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21 December 2022

The Baroness Brown of Cambridge DBE FREng FRS

Chair, Lords Science and Technology Select Committee
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Dear Lady Brown of Cambridge,

I would like to extend my thanks to the Committee for your recent invite to provide oral evidence to your inquiry into Clinical academics in the NHS. I, and many others in the clinical academic community, have been encouraged to see the issues affecting the future of clinical academia given such prominence by the Committee, and I am grateful for the attention that has been given to these issues during oral evidence sessions. I further welcome the Committee's focus on solutions and I now write to you in my capacity as Chair of the Clinical Academic Training Forum (CATF) to highlight some priority themes and potential solutions for your consideration in the next stages of your inquiry.

CATF was established in 2018 to bring together *all* stakeholders with expertise on the training of clinical academics to provide strategic coordination of clinical academic training pathways across the UK. The membership of CATF includes public and charitable funders, representatives from the four nations and trainees. The stakeholders represented on CATF are highly involved in clinical academic training and understand first-hand the challenges that the Committee has been presented with in recent evidence sessions. A number of the witnesses you have heard from also sit on CATF. As Chair, I would like to take this opportunity to highlight that CATF has an important role to play in addressing many of the issues which you have heard about during the course of evidence.

Following a discussion with CATF on Thursday 8 December 2022, I write to you as CATF Chair to highlight a few critical areas which I consider to be integral to the sustainable future of clinical academia in the NHS.

Opportunities, incentives and rewards for pursuing clinical academic careers

Opportunity: PhD and post-doctoral opportunities

In clinical academic careers, the mid-career point (encompassing post-doctoral research funding and employment opportunities) is a critical stage in which talented people have the opportunity to fully establish their research careers. However, at present too many are lost due to a lack of opportunities post-PhD.

The UK is fortunate to have a wide range of opportunities for PhD-level training for clinical academics, including those provided by public funders, medical research charities

and local awards. However, this is not matched by similar opportunities for postdoctoral training.

This issue is felt acutely across doctors, dentists and nurses, midwives and allied health professionals (NMAHPS), and is disproportionately affecting people with underrepresented protected characteristics (supported by evidence provided to the Committee throughout this inquiry). There are also differences in the number of clinical lectureship positions available across the four nations of the UK, due to differing schemes between NIHR, Health and Care Research Wales, NHS Education for Scotland and Health and Social Care Research and Development in Northern Ireland.

I would strongly support the Committee's consideration of recommendations targeted at enhancing the post-doctoral funding available to talented clinical academics in all disciplines. I would also encourage the Committee to consider the need for coordination across public, charitable and industry sectors to ensure the appropriate balance of pre- and post-doctoral support available to clinical academics. Where possible, I would invite the Committee to consider interventions which can boost the diversity of the clinical academic workforce, particularly targeted at addressing gender imbalance and other underrepresented protected characteristics.

I would also like to take this opportunity to highlight the critical role that higher education institution (HEI) employers have in improving the 'pull-through' of clinical academics at a post-doctoral level. Clinical academics often hold joint appointments between the NHS and HEIs, and both partners have an important role in supporting their career development. As the next iteration of the Research Excellence Framework is developed, there should be opportunities to ensure that this incentivises and rewards HEIs for the protection and development of clinical academic careers in HEIs.

Finally, I would highlight that collaborating with industry will be critical to ensuring improved opportunities for post-doctoral clinical academics. Collaboration and cross-sectoral working will also be essential for maximising innovation and translation of new biomedical and technological approaches to healthcare. As I mentioned during my oral evidence, the Academy of Medical Sciences is currently developing a *Clinical Innovators* scheme, which we hope will help to increase opportunities for these collaborations at this critical point in career development.

Incentives and reward: Pensions and pay equity

The Committee has heard throughout the evidence sessions that clinical academic trainees often experience a pay differential compared to their non-academic counterparts, particularly due to an extension of training to incorporate academic education and, in some cases, due to pension and tax implications. These pay disparities risk making clinical academic careers less accessible or appealing for those with less financial security or those with dependents.

Funders and employers commit to supporting continuous pay and employment benefits for clinical academic medics, dentists and NMAHPS.^{1,2} However, there are concerns regarding access of clinical academics to local clinical excellence awards and regarding a loss of employment benefits, particularly for NMAHPS who are less likely to hold joint appointments between NHS and HEIs.

In addition to the pay disparities that affect clinical academics specifically, they are also subject to issues affecting the wider NHS workforce. In a report published in July 2022, the Health & Social Care Select Committee (Commons) noted with concern that some

senior doctors are facing punitive pension implications for continuing to work within the NHS.³ This is particularly concerning as the age profile of the clinical academic workforce is shifting upwards; we have seen an increase in the proportion of the workforce aged 56 and older since 2011 coupled with a decrease of those aged 36-55. Clinical academics aged 56 and older now make up 35% of the clinical academic workforce. Whilst it is promising to see senior clinical academics remaining in work, this may result in a potentially substantial loss of clinical academics from the profession in the coming years.

Culture: NHS-academia integration

Embedding a strong research foundation in NHS culture and practice is critical to patient and public health, and the benefits of research in the NHS have been widely evidenced throughout the Committee's inquiry. Embedding research in this way is important for maintaining and developing clinical academic careers, facilitating the engagement of the wider healthcare workforce in research (research-active clinicians) and, most importantly of all, delivering patient benefit.

A research-engaged healthcare workforce is vital to supporting the delivery of clinical research in the NHS. It is therefore critical that healthcare professionals have sufficient time and opportunities to engage in research, particularly through effectively protecting research time for research-active clinicians. This is particularly important in primary care and population health, where the proportion of clinical academics within these workforces is chronically low (persistently below 1% in general practice).

I would like to take this opportunity to highlight the significant opportunities presented by the Health and Care Act 2022, which embeds research and innovation responsibilities within Integrated Care System duties in England and mandates that Integrated Care Boards must "facilitate or otherwise promote" research. This provides a welcome foundation on which NHS organisations in England can prioritise and support research, to create a culture in which research is supported in equal measure to education and training, leadership and direct clinical care. NHS England is currently developing guidance on delivering on these research duties and the Committee may wish to consider how this process could support the wider ambitions of this inquiry. While this mandate is specific to England, it is also essential that research is embedded in NHS organisations across Scotland, Wales and Northern Ireland, and I would welcome the Committee's consideration of all four UK nations in the next stages of your inquiry.

Training and diversity

Research exposure

For many clinical academics, exposure to research at an undergraduate level sparked their interest and passion for the career in the long-term. Research exposure at this stage can include opportunities for undergraduates to intercalate in a scientific subject, or shorter-term 'research tasters' throughout undergraduate medical, dental and NMAHP training courses.

While exposure to research opportunities is vital for undergraduates, it is not equally available to all medical, dental and NMAHP trainees. Intercalation remains mandated in some medical and dental schools and is optional in others. However, the additional costs associated with extending higher education through intercalation may disproportionately exclude those with less financial security or with dependents. Additionally, intercalation is not an option for healthcare undergraduates outside of medicine and dentistry.

Meanwhile, research exposure may also be harder to access for students at universities with less established research environments, for example at newer medical schools.

Partnerships between research intensive schools and newer schools do exist to improve research opportunities for medical and dental students. However, further consideration is needed to ensure that all medical, dental and NMAHP trainees have access to sufficient research exposure throughout their undergraduate training. Efforts to enhance research opportunities for undergraduate students should consider how they can enhance equity and inclusivity at selection phases to ensure equal access to research exposure for all students and ultimately feed into a more diverse clinical academic workforce.

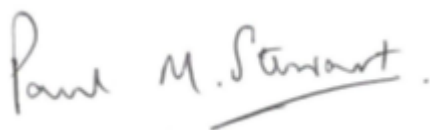
Similarly, shortly after entering the NHS, reforms to the Academic Foundation Programme (which is expected to be renamed as the 'Academic Clinical Leadership Foundation Programme') should ensure that this programme is available to new graduates who have shown previous interest in research at undergraduate or postgraduate level, as well as those who haven't had prior research opportunity. Expansion of the number of academic foundation places in line with overall expansion of the Foundation Programme is welcome, and further review of selection criteria should ensure fair and equitable access to the training programme.

Competency-based training

Finally, clinical academics with joint roles are required to be both capable of delivering excellent patient care to the same level as their non-academic peers, as well as being capable of leading and delivering excellent research to further innovate patient care. This involves a complex balance throughout clinical training to ensure attainment of all the requisite skills in a timely way. The 2015 Shape of Training Review, led by Professor David Greenaway, acknowledged this challenge and recommended flexibility in training for clinical academic trainees.⁴ While this is widely recognised in guidance for the management of clinical academics, and is successfully implemented in many NHS organisations, the consistent and widespread implementation of competency-based training continues to be a challenge. Embedding competency-based training in clinical assessment processes requires university academic training leads to work in partnership with post-graduate deans and the heads of specialist training committees to collaboratively ensure that all necessary competencies are completed to the required standard, without defining specific time or numerical standards. Greater consistency in competency-based assessment would be particularly beneficial for clinical academics working less than full time, or for those who have taken time out of training for out of programme research, parental or sick leave.

My thanks again to you and the Committee for your interest in exploring the vital contributions that clinical academics and research-active clinicians make to the UK's health and wealth, and your focus on addressing the issues that threaten to derail these benefits. I look forward to hearing the outcomes of your inquiry.

Yours sincerely,

A handwritten signature in blue ink that reads "Paul M. Stewart". The signature is written in a cursive style and is underlined.

Professor Paul Stewart FMedSci
Chair, Clinical Academic Training Forum
Professor of Medicine (Emeritus)

References

- ¹ <https://www.nihr.ac.uk/documents/clinical-principles-and-obligations-march-2018/22067>
- ² <https://www.nihr.ac.uk/documents/uk-clinical-academic-training-for-nurses-midwives-and-other-professionals-allied-to-medicine-principles-and-obligations/27109>
- ³ <https://committees.parliament.uk/publications/23246/documents/171671/default/>
- ⁴ https://www.gmc-uk.org/-/media/documents/shape-of-training-final-report_pdf-53977887.pdf