



Science and Technology Committee

Corrected oral evidence: Clinical academics in the NHS

Tuesday 6 December 2022

11.30 am

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Members present: Baroness Brown of Cambridge (The Chair); Lord Holmes of Richmond; Lord Krebs; Baroness Manningham-Buller; Lord Mitchell; Lord Rees of Ludlow; Baroness Sheehan; Baroness Walmsley; Baroness Warwick of Undercliffe; Lord Wei; Lord Winston.

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Heard in Public

Questions 32 - 40

Witness

The Rt Hon Lord Kakkar KBE, Chair, Office for the Strategic Coordination of Health Research.

USE OF THE TRANSCRIPT

This is a corrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.

Examination of Witness

Lord Kakkar.

Q32 The Chair: I welcome Lord Kakkar to the Science and Technology Committee's fourth and final evidence session for its inquiry into clinical academics in the NHS. Our witness is Lord Kakkar, chair of the Office for Strategic Coordination of Health Research. The session is being broadcast on parliamentlive.tv. A full transcript will be taken and made available shortly after the meeting for you to make any small corrections. Welcome, Lord Kakkar. Thank you so much for joining us. Would you like to give us a short opening statement before we start the questions?

Lord Kakkar: Thank you very much indeed. It is a great pleasure to be here. I will start by drawing the committee's attention to my registered interests. In particular, as you have heard, I am chairman of the Office for Strategic Coordination of Health Research. I am also chairman of the UK Biobank, King's Health Partners, and the King's Fund.

I will begin by outlining a little of the history of OSCHR, which was established as a result of the review undertaken by Sir David Cooksey in 2006. It came into being in 2007 with the specific view that there was a need for a shared vision, a clarity of purpose, regarding co-ordination between the Medical Research Council and the National Institute for Health Research to identify funding needs and priorities and to put them to the Treasury so that the funds to support publicly funded health research could be secured and to ensure that, in their application, those funds delivered what was envisaged. The devolved Administrations were invited to join the OSCHR table in 2008.

During that first period of OSCHR, there was a focus on ensuring that there was a properly defined health research strategy which the funding organisations were required to comply with, agreeing on the funding needs, as I said, ensuring that they could be secured, and monitoring the results of the application of that substantial amount of public money with regard to the health research agenda. In 2011, there was a review of OSCHR and it was decided that those principal objectives had been met but that OSCHR should continue to focus on monitoring the translation of research activity funded by government in our country and ensuring, as best as possible, that the funders' contributions could also drive the broader economic growth agenda.

It is in that context that I was invited, after application and appointment, to become chairman of OSCHR, about a year ago. Since then, I have tried to return the organisation to its founding principles, because, as I think we will explore as part of the discussion about clinical academic careers and the role of those who wish to perform research in the NHS, the funding landscape now for life sciences and health research in our country has become much more fragmented and there is not the co-ordination that one might hope to see across that entire landscape to facilitate the greatest achievements, outputs and benefits of health research funding and to ensure that we can develop and continue to

motivate those who wish to contribute to our national research agenda and effort.

The Chair: Thank you. That is helpful context for us.

Q33 **Lord Wei:** How much capacity does the NHS currently have to deliver research? What are the implications of this capacity for clinical academics and associated healthcare professionals who want to participate in and contribute to research? How has this capacity changed as a result of Covid?

Lord Kakkar: There are a number of questions there. At the outset, it is important to recognise that establishing the infrastructure for health research in the NHS and ensuring that that clinical research capacity is available for those who wish to conduct research has been a success story for our country.

From 2006-07 onwards, there have been a number of initiatives, based principally on the two obligations of the National Institute for Health Research, which are to create the infrastructure for research and to ensure that there is sufficient capacity. However, in recent years, after an important growth in clinical research output, we have seen something of a decline. We need to recognise that research capacity and delivery are not evenly distributed across the whole National Health Service. That is an important issue. It is unrealistic to expect that the centres of excellence, with substantial additional research resources, will deliver at the same rate as those that do not have that capacity. Those major centres of research excellence and clinical research excellence will inevitably have greater opportunity for research.

Trying to embed a research culture across the whole National Health Service is very important. This was recognised some time ago. It is very important for individuals; not only clinicians but healthcare professionals can be very strongly motivated by the opportunity to participate in research. It attracts them to work in institutions. It is very important in retaining them in those institutions. It provides the kind of variety across a long career, providing this substantial flexibility to move in and out of research opportunities, which can have a profound impact on ensuring that we develop colleagues over those long careers and that they are therefore deeply committed to the research activity and to ensuring the best clinical outcomes for the NHS more generally.

In 2021, only 14% of NHS trusts accounted for some 53% of recruitment to clinical trials in secondary care, which means that the remaining 47% of recruitment was from the remaining 86% of NHS trusts. Thirty or so institutions are particularly research-active, but if you look at the NIHR's own data from its Clinical Research Network, in October 2022 every trust had recruited at least one participant. Whether that is relevant is another question, but it demonstrates the NIHR's deep commitment to driving a research base across the entire NHS. That is important to recognise. We might come in a moment to how that is deployed.

In performance, however, there has regrettably been a decline. If one looks at the Clinical Research Network's own data, clearly there have

been and are problems. Some 54% of new commercial studies performed in the NHS, for example, delivered to time and on target. That is below the target of 80%, and lower than the performance in the previous year of 74%. There are broader pressures on the NHS that make the delivery of research more difficult, but it continues to be very carefully monitored. I think you would have heard from previous contributors to this inquiry that there are programmes to try to ensure that the NHS's research capacity and its delivery, which was impressive before Covid but regrettably was also declining, continues to achieve what we all need it to not only in its impact on the delivery of healthcare but for the broader benefits that research can bring to our economy.

I will make just one more point. Looking at research performance, between 2017 and 2020 the number of phase 1 clinical trials initiated in our country, at the beginning of the clinical research pathway, fell by some 29% and phase 2 trials fell by 17%. Pharmaceutical R&D spend in the period 2011-20 grew by only 2% in our country as opposed to a global increase in R&D spend by pharma of some 45% and an 87% increase in US pharma spend on R&D, much of which we would have hoped and expected to be spent in our country.

Unfortunately, this has been attributed to some problems in performance, long start-up times, with a median of some 247 days still in the NHS, and a number of other metrics that we can discuss. In reality, our performance has fallen regarding industry-sponsored research in the NHS. We were fourth globally in the rankings for such activity in 2017; in 2021 we had fallen to 10th in the global rankings. We have an important commitment to the infrastructure, but when OSCHR looks at these questions there are issues that we need to address.

Lord Krebs: Thank you for that comprehensive answer. To what extent is the leadership in particular NHS trusts crucial to whether clinical academics conduct research? Is this a matter of local or national leadership?

Lord Kakkar: It is a combination of both. There is a strong commitment in the leadership to the delivery of clinical research in terms of a strategic national view, led by the NIHR but with other partners, such as UKRI, the Office for Life Sciences and so on. There is also a strong commitment to and understanding of the importance of research at the local NHS level in terms not only of the delivery of research itself but of the performance of the NHS, the achievement of the best clinical outcomes and for the development and retention of staff.

However, we have to recognise that the NHS faces considerable pressures and challenges regarding delivery of healthcare. One wonders how much that is impacting on the capacity to do research. As chairman of OSCHR, I am reassured that the 11,000 staff employed by the NIHR and the Clinical Research Network as part of their obligation to provide infrastructure for research in the NHS are ring-fenced. Some of them were transferred away from research activity to front-line clinical care during the Covid pandemic, but that has now been reversed. That is an important point: without that infrastructure and the staff infrastructure

for the delivery of clinical research, the capacity of clinical academics and others who wish to conduct research in the NHS will be substantially diminished.

Q34 Lord Winston: Excluding clinical trials for a moment, because you spent a lot of time talking about them and you have metrics on them, I am very interested in the sort of research that innovates in the health service. There have been a number of things where the NHS has led with new technologies that certainly did not involve trials but did involve the use of basic science that is integrated in clinical care. That is an important thing that we should be doing. Are you able to give me some idea of how clinical research is prioritised in this way and funded, the current model that is there and how the various organisations, such as UKRI and so on, integrate what they are doing and collaborate?

Lord Kakkar: That is a vital question and issue. To divide it out, as I said there has been a decline in participation in industry-sponsored studies, with some 50,000 participants in 2017-18 down to just 28,000 in 2021-22. If one looks at overall participation over that same period, industry and non-industry, the numbers have increased from some 853,000 to 1.28 million in 2021-22, although that is a decline of 100,000 from the previous year. Much of that will be the kind of activity you describe.

One of the very important aspects of the original purpose of OSCHR and something we need to return to beyond the review of 2011 is to ensure that funding streams for that kind of activity—clinical research driven by basic and translational science insight and clinical observation, conducted in institutions that have that kind of biomedical research capacity, innovative medicines and innovative therapies development strategies, and early experimental medicine centres—are very strongly supported. There are schemes to support that. The NIHR has, for instance, its network of biomedical research centres. There are a number of experimental research centres beyond those early therapy centres, supported through public funds and the major research charities. I have not seen detailed data on that activity, but I think we all know from our own institutions that much of the important innovation comes about in exactly the fashion you describe.

Lord Winston: What are the challenges of co-ordinating these, therefore? For example, there are a lot of charities supporting cancer research. How is that all co-ordinated? Is that the best way of doing it at present?

Lord Kakkar: The Association of Medical Research Charities has a seat on the OSCHR board, so it is aware of and participates in the discussion regarding understanding and setting the national research priorities. Those are the priorities that I believe very strongly organisations that receive public funding to support health research should be committed to and should be held to account for.

Once that strategy and the public funding contribution are properly understood, Wellcome and the other charities have an opportunity to align their funding objectives and priorities accordingly. Subsequent to all

that, industry and commercial funding can be aligned. Finally, all that should align with what Innovate UK does to drive the broader growth agenda.

I strongly believe that we need to maintain that approach—indeed, reinvigorate it—because ultimately there is only a certain quantum of money available for health research in our country. We have identified important priority areas, we have developed an infrastructure, and we have certain institutions that can make contributions at different points in that development pathway.

However, if things are not properly co-ordinated, we lose that opportunity. Are there challenges and problems? Invariably there are, and I think some of those relate to the purpose of this inquiry, such as ensuring that we can both support clinicians who wish to contribute to the kind of research that Lord Winston describes and develop clinical academics at different stages of their own career and give them the time, opportunity and flexibility to make that kind of very important early innovation contribution and bring those early innovations to the patient and the bedside rapidly, because that is how we can make substantial progress.

The Chair: Lord Krebs, do you have a very brief intervention? Perhaps we could have a very short answer to it.

Lord Krebs: Thank you, Lord Chair. I am sorry to intervene again. I have heard it said that the Wellcome Trust has ceased its clinical academic training fellowship scheme and folded it into its more general training scheme. Is that true? If so, does that have implications for the future recruitment of clinical academics?

Lord Kakkar: As the committee will be aware, Wellcome has changed its research priorities for its next strategic period. It remains deeply committed to the United Kingdom across a range of funding options. The research councils and the National Institute for Health Research also have a variety of different fellowships available at different stages. The capacity to develop individuals remains in the country, but it is being delivered in a different way.

Q35 **Baroness Warwick of Undercliffe:** My question follows on very closely from Lord Winston's, and your opening remarks about the importance of co-ordination. Could you tell us whether—and, if so, how—the co-ordination of funding and research changed during the pandemic, and then perhaps what is happening now as the pandemic ends? Are there any trends that you would highlight that we should have a look at? As a corollary of that, is there appropriate recognition within the NHS that research-led clinical work produces better patient outcomes?

Lord Kakkar: If I may deal with the last point first, I think there is a general recognition that research-active institutions are broadly good, as I have said, in both the delivery of healthcare and the development and retention of staff. Patient participation in research protocols, because of the intensity of supervision, is often associated with improved clinical

outcomes, even if patients are participating in the standard of care or placebo arm of a study.

Overall, it is a very good thing to do, and our country has recognised this with a deep commitment to the broader academic health sciences agenda, the establishment of academic health science centres, and the establishment across the entire NHS of academic health science networks for the adoption of innovation across entire health economies.

On the broader question about how the landscape has changed, Covid represents an interesting paradox. Although there were some concerns about the research base in our country pre Covid, the system was rapidly mobilised and it was understood that research was essential to deal with Covid—a disease that we knew little, if anything, about. In that regard, the recovery trial programme was able very rapidly to recruit large numbers of patients being admitted with Covid, to apply rigorous methodology to addressing important questions about therapy, and to establish, for instance, the importance of dexamethasone as a simple intervention, which is believed to have saved some 1 million lives as a result of appropriate intervention in hospitalised Covid patients and so on. There is no doubt that we had in the country an established infrastructure and base to be able to conduct that clinical research rapidly.

Post Covid, mobilising that base and putting it on to a more sustainable footing in order to address some of the other major priority areas identified in the life sciences vision—cancer, dementia, mental health, obesity, ageing, respiratory diseases, the development of vaccines, and so on—does not appear to be happening. There is an awful lot of enthusiasm to make it happen, and there is no doubt that substantial public funding has been mobilised through the spending review and devoted to these areas and to the public institutions that marshal those funds, but we need to ensure that these multiple organisations—be it the devolved Administrations, the Office for Life Sciences, UKRI, the Medical Research Council or the NIHR—are strategically co-ordinated to the agreed national priorities, and that the NIHR is then able to mobilise its infrastructure and capacity to ensure that research, be it translational, early-stage clinical and experimental research or later-stage clinical research, can be delivered effectively and that we can mobilise the co-funding from the third sector and industry to address those priority areas. There is more to be done.

Baroness Warwick of Undercliffe: Can you indicate what the stimulus would be for that? It is potentially extremely disappointing to get that amazing strength of research recognised and acted on and then to find that the opportunity to exercise the same speed in other areas might slip away from us.

Lord Kakkar: There is one part that has given me assurance, and that is the deep commitment of all these funding organisations not to allow that to happen. Let us go to the pre-2011 era of OSCHR, when the objective was to ensure that strategic co-ordination and an alignment of the funding and funding needs, and then to monitor the application of those

funds against a clear programme of delivery. That is where I hope the system will agree we should go to in order to ensure that what has been achieved through Covid will not be lost.

Great credit to the NIHR: it has recognised that there are problems and has a programme called Research Recovery and Reset to try to deal with the underperforming studies in the national research portfolio and to ensure that capacity is properly aligned with opportunity. We need to continue to monitor the performance of those interventions to determine whether they can mobilise the kind of research opportunity that is consistent with what we achieved during Covid.

- Q36 **Baroness Walmsley:** In your answer to Lord Wei you touched on the fact that in some parts of the country there are centres of clinical excellence that tend to attract a greater share of research funding, but that in other areas of the country there may well be challenges with respect to their capacity to take on clinical research work. What might be the implications for regional inequalities of funding of those facts and, as a consequence, inequalities of outcomes for patients and of the ability to retain health professionals, for whom the opportunity to do research can be a great aspect of the ability to retain them, as you also said?

Lord Kakkar: I certainly believe that the question of health research sits at the very centre of the Government's levelling-up agenda.

We know, for instance, that the most important determinants of health outcome are actually the social determinants. We know that much of the burden of disease attending the national priority areas identified as part of the life sciences vision reside in parts of the country with the greatest economic challenge and deprivation. We also know that in the parts of the country that are attended by poor outcomes frequently there are fewer GPs per head of population and there is much less access to secondary and tertiary care facilities.

It is therefore very important that we try to have a national research effort that is conducted where the burden of disease sits, so that we can ensure that patients with that burden of disease from those communities participate in our research programmes, and that we have the best understanding of the performance of innovation and intervention in those populations and how we might address those populations with regard to the appropriate adoption of that innovation.

We also have to be very clear that much of the fundamental science, translational science and early clinical evaluation will occur in highly specialist centres. That is why we need proper co-ordination throughout the innovation pathway, right through to its adoption. One way to address the challenge that you have identified is for some of our highly specialist institutions—academic health science centres and so on—to work not only with their local populations but with other parts of the country where there is a huge research need and a substantial population of patients who could contribute to that research effort.

Baroness Walmsley: Do you think that researchers in those centres of clinical excellence understand the opportunity of conducting their

research in the areas where that burden of disease occurs?

Lord Kakkar: I think there is an increasing understanding of that. It should not only be NHS clinicians, doctors, who do research in the NHS; we should facilitate research opportunity for all healthcare professionals. I should have declared at the beginning that I am a clinical academic and that my career was supported by the Medical Research Council through a clinical training fellowship and then a clinician scientist fellowship before I took on my professorial roles. So I have benefited from all this investment over a long time in our country.

It is striking that I could do that and still be an active clinician. But a nurse can be either a clinical nurse or a research nurse; one cannot be both at the same time. That seems a terrible waste of opportunity for patients, for professionals and for our system more broadly.

Do colleagues understand the opportunity? I think that increasing numbers do. Are they excited and motivated by that opportunity? Definitely. Do those institutions, which are not seen traditionally as research-active, have the capacity to do the research? Not always, but they do increasingly because of the attention the National Institute for Health and Care Research is paying to the broad base of research in our country.

However, there needs to be much more collaboration between institutions and centres that have the natural capacity to do this, because although they are supported not only by public funds but by a broader funding base, they will not necessarily always have the population of patients adjacent to them. That is where the national infrastructure is very important.

As your inquiry is trying to identify, we need to continue to put effort into developing the opportunities both for the deeply committed clinical academics and for the deeply committed contributors from their strong clinical base to the broader national research effort.

Baroness Walmsley: Thank you. That sounds like a recommendation for us.

Q37 **Baroness Manningham-Buller:** Good afternoon, Lord Kakkar, and thank you for appearing in front of us.

Would you like to elaborate on the future—you have already, to a degree, covered some of the things that you wish to do—and on some of the NIHR's ambitions? We have heard throughout the evidence that some of your successors as clinical academics are finding it difficult to get started because of uncertainty about the future, pay and pensions, and that the pipeline is at risk. Would you like to give us an observation on how we can encourage that pipeline to expand and develop, as you say, not only doctors but other health professionals?

Lord Kakkar: It is a very important part of your inquiry and your Lordships' capacity to make recommendations. I too am concerned in this regard. It is always important to recognise the good things that we have

in our country and what we have been able to achieve. A lot of the research base and the NHS's capacity to deliver research, if it is properly motivated to do so, is a national success story.

However, current performance in delivery of that research base is not a national success story, although the NIHR is delivering it. There is no doubt that a strong research environment in the NHS is critical, be it a broad clinical trial or clinical research environment, or, as Lord Winston put to us, clinical research sitting right next to the laboratory with a rapid translation environment. If they are not properly sustained, that will have a profound impact on the confidence of our younger clinicians to commit themselves to a clinical academic career.

All clinical careers are hugely demanding, but a clinical academic career is incredibly demanding, because one has to be a good clinician to be able to stand shoulder to shoulder with colleagues in the hospital and a good academic and a good scientist to stand shoulder to shoulder with the great scientists in our institutions. One cannot afford to fail on either of those counts. Therefore, it is very demanding for those who decide to pursue this career. They need to be supported, and we have to be clear that not all of them will necessarily be very successful in this regard.

We then have to be clear about what that support means. In the early phase, it means the capacity to complete one's clinical training while being trained properly in research methodology, be it basic, translational or clinical research methodology, or indeed all those domains.

One then needs to ensure that there is flexibility in the clinical academic career, because there will be times when clinical academics need to do more clinical work but still have the capacity to continue their research. There are other times when they will want to focus more on their research, which may be clinical or experimental. Then there are times, and I do not think we are very good at this, when those individuals may want to leave completely for a while and go into industry or other elements of the broad research ecosystem to develop themselves or to pursue questions. They need to be able to do that and come back into the system.

We also need to be clear that the NHS can support clinicians who wish to be research-active but not full-time clinical academics to give perhaps one or two sessions of their time every week to participate in the research activity to assist in a broader team for research delivery and so on, and we need to be clear that that funding can be flexible and that clinicians at different stages in their career can move in and out of those different opportunities.

Q38 Baroness Manningham-Buller: Thank you very much. That is very clear agenda to stem some of the decline in our success that you mentioned earlier. Other things are also important, such as recognising what clinical academics do beyond their research and the clinics—in other words, tutoring and attracting young people to go into this. Are people given credit and measurement for that, or is it just thought to be part of the day job?

Lord Kakkar: I think they are. Clinicians and clinical academics have programmed activities which they can devote to teaching and training, and it is hugely important. When we talk about clinical academics, of course the research and the contribution to the broader national research life sciences agenda is what catches the eye, but academics and NHS clinicians have a hugely important role to play in teaching and training.

That needs to be supported and encouraged, and that support needs to be reflected in job plans and time dedicated to that activity. Without that teaching and training, the generations that follow will not be developed and inspired. Those of us who trained 30 to 35 years ago have really benefited from the fact that we were surrounded by clinicians, clinical academics and clinical scientists who were deeply committed to training and developing the generations that followed.

Baroness Manningham-Buller: You have described a number of things that you think need to be addressed. You started, correctly, by saying what is good, but you identified a number of areas that needed improvement. As chair of OSCHR, you can have some effect on that, but where do you think the bulk of responsibility for addressing these problems lies, and how would you prioritise what should be done?

Lord Kakkar: The first is with the Secretaries of State who take responsibility in this area. This afternoon I am going to see the Secretary of State for Health and Social Care. OSCHR reports to the Secretaries of State for Health and Social Care and for Business, Energy and Industrial Strategy. I hope there will be an agreement that, despite success over a number of years, our system for the delivery of health research and the broader life sciences agenda is now quite fragmented.

Funding goes to a number of organisations, and there needs to be a proper strategic co-ordination between them. I hope that OSCHR might assist in achieving that and therefore provide the opportunity for Ministers to put the full weight of government behind agreed strategies, programmes of activity and funding to deliver the kind of opportunity that the previous commitment to and investment in infrastructure uniquely provide in our country.

The second is that once the funding bodies have agreed the internal alignment, they need to ensure that they are engaging broadly across the academic and clinical systems in our country, ensuring that they are applying the funds that have been secured in a sensible fashion both geographically and in terms of the broader research opportunity. That means attention to building capacity where capacity needs to be built but, very importantly, securing, sustaining and promoting excellence in centres where that excellence provides the greatest opportunity for rapid and globally competitive innovation.

Thirdly, we need to ensure that all this aligns with the substantial research funding opportunities that come from charities, both the Association of Medical Research Charities and organisations such as Wellcome, which are very deeply committed, and remain committed, to the UK biomedical research opportunity, and that that ultimately is able to interact with the Life Sciences Council and the work of the Office for

Life Sciences, which is now the interface for industry funding, and that finally all of this can be effectively mobilised within Innovate UK so that the broader growth agenda can benefit from the activity across this pathway.

Baroness Manningham-Buller: Thank you very much. I think the committee would want to wish you every luck in your meeting this afternoon with the Secretary of State.

Q39 **Lord Rees of Ludlow:** I would like to stray somewhat beyond the agenda of this session and take advantage of your presence to ask you more generally about the predicament of the NHS, which of course makes headlines every day, and in particular about the medical schools and the training of doctors.

As an outsider, one reads of the huge numbers of highly qualified students who would like to enter medical school but are not able to, and about the fact that some medical schools are taking mainly foreign students and not our own. This is surely a situation that we have known about for the last 10 years, from international comparisons. I wonder what you think about this. Is there any real chance of us catching up with other countries in our ratio of medics to population, et cetera? It seems shameful that we are in such a low state when it has been obvious for many years that this is a crisis.

Lord Kakkar: Your Lordships' ad hoc Long-term Sustainability of the NHS and Adult Social Care Committee, chaired by Lord Patel, presented its report in the 2017-18 Session. That touched on this very question of the need for a properly thought-through long-term workforce strategy for the NHS. The proposal of your Lordships' committee on that occasion was to create an office for health and care sustainability, which would independently report, having taken due account of the population demographic, the changing needs in terms of chronicity of disease, the opportunity for innovation and the changing pathways of practice, in defining the clear workforce needs over a 10-year planning horizon, at the very least; and, importantly, understanding the different skills that would need to attend different professional groups in the NHS.

It is a question not only of doctors but of understanding what work doctors should do in the future, and what other parts of the delivery of healthcare, which is a truly collaborative team effort, might be discharged by other members of the team, properly developed. I think I understood from the Chancellor's Autumn Statement that some approach is now being made to develop that kind of independent, long-term assessment of workforce need in the NHS.

With regard to medical schools, it would seem completely intuitive to increase the number of medical school places, as the Government have done, although maybe to an even greater extent, but there seems little merit in doing that if medical schools are not funded to take UK students. It is all these things that we need a proper, co-ordinated view on. We need to take a view not only on the funding opportunity to build the infrastructure, in this case capacity in medical schools, but on taking

medical students through that undergraduate, or indeed postgraduate, medical school education, and then ensuring that we have training opportunities for properly skilled individuals to develop themselves to discharge into the different disciplines—primary care, secondary care, et cetera—that will be required for the country. However, all that needs to be done alongside understanding how other healthcare professionals may also be developed on a long-term basis.

Lord Rees of Ludlow: Clearly, we need long-term planning, but I still do not understand why there is not more pressure, maybe from the medical profession, to address this urgently. We all know about the crisis, and it could be eased simply by more numbers and, incidentally, by disincentivising early retirement and things of that kind. I wonder why the short-term remedies that could be applied are not being. You want to think over the long term as well, but I am sure that most of the public are worried about the lack of urgency in addressing these questions.

Lord Kakkar: You are quite right. The Medical Schools Council, for instance, which brings together the leadership of all the medical schools in the country, had its annual meeting last week. We are addressing exactly that kind of issue and the arguments that may be put to government with regard to numbers.

The leadership of the medical professions—there are many organisations that lead in medicine—have a collective view on the importance of addressing such issues as pensions to avoid the early retirement of many clinicians in their 50s. Indeed, I was reading in one of the papers only today or yesterday that the Government are now starting to make a move in that direction, given the complexity of retirement and return to NHS clinical practice.

I agree that there needs to be very thoughtful thinking in NHS England itself regarding the nature of a clinical career over a sustained, longer period of time. For instance, it may be difficult for clinicians over 65 to do active on-call in an acute speciality or to be a busy acute general surgeon over 60, but they could very easily stay in practice, treating out-patients, doing training and teaching, doing endoscopy lists and elective surgical lists, and so on. There needs to be a lot more imagination in the way we plan for very long, extended careers to avoid the kinds of problems that we see now.

Lord Rees of Ludlow: Are there particular recommendations that we could make without straying too far outside our remit that would help with this agenda?

Lord Kakkar: As part of this agenda, the most important recommendation would be to ensure that the Medical Schools Council has the appropriate interface with NHS England and the new body that is going to deliver workforce planning, so that in the short term those delivering care can have a real understanding—I suspect they probably have these conversations, but it is to be strongly encouraged—of what the capacity for delivery would be, not only in numbers but in the delay between taking new medical students and delivering doctors who can perform meaningfully in clinical practice, and that the opportunity is not

lost in the future by the Medical Schools Council having a proper interface with workforce planning.

Q40 The Chair: Thank you very much for taking us so comprehensively through the very complex ecosystem that makes up clinical academic research and the support for it. I cannot help but ask you whether there are perhaps too many bodies in this area, all trying to do co-ordination and prioritisation, and perhaps we are not getting the clarity of leadership that we need in this area. I would really value your opinion on that.

Lord Kakkar: When thought was given to having a co-ordinated health research strategy across the country, there were two principal bodies: the Medical Research Council and the National Institute for Health Research.

The landscape since then has one positive and one negative. The positive is that a lot more public funding is committed to health research and the life sciences agenda in our country. That is to be welcomed. As a corollary of that, the infrastructure to deliver research is much better than it was. The problem is that, with so many bodies, there is a risk of a lack of co-ordination. We need to bring those bodies together and in the first instance determine—because it may well exist but is not well described—that there is clarity of purpose and strategy and that participants and stakeholders are reassured by that and can, beyond the public funds, mobilise the third sector and commercial funds to deliver to this national effort.

If we find that the co-ordination of strategy does not exist, it needs to be achieved quickly, and that achievement might be through realigning or reorganising bodies, although all that reorganisation runs the risk of quite a lot of delay. I think Ministers are committed to this area, and it is now just a question, having come out of Covid and of course dealing with the major challenges in the NHS, of us not allowing the research agenda, and the attending agenda, to develop those who wish to participate in research to be lost. That is something that I know a number are committed to and certainly OSCHR is very committed to.

The Chair: Can I interpret that as, yes, we need more clarity, but that that does not necessarily necessitate more simplification?

Lord Kakkar: We need certainty about strategic alignment. That is what I would equate to clarity. What one would not want to do is propose lots of reorganisation that meant that everything else is delayed. We live in an era of huge challenge for our fellow citizens in securing access to care, and we want to ensure that that care is advanced to deliver better and better clinical outcomes in the safest possible environment.

To do that, we need the right people delivering it, and we want to avail ourselves of what is a golden era of innovation in biomedical research and ensure that that innovation can be adopted at scale and pace in our health economy, because that improves outcomes, it is exciting for those who work in the health economy and, of course, it has a profound potential impact on our economic growth, not only because we have a

healthier population but because of the wealth creation that flows from that innovation.

The Chair: Thank you very much indeed for giving us your time. It has been a really informative session.