UNIVERSITIES & COLLEGES EMPLOYERS ASSOCIATION

UCEA's CASAG feedback to the development of the NHS workforce implementation plan 2019

Executive Summary

- The clinical academic role is fully integrated into the NHS. Clinical academics have one job – not two part-time roles - and the whole of that job is for the benefit of the NHS. They are honorary employees of NHS trusts and must be included in NHS workforce planning.
- The NHS long term plan highlights the critical importance of research and innovation to drive future medical advancements but does not mention the clinical academics who lead such research.
- Clinical academics are critical in terms of educating the expanding medical workforce, at undergraduate and postgraduate levels, and in terms of lifelong learning for existing staff.
- The clinical academic workforce has decreased since 2000 and whilst there are more clinical academic trainees, they are not staying on to pursue clinical academic careers. The clinical academic training pathway is long and complex, spanning two sectors, and more must be done to support trainees in navigating it. The consultant reward package must also explicitly include clinical academic consultants to ensure pay parity across the consultant workforce.
- Clinical academic GPs and public health specialists should also be given particular consideration, given the importance of primary care services and population health, yet there are very small numbers of clinical academics currently working in these areas.

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 162 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 feedback to support the development of the NHS workforce implementation plan that will follow from the NHS long term plan. CASAG is willing to provide more information, if needed, and to work with NHS Improvement, HEE and their partners in developing the workforce plan.

Introduction

UCEA and its Clinical Academic Staff Advisory Group (CASAG) are very concerned that the long term plan makes no mention of the clinical academic workforce. The plan discusses the expansion of medical school places and the importance of research and innovation, but does not mention the very staff at the heart of driving these agendas.

The clinical academic workforce

There were 2520.78 full-time equivalent (FTE) clinical academic medics and 461.2 FTE clinical academic dentists in England in 2017[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 12.4% in the number of medical clinical academics since 2000, principally due to declining numbers of clinical academic Lecturers and Readers (akin to assistant professor). More worryingly, whilst the number of NHS consultants has increased by 91.8% since 2000, the number of clinical academics at consultant level has increased by only 10% over the same period (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 the 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% of its current numbers retire within ten years. 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), and 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 established research career grade.

With the clinical academic workforce as a whole decreasing in size, it is vital that the NHS workforce plan 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 HEIs, but have honorary contracts with an NHS body and usually spend half of their time working in one or more NHS organisations.

Clinical academics often deliver specialised services at the cutting edge of research: the majority of major health research initiatives are led by clinical academics. Clinical academics lead medical education to deliver the future NHS medical, dental and allied health workforce, to both undergraduate and postgraduate students. They also enhance the current workforce, through continuing professional development for existing staff. The time, training and resources to address research and education are not available in the NHS alone and require working in partnership across the 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

[1] file:///C:/Users/n.carter/Downloads/msc-clinical-academic-survey-report-2018.pdf

(clinical work and education/research), as recommended by the Follett report (2001)[2]. It is vital to recognise that the whole of a clinical academic's role is of direct benefit to the NHS. However, this is often misunderstood as two part-time jobs and that clinical academics are only part-time clinicians. As such, 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 implementation plan 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.

One key issue is that clinical academic trainees need to move between the NHS and HE sectors so that they can conduct their research and complete all stages of clinical training required for the certificate of completion of training (CCT). Indeed, the junior doctor contract 2016 recognises this movement, and longer time in training, through the academic flexible pay premium payable on return to the NHS. However, individual NHS trusts often do not recognise trainees' service from substantive employment in HE when they return to the NHS, which can affect trainees' entitlement to family-friendly benefits (such as maternity pay) and sick pay. Trainees constantly report this as being a real disincentive to pursuing a clinical academic career path; so much so that the funders of clinical research implemented a set of 'principles and obligations'[5] that include a commitment from HEIs and trusts to recognise service in the other sector, for trainees on nationally competitive training Awards who are required to change employers to pursue a clinical academic path. The workforce plan should acknowledge that some staff need to spend periods of time employed outside the NHS, whilst pursuing an NHS career, and they should not be penalised for this in terms of access to the full NHS benefits package.

The NHS long term plan

Whilst it is positive that the long term plan includes reference to the "critical importance of research and innovation to drive future medical advance", it is worrying that there is no mention of clinical academics in any discipline - medicine, dentistry, midwifery, nursing or the allied health professions – who lead such research. The plan also commits to investment in spreading innovation between organisations: clinical academics, spanning two sectors, are well placed to share research and innovative practices with and across the NHS.

In terms of recruitment, Sir Bruce Keogh's Review into the quality of care and treatment provided by 14 hospital trusts in England (2013)[6] also highlighted the importance of

[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
[5] https://wellcome.ac.uk/sites/default/files/clinical-principles-and-obligations-plus-faqs-2018-08.pdf
[6] http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

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 long term plan does recognise explicitly the importance of research for patient outcomes, in that research-active hospitals have lower mortality rates. These hospitals are the main honorary employers of clinical academics, whose work directly contributes to the improved patient outcomes, and must be included in a workforce implementation plan.

Three of the five educational outcomes published by Health Education England[7] 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 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 implementation plan and nurtured to reverse the decline in the numbers of clinicians choosing or continuing on this career path.

In terms of workforce skills and development, clinical academics provide so much in terms of education and innovation, yet they are not mentioned once in the long term plan. The long term plan does, however, note the risk of NHS staff leaving the service if they are not offered more development opportunities. The possibility of combining research and/or education with clinical practice, through a clinical academic career path, could be a very attractive opportunity for some existing staff, or for those considering a career in the NHS. Such opportunities for parallel career paths could help the NHS to motivate and retain excellent staff who want to continue to work in clinical practice.

Increases in medical student places

The long term plan notes the additional 1,500 medical school places, 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 increasing substantially.

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

[7] https://www.hee.nhs.uk/our-work/education-outcomes-framework

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 long term plan acknowledges pressures on primary care services and recruitment and retention issues with GPs; 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 are only now being provided with honorary contracts with NHS England, after five years of having 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 (LCEAs) 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 there are still no plans for a LCEA scheme from NHS England for SAGPs. Unfortunately, the experiences of the past five years will not have helped in encouraging more doctors in training or GPs to consider a career as an academic GP.

The long term plan also seeks to improve population health. Advances in population 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 the long term plan, this means that PHE does not have influence over their research choices, for example the PHE priority areas. Given the prominence of public health aims in the long term plan, the workforce implementation plan should also give thought as to how to support the clinical academic public health workforce.

Appropriate reward for the clinical academic workforce

It is vital that the workforce strategy covers clinical academics, not least in terms of incentivisation and reward. As noted above, this is a section of the workforce that is in decline, yet a key element of the consultant reward package – LCEAs - was changed last year, such that it is contractual now for consultants apart from clinical academics. Prior to April 2018 the majority, if not all, of NHS trusts included clinical academics in their LCEA scheme, where they ran one. Prior to April, no consultants had a contractual right to an LCEA scheme, but now a distinction has been introduced between NHS consultants and clinical academic consultants, which is causing NHS trusts to reconsider to whom they extend their LCEA scheme. Even where clinical academics are included, some trusts are seeking to reduce or cease their funding for honorary consultants' LCEAs, despite the cost envelope for the new scheme having been modelled on data that included academic consultants. The changes to LCEAs are entirely inappropriate, particularly as clinical academic posts are joint appointments, jointly managed by the NHS and HEIs, and fully integrated into the local trusts. It is not at all productive to differentiate between different types of consultants, who are all working for the benefit of the NHS across all elements of

their work. It is incredibly demotivating for clinical academics to have been left out of the new scheme, and the financial implications for individuals are a very real disincentive to pursuing or continuing a career as in academic medicine or dentistry.

Conclusion

The final workforce implementation plan 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 HEI should not mean that they are outwith the scope of this plan, nor that their access to the full NHS consultant remuneration package is restricted. Their work is vital to the success of the strategy in terms of:

- Educating the future NHS workforce (which is increasing 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, including parity of reward. The implementation plan 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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