department of Health Policy Research Programme to carry out a study to evaluate the impact of this strategy. As an individual who has played a key role in the delivery of this strategy and policy, we would like to hear your views and perceptions of VBR - including what you consider to be the challenges, opportunities and impacts of VBR.

Further information about the study is attached to this email (Participant Information Sheet and Consent form). If you are potentially interested in contributing to this study, then please reply to this email and a member of the research team will get back to you to arrange a suitable time to respond to any queries you may have and/or to arrange a suitable time for an interview (lasting no more than 40 minutes). If you are not interested in taking part in an interview (and do not want reminders sent to you) then please let me know. You do not need to provide a reason.

We appreciate that you will be very busy and thank you for taking the time to consider your involvement in this research

Kind regards

Professor Karen Spilsbury (Principal Investigator)
School of Healthcare, Faculty of Medicine and Health, University of Leeds
Tel: 0113 343 1329
Email: k.spilsbury@leeds.ac.uk
Further information about VBR project is available at http://medhealth.leeds.ac.uk/VBR

APPENDIX 10: Stage 2 Participant Information Sheet (staff and trainee health professionals)

UNIVERSITY OF LEEDS

School of Healthcare
Faculty of Medicine and Health

Participant Information Sheet (staff and trainee health professionals)
Values based recruitment: What works, for whom, why, and in what circumstances?

You are being invited to take part in the above named study. Before you decide whether or not to take part it is important to understand what this research study is about, and what will be involved if you decide you would like to take part. Please read this information sheet carefully, and if there is anything you want to discuss in more detail, or if there is anything that is unclear, please contact the person named at the end of this information sheet. Take as much time as you need, to decide whether or not to take part. Your involvement is important to us, but it is entirely voluntary.

What is the purpose of this study?
The National Health Service (NHS) employs over a million people, and it is important to ensure the 'right' people are recruited to NHS caring positions and to the educational programmes that train them in universities. Values based recruitment (VBR) is an approach being used with the expectation that it will align the values and behaviours of NHS staff and students with the values of the NHS, and expectations of the public. VBR assumes that recruiting for values and behaviours, and then maintaining and encouraging them, will improve the quality of healthcare provision. Whilst this is appealing, there is no evidence to support this assumption. This research study aims to evaluate the effects of VBR, in particular to explore its implementation, how people respond, what is working well and what lessons can be learned.

Who is doing the study?
This study is being carried out by a research team from the Universities of Leeds, York and Birmingham, alongside researchers from Firefly Research and Evaluation. The study is being led by a Professor of Nursing (Karen Spilsbury), employed in the School of Healthcare at the University of Leeds. The team includes other clinicians, as well as experts on the culture of organisations and on evaluating health policy change. Our study is funded by the Department of Health's Policy Research Programme.

Why have I been asked to participate?
You are being approached to take part in this study because you are either a healthcare professional or trainee healthcare professional, or you are involved in the delivery of values based recruitment in a university or hospital setting.

What will be involved if I take part in this study?
The study involves four stages. In this stage (stage two), we are conducting interviews with people involved with, or affected by values based recruitment, including trainee healthcare professionals, patients and their relatives, NHS staff, and representatives from education providers. We are inviting you to take part in one interview (face to face or telephone), that will last no more than 40 minutes. The interview will be scheduled for a date and time that best suits you (in the next couple of weeks), and will be at your place of work. The interview will focus on your perceptions of VBR, including the challenges and opportunities presented by VBR and its impacts. If you would like to take part, you will be asked to sign a consent form. With your permission, the interview will be audio recorded and transcribed word for word so that we can identify the main issues that you raise. We may use some anonymised direct quotations that you provide in our study report.

If you have decided not to take part in the interview, we would like to take this opportunity to thank you for reading this information sheet and for giving this matter your consideration.

What are the advantages and disadvantages of taking part?
We do not consider there to be any personal advantages to you for taking part. However, your contribution will be greatly valued. The study is important for understanding the key issues in relation to the national

implementation of VBR - what works, for whom, how, and in what circumstances. The findings will be important to a wide range of people: patients and their relatives, the health care workforce and its students and trainees, education and service providers, commissioners and regulators. Ultimately, this study aims to model the 'ingredients' required for interventions that will best support NHS organisations recruiting, selecting, managing and supporting health care professionals and students to deliver services and care in line with the aspirations of the NHS Constitution and the expectations of the public which the NHS serves.

Can I withdraw from the study at any time?

Even if you initially agree to take part, you are free to withdraw before or during the interview without giving a reason for your withdrawal. If you choose to withdraw then we will destroy any recordings. At the end of the interview we will check that we can progress to transcribe your interview. You can withdraw from the study any time up to one week post interview, without having to give a reason. If you withdraw within one week, any data collected will be destroyed and not used for the purposes of the study. After this time period, we will transcribe your interview and analyse the data, and we would like your consent to be able to use the anonymised data.

Will the information I give be kept confidential?

Your interview is confidential: only the research team (based in Leeds) will have access to the full audio recording. However, if you disclose information that indicates the safety of patients may be at risk, it is the duty of the research team to report this information through the appropriate reporting systems. When we have transcribed your interview (word for word) we will destroy the audio recording. We will use a unique study identification (ID) number for you, rather than your name. In the report, we may use some of your words, but any report will not allow identification of you – we will use your study ID and ensure no information is reported that may lead to your identification. We will keep all audio recordings and interview notes on a password protected computer. We will store consent forms in a separate electronic folder or in a locked filing cabinet (hard copies), and will comply with the Data Protection Act 1998.

With your permission we would like to deposit your anonymised interview transcript in a data repository to support data sharing with researchers studying similar policy areas. We will share a copy of the anonymised transcript with you (if you would like it). It is entirely up to you whether you provide this permission, and you can withdraw permission at any stage up to it being deposited (at the end of the study: 30 September 2019). Your decision related to this matter does not affect whether you can contribute to this study. This is a separate decision.

What will happen to the results of the study?

We consider this research to be an important national study. The interview study you are being asked to take part in is one part of the overall study. We will publish articles and produce reports on this work at national conferences. We have created a project web page and blog (http://medhealth.leeds.ac.uk/VBR) which will share headlines from different parts of the study and encourage engagement, discussion and debate about the findings amongst interested parties. You are invited to keep up to date with the study and join the blog discussion.

Who has reviewed this study?

Ethical approval has been granted by the School of Healthcare Research Ethics Committee (HREC 15-041, 15-3-2016).[1]

If you agree to take part, would like more information or have any questions or concerns about the study please contact

Dr Kate Farley – Telephone 0113 343 1263 or email k.farley@leeds.ac.uk
Prof Karen Spilsbury - Telephone 0113 343 1329 or email k.spilsbury@leeds.ac.uk

Thank you for taking the time to read this information sheet.

[1]All projects carried out in the School of Healthcare must be reviewed and approved by the School's Research Ethics Committee before it goes ahead. Approval means that the Committee is satisfied that your rights will be respected, that any risks have been reduced to a minimum and balanced against possible benefits, and that you have been given sufficient information on which to make an informed decision about whether to take part or not.

APPENDIX 11: Stage 2 Participant Information Sheet (patient and public representatives)

UNIVERSITY OF LEEDS
School of Healthcare
Faculty of Medicine and Health

Participant Information Sheet (public and patient representatives)
Values based recruitment: What works, for whom, why, and in what circumstances?

You are being invited to take part in the above named study. Before you decide whether or not to take part it is important to understand what this research study is about and what will be involved if you decide you would like to take part. Read this information sheet carefully and if there is anything you want to discuss in more detail or that is unclear please contact the person named at the end of this information sheet. Take as much time as you need to decide whether or not to take part. Your involvement is entirely voluntary.

What is the purpose of this study?
The National Health Service (NHS) employs over a million people and it is important to ensure the 'right' people are recruited to NHS caring positions and to the educational programmes that train them in universities. Values based recruitment (VBR) is an approach being used in the expectation that it will align the values and behaviours of NHS staff and students with the values of the NHS and expectation of the public. VBR assumes that recruiting for values and behaviours, and then maintaining and encouraging these, will improve the quality of healthcare provision. Whilst intuitively appealing, there is no evidence to support this assumption. This research study aims to evaluate the effects of VBR, in particular to explore its implementation, how people respond, what is working well and what lessons can be learned.

Who is doing the study?
This study is being carried out by a research team from the Universities of Leeds, York and Birmingham, alongside researchers from Firefly Research and Evaluation. The study is being led by a Professor of Nursing (Karen Spilsbury), employed in the School of Healthcare at the University of Leeds, and the team includes other clinicians, and experts on the culture of organisations and on evaluating health policy change. Our study is funded by the Department of Health's Policy Research Programme.

Why have I been asked to participate?
You are being approached to take part in this study because you are a member of the public or a patient representative that is, or has been, involved in processes associated with VBR.

What will be involved if I take part in this study?
The study involves four stages. In this stage (stage two) we are conducting telephone interviews with people involved with or affected by values based recruitment, including trainee healthcare professionals, patients and their relatives, NHS staff, and representatives from education providers. We are inviting you to take part in one interview (either face to face, or by telephone) which will last no more than 40 minutes. The interview will be scheduled for a date and time that best suits you (in the next couple of weeks). The interview will focus on your perceptions of VBR, including the challenges and opportunities presented by VBR and its impacts. If you would like to take part, you will be asked to sign a consent form. With your permission, the interview will be audio recorded and transcribed word for word so that we can identify the main issues that you raise. We may use some anonymised direct quotations that you provide in our study reporting.

If you have decided you do not wish to take part in the interview, we would like to take this opportunity to thank you for reading this information sheet and for giving this matter your consideration.

What are the advantages and disadvantages of taking part?
We do not consider there to be any personal advantages to you for taking part. However, your contribution will be greatly valued. The study is important for understanding the key issues in relation to the national implementation of VBR - what works, for whom, how, and in what circumstances. The findings will be important to patients and their relatives, the health care workforce and its students and trainees, education

and service providers, commissioners and regulators. Ultimately, this study aims to model the 'ingredients' required for interventions that will best support NHS organisations recruiting, selecting, managing and supporting health care professionals and students to deliver services and care in line with the aspirations of the NHS Constitution and the expectations of the public which the NHS serves.

Can I withdraw from the study at any time?

Even if you initially agree to take part, you are free to withdraw before or during the interview without giving a reason for your withdrawal. If you choose to withdraw then we will destroy any recordings. At the end of the interview we will check that we can progress to transcribe your interview. You can withdraw from the study up to one week post interview, without having to give a reason. Any data collected will be destroyed and not used for the purposes of the study if you withdraw within one week. After this time period, we will transcribe your interview and analyse the data and we we would like your consent to be able to use the anonymised data.

Will the information I give be kept confidential?

Your interview is confidential: only the research team (based in Leeds) will have access to the full audio recording of your interview. However, if you disclose information that indicates the safety of patients may be at risk, it is the duty of the research team to report this information through the appropriate reporting systems. When we have transcribed your interview (word for word) we will destroy the audio recording. We will use unique study identification (ID) number for you, rather than your name. In the report, we may use some of your words but any report will not allow identification of you – we will use your study ID and ensure no information is reported that may lead to your identification. We will keep all audio recordings and interview notes on a password protected computer. We will store consent forms in a separate electronic folder or in a locked filing cabinet (hard copies). We will comply with the Data Protection Act 1998.

With your permission we would like to deposit your anonymised interview transcript in a data repository to support data sharing with researchers studying similar policy areas. We will share a copy of the anonymised transcript with you (if you would like it). It is entirely up to you as to whether you provide this permission and you can withdraw permission at any stage up to it being deposited (at the end of the study: 30 September 2019). You decision related to this matter does not affect whether you can contribute to this study. This is a separate decision.

What will happen to the results of the study?

We consider this research to be an important national study. The interview study you are being asked to take part in is one part of the overall study. We will publish articles, produce reports and this work at national conferences. We have created a project web page and blog (http://medhealth.leeds.ac.uk/VBR) which will share headlines from different parts of the study and encourage engagement, discussion and debate about the findings amongst interested parties. You are invited to keep up to date with the study and join the blog discussion.

Who has reviewed this study?

Ethical approval has been granted by the School of Healthcare Research Ethics Committee (HREC 15-041, 15-3-2016).[1]

If you agree to take part, would like more information or have any questions or concerns about the study please contact

Dr Kate Farley – Telephone 0113 343 1263 or email k.farley@leeds.ac.uk

Prof Karen Spilsbury - Telephone 0113 343 1329 or email k.spilsbury@leeds.ac.uk

Thank you for taking the time to read this information sheet.

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APPENDIX 12: Stage 2 Participant Information Sheet for focus group (staff, student or patient and public representatives)

UNIVERSITY OF LEEDS

School of Healthcare
Faculty of Medicine and Health

Participant Information Sheet – Focus Groups
Values based recruitment: What works, for whom, why, and in what circumstances?

You are being invited to take part in the above named study. Before you decide whether or not to take part it is important to understand what this research study is about, and what will be involved if you decide you would like to take part. Please read this information sheet carefully, and if there is anything you want to discuss in more detail, or if there is anything that is unclear, please contact the person named at the end of this information sheet. Take as much time as you need, to decide whether or not to take part. Your involvement is important to us, but it is entirely voluntary.

What is the purpose of this study?

The National Health Service (NHS) employs over a million people, and it is important to ensure the 'right' people are recruited to NHS caring positions and to the educational programmes that train them in universities. Values based recruitment (VBR) is an approach being used in the expectation that it will align the values and behaviours of NHS staff and students with the values of the NHS and expectations of the public. VBR assumes that recruiting for values and behaviours, and then maintaining and encouraging them, will improve the quality of healthcare provision. Whilst this is appealing, there is no evidence to support this assumption. This research study aims to evaluate the effects of VBR, in particular to explore its implementation, how people respond, what is working well and what lessons can be learned.

Who is doing the study?

This study is being carried out by a research team from the Universities of Leeds, York and Birmingham, alongside researchers from Firefly Research and Evaluation. The study is being led by a Professor of Nursing (Karen Spilsbury), employed in the School of Healthcare at the University of Leeds. The research team also includes other clinicians, as well as experts on the culture of organisations and health policy evaluation. Our study is funded by the Department of Health's Policy Research Programme.

Why have I been asked to participate?

You are being approached to take part in this study because you are an employee, a trainee health professional, or a member of the public that is, or has been, involved in processes associated with VBR.

What will be involved if I take part in this study?

The study involves four stages. In this stage (stage two), we are conducting focus groups with people involved with, or affected by values based recruitment, including trainee healthcare professionals, patient and service user representatives and their relatives, NHS staff, and representatives from education providers. We are inviting you to take part in one focus group that will last no more than ninety minutes. The focus group will be scheduled for a date, time and location that best suits you (in the next 4 to 6 weeks). The focus group will explore your perceptions of VBR, including the challenges and opportunities presented by VBR and its impacts. If you would like to take part, you will be asked to sign a consent form. With your permission, the focus group will be audio recorded and transcribed word for word so that we can identify the main issues that you raise. We may use some anonymised direct quotations that you provide in our study report.

If you have decided not to take part in the focus group, we would like to take this opportunity to thank you for reading this information sheet and for giving this matter your consideration.

What are the advantages and disadvantages of taking part?

We do not consider there to be any personal advantages to you for taking part. However, your contribution will be greatly valued. The study is important for understanding the key issues in relation to the national implementation of VBR - what works, for whom, how, and in what circumstances. The findings will be important to a wide range of people: patients and their relatives, the health care workforce and its students and trainees, education and service providers, commissioners and regulators. Ultimately, this study aims to identify the 'ingredients' required for interventions that will best support NHS organisations. This includes

things like recruitment, selection, and the management and support for health care professionals and students. This is so care and services are delivered in line with the values of the NHS Constitution and public expectations.

Can I withdraw from the study at any time?

Even if you initially agree to take part, you are free to withdraw before the focus group takes place, without giving a reason for your withdrawal. At the end of the focus group we will check that we can progress to transcribe the focus group discussion. You can withdraw from the study up to one week after you have taken part in the focus group, without having to give a reason. If you choose to withdraw after you have taken part in the focus group, we would like your permission to use the recording, because this will contain the views of other participants. However, we can omit your contribution if you would prefer. After this time period, we will transcribe the focus group and analyse the data and we would like your consent to be able to use the anonymised data.

Will the information I give be kept confidential?

The focus group discussion is confidential: only the research team (based in Leeds) will have access to the full audio recording of the focus group. However, if you disclose information that indicates the safety of patients may be at risk, it is the duty of the research team to report this information through the appropriate reporting systems. When we have transcribed the focus group (word for word) we will destroy the audio recording. We will use unique study identification (ID) number for you and other participants, rather than your name. When we write up our report, we may use some of your words, but we will only use your study ID and ensure no information is reported that may lead to your identification. We will keep all audio recordings and focus group notes on a password protected computer. We will store consent forms in a separate electronic folder or in a locked filing cabinet for hard copies. We will comply with the Data Protection Act 1998 at all times.

With your permission, we would also like to deposit your anonymised focus group transcript in a data repository to support data sharing with researchers studying similar policy areas. We will share a copy of the anonymised transcript with you (if you would like it). It is entirely up to you whether you provide this permission and you can withdraw permission at any stage up to it being deposited (at the end of the study: 30 September 2019). Your decision on this will not affect whether you can contribute to this study, as this is a separate decision.

What will happen to the results of the study?

We consider this research to be an important national study. The focus group study you are being asked to take part in is one part of the overall study. We will publish articles, and produce reports on this work at national conferences. We have also created a project web page and blog (http://medhealth.leeds.ac.uk/VBR) where we will share key findings from different parts of the study, and encourage engagement, discussion and debate. You are invited to keep up to date with the study and join the blog discussion.

Who has reviewed this study?

Ethical approval has been granted by the School of Healthcare Research Ethics Committee (HREC 15-041, 15-3-2016).[1]

If you agree to take part, would like more information or have any questions or concerns about the study please contact

Dr Kate Farley – Telephone 0113 343 1283 or email k.farley@leeds.ac.uk
Prof Karen Spilsbury - Telephone 0113 343 1329 or email k.spilsbury@leeds.ac.uk

Thank you for taking the time to read this information sheet.

[1] All projects carried out in the School of Healthcare must be reviewed and approved by an Ethics Committee before it goes ahead. Approval means that the Committee is satisfied that your rights will be respected, that any risks have been reduced to a minimum and balanced against possible benefits, and that you have been given sufficient information on which to make an informed decision about whether to take part or not.

APPENDIX 13: Stage 2 consent forms for interview with patient and public representatives

UNIVERSITY OF LEEDS

School of Healthcare, Faculty of Medicine and Health

Participant Consent Form for Public and Patient Representatives – Interviews

Title of Study: Values based recruitment: What works, for whom, why, and in what circumstances?

	Please confirm agreement to the statements by putting your initials in the box below	
I have read and understood the participant information sheet for public and patient representatives (Stage Two, Version 3, 25-10-16)		
I have had the opportunity to ask questions and discuss this study		
I have received satisfactory answers to all of my questions		
I have received enough information about the study		
I understand that I am free to withdraw from the study:- 1 At any time/up to one week post-interview; 2 Without having to give a reason for withdrawing; and 3 That data collected will be destroyed and not used for the purposes of the study if I withdraw within one week		
I understand that my interview will be audio-recorded with my permission		
I understand that any information I provide, including personal details, will be kept confidential and stored securely, in line with the Data Protection Act, and the University of Leeds Data Protection Code, and will only be accessed by those carrying out the study		
I understand that if I disclose information that may indicate risk or future risk to myself, patients, or others then it may be necessary for the research team to report this information through appropriate reporting systems in my organisation		
I understand that any information I give may be included in published documents but all information will be anonymised		
I agree to take part in this study		
I agree to an anonymised transcript of my interview being deposited in a data sharing repository for possible future use	Yes	No
I understand a copy of this anonymised transcript will be shared with me and that I can withdraw this consent at any time up until it is deposited (at the end of the study: 30 September 2019)		
Participant Signature ..... Date		
Name of Participant		
Researcher Signature ..... Date		
Name of Researcher		
Note: Participants to receive signed original. Copy to be kept in the investigator file.		

Thank you for agreeing to take part in this study.

APPENDIX 14: Stage 2 consent forms for focus group with patient and public representatives

UNIVERSITY OF LEEDS

School of Healthcare, Faculty of Medicine and Health

Participant Consent Form for Public and Patient Representatives – Focus Groups

Title of Study: Values based recruitment: What works, for whom, why, and in what circumstances?

	Please confirm agreement to the statements by putting your initials in the box below	
I have read and understood the participant information sheet for focus groups (Stage Two, Version 3, 25-10-16)		
I have had the opportunity to ask questions and discuss this study		
I have received satisfactory answers to all of my questions		
I have received enough information about the study		
I understand that I am free to withdraw from the study:- 1 At any time/up to *one* week post-focus group discussion; 2 Without having to give a reason for withdrawing; and 3 That my participation in the focus group discussion will be deleted from the transcription and for the purposes of the study if I withdraw within one week. I understand that data from other participants in the discussion will be included in the study.		
I understand that the focus group will be audio-recorded with my permission		
I understand that any information I provide, including personal details, will be kept confidential and stored securely, in line with the Data Protection Act, and the University of Leeds Data Protection Code, and will only be accessed by those carrying out the study		
I understand that if I disclose information that may indicate risk or future risk to myself, patients, or others then it may be necessary for the research team to report this information through appropriate reporting systems in my organisation		
I understand that any information I give may be included in published documents but all information will be anonymised		
I agree to take part in this study		
I agree to an anonymised transcript of the focus group being deposited in a data sharing repository for possible future use	Yes	No
I understand a copy of this anonymised transcript will be shared with me and that I can withdraw this consent at any time up until it is deposited (at the end of the study: 30 September 2019)		
Participant Signature ..... Date		
Name of Participant		
Researcher Signature ..... Date		
Name of Researcher		
Note: Participants to receive signed original. Copy to be kept in the investigator file.		

Thank you for agreeing to take part in this study.

APPENDIX 15: Stage 2 consent forms for interview with staff and students

UNIVERSITY OF LEEDS

School of Healthcare, Faculty of Medicine and Health

Participant Consent Form for Staff and Trainee Health Professionals – Interviews

Title of Study: Values based recruitment: What works, for whom, why, and in what circumstances?

	Please confirm agreement to the statements by putting your initials in the box below	
I have read and understood the participant information sheet staff and trainee health professionals (Stage Two, Version 3, 25-10-16)		
I have had the opportunity to ask questions and discuss this study		
I have received satisfactory answers to all of my questions		
I have received enough information about the study		
I understand that I am free to withdraw from the study:- 1 At any time/up to one week post-interview; 2 Without having to give a reason for withdrawing; and 3 That data collected will be destroyed and not used for the purposes of the study if I withdraw within one week		
I understand that my interview will be audio-recorded with my permission		
I understand that any information I provide, including personal details, will be kept confidential and stored securely, in line with the Data Protection Act, and the University of Leeds Data Protection Code, and will only be accessed by those carrying out the study		
I understand that if I disclose information that may indicate risk or future risk to myself, patients, or others then it may be necessary for the research team to report this information through appropriate reporting systems in my organisation		
I understand that any information I give may be included in published documents but all information will be anonymised		
I agree to take part in this study		
I agree to an anonymised transcript of my interview being deposited in a data sharing repository for possible future use	Yes	No
I understand a copy of this anonymised transcript will be shared with me and that I can withdraw this consent at any time up until it is deposited (at the end of the study: 30 September 2019)		
Participant Signature ..... Date		
Name of Participant		
Researcher Signature ..... Date		
Name of Researcher		
Note: Participants to receive signed original. Copy to be kept in the investigator file.		

Thank you for agreeing to take part in this study.

APPENDIX 16: Stage 2 consent forms for focus group with staff and students

VBR Stage Two: Version 3 (25-10-16) IRAS ID 197167

UNIVERSITY OF LEEDS

School of Healthcare, Faculty of Medicine and Health

Participant Consent Form for Staff and Trainee Health Professionals – Focus Groups

Title of Study: Values based recruitment: What works, for whom, why, and in what circumstances?

	Please confirm agreement to the statements by putting your initials in the box below	
I have read and understood the participant information sheet for focus groups (Stage Two, Version 3, 25-10-16)		
I have had the opportunity to ask questions and discuss this study		
I have received satisfactory answers to all of my questions		
I have received enough information about the study		
I understand that I am free to withdraw from the study:- 1 At any time/up to *one* week post-focus group discussion; 2 Without having to give a reason for withdrawing; and 3 That my participation in the focus group discussion will be deleted from the transcription and for the purposes of the study if I withdraw within one week. I understand that data from other participants in the discussion will be included in the study.		
I understand that the focus group will be audio-recorded with my permission		
I understand that any information I provide, including personal details, will be kept confidential and stored securely, in line with the Data Protection Act, and the University of Leeds Data Protection Code, and will only be accessed by those carrying out the study		
I understand that if I disclose information that may indicate risk or future risk to myself, patients, or others then it may be necessary for the research team to report this information through appropriate reporting systems in my organisation		
I understand that any information I give may be included in published documents but all information will be anonymised		
I agree to take part in this study		
I agree to an anonymised transcript of the focus group being deposited in a data sharing repository for possible future use	Yes	No
I understand a copy of this anonymised transcript will be shared with me and that I can withdraw this consent at any time up until it is deposited (at the end of the study: 30 September 2019)		
Participant Signature ..... Date		
Name of Participant		
Researcher Signature ..... Date		
Name of Researcher		
Note: Participants to receive signed original. Copy to be kept in the investigator file.		

Thank you for agreeing to take part in this study.

APPENDIX 17: Example of Stage 2 topic guide

STAGE 2 INTERVIEWS – PHASE 1 (UNIVERSITY)

NHS Constitution Values:
1. working together for patients; 2. respect and dignity; 3. everyone counts; 4. commitment to quality of care; 5. compassion; 6. improving lives.

- **DID YOU EXPECT THAT?**
- **WAS THAT SUPPOSED TO HAPPEN?**

Open Questions

1. Can you tell me about your own involvement in values based recruitment here at [UNI]?

   Prompt: check when VBR (change in recruitment process) commenced – When was it implemented?

2. Can you talk me through the VBR process here, please?

3. **(A)** Were you (or your organisation) using a form of values based recruitment before April 2015 when it was mandated by HEE?

   If so, how is this method different? What has changed?

   Prompts: different questions; measuring different values; increase standardisation; difference in outcomes; ease of use; equality and diversity; resources required; interpretation; advantages or benefits; any disadvantages?

   (B) Do you think implementing the VBR framework might be easier for universities who were already using some form of values based recruitment?

4. Can you tell me what you know about why VBR is being used to recruit students onto healthcare educational programmes?

   Prompts: from your own personal and organisational perspective/ is there a difference?

5. The aim for HEE is to promote and support the embedding of the NHS Constitution values into education and training. Are you aware of the resources developed by HEE for this purpose?

   Prompts: values based framework and facilitated workshops; readiness check list; guidance on choosing a selection method; equality and diversity document, interview training course/training pack; Framework 15

6. **(A)** Were you (or your organisation) using a form of values based recruitment before April 2015 when it was mandated by HEE? .....

   If so, how is this method different? What has changed?

Prompts: different questions; measuring different values; increase standardisation; difference in outcomes; ease of use; equality and diversity; resources required; interpretation; advantages or benefits; any disadvantages?

(B) Do you think implementing the VBR framework might be easier for universities who are already using some form of values based recruitment?

7. HEE indicate a number of stages for VBR: attraction, pre-screening and selection. Can you describe what and who is involved in your organisation for each of these stages?

   Prompts: Are there leads for each stage; who/which department is responsible? Does each department work well together; are there any policies or protocols in place; does the system work well as a whole?

8. Can you tell me how the pre-screening stage works?
   Prompts: criteria for grades/personal statements/is it standardised/any training?

Programme Theory Questions

9. (A) The thinking is that VBR will enhance existing recruitment processes, do you think it has? Do you find your colleagues share your view?

   Prompts: Involving Service Users; having a collective understanding of the NHS Constitution Values, embedding the values into each stage – attraction, pre-screening, selection.

   (B) Some people have talked about the possibility that the more interviews student apps. attend, the more proficient at demonstrating their values they become.

10. The official line is that VBR provides an objective measure for assessing candidate's values during the interview process, do you think it does? How do you know?

    Prompts: training interviewers; unconscious bias

11. **(A)** One of the expected outcomes of using VBR is that it will increase student retention, do you have any thoughts about this? Are you aware of any figures for student retention?

    (B) Another expectation was that VBR would promote a fairer system, do you think it does? What do you to ensure this? Have any changes been made? How do you know - monitoring/evaluation?

    Prompts: equality and diversity framework; feedback from students/to students?

(C) Do you always stick to the assessment method's criteria, or are there occasions when different decisions are made using different criteria,

Prompts: individual or team judgement/departmental/organisational?

(D) Are you aware of any other expected outcomes that you can comment on?

12. Do you think there are any downsides to VBR?
    Prompts: unintended consequences; dysfunctional outcomes

13. (A) Do you consider VBR embedded in your organisation – how would you know this? Do you monitor or evaluate the system?

    (B) Does the new/adapted method take longer than it used to? If yes, can you say how much longer, and what factors contribute to this?
    Prompts: equipment; staff, service user numbers; time; any other resources.

14. What difference has this approach made to your recruitment? Monitor/Evaluate?

    Prompts: how do you know; are you aware of any data that has been/will be recorded from this new process, and if so, which data, and do you know how it might be used in the future?

15. Having gone through the VBR process in your organisation (X times) can you give me any examples of how you have changed the way you have developed this approach/ plan to develop this approach?

16. Do you think anything will change about the recruitment process when NHS bursaries are removed?

    Prompts: Jurisdiction and government/HEE regulation.

APPENDIX 18: Ethics approval Stage 4

The Secretariat
University of Leeds
Leeds, LS2 9JT
Tel: 0113 3431642
Email: FMHUniEthics@leeds.ac.uk

UNIVERSITY OF LEEDS

Professor Karen Spilsbury
Professor of Nursing
School of Healthcare
Faculty of Medicine and Health
Baines Wing Rm 2.28
University of Leeds
LEEDS LS2 9JT

21 June 2019

Dear Karen

Ref no: HREC 18-027

Title: VBR: What works, for whom, why, and in what circumstances?

Thank you for submitting your documentation for the above project. Following review by the School of Healthcare Research Ethics Committee (SHREC), I can confirm a favourable ethical opinion based on the documentation received at date of this letter:

Document Received	*Version*	*Date Received*
Spilsbury_VBR_Ethical_Review_Form_V3	3.0	11/04/2019
REC ID INSERTED_VBR STAGE 4 interview contact text by email v1 11-04-19	1.0	03/06/2019
REC ID INSERTED_VBR STAGE 4 interview topic guide	1.1	03/06/2019
REC ID INSERTED_VBR STAGE 4 survey contact text by email v1 11-04-19	1.0	03/06/2019
Revised_VBR Consent Form STAGE 4 public and patient representatives INTERVIEWS Version 2 03-06-19	2.0	03/06/2019
Revised_VBR Consent Form STAGE 4 staff and students INTERVIEWS Version 2 03-06-19	2.0	03/06/2019
Revised_VBR Info Sheet STAGE 4 staff and student Version 2 03-06-19.	2.0	03/06/2019
Revised_VBR Info Sheet STAGE4 public and patient reps Version 2 03-06-19	2.0	03/06/2019
Revised_VBR STAGE 4 draft survey v2 03-06-19	2.0	03/06/2019
Spilsbury_VBR_Revised proposal_January 2015_FINAL_9-1-15	1.0	11/04/2019

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval. This includes recruitment methodology and all changes must be ethically approved prior to implementation. Please contact the Faculty Research Ethics Administrator for further information FMHUniEthics@leeds.ac.uk

Ethical approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The SHREC takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, and may be subject to an audit inspection. If your project is to be audited, you will be given at least 2 weeks notice.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

The committee wishes you every success with your project.

Yours sincerely

Helen Convey
Chair, School of Healthcare Research Ethics Committee

APPENDIX 19: National survey of the implementation of VBR in HEIs for the recruitment of students to health care (Stage 4)

UNIVERSITY OF LEEDS

School of Healthcare

Faculty of Medicine and Health

Values based recruitment: What works, for whom, why, and in what circumstances?

PARTICIPANT INFORMATION SHEET
SURVEY

You are being invited to take part in the above-named study. Before you decide whether or not to take part it is important to understand what this research study is about, and what will be involved if you decide you would like to take part. Please read this information sheet carefully, and if there is anything you want to discuss in more detail, or if there is anything that is unclear, please contact the person named at the end of this information sheet. Take as much time as you need, to decide whether or not to take part. Your involvement is important to us, but it is entirely voluntary.

What is the purpose of this study?

The National Health Service (NHS) employs over a million people, and it is important to ensure the 'right' people are recruited to NHS caring positions and to the educational programmes that train them in universities. Values based recruitment (VBR) is an approach being used with the expectation that it will align the values and behaviours of NHS staff and students with the values of the NHS, and expectations of the public. VBR assumes that recruiting for values and behaviours, and then maintaining and encouraging them, will improve the quality of healthcare provision. Whilst this is appealing, there is no evidence to support this assumption. This research study aims to evaluate the effects of VBR, in particular to explore its implementation, how people respond, what is working well and what lessons can be learned.

Who is doing the study?

This study is being led by a Professor of Nursing (Karen Spilsbury), employed in the School of Healthcare at the University of Leeds. The research team is made up of a range of individuals from other universities and a researcher from Valid Research (http://validresearch.co.uk) to ensure the right skills and expertise are in place to conduct the study and to understand the relevance of the findings for the sector.

Why have I been asked to participate?

You are being approached to take part in this study because you are an admissions tutor for a health care programme delivered in your university.

What will be involved if I take part in this study?

In this final stage (stage four) of our study, we are asking you to complete one online survey. The survey asks you questions about implementation of VBR in your organisation and you perceptions of its impact. We ask that you complete the survey at a time most convenient for you in the next 2

weeks: it will take you no more than 30 minutes to compete. If you would like to take part, then please progress with completion of the survey. You do not need to sign a consent form: completion of the survey is sufficient indication of your willingness to take part. We may use some anonymised direct quotations that you provide in our study report.

If you have decided not to take part in the survey, we would like to take this opportunity to thank you for reading this information sheet and for giving this matter your consideration.

What are the advantages and disadvantages of taking part?
We do not consider there to be any personal advantages to you for taking part. However, your contribution will be greatly valued. The study is important for understanding the key issues in relation to the national implementation of VBR - what works, for whom, how, and in what circumstances. The findings will be important to a wide range of people: patients and their relatives, the health care workforce and its students and trainees, education and service providers, commissioners and regulators. Ultimately, this study aims to model the 'ingredients' required for interventions that will best support organisations for recruiting, selecting, managing and supporting health care professionals and students to deliver services and care in line with the aspirations of the NHS Constitution and the expectations of the public which the NHS serves.

Can I withdraw from the study at any time?
Even if you initially agree to take part, you are free to withdraw at any time during completion of the survey. Once you submit your responses to the survey questions then the information already collected from you will be included in the final study analysis unless you specifically request that we do not use it.

Will the information I give be kept confidential?
Your information will be kept confidential and securely stored at the School of Healthcare, University of Leeds. You will be given a unique study number (ID) and only researchers involved in the study will be able to link your ID to the information you provide on your role. This anonymised ID will be used when using any of your words (as illustrative quotes) in the report of findings.

Once the study findings have been published, the anonymised survey responses will be securely archived for 2 years and then destroyed.

Who is responsible for handling any data collected for this study?
The University of Leeds is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Leeds will keep identifiable information about you for 1 year after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information as possible.

You can find out more about how we use your information at https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf or by contacting one of the researchers named at the end of this information sheet.

What will happen to the results of the study?
We consider this research to be an important national study. The survey you are being asked to take part in is one part of the overall study. We will publish articles and produce reports on this work at national conferences. We have created a project web page (http://medhealth.leeds.ac.uk/VBR) which will share headlines from different parts of the study and encourage engagement, discussion and debate about the findings amongst interested parties.

Who has reviewed this study?
Ethical approval has been granted by the School of Healthcare Research Ethics Committee (HREC 18-027).

Thank you for taking the time to read this information sheet.

If you would like more information or have any questions or concerns about the study please contact:

Prof Karen Spilsbury - Telephone 0113 343 1329 or email k.spilsbury@leeds.ac.uk

If you are happy to take part then please progress to the survey.

UNIVERSITY OF LEEDS

Values based recruitment: What works, for whom, why, and in what circumstances?

Survey instructions

This survey forms part of a study being funded by the National institute for Health research Policy Research Programme. The aim of the study is to evaluate the effects of VBR, in particular to explore its implementation, how people respond, what is working well and what lessons can be learned.

The survey asks you questions about implementation of VBR in your university and your perceptions of its impact. You have been invited to participate because you have an admissions role for undergraduate health care programmes within your university. We ask that you complete the survey at a time most convenient for you in the next 2 weeks.

Please try to answer all questions. Most of the questions can be answered with only a single selection (by ticking a box). Some questions ask you about your level of agreement with a statement (from strongly agree to strongly disagree). Where appropriate, a space has been provided for you to add any additional information that you feel is important, but not captured by the survey questions. The survey should take no more than 30 minutes. Completion of the survey constitutes your consent to take part (there is no separate consent form for you to complete).

Click ‘next’ to proceed.

Which University do you work for? _____

1. Do you work in an admissions role for any of the following undergraduate degree programmes?

Undergraduate degree programmes*	**Answer**
Occupational therapy	Yes/No
Physiotherapy	Yes/No
Diagnostic radiography	Yes/No
Dietetics	Yes/No
Podiatry	Yes/No
Speech and language therapy	Yes/No
Midwifery (3 years)	Yes/No
Midwifery (18 months)	Yes/No
Adult nursing	Yes/No
Children's nursing	Yes/No
Learning disabilities nursing	Yes/No
Mental health nursing	Yes/No
Other *(please state)*	

**Participants will be required to answer Q2-6 for each undergraduate degree programme selected.*

2. Are values promoted in the marketing materials (for example web pages, prospectus)? Please tick the relevant response:

	Please tick
Yes	
No	

If you answered yes, please provide detail in the box below:

Go to Q.3

3. What methods do you use for screening potential students? Please tick all relevant responses:

Please tick	
	Application form
	Social Judgement Test
	Personality test
	Other (please state):

4. What methods do you use for selecting potential students? Please tick all relevant responses:

Please tick	
	Social Judgement Test
	Personality test
	Group interview (task)
	Multiple mini interview
	Structured interview
	Other (please state):

5. Are public or patient representatives involved in recruitment processes? Please tick the relevant response:

	Please tick
Yes	
No	

If you answered yes please indicate which stages of the process public and patient representatives are involved in. Please tick all relevant responses:

Please tick	
	Screening applicants
	Selecting applicants
	Other (please state):

Go to Q.6

6. Are clinical partners (i.e. health care professionals from partner NHS Trusts) involved in recruitment processes? Please tick the relevant response:

	Please tick
Yes	
No	

If you answered yes please indicate which stages of the process clinical partners are involved in. Please tick all relevant responses:

Please tick	
	Screening applicants
	Selecting applicants
	Other (please state):

7. I consider VBR to have relevance when recruiting potential students

Please tick	
	Strongly agree
	Agree
	Neither agree or disagree
	Disagree
	Strongly disagree

8. I believe it is possible to measure values in potential students

Please tick	
	Strongly agree
	Agree
	Neither agree or disagree
	Disagree
	Strongly disagree

9. Recruiting students based on their values has a positive impact on the programme (for example, reduced attrition of students from the programme)

Please tick	
	Strongly agree
	Agree
	Neither agree or disagree
	Disagree
	Strongly disagree

10. Recruiting students based on their values has a positive impact on their first professional post (for example, showing empathy to their patients)

Please tick	
	Strongly agree
	Agree
	Neither agree or disagree
	Disagree
	Strongly disagree

11. VBR leads to a positive impact for patients (for example, improved standards of care) because care is being delivered by people with the right values

Please tick	
	Strongly agree
	Agree
	Neither agree or disagree
	Disagree
	Strongly disagree

12. VBR leads to a positive impact on the health care system (for example increased staff commitment to their role) because their values align with the system in which they work

Please tick	
	Strongly agree
	Agree
	Neither agree or disagree
	Disagree
	Strongly disagree

13. I believe there is a commitment in my organisation to embed VBR in our recruitment of students

Please tick	
	Strongly agree
	Agree
	Neither agree or disagree
	Disagree
	Strongly disagree

14. I believe it is sufficient to recruit students for a health care programme of study solely on their values

Please tick	
	Strongly agree
	Agree
	Neither agree or disagree
	Disagree
	Strongly disagree

15. Our approach to VBR is well designed and implemented when recruiting potential students

Please tick	
	Strongly agree
	Agree
	Neither agree or disagree
	Disagree
	Strongly disagree

16. When assessing potential students we ensure they understand the challenging nature of healthcare work to align the values of the individual with the system in which they will work.

Please tick	
	Strongly agree
	Agree
	Neither agree or disagree
	Disagree
	Strongly disagree

17. I believe my colleagues are committed to engaging with VBR when recruiting potential students

Please tick	
	Strongly agree
	Agree
	Neither agree or disagree
	Disagree
	Strongly disagree

18. Among my colleagues there is a consistent view about how values should be assessed when recruiting students

Please tick	
	Strongly agree
	Agree
	Neither agree or disagree
	Disagree
	Strongly disagree

19. Please use the space below if there is anything you think is important to share with us about your experiences of VBR, using the approach, and the impact on the undergraduate health care programmes at your university?

We will share a report of the survey findings towards the end of this year. Please provide your email address if you would like a copy of the survey findings.

Thank you for completing this survey.

Click 'finish' to submit your responses.

APPENDIX 20: National survey initial email contact

UNIVERSITY OF LEEDS

School of Healthcare
Faculty of Medicine and Health

Values based recruitment: What works, for whom, why, and in what circumstances?

Initial contact by email

[Date]

Dear [Name]

Your help needed for a national funded study:
Values based recruitment: What works, for whom, why, and in what circumstances?

You are being invited to help us with a study funded by the National Institute for Health Research which seeks to evaluate the effects of values based recruitment (VBR), an approach being used with the expectation that it will align the values and behaviours of NHS staff and students with the values of the NHS, and expectations of the public.

You are being approached as an admissions tutor for a health care programme being provided by your university to participate in a survey. The survey aims to gather your views and experiences of implementing VBR and perceptions of impact.

The link to our survey is XX and further study information is included in the front pages of the survey. You will only be asked to complete the survey once and it should take no more than 30 minutes.

If you are interested in taking part then please go to the survey and complete this at a time most convenient for you in the next 2 weeks. If you have any questions prior to completing the survey then please do not hesitate to contact me (details below).

We appreciate that you will be very busy and thank you for taking the time to consider taking part in this study.

Kind regards

Professor Karen Spilsbury (Principal Investigator)
School of Healthcare, Faculty of Medicine and Health, University of Leeds
Tel: 0113 343 1329
Email: k.spilsbury@leeds.ac.uk

APPENDIX 21: Initial contact by email for Stage 4 follow-up interview

UNIVERSITY OF LEEDS

School of Healthcare
Faculty of Medicine and Health

Values based recruitment: What works, for whom, why, and in what circumstances?

Initial contact by email

[Date]

Dear [Name]

Your help needed for a national funded study:
Values based recruitment: What works, for whom, why, and in what circumstances?

You are being invited to help us with a study funded by the National Institute for Health Research which seeks to evaluate the effects of values based recruitment, an approach being used with the expectation that it will align the values and behaviours of NHS staff and students with the values of the NHS, and expectations of the public.

You have already participated in an earlier interview for this study and gave your permission for us to contact you about a follow-up interview at a later date. We attach a study information sheet to this email which explains more about the study and what would be involved. We are asking you to consider taking part in one interview that will last no more than 30 minutes.

If you are interested in taking part then please reply to this email (please reply to all) at your earliest convenience. Our colleagues at Valid Research Limited (Cath Jackson and Nicola Gallagher) will then contact you to arrange a date and time to discuss the study further with you and/or to conduct the interview.

We will follow-up our email after 7 and 14 days if we do not hear back from you. If you would rather not take part in the study then please let us know.

We appreciate that you will be very busy and thank you for taking the time to consider taking part in this study.

Kind regards

Professor Karen Spilsbury (Principal Investigator)
School of Healthcare, Faculty of Medicine and Health, University of Leeds
Tel: 0113 343 1329
Email: k.spilsbury@leeds.ac.uk

APPENDIX 22: Participant information sheet for Stage 4 follow-up interviews (public and patient representatives)

UNIVERSITY OF LEEDS

School of Healthcare
Faculty of Medicine and Health

Participant Information Sheet (public and patient representatives)
Values based recruitment: What works, for whom, why, and in what circumstances?

You are being invited to take part in the above named study. Before you decide whether or not to take part it is important to understand what this research study is about and what will be involved if you decide you would like to take part. Read this information sheet carefully and if there is anything you want to discuss in more detail or that is unclear please contact the person named at the end of this information sheet. Take as much time as you need to decide whether or not to take part. Your involvement is entirely voluntary.

What is the purpose of this study?
The National Health Service (NHS) employs over a million people, and it is important to ensure the 'right' people are recruited to NHS caring positions and to the educational programmes that train them in universities. Values based recruitment (VBR) is an approach being used with the expectation that it will align the values and behaviours of NHS staff and students with the values of the NHS, and expectations of the public. VBR assumes that recruiting for values and behaviours, and then maintaining and encouraging them, will improve the quality of healthcare provision. Whilst this is appealing, there is no evidence to support this assumption. This research study aims to evaluate the effects of VBR, in particular to explore its implementation, how people respond, what is working well and what lessons can be learned.

Who is doing the study?
This study is being led by a Professor of Nursing (Karen Spilsbury), employed in the School of Healthcare at the University of Leeds. The research team is made up of a range of individuals from other universities and a researcher from Valid Research (http://validresearch.co.uk) to ensure the right skills and expertise are in place to conduct the study and to understand the relevance of the findings for the sector.

Why have I been asked to participate?
You are being approached to take part in this study because you are a member of the public or a patient representative that is, or has been, involved in processes associated with VBR in a university setting. You have already participated in an earlier interview for this study and gave us permission to contact you again to conduct a follow-up interview with you.

What will be involved if I take part in this study?
The study involves four stages. In this final stage (stage four), we are conducting interviews with people involved with, or affected by values based recruitment, including trainee healthcare professionals and representatives from education providers. We are inviting you to take part in one short telephone interview that will last no more than 30 minutes. If you prefer we can arrange a video call via Skype or Zoom. The interview will be scheduled for a date and time that best suits you (in the next couple of weeks). The interview will focus on your perceptions of VBR, including the challenges and opportunities presented by VBR and its impacts. If you would like to take part, you will be asked to sign a consent form. With your permission, the interview (whether conducted by telephone or video call) will be audio recorded and transcribed word for word so that we can identify the main issues that you raise. We may use some anonymised direct quotations that you provide in our study report.

If you have decided not to take part in the interview, we would like to take this opportunity to thank you for reading this information sheet and for giving this matter your consideration.

What are the advantages and disadvantages of taking part?
We do not consider there to be any personal advantages to you for taking part. However, your contribution will be greatly valued. The study is important for understanding the key issues in relation to the national implementation of VBR - what works, for whom, how, and in what circumstances. The findings will be

important to a wide range of people: patients and their relatives, the health care workforce and its students and trainees, education and service providers, commissioners and regulators. Ultimately, this study aims to model the 'ingredients' required for interventions that will best support organisations for recruiting, selecting, managing and supporting health care professionals and students to deliver services and care in line with the aspirations of the NHS Constitution and the expectations of the public which the NHS serves.

Can I withdraw from the study at any time?

Even if you initially agree to take part, you are free to withdraw before or during the interview without giving a reason. If you choose to withdraw then we will destroy any recordings. At the end of the interview we will check that we can progress to transcribe your interview. If you withdraw at a later date then the information already collected from you will be included in the final study analysis unless you specifically request that we do not use it.

Will the information I give be kept confidential?

Your personal information will be kept confidential and securely stored at the School of Healthcare, University of Leeds. With your permission, the interview will be audio recorded and transcribed word for word so that we can identify the main issues that you raise. We will use a University approved transcribing service who have a confidentiality agreement with the University of Leeds. You will be given a unique study number (ID) and only researchers involved in the study will be able to identify you from your ID. This anonymised ID will be used when using any of your words (as illustrative quotes) in the report of findings. No personal information will ever be used. However, in the very unlikely event that you disclose any information that the researcher considers may threaten patient safety then the research team may have to disclose this information to the relevant bodies. In this situation we would have to disclose personal information.

The recordings of the interviews will be destroyed once the study is completed. Once the study findings have been published, the anonymised transcripts will be securely archived for 2 years and then destroyed.

Who is responsible for handling any data collected for this study?

The University of Leeds is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Leeds will keep identifiable information about you for 1 year after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information as possible.

You can find out more about how we use your information at https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf or by contacting one of the researchers named at the end of this information sheet.

When you agree to take part in this research study, we would like your permission to deposit your anonymised interview transcript in a data repository to support data sharing with researchers running other research studies in this organisation and in other organisations studying similar practice or policy areas. These organisations may be universities, or health and care organisations in this country or abroad. Your information will only be used by organisations and researchers to conduct research in accordance with the UK Policy Framework for Health and Social care Research. This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of health and care research, and cannot be used to contact you. We will share a copy of the anonymised transcript with you (if you would like it). It is entirely up to you whether you provide this permission, and you can withdraw permission at any stage up to it being deposited (at the end of the study: September 2019). Your decision related to this matter does not affect whether you can contribute to this study. This is a separate decision.

What will happen to the results of the study?

We consider this research to be an important national study. The interview study you are being asked to take part in is one part of the overall study. We will publish articles and produce reports on this work at national conferences. We have created a project web page (http://medhealth.leeds.ac.uk/VBR) which will share headlines from different parts of the study and encourage engagement, discussion and debate about the findings amongst interested parties.

Who has reviewed this study?

Ethical approval has been granted by the School of Healthcare Research Ethics Committee (HREC 18-027).[1]

If you agree to take part, please reply to the invitation email you have received (please reply to all).

If you would like more information or have any questions or concerns about the study please contact:

Prof Karen Spilsbury - Telephone 0113 343 1329 or email k.spilsbury@leeds.ac.uk

Thank you for taking the time to read this information sheet.

[1]All projects carried out in the School of Healthcare must be reviewed and approved by the School's Research Ethics Committee before it goes ahead. Approval means that the Committee is satisfied that your rights will be respected, that any risks have been reduced to a minimum and balanced against possible benefits, and that you have been given sufficient information on which to make an informed decision about whether to take part or not.

APPENDIX 23: Participant information sheet for Stage 4 follow-up interviews (staff and trainee healthcare professionals)

UNIVERSITY OF LEEDS

School of Healthcare
Faculty of Medicine and Health

Participant Information Sheet (staff and trainee health professionals)
Values based recruitment: What works, for whom, why, and in what circumstances?

You are being invited to take part in the above named study. Before you decide whether or not to take part it is important to understand what this research study is about, and what will be involved if you decide you would like to take part. Please read this information sheet carefully, and if there is anything you want to discuss in more detail, or if there is anything that is unclear, please contact the person named at the end of this information sheet. Take as much time as you need, to decide whether or not to take part. Your involvement is important to us, but it is entirely voluntary.

What is the purpose of this study?
The National Health Service (NHS) employs over a million people, and it is important to ensure the 'right' people are recruited to NHS caring positions and to the educational programmes that train them in universities. Values based recruitment (VBR) is an approach being used with the expectation that it will align the values and behaviours of NHS staff and students with the values of the NHS, and expectations of the public. VBR assumes that recruiting for values and behaviours, and then maintaining and encouraging them, will improve the quality of healthcare provision. Whilst this is appealing, there is no evidence to support this assumption. This research study aims to evaluate the effects of VBR, in particular to explore its implementation, how people respond, what is working well and what lessons can be learned.

Who is doing the study?
This study is being led by a Professor of Nursing (Karen Spilsbury), employed in the School of Healthcare at the University of Leeds. The research team is made up of a range of individuals from other universities and a researcher from Valid Research (http://validresearch.co.uk) to ensure the right skills and expertise are in place to conduct the study and to understand the relevance of the findings for the sector.

Why have I been asked to participate?
You are being approached to take part in this study because you are either a trainee healthcare professional or you are a staff member involved in the delivery of values based recruitment in a university setting. You have already participated in an earlier interview for this study and gave us permission to contact you again to conduct a follow-up interview with you.

What will be involved if I take part in this study?
The study involves four stages. In this final stage (stage four), we are conducting interviews with people involved with, or affected by values based recruitment, including trainee healthcare professionals and representatives from education providers. We are inviting you to take part in one short telephone interview that will last no more than 30 minutes. If you prefer we can arrange a video call via Skype or Zoom. The interview will be scheduled for a date and time that best suits you (in the next couple of weeks). The interview will focus on your perceptions of VBR, including the challenges and opportunities presented by VBR and its impacts. If you would like to take part, you will be asked to sign a consent form. With your permission, the interview (whether conducted by telephone or video call) will be audio recorded and transcribed word for word so that we can identify the main issues that you raise. We may use some anonymised direct quotations that you provide in our study report.

If you have decided not to take part in the interview, we would like to take this opportunity to thank you for reading this information sheet and for giving this matter your consideration.

What are the advantages and disadvantages of taking part?
We do not consider there to be any personal advantages to you for taking part. However, your contribution will be greatly valued. The study is important for understanding the key issues in relation to the national

implementation of VBR - what works, for whom, how, and in what circumstances. The findings will be important to a wide range of people: patients and their relatives, the health care workforce and its students and trainees, education and service providers, commissioners and regulators. Ultimately, this study aims to model the 'ingredients' required for interventions that will best support organisations for recruiting, selecting, managing and supporting health care professionals and students to deliver services and care in line with the aspirations of the NHS Constitution and the expectations of the public which the NHS serves.

Can I withdraw from the study at any time?

Even if you initially agree to take part, you are free to withdraw before or during the interview without giving a reason. If you choose to withdraw then we will destroy any recordings. At the end of the interview we will check that we can progress to transcribe your interview. If you withdraw at a later date then the information already collected from you will be included in the final study analysis unless you specifically request that we do not use it.

Will the information I give be kept confidential?

Your personal information will be kept confidential and securely stored at the School of Healthcare, University of Leeds. With your permission, the interview will be audio recorded and transcribed word for word so that we can identify the main issues that you raise. We will use a University approved transcribing service who have a confidentiality agreement with the University of Leeds. You will be given a unique study number (ID) and only researchers involved in the study will be able to identify you from your ID. This anonymised ID will be used when using any of your words (as illustrative quotes) in the report of findings. No personal information will ever be used. However, in the very unlikely event that you disclose any information that the researcher considers may threaten patient safety then the research team may have to disclose this information to the relevant bodies. In this situation we would have to disclose personal information.

The recordings of the interviews will be destroyed once the study is completed. Once the study findings have been published, the anonymised transcripts will be securely archived for 2 years and then destroyed.

Who is responsible for handling any data collected for this study?

The University of Leeds is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Leeds will keep identifiable information about you for 1 year after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information as possible.

You can find out more about how we use your information at https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf or by contacting one of the researchers named at the end of this information sheet.

When you agree to take part in this research study, we would like your permission to deposit your anonymised interview transcript in a data repository to support data sharing with researchers running other research studies in this organisation and in other organisations studying similar practice or policy areas. These organisations may be universities, or health and care organisations in this country or abroad. Your information will only be used by organisations and researchers to conduct research in accordance with the UK Policy Framework for Health and Social care Research. This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of health and care research, and cannot be used to contact you. We will share a copy of the anonymised transcript with you (if you would like it). It is entirely up to you whether you provide this permission, and you can withdraw permission at any stage up to it being deposited (at the end of the study: September 2019). Your decision related to this matter does not affect whether you can contribute to this study. This is a separate decision.

What will happen to the results of the study?
We consider this research to be an important national study. The interview study you are being asked to take part in is one part of the overall study. We will publish articles and produce reports on this work at national conferences. We have created a project web page (http://medhealth.leeds.ac.uk/VBR) which will share headlines from different parts of the study and encourage engagement, discussion and debate about the findings amongst interested parties.

Who has reviewed this study?
Ethical approval has been granted by the School of Healthcare Research Ethics Committee (HREC 18-027).[1]

If you agree to take part, please reply to the invitation email you have received (please reply to all).

If you would like more information or have any questions or concerns about the study please contact:

Prof Karen Spilsbury - Telephone 0113 343 1329 or email k.spilsbury@leeds.ac.uk

Thank you for taking the time to read this information sheet.

[1]All projects carried out in the School of Healthcare must be reviewed and approved by the School's Research Ethics Committee before it goes ahead. Approval means that the Committee is satisfied that your rights will be respected, that any risks have been reduced to a minimum and balanced against possible benefits, and that you have been given sufficient information on which to make an informed decision about whether to take part or not.

APPENDIX 24: Consent for Stage 4 follow-up interviews (public and patient representatives)

UNIVERSITY OF LEEDS

School of Healthcare, Faculty of Medicine and Health

Participant Consent Form for public and patient representatives – Interviews

Title of Study: Values based recruitment: What works, for whom, why, and in what circumstances?

	Please confirm agreement to the statements by putting your initials in the box below	
I confirm that I have read and understood the Participant Information Sheet dated 28/10/19 (Version 2.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.		
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.		
I understand that my data collected during the study may be looked at by individuals from the School of Healthcare (University of Leeds) where it is relevant to my taking part in this research.		
I understand that even if I withdraw from the study, the data already collected from me will contribute to the study unless I specifically request for it be removed.		
I understand that a copy of this Consent Form will be stored at the School of Healthcare, University of Leeds.		
I agree to take part in the interview and understand I can request this interview be by telephone or video call		
I agree for the interview to be audio-recorded and transcribed as described in the information sheet.		
I agree that anonymised quotes from the interview can be used in meetings relating to the study, and associated publications and presentations.		
I agree to an anonymised transcript of the interview being deposited in a data sharing repository for possible future use.	Yes	No
I understand that if during the interview I disclose information that that the researcher considers may threaten the personal safety of residents or relatives then the research team may have to disclose this information to the relevant bodies. In this situation I understand they would have to disclose personal information.		
Participant Signature …… Date		
Name of Participant		
Researcher Signature …… Date		
Name of Researcher		
Note: Participants to receive signed original. Copy to be kept in the investigator file.		

Thank you for agreeing to take part in this study.

APPENDIX 25: Consent for Stage 4 follow-up interviews (staff and trainee healthcare professionals)

UNIVERSITY OF LEEDS

School of Healthcare, Faculty of Medicine and Health

Participant Consent Form for Staff and Trainee Health Professionals – Interviews

Title of Study: Values based recruitment: What works, for whom, why, and in what circumstances?

	Please confirm agreement to the statements by putting your initials in the box below	
I confirm that I have read and understood the Participant Information Sheet dated 28/10/19 (Version 2.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.		
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.		
I understand that my data collected during the study may be looked at by individuals from the School of Healthcare (University of Leeds) where it is relevant to my taking part in this research.		
I understand that even if I withdraw from the study, the data already collected from me will contribute to the study unless I specifically request for it be removed.		
I understand that a copy of this Consent Form will be stored at the School of Healthcare, University of Leeds.		
I agree to take part in the interview and understand I can request this interview be by telephone or video call.		
I agree for the interview to be audio-recorded and transcribed as described in the information sheet.		
I agree that anonymised quotes from the interview can be used in meetings relating to the study, and associated publications and presentations.		
I agree to an anonymised transcript of the interview being deposited in a data sharing repository for possible future use.	Yes	No
I understand that if during the interview I disclose information that that the researcher considers may threaten the personal safety of residents or relatives then the research team may have to disclose this information to the relevant bodies. In this situation I understand they would have to disclose personal information.		
Participant Signature ..... Date		
Name of Participant		
Researcher Signature ..... Date		
Name of Researcher		
Note: Participants to receive signed original. Copy to be kept in the investigator file.		

Thank you for agreeing to take part in this study.

APPENDIX 26: Topic guide for Stage 4 follow-up interviews

Topic guide

Values based recruitment: What works, for whom, why, and in what circumstances?

INTRODUCTIONS: STUDY PURPOSE AND INTERVIEW

- Have they read the information sheet, and do they have any questions
- Confirm receipt of consent form (we should have received this)
- Interview should take up to 30 minutes
- Remind participant of how data will be used
- Anonymising transcript
- Seek verbal consent on recording

ABOUT YOU

- Understanding the participant's role and involvement in VBR strategy and policy over time
- Check their current role in the university (has it changed since previous interview)
  - Can you remind me about your own involvement in VBR here at [name university]?
  - Has your involvement changed since you were last interviewed? How?

PERCEPTIONS OF VBR

Questions aimed at exploring the participant's perceptions of:

- Development/ changes in use of VBR in their organisation
  - Have VBR processes changed in any way since you were last interviewed?
  - If so, what has changed and why?
  - If not, what works well and has supported ongoing use of these processes for recruitment?

- Advantages and disadvantages of VBR (perceived 'success' in recruiting for values)
  - How relevant is VBR for recruiting the 'right' students to your health care programmes? Why do you think that?
  - Have you noticed any changes in student applications/ recruitment since removal of NHS bursaries? If so, has this influenced your opinion of VBR?
  - How successful do you think VBR has been? Why do you have this view/ what examples do you have that help explain this view?
  - Has your opinion of VBR changed over time? If so, why/ what has influenced this change of opinion?

- Contextual factors (individual and organisational) that have influenced use of VBR
  - How committed is your organisation embedding VBR in your programme? What makes you think this/ have this opinion? Can you provide examples?
  - How committed are you and your colleagues at engaging with VBR for the recruitment of students to your programme? What makes you think this/ have this opinion? Can you provide examples?

- Mechanisms and processes through which VBR outcomes are achieved
  - How have you evaluated the processes and outcomes of VBR for your programme?
  - Please provide examples that demonstrate VBR outcomes achieved/ not achieved.

- Potential costs and consequences of VBR
  - What do you think the impact of VBR has been on students? On patients? On the health care system?
  - Do you think there are any downsides or unintended consequences of VBR? What are they?
  - Do you consider the time invested in the VBR to be worthwhile? Why/Why not?

FUTURE/VISION

- Exploring how the participant envisages development of VBR and how this links with other key policies and strategies
  - What do you think will happen to VBR in the future? Is it sustainable? If so, why? If not, why?

ANYTHING ELSE

Opportunity to explore any areas the participant considers important that they have not had the opportunity to discuss in the interview.

THANKS, AND ENDING THE INTERVIEW

- Remind participant of how data will be used – contribute to a final report of the entire study and also to any publications we write – it will be anonymised – university and individual not identified
- Information about summary report for participants: do they want a copy? If so we will keep their email address. If not, no contact information will be stored
- Anonymising transcript – establish if participant would like to see this version that may be deposited in data repository
- End of interview

APPENDIX 27: A response from Sally Bibb, Director of Engaging Minds, to the Acute NHS Trust case study findings

Sally Bibb led the introduction of strengths-based recruitment in The Shelford Group Hospital Trusts, including the Acute NHS Trust included in this evaluation. Here she provides her reflections on our findings and the lessons learned. We thank Sally for giving her time to orientate the research team to SBR and for providing this response.

"Your report clearly throws up the challenge this case site had with implementation of strengths-based recruitment (SBR). Effective implementation and a lead sponsor is key for any organisational change. Unfortunately, the SBR Champion who was leading implementation at this Acute NHS Trust left the organisation fairly early in the process and that had an impact on consistent roll out.

There were two other Shelford Group Hospital Trusts that launched SBR at the same time as this case Site. They each had a senior person consistently leading the implementation and quality monitoring and have seen qualitative and quantitative results. In some of The Shelford Group Hospital Trusts, SBR data is part of the Chief Nurse's dashboard and figures are reported regularly. These Trusts also consistently used the strengths-based job adverts and have tracked numbers of candidates interviewed, successful, appointed and successful in the role.

This was a nursing led initiative and I don't think Human Resource departments had much involvement so it's not surprising that they didn't participate in your study.

With the process not joined up (no reference to strengths in job adverts, or documentation) and only 20% of interviews being strengths-based, and the organisation not collecting data, I can see why your report of this case is reported as a 'limited case history'.

Below is a copy of the summary of a report into the implementation of SBR in the Shelford Group Hospital Trusts, including lessons learned. The document this was

taken from is *Summary of SBR mini-conference hosted by UCLH 22 November 2017*."

The implementation of SBR into the Shelford Group NHS Trusts is a change management challenge like any other. Senior level sponsorship, effective SBR Leads, strong collaboration between HR and the operation, a 'felt' need, efficient and effective planning and monitoring, the right staff skilled in strengths-based interviewing and on-going tracking are all crucial.

In Trusts (or divisions within Trusts) where these success factors are in place, SBR has been embedded and is now the norm. Where one or more of these success factors is not in place, SBR is not well established.

All the speakers spoke about how difficult evaluation is due to a variety of factors; availability of data and the difficulty of establishing cause and effect are the main challenges. Having said that it was noted that the attempt to evaluate the impact of SBR is far greater than is done for other recruitment methods which are not evaluated at all.

[Names 3 other Shelford Group Hospital Trusts, labelled Trust A, B and C] have all experienced enough benefits that they continue their commitment to the approach. [Trust A] believe that SBR has been crucial in ensuring the right ward leaders are in place. At [Trust A], ward leaders have delivered £1.05million of cost avoidance through effective deployment of staff, avoidable harm has reduced, there has been improved compliance with care processes, and key workforce metrics (vacancy rates, turnover and agency rates) have all improved. [Trust B] believes that SBR is affecting safety and performance positively and [Trust C] reported that a better quality of staff is being recruited. Although it can be difficult to provide quantitative proof, it was noted that Matrons generally like the approach, as it gives them confidence that they are appointing the right person. In a survey across the Shelford Group, 77% of respondents reported having strong confidence in the approach.

In [Trust A's] Equality Impact Assessment, it was found that SBR has had no impact on gender or marital status, but that 9% more staff from BAME backgrounds have been appointed.

The lessons arising from the discussions are mostly around the implementation of the approach and effective change management. More systematic evaluation would be beneficial, as well as more learning from the experiences of Trusts that are successfully implementing, and deriving benefits from, the approach.

Summary of learning

- *SBR has been largely welcomed as an effective way to select people who are a good fit for the Band 7 Ward Sister/Charge Nurse role, Band 2 and, at [Trust B], Band 5*
- *Close collaboration and ownership between Nursing and HR colleagues is extremely helpful for successful implementation*
- *Senior level sponsorship and effective SBR Lead is essential to keep up momentum and quality*
- *Implementing SBR is like any change management process and the same success factors apply i.e. visible senior leadership, champions*
- *Evaluation is not straightforward – we need to stop looking for a perfect approach and utilise the data we have. It is also noted that the impact of the previous competency-based selection approaches have never been studied so a comparison is not possible.*

"The value of implementing SBR in ten NHS Trusts at the same time was that the different variables could be compared between The Shelford Group Hospital Trusts and the success or otherwise of the approach could be learned from. I hope the above gives reassurance that SBR is an effective approach to recruitment and selection and is yielding qualitative and quantitative results in other Trusts."

Sally Bibb
14 March 2021