Allocation of programmed activities for research in NHS Trusts

Background

All NHS Consultants are expected to engage in and contribute to the wider research and teaching agenda. Many Trusts allocate programmed activities (PAs) to consultants for research purposes. In most cases research is badged against supporting professional activity (SPA) time within a consultant's job plan. In addition, Direct Clinical Care (DCCs) may be "bought-out" using various research funding sources and/or the consultant may be paid additional programmed activities (APAs) to deliver research. A recent comprehensive survey of AUKUH Trusts demonstrated that both the numbers of research PAs and the processes by which these monies were disbursed, were variable between trusts, dependent in part on the scale of their research infrastructure and funding. The metrics used and the processes of allocation were equally variable, with responsibilities lying with the Medical Director, R&D Departments, or in some cases being devolved to clinical departments.

It was therefore agreed that a set of simple principles and guidelines was needed to encourage the adoption of equitable and cost-effective ways of distributing the resources available for research, noting there is no expectation of a "one size fits all" solution.

Recommendations

1. All Trusts that allocate research PAs (whether SPA, APA and/or DCC) should keep an accurate and contemporaneous record of how these resources are distributed and to whom, at the level of the individual consultant, the Division/Directorate/Department and Organisation. Similarly, an accurate record should be maintained of those who are allocated time to undertake teaching or other non-clinical purposes.
2. It should be the primary responsibility of the Medical Director, in partnership with the Director/Head of R&D and the Chief Executive, to regularly review research PA allocations, and to ensure the mechanism of allocation is both equitable and transparent. In some trusts the Medical Director may not have board level responsibility for R&D, but should still be involved in the review process.
3. The source of the funding and the principal reason(s) for the allocation of the research PAs should be documented and reviewed, at least biannually. Transparency is key to the process of allocating research PAs and activity levels must be evidenced-based. Historical activity should not be rewarded unless it is sustained and it should not be assumed that because a consultant has had an allocation of time in their job plan with commensurate remuneration for research activity for some years that this should continue automatically, in the absence of continued performance.

4. Trusts should identify the funds, and a transparent method, to allocate research PAs to newly appointed consultants to pump-prime their research activity, thus allowing them to develop an appropriate research portfolio. If "pump priming" funding is offered, this should be on the basis of clear and pre-agreed achievable outcomes that could include recruitment to new studies and/or obtaining grant funding.
5. At the level of the individual consultant the assignment of research PAs should be integral to the job planning process, and the relevant Departmental managers and/or Medical Director involved in that process should have full access to the relevant information relating to the research productivity of both the individual and the Department in which he/she works. Suggested indices of research productivity are listed below.
6. The award of a research PA when accompanied by sustained productivity in terms of volume and quality of activity, may be used in support of evidence of research activity, for example in ACCEA applications or for consideration of an honorary academic title by partner Universities.
7. In addition to the assessment of research activity performed at the level of the individual consultant as part of the job planning process, it is also suggested that the Director/Head of R&D, meets on at least an annual basis with the relevant local Clinical Research Network (LCRN) speciality and/or Divisional leads and the clinical Departmental/Divisional leads to discuss the research activities (both historical and planned) of every clinical area. Such a review should also involve the relevant academic leads from the major partner teaching hospitals and universities, where relevant.
8. Trusts should carefully consider whether to invest in areas where clinical research is unlikely to be sustainable as a consequence of a service transfer or other major modifications in patterns of service provision. Conversely, the allocation of research funding may in some cases facilitate and/or develop a commissioned clinical service.

Metrics of research productivity that can be used to allocate research SPAs

1. Recruitment of patients into non-commercial and/or commercially funded NIHR portfolio trials, at Chief or Principal Investigator (CI/PI) level. This provides the opportunity for all eligible patients to participate in the evaluation of new therapies and generates significant prestige and income for the organisation. Being PI or CI on one or more clinical trials should therefore be regarded as a measure of success in this context, with an emphasis on numerical recruitment into NIHR portfolio trials, as compared to "own-account" research.
2. All trusts in receipt of NIHR research capability funding (RCF) and/or local charity funds are strongly encouraged to set up a transparent and peer-reviewed mechanism to allocate staff (medical, nursing, AHP and medical scientists) dedicated pump-priming time/research PAs to develop NIHR (and other funding bodies) grant applications. These research PAs are can be allocated for a preliminary period (for

example up to one year) to generate pilot data that underpins an application and then prepare the grant application. Dedicated research PA time should be included as a direct cost in the grant application for the individual to deliver the study, and if awarded then that funding is allocated appropriately to their Division/Directorate/Department.

3. Innovation and product development may also be used as a metric for allocation of research PA(s). Trusts should recognise the benefit of consultants developing new devices, surgical procedures or imaging techniques, which attract additional income, clinical activity and referral to the organisation, particularly if this is at a regional or supra-regional level.
4. Consultants may also be considered for the allocation of a research PA by a trust if they meet a sufficient number of the standard academic indicators of productivity. Each trust should agree and publish that threshold of activity. These measures could include first or senior author publications, grant income (e.g. NIHR, funding council, or charitable funding), co-supervision of higher degree students, measures of esteem and demonstrable public impact. It should be recognised that busy NHS consultants are less likely than university clinical academics to be senior or last authors on papers, and may provide a facilitatory role in academically led research by identifying eligible patients and/or providing clinical materials.

Other activities

Some hospital consultants receive remuneration for coordination and/or managerial roles such as LCRN speciality leads, teaching roles (funded by partner academic organisations) or as clinical leads. These are usually funded in the form of additional programmed activities and are included in an individual's job plan to ensure they can deliver that activity. Such funding is independent of research PAs and is therefore beyond the scope of this paper.