The StLaR HR Plan Project

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Phase II Strategic Report

Developing and Sustaining a World Class Workforce of Educators and Researchers in Health and Social Care

June 2004

Developing and sustaining a world class workforce of educators and researchers in health and social care

A report to the Strategic Learning and Research Committee (StLaR) containing an account of present circumstances and suggested recommendations, leading to a Human Resource Plan for educators and researchers in health and social care.

Executive Summary

There is confidence that some of the best health educators and researchers in the world are to be found in the United Kingdom. However, it is clear from our work that this workforce is currently facing a crisis caused by under-recruitment, disparities in pay and reward, and rigid or poorly articulated career opportunities, all of which militate against flexible careers that might embrace practice, education and research.

It is clear that there are particular barriers to the recruitment of service staff from the NHS or Social Care into the educator/researcher workforce. In some professions there may be differences in the basic salaries between service and academia, particularly at senior/advanced and consultant practitioner grades. In other fields there may be parity in basic salary between service and academia but substantial differences in terms and conditions of employment.

To neglect this important workforce will degrade future plans for education and research in health and social care and place future learner/student education at risk; however, the nature, extent and capacity of the health and social care educator and researcher workforce are not well understood. An estimate of activity suggests that as many as 300,000 people in the health and social care professions are directly involved in educational and research-related work on a day-to-day basis.

It is important to sustain and develop the careers of those already in post (through an appropriate human resources plan), while at the same time anticipating the needs of those wishing to embark on a career as educators and researchers for the first time. However, one of the challenges in preparing such an HR plan is that not all of them would consider themselves to be part of the teaching and research workforce.

It is the purpose of the current project and its associated report to articulate the principal staffing problems faced in health and social care related teaching and research, to identify possible solutions and strategies, and to make a number of recommendations for consideration at the national, regional and institutional levels. Taken together, it is argued that this range of proposed initiatives has the potential to overcome many of the identified challenges and barriers.

This report has been prepared as a prelude to, and in anticipation of, the development of an integrated, high-level cross-sectoral HR plan. Accordingly, the attributes of such a plan are detailed in Appendix A hereto.

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Project Director

Developing and sustaining a world class workforce of educators and researchers in health and social care

1. Background and introduction

> Medical care is a basic human need; a healthful community is a basic social need. The present system gives medical care to less than half the population, and it gives it under conditions which militate against a first-class service. It is impossible to see any changes within the existing framework which would remedy these defects. (Clarke 1943)[1]

At the time these words were written, more than 60 years ago, England had a highly fragmented healthcare system, with a mixture of central and local provision, public and private initiatives, professional and voluntary agencies. The creation in 1948 of the National Health Service unified many of these activities; providing a framework that simultaneously allowed universal provision, maintained the status of the great teaching hospitals, and supported continuing high quality medical research.

In the intervening years, the NHS has achieved an enviable reputation worldwide, much of it built on its educational and research activities which, whilst not directly supporting patient care, nevertheless provide the context within which such care is provided. People who use health and social care services can reasonably expect that the education that prepares and sustains their doctors, nurses, allied health professionals, health scientists and social care workers is both high quality and widely available, indeed that it is at least comparable with the best in the world. They must be equally confident that research, which of course is ultimately for their benefit, is undertaken by safe, highly qualified and up-to-date researchers, working in laboratories and practice settings that are underpinned by quality standards agreed at a national level.

There are, however, worrying signs that the excellent infrastructure, and more particularly the world-class health and social care teaching and research workforce in England are under threat. The most cursory survey of opinion from all the professions (medicine, dentistry, nursing allied health professions, social work/care and health sciences) quickly reveals some common concerns. These include issues of recruitment and retention; the need for joint systems of appraisal; pensions and issues of transferability; the need to engage other strands of Government work such as leadership, modernisation, the gender and diversity agenda and new ‘consultant’ appointments in non-medical professions and poor workforce intelligence data.

Shortages are reported in senior academic appointments across all professions and clinical specialities, and a commitment to teaching in the clinical environment is reportedly at risk. The burden of work created by record numbers of students and education commissions brings with it additional complications. New tensions are emerging, created by a growing ‘status gap’ between excellent research and ‘highest quality’ education. Employers in the health and education sectors struggle with this dilemma. Yet there is now developing evidence that good

1 Clarke J.S. (1943) National Health Insurance. In Robinson W. A. (Ed) Social Security Allen Unwin. London

HR improves care[2] in the short to medium term and that education has the same effect in the longer term.

The problem does not seem to be primarily related to funding, although our research certainly identified some areas where additional resources are clearly required. Overall, it is hard to sustain an argument that Government does not invest substantial resources in education and research in health and social care. More than £5 billion (excluding research councils, industry and charities) is directed to health and social care related education and research each year, and, although a considerable portion of that investment is pre-determined through existing education and research contracts, there are elements that might be better used to support a workforce that delivers what is arguably one of the best health research and education systems in the world.

To maintain this premier status we must develop a dynamic human resources plan for those who would teach or undertake research. The plan must encourage the most able into our research and education workforce and then offer guidance to them in the progression of their careers. It must be relevant and understood by the staff and potential staff members, and it must also be supported by our health, social care and education economies so that they can attract and retain sufficient educators and researchers in health and social care.

In England the Department of Health and the Department for Education and Skills have jointly commissioned work through their StLaR Committee (a strategic committee chaired by their respective permanent secretaries) to prepare an appropriate human resources plan to support the educator and researcher workforce in health and social care. The study reported here has sought to identify the major issues that threaten the teaching and research workforces in health and social care, and then to offer a number of interlinked recommendations as to how these problems may be tackled. Some of our recommendations are relatively inexpensive and simply involve a reassignment of existing resources; others will necessarily entail the allocation of additional funds. It is strongly emphasised that these recommendations are interwoven, and that the overall success of the Plan will depend on a combination of new and redeployed funds and other resources.

1.1 The Context for this HR Plan

There is certainly no shortage of strategies, plans, directives and other documents surrounding the HR context. Indeed, the health and social care workforce is subject to parallel and on some occasions competing human resources strategies. *Delivering the HR in the NHS* Plan (2004)[3] describes the considerable impact on the workforce whose principal employer is an NHS body. The large pay modernisation programme rolling out in the NHS inevitably affects those in the educator and researcher workforce. There are strands of work that will also affect the provision of a 'model career', learning and personal development, the modernisation of professional regulation, the modernisation of workforce development, staff morale and building people management skills, the equality and diversity agenda and current and future employment legislation.

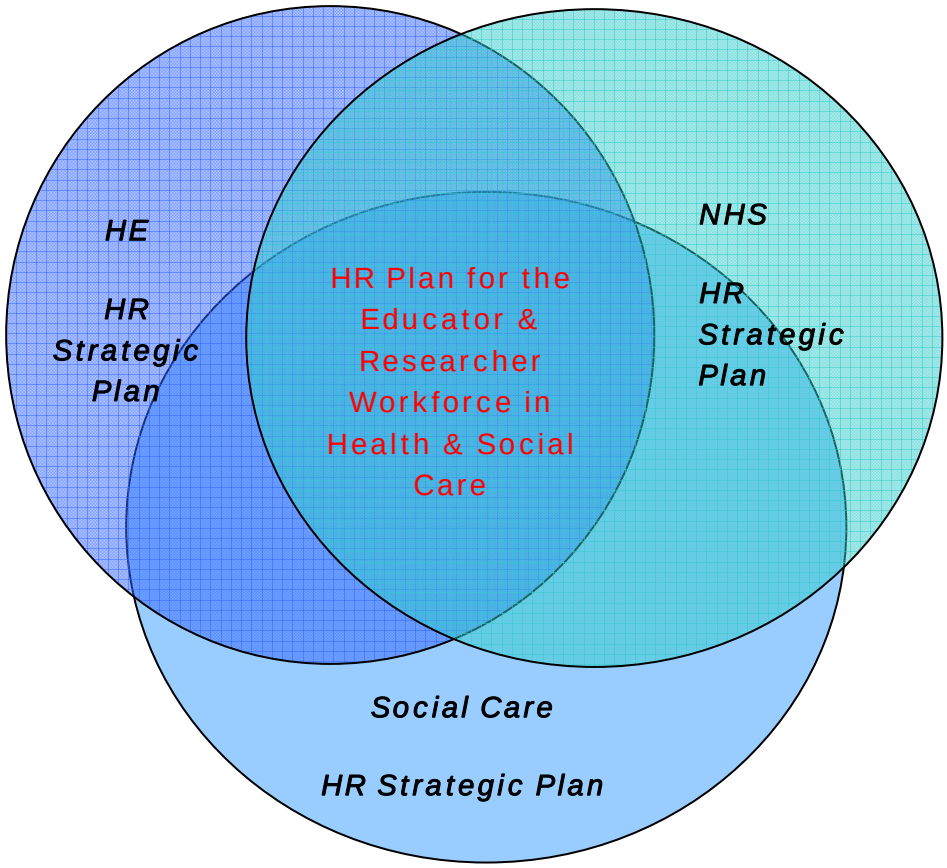
2 West et al 2002, The link between the management of employees and patient mortality in acute hospitals. Int Jnl of HR Management

3 Delivering the HR in the NHS Plan. Department of Health May 2004

There are a number of reports from health and social care organisations relating to the diversity agenda. The HR Plan endorses the continuing work of the diversity agenda and regards it as integral to the successful implementation of the Plan.

The Higher Education Funding Council for England (HEFCE) published a guide to good practice on 'Implementing HR Strategies' in 2003. This report offers an account of progress on recruitment and retention, staff training and development, equal opportunities, personal development reviews and necessary action to tackle poor performance. An interim, but unreleased report from the 'Research for Patient Benefit' Working Party has submitted a paper to ministers in which its strategic vision is one of developing clinical research through investment in a widely applicable clinical infrastructure with an appropriate workforce capability with better regulation. This report proposes a series of recommendations for building capacity in the researcher workforce that will support their preparation and eventual employment.

While these strategic documents are helpful and set a direction, the needs of educators and researchers are quite particular and the necessity for a dedicated human resources plan is self evident. There will need to be recognition of the plan by the Healthcare Commission and the Commission for Social Care Inspection[4] both of which have wide-ranging mandates for quality care and its provision.



4 The Health Care Commission came into being on April 1st 2004 (replacing CHI) The commission will work closely with the Commission for Social Care Inspection (CSCI)

1.2 The purpose of this HR Plan

The HR Plan will guide and maintain educators and researchers in health and social care. It will have value for those about to embark on a career in education and research as well as assisting those educators and researchers who wish to advance their careers further. No less importantly, it will provide a framework for employers in the health, social care and education economies.

The vision for this HR Plan is:

To provide a human resources plan to develop and sustain a world class workforce of educators and researchers for the health, social care and education economies thus contributing to health improvement, excellent patient/service user care and safety through education and research.

When we began this study, we were faced with a large number of issues which at first sight seemed very different as between academic and clinical careers; health and social care; and further and higher education. However, as the study progressed it became apparent that there are many more similarities than differences. Indeed, in discussing the major issues underlying the development and implementation of an integrated HR plan, three major clusters of issues have been identified: the concept of a clinical-academic career and its consequences for HR practices, the provision of high quality staff and professional development and of appropriate recognition and reward, and more systematic workforce planning and recruitment. Accordingly, although these three domains are intimately interconnected, the body of the report is presented under these three headings.

2. The concept of a clinical academic career and its consequences for HR practices

In order to allow practitioners in health and social care to experience clinical excellence, confident teaching and good research the model of a clinical academic career has value. A report concerning medicine from the Academy of Medical Sciences published in 2000[5] seeks to encourage the brightest and the best into a medical clinical academic career. However, it highlights impediments which stand in the way. These include:

- lack of a clear career structure
- insufficient flexibility between post doctoral research and clinical training
- prolonged insecurity in short term appointments as careers are built
- limited research training opportunities

These mirror similar experiences in other health and social care professions and the notion of a clinical academic career that is flexible, supportive and encouraging is necessary to support our educators and researchers. A clinical academic career needs a suitable HR plan.

In a subsequent report *Clinical Academic Medicine in Jeopardy* published in 2002[6] the Academy also suggests that the role of clinical academics is to "teach undergraduate and postgraduate students and doctors to pursue research, particularly patient based research, and to inspire in others a culture of enquiry". The report also says that "clinical academic practice also includes leadership and providing specialist clinical services". This is a good definition for the purposes of this report and the principles might be applied with some small changes to a wider workforce across health and social care.

2.1 Lack of clear career structure

At the time of the most recent HEFCE Research Assessment Exercise (RAE), there were more than 7000 category A or A* researchers working in medicine, dentistry, nursing, pharmacy, the allied health professions and social work. Yet despite these considerable numbers, the course of their careers is not well described.

Other than in medicine, there are no clearly articulated career paths for aspirant researchers in health and social care. Medicine has developed a system for its clinician scientists through which National Training Numbers are identified (NTN A's) that supports individuals who are developing a research career and who, it is hoped, will become the best medical researchers of tomorrow. There are presently 68 individuals in receipt of funding and, although the process is developing well, there are probably more trainees that could be drawn into this helpful process. The clinician scientist scheme represents the cream of the developing researcher workforce in medicine. For more junior research training posts in medicine and in **all** other professions the process of embarking on a research career is much more serendipitous.

Some supportive and well-defined doctoral and post–doctoral research schemes are funded by the Department of Health and the research charities, but these will only support a limited number of people each year. One hundred and fifty individuals from across the professions are presently in receipt of DH doctoral and post-doctoral awards schemes and there are probably 100 other individuals similarly supported by medical research charities. Other than

5 A new career pathway to promote recruitment into clinical academic medicine; The Academy of Medical Sciences; March 2000)
6 Clinical academic medicine in jeopardy; The Academy of Medical Sciences; June 2002

this, researcher career paths are neither well planned nor articulated and depend on the ability of established academics or research teams to identify and nurture promising individuals. This obviously depends too heavily on opportunity and chance. Uncertainties about working in research are therefore common and unwelcome to those making career choices.

In medicine, the number of organisations involved creates particular difficulties, and there will need to be significant culture change in approaches to the needs of academic medicine. An example serves to make the point. In the requirements for clinical training, clinician scientists are often treated adversely compared to 'standard' specialist registrars. This affects the post graduate deaneries, the specialist advisory committees of the various royal colleges and the new Postgraduate Medical Education and Training Board (PMETB).

It is likely that most of the researchers identified above will also make some teaching contribution, but there are many other educators who are not research active. It is important to consider how to better encourage a teaching and research philosophy through which each can co-exist in a mutually supportive environment[7]. There is a need for educators and researchers to engage in professional pedagogic (institutional) research through scholarly activity that should further help our understanding of teaching and student learning.

The 'researcher as educator' and 'educator as researcher' debate has given rise to a number of propositions about scholarly activity. The most quoted is the so-called 'Boyer model'. Boyer[8] proposes four separate but overlapping functions of scholarly activity, discovery (investigative work), integration (making connections and giving perspective), application (using knowledge to solve problems) and teaching (mastery and transmission of knowledge). Taking issue with the linear cause and effect model where work moves inexorably from research to publication to application to teaching, Boyer suggests that the "arrow of causality can, and frequently does point in both directions. Theory surely leads to practice but practice also to theory. Teaching, at its best, shapes both research and practice." It is widely accepted that health care students are best educated in a research rich environment. (However this does not mean that all their teachers will be principle holders of research funds.) Only in this way can they fully understand the principles behind evidence-based health care. Indeed, it is an explicit requirement from the General Medical Council (GMC) that medical students are so educated, a situation mirrored by support from the Council of Deans (nursing and AHPs), Health Care Science and Social Care Institute for Excellence (SCIE).

However, there are reports that teaching has become downgraded as a scholarly activity. In some places there are reports that the teaching workforce is becoming 'casualised' which is most inappropriate. To attract the best into teaching and keep them, and to provide for student educators who can demonstrate mastery of their craft would be a hall mark of 'world class' endeavour.

Preliminary investigations undertaken by the StLaR project team[9] confirm the widely held and well-established view that the Research Assessment Exercise (RAE) has had the unfortunate effect of discouraging teaching activities while properly stimulating research

7 Imagining a different future; working paper 4 LTSN-IL the HEDA 2003.
8 Boyer E. L. (1990). *Scholarship reconsidered: The priorities of the professoriate.* Princeton: NJ: The Carnegie Foundation for the Advancement of Teaching

9. StLaR HR Project Phase One Report 2003

endeavour. It has however to be recognised that universities have regarded research as a more important activity than teaching for many years and the RAE has merely exacerbated this differential. A great deal has been written about research assessment exercise and the systemic effects it has had on the value and esteem in which education and research are held. There is little doubt that the 'additional' value now placed on research and researchers is giving cause for concern. Views are variously expressed that teaching, one of the principal functions of education institutions is now regarded less highly than research. Despite the various teaching quality exercises and investments by institutions and Government into teaching to raise standards over the last decade and redress the balance, it is generally understood and reported that differences remain. There is still a widely held view that the best research and the best education will be delivered by one and the same individuals. This has no foundation in fact and it is possible that the characteristics of excellent researchers and excellent educators are different. Both however feed from each other and the symbiosis is self-evident.

In the past few years, HEFCE, through its Teaching Fellowships, its Learning and Teaching Support Network (LTSN), its Institute for Learning and Teaching in Higher Education (ILTHE) and its judicious use of funds to help reward and develop staff, has done much to redress the balance and to bring about greater 'parity of esteem' between different kinds of scholarly activities – notably research and teaching. Nevertheless, in the fields of health and social care, there is relatively little incentive for teachers in higher/further education to improve their skills, comparatively few opportunities for promotion to more senior positions on the basis of teaching skills or teaching innovation alone. As Boyer argues so cogently, it is imperative to see a situation where research and teaching are valued equally, with opportunity for flexible career advancement in and between both.

It is to be hoped that planned activities of HEFCE and the Learning and Skills Council to stimulate the development of teaching and to raise standards, most notably through the Centres for Excellence in Teaching and Learning (CETLs), HE Academy and Centres of Vocational Excellence (COVES) will have the effect of encouraging educational institutions to place more emphasis on the development of teaching.

On the subject of research, the report from the Research for Patient Benefit Working Party suggests ways of increasing emphasis on clinical research. It makes recommendations that a sub-group takes a new look at careers for research staff which will clearly link with the work of this project. This sub-committee, currently called the Academic Careers Sub-Committee of Modernising Medical Careers and the UK Clinical Research Collaboration, is likely to have a major impact on the problems since all parties (including the funders) are represented. This sub-committee has already subsumed the work of the academic sub-group of Modernising Medical Careers. It is important that this process continues and that there is good co-ordination between the groups that are looking at the problems of academic medicine.

Changes are also needed in primary health care. In a recently published Joint Ministerial Review of the role of Primary Care Trusts[10] a series of recommendations are offered that identify key learning and research responsibilities for PCTs. All of them require educators and researchers who are creative and competent.

10 Department of Health (2004) Joint Ministerial Review of Primary Care Trusts in relation to learning and research in the new NHS

Recommendation One
A human resources plan for the educator and researcher workforce in health and social care should be implemented immediately with the aim to recruit, retain and retrain an excellent workforce. It should be developed systemically with existing HR strategies already available for the health, education and social care economies

2.2 A flexible and model career for the researcher and educator workforce

The career prospects for clinicians and practitioners who enter health and social care offer several alternative pathways. These are broadly;

- Advancement through progressive expertise in practice
- Clinicians/practitioners into management
- Career development as a researcher
- Career development into education

(Further work will be developed by the project team to demonstrate flexible and innovate careers that allow free movement between the practice environment, management and research.)

Recommendation Two
Centres for excellence in education and research are being established in higher and further education. Work streams should be identified and centres encouraged through periodic contract performance to address the particular needs of educators and researchers in health and social care.

2.3 Creating model career templates

Central to the notion of the clinical academic career is the provision and recognition of flexible employment arrangements. For individual practitioners, three alternative patterns are possible:

1. Alternation between employers, such that the practitioner moves back and forth between health/social care and education without financial or promotional disadvantage.

2. Conjoint appointments serving two (or sometimes more) employers simultaneously, where part of the professional's time is spent working for one employer and some spent working for another or others.

3. An arrangement whereby there is a principal employer that gives continuity, but the individual is seconded, shared or otherwise released to work for someone else part of the time.

Whichever of these arrangements is selected, there must be well recognised, easily negotiated and widely accepted model contracts that do not entail the individual in forging his or her separate arrangements, and which importantly do not adversely affect the individual's career trajectory or financial stability and prospects. Flexible careers between practice, research and education should be realised without disadvantage. Innovative model careers can already be observed and this useful creative work can be built upon.

Informants to this report have been very keen to express a view that 'silo' careers in practice, education and research are no longer universally appropriate. It will be the case that a core of professionals will wish to hold full-time appointments in one of these three domains. Increasingly, there are others who want to develop a more varied career. An increasing number of educators and researchers wish to develop a career portfolio that will allow them to experience practice, education and research. Many will start out by having mentorship and support from experienced educators and researchers who can advise them. They may then progress to joint appointments (but with a single employer) that allow them to undertake practice and education or research. These first 'tasters' are important and will encourage people into different career paths. There is room for local work that will engage the health, social care and education sectors so that they can purposefully work together to design flexible career pathways in education and research. This will enable practitioners with ambitions to hold 'mixed career portfolios' and ensure they will not be disadvantaged or treated differently.

Recommendation Three
A series of flexible 'off-the shelf' employment models, embracing full-time, part-time and joint appointments, with associated and pre-approved employment contracts should be made available to facilitate a range of different employment patterns. Career options should be provided for lecturer-practitioners, academics with a defined teaching pathway, academics with a defined research pathway and a combined teaching/research pathway. In cases where such arrangements have already been successfully pioneered, they should be held up as exemplars and used as models.

2.4 Principal employers/shared responsibility and appraisal
Flexible and different careers will demand 'ownership' of employment by one named employer. Where employment demands that there is a principal employer such as in the case of clinical academic medicine, responsibilities should be identified such that they follow the recommendations of the Follett Report where a lead employer holds responsibility for pay and conditions of service. The identified employer will lead in personal development plans and appraisal (although it will require multiple input) and commission programmes that prepare teachers to teach and researchers to undertake research through workforce leads in strategic health authorities.

Recommendation Four
The key proposals in the Follett report, aimed at clinical academics in medicine must now be applied to other relevant professionals involved in education and research in health and social care. This will result in an individual having a single key employer and being jointly appraised by senior colleagues in the education and service fields. Job planning for such professionals should also be a joint endeavour between service and education.

2.5 Gaining best value from consultant and advanced practitioner appointments

Consultant appointments in health and social care are held by our most senior and expert practitioners and clinicians. The title 'consultant' has long applied in medicine, but is now also offered to health care scientists, nurses and the allied health professions. Advanced practitioner roles are being developed apace in social care. Teaching and research contributions from consultants and advanced practitioners across the professions provide opportunities to realise much needed input from these most expert individuals. In medicine, pay modernisation is beginning to address the research and teaching contribution made by medical consultants. Disappointingly, there is evidence from the debates that have informed this report that consultants in the nursing and allied health professions are expected to teach and support research but are not able to fulfil those parts of their job descriptions that specifically demands their engagement in these activities.

Pay modernisation processes in the health sector are becoming unambiguous about the education and research obligations of health professionals. Session elements for doctors and the required knowledge and skills demanded by pay modernisation and Agenda for Change are beginning to explicitly show where contributions to education and research are being made. As all pay modernisation processes are about working differently for appropriate reward and it is reasonable to expect that employers will allow staff to fulfil their obligations to educate and undertake research having paid them to do so.

Recommendation Five
Consultant and advanced practitioner appointments in all professions must be allowed to fulfil their obligations towards education and research. Pay modernisation processes should ensure these obligations are fully described in contracts of employment and employers must be charged with appropriately supporting teaching and research activities by these senior staff.

2.6 Pensions and Employment rights

In addition to the general impediments that stand in the way of flexible employment arrangements and dissuades people from moving freely between sectors, one issue stands out in particular; namely the inequities – both real and perceived – in pension schemes. There are many ways in which pensions schemes differ from one another. These include the employer contribution, the percentage of income that must be contributed by the member, the age at which the member may retire, and the actual conditions – the so-called generosity – of the final payment scheme.

The 'public sector club' for pensions should allow easy transfer between schemes for those wishing to move between public sector employers. While this happens already to some extent, problems remain.

Some pension guidance already available is unhelpful to educators and researchers who will not necessarily understand the technicalities involved. It is noted that heads of departments across HE and FE view pension and employment issues as a major barrier to staff transfer between sectors. A small working group has already been established to determine how comparability can be maintained between schemes while developing transparent and accessible guidance for individuals. The question of an individuals' right to maintain membership of a scheme to which they formally belonged has yet to be resolved and may

well not change in the immediate future given the pending pensions review in the public sector.

Recommendation Six
Transparent and accessible guidance that explains employment rights and pension transfer across the different sectors of the 'public sector pensions club' should be produced as a matter of urgency. Any future or forthcoming reviews of pensions in the public sector should hold in view the need to encourage career flexibility.

3. Providing high quality staff and professional development and appropriate recognition and reward

In the preceding part of this report, it was argued that there needs to be a fully articulated and widely accepted concept of a clinical academic career – in medicine and in other related fields – that this needs to be exemplified through some 'worked examples' so that individuals can envisage how their careers might unfold, and that there need to be changes in employment contracts in order to allow people to move seamlessly and without disadvantage into, out of and between different employers to fulfil their career ambitions.

However, the mere existence of such possibilities is not in itself any guarantee that the teaching and research workforce will be strengthened. For that to happen, managers and other advisers have both to encourage and to facilitate such career choices. Moreover, there needs to be a general shift in the general esteem accorded to the various kinds of professional activity. In this respect, the work of Boyer already alluded to is vital, so that the various kinds of professional practice are accorded 'parity of esteem'. As desirable as this might be, it cannot be legislated but may be only encouraged and supported, for instance through reports such as this.

3.1 Developing equity between practice, education and research

Extensive consultations that have shaped this report support the view that inequities exist between practice, education and research. These inequities are shown through pay, esteem factors and other rewards. The 'culture carriers' who continue to value one group above the other and persist in maintaining 'elitist positions' do service users, families and carers in the health and social care sectors a disservice.

Equities (or inequities) between practice, education and research begin early in professional life. It should be a matter of course that all programmes of professional/vocational preparation contain introductory level work on basic teaching skills, mentorship and research understanding to an agreed level of competence. This in turn may precipitate interest and a capability to choose a career as an educator or researcher. Many programmes already address this but some do not. The emerging quality assurance processes that will assure the relevance, quality and content of health and social care education programmes have the capacity to develop this further. Programme commissioners have the necessary levers to be certain that programmes offer appropriate content.

Recommendation Seven
All students following professional courses in health and social care should be taught the basic skills of teaching and research awareness for patient/service user benefit during their professional preparation. It should be the responsibility of educational commissioners and quality assurance agencies to make sure this is done. The basic skills can then be enhanced in those individuals who wish to become teachers and researchers

3.2 Fast Track opportunities

The dedicated NTN (A) research training opportunity offered to medicine and dentistry should be enhanced further to embrace both education and research and similar opportunities offered to other professions. This will allow talented individuals who are going to be the 'world class' educators and researchers and leaders of tomorrow chance to be nurtured and supported into careers in education and research early in their careers.

Recommendation Eight
A specific initiative should be established that will enhance the NTN(A) scheme in medicine and dentistry. Clinical trainees in medicine on a defined academic career track should receive an NTN(A). Government should extend this to other health and social care professions. A national budget stream should be sustained but developed further.

3.3 Education and research set in the context of short term service targets

During extensive discussions held by the project team with key stakeholders and informants, continuous representations have been made about the importance of making education and research key priorities in health and social care agendas. At present, education and research are often given only passing attention by service because of the overriding demands of short-term service targets and staff shortages. Dominant short term targets are pushing education and research imperatives to one side. It is vital that chief executives in health and social care are champions for education and research and help others to understand the importance of education and research in the delivery of service objectives. It is important to note, however, that some Trusts and social care organisations do not have a specific teaching and/or research remit. Their attention is more likely to be focussed on capacity building for evidence based clinical work for their staff than the actual conduct of research and delivery of programmes of preparation for professional registration.

The possibility of introducing specific targets related to education and research has been discussed but no performance specific recommendations are offered here. Nonetheless it is vital to find a way to accommodate the demands of targets and the place of education and research.

Recommendation Nine
Employers in health and social care have a duty to support the education and research enterprise that will deliver evidence based care and a next generation of employees. This support should be demonstrable through board level accountability by executive and (for Trusts) non-executives members. Responsibility can be evidenced and enhanced by the Healthcare Commission and the Commission for Social Care Inspection.

3.4 Career development and progression through personal development plans (PDPs) for clinicians and practitioner

If clinicians and practitioners are to consider spending some part of their careers are teachers or researchers, it is essential for these alternative career trajectories to be explained and where possible modelled during their early training. In this respect, it is incumbent on those providing both clinical education and careers advice to young or early career clinicians about the rewards – both professionally and financially – from pursuing a career that concentrates on, or at the least includes, educational and research components.

Personal development plans should ensure explicit discussions about potential careers in education and research. There will be opportunities to identify promising candidates who can be drawn into careers in education and research through the normal PDP process. Promising candidates should be directed to appropriate staff in the education and research setting who will be able to offer suitable career advice and appropriate mentorship. A system to identify appropriate educational and research mentors must be established.

Recommendation Ten
Managers should be assisted to work with their employees in order to consider potential career options as educators and researchers into their annual review cycle and to facilitate suitable expert support and information gathering for those who might benefit from such a career move.

4. More systematic workforce planning and recruitment

For the purposes of this report, educators and researchers are defined as being those individuals whose job description demands that they are actively engaged in the research and education enterprise. Considerable numbers of clinicians and practitioners will teach and be part of research work on an occasional basis, but they are not the principal focus of this report. Nonetheless, it is important to recognise and applaud their contribution, indeed without their support, research and education programmes would not be delivered and they need appropriate preparation for their work. Some of this workforce will eventually wish to move and take up full-time or part-time education and research posts. The proposed HR Plan will encourage this and offer signposts to assist.

4.1 The need for improved labour market intelligence

Accurate workforce mapping is problematic. The further education sector offers no comprehensive data set to describe a relevant work force. In the higher education sector HESA (Higher Education Statistical Analysis) data of staff returns show data as at table one for 2001/2.

Table one: The number of full time academic staff by cost centre (UK wide)

Anatomy and Physiology	1530
Clinical Dentistry	800
Clinical Medicine (Institutionally funded)	4170
Clinical Medicine (Other sources of funding)	11,330
Health and Community Studies	2265
Nursing and Paramedical Studies	6900
Pharmacology	570
Pharmacy	860
Psychology and Behavioural Sciences	3090

Source: 2001-02 HESA Staff Returns

Labour market intelligence on educators in health and social care is poor. Medicine has developed a good account of the disposition of its staff (except for those on short-term contracts) but for other professions the data is limited. Some initial work has begun with relevant bodies to develop data sets that will have value to individuals and institutions that need labour market intelligence on the research and educator workforce. Appropriate investment from technical experts and relevant bodies is needed.

It is important to understand that substantial contributions to education and research are made by professional staff whose main employment is in the service sector and who may have an honorary appointment for education and/or research with an HE or FE institution. Data collection systems should accurately reflect the contribution of this section of the workforce.

Recommendation Eleven
A labour market intelligence system designed to provide continuous accurate data on the employment and disposition of the research and educator workforce for health and social care should be developed without delay. It should be driven by contractual arrangements between HESA, the further education sector and the Department of Health.

4.2 Putting the issue in International context

We live in increasingly global times in which workforces are drawn from many parts of the globe. The NHS, in particular, routinely recruits staff from a number of overseas jurisdictions, with consequences for their integration into the culture, standards and processes expected in this country. But the traffic is far from one-way, with significant numbers of professional staff moving away from health and social care in England.

Sometimes these moves are within the UK, in which case there is a need for some calibration of salaries and conditions of service between England and the devolved administrations. Some of these moves, however, are on a broader scale. With more countries joining the EU, many professionals will seek to spend at least some of their working lives elsewhere in Europe, and of course many people may choose to relocate to North America, to Asia or to Oceania, where the rewards of service are held to be preferable to those available locally. This phenomenon is even more pronounced among academics – both teachers and researchers – who are amongst the most highly qualified and globally mobile members in the workforce internationally.

Recommendation Twelve
It is recommended that, as part of the ongoing monitoring of conditions of service for health and social care academics, note should be taken of the conditions that apply – including salary, superannuation, annual and study leave, and working circumstances generally of those countries and jurisdictions that are most likely to prove attractive alternative destinations for clinical academics and to calibrate the structures and systems in this country accordingly.

4.3 Dedicated funding and strategic workforce planning

The knowledge and skills that mark out an expert practitioner can be described and are being better articulated through such modernisation activity as the health sector pay modernisation processes. The knowledge and skills that determine excellence in education and research are just as easy (or difficult) to determine. Pay and reward should be equitably attached to education, research and practice when the knowledge and skills for each have been properly determined. The climate for making change is good. A series of work streams are underway that will support the proposed HR plan for educators and researchers in health and social care. Government policy in health characterised as ‘payment by results’, is now influencing education and research, particularly in health and social care education.

An extensive review of the Multi-Professional Education and Training Levy (the MPET review) will explore how the multi-professional education and training levy is being determined in the health sector and it will have far reaching effects on investments. Work

streams to identify placement funding, capital investments, benchmarked prices for education programmes, standard contracts with education institutions, learning and development contracts and continuing professional development (CPD) are being addressed by the MPET review. One possible outcome is that student placements will become funded and as a consequence of this, the education enterprise will be better recognised and supported by employers and a more equitable distribution of CPD funds.

It is concerning to note that investments that have previously supported post-graduate degrees and teacher preparation programmes are at risk. NHS trusts and social care agencies do not have a dedicated resource to support this kind of endeavour. Research and development monies in health previously held and distributed by regional health authorities have been lost or are now impossible to track. These funds offered considerable support to aspirant researchers (and in some cases educators) and it is no longer available. Some Workforce Development Confederations have invested in educator preparation programmes for the health sector but the changing face of workforce development arrangements may put this at risk. In social care, extensive demands for educational support will emerge from the workforce development plans as all social care workers are obliged to gain qualification. The placement teaching activity needed to support the new degree in social work will place new demands on the social and health care sectors. The education burden can not be underestimated.

Health and Education Strategic Partnerships (HESPs) are recently established organisations that could exert a significant influence in these areas and, in particular, would be able to co-ordinate activities across traditional boundaries. We would like to see their further development.

There are extensive reviews of research funding underway. The Department of Health is reviewing their personal awards scheme, infrastructure support, research and development unit support and career scientist awards. Funding to support a broader investment into research capacity is less well articulated. The MPET levy in health and Topss (soon to be a Sector Skills Council) in social care could be reasonably expected to support research capacity building up to post-graduate degree level.

It can be shown the twin demands for the workforce to be research knowledgeable and for part of the workforce to be research competent can be fulfilled.

Recommendation Thirteen
Strategic health authorities, educational institutions and trusts in tandem with social care agencies and should conduct a 5 year prospective planning survey to determine the workforce demand for educators and researchers in their health and social care communities. The newly emerging HESPs could play a significant role in this work.

Recommendation Fourteen
Investments through the MPET levy and Skills for Business Networks should be made so that the workforce identified through recommendation eleven is appropriately qualified and supported to obtain the necessary knowledge and skills to be 'world class' educators and researchers.

4.4 Recruitment into the educator and researcher workforce

Practitioners and clinicians entering their specialist field in health and social care will seldom consider a career as an educator or researcher as they first enter their occupation. Career choices into education and research are often made later, and for a variety of reasons. There are therefore three alternative approaches to recruitment; one before people even choose a clinical or practitioner role; one focussing on those in the early stages of their careers; and one for those who are already part–way into their professional lives.

In the case of early interventions, before people actually choose a vocation in health and social care, there is doubtless merit in suggesting education and research as possible career pathways and actively encouraging suitable candidates to consider this alternative as early as possible. Advertising and recruitment campaigns in health and social care receive substantial investment. Junior and secondary school teaching as a career in schools has had extensive media coverage and offers a good example of how rewarding a career in education can be. A combination of these well developed recruitment and retention programmes could quickly craft a focussed campaign about prospective careers for educators and researchers in health and social care. The campaign should address different career levels and suggest creative opportunities whereby full-time, part-time, secondment and joint appointment opportunities can be realised.

In the case of those who have elected to work in health and social care, but have not previously considered teaching and research, explicit guidance about career prospects as educators and researchers should be written into general career guidance that is provided to all professions and sent to prospective candidates. Sections explaining career pathways beyond registration that are available in education and research should be detailed. Appropriate entry points, available support and training should be described. Proposals that surround the 'Modernisation of Medical Careers' (MMC) include suggestions to have short periods of academic experience during Foundation Year Two (F2) for a proportion of the workforce.

These 'academic tasters' offer a good way to encourage interest in academic medicine at an early stage in the career of young professionals and it is an idea that might be extended to other professional groups in health and social care. The initial proposals for academic tasters in the MMC system have been well received and the initiative has now passed to the Academic Careers Sub-Committee of MMC and the UK Clinical Research Collaboration.

Finally, there is the recruitment of staff who are already in service. In medicine and dentistry it is established practice for academics to engage in clinical practice in the NHS, and this is seen to have many advantages. In addition, service staff play a vital role in supporting vocational programmes in FE through honorary contracts. There have been numerous representations to the Project Team for these models to be extended to other health and social care professions as one career pathway option so that academics remain up to date in terms of their clinical skills and enhance the relevance of their teaching and research and service staff have the opportunity to extend their teaching roles.

Teacher/practitioners have been developed in some fields but this could be extended more widely to other professionals in health and social care. It would be helpful to have an agreed name for them; for instance 'clinical researcher' or 'clinical lecturer'. For many health and social care professions it is noted that there are considerable difficulties in recruiting

experienced professionals into academia and the combination of the two roles would be of great benefit to both service and academia. It is likely that new resources will be needed in order to ensure sufficient recruitment.

Recommendation Fifteen
A recruitment and awareness campaign aimed at drawing practitioners into education and research should be developed and launched. The Department of Health, social care agencies and the Department for Education and Skills should drive the campaign jointly. It should be directed at those entering the professions, but also those with experience beyond registration. The known barriers to recruitment and retention should be addressed nationally and locally.

5. Conclusion

The essential focus of this study has been on the looming shortage of teachers and researchers to support the ongoing development of health and social care in England.

It has been shown that the excellent reputation built up over the past 60 years is in severe danger of being reversed through a combination of a poorly articulated and enacted concept of a clinical academic career, poor modelling of these various career options especially early in the practitioner's training and career, complex and inflexible employment arrangements (including pension arrangements) that militate against fluid movement between various employment situations, lack of active management of careers by managers and those in a position to influence the career choices of relevant staff, and poorly coordinated recruitment arrangements.

It has been the purpose of this discussion paper to indicate that none of these problems is insuperable and indeed many of them have been overcome by particular employment groups or by inspirational and innovative use of existing mechanisms.

However, the central argument of this study is that there is an urgent requirement for an integrated human resources plan to cover all aspects and levels of the health and social care teaching and research workforce, and that such an integrated, cross-sectoral plan must be developed and fully implemented if England is to avoid losing its pre-eminent position internationally and suffering serious and possibly irreversible losses of excellent staff and of the momentum and credibility they exemplify.

Appendix A

A proposed Human Resources Plan for the Educator and Researcher Workforce in Health, Social Care and Education

Criteria that would indicate the successful implementation of this HR plan

- a list of senior champions for the implementation of the HR plan will be known
- a minimum set of 'performance milestones' to implement the HR plan will be identified and agreed
- education and research will be 'careers of choice' for some of the best practitioners in the health and social care workforce
- an identifiable career pathway for educators and researchers will be understood and agreed by the health, social care and education economies
- by 2010 there will be few or no reported shortages in this workforce
- there will be an identifiable reduction in turnover, sickness and absence in this workforce
- there will be demonstrable changes in the diverse nature of this workforce
- staff development for this workforce will be clearly expressed through robust personal development plans

Cultural changes needed to ensure the success of this HR plan

- ensure an appropriate national champion such as StLaR to progress the plan.
- establish an on-going work stream to change the perceptions of different esteem factors between 'research and teaching''
- use the business plans of organisations in the health and social care sectors to encourage ownership of, and support for the education and research workforce
- utilize the teaching and learning plans of health and social care organisations to identify the prospective workforce in health and social care education and research
- use the emerging HESPs (Health and Education Strategic Partnerships) to drive and support the HR plan in local health, social care and education communities to ensure appropriate roll-out

Technical work required to support the implementation of this plan

- sector agreement on appropriate and modernised pay schemes for researchers and educators (HE and FE)
- create or commission work streams to remove obstacles on pension scheme transferability between the health, social care and education systems and improve employment rights advice
- identify the necessary common skills and competencies for educators and researchers across the sectors
- produce model programmes of preparation for careers as educators and/or researchers

The Human Resources Plan

In the consultations that were undertaken as a background to this report, informants offered commonly held views about what the key elements of an HR plan should look like. Broadly they fell into the following dimensions.

An HR plan should be:-

- ***Explicit about the attraction of careers in education and research***
- ***Flexible enough to allow career opportunities, career transferability between research, education and practice***
- ***Innovative with respect to recruitment and retention in teaching, learning and research***
- ***Respectful of cultural differences between service delivery and the academic environment***
- ***Equitable with regard to esteem, rewards, pensions, workload***
- ***Simple in design, presentation and utility***

These dimensions offer sound building blocks for any HR plan .

Recommendations made throughout this report recognise and respond to these six dimensions.

Appendix B

Recommendations 1 – 15

Recommendation One
A human resources plan for the educator and researcher workforce in health and social care should be implemented immediately with the aim to recruit, retain and retrain an excellent workforce. It should be developed systemically with existing HR strategies already available for the health, education and social care economies

Recommendation Two
Centres for excellence in education and research are being established in higher and further education. Work streams should be identified and centres encouraged through periodic contract performance to address the particular needs of educators and researchers in health and social care.

Recommendation Three
A series of flexible 'off-the shelf' employment models, embracing full-time, part-time and joint appointments, with associated and pre-approved employment contracts should be made available to facilitate a range of different employment patterns. Career options should be provided for lecturer-practitioners, academics with a defined teaching pathway, academics with a defined research pathway and a combined teaching/research pathway. In cases where such arrangements have already been successfully pioneered, they should be held up as exemplars and used as models.

Recommendation Four
The key proposals in the Follett report, aimed at clinical academics in medicine must now be applied to other relevant professionals involved in education and research in health and social care. This will result in an individual having a single key employer and being jointly appraised by senior colleagues in the education and service fields. Job planning for such professionals should also be a joint endeavour between service and education.

Recommendation Five
Consultant and advanced practitioner appointments in all professions must be allowed to fulfil their obligations towards education and research. Pay modernisation processes should ensure these obligations are fully described in contracts of employment and employers must be charged with appropriately supporting teaching and research activities by these senior staff.

Recommendation Six
Transparent and accessible guidance that explains employment rights and pension transfer across the different sectors of the 'public sector pensions club' should be produced as a matter of urgency. Any future or forthcoming reviews of pensions in the public sector should hold in view the need to encourage career flexibility.

Recommendation Seven
All students following professional courses in health and social care should be taught the basic skills of teaching and research awareness for patient/service user benefit during their professional preparation. It should be the responsibility of educational commissioners and quality assurance agencies to make sure this is done. The basic skills can then be enhanced in those individuals who wish to become teachers and researchers

Recommendation Eight
A specific initiative should be established that will enhance the NTN(A) scheme in medicine and dentistry. Clinical trainees in medicine on a defined academic career track should receive an NTN(A). Government should extend this to other health and social care professions. A national budget stream should be sustained but developed further.

Recommendation Nine
Employers in health and social care have a duty to support the education and research enterprise that will deliver evidence based care and a next generation of employees. This support should be demonstrable through board level accountability by executive and (for Trusts) non-executives members. Responsibility can be evidenced and enhanced by the Healthcare Commission and the Commission for Social Care Inspection.

Recommendation Ten
Managers should be assisted to work with their employees in order to consider potential career options as educators and researchers into their annual review cycle and to facilitate suitable expert support and information gathering for those who might benefit from such a career move.

Recommendation Eleven
A labour market intelligence system designed to provide continuous accurate data on the employment and disposition of the research and educator workforce for health and social care should be developed without delay. It should be driven by contractual arrangements between HESA, the further education sector and the Department of Health.

Recommendation Twelve
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