

National School of Healthcare Science Independent Review – Written Evidence Submission

1. Name of the organisation submitting the written evidence: Association for Laboratory Medicine

2. Name of the person submitting evidence on behalf of the organisation: Katie Hadfield

3. Role of the person submitting evidence on behalf of the organisation: Director of Education Training and Workforce

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5. Please provide background information on your organisation and the expertise of your organisation:

The Association for Laboratory Medicine (LabMed) is one of the world's leading professional membership organisations dedicated to the practice and promotion of clinical science and the major body for clinical biochemistry, immunology and microbiology in the United Kingdom.

What we do:

- We foster the highest standards in laboratory medicine and patient care.
- We use data, science and technology to support human health.
- We provide trade union support for members.
- We promote laboratory medicine to the wider community.
- We provide training, professional leadership, examples of best practice and guidance to the profession, governments, the public and media.
- We support scientists, clinicians and other health professionals through scientific and educational initiatives, bursaries and awards.

Prior to the introduction of the Scientist Training Programme and the founding of the National School of Healthcare Sciences, the Association for Laboratory Medicine (previously the Association for Clinical Biochemistry) had responsibility for overseeing the training of Clinical Scientists in its affiliated disciplines and, through the Association of Clinical Scientists, for assessing trainees as a preliminary to registration as a Clinical Scientist with the Health and Care Professions Council (HCPC). A role it maintains for trainees applying through equivalence routes.

Members of the association, particularly those affiliated with the Education, Training and Workforce Committee, continue to be highly involved in both the STP and HSST programmes as short listers for the STP recruitment process, educational supervisors, regional tutors providing support to trainees within their regions, trainee representative, NSHCS lead station writers, exit assessment

assessors and, in the case of the HSST, examiners for the Royal College of Pathologists. LabMed also provides additional education and training opportunities for members within the STP and HSST programmes (as well as our members not on formal training programmes) to help ensure that trainees enter the workforce with all of the skills required to excel as a post-registration clinical scientist and are successful in completion of the FRCPath exams.

Responses to the following questions are optional:

6. Your vision for how the HCS workforce may need to adapt and change to meet the requirements of the NHS three strategic shifts.

Given the central importance of diagnostics in all three of the NHS strategic shifts these changes to healthcare delivery are likely to have a significant impact on the current (and future) HCS workforce.

The movement of care from hospitals to communities is likely to mean a significant expansion in point of care (POC) testing activities across the disciplines represented by LabMed. Currently the expertise for the introduction, management and governance of these services sits within the HCS workforce, with teams often sitting within the clinical biochemistry, or blood sciences, discipline due to historic circumstances related to the first tests that were introduced into patient settings at the point of care. However increasingly the POC tests available and the technologies that they employ are multidisciplinary with many innovations seen during/post-covid in microbiology/infectious disease testing. Many POC teams are under-resourced and under-staffed making it difficult for HCS within those teams to expand services or to respond proactively to new technologies. It is not sustainable for POC testing to be considered an offshoot of clinical biochemistry, or any one individual HCS discipline, instead it must be recognised as a discipline within its own right and resourced/staff accordingly. For this to be most effective these teams will need to be multidisciplinary, incorporating HCS expertise from across the specialities.

Traditionally uptake of new technologies has been slow within NHS environments with several barriers to proactive introduction of digital/technological innovation and a general lack of digital readiness. The HCS workforce, at all levels, needs to be upskilled with regards to data interpretation, digital, coding and AI/machine learning skills to promote effective technological/digital transformation. There should be provision for some HCS across all disciplines to become experts in this field and to expand their skills to lead this type of transformation, however the requirement for this skillset is now so pervasive across the health service that all HCS should have a baseline level of practical knowledge appropriate to their role/discipline. Increased sharing of knowledge, expertise and previous work between HCS across different disciplines and between trusts, as well as standardisation of the process to implement new technologies, would also reduce the duplication of work that often delays implementing of a new technology into routine clinical use. Stronger links with stakeholders researching and implementing new testing strategies/technologies such as academic institutions, industry partners, guideline committees, NHS England and integrated care

boards would also improve the pipeline for introduction of new technologies and reduce health inequalities related to the ease of introduction in different areas.

7. Your vision for how the NSHCS in partnership with stakeholders can provide high quality education and training to meet future NHS service needs and the NHS three strategic shifts.

- Recognition of POC testing, including governance and leadership of services, as a key component of the STP and HSST curriculum. Currently, due to the small size of many POC teams, most HCS involved in POC services gain experience within their roles post-registration and may even become involved in leadership of these services without prior experience of the day-to-day running of these teams. Without the recognition of POC as it's own discipline within pathology services, there is a lack of formal training available for HCS working within these services and therefore a potential skill gap.
- Increased availability of digital/data skills training for HCS across all disciplines. At the inception of the STP programme it was agreed that for life sciences trainees the impact of genomics on their careers would be so significant that there should be genomic training provided irrespective of final discipline. A similar approach should be considered for digital/data skills. These skills are currently lacking across the HCS workforce and so the availability of modules/training either provided or endorsed by the NSHCS that could be access by HCS outside of formal training programmes would be beneficial.
- Stronger links with professional bodies, and members of those professional bodies responsible for delivering training, as experts in the education and training needs of the professions they represent to ensure that education and training provided by the NSHCS adapts and stays relevant to the changing needs of each profession. Trainees leaving the programmes must have the skills required to step into the roles that each discipline determines to be required in the changing NHS landscape.
- Recognition of likely expanded roles for clinical scientists to fill gaps in the medical workforce eg. non-medical prescribing. Education and training provided to equip those on the STP and HSST with the foundational skills required to take on these expanded roles.

8. What changes (if any) to the current ways of working of the NSHCS you would recommend to achieve your vision.

- A stronger voice for professional bodies and those in the professions delivering training or employing those exiting the STP and HSST to highlight when programme content or assessments need updating.

- More flexibility in the provision of the programme content and mode of delivery to ensure that, particularly for in-service trainees whose future professional roles are already known, the content of the training provided is appropriate for the role that they will ultimately be undertaking and takes account of any other personal or professional commitments.
- Consideration of use of alternative models for provision of programme placements eg. virtual placements. This may benefit smaller specialities, those training in more remote areas and those with other work/personal commitments as well as reducing the cost-burden to trainees of attending lengthy placements away from their employing trust. It would also help to ensure consistency of training for key specialist modules.
- Consideration of the provision of educational modules that could be accessed by HCS outside of formal training programmes and/or which could be added to a trainees' academic curriculum to provide a level of specialism in a particular topic eg. one that is desirable to the profession as a whole or that trainees' training centre. This may be of particular interest to those on the HSST programme.
- Formal recognition of the equivalence process as a route for registration as an HCS. Provision of resources that could be accessed by HCS who are seeking to demonstrate equivalence to the STP or HSST programmes eg. educational modules which could be used to 'top up' knowledge or skills in a particular areas (see above). Stronger relationships between the NSHCS and bodies who are providing accreditation via the equivalence route eg. ACS, IBMS.

9. How the NSHCS should approach the education and training of small, specialist HCS specialities to provide a sustainable workforce.

The NSHCS should collaborate more closely with those from and representing small, specialist HCS specialities to ensure that the programmes provided meet the needs of the HCS workforce in those disciplines. A one-size-fits-all approach to education and training designed to meet the needs of larger specialties with more established training structures may not be appropriate for specialities with small numbers of trainees. A level of flexibility is required to ensure that those exiting training programmes for these smaller specialities can meet the specific needs of the workforce as it stands at the time. This will require increased trust in those providing training that the decisions made on behalf of a trainee/profession are in the best interests of that speciality.

It is critical that those providing/overseeing training are experts in the speciality in question. Trainees should not be recruited into posts at NHS trusts that do not have consultant clinical scientists in the relevant specialism to perform the training. If it is unclear whether a training centre has the appropriate expertise to host a trainee eg. they haven't trained a trainee in this speciality before or

they are new to the training process all together, expert opinion should be sought from eg. professional bodies to determine whether the proposed training can be safely provided.

There is an expectation from the NSHCS that current members of the profession from each HCS speciality will manage/take responsibility for many aspects of the training programmes eg. advising on curriculum development, assisting trainees who are struggling, writing question banks and assessing exit assessments. This is a significant, unpaid, administrative burden for professional members from all specialities. However, it is particularly burdensome for those in small specialities where the work is spread between only a small number of individuals many of whom already have other additional roles eg. within professional bodies or as training officers. The NSHCS should acknowledge the large amount of work expected from these individuals and consider ways to either reduce the burden or to formally recognise it eg. financial compensation.

Many of the smaller laboratory specialities find themselves with large numbers of medical consultant vacancies and increasing issues with recruitment of medical staff. It has been suggested that consultant clinical scientists could fill these roles, however the route to achieve this is not well established. Increased uptake of the HSST programme in these specialities is one way to action this strategy. However, in the current financial climate it can be difficult to persuade individual trusts to finance HSST posts particularly if those trusts haven't seen the benefit of a consultant clinical scientist in the past. We think it would be of benefit for the NSHCS to consider central funding of HSST posts in high-risk areas using the same model as the STP to help safeguard the future of the HCS workforce in these specialities. Attrition rates from the HSST programme are also currently high meaning that those trusts who do fund these posts often do not see the benefit of them. The NSHCS should review the reasons for the high attrition rates from the HSST programmes with the aim of addressing these to improve completion rates.

10. How the NSHCS should work with Higher and Further Education partners including the geographical availability of academic provision across the UK.

We note that, while the single provider HEI model for many of the STP/HSST programmes is likely to be required to make these programmes financially viable, this model introduces significant financial costs to trainees during the years that they are accessing these programmes due to the travel and accommodation costs involved. The NSHCS should work with their higher and further education partners to determine whether more content could be provided virtually and whether more efficiencies could be introduced with regards to planning of in person teaching to ensure that trainees aren't travelling frequently for short amounts of time.

We also note that the STP study budgets have remained static at £2000 for many years with no increase to even accommodate inflation. Increasingly these budgets are unable to cover even basic accommodation/travel costs for trainees

attending the HEI providers and completing their mandated rotations, leaving trainees with no budget remaining to attend additional educational meetings/conferences or specialist rotations that may be of value to their specific roles in their trusts/specialities. This is at the detriment of their education and personal development. It also introduces inequalities between trainees in different regions/trusts eg. advantaging those with healthy trust budgets for education/CPD or those who are local to the HEI providers and do not need to travel to attend their teaching. We ask that the NSHCS reviews these study budgets as a priority to address this increasing inequality in the training programmes.

11. How the NSHCS should work with the devolved administrations of the UK and what changes (if any) are needed for the future.

The NSHCS should work more closely with the devolved administrations to ensure that the training programmes meet the needs of their HCS workforce. This includes devolved administrations having adequate control of the recruitment and training processes to be proactively responsive to regional changes to strategy or workforce requirements. As with the smaller specialities, a one-size-fits-all approach based on the strategy identified for England is unlikely to be successful in these regions.

It is noted that Wales and Scotland have withdrawn from the national recruitment process for some of the STP programmes due to concerns that this process disadvantages the trusts in these devolved administrations. Concerns include: difficulty recruiting to STP posts in these regions, particularly those in more remote areas, from a pool of national candidates with no geographical ties to these regions and lack of retention of candidates post-training who are assigned to these regions from other parts of the country. The NSHCS should work with the devolved administrations to ascertain whether re-engagement with the national process could be achieved.

12. Please give up to a maximum of 5 suggestions that your organisation think would improve the NSHCS and/or the education and training programmes they provide for the HCS workforce.

1. Review of the direct entry STP recruitment process to include review of:
 - a. Application questions which have remained the same for many years and which must now be anticipated and planned for by applicants.
 - b. The scoring process for applications which again has remained the same for many years and where the scope for separating candidates of different calibres is limited. The relatively high weighting given for grammar and the candidate's physical ability to do their jobs (which isn't relevant for many of the specialties) within the scoring also risks introducing bias into the scoring process which would disadvantage those with disabilities or those with English as a second language.



2. Increase scrutiny of centres applying for training status, particularly if they haven't taken a trainee before and/or do not have Consultant HCS expertise in the speciality they are applying for.
3. Reduced focus on lengthy written work as evidence of competence, more emphasis on demonstrating true competence in the practical aspects of the role eg. duty biochemist experience, audits, EQA, IQC, method verification/validation. Greater flexibility for individual training centres to fulfil the competencies in a way that is meaningful for their trainee and training environment.
4. Consideration of honorary contracts and financial compensation for those working on behalf of the NSHCS eg. lead assessors/lead station writers and even training officers to recognise the significant contribution of these members and legitimise these roles to employers as requiring significant time/resource input from those undertaking them.
5. Review of the STP study budgets.

13. Is there anything else you would like to tell us about the role of the NSHCS, the education and training needs of the current and/or future HCS workforce, workforce planning and alignment to NHS workforce requirements? Please share your comments below.

It is noted that attrition rates for the HSST among all the specialities represented by LabMed are high. This is of concern to the profession and needs reviewing urgently by the NSHCS as it suggests that the programme, or the way that it is delivered, is not fit for purpose.