A Survey of Staffing Levels of Medical Clinical Academics in UK Medical Schools as at 31 July 2015

A Report by the Medical Schools Council

June 2016
Medical Schools Council

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## Contents

List of figures  
List of acronyms  
Preface  
Introduction  
Methodology  

### Medical Clinical Academic Staffing Levels in UK Medical Schools in 2015

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 OVERVIEW</td>
<td>9</td>
</tr>
<tr>
<td>2 ACADEMIC GRADE</td>
<td>10</td>
</tr>
<tr>
<td>3 FUNDING</td>
<td>10</td>
</tr>
<tr>
<td>4 REGION</td>
<td>12</td>
</tr>
<tr>
<td>5 SPECIALTY</td>
<td>13</td>
</tr>
<tr>
<td>6 VACANCIES</td>
<td>13</td>
</tr>
<tr>
<td>7 AGE, GENDER and ETHNICITY</td>
<td>15</td>
</tr>
<tr>
<td>8 CLINICAL EXCELLENCE and DISTINCTION AWARDS</td>
<td>20</td>
</tr>
<tr>
<td>9 RESEARCHERS and OTHER ACADEMIC GRADES</td>
<td>22</td>
</tr>
<tr>
<td>10 CONCLUDING REMARKS</td>
<td>25</td>
</tr>
</tbody>
</table>

### Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1: Profile by specialty and source of funding (FTE)</td>
<td>27</td>
</tr>
<tr>
<td>Appendix 2: Profile by region and source of funding (FTE)</td>
<td>28</td>
</tr>
<tr>
<td>Appendix 3: Profile by medical school and source of funding (FTE)</td>
<td>30</td>
</tr>
<tr>
<td>Appendix 4: Summary of changes (pre- and post-2002 medical schools) (FTE)</td>
<td>33</td>
</tr>
<tr>
<td>Appendix 5: NHS and clinical academic consultants by specialty and UK medical student intake (FTE)</td>
<td>33</td>
</tr>
<tr>
<td>Appendix 6: Profile by academic grade (2004–2015) (FTE)</td>
<td>34</td>
</tr>
<tr>
<td>Appendix 7: Profile by region (2004–2015) (FTE)</td>
<td>34</td>
</tr>
<tr>
<td>Appendix 8: Profile by specialty (2000–2015) (FTE)</td>
<td>35</td>
</tr>
<tr>
<td>Appendix 9: Profile by specialty, grade, gender and full-time/ LTFT working (headcount)</td>
<td>36</td>
</tr>
<tr>
<td>Appendix 11: Profile by age, gender and academic grade (headcount)</td>
<td>37</td>
</tr>
<tr>
<td>Appendix 12: Profile by age and ethnic origin (headcount)</td>
<td>37</td>
</tr>
<tr>
<td>Appendix 13: Profile by academic grade and ethnic origin (headcount)</td>
<td>37</td>
</tr>
<tr>
<td>Appendix 14: Profile by specialty and ethnic origin (headcount)</td>
<td>38</td>
</tr>
<tr>
<td>Appendix 15: Clinical Excellence and Distinction Awards held by clinical academics (2009–2015) (headcount)</td>
<td>39</td>
</tr>
<tr>
<td>Appendix 16: NHS and clinical academic consultants with a Clinical Excellence or Distinction Award (headcount)</td>
<td>40</td>
</tr>
<tr>
<td>Appendix 17: Clinical Excellence and Distinction Awards by gender and academic grade (headcount)</td>
<td>40</td>
</tr>
<tr>
<td>Appendix 18: Corrections to previously published data (FTE)</td>
<td>40</td>
</tr>
<tr>
<td>Appendix 19: Medical specialty groups and sub-specialties</td>
<td>41</td>
</tr>
</tbody>
</table>
List of figures

**Figure 1:** Timeline of clinical academic staffing level by academic grade since 2000 (FTE) 9

**Figure 2:** Summary of change in staffing levels by academic grade since 2000 and since 2014 (FTE) 10

**Figure 3:** Source of funding for clinical academic posts (2000–2015) (FTE) 11

**Figure 4:** Clinical academic grade by source of funding and region (FTE) 11

**Figure 5:** Funding profile of clinical academic posts by medical school (FTE) 12

**Figure 6:** Clinical academic staffing levels by region since 2000 (FTE) 12

**Figure 7:** Clinical academic staffing levels by specialty since 2000 (FTE) 13

**Figure 8:** Vacancies by academic grade (2007–2015) (FTE) 14

**Figure 9:** Vacant posts by academic grade (FTE) 14

**Figure 10:** Vacant posts by specialty (FTE) 15

**Figure 11:** Age profile of clinical academic consultants and NHS consultants (headcount) 15

**Figure 12a:** Age profile since 2004 (headcount) 16

**Figure 12b:** Age profile since 2004 (men, headcount) 16

**Figure 12c:** Age profile since 2004 (women, headcount) 16

**Figure 13:** Academic grade, age group and gender (headcount) 17

**Figure 14:** Academic grade and gender since 2004 (headcount) 17

**Figure 15:** Academic grade and gender (2004 and 2015) (headcount) 18

**Figure 16:** Specialty by gender and full-time/ LTFT (headcount) 18

**Figure 17:** Academic grade by gender and full-time/ LTFT working (headcount) 19

**Figure 18:** Academic grade and ethnic origin (headcount) 19

**Figure 19:** Ethnic origin and country (headcount) 19

**Figure 20:** Specialty and ethnic origin (headcount) 20

**Figure 21:** NHS and clinical academic consultants with a Clinical Excellence or Distinction Award (headcount) 21

**Figure 22:** Clinical Excellence and Distinction Awards by specialty and gender (headcount) 22

**Figure 23:** Clinical Excellence Awards held (2009–2015) (headcount) 22

**Figure 24:** Researcher and Other clinical academic posts by source of funding (FTE) 23

**Figure 25:** Academic grade (including Researchers and Others) by specialty (FTE) 23

**Figure 26:** Academic grade (Researchers and Others) by gender and full-time/ LTFT working (headcount) 24

**Figure 27:** Age profile by academic grade (headcount) 24

**Figure 28:** Academic grade (Researchers and Others) and ethnic origin (headcount) 25

**Figure 29:** Timeline of numbers of NHS and clinical academic consultants since 2000 (FTE) 25
List of acronyms

ACCEA  Advisory Committee on Clinical Excellence Awards (England and Wales)
AGMETS  Advisory Group on Medical Education, Training and Staffing
AoMRC  Association of Medical Research Charities
BSMS  Brighton and Sussex Medical School
CEA  Clinical Excellence Award (England and Wales)
DDRB  Review Body on Doctors’ and Dentists’ Remuneration
FTE  Full-Time Equivalent
HEFCE  Higher Education Funding Council for England
HESA  Higher Education Statistics Agency
IATP  Integrated Academic Training Pathway (England)
KCL  King’s College London
LSHTM  London School of Hygiene & Tropical Medicine
LTFT  Less Than Full-Time
MRC  Medical Research Council
NES  NHS Education Scotland
NICEAC  Northern Ireland Clinical Excellence Awards Committee
NIMDTA  Northern Ireland Medical & Dental Training Agency
NIHR  National Institute for Health Research
REF  Research Excellence Framework
SACDA  Scottish Advisory Committee on Distinction Awards
SCREDS  Scottish Clinical Research Excellence Development Scheme
STEMM  Science, technology, engineering, maths and medicine
STMTI  Scottish Translational Medicine and Therapeutics Initiative
SWAN  Scientific Women’s Academic Network (Athena)
TEF  Teaching Excellence Framework
UCAS  Universities and Colleges Admissions Service
UCL  University College London
WCAT  Wales Clinical Academic Track
The Medical Schools Council represents the interests and ambitions of UK medical schools as they relate to the generation of national health, wealth and knowledge through biomedical research and the profession of medicine. As an organisation it occupies a unique position embracing medical undergraduate education, health-related research, and critical interfaces with the health service and with postgraduate education and training. It aims to optimise locally, nationally and internationally the impact of the work undertaken in medical schools across the UK.

The Medical Schools Council is made up of the Head or Dean of each medical school representing his/her institution. Council meets four times each year, with an elected Executive Committee which meets five times each year. The three sub-committees of the Medical Schools Council undertake additional work in particular areas of interest: Clinical Staffing and Employment; Education; and Research.

The aims of the Medical Schools Council are:

1. To be the authoritative voice of all publicly funded UK medical schools
2. To identify issues and to come up with solutions which optimise the public investment in medical education and research
3. To provide high-quality services which add value for members
4. To respond proactively to the development and change that characterises the interface between higher education and the NHS
5. To facilitate the transition between undergraduate and postgraduate environments
6. To optimise the quality of medical education and to be a global leader in the assessment arena
7. To promote clinical academic careers
8. To support the high-quality, health-related research in all medical schools, recognising that the nature and scale of such research will differ between institutions
9. To maintain close working relationships with partner institutions

The Medical Schools Council is a company limited by guarantee and registered in England and Wales, Company No. 8817383, Registered Charity No. 1155370.
Clinical academics make up around five per cent of the medical consultant workforce. Clinical academics are university employees and, in addition to academic activities, they have honorary contracts with the NHS and spend about half of their week as practising doctors involved in patient care.

Clinical academia offers an exciting and varied medical career, with opportunities to work across teaching, research and clinical practice. Clinical academics are responsible for delivering the undergraduate curriculum, inspiring and educating the next generation of doctors, and they contribute substantially to postgraduate medical training. Equally importantly, clinical academics play a leading role in basic, translational, clinical health service and public health research, bridging the divide between laboratory bench, bedside and community, and providing a key interface with industry and policy-makers.

Higher education institutions, with their medical schools, are autonomous from the NHS and have separate arrangements for teaching by NHS-employed staff and the provision of clinical care by university-employed staff. The valuable contribution made by NHS-employed staff is recognised by honorary academic appointments, although this data is not captured in this report.

Increasingly, delivery of clinical care is moving away from acute settings into the community. Teaching practice has had to adjust to this and will need to adapt further. Medical practice continues to evolve rapidly in response to changes in patient needs, with an ageing population and an increasing burden of longstanding and complex multi-system diseases, alongside rapid technological developments, advanced understanding of medical conditions and their treatment, and the greater involvement of informed patients in decisions about their own care.

Clinical academics are uniquely placed to play a leading role in the NHS using their clinical experience to generate research and applying this knowledge to ensure that patients have access to the very best available care. Embedding health research and innovation throughout the NHS is crucial to realising these opportunities.

In the late 1990s, a number of reports highlighted a need for robust data on clinical academic staffing levels as the basis for partnership between the NHS and universities to tackle difficulties facing academic medicine. In consultation with the Department of Health’s Advisory Group on Medical Education, Training and Staffing (AGMETS), and with the support of the Medical Research Council (MRC), the Association of Medical Research Charities (AoMRC) and the Wellcome Trust, the Medical Schools Council and the Dental Schools Council agreed jointly to undertake a comprehensive survey of clinical academic staff employed by UK universities in medical and dental schools.

Since 2000, the Medical Schools Council has undertaken a regular (annual since 2003) survey of clinical academic staffing levels in UK medical schools, available online at www.medschools.ac.uk. This is the 14th survey of clinical academic staffing levels. This report is an update of data reported in previous years, detailing staffing levels of university-employed clinical academic doctors in UK medical schools as at the end of the academic year, 31 July 2015.

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Methodology

The data reported in the annual Survey of Staffing Levels of Medical Clinical Academics in UK Medical Schools are collected electronically using a pro forma with accompanying guidance notes. All publicly funded UK medical schools return anonymised data for each individual in post and for each vacant clinical academic post on the census date of 31 July 2015, the end of the academic year. The definitions are aligned to those used by the Higher Education Statistics Agency (HESA), with a view to using HESA data as source material in future.

For the purpose of the Medical Schools Council survey, a clinical academic is defined as someone who:

1. Holds full registration with the General Medical Council; and
2. Holds a substantive contract of employment with a university; and
3. Holds an honorary clinical contract with the NHS or a formal A+B contract; or
4. For public health academics, holds an honorary contract with a nominated body i.e. Public Health England or a local authority.

The methodology for the first survey of clinical academic staffing levels in 2000 was designed in consultation with the Advisory Group on Medical Education, Training and Staffing (AGMETS), the Medical Research Council (MRC), the Wellcome Trust, the Medical Schools Council and the Dental Schools Council. Subsequent revisions to the scope of data collection and to the accompanying guidance have been undertaken in consultation with medical schools and with the individuals who complete the data return on behalf of their institution.

Data analyses in Chapters 1–10 relate to the total staffing levels of Clinical Professors, Clinical Readers/ Clinical Senior Lecturers and Clinical Lecturers, referred to hereafter as Professors, Readers/ Senior Lecturers and Lecturers. Individuals working less than 0.1 FTE – including those on secondment who are recorded by the reporting institution as a 0 FTE – are excluded from analysis (in 2015 this was a total of six individuals, equivalent to 0.3 FTE).

The Medical Schools Council has published data on Researchers and Other clinical academics meeting the four-point definition above but there are limitations. Only 30 of 35 schools have returned data on clinical academics at these grades, and some researchers and trainees, including trainees on the integrated NIHR Clinical Academic Training programme, hold a substantive contract with the NHS and honorary contract with the university, thus being excluded from this data collection. Nonetheless the data are important and are shared in a public forum to help monitor and track the emerging clinical academic workforce.

The survey does not include the newly established private medical schools.

Full data are available in the Appendices. Further detail is available on request from the Medical Schools Council.
1 OVERVIEW

There were 3,103 FTE medical clinical academics employed by UK medical schools on 31 July 2015, a headcount of 3,417. There were in addition 1,995 FTE (headcount 2,331) Researchers and Other clinical academics in post, making up 39% of the overall clinical academic team. Although the size of the workforce is now relatively stable, Figure 1 illustrates a gradual overall decline in the clinical academic workforce from a high of 3,174 FTE in 2010. There has been a cumulative decline of 2.2% since then, although the staffing level remains 173 FTE and 6% higher than the 2006 low. This contrasts with the NHS Consultant workforce, which has increased in number by an average 3–4% annually.

There were 593 FTE Lecturers in post at the census date, the highest number since 2003. Reader/ Senior Lecturer numbers are down by 3% since 2014 to 1,164 FTE, continuing the downward trend over the past 15 years. Professorial numbers remain high at 1,347 FTE, the second highest level to date, although the rate of increase has slowed in the last six years.

The NHS, including NIHR, funds nearly half of all clinical academic posts in UK medical schools (44%), with the Higher Education Funding Councils contributing 43% and other sources, 13%. The contribution of NHS funding to the clinical academic workforce has increased by 20% since 2006, with the majority of this increased funding allocated to Lecturer posts. The funding profile for Researchers is different, with 76% of posts funded from other sources including charitable grants and research councils.

The distribution of clinical academic posts broadly mirrors the distribution of student numbers across the UK, with 81% located in England, 2% in Northern Ireland, 13% in Scotland and 4% in Wales.

Over 40% of the FTE clinical academic workforce are specialists within Physicians/ Medicine, followed by Surgery (9%), Psychiatry (8%) and General Practice (7%). The capacity of the academic GP workforce may be underestimated, as only 30% hold full-time university contracts compared with 82% of all clinical academics. The number of vacancies comprises 5% of the total available posts in clinical academia, and 11% at Lecturer grade. More than half of medical schools reported difficulties in recruitment to particular specialties, including Oncology, Paediatrics & Child Health, Pathology, Clinical Pharmacology, Psychiatry, Public Health and Surgery. Reasons for difficulties in recruitment relate to a small pool of suitable candidates and a shortage of trainees, as well as concerns about roles not contributing to the Research Excellence Framework (REF) for example intensity of clinical work, and funding structures.

Figure 1: Timeline of clinical academic staffing levels by academic grade since 2000 (FTE)
In 2004, 47% of the clinical academic workforce was aged under 46; in 2015 this figure was 36%, with 64% aged over 46 years. The clinical academic workforce has an increasing age profile compared with the NHS medical workforce. In the last decade there has been a 44% increase in the number of women in clinical academic posts and a 5% decline in the number of men. This increase has been across all age groups and academic grades, although women remain under-represented in clinical academia, making up 29% of the overall team. The ethnic profile of the clinical academic workforce is increasingly diverse, with an increase in the number of Black and Minority Ethnic (BME) academics in recent years, and particularly amongst the early career stages (Researchers and Lecturers), although numbers are low compared with the medical population.

A higher percentage of clinical academics hold a Clinical Excellence Award (CEA) or Distinction Award than NHS Consultants as a whole (64% compared with 57%), particularly when looking at national level awards (39% compared with 11%). These awards are made to recognise exceptional contribution to the NHS, and the work undertaken by clinical academics often has national or international significance in additional to local impact. The number of national awards held by clinical academics has declined by 5% since the 2011 UK-wide freeze on new awards. Whilst a reduced number of new awards have been made in recent years in England and Wales, the freeze on new awards has continued in Scotland (numbers have fallen by 9% in the same time period).

2 ACADEMIC GRADE

There were 3,103 FTE medical clinical academics employed by UK medical schools in July 2015, a headcount of 3,417. This represents a gradual decline in the clinical academic workforce from a high of 3,174 FTE in 2010, and a cumulative decline of 2.2%.

The substantial decline in clinical academic staffing levels in the late 1990s was, in part, the reason that these numbers have been monitored by the Medical Schools Council (MSC). There was a particular fall in the number of Lecturers, with difficulties in securing career progression in academia. Sustained efforts by the major research charities and the creation of the National Institute for Health Research (NIHR) in England in 2006, with parallel efforts in Scotland, Wales and Northern Ireland to secure run-through training programmes, have enabled a sustained, significant expansion in the clinical academic workforce. Following a sharp decline in staffing numbers from 3,549 FTE in 2000 to 2,930 FTE in 2006, there was a slow but steady recovery through to 3,174 FTE in 2010. Since then however numbers have fallen slightly (by 0.5% each year) to around 3,100 FTE – the same level as in 2009.

The number and proportion of Professors has increased by 29% or 305 FTE since 2000, to a total of 1,347 FTE. Since 2011, Professors have outnumbered clinical academics at Reader/Senior Lecturer grades, and now make up more than 40% of the clinical academic workforce. Between 2000 and 2008, there was an average yearly increase of 4% in FTE number, although this has slowed to an average 0.3% a year.

There were more Lecturers in post in 2015 than any year since 2003, up to 593 FTE. As shown in Figure 2, this represents an increase of 50% since a low of 396 FTE in 2006, although the number is still substantially lower than in 2000. For the last four years, the number of Readers/Senior Lecturers has declined by around 4% each year, with a cumulative 12% decline between 2011 and 2015, and a 30% decline since 2000, to a low of 1,164 FTE.

Figure 2: Summary of changes in staffing levels by academic grade since 2000 and since 2015 (FTE)

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<tbody>
<tr>
<td>Professor</td>
<td>1,041.9</td>
<td>1,218.2</td>
<td>1,318.3</td>
<td>1,362.1</td>
<td>1,346.6</td>
<td>304.8</td>
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<tr>
<td>Reader/ Senior Lecturer</td>
<td>1,663.0</td>
<td>1,324.8</td>
<td>1,319.6</td>
<td>1,194.6</td>
<td>1,164.1</td>
<td>-498.8</td>
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<tr>
<td>Lecturer</td>
<td>844.2</td>
<td>414.0</td>
<td>536.6</td>
<td>552.2</td>
<td>592.6</td>
<td>-251.7</td>
<td>40.3</td>
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<td>Grand Total</td>
<td>3,549.1</td>
<td>2,957.4</td>
<td>3,174.5</td>
<td>3,109.0</td>
<td>3,103.3</td>
<td>-445.8</td>
<td>-5.7</td>
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3 FUNDING

Medical clinical academic posts in UK medical schools are funded in combination by the Higher Education Funding Councils (43%), the NHS including the NIHR (44%) and other sources including research councils, charities and endowments (13%).

The number of posts funded by the NHS is proportionately at its highest level since the first MSC staff survey, and a consistently high level for the last three years, now contributing funding for more than 1,365 FTE posts and 44% of all clinical academic posts. Figure 3 also shows that the level of funding from the four Higher Education Funding Councils was largely stable between 2007 and 2012, but has since declined slightly (-58 FTE, -4% since 2012). Funding from other
sources has been comparatively low, contributing funding for around 13% of all posts, and this has also been stable in recent years.

There have been significant changes in the pattern of funding over the last decade. The level of funding for Lecturers from the Higher Education Funding Councils has halved since 2006 but there has been a 175% increase in NHS-funded Lecturers in the same time period (from 154 FTE to 425 FTE). This NHS funding for posts is largely through the NIHR Integrated Academic Training Pathways (IATP) in England, the Scottish Clinical Research Excellence Development Scheme (SCREDS), through academic pathways funded by the Northern Ireland Medical & Dental Training Agency (NIMDTA) and the Wales Clinical Academic Track (WCAT).

The source of funding for clinical academic posts is correlated with academic grade. The four Funding Councils fund comparatively more Professorial posts (58%) and fewer earlier career grades. Funding for clinical academic posts from the NHS is however higher for Lecturers (72%) followed by Readers/ Senior Lecturers (49%). Other sources fund around

Figure 3: Source of funding for clinical academic posts (2000–2015) (FTE)

Figure 4: Clinical academic grade by source of funding and country (FTE)
13% of all grades. Figure 4 shows the relationship between academic grade and funding by UK country. The funding profiles across England, Northern Ireland, Scotland and Wales are relatively stable year on year. The funding profile in Wales looks different from the rest of the UK, with a much higher proportion of posts, particularly at Lecturer grade, funded by Other sources – although this is distorted as only 2% of UK Lecturers are employed in Wales.

Figure 5 illustrates the range of funding profiles across the UK. Six of the nine ‘new’ medical schools which opened since 2001/02 notably have fewer than one FTE post funded by other sources, and a higher proportion of posts funded by HEFCE. St Andrews also has significant Funding Council support. Durham Medical School also has a different funding profile, with no HEFCE funding – although this is a small school (seven FTE posts) which delivers teaching for year 1 and 2 students as part of Newcastle Medical School. Individual institutional arrangements explain, in part, the different levels of NHS funding for clinical academic posts, linked to the medical school’s research focus and range of taught programmes. In most parts of the country, these arrangements result from collaborations between the medical school, local Trusts (acute, mental health and community-based), local authorities (for Public Health) and primary care.

Full data on clinical academic staff by source of funding are available as Appendices 1, 2, 3 and 4.

4 REGION

The distribution of clinical academic posts mirrors the distribution of student numbers at the UK’s 35 publicly funded medical schools, with 81% of clinical academics located in England, 2% in Northern Ireland, 13% in Scotland and 4% in Wales. Unsurprisingly, London, with its concentration of the UK population, and five undergraduate medical schools plus the postgraduate LSHTM, has the largest concentration of clinical academics, with 40% of the clinical academic workforce in England and 33% of the workforce from across the UK.

Between 2014 and 2015, the clinical academic staffing levels remained relatively stable across all regions. Figure 6 depicts the changes in staffing levels every five years, with longer term declines in the staffing levels in Wales, Scotland and Northern Ireland. Conversely in other regions, particularly those with newer medical schools (the East of England, Wessex and the West Midlands), staffing levels have expanded consistently. Between 2014 and 2015, the most noticeable changes were in Yorkshire and Humber (-9 FTE, -4%), the South West (-11 FTE, -9%) and Northern Ireland (+3 FTE, +5%). Across the other regions, changes were +/-2% which in itself could reflect natural fluctuations.

Full data on clinical academic staff by region are available as Appendices 2 and 7.
5 SPECIALTY

The Medical Royal Colleges oversee the 66 GMC-approved specialty and sub-specialty training curricula. For the purposes of this report, these are broadly grouped into 15 clinical specialty groups, plus Medical Education and Other specialties, as defined in Appendix 19. Ensuring capacity across the range of specialties is key to delivering modern education programmes and the translational research agenda.

The majority of clinical academics are in hospital specialties, but with an increasing number of academics in medical education, General Practice and community specialties including Public Health. More than 40% of clinical academics are specialists in the sub-specialties of Physicians/ Medicine, consistent with the wider NHS consultant population. The next largest specialties are Surgery (9%), Psychiatry (8%) and General Practice (7%) – even though General Practice is likely to be underestimated. Numbers reported in this survey should reflect the full-time role including research, teaching and clinical commitments. However, owing to contractual arrangements, many GPs hold separate contracts for their NHS and academic work, and so their full contribution may not be recorded here. Amongst academic General Practitioners, 50% are employed by HEIs for 0.5 FTE or less and only 30% hold full-time contracts with the university, compared with 11% and 82% for all clinical academics.

Figure 7 maps changes to the clinical academic staffing levels since the 2000 data collection. Some of the data relate to small specialties, with year on year fluctuations. Psychiatry, Surgery and Pathology have all undergone periods of significant decline, most pronounced between 2000 and 2004, although some of this will be as a direct result of separate reporting in the specialties of Emergency Medicine, Infection/ Microbiology, Medical Education and Oncology. Three of the clinical academic specialties are small and thus particularly vulnerable to change – Emergency Medicine (6 FTE), Medical Education (11 FTE) and Occupational Medicine (7 FTE).

Between 2005 and 2010, there was an overall increase of 146 FTE or 5% in the staffing level – but seven specialties have reduced in size by as much as 52%: Medical Education (-12 FTE, -52%), Pathology (-72 FTE, -37%), Occupational Medicine (-3 FTE, -32%). In contrast, eight specialties have grown, three by more than 60%: Radiology (+21 FTE, +62%), Infection/ Microbiology (35 FTE, +64%), Ophthalmology (+26 FTE, +68%).

Changes in staffing level need to be understood in the context of the future health needs of the population and the emerging education, research and service agendas. Predicted changes in the NHS include a greater staffing resource for General Practice and the community based specialties including Public Health, Psychiatry and Paediatrics & Child Health.

Full data on clinical academic staff by specialty are available as Appendices 1, 5, 8 and 14.

6 VACANCIES

This survey reports the number of vacant clinical academic posts that universities were intending to retain on 31 July 2015, even if not actively recruiting to the post. There are different institutional policies about the recording of established posts and vacancies. In some institutions a post is not considered vacant until it is advertised; in others, vacancies are considered against funding and strategic objectives at institutional level. Decisions relating to recruitment and staff turnover affect not just the critical mass within the medical school, but also...
The principles of the Follett Review are that appointments and appraisals are conducted jointly by the NHS and the university.

It should be noted that the information in this section is based on data returned by 23 medical schools (typical response rate), and so is only indicative of the vacancy level.

The number of vacancies has increased for the third consecutive year to 257 FTE, including the 91 posts with Other/ yet to be decided academic grades, and must be considered alongside the documented decline in staffing numbers in post. Figures 8 and 9 illustrate the distribution of vacancies by academic grade, which is not related to the proportion of staff in post at each grade. There are more Lecturer vacancies than at senior grades, and this number has increased in the last three years to 76 FTE or 11% of all Lecturer posts, compared with a vacancy of 3–4% at Professor and Senior Lecturer grades.

The increase in the number of vacancies is to be welcomed provided they can be filled – however 15 medical schools raise concerns about the ability to recruit and a small pool of candidates, sometimes with only one or two applicants for each post. Reasons for difficulties in recruitment include the lack of Distinction Awards in Scotland; no overarching contractual framework for the appointment of GPs in Northern Ireland; candidates unwilling to move institution; and funding arrangements with NHS partners.

Figure 10 reports that there are vacancies in all specialties, except Occupational Medicine which is a very small specialty. There is a high number of vacant posts in General Practice (12 FTE or 5%), Oncology (17 FTE or 10%) and Radiology (7 FTE or 11%). Across the UK, there is a sense of a lack of trainees coming through in Oncology, Pathology, Clinical Pharmacology, Psychiatry and Surgery; at senior level, concerns were raised specifically about specialties within Infection/ Microbiology, Oncology, Paediatrics & Child Health, Pathology, Primary Care, Public Health and Surgery especially Neurosurgery. There were several examples given for advertisements for Chairs in these specialties, but no suitable applicants, or even no applicants, across multiple recruitment rounds. Two schools cited difficulties in securing contracts for academic GPs.

---

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Total staffing level</th>
<th>Vacant posts</th>
<th>Total available posts</th>
<th>Vacant posts as % of total available posts</th>
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</thead>
<tbody>
<tr>
<td>Anaesthetics</td>
<td>55.3</td>
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<td>59.3</td>
<td>6.7%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>6.1</td>
<td>1.0</td>
<td>7.1</td>
<td>14.1%</td>
</tr>
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<td>236.1</td>
<td>5.1%</td>
</tr>
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<td>Infection/ Microbiology</td>
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<td>6.0</td>
<td>95.2</td>
<td>6.3%</td>
</tr>
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<td>Medical Education</td>
<td>10.7</td>
<td>2.8</td>
<td>13.5</td>
<td>20.7%</td>
</tr>
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<td>Obstetrics &amp; Gynaecology</td>
<td>128.8</td>
<td>5.0</td>
<td>133.8</td>
<td>3.7%</td>
</tr>
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<td>Occupational Medicine</td>
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<td>6.8</td>
<td>0.0%</td>
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<td>Oncology</td>
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<td>17.0</td>
<td>178.3</td>
<td>9.5%</td>
</tr>
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<td>65.0</td>
<td>2.0</td>
<td>67.0</td>
<td>3.0%</td>
</tr>
<tr>
<td>Paediatrics &amp; Child Health</td>
<td>186.8</td>
<td>7.8</td>
<td>194.6</td>
<td>4.0%</td>
</tr>
<tr>
<td>Pathology</td>
<td>120.3</td>
<td>6.0</td>
<td>126.3</td>
<td>4.7%</td>
</tr>
<tr>
<td>Physicians/ Medicine</td>
<td>1,254.0</td>
<td>48.5</td>
<td>1,302.5</td>
<td>3.7%</td>
</tr>
<tr>
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<td>257.9</td>
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<td>3.9%</td>
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<tr>
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<td>7.0</td>
<td>62.7</td>
<td>11.2%</td>
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<tr>
<td>Surgery</td>
<td>278.8</td>
<td>23.0</td>
<td>301.8</td>
<td>7.6%</td>
</tr>
<tr>
<td>Other</td>
<td>34.7</td>
<td>11.0</td>
<td>45.7</td>
<td>24.1%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>3,103.3</td>
<td>166.2</td>
<td>3,269.6</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

Figure 11: Age profile of clinical academic consultants and NHS consultants (headcount) 5, 6, 7

7 AGE, GENDER AND ETHNICITY

The majority of university appointments at Lecturer grade and above require a doctorate degree and an established academic track record, alongside clinical training. In addition to completing a medical degree (typically five years), the two-year Foundation Programme, and postgraduate specialty training (four–six years), many clinical academics spend an additional three–five years undertaking research, for example

4 Vacancies reported as Professor, Senior Lecturer or Lecturer grades. There are a further 90.7 FTE vacancies at other academic grades including Researcher.
5 NHS Consultants as at 30 September 2014, clinical academics as at 31 July 2015. Source: Table 7 NHS Hospital and Community Health Services (HCHS): Medical staff by grade and age band, as at 30 September 2014, headcount; Medical Schools Council.
6 Clinical Academic data reported in age groups 26–35, 36–45 etc elsewhere in this report for consistency with comparison with previous years, however re-grouped for the purpose of comparison with NHS Consultant data.
7 Clinical Academic Consultants are taken to be Senior Lecturers/ Readers or Professors.
through an intercalated undergraduate degree and then later a doctorate. Doctors following full-time training should be able to qualify as a Consultant or a clinical academic Consultant by their mid-30s. The age profile of clinical academic consultants compared with NHS consultants, depicted in Figure 11, reflects the longer time to train and qualify at consultant level for academics, and the large increase in NHS Consultant appointments over the last decade.

Figure 12a shows the age profile for the clinical academic team across the last decade. Men make up 71% of the clinical academic team, and inevitably the age profile for the whole team predominantly reflects the age profile of male clinical academics – but Figures 12b and 12c show that there are different trends for men and women. Between 2004 and 2015, the number of male clinical academics has increased slightly (+73, +3%) – but the number of men aged 46 and under has declined by more than 24% (-249 individuals), offset by a 24% increase in the number of men aged 46 and over
(322 individuals). Conversely, the number of women in the clinical academic team has increased by 55% (350 individuals) across the same time period, although from a very low base of 631, with increases for every age group. There has been a 19% increase in the number of women clinical academics aged under 46 (+73) – and the number of women clinical academics aged 46 and over has more than doubled since 2004 (+277, +115%).

Women make up 29% of the clinical academic team, up from 21% in 2004, but compared with 45% of licensed doctors on the specialist register. Figure 13 shows that the pattern of promotion is broadly related to age group for men and women. The proportion of women decreases with academic seniority: 18% of Professors, 34% of Readers/ Senior Lecturers and 41% of Lecturers are women, compared with 11%, 24% and 36% in 2004 (see also Figure 15). The overall annual data reported by this survey demonstrate an increase in the number of women at every clinical academic grade (+301, +44% between 2004-2015) compared with a small decrease in the number of men (-130, -5%).

There are gender differences when looking at the staffing profile of different clinical specialties. Whilst 29% of the clinical academic workforce are women, four specialties have more than 40% women: Public Health, Emergency Medicine, Obstetrics & Gynaecology and General Practice. The general balance of women by specialty is broadly consistent with the pattern of NHS clinicians by gender and specialty, allowing for around 15% more women in each specialty group for licensed doctors with the exceptions of Emergency Medicine (32% of both are women), Ophthalmology (27% of licensed doctors are women, compared with 32% of clinical academics) and Pathology (44% of licensed doctors are women compared with 22% of clinical academics).

Figure 16 contrasts not only the gender profile for each specialty, but also the proportion of clinical academics working less than full-time (LTFT). General Practice is an outlier, as many GPs hold separate contracts for their NHS and academic work, and so their full contribution may not be recorded here. Across the clinical academic workforce excluding General Practice, 18% of clinical academics work LTFT – 13% of men and 31% of women. A high proportion of women work LTFT in Emergency Medicine (67%), Medical

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9 ibid
Education (60%), Occupational Medicine (59%) and Public Health (37%), and more men work LTFT in the latter three also (33%, 58% and 18% respectively). Pathology is the only specialty where proportionately more men (14%) than women (10%) work LTFT.

More women than men work LTFT at all grades. Figure 17 shows that more Readers/ Senior Lecturers work LTFT than at other grades (17% of men and 38% of women). At Lecturer grade, the difference is most marked (8% of men and 34% of women). At Professorial level, the proportions are more similar with 13% of men and 14% of women working LTFT.

Medical schools have long been engaged in programmes to promote and advance gender equality in employment, for example through return to work grants, flexible working practice, childcare support and others. In 2011, NIHR linked its future funding of translational research infrastructure to Athena SWAN awards which recognise commitment to advancing the careers of women in science, technology,
Figure 17: Academic grade by gender and full-time/ LTFT working (headcount)

Figure 18: Academic grade and ethnic origin (headcount)

Figure 19: Ethnic origin and country (headcount)
engineering, maths and medicine (STEMM) in higher education. This has led to an acceleration of efforts by medical schools and an exponential increase in the number of schools seeking formal recognition under the Athena SWAN programme. All schools are now formally engaged in the Athena SWAN recognition process, and following the April 2016 awards round, more than half of medical school departments hold an Athena SWAN Silver award.

Medicine attracts a higher proportion of Black and Minority Ethnic (BME) students than many other university subjects. Of the medical student population, 33% are of BME origin, as are 29% of all doctors. In academic medicine, 16% of clinical academics at Lecturer grade and above are from BME backgrounds, 76% are white, and 10% are unreported. A significant minority of clinical academics identify themselves as Asian/British Asian (10%), followed by Chinese (2%), mixed (2%) and Black/Black British (1%).

The GMC reports that 39% of licensed doctors in England are of BME origin (where ethnicity is known), with 19% in Scotland, 32% in Wales and 9% in Northern Ireland. By comparison, data on the ethnic profile of clinical academics presented in Figure 19 show around 20% in England, 12% in Scotland and Wales and 3% in Northern Ireland.

The different clinical specialties have between 9% and 34% of the workforce from BME ethnic groups, excluding the two smallest specialties with fewer than 10 individuals in total (Occupational Medicine and Emergency Medicine). The specialties with the greatest proportion of clinical academic staff of BME origin are Obstetrics & Gynaecology (24%), Ophthalmology (34%) and Surgery (24%). By contrast just 9% of clinical academics in Pathology and Infection/Microbiology are BME.

Full data on the age, gender and ethnicity profile of clinical academic staff are available as Appendices 9–14.

8 CLINICAL EXCELLENCE AND DISTINCTION AWARDS

Clinical Excellence Awards (CEAs) (England and Wales12; Northern Ireland13) and Distinction Awards (Scotland14, England and Wales old system15) are financial awards made to recognise and reward exceptional and sustained contributions to the NHS by clinicians, above and beyond contractual expectations. The Awards are currently valid for five years. Local awards are assessed by the local NHS organisation, and national awards are overseen by a national panel. Awards are funded at levels recommended by the Review Body on Doctors’ and Dentists’ Remuneration (DDRB).

Across the UK, 57% of consultant-level doctors hold a CEA at local or national level: 46% hold a local award and 11% hold a national (or equivalent) award. This is higher for clinical academics, of whom 64% hold a CEA: 24% hold a local award and 39% hold a national (or equivalent) award. The

11 ibid
work undertaken by clinical academics often has national or international significance, in addition to local impact. As expected, there is an increase in the level of awards held with career progression. Ten Lecturers hold a CEA across the UK—nine local awards and one at Level 9 (Bronze). This section focuses on Consultant-level clinical academics.

Figure 21 shows differences between the four UK countries, as well as a comparison with NHS consultants in England—note that Northern Ireland has historically had a lower proportion of clinical academics holding a CEA or Distinction Award, and the number of local awards in Wales was unavailable in 2015. Figure 22 illustrates the gender difference in the number of clinical academics holding CEAs and Distinction Awards at Professor and Reader/Senior Lecturer grades. Across consultant-level clinical academics, 24% of men and 26% of women hold a local CEA or equivalent, and a further 44% of men and 26% of women hold a national level award. The Advisory Committee on Clinical Excellence Awards (ACCEA) report of the 2014 awards round in England and Wales confirmed that, whilst women were less likely to apply for a national award, when they applied they were as competitive and as successful as men.

Figure 23 shows that the number of national awards held by clinical academics has declined by 5% since the UK-wide freeze on new awards in 2011, and the freeze continuing in Scotland (−9% in the same time period). In England, despite an increase in the number of Professors and Readers/Senior Lecturers, there was a 4% decline in the number of national CEA award holders between 2014 and 2015, following several years of consistent numbers. In Northern Ireland, where the freeze on new awards has now been lifted, there has been a 53% decline in national awards between 2009 and 2015, offset by a small increase in the number of local awards. In Scotland, the freeze on national new awards continues, with a 16% decline in the number of national award holders since 2009, offset in part by a 69% increase in the number of local awards. In Wales information on local awards was unavailable; the number of national awards has been relatively stable.

Full data on clinical academic staff by Clinical Excellence Awards are available in Appendices 15–17.

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16 NHS Consultant Awards recorded in payment as at July 2015. Taken from the NHS Information Centre Annual Workforce Census, Medical and Dental Staff, published in ACCEA Annual Report, published August 2015
17 Clinical Academic Consultants are Reader/Senior Lecturer and Professor
18 Data on local Clinical Excellence Awards held in Cardiff were unavailable
The Medical Schools Council has sought to collect data on the pathway into clinical academic roles at Lecturer grade and above, recognising that the clinical academic workforce includes a large number of staff in the pipeline to substantive university posts. Last year, the data were published for the first time, however they should be interpreted with caution and considered in the context of other information published by the NIHR, the MRC, the Royal Colleges and others. Specific caveats include:

- These data are likely to be an underestimation of the staffing levels at these grades.
- Thirty medical schools, from 35, returned data on clinical academics at Researcher and other grades. The five medical schools not returning these data were Durham, Exeter, Lancaster, LSHTM and Newcastle.
- Not all researchers or clinical tutors hold their substantive contract of employment with the university. In particular, fellows on the NIHR Integrated Academic Training Pathway whose substantive contract of employment is with the NHS do not meet the definition for the scope of this data collection, and are thus excluded from analysis.

19 Data on local Clinical Excellence Awards held in Cardiff were unavailable.

### 9 RESEARCHERS AND OTHER ACADEMIC GRADES

The Medical Schools Council has sought to collect data on the pathway into clinical academic roles at Lecturer grade and above, recognising that the clinical academic workforce includes a large number of staff in the pipeline to substantive university posts. Last year, the data were published for the first time, however they should be interpreted with caution and considered in the context of other information published by the NIHR, the MRC, the Royal Colleges and others. Specific caveats include:
The term ‘Researchers’ encompasses a range of fellowships, including pre- and post-doctoral level. These data were not consistently recorded and the data have been grouped to demonstrate the total number of staff in these roles.

Clinical academics recorded as ‘Other’ academic grades are, for the most part, clinical tutors and clinical teaching fellows.

There were 1,872 FTE Researchers and 123 FTE clinical academics at other grades employed with substantive university contracts in July 2015. Figure 24 shows that the majority of funding (76%) for research fellowships is from other sources, namely charities and research councils, with 13% of funding from the NHS and 11% from the Funding Councils. Other clinical academic posts were funded by the Funding Councils (33%), the NHS (52%) and Other sources (15%).

Figure 25 compares the number of Researchers and other clinical academics with the wider clinical academic team, showing that they make up 39% of the team overall. The specialties with a noticeably high proportion of university-employed Researchers and clinical academics at other grades are Medical Education (66%), Surgery (46%) and Infection/Microbiology (46%). General Practice and Medical Education comprise a high level of Other clinical academics (17% and 56% of the clinical academic team respectively). By contrast, 19% of the clinical academic team in Public Health and Pathology are Researchers and Others. These are both specialties where schools have raised specific concerns about the pipeline of clinical academics and recruiting to vacancies (see section 7).

The pattern of flexible working for Researchers is not dissimilar to that of the wider clinical academic team, with 9% of men and 18% of women working LTFT. For Other clinical academics, however, more than 70% of both men and women...
work LTFT, suggesting that this relates more to the nature of roles as visiting Lecturers or sessional clinical tutors.

Sixty percent of Researchers are aged 36 and under, and 91% are aged under 46, reflecting the early career stage for many research fellowships. By contrast Other clinical academic grades are drawn from across the age groups. Figure 28 shows the profile of Researchers and Other clinical academics by ethnic origin. There is a high proportion of unknown information (22%), but 56% of Researchers and 75% of Others are white and 14% and 20% are of BME origin, higher than the clinical academic team more generally.

Significant and sustained investment into run-through academic training programmes has sought to address issues around transparency and entry routes including programmes funded by NHS Education Scotland (NES), the Medical Research Council, the Wellcome Trust, NIHR, the Scottish Translational Medicine and Therapeutics Initiative (STMTI), WCAT in Wales and the Northern Ireland Academic Career Fellowships. These are vital schemes which must be sustained, protected and supported to ensure the pipeline of clinical academics, so that medical research in the UK continues to push boundaries, to enhance our understanding and deliver world-class patient care.

Figure 26: Academic grade (Researchers and Others) by gender and LTFT working (headcount)

Figure 27: Age profile by academic grade (headcount)
\section*{10 CONCLUDING REMARKS}

This report, as in previous years, gives the most complete picture of clinical academic staffing in the UK. Nonetheless there are limitations to the data and its interpretation. Where there is incomplete data capture this has been noted in the text. Some activities of academic medicine are delivered by NHS-employed individuals (for example teaching) and if this could be captured the picture would be likely to appear different.

The workforce for academic medicine as a whole is at best stable compared with the year on year growth of NHS staff illustrated in Figure 29.

The academic workforce appears to be growing in the older age groups and the senior (professorial) positions. This imbalance between the incoming group (Lecturers) and those who are likely to retire in the next 10 years may represent a manpower problem in future years. This cannot be certain as growth in the senior grades could arise through recruitment from outwith the UK, but it is a warning.

The impact of NIHR funding in England over the last 10 years has been substantial, reversing some adverse trends that were present before this funding was available. It is encouraging that work is actively being pursued to support early stage clinical academics.
Female representation in the academic workforce is slowly increasing with greater growth at the more junior grades. There are however still major differences between specialties. The Athena SWAN process has been widely engaged with across the medical schools of the UK.

The Physicians/Medicine specialty is by far the largest group in academic medicine and data from this group distorts the overall picture. Careful examination of the smaller groups shows some significant differences between the specialties.

The picture across a number of domains reported in this report show substantial variation across the devolved nations with some showing trends towards increasing difference.

There remain substantial challenges in BME representation in academic medicine.

It is vital that clinical academia continues to be recognised and protected through the efforts of medical schools and also all funders, particularly in the context of funding pressures facing the higher education sector and the NHS. Sustaining the pipeline of the clinical academic workforce is pivotal to ensuring continued excellence in patient care through innovative discoveries in healthcare.
## Appendix 1: Profile by specialty and source of funding (FTE)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Funding Council</th>
<th>NHS</th>
<th>Other</th>
<th>Total 2015</th>
<th>Total 2014</th>
<th>% change since 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anaesthetics</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Professor</td>
<td>8.1</td>
<td>39.8%</td>
<td>11.3</td>
<td>0.9</td>
<td>4.5%</td>
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</tr>
<tr>
<td>Reader/ Senior Lecturer</td>
<td>6.0</td>
<td>24.2%</td>
<td>16.3</td>
<td>2.5</td>
<td>10.1%</td>
<td>24.8</td>
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<td>Lecturer</td>
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<td>0.0%</td>
<td>10.0</td>
<td>0.2</td>
<td>2.0%</td>
<td>10.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14.1</strong></td>
<td><strong>25.5%</strong></td>
<td><strong>37.6</strong></td>
<td><strong>3.6</strong></td>
<td><strong>6.5%</strong></td>
<td><strong>55.3</strong></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Professor</td>
<td>1.6</td>
<td>51.7%</td>
<td>1.2</td>
<td>0.3</td>
<td>8.3%</td>
<td>3.0</td>
</tr>
<tr>
<td>Reader/ Senior Lecturer</td>
<td>0.5</td>
<td>20.0%</td>
<td>2.0</td>
<td>0.0</td>
<td>0.0%</td>
<td>2.5</td>
</tr>
<tr>
<td>Lecturer</td>
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<td>0.0%</td>
<td>0.6</td>
<td>0.0</td>
<td>0.0%</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2.1</strong></td>
<td><strong>33.6%</strong></td>
<td><strong>3.8</strong></td>
<td><strong>0.3</strong></td>
<td><strong>4.1%</strong></td>
<td><strong>6.1</strong></td>
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</tr>
<tr>
<td>Professor</td>
<td>55.8</td>
<td>66.7%</td>
<td>18.1</td>
<td>9.8</td>
<td>11.7%</td>
<td>83.6</td>
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<td>93.5</td>
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<td>14.7%</td>
<td>46.9</td>
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<td><strong>Total</strong></td>
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<td><strong>53.2%</strong></td>
<td><strong>72.5</strong></td>
<td><strong>32.4</strong></td>
<td><strong>14.5%</strong></td>
<td><strong>224.0</strong></td>
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<tr>
<td>Professor</td>
<td>22.0</td>
<td>57.3%</td>
<td>9.5</td>
<td>6.9</td>
<td>18.0%</td>
<td>38.4</td>
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<tr>
<td>Reader/ Senior Lecturer</td>
<td>14.0</td>
<td>42.2%</td>
<td>13.3</td>
<td>5.8</td>
<td>17.5%</td>
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</tr>
<tr>
<td>Lecturer</td>
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<td>11.3%</td>
<td>13.2</td>
<td>2.5</td>
<td>14.1%</td>
<td>17.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>38.0</strong></td>
<td><strong>42.6%</strong></td>
<td><strong>36.0</strong></td>
<td><strong>40.4%</strong></td>
<td><strong>15.2</strong></td>
<td><strong>89.2</strong></td>
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</tr>
<tr>
<td>Professor</td>
<td>2.0</td>
<td>66.7%</td>
<td>1.0</td>
<td>0.0</td>
<td>0.0%</td>
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</tr>
<tr>
<td>Reader/ Senior Lecturer</td>
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<td>0.0%</td>
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<td>Lecturer</td>
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<td>100.0%</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0%</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6.3</strong></td>
<td><strong>58.4%</strong></td>
<td><strong>4.5</strong></td>
<td><strong>41.6%</strong></td>
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<td><strong>10.7</strong></td>
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<td><strong>Obstetrics &amp; Gynaecology</strong></td>
<td></td>
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</tr>
<tr>
<td>Professor</td>
<td>30.8</td>
<td>64.5%</td>
<td>14.4</td>
<td>2.6</td>
<td>5.4%</td>
<td>47.8</td>
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<tr>
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### Appendix 1: Profile by specialty and source of funding (FTE) (cont.)

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<th>% change since 2014</th>
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### Appendix 2: Profile by region and source of funding (FTE)

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<th>Total 2014</th>
<th>% change since 2014</th>
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Notes: LETB regions include medical schools as follows: East Midlands includes Leicester, Nottingham; East of England includes: Cambridge, Norwich at the University of East Anglia; Kent, Surrey and Sussex includes Brighton and Sussex; London includes Barts and The London, Imperial College, London School of Hygiene & Tropical Medicine, King’s College London, St George’s, University of London, University College London; North East includes Durham, Newcastle; North West includes Lancaster, Liverpool, Manchester; South West includes Bristol, Exeter and Plymouth; Thames Valley includes Oxford; Wessex includes Southampton; West Midlands includes Birmingham, Keele, Warwick; Yorkshire and Humber includes Hull York, Leeds, Sheffield; Northern Ireland includes Queen’s University Belfast; Scotland includes Dundee, Edinburgh, Glasgow; St Andrews; Wales includes Cardiff, Swansea.
Appendix 3: Profile by medical school and source of funding (FTE)

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## Appendix 3: Profile by medical school and source of funding (FTE) (cont.)

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### Appendix 4: Summary of changes (pre- and post-2002 medical schools) (FTE)

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<th>Total 2014</th>
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<td>13.0%</td>
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</table>

| **Post-2002 Medical Schools** |                 |     |       |            |            |                     |
| Professor              | 54.0            | 52.1% | 35.8  | 34.6% | 13.8  | 13.3% | 103.7  | 102.8  | 0.8%  |
| Reader/ Senior Lecturer | 38.0            | 40.4% | 48.2  | 51.2% | 7.9   | 8.4%  | 94.0   | 97.3   | -3.4% |
| Lecturer               | 7.5             | 28.0% | 14.9  | 55.4% | 4.4   | 16.6% | 28.8   | 37.3   | -28.2% |
| **Total**              | 99.5            | 44.3% | 98.8  | 44.0% | 26.1  | 11.6% | 224.5  | 237.4  | -5.4% |

| **Pre-2002 Medical Schools** |                 |     |       |            |            |                     |
| Professor              | 729.2           | 58.7% | 387.1 | 31.1% | 126.7 | 10.2% | 1,243.0 | 1,259.3 | -1.3% |
| Reader/ Senior Lecturer | 428.1           | 40.0% | 468.8 | 43.8% | 173.2 | 16.2% | 1,070.1 | 1,097.4 | -2.5% |
| Lecturer               | 77.4            | 13.7% | 410.3 | 72.5% | 78.1  | 13.8% | 565.8  | 514.9  | 9.9%  |
| **Total**              | 1,234.7         | 42.9% | 1,266.2 | 44.0% | 378.0 | 13.1% | 2,878.9 | 2,871.6 | 0.3%  |

**Note:** Medical Schools established post 2001/02 are: Brighton and Sussex, Durham, Exeter, Hull York, Keele, Lancaster, Norwich at University of East Anglia, Plymouth, Swansea, Warwick.

### Appendix 5: NHS and clinical academic consultants by specialty and UK medical student intake (FTE)

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<th>Specialty</th>
<th>UK NHS Consultants/ GP Practitioners</th>
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<th>UK Clinical Academic Consultants</th>
<th>% change since 2000</th>
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</tr>
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<td>*</td>
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</tr>
<tr>
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<td>49,260.0</td>
<td>74.2%</td>
<td>2,631.1</td>
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<tr>
<td>Grand Total (inc. GP)</td>
<td>60,315.7</td>
<td>90,304.2</td>
<td>49.7%</td>
<td>2,704.9</td>
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**Medical Student Intake (headcount)**

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<th>2015</th>
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<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>7,736</td>
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<tr>
<td>Paediatrics &amp; Child Health</td>
<td>37.9%</td>
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</table>

**Notes:**

1. Consultants in the following specialties: Anaesthetics (Intensive Care Medicine), Obstetrics & Gynaecology, Paediatrics & Child Health, Pathology, Physicians/ Medicine (Infection/Microbiology, Oncology, Ophthalmology and Occupational Medicine), Psychiatry, Public Health, Radiology, Surgery (including Emergency Medicine), Other including Medical Education.


3. GP practitioner data is an estimation only, as FTE data are unavailable for Wales and Northern Ireland for 2014. A multiplier of 0.831 was used with known headcounts, which is the ratio of PT:FT for the known workforce in England and Scotland in 2015.

4. Public Health England data is an estimation only, as FTE data are unavailable. A multiplier of 0.784 was used with known headcounts for Public Health Consultants, which is the ratio of PT:FT for the known Public Health workforce in England reported by the NHS Information Centre. A multiplier of 0.957 was used with known headcounts for Microbiologist Consultants employed by Public Health England, which is the ratio of PT:FT for the known Microbiology workforce reported by the NHS Information Centre.

5. Clinical academic consultants are Professors and Readers/ Senior Lecturers.

6. Intake of pre-clinical student numbers at the start of the autumn term 2015 (HEFCE numbers).

7. Sources: Medical Schools Council; HEFCE; UCAS; NHS Information Centre, England; Public Health England; Information Services Division, NHS National Services Scotland; Department of Health, Social Services and Public Security, Northern Ireland; Health and Social Care Department, Wales.
## Appendix 7: Profile by region (2004–2015) (FTE)

<table>
<thead>
<tr>
<th>Year</th>
<th>East Midlands</th>
<th>East of England</th>
<th>Kent, Sussex &amp; Surrey</th>
<th>London</th>
<th>North East</th>
<th>North West</th>
<th>South West</th>
<th>Thames Valley</th>
<th>Wessex</th>
<th>West Midlands</th>
<th>Yorkshire &amp; Humber</th>
<th>Northern Ireland</th>
<th>Scotland</th>
<th>Wales</th>
<th>Grand Total</th>
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<td>87.9</td>
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<td>399.4</td>
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</table>

Change since 2014 (FTE): -6.5 5.2 0.6 -11.5 -3.5 -11.4 -3.2 0.0 -0.3 -8.8 2.8 4.3 -2.5 -5.7  
Change since 2014 (%): -3.4% 3.0% 2.1% -11.5% 1.4% -8.6% -3.0% 0.0% -0.2% -4.1% 4.8% 1.1% -1.9% -0.2%
### Appendix 8: Profile by specialty (2000–2015) (FTE)

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<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
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<td>161.7</td>
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<td>187.1</td>
<td>186.5</td>
<td>186.2</td>
<td>201.5</td>
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<td>*</td>
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<td>*</td>
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<td>*</td>
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## Appendix 9: Profile by specialty, grade, gender and full-time/ LTFT working (headcount)

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<th>Reader/ Senior Lecturer Women FT</th>
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<th>Lecturer Women FT</th>
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**MEN**

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**WOMEN**

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### Appendix 11: Profile by age, gender and academic grade (headcount)

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### Appendix 12: Profile by age and ethnic origin (headcount)

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<td>17</td>
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### Appendix 13: Profile by academic grade and ethnic origin (headcount)

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<td>Black/ Black British</td>
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<td>9</td>
<td>0.7%</td>
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<tr>
<td>Chinese</td>
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<td>1.5%</td>
<td>28</td>
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<tr>
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<td>1.7%</td>
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## Appendix 14: Profile by specialty and ethnic origin (headcount)

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## Appendix 15: Clinical Excellence and Distinction Awards held by clinical academics (2009–2015) (headcount)

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**Note:** Data on local awards were unavailable from Cardiff.
### Appendix 16: NHS and clinical academic consultants with a Clinical Excellence or Distinction Award (headcount)

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### Appendix 17: Clinical Excellence and Distinction Awards by gender and academic grade (headcount)

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### Appendix 18: Corrections to previously published data (FTE)

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## Appendix 19: Medical specialty groups and sub-specialties

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<td>Anaesthetics</td>
<td>Blood Transfusion Medicine</td>
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<td>Clinical Cytogenetics and Molecular Genetics</td>
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<td>Cytopathology</td>
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<td>Nuclear Medicine</td>
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<td>Paediatrics and Child Health</td>
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<td>Rheumatology</td>
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### Other

Any medical specialty not included in the above list.