
Non-medical staff in academic departments of Primary Care

Report of a Working Party set up by the Executive Committee of the Society for Academic Primary Care

Working Party members:

Sue Wilson,
Catherine O'Donnell,
Hilarie Bateman,
Claire Goodman

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Correspondence to s.wilson@bham.ac.uk

Executive summary

This report discusses the current position of non-medical (i.e. non-clinical, nursing and allied health professionals) academic staff employed in academic departments of primary care. Academic departments of general practice and primary care are located in the University environment and play a key role in research, education and policy development.

UK academic departments of General Practice and Primary Care deliver research of the highest standard and multi-professional research undertaken by these Departments has played a key role in recent primary care policy developments.

This report recommends that the SAPC furthers the debate in the following ways.

1. Providing examples of good practice: The SAPC should seek to identify examples of good practice and disseminate these through the HODS group.
2. Lobbying of research funding bodies: The SAPC should identify those funding bodies that will still not allow individuals to apply for funding as principal investigators and work on the project as the main researcher. It should seek to open a dialogue with these funding bodies and to lobby them to change their policies.
3. Lobbying Universities to identify methods to ensure staff retention: Short-term contracts and low salaries for non-medical research staff compromise the recruitment and retention of contract researchers in academic departments of general practice and primary care. Methods of ensuring closer financial parity between service and academic roles need to be identified; otherwise strong individuals will increasingly be attracted away from the academic job market to NHS employment in response to better salaries.
4. Active encouragement of non-medically qualified members within SAPC: It appears that many non-medically qualified research staff currently prioritise other professional societies (e.g. RSS, Soc Soc Med, FPH), this may be because the agenda of non-medical staff is not adequately encompassed within the current activities of the Executive and the content of the Annual Scientific Meeting. This may require imaginative and proactive strategies to further encourage the participation of the non-medical membership in the strategic development of the Society.
5. Code of Good Practice: The SAPC could endorse the University Concordat for contract research staff and promote this through its close links with the Heads of Departments of Academic Primary Care and General Practice (HODs) Group.

Conclusions

Enhancing the status of academic primary care requires collaboration between both medical and non-medical staff. High quality research and teaching requires both groups. However, the difficulties faced by non-medically qualified staff, particularly those on short-term contracts, are real and deep-rooted. The SAPC has an opportunity to develop and inform the debate on supporting non-medical staff, which will be to the advantage of all professional groups working within primary

Purpose of this report

This report discusses the current position of non-medical (i.e. non-clinical, nursing, pharmacists and allied health professionals) academic staff employed in academic departments of primary care. Our aim is to highlight key concerns about the position of these staff which impact on the capacity of academic primary care to deliver required outcomes. A particular focus of this paper is the position of non-clinical staff employed on short-term contracts, of which the majority have no clinical discipline. However, the issues raised are also of relevance to other non-medical staff on short-term contracts (i.e. nurses and health professionals allied to medicine). It draws principally on the work of the Academy of Medical Sciences, who recently reported on the experiences of non-clinical contract research staff (Academy of Medical Sciences 2002) and seeks to identify areas where the SAPC can continue to lobby for improvements.

Whilst this reports aims to focus on areas of concern there are a number of academic departments that have made considerable progress in developing and promoting non-medical staff. The positive attitude of many departments and the advances that have been made towards developing successful careers for non-medical staff in academic primary care should not be undermined by this report that aims to build on this progress. It should also be recognised that our medically qualified colleagues also experience some of the difficulties that are described; problems relating to equity of salary and short term-contracts affect all those attempting to develop an academic career.

Why does it matter?

Academic departments of general practice and primary care are located in the University environment and play a key role in research, education and policy development. This can only be furthered and maintained by a multi-disciplinary mix of professionals working together.

1. The Research Assessment Exercise.

UK academic departments of General Practice and Primary Care can deliver research of the highest standard. In the 2001 RAE, 27 departmental groupings were returned within the Community Clinical Sciences Units of Assessment. Of these, 24 (88%) achieved a score of 4 or above, indicating at least a national level of research excellence. In the sub-panel assessments for primary care, five achieved a rating of 5 or 5*, indicating research of the highest international standard. As Universities prepare for the next RAE, this standard must be maintained and bettered. However, such success is dependent on the availability of a highly skilled, well-motivated and multi-disciplinary workforce (Academy of Medical Sciences 2002).

The Mant Report (1997) emphasised the essential importance of drawing on specialist expertise from related academic disciplines such as social sciences, epidemiology and statistics if the quality of research in primary care was to be maintained. The report recommended that academic primary care should seek to attract non-clinical researchers from other relevant disciplines by identifying and addressing the disincentives that exist. More recently, in his forward to the SAPC's report "*New Century, New Challenges*", Howie noted the continuing inequitable treatment of highly valued researchers, such as social scientists, and perceived this continuing disadvantage as a real threat to continued progress in primary care research. This report also highlighted the extent to which research in general practice and primary care is characterised by multi-method approaches, as identified by a range of high quality peer reviewed papers illustrative of the best primary care research. The 58 papers included in *New Century, New Challenges* had 259 authors identifiable, comprising 104 (40%) GPs, 39 (15%) were from other medically qualified disciplines, 16 (6%) were nurses or other allied health

professionals and 100 (39%) were non-clinical scientists. This diversity of professional expertise must be maintained and expanded if academic research is to flourish.

2. Enhancing educational delivery.

Undergraduate Education: Universities play an important role in educating and training dentists, doctors, nurses, therapists and other NHS staff. In 2000/01 for example, there were nearly 146,000 full-time undergraduates in a variety of health related subjects (Partners in Care 2003). Medically qualified staff teach substantial elements of the undergraduate curriculum but non-medical academics also provide teaching with specialist expertise in, for example, communication skills, research techniques and social and community care; the importance of the contribution from non-medical staff in the expansion of community-based teaching was noted in *New Centuries, New Challenges*. The role of non-medical staff has been further extended within the medical curricula since the GMC guidance ("*Tomorrow's Doctors*"), which emphasised the need to develop a greater awareness of the social sciences and humanities (GMC 2002).

Postgraduate/continuing education: The provision of continuing education for professionals in primary care draws upon academic expertise. In addition to facilitating the development of clinical expertise, professionals in primary care are supported as they develop interests in research and teaching. Non-medical staff with specialist knowledge and qualifications are often involved in helping practitioners to develop their skills in these fields and often act as supervisors and/or mentors.

3. Policy development.

Multi-professional research from academic departments has played a key role in recent primary care policy developments. Examples include the evaluation of GP fund holding and purchasing schemes (Coulter 1995; Goodwin 1998; Wyke 2003), NHS Direct (Munro 2000; O'Cathain 2000) and walk-in centres (Grant 2002; Chalder 2003); work developing patient enablement measures (Howie 1999); and work into quality outcomes that have now been adopted into the Quality Outcomes Framework of the GMS Contract (for example Ramsay 2000; Campbell 2001).

What is the current situation?

Several reports have described various elements of the current situation (see appendix 1). Of particular relevance are:

- Concordat for Contract Research Staff - 1996, *Research Careers Initiative (RCI)*
- Mant Report – 1997, *R&D in Primary Care National Working Group Report*
- AUDGP Report – 2000, *Careers in Departments of General Practice and Primary Care*
- Roberts Report – 2001, *Research Careers Initiative*
- Academy of Medical Sciences Report – 2002, *Non-clinical scientists on short term contracts in medical research*
- SAPC Report – 2002, *New Century, New Challenges*

In monitoring the current situation in academic departments of general practice and primary care *New Century, New Challenge* noted that between 1986 and 2001 the proportion of non-medical staff within such departments had increased from 10% to 32%. The same report identified that although only 32% of staff were non-medical, they accounted for 81% of contract research staff.

These Reports have tended to concentrate on the position of non-medical academics involved in research (due to their numbers). It is likely that the problems and solutions identified also apply to those involved in teaching although we have less information about the latter group.

Concerns

a) Salary and status

'.....their status is lower than medically qualified researchers and this is intensified by their lower salaries.' (Mant Report, 1997, describing non-medical research academics)

The issues of salary and status are inexorably linked and are associated not only with professional group but also with gender. Despite the fact that non-medically qualified staff in many academic departments feel equally valued within their Units, medically qualified staff are remunerated at a significantly higher level than non-medical staff and clinical staff such as nurses tend to be on non-clinical pay scales. For example, a newly promoted clinical senior lecturer receives almost twice the salary of their non-clinical equivalent (£63,800 vs. £37,500) (<http://www.personnel.bham.ac.uk/salary/index.htm>). Non-medical researchers are often involved in training clinical research fellows who are receiving substantially higher salaries (Academy of Medical Sciences 2002).

Significant pay differentials also exist between the salaries offered in academia and those offered for comparable non-medical responsibilities in the NHS. The development of the role of Specialist in Public Health and the transfer of Research Management and Governance functions to PCTs have dramatically increased the number of NHS positions available to non-medical staff with research expertise. NHS based posts have consistently paid significantly more than academic posts during the past five years and attract many of those, who may otherwise have made a significant contribution, away from academic primary care.

The Academy of Medical Sciences report summarises the findings of focus groups conducted with non-medical researchers working in medical environments. It demonstrates that "they frequently considered themselves to be treated as second-class citizens. They believe they are often allocated the more mundane tasks, on the basis that they are perceived to have more time than their clinical colleagues. They may find themselves excluded from social and academic networks, often with a detrimental effect on their work. They feel that they are consulted less on decision-making and are often the last to know when a decision has been made." This perceived discrimination is more likely to be reported by more junior research staff (Academy of Medical Sciences 2002). This lack of status is compounded by the use of job titles conferring similar status ("research fellow") to groups that have significantly different levels of research training and expertise.

b) Security and career progression

"Non-clinical researchers are often employed as contract researchers on short term funding and do not always get adequate academic support. A preponderance of short-term project contracts and short-term posts makes a career in health and social care research unstable, unattractive and insecure". (Mant Report, 1997)

Short-term contracts are a problem for both medical and non-medical academics. However, it is widely believed by non-medical academics that those with medical qualifications are more likely

to secure tenured posts in clinical academic departments (Academy of Medical Sciences 2002). Non-medical scientists perceive that they are expected to train medically qualified PhD students who, often have limited previous formal research training, yet, “once trained, these students seem to advance above those who have trained them in terms of salary, status, job security and future prospects” (Academy of Medical Sciences 2002). Non-clinical scientists have an added disadvantage compared with their clinical colleagues, in not having a clinical career to return to if there is a gap between contracts; this adds to the general sense of insecurity.

Some Universities continue to appoint Clinical Lecturers who do not hold a higher degree, are not responsible for the organisation and delivery of teaching and have not got a publication record. The need to recruit and retain clinical academics may be cited as justification. However, discrimination in the criteria used as the basis for appointments and promotion can create resentment from non-medically qualified staff, particularly when the disparate salary levels associated with medical and non-medical grades are also taken into account.

As non-medical research workers develop their research career, career progression becomes more difficult. They may well be forced to sustain their career by obtaining grant funding that includes their own salary. However, some funding bodies still will not allow contract research staff to be a grant-holder (e.g. Wellcome) whilst others prohibit individuals from being both the principal investigator and the main researcher (e.g. Chief Scientist's Office, Scotland) (Appendix 2). This forces non-medical researchers to abrogate principal investigator responsibility and status to another, usually tenured, member of staff.

c) Professional marginalisation

‘Young academics in social sciences are very interested in primary care but they fear being marginalized if they work mainly in clinical groups they risk losing contact with their original discipline’ (Mant Report, 1997)

Both medical and non-medical researchers recognise the benefits from operating in a medical environment. These include the opportunity to undertake scientific research that relates to real and immediate clinical questions, working closely with people with different but complementary skills, and forming productive multi-disciplinary networks. (Academy of Medical Sciences 2002).

A sense of ‘professional community’ is important both in terms of maintaining currency over skills and knowledge and in terms of continuing professional support and career progression. Non-medical researchers moving into general practice and primary care research may be taking a greater risk with their professional futures than would be the case were they to stay embedded within their own home professional discipline and networks.

Many senior level (i.e. career scientist level) Fellowship Awards are available only to medically or clinically qualified practitioners. The Department of Health runs a successful fellowship scheme that is open to researchers from all disciplines and awarded 68 new fellowships in the 4 year period 199-2003. However, although 70% of the applications for NHS R&D Researcher Development Awards, in this period, were from non-medically qualified researchers, the success rate of these applications was only 10% whilst the success rate of applications from medically qualified applicants was 23% (Appendix 2). Other clinical specialties (excluding GPs) have marginally higher success rates than non-clinicians. This pattern of differential success rates is apparent at all three levels of award. The reason for the relatively poor success rate achieved those who are not medically qualified is not known.

What can be done?

Recent reports (Mant 1997, Roberts 2001, Academy of Medical Sciences 2002, SAPC 2002) provide a variety of recommendations to tackle the problems identified. Primary care research is enriched and strengthened by the formation and retention of experienced multidisciplinary teams. In the current climate when it maybe becoming increasingly difficult to recruit junior medics into academic primary care it is particularly important that we encourage the retention of staff from other disciplines. The sections below summarise some of the more immediate and achievable steps that can be taken.

Lack of financial parity

It seems unlikely that there will be any easy route towards reducing the financial disparity between medical and non-medical (many nurses and other health professionals are employed on non-clinical contracts by Universities) salaries. There is also a significant gap between academic salaries and salaries for those providing similar R&D services within the NHS. It may be easier to argue that there should be closer financial parity between service and academic roles than between medical and non-medical roles on the basis that strong individuals will increasingly be attracted away from the academic job market to NHS employment in response to better salaries.

Lack of status

Responses received to the Consultation exercise around the draft of this report suggest that the experience of many non-medical staff in academic departments of primary care is better than that indicated by the AMS report (Academy of Medical Sciences 2002).

Perceived status and career progression are improved when the academic unit emphasises the encouragement and support of contract research staff in publications, report writing and conference presentations. It is important to name individual contract research staff as key contributors within research wherever this is appropriate (Academy of Medical Sciences 2002). This applies to grant applications, publications, research reports, departmental reports and conference presentations. By so doing the contribution of contract researchers will become more visible and this visibility may, in time, have a positive impact on the status of individuals and non-medical researchers as a whole.

Job grades e.g. 'research assistant' may not give a sufficient impression of seniority. The Roberts Report recommends more widespread use of the term 'Research Fellow'. Alternatively, it may be that individual job titles can be defined which are more directly relevant to the research post/project and its standing e.g. 'Trials data co-ordinator' or 'Research recruitment manager'. Considered use of job titles in this way may contribute to future career prospects since titles such as 'research assistant' and 'research associate' have little meaning within R&D departments in commercial and NHS settings and may not create an accurate impression of existing responsibilities and seniority when applying for posts. Where titles such as lecturer or research fellow are used within a Unit then staff appointed to these grades should have comparable teaching and research experience irrespective of whether or not they are medically qualified.

One measure of the value attached to a particular group is the nomenclature used to describe them. It may be preferable for non-medical or non-clinical staff to be more consistently referred to by what they are rather than what they are not, e.g. social scientists, epidemiologists, statisticians.

Lack of security

Reducing the insecurity associated with careers based around research contracts is unlikely in the short term. Greater security is most likely to emerge alongside longer-term changes to funding and employment policy. Moves towards the funding of programmes and research units, rather than individual projects, may give more scope for continuity of investment in researchers. Changes in national employment policy (EU legislation) will have implications for the use of short-term contracts within Universities.

Examples of good practice do exist. For example, Robert Gordon University in Aberdeen recently moved all contract research staff onto permanent contracts and removed the term contract-research staff. This exemplar could possibly be repeated in other Universities, if there was greater understanding of how this had been achieved in Aberdeen. The Universities of Bristol and Birmingham have 'bridging' funding schemes that are centrally funded by the University to buy time to retain the services of experienced and valued researchers. Such schemes enable individuals to be retained within the Unit and maximises the research outputs from previous contracts.

In the short term we may also need to consider how to manage the inevitable insecurity rather more effectively. It is necessary to accept that insecurity is a feature of the current research environment for all academic staff. Contract research staff and their managers need to engage in frank but sensitive discussion about future prospects. This discussion should embrace a realistic assessment of the abilities and aspirations of the researcher and also of the viability of the research areas and programmes in which they may be choosing to work (Roberts 2001, Academy of Medical Sciences 2002). Such discussion should help to highlight whether career progression should lie: within the current research unit, in another research unit, in another area of R&D or outside of R&D. The discussion should take place early enough to allow preparation and planning to take place towards a different post or career (see below) (Academy of Medical Sciences 2002).

Lack of career progression

There should be recognition that not all staff wish for career progression. However, it is important that contract research staff and their managers acknowledge the joint responsibility for career progression. Regular staff review is an important aspect of career development for all academic staff. Academic promotion is closely related to research outputs and grant income and individuals must be proactive in addressing their training needs and generating publications and grant funding.

In deciding how to progress their careers it is recommended that contract research staff seek the advice of their managers and from University careers advisers. In addition it may be appropriate for a manager to help a researcher to seek out relevant training opportunities with the intention of building on current strengths or addressing current weaknesses in order to place the researcher in a stronger position for the type of post s/he would like to undertake in future. All staff should have reasonable access to relevant training. Within the Roberts Report (Roberts 2001: Annex 4) it was noted that only 23% of contract research staff had received training in financial and resource management and yet the demonstrable ability to manage resources within projects might provide contract researchers with an additional and relevant suite of skills on which to draw, particularly with the recent emphasis on enhanced research management and governance processes. A similar argument may be made for training in people management. Courses concerning project, financial and people management are often offered free within most University's staff development programmes. The Roberts Report suggests that these

opportunities are not as well used as they might be and that supervisors and researchers should jointly recognise their responsibility for identifying and making constructive use of these opportunities.

It is suggested that researchers should also have a designated mentor appointed from outside the research team with sufficient seniority to offer authoritative independent advice (Academy of Medical Sciences 2002). In view of the concerns raised about professional marginalisation (see above) it might be valuable to consider whether such mentors should provide a link to the researchers 'home' professional discipline. This would help the researcher to maintain currency with developments in their original academic discipline and engagement within the professional networks that might enable them to find a subsequent role.

The SAPC Annual Scientific Meeting (ASM) is perceived by some non-medical staff to be very clinically focussed with little opportunity for the presentation of papers with a predominantly methodological focus. Some methodologists have reported prioritising other professional associations which have more of a methodological edge. Consideration should be given to ensuring the availability of parallel sessions at each ASM that are dedicated to methodological issues. This would not only encourage non-medical staff to be more involved with SAPC but would also (a) encourage more methodologists to become involved in primary care research; (b) enhance the quality of research in primary care by allowing methodological issues pertinent to primary care to be more widely discussed, and, (c) enhance the quality of methodological research

Why should SAPC do anything about it?

The aim of the Society is to promote excellence in research, education and policy development in general practice and primary health care (SAPC website). Recent policy recommendations (e.g. Mant 1997 and SAPC 2002) have emphasised the importance of addressing the issues that face non-medical academics if excellence in research and education is to be maintained. However, despite these publications, recent articles on the future of clinical research (Bell 2003, Stewart 2003) have failed to mention the importance of the non-medical research community (Hopkins 2004).

Doctors have particular skills and experience that warrant rewards, however, successful research teams also need people with other backgrounds and experience. As well as people with for example methodological, statistical or IT expertise, clinical research also needs a broader range of paramedical professions. For example, a research project investigating the psychological sequelae of a diagnosis might have added value if a psychologist rather than a GP, assuming they both had the necessary research experience, led it. The most productive research collaboration is most likely to be the one that values the input of all specialties. The emphasis in the community is now about a wider disciplinary team and this should be reflected in academic research teams.

The SAPC provides an important forum for translating national policy recommendations relating to the development of academic primary care into achievable practical steps. Its membership is comprised of medical and non-medical academics and, traditionally, it has responded to the needs and concerns both of academic organisations and academic professional groupings. The position of non-medical academics is a sensitive issue and potentially divisive for these different constituencies. For example, academic departments may feel reluctant to accept a policy which advocates frank discussion with contract research staff about prospects 18 months before the end of a researcher's contract in case this leads to premature departure to the detriment of the

research project. Doctors may feel reluctant to support increased opportunities for advancement and status for those who are not medically qualified if there is any possibility that this may have a negative affect on opportunities for their own professional group. These concerns are entirely reasonable. In order to make progress that constructively embraces the perspectives of academic organisations and doctors, as well as other clinicians and non-clinicians we need to engage in responsible and respectful debate. This is an area in which SAPC can provide a forum for discussion, leadership over workable policy and models of emergent good practice.

Recommendations for the SAPC.

The SAPC can further the debate in a variety of ways.

1. Providing examples of good practice.

Examples of good practice do exist e.g. the imaginative use of bridging funds and Universities that have ceased to use short-term contracts. The SAPC should seek to identify examples of good practice and disseminate these through the HODS group.

2. Lobbying of research funding bodies.

The SAPC should identify those funding bodies that will still not allow individuals to apply for funding as principal investigators and work on the project as the main researcher. It should seek to open a dialogue with these funding bodies and to lobby them to change their policies.

3. Lobbying Universities to identify methods to ensure staff retention.

Short-term contracts and low salaries for non-medical research staff compromise the recruitment and retention of contract researchers in academic departments of general practice and primary care. Methods of ensuring closer financial parity between service and academic roles need to be identified; otherwise strong individuals will increasingly be attracted away from the academic job market to NHS employment in response to better salaries.

The opportunity for using the recommendations of Agenda for Change (one salary scale for all NHS staff excluding doctors and dentists) as a basis for University salary scales should be investigated.

The legal position regarding short-term contracts is changing with the introduction of EU legislation. Simple guidance regarding the current position and its implications could be made available on the website

4. Active encouragement of non-medically qualified members within SAPC.

About 35% of the SAPC membership is non-clinical; they are currently represented by three members on the Executive. The objectives of the SAPC reflect its responsibilities to the development of excellence within research, education and policy development in general practice and primary health care, irrespective of specialty. It appears that many non-medically qualified research staff currently prioritise other professional societies (e.g. RSS, Soc Soc Med, FPH), this may be because the agenda of non-medical staff is not adequately encompassed within the current activities of the Executive and the content of the Annual Scientific Meeting. This may require imaginative and proactive strategies to further encourage the participation of the non-medical membership in the strategic development of the Society.

5. Code of Good Practice

The SAPC could endorse the University Concordat for contract research staff and promote this through its close links with the Heads of Departments of Academic Primary Care and General Practice (HODs) Group.

In addition, academic departments should be encouraged to support non-medical staff in maintaining an involvement with their parent discipline; this may be achieved through seminars, conference attendance and publication. This is advantageous not only for the researcher but also for academic primary care as it ensures that ideas and thinking are up to date.

Conclusion.

If non-medical staff (i.e. non-clinicians, nurses and allied health professionals) wish to be seen as an integral part of academic primary care then they need to pursue opportunities to be seen as respected research leaders and they must share the responsibility for negotiating pathways that will make this possible. General practitioners are required to maintain a balance between their clinical practice and academic endeavours. Similarly, those who are not medically qualified must learn how to balance and promote the needs of their specialty (epidemiology, psychology etc.) and their profile within academic primary care.

Enhancing the status of academic primary care requires collaboration between both medical and non-medical staff; high quality research and teaching requires both groups. However, the difficulties faced by non-medically qualified staff, particularly those on short-term contracts, are real and deep-rooted. The SAPC has an opportunity to develop and inform the debate on supporting non-medical staff, which will be to the advantage of all professional groups working within primary care.

Appendix 1: Key Publications

Research Careers Concordat

(<http://www.universitiesuk.ac.uk/activities/RCI/downloads/rciconcordat.pdf>) – in 1996 the bodies representing HEIs, the Research Councils, the British Academy and the Royal Society agreed a Concordat on Contract Research Staff Career Management. The signatories agreed that as the number of contract research workers (CRW) had grown, so had problems and tensions relating to their employment and careers. The Concordat gave a framework for improving their management and career development. Its key components were:

- Terms and contentions for CRW to be in line with those for established staff
- Provision of specialist or general training and career guidance for CRW
- Greater continuity of funding and employment where the research justified this

Research Careers Initiative – (www.universitiesUK.ac.uk/activities/rci) In 1997 the signatories (research sponsors and universities) set up the RCI to monitor the Concordat's implementation and to identify, encourage and disseminate best practice. The RCI produced its first report in October 1998, along with data charting progress, reports from working groups, career guidance and staff training and a Guide to Best Practice in Employing CRW. It published a second report in May 2000 along with further data and a selection of initiatives reported by individual HEIs.

Scottish Contract Research Initiative – The Scottish Higher Education Funding Council has provided funding since 1996 to encourage and disseminate good practice in the employment of CRWs.

Other Initiatives – The Higher Education Funding Council for England, the Office of Science and Technology, the Engineering and Physical Sciences Research Councils and the Department for Education and Employment have, at various times, funded special initiatives.

The Higher Education Staff Development Agency (HESDA) – (www.hesda.org.uk/crs) Provides resources dedicated to supporting the professional development of all staff employed by Universities and colleges. There are specific materials for contract research staff

The Academy of Medical Sciences report "*Non-clinical scientists on short term contracts in medical research*" (Feb. 2002) highlights the role of contract research workers in medical research and the importance of multidisciplinary teams, bringing together a variety of specialist skills, in producing effective research.

The Universities UK report "*Partners in Care*" (<http://www.universitiesuk.ac.uk/partnersincare/>) demonstrates the importance of university staff, working alongside their NHS colleagues, in educating healthcare professionals, researching treatments and delivering patient care. In March 2003, at the launch of this report, Professor Sir Martin Harris, Chair of the Universities UK Health Committee said "University staff make an often unrecognised contribution to patient care in the NHS – clinical academic staff deliver and often lead patient care alongside their NHS colleagues and healthcare students. This is in addition to educating the healthcare professionals of the future and supporting the UK's world-leading health and pharmaceutical research" (www.universitiesUK.ac.uk/mediareleases/show.asp?MR=342, accessed 23 Sept 2003). This is well-deserved recognition for clinical academics, but fails to mention the input of non-clinical academics to education and research at all. It may be simpler to use the words "clinical

academics" as opposed to "academics based in clinical departments"; the former may save three words, but in the process alienates half of the workforce.

New Century, New Challenges – Academic general practice now contributes almost 10% of the teaching to the undergraduate medical curricula of UK medical schools.

In 2001 there were 31 departments of general practice and primary care in the UK of which 27 were involved in the provision of medical education. The staff of these 31 departments comprised a total of 291fte posts, an average of 9.4fte per department – of whom 93 (32%) were non-medical. This reflects a change in both size and composition, from departments in which general practitioners predominated towards those that more represent the multidisciplinary nature of modern primary care. Academic primary care is becoming a discipline encompassing anthropology, epidemiology, ethics, health economics, medicine, nursing, pharmacy, psychology, sociology and statistics.

The 31 departments had 66 professors (56fte) of which 16 were non-medical (24%) and 159fte senior academic staff, 248 fte contract research staff were employed [the vast majority of which (81%) were non-clinical researchers], and 82.5fte research training fellows (70% clinical).

ASSET Athena Survey of Science, Engineering and Technology in Higher Education. Preliminary results. Athena Project. Equity Challenge Unit, London. 2003. - Basic audit data collection in science now provides evidence of serious inequalities between the sexes in University employment.

Key Issues Consultation Paper, June 2001, Sir Gareth Roberts' Review - in 2000, while the gross weekly wage of university and polytechnic teaching professionals was £635, and for managers and administrators £608.1, the comparable figures for chemists (£552.3), natural scientists (£528.6) and biological scientists and biochemists (£511.1) were significantly lower. The paper also points out that while salaries for managers and administrators, medical practitioners, engineers and technologists, and those in professional occupations have continued to rise since 1995, those for natural scientists and chemists declined after 1998 and have since reached a plateau, and those for biological scientists and biochemists peaked in 1998 and have since been in decline. The reasons for disparities in salary levels between different groups are invariably complex - but that does not absolve employers from the obligation to work towards a fairer allocation of resources designed to provide adequate rewards reflecting the qualifications, experience and contribution made by each member of their team.

Appendix 2: Eligibility for contract research staff to apply for research grants

Extract from Academy of Medical Sciences Report

Appendix 2

Rules of Funding Agencies

The Academy made enquiries about the rules of various funding bodies in respect of making grants to CRS without tenured university contracts. The results given in the table below are interesting and perhaps go some way to explain the misunderstandings that are currently widespread.

	CRS as principal applicant		CRS as co-applicant	
	No salary	All/part salary	No salary	All/part salary
Action Research	No	No	Yes	Yes
Arthritis Research Campaign	Yes	Yes	Yes	Yes
British Diabetic Association	Yes	No	Yes	No
British Heart Foundation	Yes	Yes	Yes	No
Cancer Research Campaign	Yes	Yes (on 3yr project grants)	Yes	Yes (may be restrictions)
Leukaemia Research Fund	No	No	Yes	Yes
Medical Research Council	Yes	Yes	Yes	Yes
*Wellcome Trust	No	No	No	No
BBSRC	No	No	No	No

** In exceptional circumstances, CRS can be principal or co-applicant on grants.*

-----Original Message-----

From: Christine Parker-Jones

Sent: 08 July 2004 15:40

1. EPSRC Funding

Ref. EPSRC.96

The funding cannot be used to pay a salary to the grant holder themselves or to any permanent research staff. Where a contribution to a salary is made, indirect costs will be paid, if appropriate, but within the overall figure of up to £60,000.

2. <http://science.cancerresearchuk.org/reps/pdfs/eligibilityguide.pdf>

Normally ineligible if you don't have 3 years post doctoral experience or tenure post. They say to talk to the CR-UK if you are applying for your own salary, and have more than 8 years post doc experience.

3. <http://www.rdinfo.org.uk/Queries/ListGrantDetails.asp?GrantID=4130>

Association of Women's Health, Obstetric and Neonatal Nurses

Awarded to members only. Membership must be current at the time of application and at the time of selection/funding. An application for membership may accompany the proposal.

Researchers who are currently principle investigators on a federally funded grant or who have already receive an AWHONN-funded research grant are not eligible. Funds may not be used for indirect costs, tuition, computer hardware/printers, attending conferences, or for the salary of the principle investigator or other investigators.

4. You are not alone in thinking this situation is not fair. This is from the NATURAL ENVIRONMENT RESEARCH COUNCIL submission to the Select Committee on Science and Technology Examination of Witnesses (Questions 60-79) Wednesday 30 April 2003,

Professor Lawton: The universities have come back with a resounding no, they are not prepared to fund the 25%. I think that is a pity but I understand given their finances. At least we thought that we would ask. The thing we are now thinking about, and we will almost certainly do is formalise, but also change slightly what happens at the moment is that if you have a young post doc and they have a good idea and they want to apply to NERC, we do not let them do it, they have to persuade a tenured member of the academic staff to front that proposal. The young scientist writes it, we know they write it, but the youngster gets no credit for having written it and they are not allowed to be the principle investigator and it is fronted by a member of staff who basically gets all of the brownie points for it. It would be much fairer to allow a young investigator to apply to NERC for their salary and to write the grant proposal and be a principle investigator, providing they have a member of the academic staff as a co-investigator. The proposal is that we are almost certainly going to do that.

Christine Parker-Jones, Dr
RDInfo, 34, Hyde Terrace, Leeds,
LS2 9LN
Tel: 0113 392 6456
www.rdinfo.org.uk

Appendix 3: Application and success rates for NHS R&D Primary Care personal awards (1999-2003)

	Researcher Development Awards						% of applications successful
	All applicants		Invited for interview		Award winners		
Total	267		79		38		
General Practice	81	30%	29	37%	19	50%	23%
Clinical (non-GP)	107	40%	25	32%	13	34%	12%
Non-clinical	79	30%	25	32%	6	16%	8%

	Post-Doctoral Awards						% of applications successful
	All applicants		Invited for interview		Award winners		
Total	44		23		10		
General Practice	8	18%	6	26%	4	40%	50%
Clinical (non-GP)	17	39%	9	39%	4	40%	24%
Non-clinical	19	43%	8	35%	2	20%	11%

	Career Scientist Awards						% of applications successful
	All applicants		Invited for interview		Award winners		
Total	91		46		20		
General Practice	41	45%	24	52%	12	60%	29%
Clinical (non-GP)	20	22%	7	15%	4	20%	20%
Non-clinical	30	33%	15	33%	4	20%	13%

The category "clinical (non-GP)" includes:

Specialty	Number of Applications		
	RDA	Post-doc	Career Scientist
Health Visiting	22	0	0
Nursing	45	9	8
Pharmacy	0	3	3
Occupational Therapy	7	0	1
Dentistry	5	0	0
Physiotherapy	7	2	4
Speech & Language Therapy	7	1	0
Podiatry	0	0	1
Health Visiting	0	1	0
Pharmacy	9	0	0
Medicine/Family Planning	1	0	0
Nutrition	4	1	3
TOTAL	107	17	20

Source of data: National Coordinating Centre for Research Capacity Development, Department of Health, Leeds

Appendix 4: Acknowledgements

This SAPC report, approved by the SAPC Executive Committee, is based on work undertaken by an SAPC working group. Thanks are due to all those who provided comments on the Draft version of this report. Constructive feedback was received from a number of individuals and organisations, in particular:

Individuals:

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Alison Elliott, University of Aberdeen

David Hannay

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Helen Rogers, University of Birmingham

Debbie Sharp, Chair, SAPC Executive Committee

E.J. Shaw, University of Leicester

Fiona Stevenson, UCL

Mags Watson, University of Aberdeen

Lesley Wye, University of Bristol

Responses on behalf of non-clinical staff in academic departments of primary care and general practice:

University of Aberdeen

Barts & the London Queen Mary School of Medicine and Dentistry

University of Birmingham

University of Bristol

University of Keele

University of Sunderland

Appendix 5: Membership of SAPC Exec

Chairperson

Professor Debbie Sharp Academic Unit of Primary Health Care, University of Bristol, Cotham House, Cotham Hill, Bristol BS6 6JL (General Practitioner)

Treasurer

Dr Blair Smith Department of General Practice & Primary Care, University of Aberdeen, Westburn Road, Aberdeen AB25 2AY (General Practitioner)

Secretary

Dr Helen Lester Department of Primary Care & General Practice, University of Birmingham, Primary Care Clinical Sciences Building, Edgbaston, Birmingham B15 2TT (General Practitioner)

Other committee members

Dr Peter Croft, University of Keele (General Practitioner)

Professor Chris Dowrick, University of Liverpool (General Practitioner)

Dr Adrian Edwards, University of Wales Swansea (General Practitioner)

Dr Karen Fairhurst, University of Edinburgh (Nursing)

Professor Tony Kendrick, University of Southampton (General Practitioner)

Dr Peter Murchie, University of Aberdeen (General Practitioner)

Dr Kate O'Donnell, University of Glasgow (Health Service Researcher)

Professor Greg Rubin, University of Sunderland (General Practitioner)

Dr Sue Wilson, University of Birmingham (Epidemiologist)

Observers

Professor Frank Smith, Wessex Deanery, Representative of Postgraduate Advisors (General Practitioner)

Dr Bill Reith, Aberdeen, RCGP representative (General Practitioner)

Appendix 6: Code of Good Practice for Heads of Departments of Academic Primary Care and General Practice

Heads of Departments will attempt to ensure that:

All staff are aware of and abide by the University Concordat for Contract Research Staff

Researchers are appointed on the grade and salary point appropriate to the duties of the post, and (subject to the nature of those duties) to the experience of the person appointed. Where titles such as lecturer or research fellow are used then staff appointed to these grades should have comparable teaching, research and supervisory experience irrespective of whether or not they are medically qualified.

Managers encourage and support contract research staff in publications, report writing and conference presentations.

Individual contract research staff are named as key contributors within research wherever this is appropriate; this applies to grant applications, publications, research reports, departmental reports and conference presentations

Contract research staff and their managers acknowledge the joint responsibility for career progression.

Regular staff review and mentors are available for all contract research staff and those research staff wishing to identify a professional mentor (i.e. from their 'home discipline') should be supported.

All staff should have reasonable access to relevant training.

Examples of good practice are disseminated through the HODS group.

Non-medical research staff are encouraged in maintaining an involvement with their parent discipline; this may be achieved through seminars, conference attendance and publication.

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