



Survey of Medical Clinical Academic Staffing Levels 2018

July 2018



msc Medical
Schools
Council
For the future of medicine

This is a report based on survey results of clinical academic staffing levels in UK medical schools at 31 July 2017.

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Published by Medical Schools Council



Medical Schools Council, London (2018)

List of acronyms

CEA – Clinical Excellence Awards
GMC – General Medical Council
LCEA – Local Clinical Excellence Awards
MRC – Medical Research Council
NIHR – National Institute for Health Research
RCGP – Royal College of General Practitioners
RCPCH – Royal College of Paediatrics and Child Health

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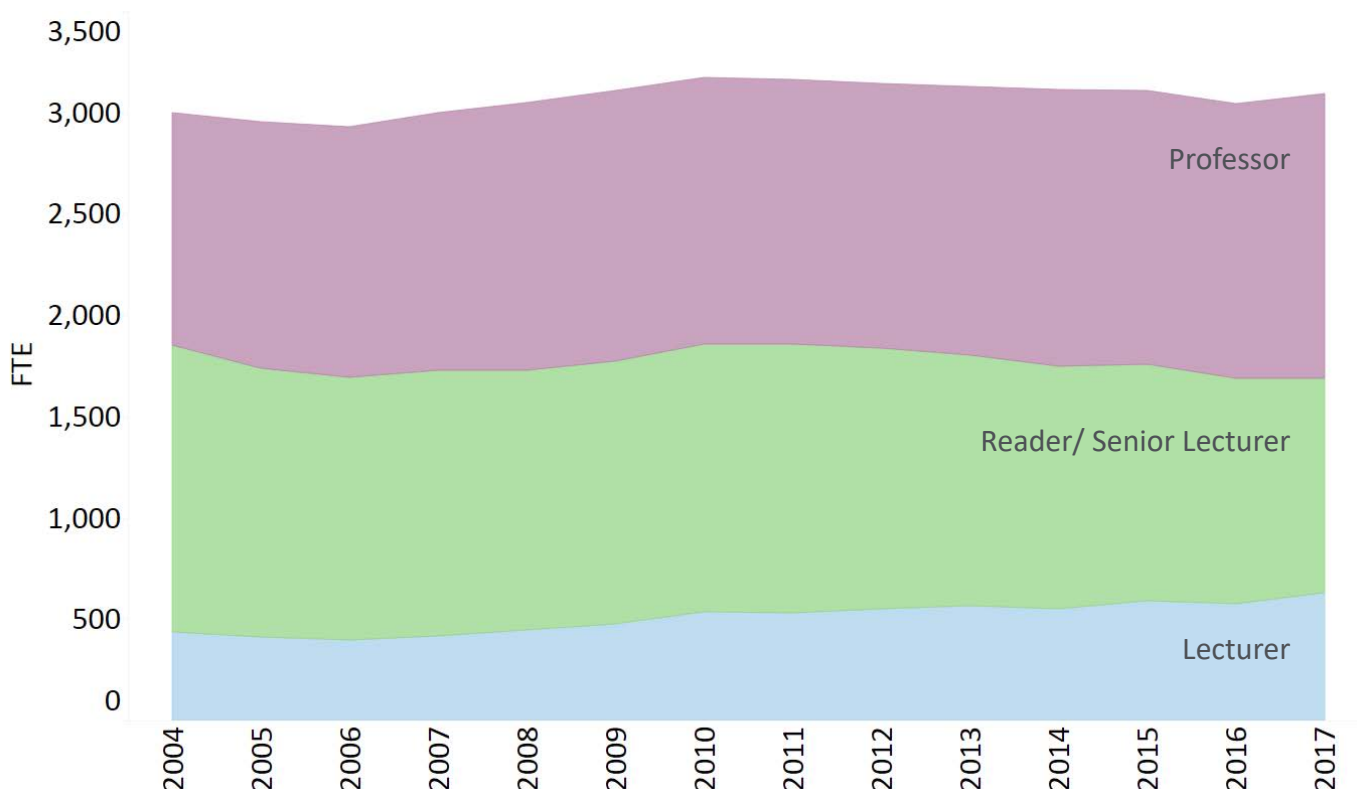
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1. Background

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 since 2000. At that time, there had been a significant drop in the number of Lecturers and there were clear difficulties in career progression, without a structured pathway in place.

The successful development of such a pathway was fostered by the creation of the National Institute for Health Research (NIHR) in England in 2006, with parallel efforts in Scotland, Wales and Northern Ireland to develop training programmes, along with sustained efforts by the major medical research funders. These developments contributed to a steady climb in clinical academic staffing levels from 2,930.2 FTE in 2006, to 3,174.5 FTE in 2010, an increase of 8.3% as illustrated by Figure 1.

Figure1. The timeline of clinical academic staffing levels by academic grade since 2004



While the appropriate individuals are employed to clinical academia there is a need to also look through the prism of the greater activities that medical schools are involved in, and acknowledge that the demands on medical educators have increased. These demands are not being compensated by an increase in clinical academics, as numbers have remained constant. The pressures faced by NHS medical and dental consultants are highlighted in the NHS 2017 Staff Survey Results.¹ Findings show:

- 91% of consultants are working extra hours.
- 38% have attended work despite feeling unwell from pressure from peers or themselves.
- 33% expressed that they felt unwell due to work related stress.

This is a cause for concern and highlights the importance of maintaining close observations of the levels of these important members of staff

Alongside this, there are several types of teaching and routes of entry, all of which clinical academics contribute towards. For instance, in August 2017 the Government announced its plans to increase the number of student places in England by 1,500 from the academic year of 2019/20. In March 2018, existing medical schools were allocated 500 of these extra places, with an additional 1,000 places allocated later in the year following a bidding process. This expansion seeks to promote doctors into regions that have been identified as struggling to attract trainee medics, and was also targeted at underrepresented social groups.² The effect of the increase will only be evident from 2023 onwards. This is because the number of medical students with UK nationality attending UK universities decreased by more than 2,300 between 2012 and 2016.³

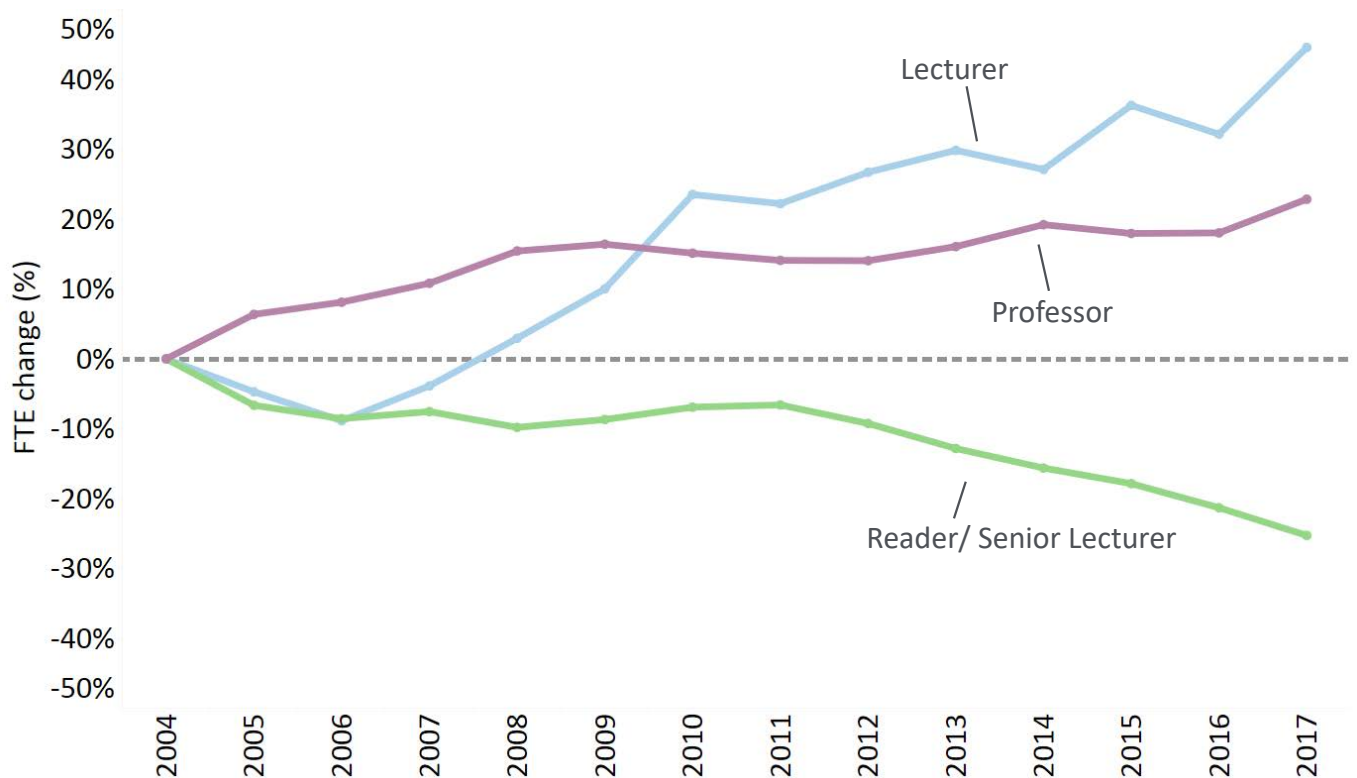
2. What does the 2017 Survey tell us?

Decline in clinical academic staffing levels, particularly at Reader/ Senior Lecturer level.

The total number of clinical academic staff employed by UK medical schools on 31 July 2017, at the three grades stood at 3,094.1 FTE, and a total number of 3,465 posts. This represents a 1.7% increase since 2016, but a 2.5% decline since its peak in 2010.

A decline in the number of Reader/ Senior Lecturer staff numbers has historically been identified across all UK nations over time, with a 25% decrease in FTE since 2004. The decline is in large part the result of the reduction of Reader/ Senior Lecturer staff by 11% since 2014.

Figure 2. Change in clinical academic staffing levels by academic grade since 2004



Professors

The number of Professor level staff remains relatively stable, with an increase of 55.2 FTE since 2016, and a percentage increase of 23% since 2004. England, Scotland and Northern Ireland show a stable or marginal increase in the number of staff at Professor level over the last few years.

The 2016 report identified that in Wales numbers had declined from 61.8 in 2014 to 53.7 FTE, the lowest level since 2004 when numbers stood at 40.7 FTE. The 2017 data highlight an increase to 58.9 FTE. In comparison, Scotland had recovered from its smallest level of Professors recorded in 2012 (149.4 FTE), to its highest level in 2015 (181.1 FTE). However, this has marginally declined again to 174.9 FTE (2017). As expected, with higher numbers there has been less proportional change in England (+6.7% since 2012).

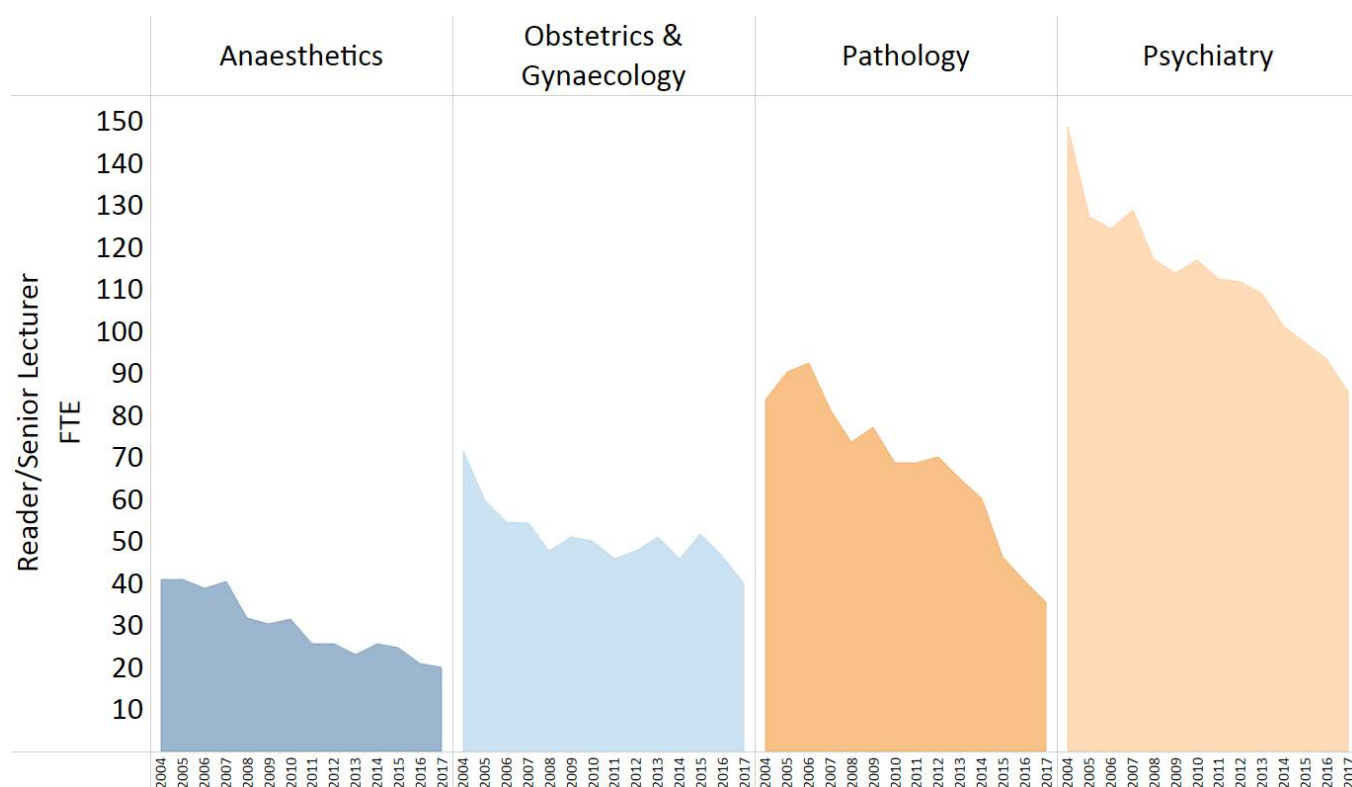
Reader/ Senior Lecturers

In Scotland, by 2017 Reader/ Senior Lecturer numbers had declined by 33%, in England by 25% and Wales by 21%. However, this has started to recover slightly in Northern Ireland over the last couple of years from 29.6 FTE (-22%) in 2014, to 34.4 FTE (-9.5%). Much of the decline observed in the UK can be seen within the following specialties; Anaesthetics, Obstetrics and Gynaecology, Pathology and Psychiatry (Figure 3).

The reduction of Reader/ Senior Lecturer staff is concerning, especially as this has not recently been compensated by the modest increase in Professor grade numbers. This may suggest that the fall at the middle grade is not due to rise in promotion in clinical academia. The recent decrease in Lecturer numbers also suggests there may be an insufficient number of individuals entering the pipeline to fill these posts if they are vacant, and highlights the need for greater support for early clinical academic career staff such as Researchers. There is a need to understand the patterns and trends in the UK clinical workforce, and so work has been initiated to understand this.

In November 2017, the '2017 UK-Wide Survey of Clinical Health Research Fellowships' was published, which highlighted a reduction in the number of fellowships to support independent research, with application rates remaining static. While the Medical Research Council (MRC) collated funders' data, the core data collection was complicated because of the variation in the completeness, format, ease of access and type of data held by funders. MRC as a result has recommended a core data collection, with annual reporting to permit for the monitoring of trends.⁴ MSC strongly supports this.

Figure 3 The timeline of Reader/ Senior Lecturers by specialties in decline since 2004



Lecturers

Since 2004, the numbers at Lecturer level have increased overall, but this is concentrated in England where there has been a 57% rise in Lecturers compared to a 1.8% increase in Scotland, following a 6.5% decline reported in 2016. While the 2016 data identified a decline in the FTE of Lecturer grade staff, the 2017 survey data highlight a 54 FTE increase of Lecturer grade

staff since 2016 (628.1 FTE), a 45% increase since 2004. Despite concerns that the freezing of the Distinction awards in Scotland would lead to an outflow of clinical academics to England, there have been no drastic changes within clinical academic staffing levels within Scotland. It might be suggested that this is a result of the establishment of the Scottish Clinical Research Excellence Development Scheme (SCREDS) which provides an integrated training and career development pathway which enables clinicians to concurrently undertake academic and clinical training within the NHS.⁵

In Wales, there has been a recent increase in Lecturers from 13.6 (2015) to 24.7 FTE (2017), but numbers have not recovered to the peak in 2012 (33.9 FTE). Northern Ireland only returned 2 FTE Lecturer staff in post in 2017, down from 7 FTE in 2011 (data were unavailable here in 2004).

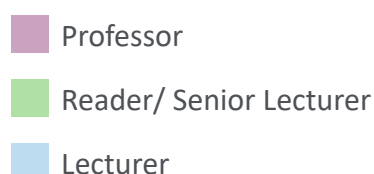


Figure 4. Clinical academic staffing levels by country since 2004

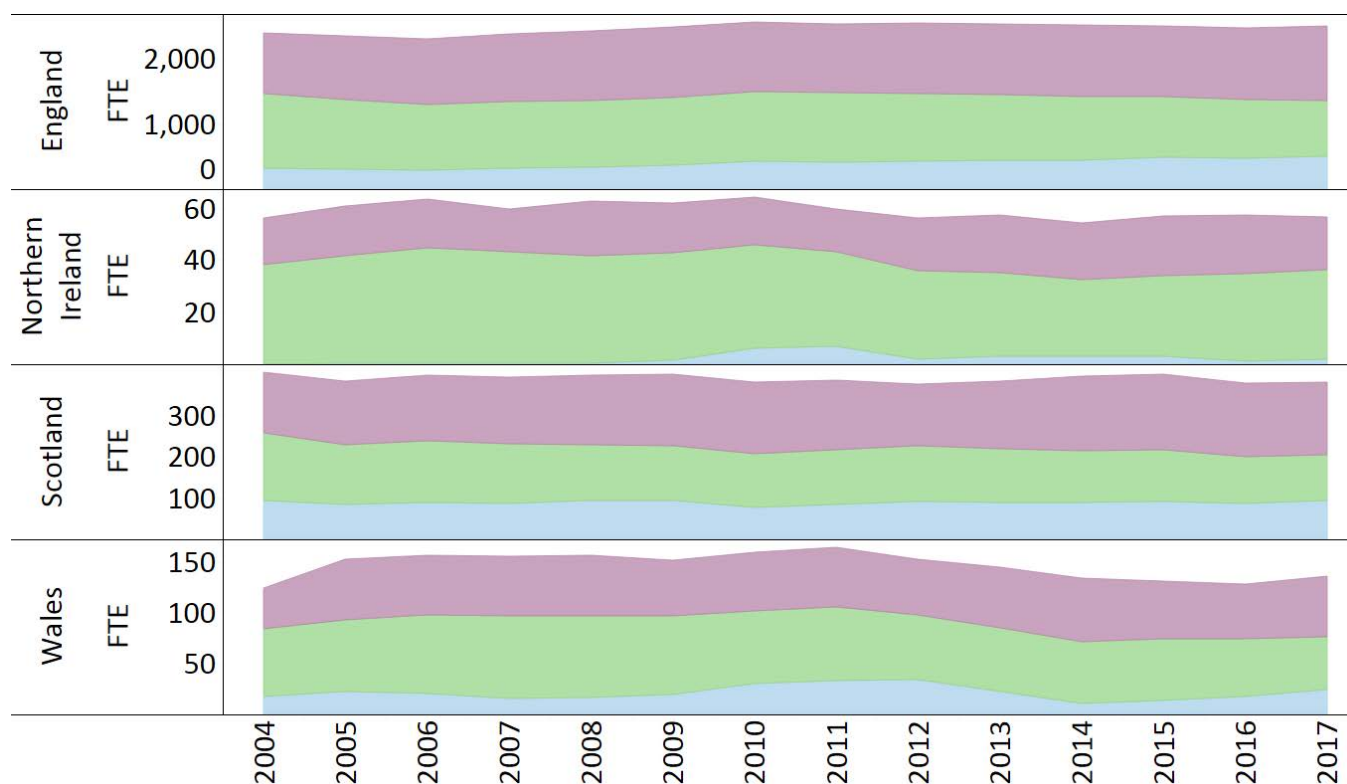
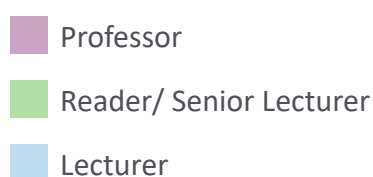
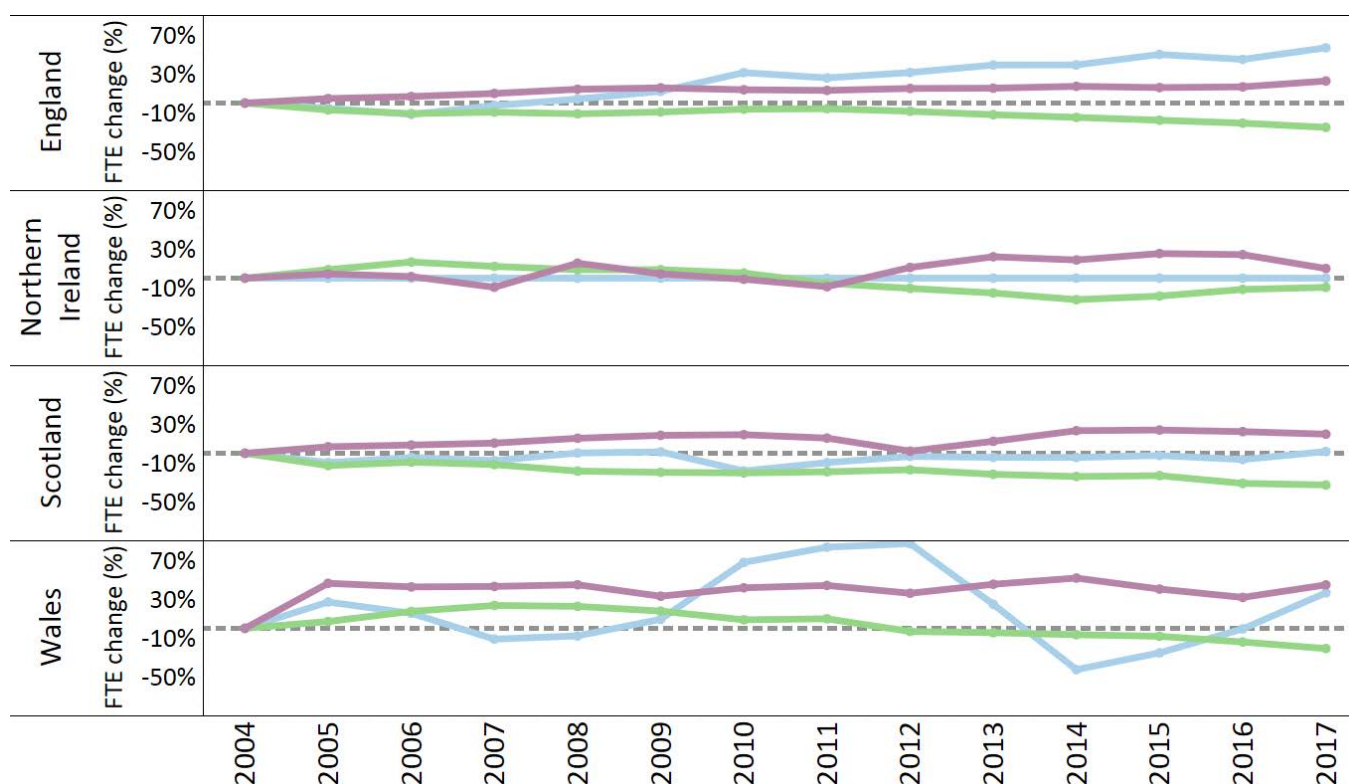


Figure 5. Change in clinical academic staffing levels by country since 2004

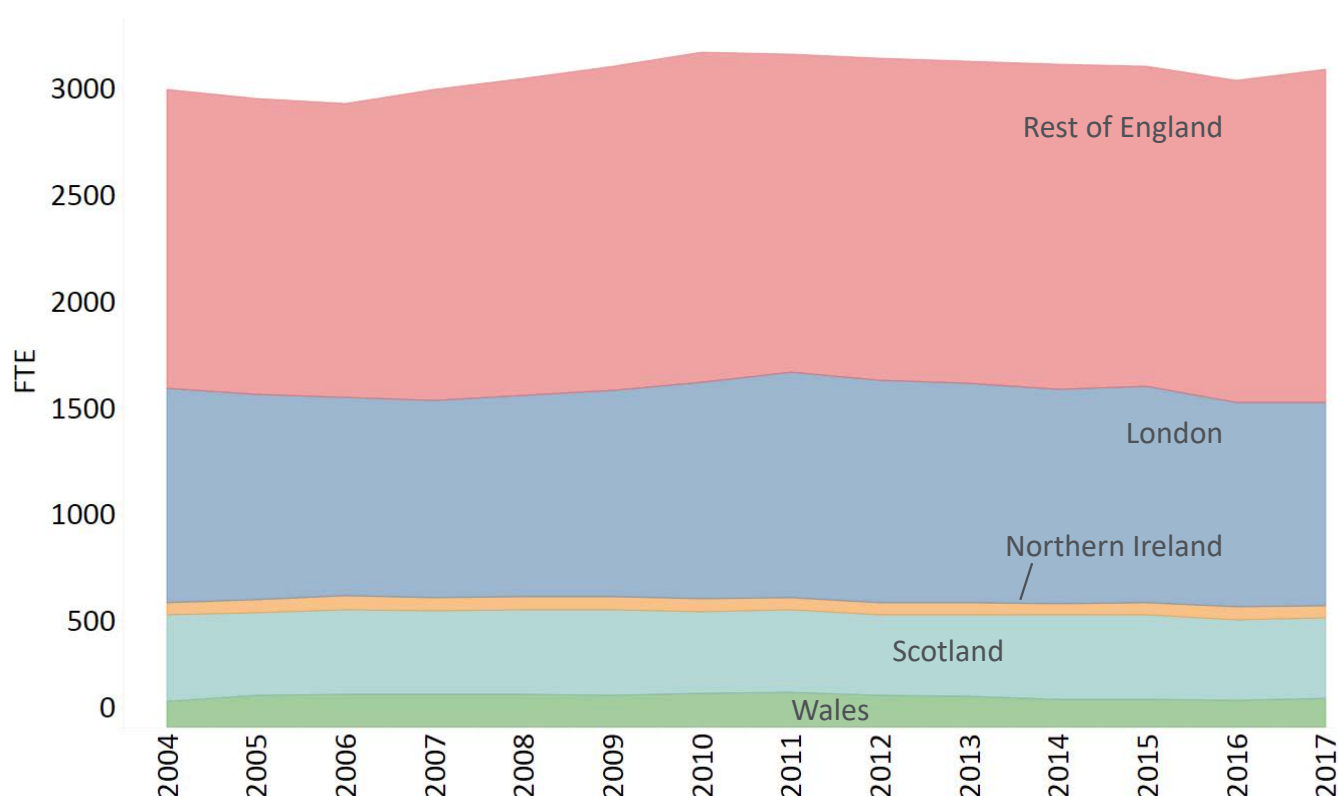


Regional variation

The highest proportion of clinical academics is in England with 82% of total UK staff, followed by 12% in Scotland, 4.4% in Wales and 1.8% in Northern Ireland. The number of posts broadly mirrors the distribution of student numbers at the 34 medical schools which are included in these data.⁶ Figure 4⁷ shows that staffing numbers at each of the three grades varies between the four nations of the UK over time. Firstly, this highlights the limitations of drawing certain conclusions from the total numbers of the UK, and the need for consideration of analysis by nation. This reflects different funding and political landscapes, as well as variation in the makeup of local populations across the different nations.

Figure 6 breaks down the clinical academic staffing further by regions. This shows there is a concentration of clinical academic staff in London, accounting for 31% of the population in 2017, but the FTE has decreased overall by 6% since 2015. The high numbers concentrated in this region reflects the high concentration of population and medical schools.

Figure 6. Clinical academic staffing levels by region since 2004 (FTE)

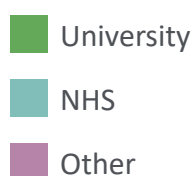
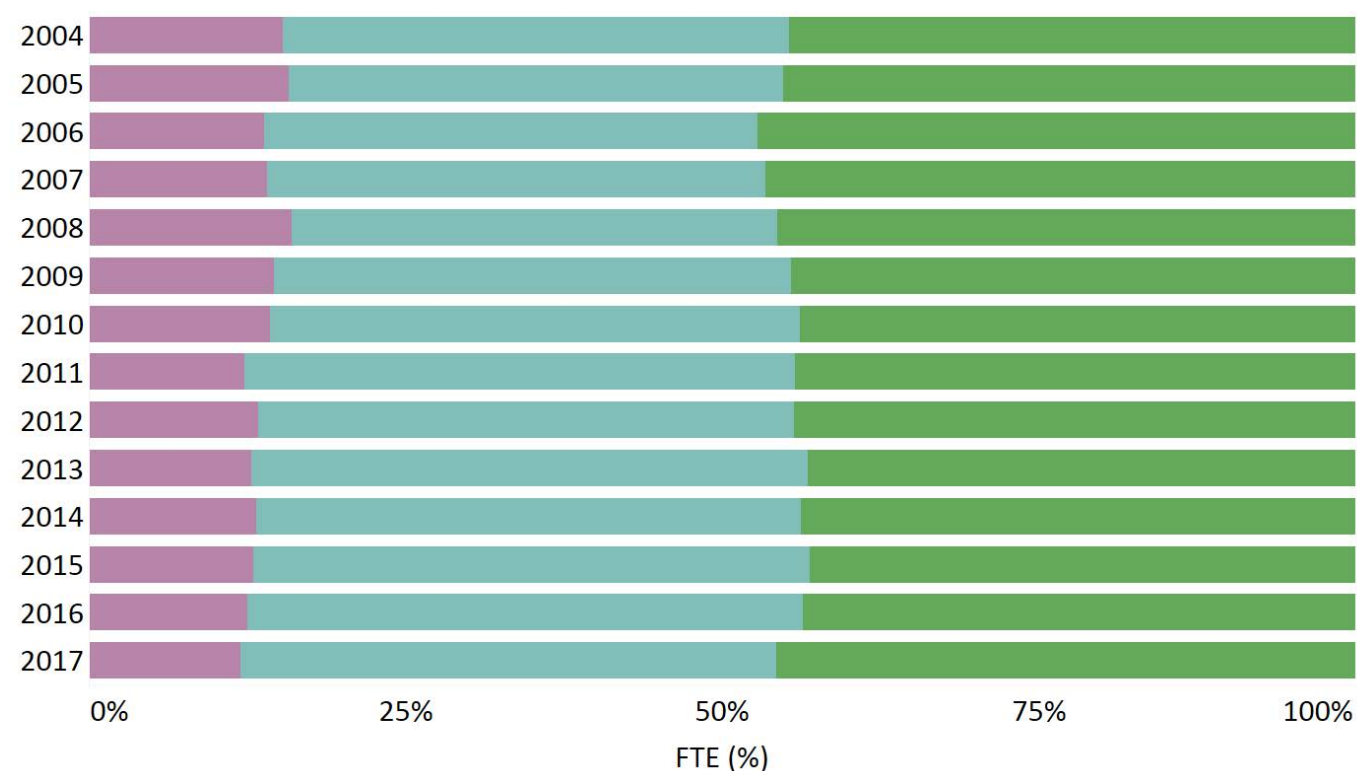


Funding

Decline in NHS and Other sources of funding, with lecturers funded by higher proportions of NHS funding.

Clinical academic posts across the UK are funded by a combination of 46% University Funding, 42% NHS (including NIHR), and 12% from Other sources, which includes research councils, charities and endowments. The 2017 data highlight an increase in the proportion of University funding by 2.1%, and a decrease in NHS funding by 1.5%. The proportion of staff funded by other sources has decreased by 0.5%. Overall proportions between funding sources have remained broadly consistent since 2011.

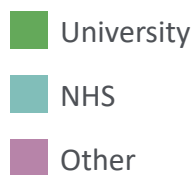
Figure 7. Source of funding for clinical academic posts (2004–2017)



The sources of funding for clinical academic posts is correlated with academic grade. UK wide universities generally fund a higher proportion of Professorial grades, and fewer earlier academic grades. Lecturer grade staff are funded by a higher proportion of NHS funding, making up one-fifth of funding. This represents a decline from one-third.

Proportions of funding for ‘Professorial’ and ‘Reader’ grade staff have remained consistent.

Shown by Figure 8, since 2010 NHS funding has been the dominant funding source for lecturers, and has been increasing ever since. Funding for other academic grades has remained relatively stable over time. There is however, some national variation in the relationship between the academic grade and funding. In Wales, where previously the largest proportion of funding for Lecturers (69%) was from ‘Other’ sources, with a low level of NHS support for this grade, the 2017 data show the highest proportion of funding is from NHS funders (45%). Similarly, in Wales ‘Other’ sources fund a greater



proportion of Lecturers (40%) than elsewhere in the UK. In Northern Ireland, there are no Lecturers funded by universities or 'Other' sources of funding. It is important to note that only a small number of Lecturers are employed in Wales and Northern Ireland.

Figure 8. Source of funding by clinical academic grade

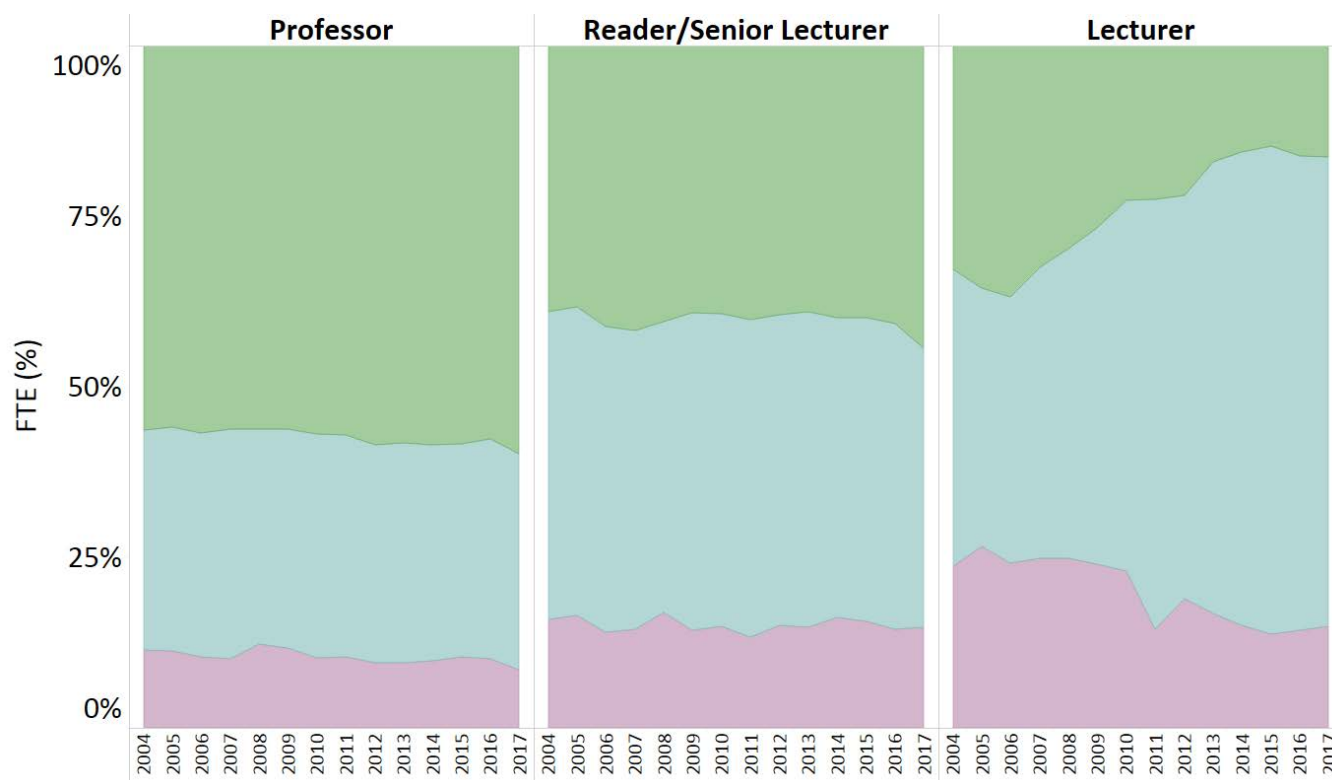
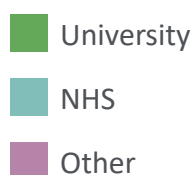


Figure 9 illustrates the funding profiles for clinical academics by individual medical schools across the UK. A notable difference for some schools is the lack of 'Other funding' (Keele, Lancaster, Queen's University Belfast, Sheffield, St Andrews and Swansea). Cardiff, Lancaster, Norwich, Plymouth and St Andrews have a significant majority of clinical academic staff funded by University Funding (between 65%– 100%).

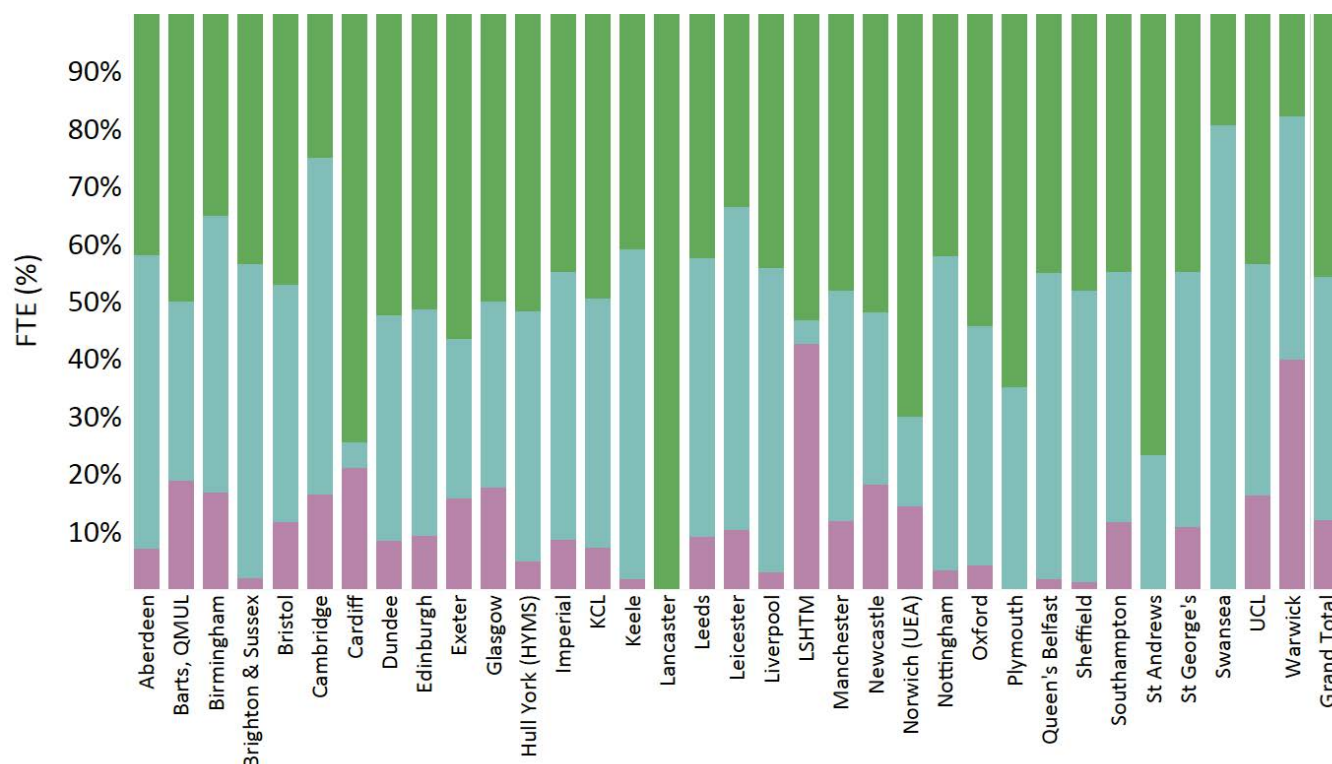
While most medical schools' clinical academic staff are funded by 23%–80% of NHS funding, Cardiff has experienced a reduction in its NHS funding: now only accounting for 4.5% of the funding compared to 39% in 2014.

London School of Hygiene & Tropical Medicine (4%) and



Lancaster (0%) additionally have the smallest proportion of NHS funded clinical academic staff. Individual institutional arrangements explain a majority of these differences.

Figure 9. Funding profile of clinical academic post by medical school in 2017 (FTE)



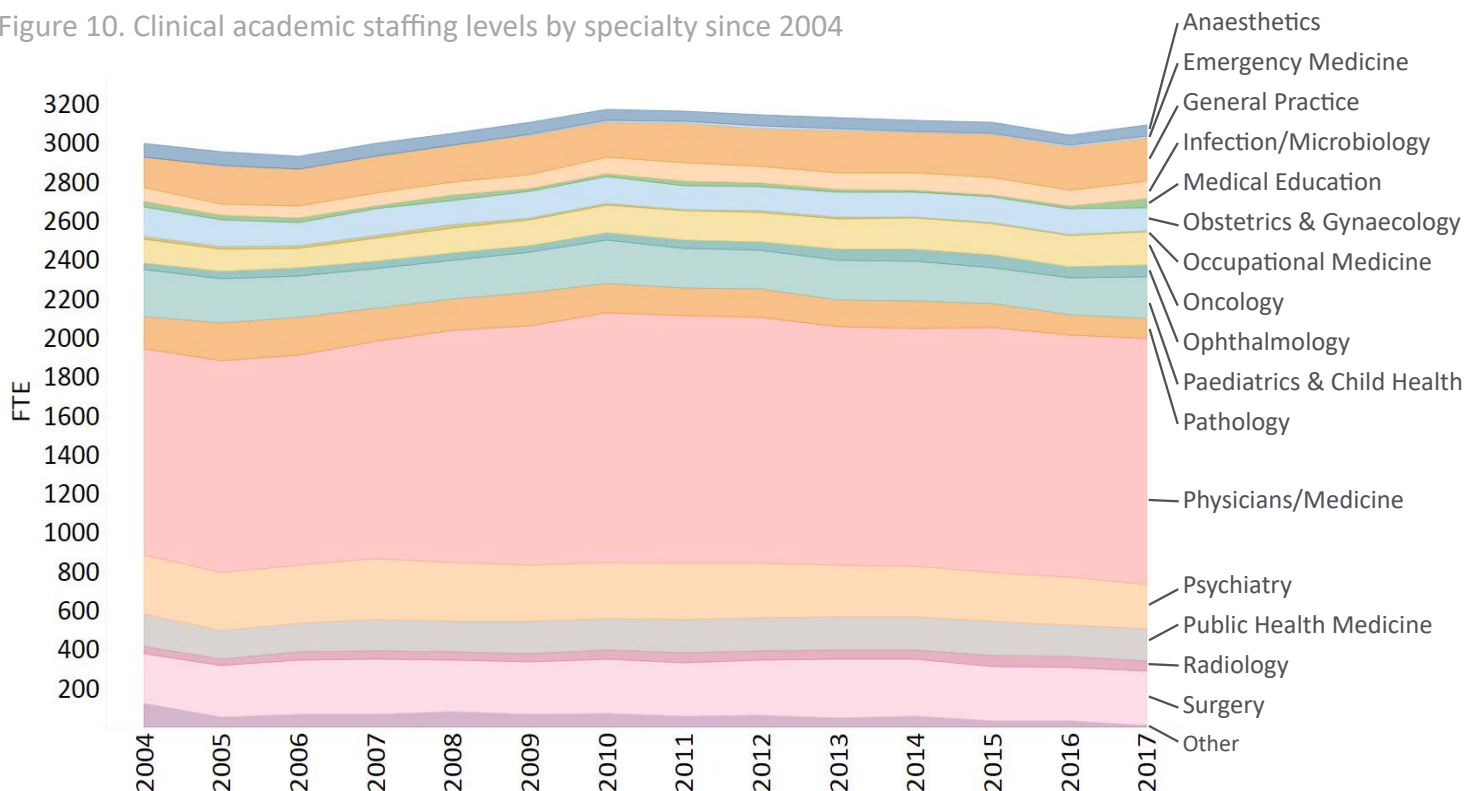
3. Specialties

Numbers in certain specialties are declining, with several others increasing.

41% of clinical academics are in sub-specialists of Physicians/Medicine (1,263.7 FTE) followed by surgery (9.1%), Psychiatry (7.3%) and General Practice (7.2%). The position of Physicians/Medicine and Surgery reflects that these subject areas also contain the highest number of licensed doctors on the Specialist Register. By 2020, the number of Physicians will be expected to rise, due to the creation of the Physician Associate, as the Department of Health aims to recruit 1,000 to primary care.⁸

After General Practice, the next largest groups on the Specialist Register are Anaesthetics and Psychiatry; the latter correlates with clinical academic numbers, while Anaesthetics has a much lower ranking here comparatively.⁹ The three smallest specialties are Emergency Medicine (7.8 FTE) and Occupational Medicine (4 FTE) and 'Other' specialty (8.3FTE), and again these are reflective of the proportion in these specialties on the Specialist Register.¹⁰ With the increase in overall clinical academic staff numbers by 52.9 FTE since 2016, most specialties have reduced in size or stayed constant. Several specialties have been in decline over a longer period, such as Psychiatry, Paediatrics and General Practice.

Figure 10. Clinical academic staffing levels by specialty since 2004



Psychiatry

Psychiatry has seen gradual losses since 2007 of 84.4 FTE. The total number of registered doctors in Psychiatry has not changed significantly since 2011 levels.¹¹ To tackle this, one recommendation made in 'Next Steps on the NHS Five Year Forward View Mental Health' (2016) proposed that the Office for Students reviews its funding requirements and criteria for decision making in support of the Research Excellence Framework, to ensure that clinical academics working in mental health are not disadvantaged, relative to other specialties.¹²

Paediatrics

Clinical Academics specialising in Paediatrics represent 6.8% (210.9 FTE) of the clinical workforce, a 0.6% increase compared to 2016. These figures represent a recovery following a decline in 2015 (186.3 FTE), the lowest since 2004 (241.9 FTE).¹³ Taking note of this decline the Royal College of Paediatrics and Child Health (RCPCH) has discussed the importance of a strong workforce to deliver the Life Sciences Strategy, and research focused clinicians. Due to this, in 2017 the RCPCH established a Children's Research Fellowship Fund to promote the growth of post-doctoral research opportunities, and to support academic track trainees to transition into independent researchers.¹⁴ In addition, in its response to the NHS's 'Facing the facts, shaping the future: A draft health and care workforce strategy for England to 2027' consultation, the RCPCH called for Health Education England to work with NIHR, universities and professional bodies to prevent further decline.¹⁵

General practice

Clinical academic staffing levels in General Practice have increased overall since 2004 (+65.7 FTE), albeit through periods of fluctuation, which is in line with the increase in the wider NHS.¹⁶

Despite rises in consultant numbers of the FTE of GPs, the number of GPs in England has only risen by 25% from 27,550 in 1996 to 34,423 in 2016.¹⁷ The Royal College of General Practitioners (RCGP) has been campaigning to promote General Practice across the four nations. RCGP has successfully lobbied for the expansion of NHS England overseas recruitment programmes and the recruitment of 5000 FTE doctors to General Practice in England by 2021. Alongside this, RCGP has called on the devolved nations to expand GP numbers and promote General Practice.¹⁸

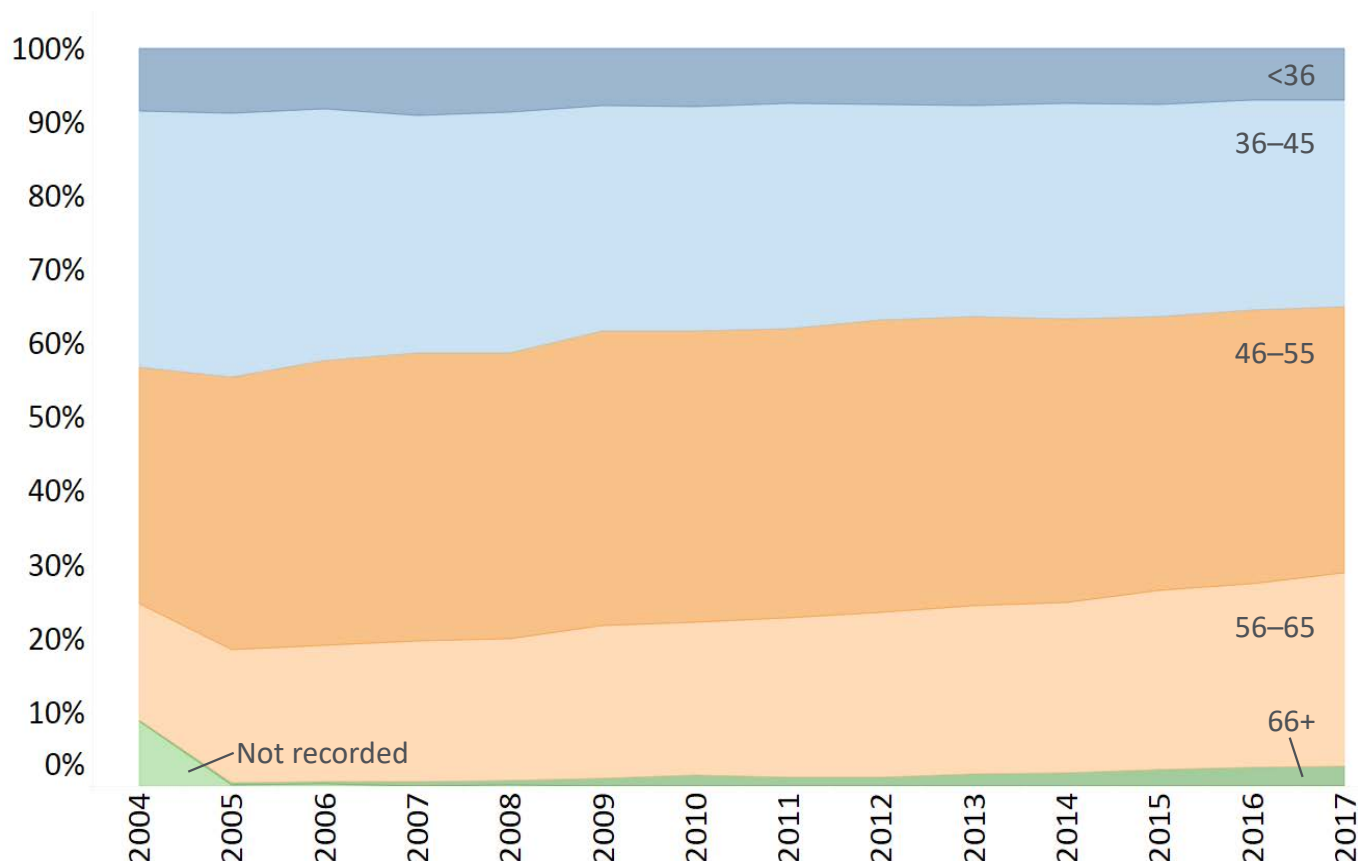
Due to the way that specialties are recorded for this survey, a limitation to the analysis above is that these data could be broken down into a range of sub-specialties. Therefore, there may be different trends over time between sub-specialties that are not captured here.

4. Ageing Workforce

An ageing workforce due to a negative or zero growth of <36 cohort.

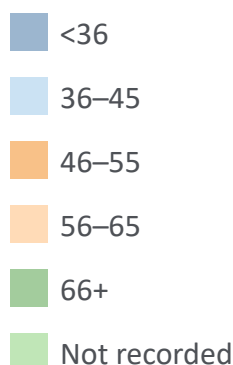
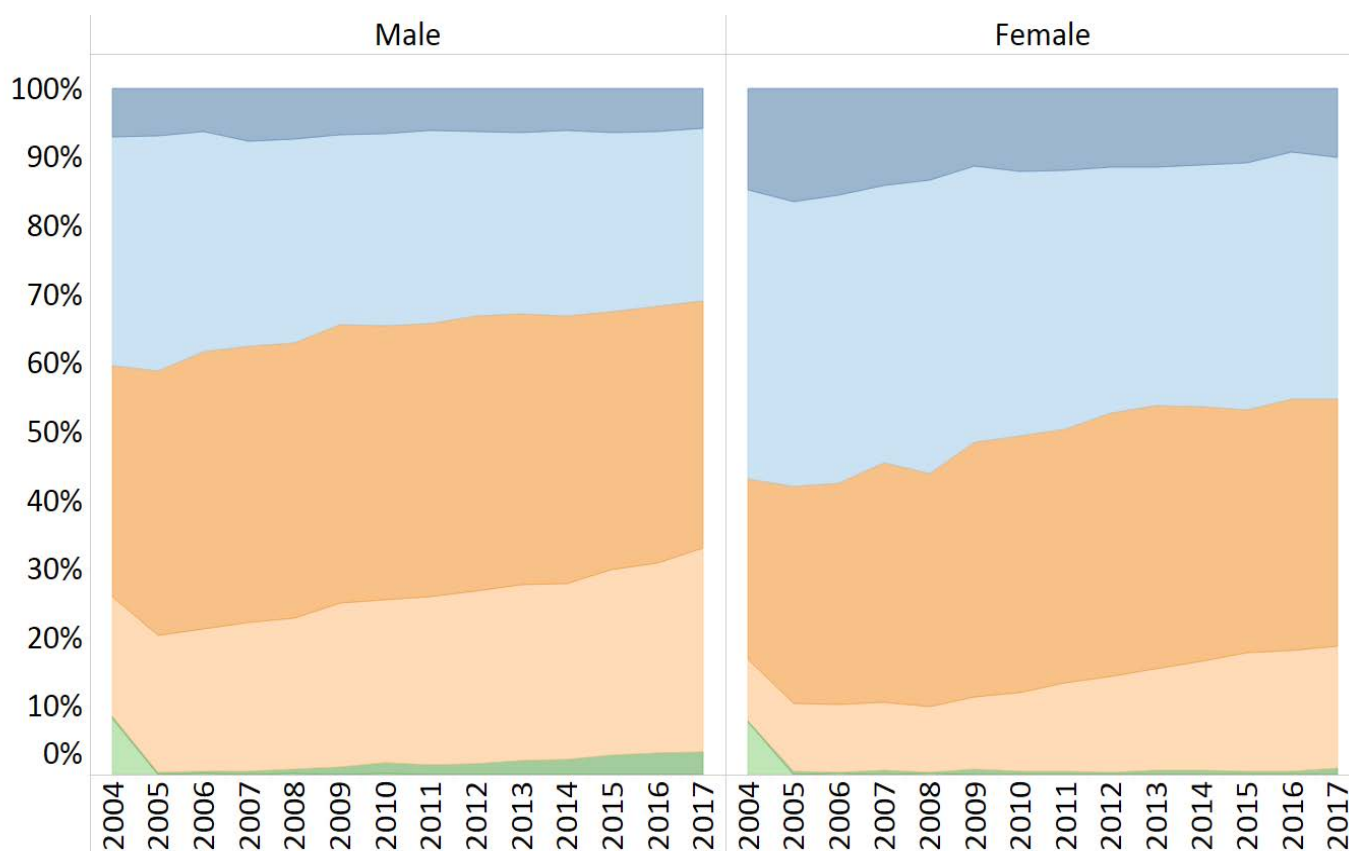
Forty-six- to fifty-five-year-olds are the highest proportion of the clinical academic workforce at 36% percent, with 36–45 the second largest cohort at 28% and the <36 cohort making up 7.1% of the workforce. Since 2004, there has been a slow decline in the number of <36 cohort, and an increase in FTE of 56–65-year-olds (340.9 FTE), and of those who are within the 66+ age cohort (73.9 FTE). This negative or zero net growth of the recruitment of the <36 cohort and continued increase in the older age brackets means that, by 2026, clinical academics in 948 posts from the 2016 cohort will have retired, or will be nearing retirement if these trends remain constant. A further 1,220 posts will also be approaching retirement age.

Figure 11. Age profile since 2004 (FTE)



When the changes in age profile are split by gender, it is clear that the ageing profile may be more evident for men than for women. Overall, Figure 14 shows a slight decrease of men in the 36–45 age bracket since 2005, and an increase in those aged 56–65 since 2004. This is also reflected in the two age groups at either end of the scale which have been moving closer in numbers since 2007, with a slight growth in those aged 66+ and decrease for those aged under 36. The male clinical academic workforce that falls within the age brackets of 56–65 to 66+ accounts for 726.6 FTE of the overall clinical academic population, compared to that of 167 FTE females.

Figure 12. Age profile since 2004 (men and women, FTE)



The age profile for female clinical academics has not changed significantly since 2004, with a majority of women aged between 36–55 (634.7 FTE: 71%). An ageing workforce is also seen in the wider population of doctors, where, of licensed doctors on the GMC register, there appears to have been an increase in older women, rather than men.¹⁹

5. Seniority of appointment

Age is broadly related to promotion through the three grades for both men and women

There has been a proportionate increase of women in clinical academia since 2004, when there were 21% women and 79% men. There was also an increase in the proportion of women at senior levels, with 4% of all staff being female Professors in 2004, up to 8.4% in 2017. This has largely been met by a decrease in the proportion of men at Reader/ Senior Lecturer level from 37% in 2004 to 23% of all clinical academic staff in 2017.

However, the proportion of women decreases with academic seniority, with women making up 19% at Professor grade, up 1.3% from 2016, 37% Reader/Senior Lecturer and 44% of Lecturers grade staff. While female doctors make up 47% of all licensed doctors and 58% of those in training,²⁰ more men (69%) than women (31%) are reported in clinical academic roles overall.

This decline in females through the academic career pathways is also referenced in the '2017 UK wide Survey of Clinical Health Research Fellowships', where a decline in the proportion of female clinical academics is cited. In addition, the Academy of Medical Sciences research (2009–2011) looking at female fellows applying for and attaining funding across grades within the Academy's Fellowship (2013) also highlighted this decline: Junior (52%), Intermediate (37%) and Senior (12%).²¹ To address this, NIHR seeks to commit to establishing a cross-funder approach to address gender disparity that builds on existing evidence and understanding.²²

Male
Female

Figure 13. Academic grade and gender since 2004 (posts)

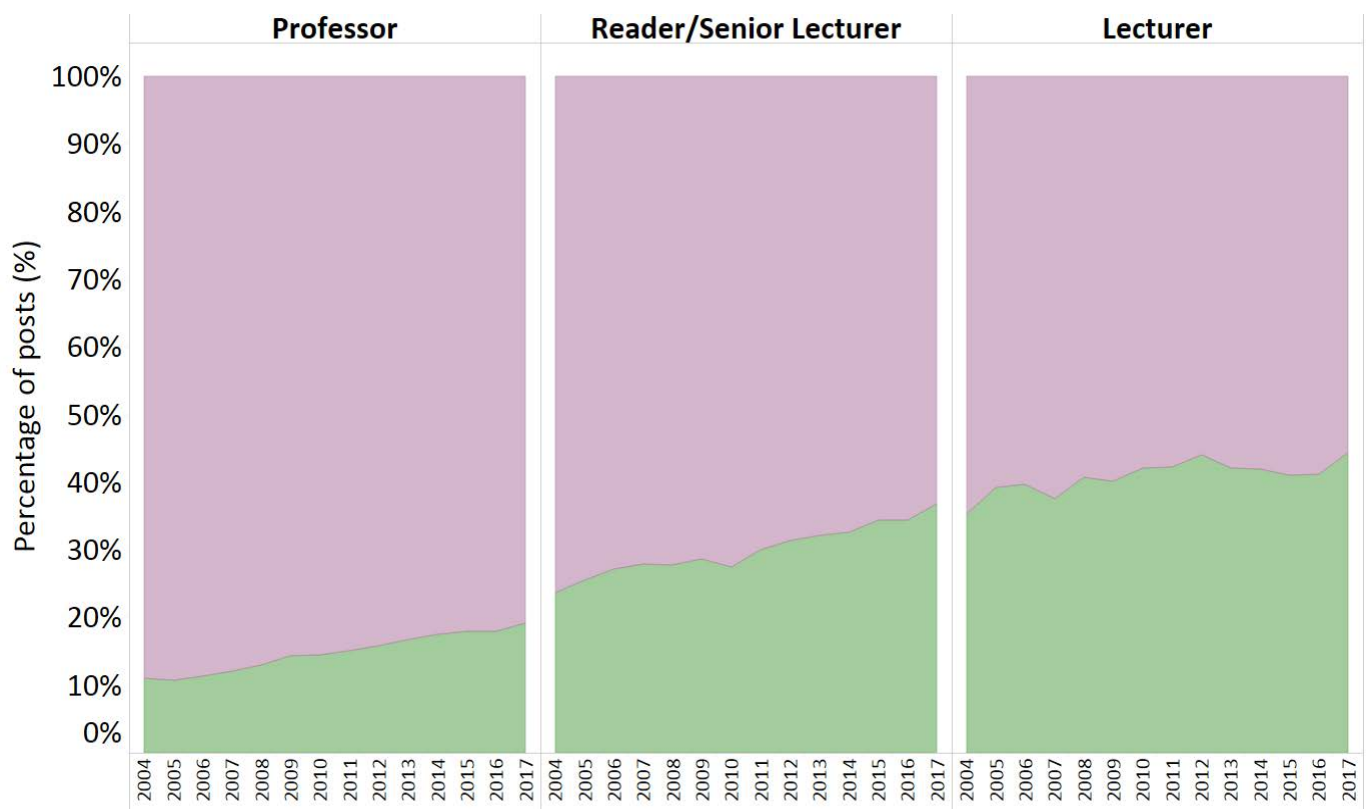
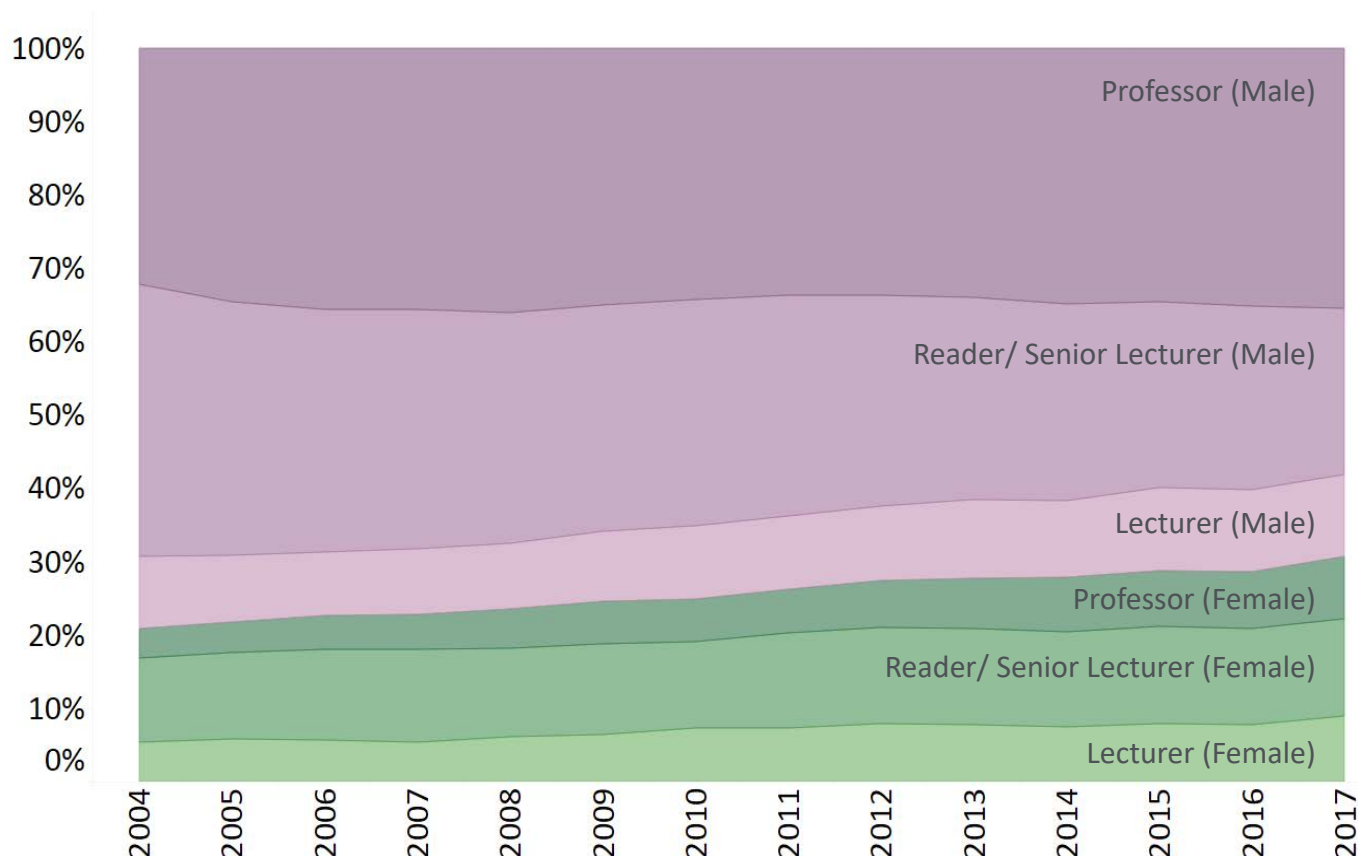


Figure 14. Academic grade by gender since 2004 (posts)



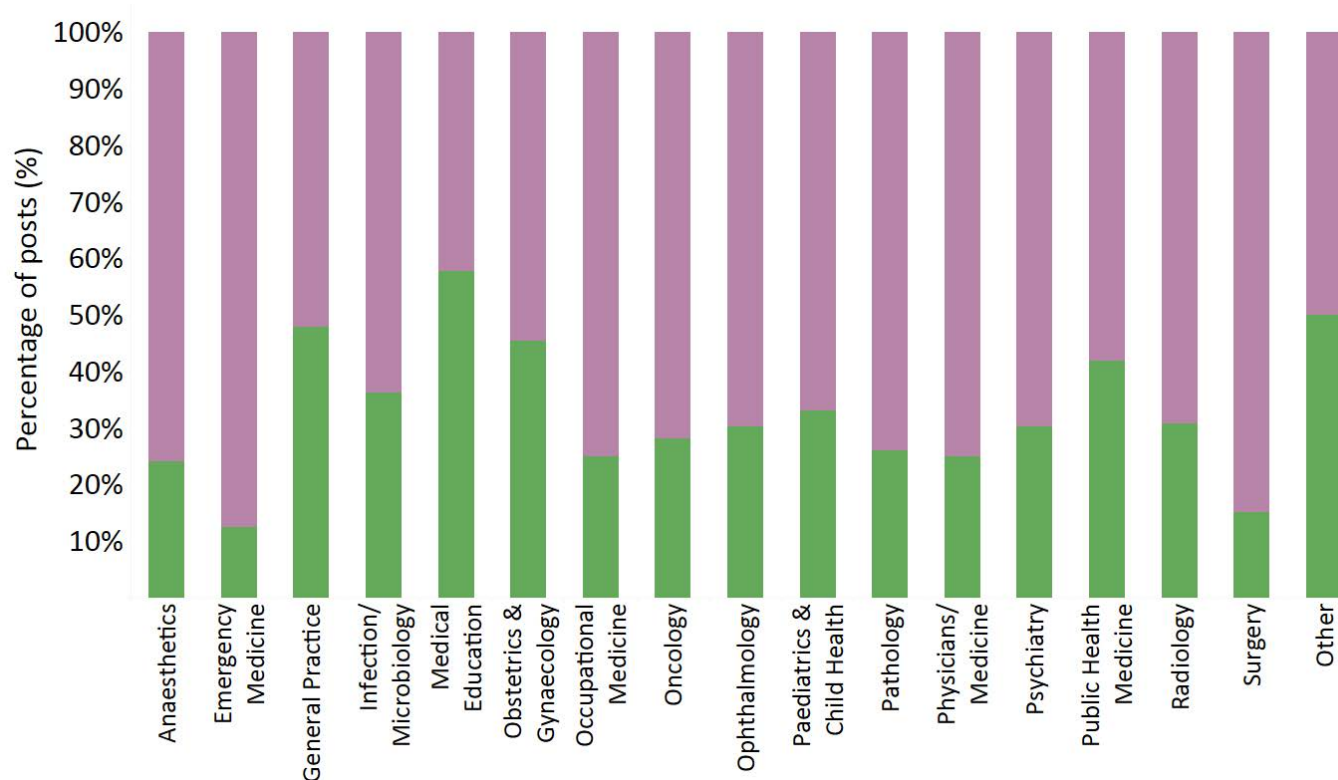
6. Profile of specialties

There have been increases in diversity but at a slow rate

The proportion of male and female clinical academic staff in each specialty is illustrated in Figure 15, which ranges from 13% to 58% women.

General Practice and Medical Education have the highest proportion of female clinical academics (both around 48%–58%), closely followed by Public Health Medicine and Obstetrics and Gynaecology (both around 43%). This largely reflects the population of women on the Specialist Register (General Practice (52%), Obstetrics and Gynaecology (51%), while Paediatrics (52%) is under represented, with only 33% of the clinical academic population being female.²³

Figure 15. Specialty by gender in 2017 (posts)



Male
Female

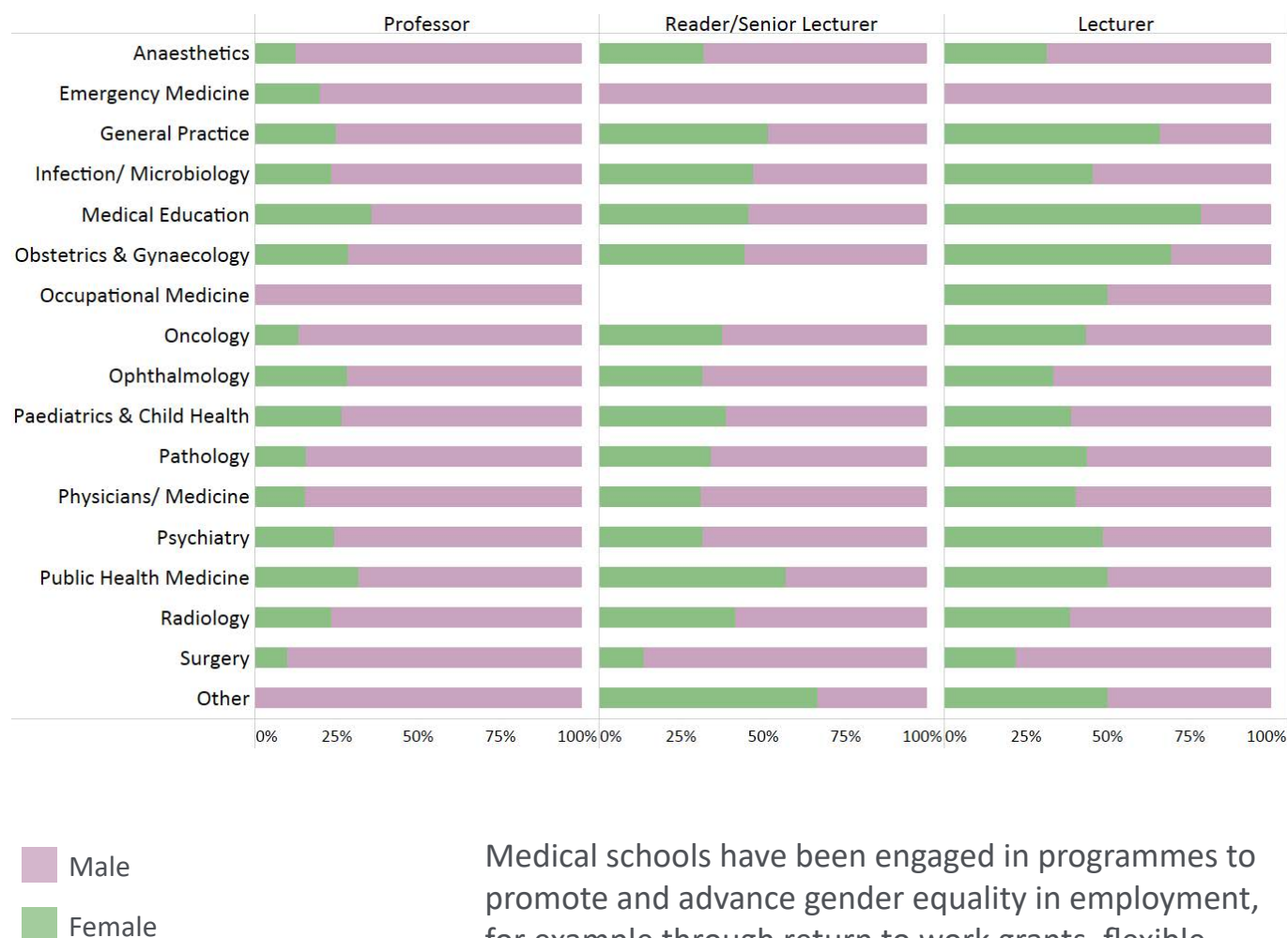
The smallest proportions of female clinical academics are found in Surgery (15%) and Emergency Medicine (13%), followed by Anaesthetics (24%) and Physicians/Medicine (25%). Surgery also has the lowest proportion of women overall on the specialist register (12%).²⁴ Since 2012, positive steps have been made to increase diversity, as the number of females in surgery training programmes has increased by 24%.²⁵

It is important to note the smaller numbers in some specialties when drawing conclusions from these proportions, as the smaller specialties such as Occupational Medicine and Emergency Medicine are more susceptible to a proportional change year on year.

Figure 16 shows further variation between gender breakdowns at each grade between specialties. Several outliers include Emergency Medicine and Occupation Medicine, where there are no women at all at certain levels; however, they also have small numbers of staff overall. The highest proportion of women are found at

Lecturer grade in Medical Education (79%), followed by Obstetrics and Gynaecology (69%) and then General Practice (66%).

Figure 16. Academic grade and gender by specialty in 2017 (posts)

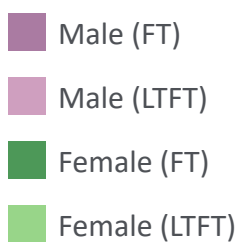


Medical schools have been engaged in programmes to promote and advance gender equality in employment, for example through return to work grants, flexible working practice, childcare support and others. The change in proportions may have also been impacted by the implementation of Athena SWAN awards, which recognise and promote commitment to advancing the careers of women in academia. These were introduced by the Equality Challenge Unit in 2005 and in 2011 NIHR linked its future funding of translational research infrastructure to Athena SWAN awards.

Working patterns

There has been an increase in the percentage of males opting to work Less than Full Time. Working patterns vary across specialties.

Figure 17 shows that the different genders have varied working patterns at each grade. Since the 2004 survey there is a 41% change in male clinical academics opting to work Less Than Full Time (LTFT), and a 104% change for female (LTFT). Of those at Lecturer grade, proportionally more women are working LTFT (17%) than men at this grade (5.6%), and this is also the case at Reader/ Senior Lecturer grade (15% of women work LTFT, compared to 12% of men). At Professor grade, there were 12% of men and 3.3% of women working LTFT.



Across the specialties, General Practice and Medical Education have more clinical academic staff working LTFT, which has remained unchanged between 2004 and 2010. Between 2010 to 2017, Oncology, Paediatrics and Surgery had higher proportions of clinical academics working FT.

Figure 17. Academic grade by gender and working pattern in 2017 (posts)

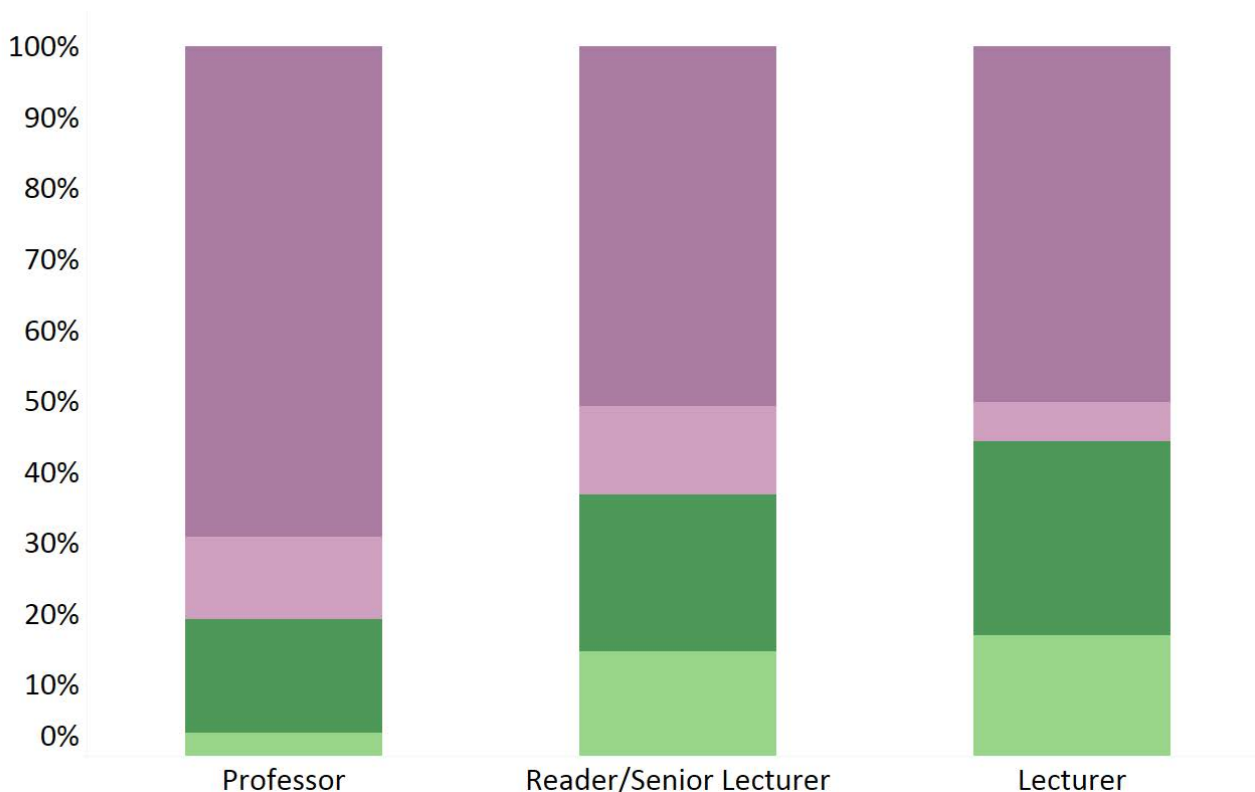


Figure 18. Change in working patterns by gender since 2004

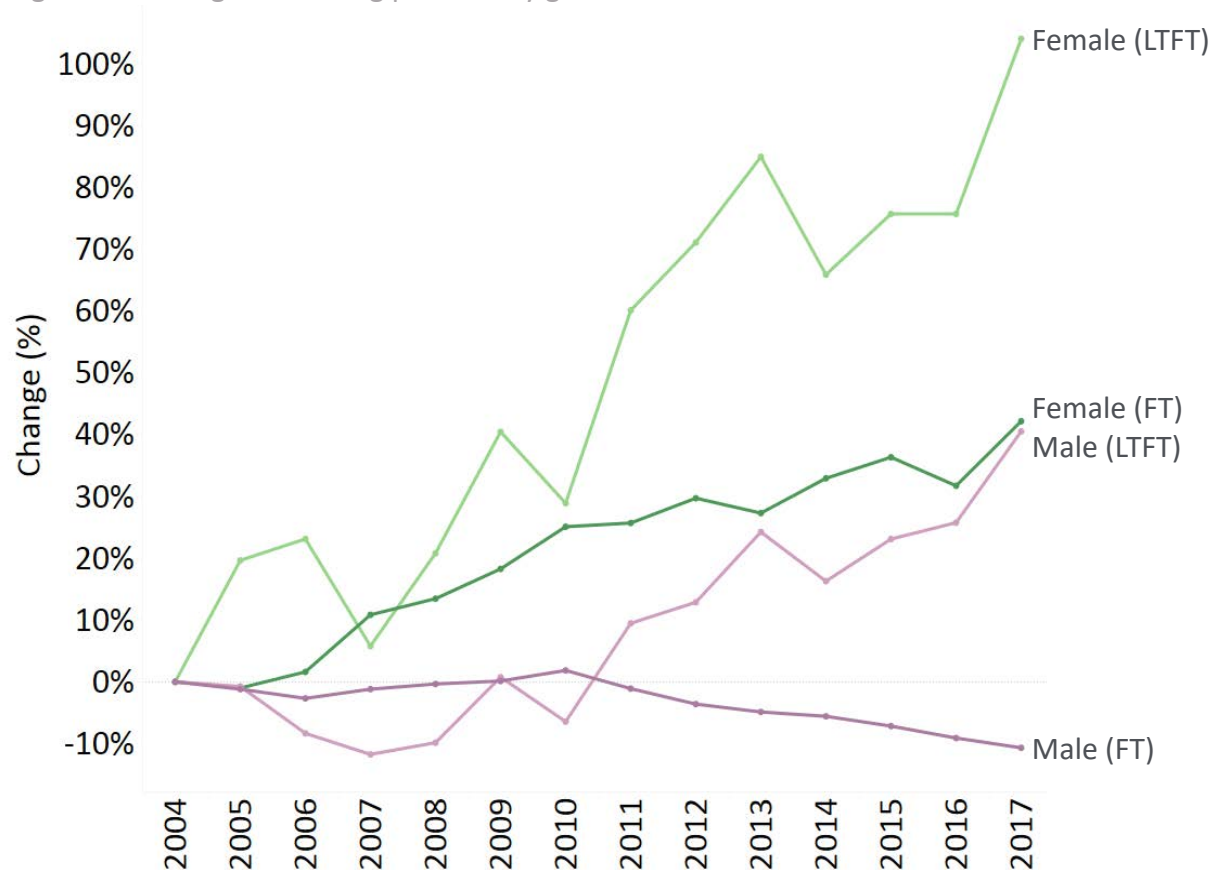
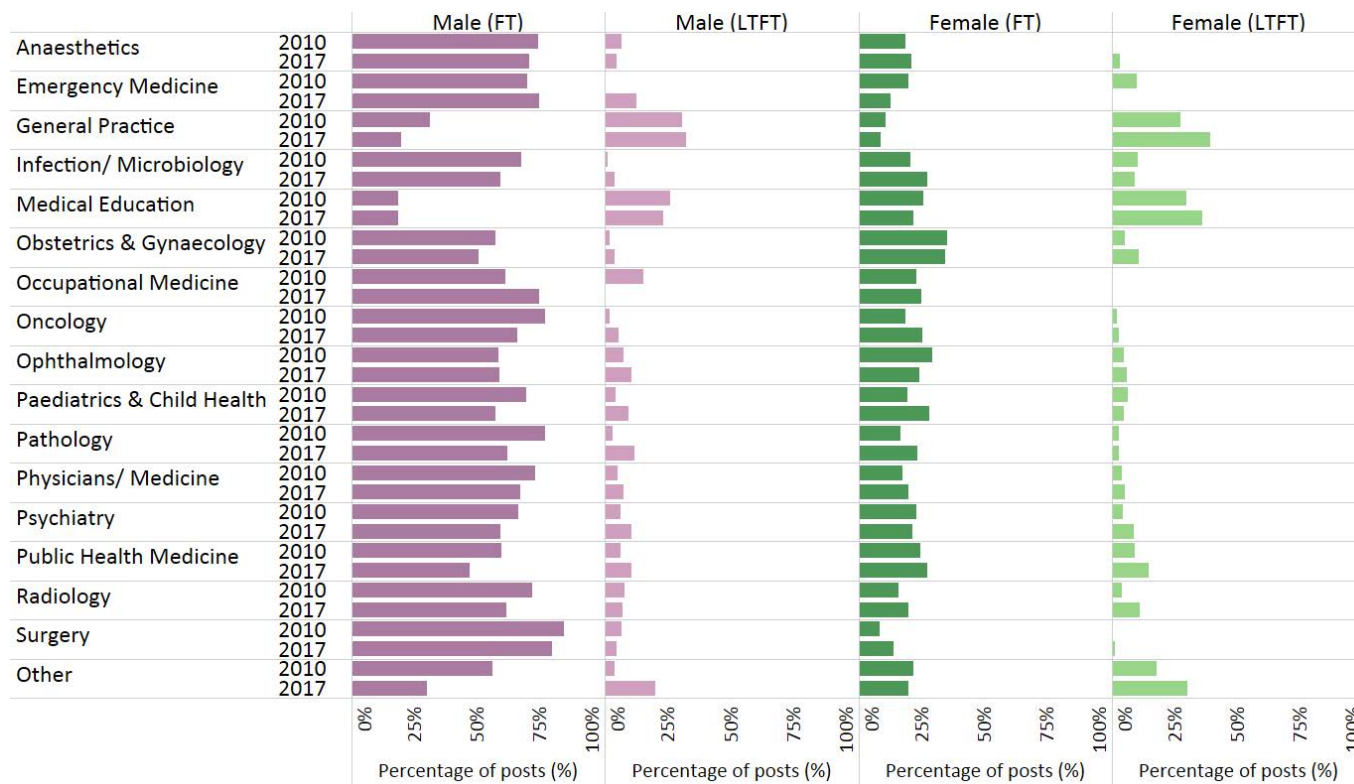


Figure 19. Specialty by gender and Full Time and working pattern



Ethnicity

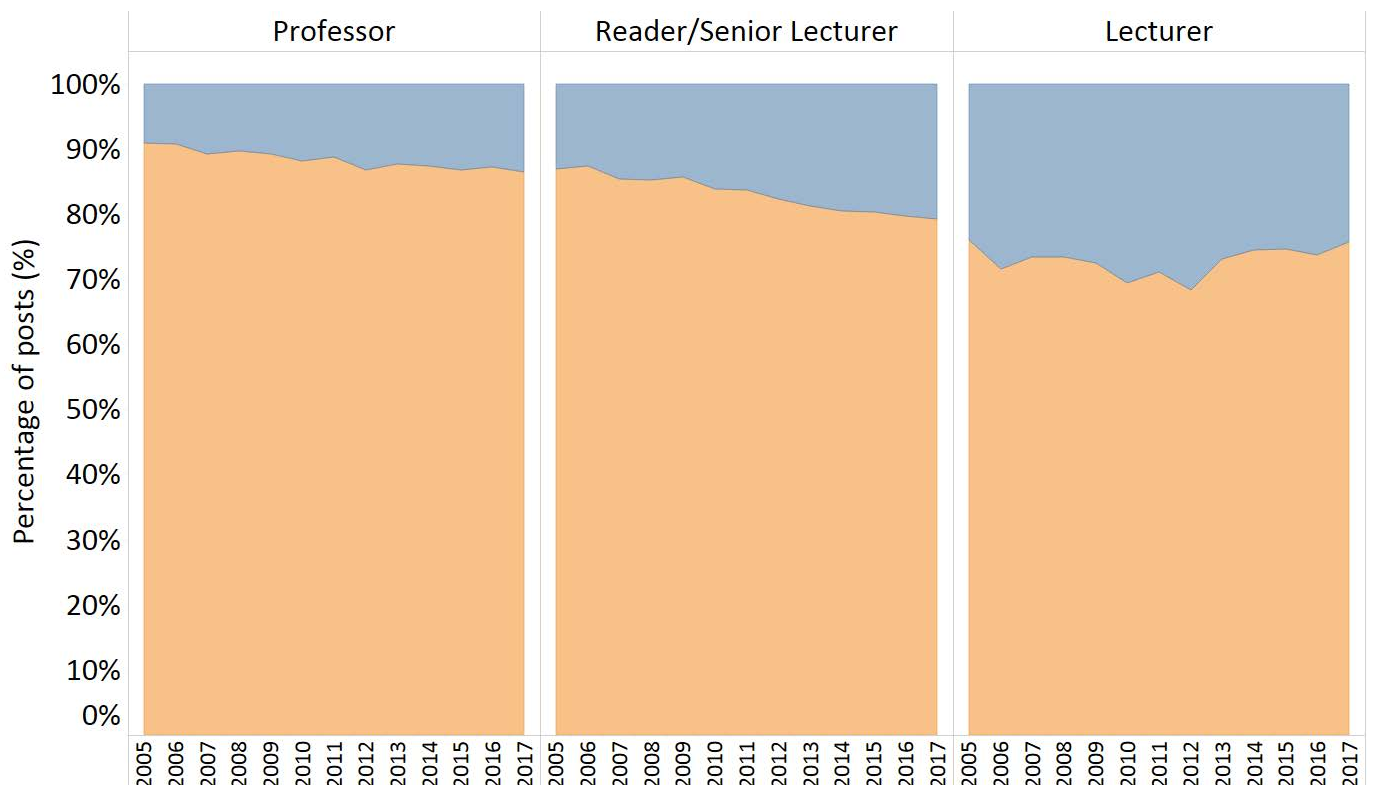
The clinical academic workforce's ethnic profile is not reflective of the wider population of doctors on the licensed register, where 54% of licensed doctors identify as White.²⁶ In comparison, 76% of clinical academics identify as White, with 17% of BME backgrounds and 6.9% not recorded. Since 2005 the clinical academic workforce has diversified from 87% identifying as White (2005), to 82% (2017), excluding those whose ethnicity is not recorded.

When looking at ethnic profile by academic grade, the data demonstrate that, as the level of seniority increases, the proportion of those who identify as White also increases, while the number of those who identify as BME decreases. This is unchanged since 2005.

Higher proportions of White clinical academics are found in Other (90%), Emergency Medicine (88%) and Pathology (85%), while higher numbers of BME clinical academics work within Surgery (24%), Obstetrics & Gynaecology (20%) and Ophthalmology (30%).



Figure 20. Ethnicity by academic grade(posts)



Nationality

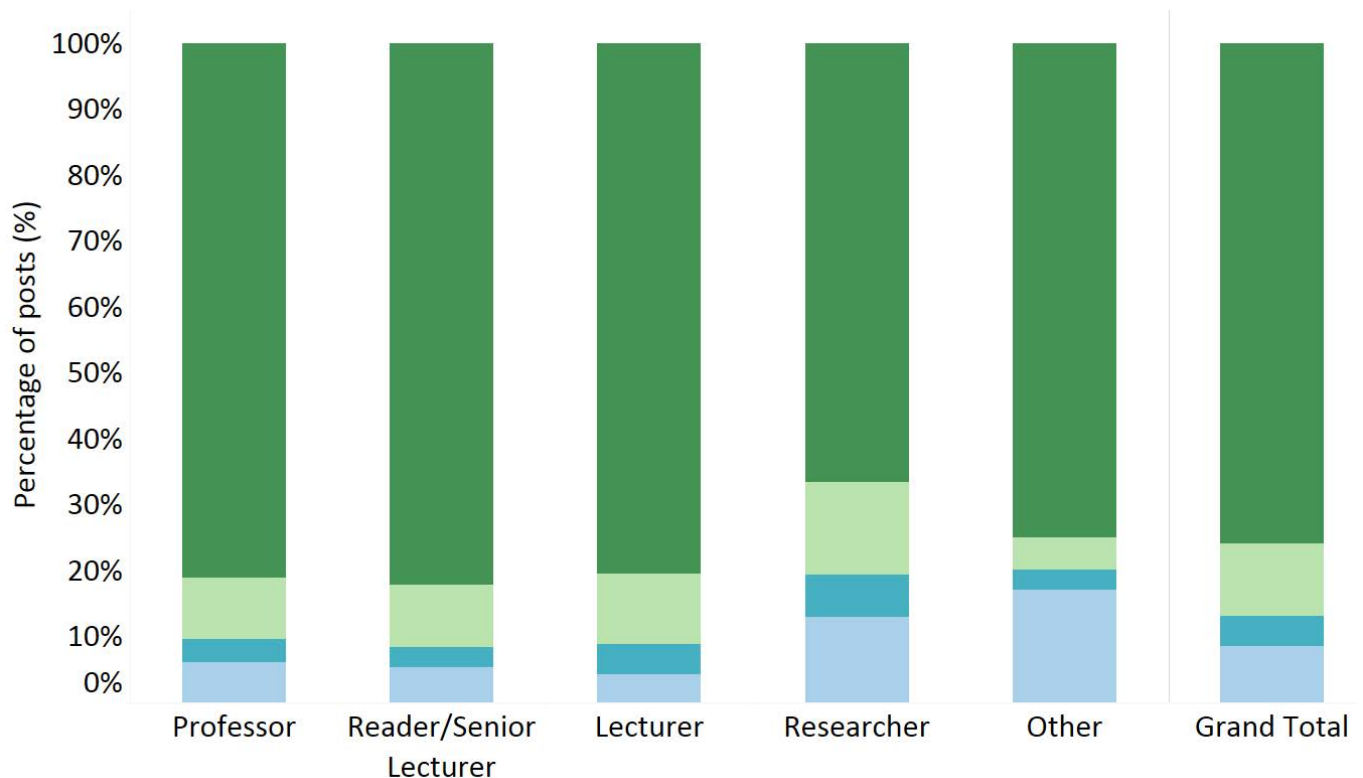
Looking specifically at nationality, 76% of clinical academics are from the UK, 11% from EEA and 4.6% from the rest of the world. The highest proportion of EEA nationals (14%) is at 'Researcher' level.

The survey data demonstrate that 21% of the clinical academic psychiatry workforce is from the EEA and the rest of the world, with 36% of lecturer grades. While 100% of clinical academics specialising in Emergency Medicine are from within the UK, 18% of those specialising in Obstetrics & Gynaecology are from the EEA and the rest of the world, 25% of whom are Lecturers.

When looking at the wider medical workforce, the GMC identified that the specialties with the highest reliance on non-UK graduate are Obstetrics & Gynaecology (55%), Ophthalmology (48%), Paediatrics (46%) while Psychiatry and Pathology draw 40% of their workforce from non-UK graduates.²⁷



Figure 21. Academic grade by Nationality in 2017 (posts)



7. Vacancies

Vacancies are on the rise, with reported issues in recruiting to a range of specialties.

Figure 22 illustrates the number of vacant clinical academic posts that universities were intending to retain on 31 July 2017, even if not actively recruiting to the post. It should be noted there are different policies across institutions about recording established posts and vacancies, which means the figures may not be entirely consistent. 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 that of its associated NHS Trust(s). The principles of the *Follett Review*²⁸ 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 25 medical schools for 2017 (and 23 on average for previous years). This may be because there are no vacancies in the other schools, or it may be because of institutional differences in reporting. Of the 25 reporting schools, two stated that they had no vacancies. Therefore the survey is only indicative of the vacancy levels. That said, the policies within each institution should not change dramatically over time, nor has there been much variation in which schools return data.

As shown by Figure 22, vacancies were listed in all specialties, except for Occupational Medicine. The most notable statistics were found in Oncology (8%), Medical Education (8%), Pathology (8.5%) and Emergency Medicine (15%), which comprise higher proportions of vacant posts. The data returned do not make clear which posts 'Other' refers to, with a vacancy rate of (69%).

Of the medical schools which returned data, some cited difficulties in recruitment due to arrangements with

NHS Trusts, Public Health England and the Department of Health in agreeing funding; others cited the shallow UK talent pool. One school discussed the difficulties of having a net vacancy level of below 15 clinical academic posts, due to the number of retirements and resignations, which impacted on recruitment to General Practice .

Vacancies within London remain low, while the North East and Yorkshire Humber have historically had higher numbers of vacancies, and this is increasing.

Figure 22. Vacant posts by specialty (FTE)

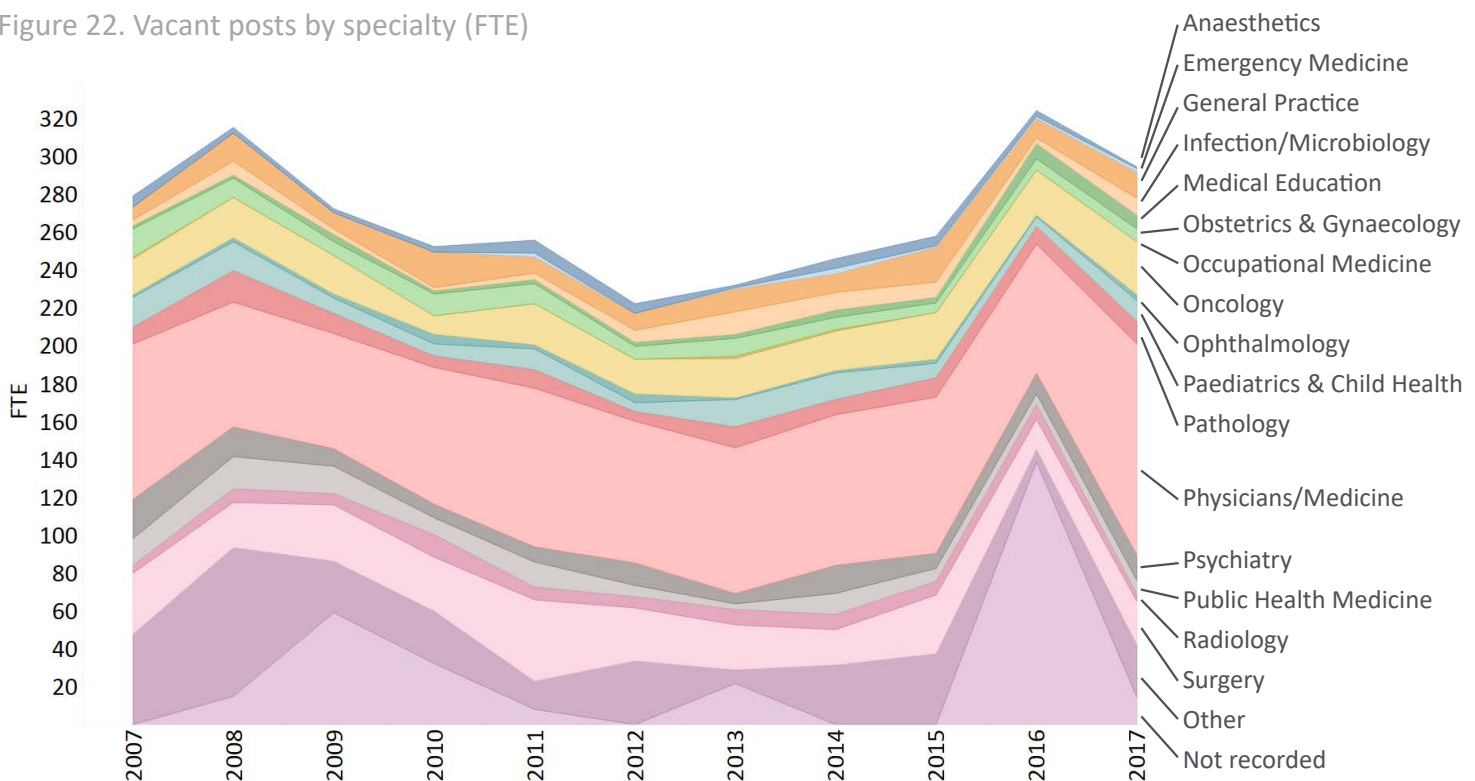
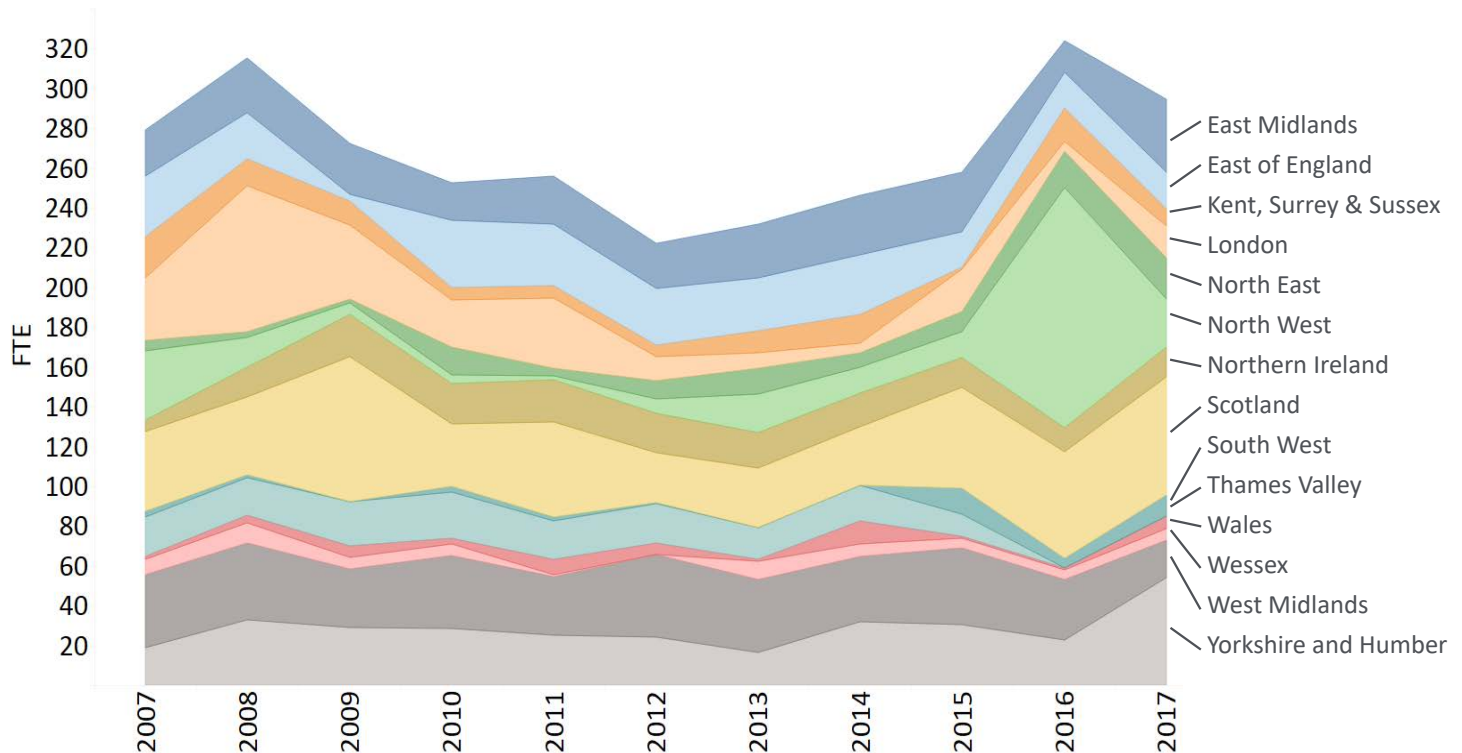


Figure 23. Vacant posts by region (FTE)



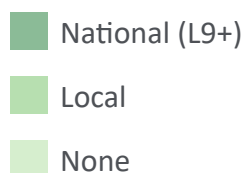
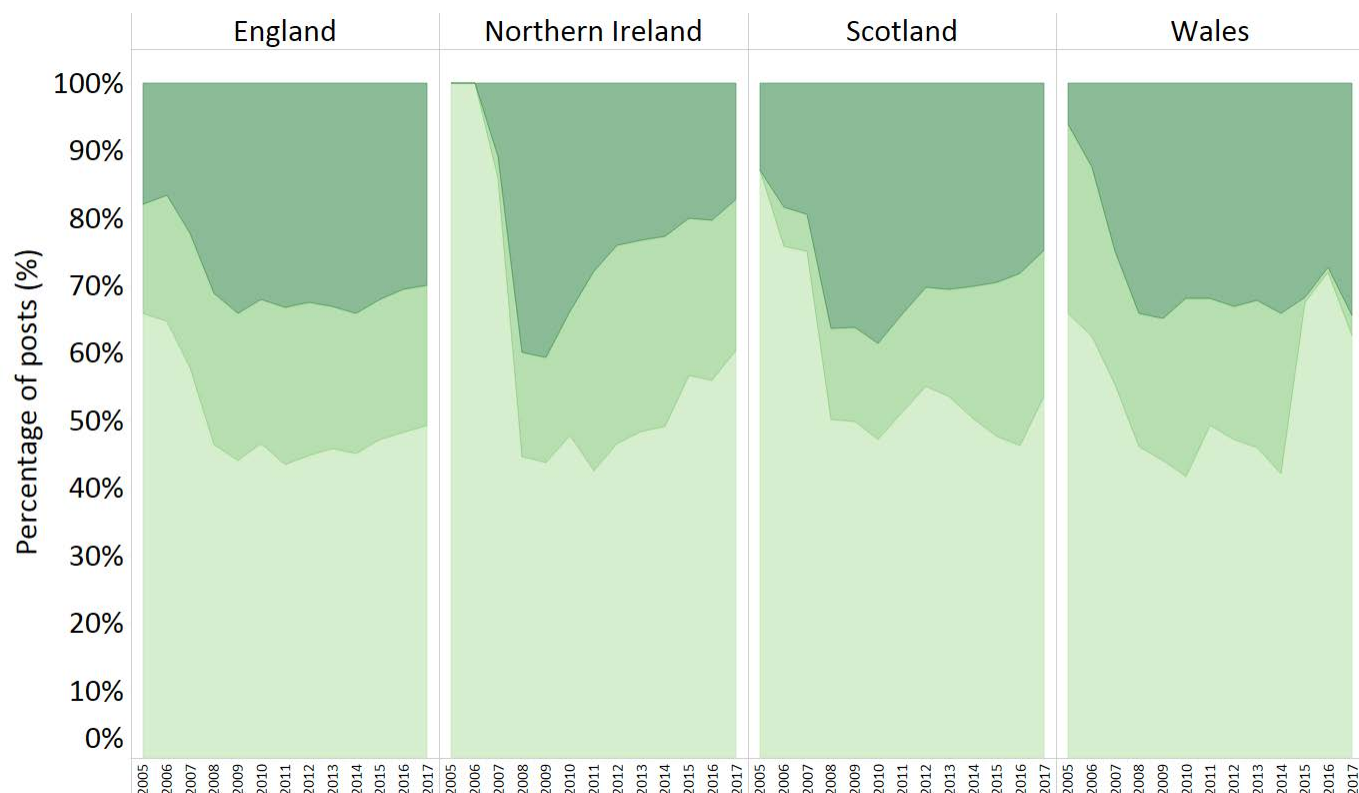
It should also be emphasised that seven medical schools reported that they had no difficulties in recruiting to vacancies in this year's return, and as mentioned above, some of the figures are positive for recruitment.

8. Clinical Excellence and Distinction Awards

National awards decline overall while local awards remain constant, but with variation by nation.

Clinical Excellence Awards (CEAs) in England, Wales and Northern Ireland, and Distinction awards in Scotland, are financial awards given to recognise exceptional and sustained contributions to the NHS by clinicians who go above and beyond contractual expectations. The awards are valid for five years. No new awards have been made in Scotland or Northern Ireland since 2010. In 2011, a cap was imposed on the number of new awards at 300 per year in England.

Figure 24. Clinical Excellence Awards held, 2005–2017 (posts)



Across the UK, a total of 1,688 (posts) clinical academic consultants hold a local or national clinical excellence award (61% of clinical academic consultants), 37% hold a national award, and 24% hold a local award.

Overall and national variation for CEAs

Overall there has been a 1.1% increase in the number of posts who hold national awards, and a -2.9% decrease in those who hold local awards since 2016.

The total number of local CEA awards or equivalent decreased in Scotland and England between in 2017 with Wales showing little recovery. In Northern Ireland, there has been an increase in those who do not hold an award. Specifically, between the period of 2010–2017 the total number of local CEAs fluctuated, presenting a -11% percentage change in national awards, and a -1% change in local awards since 2011.

From 2018 we might expect to see changes in the number of Local and National CEAs held, due to the

change implemented to the Clinical Excellence Award Scheme. In April 2018, NHS Employers announced that Trusts would run LCEAs until 31 March 2021, however there is a one to three year time limit to the awards. Existing LCEAs remain pensionable and consolidated, but will be subject to review in 2021.

From April 2021, there may be local variations to any LCEA scheme or new performance pay scheme. These LCEAs will be non-pensionable and non-consolidated, payable for a period of up to three years.

During the period of reform, consultants who hold existing NCEAs will retain their national awards, subject to the existing review process. However, from April 2018 consultants who hold an existing NCEA and submit an unsuccessful application or review, these awards can be reverted to an existing level of 8 or 7 award, or nothing.²⁹

9. Researchers and Other academic grades

Levels of researchers may be unable to fill gaps in the clinical academic workforce.

Researchers and Other academic staff in UK medical schools (hereafter Researchers) are reported separately as they underestimate the population levels, some of whom have a contract of employment with research councils and organisations rather than medical schools.

Specific caveats to the data reported in this survey include:

- 31 medical schools out of 35 returned data on clinical academics at researcher and other grades.
- Not all researchers or clinical tutors hold their substantive contract of employment with the university. 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.

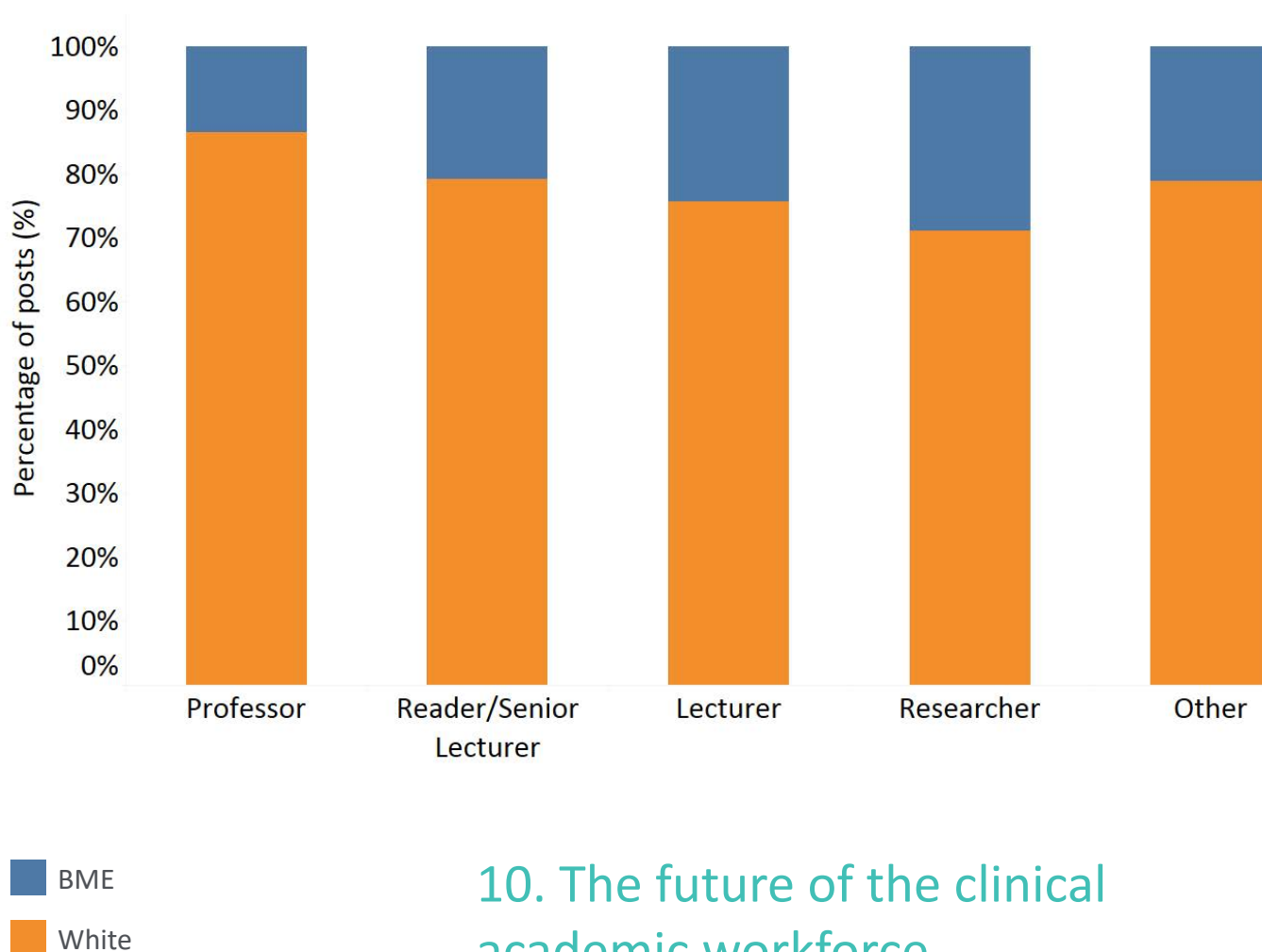
- The term 'Researchers' encompasses a range of fellowships, including pre- and post-doctoral level. These data were not consistently recorded and the data have been grouped to demonstrate the total number of staff in these roles.
- Clinical academics recorded as 'Other' academic grades are, for the most part, clinical tutors and clinical teaching fellows.

From the results of the 2017 survey, Researchers made up 36% of all clinical academic staff. The data highlight that there was a reduction in FTE of 'Researchers' of 34 FTE since 2016, and an increase in 'Other' of 15 FTE. These reductions can be seen within specialties such as Physicians/Medicine and Pathology. While the composition of 'Researchers' and 'Other' in most regions has decreased, Thames Valley and East of England have remained consistent or increased.

Researchers are funded by higher proportions of 'Other' funding, with higher proportions in Scotland (84%) and England (72%), while within Northern Ireland 33% are funded by NHS funding. In Wales 0% of 'Researcher' or 'Other' are funded by NHS funding.

In 2017 there were more men (53%) than women (47%) at Researcher grade, but a higher proportion of women working LTFT (11%) than men (5.6%). As shown by Figure 25, Researchers were of a younger age overall than those at Professor and Senior/Reader grade. Although there was also a higher proportion of Researchers aged <36 compared to Lecturers, there was also a larger proportion of staff at the top of the age scale compared to Lecturers, indicating a comparative squeeze in the middle age-range for Researcher grade staff. Figure 25 suggests a more diverse range of ethnic origin for those at Researcher grade than the other grades.

Figure 25. Ethnic profile by academic grade in 2017 (posts)



10. The future of the clinical academic workforce

The list below highlights key recommendations for further consideration emerging from this report, and links these to several recent projects in the clinical academic community.

1. ***Continue to improve the monitoring of levels of clinical academics, particularly in certain specialties and at researcher level to ensure gaps can be filled in the future pipeline.***

The Medical Research Council (MRC) has led on the development of a survey, in collaboration with the Medical Schools Council and a range of funders across the sector, to study the number of staff working as Researchers. This builds upon a 2009 survey undertaken by MRC on behalf of the Office for Strategic Coordination of Health Research. The survey makes many recommendations to improve the data available

on fellows, and the consistency in the approach adopted:

- Having an automatic data collection and reporting process, as a means for improving data collection. This will permit for a greater understanding of the trends in the UK clinical workforce to inform UK-wide planning.
- To support more informed decision making and ensure clinical academic research is viewed as an attractive career choice. To do this, MRC recommends that there should be formal research undertaken to better understand how aspiring clinical academics weigh up their future careers. Additionally, when and how key decision points are reached, and how influencing factors such as evidence and opinion are sought.
- Establishing a four-nation approach to the strategic planning for research careers to help to deliver the vision of the Life Sciences Industrial Strategy.

The aim is to provide a comprehensive map of current investments to grow and sustain the capacity for health services and public health research. This will underpin strategic planning across funders.

2. *Funders and employers should continue to develop clear clinical academic career pathways and funding, particularly in declining specialties, and to work together to ensure it is an attractive career.*

The National Institute for Health Research (NIHR) has been working in collaboration with other funders, the Medical Schools Council and other stakeholders to create new guidance for UK institutions and clinical trainees in receipt of nationally competitive funding for clinical academic research training. The resulting Principles and Obligations document is now being discussed by the funders, the Universities and Colleges Employers Association (UCEA) and NHS Employers among other relevant institutions, to look at the most

effective way to implement this across the UK.

3. *Barriers to recruitment to vacant posts in clinical academia should be investigated further, whether developments surrounding Brexit will compound this and how to mitigate against the effects.*

The Medical Schools Council intends to continue to develop this report of clinical academic staffing levels in future years to ensure it looks at all key aspects of the clinical academic workforce, including monitoring the impact of Brexit.

4. *Continued efforts are needed by employers, funders and related organisations to strive for parity between genders and other minorities in the clinical academic staff workforce. This should be a clear aim as part of the overall higher education and healthcare sectors work towards gender parity and inclusivity of all forms of diversity.*

In 2015, the Medical Schools Council formed an Equality and Diversity Advisory Group with the Dental and Veterinary Schools Councils to look at diversity and inclusivity processes of these organisations. It aimed to consider how the organisations could drive forward and ensure equality and inclusivity at the most senior staff levels in schools, the Dean, Head, or equivalent, as leading figures in clinical academia. The group has been working with the Equality Challenge Unit to develop a kite-mark award for academic membership organisations which demonstrate good practice in equality, diversity and inclusivity. The Medical Schools Council intends to carry out an application for this. This will help MSC to review its practices and highlight any potential gaps where the organisation could be doing more to promote equality and inclusivity in its work. It is hoped that this process will also serve as a basis for other membership organisations or charities to go through a similar review process.

References

1. NHS (2017) '2017 NHS Staff Survey Results' [Online] Available from: <http://www.nhsstaffsurveyresults.com/key-findings-by-occupational-group/> (Accessed:19/06/2018)
2. Department of Health and Social Care (2017) 1,500 extra medical undergraduate places confirmed [Online] Available from: <https://www.gov.uk/government/news/1500-extra-medical-undergraduate-places-confirmed> (Accessed 26/04/2018)
3. General Medical Council (2017) *The state of medical education and practice in the UK* [Online] Available from: <https://www.gmc-uk.org/static/documents/content/SoMEP-2017-final-full.pdf> (Accessed 26/04/2018)
4. Medical Research Council (2017) *2017 UK-Wide Survey of Clinical and Health Research Fellowship* [Online] Available from: <https://www.mrc.ac.uk/publications/browse/clinical-and-health-research-fellowships-survey-2017/> (Accessed: 03/04/2018)
5. Board for Academic Medicine in Scotland and NHS England for Scotland (2009) *Scottish Clinical Research Excellence Development Scheme: A Guide to the Scheme* [Online] Available from: https://www.gla.ac.uk/media/media_113042_en.pdf (Accessed: 09/0/2018)
6. Further details of the distribution of medical students can be found in the Medical Dental Student Survey data by the Higher Education Funding Council for England (2017), available at: <http://www.hefce.ac.uk/lt/Healthcare/mds/>
7. The axes in Figure 3 are not uniform by nation: The FTE differences between nations are considerable and therefore a uniform scale would make it difficult to compare nations. Fluctuation in numbers may therefore be more visible in countries with lower numbers
8. NHS England (2018) 'The physician associate will see you now – new role to assist patients in primary care' [online] available from: <https://www.england.nhs.uk/gp/case-studies/the-physician-associate-will-see-you-now-new-role-to-assist-patients-in-primary-care/> (Accessed: 18/04/2018)
9. General Medical Council (2017), *The state of medical education and practice in the UK 2017*
10. Ibid

11. Ibid
12. The Mental Health Taskforce (2016) *The Five year Forward View For Mental Health* [Online] Available from: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf> (Accessed: 29/03/2018)
13. Royal College of Paediatrics and Child Health (2018) *Turning the tide: five years on. 2018* [Online] Available from: https://www.rcpch.ac.uk/system/files/protected/page/232437_RCPCH%20Turning%20the%20Tide%20Booklet%20FINAL%20ONLINE.pdf (Accessed 03/04/2018)
14. Royal College of Paediatrics and Child Health (2018) *Securing a new generation of child health research leaders* [Online] Available from: <https://www.rcpch.ac.uk/system/files/protected/news/RCPCH%20Children%E2%80%99s%20Research%20Fellowship%20Fund.pdf> (Accessed: 03/04/2108)
15. Royal College of Paediatrics and Child Health (2018) 'RCPCH response to Facing the facts, shaping the future shaping the future: A draft health and care workforce strategy for England to 2027' [Online] Available from: https://www.rcpch.ac.uk/sites/default/files/2018-05/rcpch_response_to_facing_the_facts_shaping_the_future_-_draft_health_and_care_workforce_strategy_for_england_to_2027_march_2018.pdf (Accessed: 03/04/2018)
16. The limitations of this data should be noted here; the GP practitioner data is an estimation only. Many in General Practice hold separate contracts for their NHS and academic work than in most other specialties (the data are not reported here). This means that the reality of contributions of GPs to clinical academic work may be higher than the FTE represented here. The FTE data are unavailable for Wales and Northern Ireland for 2016. Therefore a multiplier of 0.82 was used with known headcounts, which was the ratio of PT:FT for the known workforce in England and Scotland in 2016.
17. BMJ (2017) 'Consultant numbers have doubled over the past 20 years' [Online] Available from: <https://www.bmj.com/bmj/section-pdf/954278?path=/bmj/359/8128/Careers.full.pdf> (Accessed: 10/04/2018)
18. Royal College of General Practitioners (2018) Workforce [Online] Available from: <http://www.rcgp.org.uk/policy/workforce.aspx> (Accessed: 03/04/2018)
19. General Medical Council (2017), *The state of medical education and practice in the UK 2017*
20. General Medical Council (2017), *The state of medical education and practice in the UK 2017*

21. The Academic of Medical Sciences (2013) Representation of woman within the Academy's Fellowship [Online] Available from: <https://acmedsci.ac.uk/file-download/35277-136118550861.pdf> (Accessed: 06/04/2018)
22. Medical Research Council (2017) *2017 UK-Wide Survey of Clinical Health Research Fellowships* [Online] Available from: <https://mrc.ukri.org/publications/browse/clinical-and-health-research-fellowships-survey-2017/> (Accessed: 06/04/2017)
23. General Medical Council (2017), *The state of medical education and practice in the UK 2017*
24. Ibid
25. Ibid
26. Ibid
27. Ibid
28. Follett, B (2001) *A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties*
29. NHS Employers (2018) Local Clinical Excellence Award arrangements from 1 April 2018 [Online] Available from: <http://www.nhsemployers.org/your-workforce/pay-and-reward/medical-staff/consultants-and-dental-consultants/local-clinical-excellence-awards-arrangements-from-1-april-2018> (Accessed: 2018)