UCEA's CASAG response to the Draft NHS Health and Care Workforce Strategy for England to 2027

Preamble

The Universities and Colleges Employers Association (UCEA) is a membership organisation for Higher Education Institutions (HEIs), representing them in their capacity as employers. UCEA represents 163 HEIs, including all HEIs in the UK with medical schools. UCEA has a Clinical Academic Staff Advisory Group (CASAG), which is a forum for the consideration of employment issues for clinical academic staff. CASAG acts on behalf of the UCEA Board in representing the sector's interests in matters relating to the NHS and related health bodies in the event of changes that may impact on clinical academics and HEIs.

This paper is the CASAG response to the draft NHS Health and Care Workforce Strategy for England to 2027 "Facing the Facts, Shaping the Future". CASAG is willing to provide more information, if needed, and to work with HEE and its partners in developing a revised workforce strategy.

Introduction

UCEA and its Clinical Academic Staff Advisory Group (CASAG) are very concerned that the draft strategy makes very little mention of the clinical academic workforce. The strategy makes some brief reference to clinical academics in nursing, midwifery and allied health professions, but no mention of medical or dental clinical academics.

The clinical academic workforce

There were 2,475.8 full-time equivalent (FTE) clinical academic medics and 449.8 FTE clinical academic dentists in England in 2016[1]. There are also clinical academic nurses, midwives and allied health professionals, although we do not have data on their number in England. These individuals form a key part of the NHS workforce and must be recognised and considered in the NHS workforce strategy.

Data from the Medical Schools Council show that there has been a decrease of 14.3% in the number of medical clinical academics since 2000, principally due to declining numbers of clinical academic Lecturers and Readers. More worryingly, whilst the number of NHS consultants has increased by 82% since 2000, the number of clinical academics at consultant level has increased by only 10% (which includes a trend of decline since a peak in 2010).

The stagnation of the clinical academic workforce compared with the growth of the NHS consultant workforce is of grave concern, particularly as the clinical academic workforce is aging, with more than 35% of clinical academic workforce now aged between 56 and 65, and 5% aged over 65. As such an already small section of the workforce will see 40% its numbers retire within ten years. Whilst efforts have been made to increase the supply of clinical academics in England, for example with awards from the National Institute of Health Research (NIHR), these have seen success in the earlier stages of a clinical academic career path, with increases in the numbers of pre-doctoral, doctoral and initial post-doctoral awards. However, these increases have not translated into increased numbers of more senior clinical academic awards, with declining numbers in the establishment of research career grade.

[1] https://www.medschools.ac.uk/media/2026/medical-clinical-academic-staffing-levels-2017.pdf http://www.dentalschoolscouncil.ac.uk/wp-content/uploads/2017/07/Survey-Dental-Clinical-Academic-Staffing-Levels-2017.pdf

With the clinical academic workforce as a whole decreasing in size, it is vital that the NHS Workforce Strategy includes strategies to reverse the decline of this key group of staff.

The clinical academic role
In addition to their clinical work, clinical academics deliver teaching and training, conduct research and deliver innovation in services, treatment and care. Their work supports the lifelong learning of all healthcare professionals and leads to improvements in clinical practice.

The clinical academic role includes clinical service delivery in the NHS and teaching and research conducted in HE but for the benefit of the NHS. They are usually employed substantively by HE institutions, but have honorary contracts with an NHS body and usually spend half of their time working in one or more NHS organisation.

Clinical academics often deliver specialised services at the cutting edge of research. The majority of major research initiatives are led by clinical academics. Clinical academics also lead medical education to deliver the NHS medical workforce: both undergraduate and postgraduate students, and continuing professional development. The time, training and resources to address research and education are not available in the NHS alone and require working across the Higher Education (HE) and NHS sectors.

The pathway to becoming a clinical academic is long and often complex, with clinical academic trainees needing to complete their NHS clinical training as well as undertaking a higher research degree. They must also move between the NHS and HE sectors and navigate the different options available for conducting funded research. Clinical academic posts are “one job”, albeit with two employers and integrating separate responsibilities (clinical work and education/research), as recommended by the Follett report (2001)[2]. However, this is often misunderstood and clinical academics can be an overlooked section of the clinical workforce.

Clinical academic training
The Walport Report (2005)[3] into the training of the future clinical academic workforce made a number of recommendations to seek to improve the experience of clinical academic trainees and thereby improve the pipeline of future researchers and educators. Several recommendations were taken forward, including the development of integrated training pathways across the NHS and HE. However, a review[4] of the Walport Report, in 2015, highlighted areas that still require improvement, including:

- the importance of mentoring;
- the challenge of balancing service requirements and academia; and
- the need to disseminate good practice.

A workforce strategy for the NHS should include consideration of ways to improve the experiences and opportunities for clinical academics in training, in order to improve the future talent pipeline of clinical academic staff.

The draft workforce strategy
Whilst it is positive that the draft strategy includes reference to the importance of clinical academic careers in nursing, midwifery and allied health professions, it is worrying that there is no mention of clinical or dental academics. The draft strategy proposes six system-wide

[2] http://webarchive.nationalarchives.gov.uk/20050301195452/http://www.dfes.gov.uk/follettreview/
[3] http://www.ukcrc.org/wp-content/uploads/2014/03/Medically_and_Dentally-qualified_Academic_Staff_Report.pdf
[4] https://www.bma.org.uk/advice/career/applying-for-training/academic-training

principles; one of which is to provide broad pathways so staff have careers not just jobs; however, the strategy makes no mention of clinical academia as a career option for doctors and dentists.

The draft strategy acknowledges the importance of academic practice in relation to nursing and midwifery, noting that it is essential for retention, but does not make the same connection to academic practice for the medical or dental sections of the workforce. The strategy also acknowledges that evidence based practice is essential, but again does not set out how the clinical academic workforce that provides the research base will be supported and developed.

Sir Bruce Keogh's Review into the quality of care and treatment provided by 14 hospital trusts in England (2013)[5] also highlighted the importance of academic influence on clinical practice, as well as on recruitment. The report identified a number of barriers to delivering high quality care, including: "The fact that some hospital trusts are operating in geographical, professional or academic isolation. As we've seen with the 14 trusts, this can lead to difficulties in recruiting enough high quality staff, and an over reliance on locums and agency staff."

The draft strategy notes that "upskilling and advanced clinical practice [are] vital to improving skill mix" but these aims require education and research, both of which are provided in the main by clinical academics, yet medical clinical academic staff are not mentioned once in the draft.

The strategy should also recognise explicitly that clinical academic practice is vital not only for recruitment and retention, but also for service improvement and patient outcomes. The Berwick Report[6] (2013) on improving the safety of patients in England summarised its findings with a focus on education, as follows: ""The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end." Two of the report's recommendations explicitly relate to this:

- "Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives."
- "The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS."

Similarly, three of the five educational outcomes published by Health Education England relate specifically to education, research and innovation:

- Excellent education: "Education and training is commissioned and provided to the highest standards, ensuring learners have an excellent experience and that all elements of education and training are delivered in a safe environment for patients, staff and learners."
- Competent and capable staff: "There are sufficient health staff educated and trained, aligned to service and changing care needs, to ensure that people are cared for by staff who are properly inducted, trained and qualified, who have the required knowledge and skills to do the jobs the service needs, whilst working effectively in a team."
- Adaptable and flexible workforce: "The workforce is educated to be responsive to innovation and new technologies with knowledge about best practice, research and

[5] http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf
[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

> innovation, that promotes adoption and dissemination of better quality service delivery to reduce variability and poor practice."

The clinical academic workforce leads the delivery of education and provides the research and CPD opportunities that contribute to lifelong learning across the whole of the NHS system. It is therefore vital that this section of the workforce is recognised in the strategy and nurtured to reverse the decline in the numbers of medics choosing or continuing on this career path, particularly as a key aim of the strategy is to be a "world-class provider of education and training".

Increases in medical student places

The draft strategy notes the additional 1,500 medical school places that will be in place from 2018, but does not appear to plan for the clinical academic staff who will be needed to teach these new students. As noted above, the number of clinical academics has decreased by 14.3% since 2000, yet the cohort of medical students they will be expected to teach is about to increase substantially.

Another of the six system-wide principles is relevant here: "training, educating and investing in the workforce to give new and current staff flexibility and adaptability". Clinical academic doctors, dentists, nurses, midwives and allied health professionals will deliver much of the training and educating but are hardly mentioned in the draft strategy.

In addition, although the UK is seeking to expand its domestically educated medical workforce it will remain dependent upon international doctors for some time to come. Such doctors who have attended medical school in the UK provide a particularly useful element of the workforce. Not only have they paid for their own education, but they have also enriched the cultural life of their medical school and are familiar with the NHS. It is imperative that arrangements are made to guarantee F1 posts for the overseas graduates of UK medical schools. If this is not possible, then the point of registration with the GMC must be moved to graduation, despite the current pressures on legislative time.

Medical specialisms

The draft strategy seeks to increase the number of GPs, including through the new medical student places; however, the academic GP workforce is very small and has suffered in recent years through a lack of investment and support. Senior academic GPs (SAGPs), who are equivalent in status to consultants, lead the education of medical students specialising in general practice, yet there are fewer than 200 of these staff across England. SAGPs provide substantial benefit to the NHS and the wider economy in terms of clinical care, education, clinical leadership, and providing the research underpinning innovations in healthcare. Since the abolition of primary care trusts in 2013, these staff have not been provided with honorary contracts with NHS England and have had to make honorary contractual arrangements themselves with acute trusts or GP practices to cover their clinical work. Without the appropriate honorary employer, many have been unable to apply for local clinical excellence awards and their level of remuneration has fallen in comparison with other GPs or with consultant clinical academics. We have been working hard with NHS England to resolve these issues, but the experiences of the past five years will not have helped in encouraging more junior doctors or GPs to consider a career as an academic GP.

The draft strategy also seeks a greater focus on public health and notes the need for development of the public health workforce. Advances in public health research are often led by public health clinical academics (both medical and non-medical), who have honorary contracts with Public Health England (PHE). However, the budget that PHE has to support public health research is very small: PHE contributes to the salaries of 29 individual clinical academics (13.4 full-time equivalent staff). Its budget is fixed, so PHE struggles to fund any salary increases, for example due to promotions, or additional posts. There are many more

public health clinical academics in England, many of whom have honorary contracts with PHE, but those individuals receive no direct funding from PHE unless they are conducting a particular research project for PHE. As such, these clinical academics need to find alternative sources of funding for their work and, importantly for this draft strategy, PHE does not have influence over their research choices, for example the PHE priority areas. Given the prominence of public health aims in the draft strategy, the strategy should also give thought as to how to support the clinical academic public health workforce.

Conclusion

The final workforce strategy must encompass clinical academics: medics, dentists, nurses, midwives and allied health professionals. The fact that clinical academics' substantive contracts of employment are often with an HE institution should not mean that they are outwith the scope of this strategy. Their work is vital to the success of the strategy in terms of:

- Educating the future NHS workforce (which is about to increase substantially), including the priority area of general practice.
- Promoting learning and CPD for the current NHS workforce.
- Providing innovations in healthcare delivery and improvements in clinical practice.
- Offering alternative career pathways for existing and trainee practitioners.
- Leading improvements in public health

Serious consideration must be given to ways of encouraging and supporting more trainees and existing NHS staff to pursue a career in clinical academia. The strategy must also support existing clinical academic staff to retain them and maintain their engagement in their work, which is of such significance to the whole NHS system.

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