Walport 10th Anniversary Symposium
Goodenough College
22 October 2015

Chaired by Professor Peter Kopelman (Medical Schools Council) and Professor Michael Rees (BMA Medical Academic Staff Committee)
Foreword

The report *Medically and dentally qualified academic staff: recommendations for training researchers and educators of the future*¹ was published in 2005; it later became better known as the “Walport report” after its chair, Mark Walport, the then director of the Wellcome Trust. The report was commissioned by the UK Clinical Research Collaboration in partnership with NHS Modernising Medical Careers recognising concerns about clinical academic training combined and the absence of incentives to attract and retain the most talented clinical scientists in academic careers.

The report succeeded in defining and then initiating the implementation of structured academic career training pathways for the first time in the UK. This success resulted from a strong partnership between the departments of health in the four Nations, the NHS, and NIHR, and an enduring commitment from universities with their medical and dental Schools, Academy of Medical Sciences, MRC, Wellcome Trust and medical research charities. Notwithstanding this, the report’s greatest achievement has been the recruitment of gifted young doctors into integrated academic training programmes that support progression to careers in clinical academic medicine.

A meeting bringing together representatives from UK organisations who have contributed to the implementation of the report’s recommendations was held at Goodenough College, London in October 2015. The meeting provided an opportunity to review the many successes, to consider areas that might be improved and to offer proposals about how shortcomings could be addressed.

We hope that this short paper conveys the meeting’s very evident enthusiasm and support for clinical academic careers. We are grateful to our colleagues for their contribution.

\[\text{Signatures}\]

Peter Kopelman  
Michael Rees

Acknowledgments

The BMA’s Medical Academic Staff Committee would like to thank attendees for their participation on the day and, in particular, those who gave presentations to the Symposium. The following report has been drafted from the notes taken by the Committee’s secretariat on the day but also with reference to the presentations themselves. The speakers were also asked to check the note of their talk and a number of them made some further comments by way of clarification or elucidation. The full document has also been seen and commented on by all attendees.

MASC  
March 2016

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Welcome and Introduction

Peter Kopelman and Michael Rees introduced themselves and welcomed attendees to the day. Peter Kopelman reminded the Symposium that until ten years ago there had been no structure for clinical academic training and that the current pathways had grown out of UKCRC group led by Sir Mark Walport as part of the Modernising Medical Careers process.

Opening Statement by Sir Mark Walport, Chief Scientific Adviser to HM Government

Sir Mark began by noting that it was easy to forget how many people had been involved in the work of developing and implementing the report and said that he would particularly like to thank Lisa Cotterill for her work then and since. Another vital partnership, essential for the success of the programme, has been with Sally Davies who created and led NIHR, which has provided the funding for the programme.

Until the new clinical training pathways were developed and formalised, academic doctors tended to have very individual and sometimes idiosyncratic training pathways, mixing research and clinical practice, and frequently managed to achieve outstandingly successful careers as clinician scientists. However it became necessary to consider more formal structures for academic training in light of the structure imposed on clinical training and concerns and lack of clarity about how doctors would get into research. This was the basis for the review.

Ironically, for a meeting held in Goodenough College, good enough was not good enough, Sir Mark contended: academia was about excellence and, for medical academics, how to combine it with excellent clinical training. This combination, he suggested perhaps led to an obsession with form and structure and insufficient concentration on function. He also noted the concerns that some had about the supposed incompatibility between research and training in some areas or specialty, for example some of the surgical specialties.

In terms of the success of the current programme, Sir Mark argued that the numbers spoke for themselves: each year there had been 250 pre-doctoral trainees and 100 clinical lecturers. That amounted to a total of 2,280, with a significant percentage staying on the academic pathway. 70% of clinical lecturers went to an academic role as their first destination. In 2014 40% of academic clinical fellows had been successful in obtaining a doctoral fellowship compared with only 13% of the rest of the doctors and dentists in their cohort.

Sir Mark also recognised that it was not NIHR acting in isolation and that the Academy of Medical Sciences with their starter grants and the research funding agencies played a major part too.

He reported that he had attended an interesting meeting on Health Foundation fellowships at which there had been much talk about the risks of taking academic jobs. He argued, however, that this was in the context of a very secure profession. He highlighted the Wellcome Trust review from 2013 on risks and rewards, noting that a key motivation was a passion for science and that a willingness to take risks was necessary.

He had two further messages for trainees. First that careers cannot be planned. Second the importance of mentorship, especially as academics were taking the ‘path not well trodden’. He noted that he had had many mentors throughout his career, but that they wouldn’t necessarily be recognised as such today. He would simply define mentorship as ‘advice from people you trust’. Most importantly, he added, from people that you work for. However, he did recognise that the rate at which young doctors moved on perhaps limited the opportunities to build the relationships that doctors had had in the past.

Sir Mark then turned to the importance of IT in health. He argued that medicine had not yet been transformed by information technology, unlike every other service industry. This was partly because of professional resistance: IT challenges doctors and changes what they do.

One of his roles was to advise Government on emerging technologies and the collection of information in order to make better decisions, to provide better services and improve the economy. He argued that we were only at the start of an industrial revolution moving to the ‘internet of things’ or ‘of everything’. It would transform not just pathology and radiology but medicine as a whole.
He did not fear for the future of the medical profession, however. Medicine was about integrating science with human values, and this would continue to be required. However, the job would change.

What then would be the medical career in the future and, in particular, the medical academic career? He believed that it would require doctors to be more mathematically and engineering literate, have a greater concentration on public health and make use of technology that provides ‘nudge’. Academics would have the opportunity to lead change in medicine.

Other developments could include bringing psychiatry and neurology together, the transformation of surgery through the use of robotics and greater academic research in disciplines beyond medicine.

Changes in demography would also be significant, notably the ageing population. By 2040 there will be 10 million people in the UK over the age of 70, up from 5 million today. The aim should be to keep people in their homes longer and science, engineering and technology should all be utilised to assist.

The prospects for medical science, he argued, were extraordinary and this was why clinical academic careers mattered. Training programmes will need to evolve but also, he argued, education mattered at least as much, expressing concern that medical education was being increasingly morphed towards training. Nonetheless, in short, the opportunities were fantastic.

**Discussion**

Peter Kopelman asked if a ‘Walport 2’ was required in anticipation of future changes and to engage the next generation. Sir Mark replied that he felt what was important were strong guiding hands on the tiller. He wasn’t sure that another major review was required but rather that the scheme needed to evolve. The issue was as much about the need for flexibility in clinical training and the danger that it became incompatible with research training.

Ami Banerjee noted that there were sometimes boundaries set up in academia and the panels to which trainees applied for funding were not always as open as the situation Sir Mark had described. Sir Mark agreed, noting that whilst decisions were made collectively they often reflected the position of the least imaginative member of a committee. This, along with the complications of inter-disciplinary activity, were among the reasons for the Nurse Review. Panels needed to include the imaginative and the inter-disciplinary. The divisions were being broken down but slowly.

Fiona Gilbert asked Sir Mark whether he envisaged taking engineers and the like from undergraduate training and into medicine, or for medics to step out and do another undergraduate degree. Sir Mark said that he believed that it was easier to turn a physicist, mathematician or an engineer into a doctor than vice versa and argued that medicine in the UK had missed a trick here. The United States had developed many such doctors by admitting physical scientists, mathematicians and engineers into graduate entry medical school programmes. Some of these had then developed into clinical scientists bringing the skills, education and experience from their earlier degrees and work experiences.

Anne-Marie Coriat agreed with Sir Mark’s point about panels, but also stressed the importance of inspiring doctors early and suggested that attendees reflect on how this could be done better. She highlighted to attendees the forthcoming report on clinical academic careers due out from the Wellcome Trust, NIHR and the Medical Research Council.
Review of the last ten years – what’s worked well and what needs improvement?

Julie Bishop, Policy Manager, Sponsorship, Performance and Workforce Research and Development, Research and Development Directorate, Department of Health

Julie Bishop began by noting that the NIHR itself would be 10 years old in 2016. Its focus was on what would benefit the NHS in terms of quality applied health care research. She noted that the Integrated Academic Training (IAT) programme was by far the NIHR’s largest training fund. It had had protected funding in recent years and both numbers and quality were up. The NIHR also supported research in other disciplines which together with the IAT meant that they had supported around 5,000 people. They sought to bring people together as often they could, and provided leadership and development programmes. They also provided mentorship through the Academy of Medical Sciences.

Quality assurance and improvement was provided through the NIHR Dean, now Professor Dave Jones.

The NIHR appreciated that there was more to be done. It was gathering information which it would feedback into the programme with the aim of strengthening and building the pathway. Julie Bishop closed by highlighting that clinical academic training had continued to have a strong advocate in the Chief Medical Officer for England.

Dr James Fenton, Assistant Director, National Institute for Health Research, Trainees Co-ordinating Centre

James Fenton noted that the training programme envisaged in the report had been implemented by a group chaired by Dr Lisa Cotterill (Director, NIHR TCC) who had hoped to attend the meeting. Initially posts had been allocated by competition. By coincidence the first panel had met at Goodenough College and Michael Rees had been a member. However, NIHR had moved on from that process and from 2009 posts had been allocated round the country by formula with further posts allocated by competition between institutions. The aim had been to distribute posts more widely round the country. The consensus was that the system worked well.

James noted that the NIHR had good relations with its partnerships: the medical schools, the postgraduate deaneries (now LETBs) and NHS organisations who host the ACF and CL posts. He noted that well-run partnerships provided the best training. Most of them had an academic lead with oversight of the whole academic programme.

The Academic lead at Birmingham, Professor Lorraine Harper, had brought the Academic leads together through a group called InterAct to share best practice. She also sought to involve the other countries of the UK as well. There was also a managers and administrators group as part of it.

Anecdotally the ACF scheme had shown success in that ACF post holders were more successful with doctoral fellowship applications than clinical counterparts when applying to the NIHR; follow up undertaken with the Wellcome Trust and the Medical Research Council, also confirmed that ACF post holders were more successful at doctoral level.

However, it should not be overlooked that there were other routes to develop an Academic career outside the IAT pathway in England and there were fellowship application successes amongst the clinical lectureships also. All NIHR trainees were brought together at a meeting every year, bespoke events were provided for ACFs and the NIHR assisted with events organised by other organisations.

James reminded attendees that the clinical lectureship didn’t fund research as such: hence the importance of (AMS) starter grants. NIHR also provided systematic review training and leadership and management training via Ashridge College. They also tracked outcomes and were close to completing cross-funder work on this. He recognised that, overall, partner organisations needed to work together.
Whilst he noted that the programme was the envy of the world James Fenton did suggest some possible improvements:

– Better working in some partnerships;
– More activity in and with certain hard to reach specialties, such as anaesthesia;
– Increased inter-disciplinary activities.

Areas for possible concern were the potential impact of Shape of Training and thus how to respond, and how to ensure that dentistry continues to fit with the IAT programme.

Bill Reid, NHS Education Scotland and Chair of COPMED
By way of introduction, Bill Reid stated that Sir Mark’s opening remarks rang true for him. He also added two key principles: the importance of having synergy between training north and south of the border; and the importance of trainees having satisfied the requirements of clinical training and of being safe.

He also noted that there was a cultural, or organisational, difference between the schemes in Scotland and England: in Scotland trainees were required to have an NTN before they could obtain an academic post. He believed that this mitigated against the antagonism that existed in England because of the perception that “special favours” were done for academic trainees.

In the SCREDS scheme all academic clinicians under the deanery in training were overseen throughout their training by the deanery, when they are ‘out of programme’ and in clinical lectureship. They did not adopt the ACF model and did not intend to. SCREDS also had a strategic function increasing partnership working and ensuring better alignment. The aim was to provide bespoke training to the brightest and the best with close mentorship until a trainee committed to a specialty (and vice versa). To that end NHS Education Scotland almost wholly funded 125 posts with some additional posts provided by other means. PhDs were largely funded by the Wellcome Trust, the MRC and other funds. The biggest success with the ECAT (Edinburgh Clinical Academic Training) scheme, with a very high success rate to intermediate fellowship. Bill Reid believed that this was down to the leadership of the scheme. He stressed the importance of local structures and the need for honesty and integrity in their discussions.

The concerns that he highlighted were:

– The gap in post-doc opportunities;
– The high attrition rate of women in the scheme;
– The silos and tribalism of medicine holding back progress;
– The difficulties in getting the clinical/academic interface right.

Terence Stephenson said that he was a great fan of the Walport scheme and that he liked the way Scotland did things. He argued that overall, academic skills were too small a part of the selection process. He also highlighted the importance of training for now and for academics to be as competent as their clinical equivalents.

Peter Kopelman asked how many ACFs came in at each stage. James Fenton replied that ACFs could enter at ST1-3 in all specialties and to ST4 for paediatrics, emergency medicine and psychiatry. Roughly half of ACFs entered at core medical training/ST1 and half later.
**Michael Rees, Welsh Clinical Academic Training**

Michael Rees reported that he had moved to Wales in 2005 and was then asked to look into the establishment of a new academic training programme. The initial model followed was the English one. However, under this model it proved difficult to match academic and clinical activity leading to tensions between the two and practical difficulties regarding timings and rotations. The scheme was then reformed along the lines of the ECAT model.

Having been persuaded of its importance the Welsh Government agreed to fund the scheme. 40 training posts were made available and combined run-through training with a PhD. Applicants had to be in a recognised training post. Michael Rees believed that it was the most attractive training scheme in Wales.

In summary the members of the scheme had acquired £2-£3 million of grants and membership was 50:50 male:female. However, the posts were mostly in Swansea and Cardiff and so more probably needed to be done in North Wales.

An unfortunate recent development was a steady decline in numbers because of cuts in Government funding. Michael Rees felt that the lack of the same sort of structures as had been put in place in Scotland, and which had protected the schemes there, was a problem. This highlighted the importance of persuading governments to provide both funding and structure.

Michael Rees argued that the academic components to a job made it more attractive and encouraged doctors to work longer and later in their careers. He reported that many trainees said that they wanted to be an academic in the NHS. Thus ideas needed to be developed on that and on developing additional pathways to the formal training schemes.

Partly along these lines a new scheme had been launched in Wales called the Bevan Fellowship. This was about persuading more doctors to develop academic skills, and not just those in training posts.

**Doug Pendsé, Consultant Radiologist, University College London Hospital**

Doug Pendsé outlined his career to date. He had trained in Birmingham and had then moved to Oxford for his surgical training. As an SHO in Oxford he had had contact with research as it was seen as being necessary to obtain an MD in order to pursue a career as a surgeon. By the end of his time at Oxford he had decided that he wanted to do research.

He recounted that he had first come across the ACF scheme during MTAS when it featured as a tick-box on the application form. Without really knowing whether it would be a good or bad thing to do, or knowing anything about NIHR, he chose that option. In the event it turned out to be the right thing to do.

At the start there was a lack of understanding in his university about what an ACF was. He spent his first six months paving the way for what he was able to do subsequently. However, his colleagues in his specialty were very open to the concept and he was very close to his supervisors. He had not thought about the risks involved, rather seeing it as an opportunity; even if he had not become an academic, it would be an opportunity to build his CV. The experience of colleagues in other specialties was not so positive, however.

He had, however, been occasionally told ‘not to take a day off for academic work’ and he reported that the relations between the university and the NHS had not been good. His relations with NIHR as a funder were not close. There hadn’t been a sense of belonging or of them being interested in the work that was being done.

When he became a clinical lecturer at UCL things really changed. The ACF scheme had by then become a well-trodden path and he was embedded in a pre-clinical department. He felt that he learnt a huge amount and had also been able to be the analytical person in the department and the innovator. It had helped enormously with the clinical job. Overall the scheme had been an enormous opportunity for which he was thankful.

Now as a consultant he had an honorary academic contract which enabled him to do a day of academic work per week. He supervised an ACF and was aware that there was much greater clarity for them on their objectives and rotations.
Discussion

Bill Reid noted that the attrition rate of women was a major concern with particular difficulties translating from intermediate to senior fellows. There appeared to be too many obstacles and it was not clear why. Penny James argued that the step from PhD to post-doc was the hardest. It was often the point at which women chose to start a family and thus consider transition to less than full time training. This also led to geographical constraints and a narrowing of options generally.

Katie Petty Saphon argued that one opportunity that had been missed was to track trainees properly. This had been picked up by the UKMed database with the GMC and also involving the Colleges. A soft launch on research questions was due in November. What questions needed to be asked?

Ania Koziell argued that the issues of caring for children were key. When she started she had 4 male and 6 female colleagues. Of the men 2 were already professors, of the women 2 had left to work in the NHS, 2 were pure scientists and 1 was a professor, but she had a house-husband. Peter Kopelman noted that the original report had talked about flexibility and that the recent Shape of Training had also emphasised it but actually proposed less flexibility. Ania agreed that in the past it had been easier to step in and out.

Ami Banerjee argued that the issue wasn’t attrition rates but about not making academic careers attractive: the path was simply not attractive enough.

Dave Jones agreed with the contention that the academic training schemes were the envy of the world. However, he did recognise that the lack of identification with NIHR was an issue and was concerned about the level of anxiety about the security of an academic career. He had also identified the following barriers:

– attracting people, especially in certain specialties;
– providing a secure career - the REF and performance management in universities does cause concern;
– ‘getting in the way of life’, such as the lack of continuity of maternity rights (which should be solvable) and the interface with clinical work;
– insufficient integration with the deaneries.

Bill Reid argued that there had never been a golden age of training and that much had been dependent on local leadership and the brokering of arrangements. Dave Jones agreed about the important role of training leads on the ground.

What are the challenges facing the next 10 years? — John Williams, Interim Executive Director, Academy of Medical Sciences:

John Williams stressed that he was speaking as an individual and not on behalf of his current or previous employer.

He argued that the essential objectives for the future should be to:

– Build the next generation;
– Simplify the career path;
– Build bridges for transition;
– Build a sense of shared responsibility, of all being in it together.

Thereby we would reap the benefits of the developments of the last 15-20 years.

He also argued that the sector probably already had the solutions to the problems it faced but that it was a matter of will and implementation. There wasn’t, therefore, a need to reinvent what we currently had but to make it work better: use best practice and share it.

He agreed that there had never been a golden age and that trainees had had as tough a time in the past. Nonetheless, he didn’t want more reports. He asked if there was the will to make the system work drawing on the community’s wisdom.

A further question for the future was how to democratise advice and mentorship and to do this right
through the service. He also supported the concept of a diverse workforce reflective of society today. However, he believed that the sector would struggle to develop generalisable solutions as the issues trainees faced were very personal. He did, however, recognise the issues for surgery arguing that more academic surgery was required and that stakeholders needed to work together to achieve it.

He noted that funders had a part to play in helping establish rational structures. He believed that partnership working had been one of the positive developments of the last decade.

Williams also highlighted that the UK trained 70% of clinician scientists within the South East medical cluster. He argued that this was not good enough if there was to be effective coverage across the country. We needed to think beyond it.

In summary, he believed that very real, tangible steps forward had been taken in the last ten years. He also stressed the importance of leaders and leadership in achieving these changes. The task was not to lose sight of what had been agreed in the Report and where we wanted to go.

Dr Penny James, Chair of the BMA’s Joint Academic Trainees Subcommittee and a Honorary Lecturer at UCL Institute for Women’s Health

Penny James, speaking as an academic trainee, said that she felt that the Wellcome Trust had made a personal investment in her, for which she was thankful.

Penny argued that the next steps always seemed to be the hardest ones to take. Concerns of academic trainees were the pressure to finish clinical training, maintaining academic momentum, and the availability of ‘post-docs’, which would be a challenge for the future. The number, availability and timing of post-doctoral posts were important. The strict criteria applied to them also made it difficult with success often down to luck rather than planning. She would like to remove the element of luck from the process. Fiona Gilbert agreed with Penny that the concerns of academic trainees included the pressure to finish clinical training and the completion of professional examinations, especially in specialties such as radiology which had a large number of exams.

Discussion

Anne-Marie Coriat from the Wellcome Trust said that the Trust aimed to ensure that there was more money, more flexibility and opportunities to ‘join the conversation up’. She agreed that fixed criteria were not helpful and that funders should look at the individual and their competences. She noted that these issues were being reviewed jointly by the Trust and the Medical Research Council. She also argued that geography was important, along with work on early stage careers, for example the Inspire programme.

Sarah Mills said that this was excellent news. Her main concern was about losing ground compared to her clinical counterparts for example as a result of the proposed new contract and the loss of automatic pay progression. How would people be retained in the face of that?

John Williams reported that a letter had been co-ordinated which explained these issues to the Secretary of State. He argued that there were strong recommendations in the DDRB Report which showed that academic trainees were not going to be disadvantaged. Dave Jones added that he had been involved in a lot of discussions on the issue. He noted that there had been some misunderstanding about academic contracts but that had been put right. He was not worried about the proposals and believed that academic training would come out of it alright. But he did recognise that it would need work.

Michael Rees noted, however, that the number of jobs available was not increasing and that there was a growing feeling of fragility in the system. He also noted that there was no longer the same emphasis on creating space in the NHS for academic work. Dave Jones acknowledged that there was pressure on NHS consultants to move away from research and that the immediate ‘problem’ was always this year’s flu crisis. He noted that it was even more difficult for non-medics. However, trainees should have a range of reasonable expectations of what they could do at the end of training. Christopher Day added that it should not be regarded as a failure to end up in the NHS and highlighted that there were a number of schemes that NIHR funded. Dave Jones noted that doctors had to be in post first to be eligible for the schemes. He also stressed the importance of consultants being research active in their first three years in post.
Margaret Johnson reported that this was a big concern for fellows of her college. They want to get involved in research, but their employers wanted 9 direct clinical care sessions and funding couldn’t be used to buy consultant PAs, at least not in North Thames. Christopher Day reported that CRM funding was available for consultant sessions in Newcastle.

Michael Rees asked why the number of clinical academic jobs in universities had not expanded. Attendees broadly agreed that the Research Excellence Framework (REF) was a significant factor, along with the recent declines in higher education funding, which it was feared would decline further following the comprehensive spending review. This was compounded by the squeeze in NHS funding.

Fiona Gilbert noted that universities were often very brutal about the REF: NHS consultants were not included because the quality of their work was not high enough, clinical academics with too high a clinical workload were also penalised. If an individual was not submitted they were seen as having less value to the university. Christopher Day agreed that the REF meant that universities got nothing for adding a clinical academic or NHS consultants except perhaps enhanced reputation. He believed that a rethink was needed. It was agreed by attendees that the REF had a distorting effect.

Anne-Marie Coriat argued that it came down to how the system valued and counted things. Clinical academics were welcomed if they brought in the things that were valued and counted.

David Katz noted that clinical training interrupted a research career and that this was also true for new NHS consultants. For women this was compounded by time taken out for maternity leave. Coming back to research after a gap was something that stakeholders should try and grapple with. He also noted that academia was becoming increasingly inter-disciplinary whilst clinical practice was narrowing. These trends needed to be better married together.

How then should the transitions be managed and how should mid-career entry or return be encouraged? John Williams noted that there were multiple individuals and constituencies that needed to be engaged, especially as trainees dipped in and out of the system. He also highlighted the personal responsibility of the trainee and their mentors.

Bill Reid argued that this highlighted the importance of ‘bespoking’ training to the needs of the individual trainee and moving away from the box-ticking approach encouraged by some. Anne-Marie Coriat reported that funders were thinking collectively about how to manage mid-career entry or return. She agreed about the importance of managing transitions effectively and called for a degree of simplicity and flexibility in the structure with ‘bespoking’ later in the career.

John Williams queried whether stakeholders had good information about the individual trainees. A better understanding of them was required in order to manage the transitions: different individuals would require different solutions.

It was agreed that this was more difficult than might be expected. Dave Jones noted that the difficulties included the inability simply to count the number of trainees, the definition of who was an academic trainee and the lack of information about when trainees left the academic pathway.

Attendees moved on to discussing mid-career entry to academia in more detail. Peter Kopelman suggested checking whether HEFCE had done a final review of the new blood clinical senior lecturer scheme as a starting point.

The difficulties noted were, as a university-employed clinical academic, having to meet the same requirements as a full time academic; concerns about alienating the clinical community; the engagement of Trust Boards; and the lack of emphasis of medical education research.

Marcia Schofield stressed the importance of having a very supportive trust board; of encouraging all levels of academic and for the need for conversations between funders at trust level. Anthea Mowat noted that SAS doctors had not been mentioned in the Report and pressed for their greater involvement arguing that
there were at least a handful who had the skills and ability to enter into academia. She believed that this was one of the transition points that needed to be considered. It was noted that the Bevan Fellowship in Wales was designed to help with this.

Peter Kopelman argued that, whilst medical education research had been mentioned in the Walport Report, it had not been picked up well since. James Fenton agreed, noting that the NIHR was not asked for medical education research ACFs, though they would be happy to fund them and did work with ASME on the issue. Michael Rees also noted that medical research had not had as clear an impact on clinical quality as it should, and that driving this area forward should help open doors for doctors.

Returning to the issues facing academic trainees, Ellen McCourt reported that whilst surgical trainees were expected to do research it was unusual for them to become academic trainees. How might this be changed? She also asked how trainees with interests that were not part of a traditional research agenda could be better supported. On the first Bill Reid argued that the Gold Guide gave the opportunity to push back on needless PhDs.

James Fenton argued that there should be more clinical lecturer posts and more NHS posts with dedicated research time; Penny James suggested that the restrictions often came from LETBs or trainers. Dave Jones said that the gentle expansion of ACF posts in some areas was priority for the NIHR. They also intended to take the ACF model into other areas, such as education research and clinical entrepreneurship.

Attendees agreed that NIHR ACF and CL posts were a very positive development, but that they did not and should not represent the only option and that this should be made clear to trainees. Attendees also agreed with Sarah Mills on the importance of not deterring trainees at the start, particularly in primary care, where she had been told she couldn’t do an AFT post.

**Life Post-CCT for the new cadre of medical academics - David Strain, University of Exeter and one of the ‘new blood’ clinical senior lecturers**

David Strain reported that he had taken an incredibly unconventional route to academia. He had started out wanting to do clinical work but having done an MD discovered that he loved research. He then tried to create a clinical lecturer position but found lots of barriers in the way to doing that.

This led him to apply for one of the Clinical Senior Lecturer (CSL) positions when they became available. He had been supported in this by John Took. The purpose of the scheme had been to encourage those without the standard background into academia. He obtained a position with the University of Exeter, and they offered him tenureship almost from the start. He had also sought to build links with his CSL colleagues in order to share experiences.

His counterparts elsewhere did have different experiences to him. Not all the posts were maintained, only half of the CSLs got a full lectureship, with some leaving voluntarily but others because the jobs were not made available. A number felt that they were being unfairly judged against both full-time academics and full-time clinicians.

He had been lucky in that he was REF returnable, but noted that it was tough keeping up with both his fellow academics and clinicians. He was not clear whether the lack of tenure for other CSLs was linked to their REF returnability.

The scheme had provided the university with a pot of money for his salary. However, it did not provide any funding to do anything once in post. It thus took him two years to settle into the role. There had been a lack of support from HEFCE, but Exeter was more supportive than other universities which had proved to rather aggressive in the circumstances. Other fellowships had also proved to be more supportive.

After one year he had one PhD student and one grant. He was now pulling together MD projects for people who showed an interest.

A particular concern was that universities didn’t appreciate the benefits of being on-call. Unless clinical academics had patient contact they could not generate the research questions of importance to patients and thus continue their research.
**Dr Ami Banerjee, Consultant Clinical Academic in Cardiology at UCL**

Ami Banerjee reported that he was in a CSL post at UCL, though only two months into the job. He had known that he definitely wanted to do research but didn’t follow Waldport model until he became a clinical lecturer. He went to Harvard for a year and then had some career disruption following MTAS.

One of the things that he noted as a clinical lecturer was that some clinical academics did not do enough clinical work and thus lost the respect of their clinical colleagues. He, therefore, felt that it was important to identify the things he needed to do and what could be done in the context of the 50/50 split.

He also reported that the time between the end of academic training and the CCT date had proved more difficult than expected. He had only realised that there was to be a four month gap between the two six months out. This had made this transition point difficult. Run-through training didn’t allow him to cater for all eventualities.

An unintended consequence of the Walport Report and its implementation was the perception that it had to be the Walport way or no way. He knew from his own experience that flexibility did exist in the system but many people did not believe it. He also believed that a lot more needed to be done to explain why academic medicine was exciting and that it was not just about getting through the training pathway. He was by nature a lumper rather than a splitter and, therefore, believed that more needed to be done to bring groups together.

As a member of MASC he was trying to grapple with the lack of data mentioned earlier in the day. He and others were seeking to survey clinical academics newly post-CCT. The preliminary results provided good news in that most had wanted a full-time clinical academic role, however, not all did. There were also perceived barriers to finding suitable posts and to women’s participation in academic medicine. His experience was that at all stages you find over-qualified people applying for posts with some using a CL as a means of lengthening training. The challenge then was how to recruit new people.

**Discussion**

Attendees discussed the issues raised by Dr Banerjee on the transition from the end of academic training to CCT and then to jobs post-CCT. He reported that neither the university nor NIHR had been prepared to extend the clinical lectureship. Thankfully the NHS said that it valued his research time and agreed to fund the remaining period. Nonetheless, it had been an embarrassing experience.

James Fenton argued that this should all have been managed and agreed prospectively through the ARCP process and that this should identify further funding. He also noted that NIHR would fund the period of grace post-CCT. Dave Jones said that trainees in this situation should go back into ordinary training programmes.

Peter Kopelman asked the speakers, if they were to do it again, how would they do it differently? David Strain said that he had felt very much on his own and was aware that other fellowships had had additional resources.

Ania Koziell echoed David Strain’s comments and argued that people were wasted in the system. Grants associated with the NHS were not counted by the university. David agreed noting that the university did not count NIHR funding as it was research for patient benefit. Both James Fenton and Dave Jones agreed that there should be such recognition and that it should be possible with some clever accounting. It was also noted that there wasn’t a forum where all those with a stake in the system could come together and sort these things out. Attendees agreed that it was a concern that such stories filtered out and scared people away from academia as it gave the impression of it being a bit of a lottery. Attendees agreed with Bill Reid that resilience was required.

To inform the discussion Siobhan Fitzpatrick of the Medical Schools Council outlined the work that it did on collecting data on medical and dental clinical academics. She noted that the most recent report indicated an increase in the number of lecturers and in the diversity of lecturers. The table on page 26
of the MSC’s report demonstrating the widening gap between the numbers of NHS consultants and consultant clinical academics was agreed to be particularly striking. Attendees agreed that it begged the questions: what would be the requirement in the future and what should be the role of the NHS?

Christopher Day noted that conversations regarding recruitment were all about service, and that this was a reflection of the financial position of the NHS. The members of the AUKUH acknowledged the importance of academic activity but trusts focused on their deficits. Katie Petty-Saphon argued, however, that there was huge enthusiasm amongst trust directors of research.

Christopher Day added that there was a lot work that needed to be done in advance of the next REF including attributing funding correctly, such as NIHR funding that went to trusts being linked to the relevant medical school. In previous years the dialogue had not got to the level of the individual clinician. He hoped for progress on these through Russell Hamilton.

Attendees agreed that the whole system needed looking at whilst recognising that, in Anne Marie Coriat’s phrase, it would be like turning round an oil tanker. Total costs and total benefits needed to be considered. Attendees also agreed with Peter Kopelman that the partnerships that had been strengthened over the previous ten years risked being weakened in the next, and that it was important to tie things together across the sectors.

David Katz asked why the NHS more generally did not look at the connection between failing hospitals and those that did not do research. Was the issue that NIHR was seen as the place where research was done and not the NHS as a whole?

In terms of doctors’ contracts attendees agreed that there were some sensible things in the DDRB report regarding clinical academics, including, as Peter Kopelman highlighted, the welcome fact that they had been mentioned at all. Michael Rees expressed concern that there was still the risk of significant disincentives to academic activity in the NHS. Christopher Day agreed that implementation of the contracts would be key.

Michael Rees returned to the subject of the number of posts stating that if it was not clear now whether there were sufficient posts, what would be the expected position in 10 years’ time? Christopher Day said that it would depend on a number of factors: the level of student fees, whether medical schools would be allowed to continue to run deficits (some were already being asked not to make a loss), the extent to which research would subsidise medical teaching and whether it would continue to be acceptable to charge £9,000 for history and other similar courses. He also noted that it wasn’t be possible to increase medical student numbers. Peter Kopelman added that the highest cost subject supplement for medicine was potentially under threat and that the financial circumstances of medical schools was increasingly difficult, particularly with the increasing focus on quality of teaching.

Terence Stephenson queried whether the Government would remove the cap on medical student numbers. He believed that it would be attractive to Government and that it would happen eventually.

**Less than full time training and working – the challenge**

**Dr Ania Koziell, Clinical Senior Lecturer, King's College London and Fizzah Ali, ACF in Neurology, Birmingham**

Ania Koziell stated that less than full time training and working was more of an issue for women because of their continued responsibilities for children, and not just young children, teenagers could be quite demanding also. The issue also wasn’t so much about encouraging women into academia but about encouraging them to stay. This included ensuring that they weren’t scared by the over-achieving woman and ensuring that they weren’t labelled as not being serious academically if they chose to have a child.

She argued that the problem was the lack of sophisticated job planning in academia. This would lead to a better balance for part-timers. A lower level of access to CPD was a problem for part-time academics,

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2. A Survey of Staffing Levels of Medical Clinical Academics in UK Medical Schools as at 31 July 2014: A Report by the Medical Schools Council, July 2015

3. The Association of UK University Hospitals: http://aukuh.org.uk/
especially as it was often squeezed into academic time. Conversely there was also often a lack of interaction with basic science. Ania argued that it probably meant that it was best to have one week on and one week off.

Looking ahead, Ania argued that the level of debt being accrued by medical students was a concern. A BSc was a good way into academia but it meant acquiring further debt. The relative lack of job security in the academic sector was, therefore, a real disincentive to an academic career in these circumstances.

Fizzah Ali reported that she had had a successful intercalated year in medical school and, through this, she’d had the opportunity to experience research early on. From Foundation Year onwards she had commenced the standard integrated academic pathway. As a core medical trainee she had chosen to become less than full time to secure a better work-life balance. There were a variety of benefits to flexible academic training, which included adding a degree of flexibility to work alongside clinical and academic progression. She felt that the availability of flexible training may also help retain trainees who may otherwise have been lost to academic training by providing them with more time to build their clinical confidence.

There were, however, inevitable challenges with combining two part-time posts into part-time training. These included challenging perceptions of colleagues, disruption of clinical and academic continuity and possible issues with training opportunities. Lack of visibility was cited as a concern, especially clinically and the possibility of missing out on opportunities academically, and certain clinics or seminars, depending on days worked. One solution to this was greater organisation and better planning with supervisors and departments in advance. She felt that trainees may also find the length of training time in flexible integrated clinical-academic posts off-putting.

Possible solutions to the problems, she believed, should target altering perceptions about flexible trainees including raising awareness and sign-posting, greater consideration to be given to the types of posts flexible academic trainees occupy such as working flexibly in a full-time slot versus being supernumerary versus job-shares. An alternative would also be to consider ways to de-couple academic and clinical training successfully. Having senior clinical-academic mentors with flexible careers may be encouraging.

Peter Kopelman stressed the importance of joined-up job planning, and Terence Stephenson said that clinical academics should refuse to have separate clinical and academic appraisals because that is not in the spirit of a Follett style integrated job appraisal. It was also felt that this should be the case with ARCPs.

Fiona Gilbert said that she did not wish to see a dedicated academic job plan. Katie Petty-Saphon suggested that an annualised job plan should provide sufficient flexibility. Marcia Schofield noted, however, that some Trusts were reluctant to agreed annualised plans. Concern was also expressed about the impact of seven day services in the NHS on academic work. Attendees recognised that there was something of a culture clash between the two sectors on these issues.

Anne-Marie Coriat summed up the discussion by saying that the issues regarding less than full time training were about expectation and measurement.

**Academic General Practice – Sarah Mills**

Sarah Mills noted that academic GPs tended to be over-represented in pastoral and admissions work. The problem that many faced was that once a doctor expressed a preference for primary care they were assumed not to be interested in academia. She, therefore, argued for the need for more robust primary care research and for GPs to start research earlier.

Michael Rees asked if she believed whether increasing the academic component of general practice would attract more people to it. She agreed and added that she believed that GPs would work longer too.

Peter Kopelman asked if she believed that the model was wrong. Sarah Mills replied that she believed that the problems were not in primary care but in secondary care. There was risk that people were put off academic activity at the start or by the first ‘no’. A practical problem was the need for a PhD post-CCT. The cost and uncertainty of acquiring one was the issue.
James Fenton agreed, noting that the first primary care ACFs had found difficulty in doing a PhD. Peter Kopelman noted that the report proposed that GPs first did a masters and then came back after qualification to do a PhD.

**Academic Dentistry – Giles McCracken and Richard Holliday**

Giles McCracken reported that he was from the last generation of the old pathway in training as a dental academic and had seen Walport happen. His path had been to go out of clinical training as an independently funded student to do a PhD then return to complete clinical training in a HEFCE funded lecturer post. This had been a financial sacrifice but had led to a clinical senior lectureship with an honorary NHS consultant contract.

Traditionally the academic dentist had been a clinical teacher providing hands-on undergraduate teaching. However, academic dentistry was moving closer to the medical model. Teaching was not promoted as much in medicine but was in dentistry, and this development was, therefore, of some concern. Consideration needed to be given to the levels, experience and skills required.

The Walport scheme had led to a competitive process in dentistry with 23 ACFs and 11 – 12 clinical lecturers. He recognised that it was a relatively small group but believed that it was good to see it. He also welcomed the increased alignment with medical stakeholders and the growth of joint working on common issues of concern.

Richard Holliday said that he has followed the integrated academic training pathway: ACF including masters and then a doctoral fellowship. He had, however, had a period of transition in the NHS. This pathway had worked for him, he had found it enjoyable and had felt part of the NIHR. He had attended their trainees meetings and met with medical academics locally. His dental colleagues often did not understand and he had to explain his position as it was unusual within dentistry.

**Reflections on the day – Peter Kopelman and Michael Rees**

Overall Peter Kopelman felt that it had been a very interesting day which had demonstrated that lots had been achieved and that the scheme was a successful one. However, it did show that there was a need to simplify processes and to reassure trainees that there are opportunities for them, and that they will have the necessary support. The specific points he took from the day were:

- the importance of mentoring;
- the need for partnership and close working between universities, NIHR and the deaneries/LETBs
- the challenge of balancing service requirements and academia;
- a better appreciation of the challenges faced by women and how these could better be addressed;
- the need to disseminate good practice; and
- Identify and address practices that have been less than good.

Michael Rees agreed that attendees had a joint responsibility to ensure that trainees had fulfilling jobs. He also recognised the need to deal with attrition rates and the difficulties in part-time training. Overall, he felt that the scheme had justified the need for academic training.
Key Points from the Day

Future of Medicine and Academic Medicine

- Ensure that doctors as a group have a greater understanding of maths and engineering and work in an increasingly inter-disciplinary way, facilitating this through graduate entry programmes.
- Recognise and facilitate medical academics as leaders of change.
- Seek to expand research activity into areas beyond medicine and into specialties where it had recently been weak, notably anaesthesia and surgery.
- Seek to have a greater impact on clinical quality.
- Defend the concept of medical education as something separate from and additional to medical training.
- Recognise the importance of inspiring young doctors and medical students early in their careers.

The System

- Continually persuade and remind governments of the importance of providing both the funding and the structures needed to support academic medicine.
- Strengthen existing partnership working between the NHS and universities, building on the examples of the best, especially where the partnerships are not as effective as they could be.
- Ensure that universities count and value NIHR funding for research.
- Seek to build more flexibility and clarity into the programme and ensure that the IATP is not seen as the only route.
- Provide trainees with the assurance of a secure career with an acceptable work-life balance.
- Tackle the distorting effect of the Research Excellence Framework.
- Work to ensure that dentistry continues to fit with the integrated academic training programme.

Trainees

- Help trainees to build better, more supportive relationships with their supervisors.
- Establish more clinical lecturer posts.
- Provide better support for GPs early in their careers to enable them to undertake research.
- Plug the gap in post-doctoral opportunities.
- Build bridges to help trainees get over the difficult periods of transition in academic careers – from ACF to CL and from CL to consultant.
- Ensure that clinical academics are seen to do sufficient clinical work.
- Tackle the high attrition rate amongst women medical academics.
- Ensure ‘bespoke’ training for individuals without seeming to be unfair or discriminatory.
- Work to facilitate trainees being academic in the NHS.
- Help trainees and the programme to learn from those who have gone before.
- With the improvements in tracking trainees, consider what we need to know about them and their career patterns.

Other Doctors

- Encourage academic activity at all levels of the profession and especially amongst specialty doctors.
- Better use of job planning in academia to encourage and support part-time academics.
- Establish and support more NHS posts with dedicated research time.
- Help doctors to return to research after time away.
Attendees, Walport Symposium, Goodenough College, London, 22 October 2015

Dr Fizzah Ali
ACF Neurology and Core Medical Trainee, Queen Elizabeth Hospital, Birmingham

Ms Julie Bishop
Policy Manager, Research and Development Directorate, Department of Health

Dr Ami Banerjee
Senior Clinical Lecturer in Clinical Data Science and Honorary Consultant Cardiologist, Farr Institute of Health Informatics Research, University College London

Nicola Carter
Head of HR Advice, Universities and Colleges Employers Association

Dr Lee-Ann Coleman
Interim Director of Biomedical Grants and Policy, Academy of Medical Science

Dr Anne-Marie Coriat
Head of Research Careers, Wellcome Trust

Dr Peter Dangerfield
Co-Chair, BMA Medical Academic Staff Committee

Professor Christopher Day
Vice-President for Clinical Research, Academy of Medical Science

Dr James Fenton
Assistant Director, National Institute for Health Research (NIHR TCC)

Siobhan Fitzpatrick
Policy Adviser, Medical Schools Council

Professor Fiona Gilbert
Chair, Clinical Academic Committee, Royal College of Radiologists

Professor Anne Greenough
Director of Education and Training, Royal College of Paediatrics and Child Health

Richard Holliday
StR in Restorative Dentistry, Newcastle University

Dr Penny James
Honorary Lecturer UCL, Institute for Women’s Health

Professor Margaret Johnson
Vice-Chair, Research and Academic Medicine Committee, Royal College of Physicians

Professor Dave Jones
Dean, National Institute for Health Research

Professor David Katz
Deputy Chair, BMA Medical Academic Staff Committee

Professor Peter Kopelman
Principal, St George’s University of London

Dr Ania Koziell
HEFCE Senior Clinical Lecturer, Kings College London

Miss Ellen McCourt
Deputy Chair, BMA Junior Doctors Committee

Dr Giles McCracken
Chair, Central Committee for Dental Academic Staff, British Dental Association

Dr Sarah Mills
GP Academic Trainee, GP Trainees Subcommittee, BMA

Dr Anthea Mowat
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Sir Mark Walport
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