

The Medical Academic Handbook



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Please note where links are not provided documents are generally available on the BMA website www.bma.org.uk

Where reference is made to 'institution policy' members are advised to check the information on their higher education employer's website.

Foreword

Medical academics play a pivotal role within the medical workforce; driving innovation in medicine, educating our future doctors, and providing clinical leadership and expertise to ensure the provision of high-quality care to patients across the health service.

The BMA recognises the invaluable contribution of medical academic doctors, yet we know they are facing difficult and challenging times. We are committed to providing the professional support our members need to lead successful and fulfilling careers, and to ensure the development and continued success of medical academia in the UK.

I feel certain that the *Medical Academic Handbook* will prove an essential and valuable resource, particularly if it is used and developed as a living document to which you all contribute. I'd like to take this opportunity to thank and congratulate all those who have worked to produce the guide.

A handwritten signature in black ink, reading "Hamish Meldrum". The signature is written in a cursive style with a long horizontal line extending to the right.

Dr Hamish Meldrum
BMA Chairman of Council

Introduction

Dear Colleague,

This handbook has been published as a resource document for medical academic staff, who are members of the BMA and those BMA staff who are supporting them. The publication of a handbook for medical academic staff has long been an aim of the BMA Medical Academic Staff Committee (MASC), and we are proud that we have finally achieved our aim.

The handbook has been put together under the editorial guidance and mentorship of the MASC with contributions from a wide group of medical academics in conjunction with extensive input from BMA national and regional staff. The task has been coordinated by the MASC secretariat, who have spent over a year in putting this document together and have our grateful thanks for all their tireless efforts. The document will be used as a reference and source of information for askBMA and our Regional Services team. It is hoped that members will be able to use this handbook to ensure that they understand the structures they deal with and how to help develop a more effective working environment. It is also intended that this handbook will provide useful information for doctors considering the exciting prospect of a career in academic medicine.

It is intended as a 'living document' for medical academics across the UK and will be updated frequently. We are particularly interested in the opinions of our members and would encourage that you contact the committee with comments on its use and content:
info.masc@bma.org.uk



Professor Michael Rees
MASC Co-chairs



Dr Peter Dangerfield

Acknowledgements

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About the British Medical Association

The British Medical Association (BMA)

The BMA is a voluntary association set up in 1832 'to promote the medical and allied sciences and for the maintenance of the honour and interests of the medical profession'. It is the professional association of doctors in the UK and is registered and certified as an independent trade union under employment legislation. The BMA has sole bargaining rights for all NHS doctors employed under national agreements, irrespective of whether or not they are members. It is also recognised by many employers of doctors practising in other fields.

The BMA offers advice to members on contractual and professional matters and provides individual and collective representation at both a national and a local level. It speaks on behalf of the medical profession to the public, governments, employers, MPs and the media. The BMA addresses matters from medical ethics to the state of the NHS. It has representative committees for all the main groups of doctors (for example, GPs, consultants and juniors) which are known as branch of practice committees.

Medical academic staff committee (MASC)

The MASC is the BMA UK branch of practice committee responsible for representing the interests of doctors employed by a university or research organisation in the United Kingdom. The MASC works with university and NHS employers, the Department of Health Research & Development Directorate and other stakeholders to ensure that there are sufficient incentives to attract and retain doctors in the discipline. The MASC also has input into key policy issues affecting academia that are the responsibility of the UK Government. This includes policy issues covered by the Department of Health (DH) in England and affecting the NHS in England.

The purpose of the MASC is to act upon matters affecting medical academics. The MASC also functions to ensure that the views of medical academics are represented in a range of forums from within the BMA, to external stakeholders. The MASC is part of the BMA Representational and Political Activities Directorate which reports to BMA Council. MASC

has an internal committee, the Regional Services Liaison Group, which comprises members from MASC and representatives from BMA Regional Services.

The MASC is composed of 16 voting members elected by the Conference of Medical Academic Representatives (COMAR) in addition to the chairs of the national MASCs, co-opted members and observers. It meets three times per year to discuss issues relevant to both academics, and the profession as a whole. Committee members use their experience to contribute to work throughout the session, in addition to representing medical academics on other BMA committees and at external organisations.

Conference of Medical Academic Representatives (COMAR)

COMAR is the BMA's annual representative conference for doctors employed at higher education institutions and other institutions engaged in medical research. It is the opportunity for medical academics from across the UK to meet together, to discuss key issues and set priorities for the medical academic staff committee (MASC) for the coming year. The conference also elects the 16 voting members of MASC for the succeeding session.

All representatives to COMAR hold office from the beginning of the annual conference to which they have been elected, to the eve of the following year's annual conference. Medical academics attend from each medical school and higher education institution without a medical school and other institutions engaged in medical research.

Medical academic staff committees in the devolved nations

In addition to the UKMASC, there are medical academic staff committees in Scotland (SMASC), Wales (WMASC) and Northern Ireland (NIMASC) made up of representatives of medical academics in the higher education institutions in those nations. These committees deal with matters specific to medical academic staff within the devolved

health systems. Representatives from each of these committees sit on MASC and on the relevant national councils of the BMA.



Information

SMASC:

www.bma.org.uk/ap.nsf/Content/Hubscottishmedicalacademicstaffcommittee?OpenDocument&Highlight=2,smasc

WMASC:

www.bma.org.uk/ap.nsf/Content/Hubwelshmedicalacademicstaffcommittee?OpenDocument&Highlight=2,welsh,masc

NIMASC:

www.bma.org.uk/ap.nsf/Content/nimasctermsoref?OpenDocument&Highlight=2,Northern,Ireland,Medical,Academic,Staff,Committee

BMA divisions

The BMA divisions are the local branches of the Association, based on geographical areas, and cover all branches of practice. Every member of the BMA is automatically a member of one of 201 divisions. Each division should have a chair, secretary and an executive committee including representatives of the branches of practice locally and should appoint at least one representative to the BMA's annual representative meeting (ARM). Professional and administrative support to divisions is provided by BMA Regional Services. A regular newsletter is sent to divisional secretaries, who also have their own annual conference. A number of divisions have their own web pages, which can be accessed via the divisions page of the BMA website.

Medical staff committees (MSCs)

Each NHS hospital organisation should have a medical staff committee (or equivalent) consisting of all consultant and permanent staff and associate specialist doctors. Each MSC has a range of functions including providing professional advice to the Trust (including nominating members of audit, drug and manpower committees), monitoring local CEAs and electing representatives to a

local negotiating committee (LNC). While not being formally part of the BMA, MSCs should also elect representatives to regional consultants and specialists committees and to the annual BMA Consultants Conference held in June each year.

Local negotiating committees (LNCs)

LNCs are now established in almost all NHS organisations that employ doctors. LNCs consist of representatives of all grades of doctor elected by the MSC. LNCs meet regularly to identify issues for negotiation with local management and agree objectives. Each LNC of an NHS organisation with clinical academic staff should have at least one representative of those staff on it. If you are an academic LNC representative please contact the committee on info.masc@bma.org.uk LNCs will meet with management representatives in a joint negotiating committee in order to conclude local agreements and monitor their application, and agree and monitor arrangements for the implementation of national agreements within the organisation. Professional and administrative support to recognised LNCs is provided by BMA Regional Services. Industrial relations officers (assistant secretaries in Scotland, Wales and Northern Ireland) are the key point of contact on collective issues with the academic representative member on the local Trust/board.



Information

BMA LNC handbook:

www.bma.org.uk/representation/local_representation/3_local_neg_committees/Inchandbook.jsp

BMA Council

Council is the central executive committee of the BMA as a trade union and the Association's Board of Directors under company law. It is responsible for administering the affairs of the Association subject to the decisions of representative meetings. It has powers, in the interval between successive meetings of the representative body, to formulate and implement policies on any matter affecting the Association. Medical academics are represented on Council by at least two voting members plus the Chair of the Committee if he

or she is not a voting member of Council. Council members are elected from a single UK constituency. Half of BMA Council is elected biennially by postal ballot of the membership of the BMA. Council delegates its authority to seven major branch of practice committees including the MASC.

There are also national councils in Scotland, Wales and Northern Ireland which meet to discuss issues pertinent to members in the devolved nations and report to the central BMA Council.

BMA Regional Councils

The 2007 ARM passed a resolution instructing that regional councils should be established in all parts in England. The boundaries of regional councils in England coincide with those of SHAs, so that the councils have a clear local identity. The exception being Southern Regional Council which covers two SHAs: South East Coast and South Central SHA.

Regional councils are open to all BMA members and provide a forum where matters of regional interest and issues affecting the profession can be discussed across divisions and inclusive of all branches of practice. The MASC is keen to ensure that academics are represented on regional councils.

Political Board

The interests of medical academic staff are also represented at the BMA Board of the Representational and Political Activities Directorate, which was established at the 2002 ARM. After the 2008 ARM the name was changed to the Political Board.



Information

BMA Regional Councils:

www.bma.org.uk/representation/bma_councils/regionalcouncils.jsp

BMA Political Board:

www.bma.org.uk/representation/political_board/index.jsp

Annual representative meeting (ARM)

The ARM determines the policy of the BMA and provides an opportunity for doctors from all parts of the profession to debate motions relating to various aspects of their working lives and professional practice. Motions on a wide range of issues are submitted by the Association's divisions, branch of practice conferences and other constituencies and are grouped into areas of debate. Representatives also discuss some matters in less formal open debates.

Representatives to the ARM are either elected by the BMA divisions or are appointed by the branch of practice committees. The BMA's regional councils also have a role as they can appoint representatives to the places not filled by the divisions. Medical academic members of the BMA interested in attending, therefore, have three routes for attendance at the ARM.

1. They can seek one of the 280 seats allocated to BMA divisions. These are usually allocated by mid-March.
2. They can apply (via the regional councils in England and BMA national councils in the devolved nations) for division seats, which the divisions have been unable to fill.
3. They can seek one of the four seats allocated to the MASC.

BMA advice and support

The work of the BMA is supported by a professional secretariat based in BMA House in London and in the national offices in Belfast, Cardiff and Edinburgh. The BMA also has a number of regional centres staffed by secretaries, employment advisers and industrial relations officers/assistant secretaries who provide support to regional and local committees and help and advice in disputes or negotiations with NHS management and other employers. BMA Regional Services are able to support medical academics both in their academic and their NHS roles. They can support and assist both individuals and groups, and can help ensure that medical academic members do not feel isolated.

The first point of contact for all individual queries is askBMA on 0300 123 123 3 or email support@bma.org.uk

The BMA can also provide specialist advice through its pensions department, medical ethics committee and board of science. All these committees and the branches of practice are also assisted by the BMA's public affairs division, consisting of the press office and the parliamentary unit. The press office aims to maintain a high profile for the Association, the BMJ Publishing Group and the wider medical profession. It promotes positive news and features coverage of BMA activities and events and of the work of individual doctors and medical teams. The press office offers media training to members who have agreed to act as spokesmen and women, whether as members of national committees, such as the MASC, or as locally-elected honorary public affairs secretaries. Individual members of the BMA who are facing media enquiries can seek help from the press office at any time by emailing pressoffice@bma.org.uk or calling 020 7383 6254.

Helping and supporting you at work

The BMA is dedicated to supporting its members in virtually all aspects of their professional lives. For all your employment advice and information, please call our team of advisers on (0300 123 123 3) between 8.30am and 6.00pm, Monday to Friday except UK-wide bank holidays, or email your query to support@bma.org.uk anytime. Our advisers receive around 50,000 new queries a year from the membership, of which the majority can be answered the same day. These can be on topics ranging from a simple enquiry on a member's leave entitlement through to assistance and representation at grievance procedures. So, no matter whether you need a guidance note or have a serious problem at work you should contact our team of advisers on 0300 123 123 3 first.

Most queries will be answered directly over the phone or by return email. If, after contacting our team of advisers, however, it is found that you need direct representation locally, you will be referred to a member of our BMA Regional Services team. The BMA recognises

that clinical academics can have rather unusual contractual arrangements, compared with other members, because they essentially have two employers. Our advisers are trained on issues that will specifically affect clinical academics as well as those that affect all members.

A world of service from your BMA: **one line** 0300 123 123 3 and **online** www.bma.org.uk

To help us help you, please remember to keep your BMA membership and contact details up to date, including that you are an academic. You can do this online via the BMA homepage or following the link: www.bma.org.uk/representation/branch_committees/medical_academics/mascmemberinfo.jsp?page=1

Unfortunately, the BMA is unable to help non-members or assist members if their problem pre-dates membership of the Association. More details on the help and support offered to members and your eligibility for services can be found in *MyBMA – a guide to membership benefits* booklet: www.bma.org.uk/ap.nsf/Content/YourBMA



Information

Women and academic medicine – page 35

Bullying and harassment – page 172

Careers in academic medicine

What is academic medicine?

The definition of academic medicine that is used by the Academy of Medical Royal Colleges:

'Academic medicine is the work undertaken by clinicians with responsibilities to both their University and their NHS Hospital Trust. They usually combine service delivery with research, teaching and/or administration (Royal College of Physicians of London, 2004).'

In practice, doctors undertaking this role are usually employed by medical schools within universities, although also, but less commonly, employed by universities with postgraduate medical centres or without medical schools. They usually have honorary contracts with local NHS organisations and undertake a limited number of fixed clinical sessions, while the main focus of their work is on teaching and research.

Those doctors also with clinical commitments are known as clinical academics and are on a pay scale equivalent to that in the NHS. Those without clinical commitments will be on university grading and pay scales ranging from clinical lecturer (specialist registrar equivalent), senior clinical lecturer (consultant equivalent), to reader and professor at more senior levels. However, individuals may also be primarily employed by the NHS, and have a part-time or honorary contract with a university, for whom they undertake agreed research or teaching roles. There is an increasing trend for medical schools to deliver core undergraduate teaching through NHS staff closely linked to the university.

Breakthroughs in academic medicine

Academic medicine is vital to the core functioning of the NHS and healthcare provision in the United Kingdom. Its success can be measured not only by the wide-reaching benefits for patients and carers across all aspects of clinical practice, but also through the wider economic and financial benefits to the UK derived from this work. Early identification of diseases and conditions has made effective early treatment more possible and thereby reduced the risk of more hazardous surgical procedures. Through this work there have been significant advances in the availability and, ultimately, the affordability of treatment. Academic medicine has also changed the way research is undertaken. In 1948 researchers from the Medical Research Council developed what became the standard method for clinical trials with the first example of the use of randomised treatment, control groups and double-blind testing.

Medical research has delivered countless innovations in areas such as pharmacology, palliative care and health policy which, along with the development of groundbreaking surgical techniques and technological advances, have revolutionised how care is provided in the UK and across the world. Research funded by the Medical Research Council (MRC) alone has yielded 28 Nobel Prize winning scientists in the Chemistry and Physiology and Medicine awards since the MRC was founded in 1913.

Investigations carried out by Prof Christopher Langton into the use of ultrasound to detect levels of bone density, led to a method for the early detection of osteoporosis and the invention of the 'bone-box'. The disease is estimated to be responsible for 60,000 hip fractures in the UK every year at a cost of £1.73 billion to the NHS. The early-detection system is now used worldwide in an estimated 12,000 hospitals and has enabled early treatment and a reduction in the suffering experienced by patients.

Advances in imaging technology have also brought considerable benefit to patients. Sir Peter Mansfield's 1973 discovery that the magnetic properties of a cell could be harnessed to produce images of structures led to the development of magnetic resonance imaging (MRI). This diagnostic technique, safer and more sensitive than X-rays, is now used worldwide to produce images of soft tissue both prior to and after surgery.

Through the research carried out by Sir Richard Doll and Professor Sir Austin Hill the link between smoking and lung cancer, strokes and heart disease was established in 1954. The subsequent policy changes, public health awareness campaigns and cessation programmes since have seen a 56 per cent fall in the number of adults who smoke. This has not only helped save millions of lives but has also eased the potential financial burden on the health service in an area where the cost of hospital admissions and treatment of smoking-related diseases still costs the NHS around £1.7 billion a year.

The economic value of breakthroughs in academic research should not be overlooked. Technological advances such as the 'bone-box' can generate essential income for the NHS and the development of new drugs and methods of mass production can cut the existing cost of treatment and widen the availability for patients. Financial benefits though do not come from intellectual property and new product development alone. More profound and wide-reaching effects can be seen from the impact of medical research on public health policy and the progress made in the treatment of long-term illnesses and chronic diseases.

Ultimately, while the work of scientific research will not always yield automatic results which lead directly to patient care, the methods of gathering data and testing findings all add to a significant body of knowledge. Over time this incremental progress of enquiry can lead to discovery and innovation, all built on the foundations of previous findings which ultimately bring benefits for patients.



Information

BMA (2008) *Academic medicine in the NHS: driving innovation and improving healthcare*. London: BMA.

www.bma.org.uk/ap.nsf/CContent/AcademicmedicineNHS?OpenDocument&Highlight=2,Academic,medicine,NHS;driving,innovation,improving,healthcare

National Institute for Health Research (2008) *60 years of research in the NHS benefiting patients*. London: NIHR.

www.nihr.ac.uk/publications.aspx

Spheres of academic work

Academic medicine provides a lifelong, highly fulfilling and stimulating career based within university and NHS institutions involving the following spheres of professional activities:

- teaching
- research
- clinical practice
- administration.

Following initial training in the foundation years and as an academic clinical fellow, a career in academic medicine begins through the appointment of the aspiring clinical academic to the teaching/research position of clinical lecturer attached to a medical discipline. The position may be gained through following the recently established Walport/Tooke clinical academic training pathway, or through a more traditional (but now non-standard) route by development of a clinical research/teaching portfolio fostered under the tutelage and guidance of one or more clinical academic educators and mentors.

The clinical lecturer post is in a higher education institution with the NHS providing an honorary contract, usually at specialty trainee, in the relevant clinical discipline. On completion of specialist training there is an opportunity to apply for a clinical senior lecturership (CSL) linked to an honorary consultant contract with the NHS. The latter is associated with a generic job plan agreed under the relevant consultant contract in each of the devolved nations. In England this involves a split of five programmed activities (PAs) with the Trust and five PAs with the college sector. In Wales the job plan has a 6:4 NHS:college split. In Scotland it will typically involve six PAs of academic work (five core and one extra) and five PAs with the NHS.

Career progression beyond clinical senior lecturer is based on achieving a promotion to a readership followed by a professorship while retaining the NHS honorary consultant contract. Promotion opens up the opportunity of a higher salary award from the university sector based on performance output. On the NHS side there is also the opportunity each year to gain clinical excellence awards (CEAs) through the submission of achievements and outputs in the spheres of clinical service, administration, leadership, teaching and research, judged to be over and above the expected contractual level.

Teaching

Medical undergraduate and postgraduate teaching constitutes a key remit of the clinical academic position with a commitment of one to up to five sessions (four to 20 hours) per week, often dependent on the agreed job plan and the needs of the institution. The teaching involves lecturing, taking tutorials and supervising student selected component and intercalated degree related projects. At the SCL/honorary consultant level it also includes instruction of junior doctors in their subspecialist subjects, as well providing supervision for MSc, MD and PhD students' projects. At the highest level, it involves providing the role of internal and/or external examiner in NHS, as well as clinical academic, fields and is a career pathway to professorial level for innovative clinical academics.

Research

A research career initially requires undertaking research leading to a research degree (such as a PhD or MS) as the achievement for acquiring the SCL/honorary consultant posts. Doctoral research should be aimed to be relevant to the candidate's chosen clinical subspecialty. Postdoctoral research is often encouraged to be aimed at achieving translational medicine objectives pertinent to local, regional and national research themes and needs. These are designed to be of sufficient quality in terms of originality and importance to merit regular publication of the findings in high impact journals, as well as gaining research grants to support and promote further research. Research leading to innovation and enterprise, the mission of many modern university institutions, is also highly encouraged and a satisfying outcome of a clinical academic career.

Clinical practice

In common with other trainees, clinical lecturers undertake higher specialist training in their chosen clinical specialty, conducted under consultant supervision. On the successful completion of specialist training, clinical practice is undertaken independently at the honorary consultant level and delivered in the NHS on a rostered basis according to the agreed job plan. It involves taking part in regular multidisciplinary team (MDT) meetings, and participating in the pertinent subspecialist external quality assessment scheme(s). It also involves continuing professional development needs through participation in and contribution to accredited training courses and clinical and scientific meetings. The latter activity is also linked to yearly appraisal and job planning and is soon likely to become a mandatory aspect of the revalidation process.

Administration, leadership and management

The management roles of an academic in medicine involve conducting and taking part in: regular audits relevant to teaching, research and clinical service related practices, relevant academic and clinical departmental management meetings, and taking up lead roles in planning, development and/or supervision of projects based on new local, regional and national initiatives. At the higher level this may involve taking up active membership of the relevant royal colleges and clinical and scientific societies, as well as other local, regional, national and/or international committees, culminating in the delivery of organisational and management needs through the higher administrative positions of secretary, treasurer, chair, or president of a professional or Government body.

As very aptly summarised by Timothy J Underwood MRC/RCS clinical research training fellow: 'the triple thread of clinical care, teaching, and research is what defines academic medicine,' capable of taking the aspirant from 'the biochemistry lecture hall with diagrams of the DNA double helix' to the position of a professor of surgery. How one achieves this transition may seem impossible at the outset, and be strewn with lots of hurdles and uncertainties. However, there is plenty of help to be gained from the existing and established clinical academics who traditionally have been the most effective educators, mentors and role models for the next generation of doctors.

Not only are these educators providing first class clinical care for their patients, but they are also discovering the next generation of chemotherapeutic agents or doing a multi-centre randomised controlled trial. Although it is true that many doctors are great teachers and others do first class research, it is the synergy between the three pillars of academic medicine (teaching, research and clinical care) that makes it special. A career in academic medicine can be exciting, enjoyable, rewarding, and may be the only time in your life when you genuinely know more than anyone else about your subject.



Information

Recommendations for medically and dentally-qualified staff: recommendations for training the researchers and educators of the future (2005) – also known as the Walport Report:

www.ukcrc.org/pdf/Medically_and_Dentally-qualified_Academic_Staff_Report.pdf

National Institute for Health Research (2008) *60 years of research in the NHS benefiting patients*.

Professor Sir John Tooke (2008) *Final report of the independent inquiry into Modernising Medical Careers*.

www.mmcinquiry.org.uk/draft.htm

The International Working Party to Promote and Revitalise Academic Medicine (2004) *Challenges and opportunities for academic medicine*. London: BMJ Publishing Group.

BMA (2005) *Role models in academic medicine*. London: BMA.

www.bma.org.uk/sc/employmentandcontracts/recruitment/Rolemodels.jsp

Training opportunities in academic medicine in England

The principal outcome of the Walport Report into the training available to medical researchers and educators was the creation of three academic programmes known collectively as the 'Integrated Academic Training Pathway'. These clearly define the key entry points into this specialty area and outline a transparent career structure where progression is identifiable from the outset. Together they are designed to equip prospective medical researchers and educationalists with the skills and experience necessary for senior roles within academia.

Starting at foundation level and progressing through two specialty phases, the Pathway is intended to be the dominant career route for medical academics, while allowing enough flexibility to incorporate clinical training and practice, and also allowing academic interests the provisions and time to develop. Of the training opportunities offered, the majority will be research-focused with fewer concentrating on training for educationalists. The three training programmes are:

- foundation academic programmes (FAPs)
- academic clinical fellowships (ACFs)
- clinical lectureships (CLs).

It is important to note that, although defined as the principal career pathway into academic medicine, it is not the only route and opportunities are available to enter the academic career structure at different stages of a clinician's career, even as a consultant.

Foundation academic programmes (FAPs)

FAPs are designed to expose new graduates to the key elements of academic research and to discover whether it is an area in which they excel and enjoy. Opportunities on the programme may include:

- development of skills needed to write grant research proposals to pursue a higher degree
- participation in a research/educationalist project
- sustained academic relationships leading to further joint working (after completion of placement)
- successful outcomes to a taught component.

The programme is delivered in the foundation year 2 (FY2) either as an academic rotation or integrated throughout the entire year. As with all doctors, those on FAPs have to achieve and demonstrate the clinical and generic competences necessary for progression onto specialist training. Those on FAPs will be employed by the NHS and are paid under the same terms and conditions as apply to other foundation trainees.

Academic clinical fellowships (ACFs)

The ACF is the first phase of specialist academic training and usually leads to the attainment of a higher degree by means of a competitive peer-reviewed research fellowship or educational training programme. General clinical training and practice will still form the majority of the responsibilities of those on the fellowships, with 25 per cent of a trainee's time protected for sessions aimed at developing the

necessary academic skills required to develop ideas for and prepare applications to more substantive clinical fellowships or funding to do a higher degree. A maximum of three years (four years for a GP) is allowed to secure a research/teaching fellowship – although it is expected that one may be secured in less time – with a further three years for the completion of the higher degree.

All those accepted onto ACFs will be awarded a National Training Number (Academic) (NTN(A)). If a trainee is unsuccessful in obtaining a fellowship or decides not to pursue an academic career, they would relinquish their NTN(A) for an NTN and join a standard clinical programme and specialty training. Successful applicants to an ACF will be employed by the NHS under the national terms and conditions agreed for junior doctors by the BMA Junior Doctors Committee. They are classed as trainee members of the National Institute for Health Research (NIHR) faculty. ACFs should also have honorary academic contracts in order to have ease of access to HEI facilities and some further training.

Clinical lectureships (CLs)

CL posts are the second phase of specialist academic training and are designed to enable trainees to complete clinical training in conjunction with post-doctoral research or higher educational training. Clinical lecturers will be employed primarily by the higher education institution in which they hold a post but, as the clinical-academic timetable split will be half-half, a clinical lecturer should also have an honorary contract with the NHS and, as with ACFs, will be classed as trainee members of the NIHR faculty.

The CL phase lasts up to four years and a trainee's continued academic career development will be the responsibility of the organisation in which they are based. The programme enables the trainee to undertake a substantial piece of postdoctoral research or educationalist project and leads to the attainment of a Certificate of Completion of Training (CCT) and the end of clinical training.

Other routes

Although the three training programmes are seen as the dominant pathway for a career in academic medicine, there is flexibility, with other entry points and routes into the career framework. Indeed, training in academic medicine is entirely possible outside the integrated academic training pathway.

For example, MB and PhD graduates or medical graduates who have an intercalated PhD gained during an undergraduate medical degree can enter the career structure at either the ACF or CL phases. Prospective trainees in this instance can use the ACF to gain funding to continue research in their area of interest, for example by means of an application for a Clinician Scientist Award. There is also the option for new graduates with a higher degree to apply for a postdoctoral fellowship in the second year of specialist training and therefore open the way to a fast track to CL posts.

There are further opportunities for entry into academic medicine by securing a training fellowship from a research funding organisation through competition, or by appointment to a research position on a grant contract. Direct entry routes onto the specialist register are also available, without the completion of the requirements for a CCT, on the recommendation of the Specialist Training Authority. This route though is only suitable for doctors who intend to have research as their primary activity, with only a narrow area of clinical practice.

Training opportunities in academic medicine in Scotland

Arrangements for academic training in Scotland are based on the same principles as those in England but differ slightly in structure.

Academic foundation programmes

There are between 40 and 50 academic foundation programmes available in Scotland each year. Recruitment takes place prior to the main foundation recruitment process. Trainees on the academic programmes are given additional tuition relating to research and are

encouraged to participate in the research being undertaken in the relevant departments. Each trainee will be allocated an academic mentor. These activities are over and above the normal foundation programme teaching and competencies.

For more information see the *Academic trainees* section from page 80.

Specialist training for medical academics

The Scottish Clinical Research Excellence Development Scheme (SCREDS) was established in 2007 in response to the Walport Report recommendations to provide an integrated training and career development pathway for clinicians wishing to pursue academic and clinical training within the NHS. It allows clinicians to pursue academic and clinical training either concurrently or sequentially to provide opportunities to attain both a CCT and the experience and skills required for a senior clinical academic post. The scheme is operated by the five Scottish universities in partnership with NHS Education for Scotland (NES).

SCREDS covers three phases of academic and clinical training. Please note that job titles vary within each phase and between different institutions. Contact askBMA if you require any assistance.

- 1 Clinical Lectureships: aim to provide an opportunity to pursue an element of research training (20%) while undertaking specialty clinical training (80%). These posts are usually available from ST2 and above for the duration of specialty training. They aim to provide an opportunity to prepare for a more extended period of research while allowing the trainee to attain the competencies and training required for CCT. Trainees may take time out from this post for three years to pursue a higher degree full time (eg PhD) before returning to the integrated post for the remainder of clinical specialist training.
- 2 Out of programme research/clinical fellows: an opportunity to focus on pursuing a higher degree, usually a PhD.

- 3 Advanced academic career development: there are a number of opportunities for those with a higher degree, either at pre or post-CCT level. These include Intermediate Fellowships and Scottish Senior Clinical Fellowships.

All appointments are to substantive academic posts, are flexible and competitive (except for NTN holders returning to a NES clinical lectureship post) and are made by the universities. Participants in the scheme who are not in the GP or specialist registers must have a NTN. All appointments are required to be coupled with an honorary NHS appointment. In addition, all participants will take part in a deanery-led Annual Review of Competence Progression.

Training opportunities in academic medicine in Northern Ireland

Academic posts were included as part of national foundation programme recruitment in Northern Ireland for 2009. There was not, therefore, a separate recruitment process. Foundation posts with an academic stream in Northern Ireland are fully integrated into the foundation programme for FY2 2009.

Queens' University of Belfast, in partnership with the Northern Ireland Medical and Dental Training Agency (NIMDTA) and Belfast Health and Social Care Trust, has developed a pathway of academic clinical training opportunities. Trainees apply for academic clinical lecturer (ACL) posts at ST3 level or above within the academic medicine and paediatrics training programme. These posts have been created as part of the Modernising Medical Careers/National Co-ordinating Centre for Research Capacity Programme of Integrated Academic Training. NIMDTA states that the posts 'offer candidates a comprehensive experience in clinical academic medicine alongside internationally recognised clinicians and researchers'.

Applicants will have already obtained a medical research postgraduate degree. The aim will be to finish clinical training while continuing academic development involving a programme of postdoctoral research leading to an application to a major funding body.

Senior academic roles

Two main routes exist for advancement in medical academia beyond clinical lecturer posts. These are:

- application or promotion to substantive senior lecturer posts, including as ‘new blood’ senior lecturers by qualified clinical lecturers going into medical research and education
- competition for fellowships at consultant level (senior clinical fellowships) and some Clinician Scientist Awards.

Where a clinical lecturer will be classed as a specialist registrar in their NHS contracts, those at the next level of seniority (senior lecturer, reader and professor) are usually given honorary consultant contracts in their clinical capacity within the NHS. Under the recommendations of the Walport Report, new senior posts are to become available to accommodate those who have progressed through the phases of the Integrated Academic Training Pathway. Embarking on senior academic roles does still allow for a clear pathway back into clinical practice, although this is subject to evidence of continuing good clinical performance and potentially further training.



Information

See *Training, career progression and support* (page 140 onwards) for further information.

BMA Careers Services

www.bma.org.uk/careers

National Institute for Health Research:

www.nihr.ac.uk

UK Clinical Research Collaboration:

www.ukcrc.org/publications/reports.aspx

Clinical Senior Lectureship Awards:

www.hefce.ac.uk/research/cslaward/

Working abroad: present options and choices

Academics must often be willing to move to where the best research opportunities are and that may include working abroad. In addition, working abroad can be good for personal development and for your CV. The Postgraduate Medical Education and Training Board (PMETB) is currently responsible for approving training and only recognises training overseas that it has approved **in advance**. If you are planning on undertaking time out of your training in the NHS you should speak to your programme director or postgraduate dean.

There are many reasons for medical academics to work abroad. During training, an out-of-programme experience will increase skills not only within research-orientated medicine, but also in experiencing other healthcare systems. It may also expose trainees to centres of excellence abroad where colleagues can become long-term collaborative colleagues, lifelong friends and mentors. The benefits can extend into new jobs and questions on this training are frequent during competitive interviews.

Opportunities abroad

The opportunities for working abroad range from temporary placements (eg one month) to permanent roles (eg five years) and may arise during training or later in a career. The length of time spent abroad will vary, as will the type of role.

Given the many healthcare systems in the developed world, clinical roles and responsibilities will differ from country to country. UK training may or may not be sufficient to practice medicine and you should seek advice from the relevant responsible national body in the destination country with regard to gaining registration. These roles are likely to be competitive: therefore clinical and management skills, as well as proven research experience, will be beneficial.

Working in the developing world can offer broad exposure to different roles and challenges: these may include emergency relief work, running clinics or education programmes. Programme requirements do vary but generally volunteers will often need at least two to three years of postgraduate training and some programmes will ask for applicants who are undertaking specialty training. Particularly relevant specialties include general practice, paediatrics, obstetrics and gynaecology, trauma and surgery. Non-clinical skills, such as teaching, administration and knowledge of foreign languages, notably Spanish and French, may be advantageous. In some situations personnel may be limited but you should ensure that you do not undertake tasks that you are not adequately qualified for.

As a senior lecturer I wanted to develop technical skills that were only available in a laboratory in Europe. I obtained permission to learn these skills from the head of the laboratory and then planned time during annual and study leave not only to visit but also to explore the region. In order to finance the laboratory work, I applied for a travel grant from a professional society and carefully chose where my laboratory technician and I should stay. We were taught the techniques by a medical doctor who was interested in our own health care system and we learned about their own. The exchange of skills and ideas was stimulating and well worth the money put up for our stay by our professional colleagues. The resultant work has underpinned the development of techniques used not only in Europe but also in North America.

Emeritus Professor Anita Holdcroft, Imperial College, London

Planning your work abroad

It is important that you prepare well for your time abroad. Not only will you need to organise your personal life (mortgage payments, family commitments, health and safety, immigration checks etc) but there are also many professional issues and implications to consider. These may include funding for your time abroad, determining whether to maintain GMC registration and PMETB requirements for changes to date for completion of training, research governance issues and keeping up to date with UK medical advances while you are away.

The BMA International Department provides excellent resources to help plan your time abroad, for temporary and permanent positions, and there is also advice about returning to the UK. The department has also produced specific guidance for doctors contemplating working for a time in developing countries.

It is useful to develop contacts in advance and speaking to colleagues who have worked abroad about their experience will also be helpful. Aid agency websites also provide accounts of what it is like to live and work abroad and some offer tips for those who are thinking of going.

Erasmus scheme

The Erasmus scheme was established in 1987 to promote the exchange of students between European countries: many medical students take part and an increasing number of medical schools are offering Erasmus exchange programmes to their students. There are also opportunities for academic staff to take part in the scheme and this can enhance professional and personal development, help make new contacts, strengthen research links, innovate and develop teaching methods and courses.

Funding is available from the European Commission for student mobility grants to help with living expenses; teaching staff mobility grants to support academic staff for teaching visits to partners; and for programme organisation and administration. Unlike an elective, that will usually focus on clinical experience, the Erasmus scheme operates in European universities only.

Please see links below for further information.

Humanitarian Fund

The BMA jointly administers the Humanitarian Fund with the Department of Health and the Royal College of Nursing. The Humanitarian Fund offers grants of up to £3,000 to doctors undertaking humanitarian work in developing nations. Projects must be sustainable in their focus and related to the Millennium Development Goals. A huge range of projects have been given grants by the Humanitarian Fund. Some have been educational in their focus, others research-driven. A number have also consisted of multidisciplinary teams giving clinical care and performing operations in the local community. Typically applications are sought in February/March. Details will be available on the BMA website or from the BMA International Department.



Information

BMA International Department:

www.bma.org.uk/ap.nsf/Content/Hubgoingtoworkabroad

BMA (2009) *Broadening your horizons: a guide to taking time out to work and train in developing countries*. London: BMA.

www.bma.org.uk/careers/working_abroad/broadeningyourhorizons.jsp

Opportunities for doctors within the European Economic Area:

www.bma.org.uk/ap.nsf/Content/EEA

www.bma.org.uk/ap.nsf/Content/LIBJobVacancies

American Medical Association: www.ama-assn.org/

International Health Exchange – RedR: www.redr.org.uk/

Médecins Sans Frontières: www.msf.org.uk/Default.aspx

MERLIN: www.merlin.org.uk/

Médécins du Monde UK: www.medecinsdumonde.co.uk/

Voluntary Service Overseas: www.vso.org.uk/

BMJ Careers: <http://careers.bmj.com/careers/welcome.html>

Australian Medical Association (National Office): www.ama.com.au/

Canadian Medical Association: www.cma.ca/index.cfm/ci_id/121/la_id/1.htm

New Zealand Medical Association: www.nzma.org.nz/

Medical Association of South Africa: www.samedical.org/

European Commission – Erasmus: <http://europa.eu.int/comm/education/erasmus.html>

The British Council, Education and Training: www.britishcouncil.org/education

Information for University Teaching Staff:

http://europa.eu.int/comm/education/erasmus/teacher_en.html

www.medicalcareers.nhs.uk/ExploringOptions/alternativestoNHS/Pages/developedcountries.aspx

Women and academic medicine

Despite the increasing feminisation of the medical workforce, women doctors are still strikingly under-represented in the university sector compared to their male counterparts, particularly at more senior levels. This is despite women now accounting for almost 70 per cent of medical graduates. In UK medical schools women continue to be under-represented at every academic grade, accounting for 23 per cent of clinical academics (22% FTE), one in five medical schools do not have a female professor, only two out of the 33 heads of UK medical schools are women and a mere 11 per cent of clinical professors are women.

Studies of female doctors' attitudes and experience show that they have encountered barriers to career progression more frequently than men. The barriers, which may be faced by any doctor but which are more acute for women, include:

- lack of flexible training and working opportunities
- fewer opportunities for career progression and an inherent 'glass ceiling' culture in academic medicine
- medical women earning lower salaries than their male colleagues
- lack of role models for female academics
- tradition of long working hours in academic medicine
- less career flexibility for family and other domestic responsibilities
- part-time working not always being taken seriously by employers, posts are not always advertised and part-time work can be difficult in practice, given the demands of an academic medical career.

Nonetheless, outside clinical work, hours may and can be flexible and there are many examples of young female academics managing a career and a family.

What support is there for women in academic medicine?

Women in Academic Medicine (WAM) project

The BMA has begun to address the under-representation of women in the medical academic workforce and in 2008 published and launched a report on Women in Academic Medicine (WAM), a project to examine the barriers to women's careers in medicine, both in the NHS and in universities.

The UK Resource Centre for Women in Science, Engineering & Technology

A dedicated UK-wide equality organisation working directly with both individual women and organisations. The centre provides advice and services for industry and education, as well as for women entering, returning and progressing in science, engineering and technology careers.

Mentoring

The number of mentoring schemes in medical schools and research institutes is increasing and gives academics the opportunity to speak with someone about important issues including on career options, information and help with networking, feedback on fellowship applications or CVs and advice on achieving a balance between work and family. See *Mentoring* (page 165) for further information.

Maintaining a research career

Many universities and research organisations have schemes for returners to work. For example, Imperial College London established an Academic Opportunities Committee and Sheffield University a Women Academic Returners' Programme. It also provides Research Fellowships for women returning from maternity leave to provide relief from teaching and administrative duties for six months while research can be re-established. The Wellcome Trust offers post-doctoral Career Re-entry Fellowships (four years) for those who have decided to recommence a scientific research career after a break of normally at least two years.



Information

BMA (2008) *University employment good practice guide*. London: BMA.

www.bma.org.uk/employmentandcontracts/employmentcontracts/UniversityEmploymentGuide2008.jsp?page=1

Royal College of Physicians: Briefing on women in medicine (September 2006):

www.rcplondon.ac.uk/news/statements/briefing_womenmed.asp

Clinical academic staffing levels in UK medical schools as at 31 July 2007:

www.chms.ac.uk/documents/ClinicalAcademicStaffSurvey2008-Medicine.pdf

Women in clinical academia: attracting and developing the medical and dental workforce of the future (June 2007):

www.chms.ac.uk/documents/MedicalSchoolsCouncilWomeninClinicalAcademiaReport2007.pdf

Encouraging women to work in academic medicine:

www.bma.org.uk/employmentandcontracts/equality_diversity/gender/WomenInAcademicMedicine.jsp

Under-representation of Women in Academic Medicine (October 2006):

www.bma.org.uk/employmentandcontracts/recruitment/MedAcadStaff.jsp?page=4

Medical women: BMA internet resource:

www.bma.org.uk/employmentandcontracts/equality_diversity/gender/Medicalwomenscene.jsp

BMA Equal Opportunities Committee:

www.bma.org.uk/representation/pro_committees/equal_opportunities_committee/index.jsp

Making part time work – Medical Women's Federation (September 2008):

www.medicalwomensfederation.org.uk/files/Part-time%20full%20report%20final.pdf

The UK Resource Centre for Women in Science, Engineering and Technology (SET):

www.ocvc.ac.uk/content/ukrc

Improving Working Lives initiative, Department of Health:

www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modelemployeer/Improvingworkinglives/index.htm

Academic general practice

Introduction

Every undergraduate medical school in the UK has an academic department of general practice with at least one professorial chair. These departments, like any other academic unit, have two main roles within universities – to carry out teaching and undertake research. Additionally, of course, academic general practitioners (GPs) are *clinical academics* with a third responsibility of providing patient care.

The last 20-30 years have seen a substantial increase in the size, strength and range of activities of academic departments of general practice and their associated teaching and research networks, so that up to 15 per cent of the undergraduate curriculum is delivered through the university departments of general practice and primary care. These departments also typically conduct a range of research programmes with significant research grant funding. This research activity is wide-ranging, including topics across the whole spectrum of healthcare in community settings and employing both quantitative and qualitative methods, from randomised controlled clinical trials to ethnography.

Background

Many of the academic departments of general practice grew out of the old departments of public health and expanded initially as much on the basis of increased teaching responsibilities as on having a research function. The importance of undergraduate teaching in general practice and other community settings has been increasingly recognised by the GMC and the medical schools, and the large amount of teaching now conducted in the community is supported by part of the Service Increment for Teaching (SIFT) funding stream, originally paid to teaching hospitals. In some schools the proportion of clinical placements in primary care may be as high as 30 per cent.

Typically the university departments are practice linked, with a group of clinical academics working on a single university site but having clinical responsibilities in other parts of their community. The GP departments are multidisciplinary, with clinicians working alongside

non-clinical behavioural and life scientists, biostatisticians, epidemiologists, nurses, health visitors and other disciplines. Collaboration across the primary:secondary interface and with researchers in other parts of the health service is common.

Reasons to get involved

Some of our best graduates have been attracted to careers in general practice and a number of them into an academic career, which offers a stimulating combination of clinical work, research and teaching. There is rarely a dull moment in clinical general practice and the excitement of developing teaching, getting involved in research and primary care policy leadership, winning grants and seeing your papers in print are also part of the excitement of an academic career. Most clinical care takes place in general practice and the evidence base for a lot of what general practice does still needs to be built up, so there will be a continuing need for more and better research in primary care, as well as an increasing role for teaching in the community as the provision of in-hospital teaching opportunities gradually contracts.

Getting involved in teaching

Each medical school has built up a network of GP teachers and practices (many of which function as training as well as undergraduate teaching practices) who are responsible for teaching students in their surgeries across all years of the curriculum, in addition to running seminars and other learning events in the community and in general practice. A large medical school will have several hundred GPs attached in this way, which means that there are always opportunities to get involved in undergraduate education. Medical schools offer introductory 'Teaching the Teachers' courses, regular teacher support, peer review and the chance to get involved in departmental activities. Payments are generally designed to cover locum costs when GP teachers are taken out of clinical work. Most practices taking undergraduate students recognise the beneficial effects of having stimulating company with them and most patients are happy to see students in their GP's surgery.

Getting involved in research

There are now reasonably well-defined career structures for academic general practice, particularly suitable for those whose main interest is in research. Academic placements in general practice in foundation year 2 provide a 'taste' of the academic life and, with the proposed longer vocational training period, the integration of an academic component into some vocational training schemes, often coupled with an MSc, is becoming more common. The Walport career pathway proposals have allocated academic clinical fellowships and clinical lectureships and senior lectureships to universities, although these are still a fairly scarce resource. In England, the NIHR provides research training fellowships, ideal for GPs who have completed a research-based MSc, in which to work towards a PhD, with their salary fully covered by the NIHR scheme. In Scotland it is possible to apply for an integrated GP academic training post under SCREDS (Scottish Clinical Research Excellence Development Scheme) – see the section on *Medical training in Scotland* on page 25 for further information.

Experienced GPs in England interested in a research component to their career might think about the In-Practice Award scheme, also offered by the NIHR, which provides the opportunity to take up to 50 per cent of time out of practice for up to three years to work on a research proposal. In Scotland, the Scottish Chief Scientist Office offers Primary Care Research Career Awards for postdoctoral candidates from a primary care background, who are still practising clinically.

Remuneration

Most of the 'academic access' schemes have been arranged to ensure that academic GPs in training are paid at a level comparable to clinical academics in other disciplines, although in the early stages of an academic career, particularly around lecturer and senior lecturer level, the university salaries, not yet enhanced by clinical excellence awards (CEAs), may be less than the earnings of a 'standard' GP. Creating an 'A+B' arrangement, where part of the salary comes from the university and the other part, up to 50 per cent in terms of time, comes from the practice, goes some way towards ameliorating this. Successful clinical academics in general practice, as in other disciplines, are eligible for CEAs once they reach the senior lecturer/consultant grade, and these payments can provide a substantial uplift to salary in the middle and later periods of a clinical academic career.

Further information about careers in academic general practice can be found on the Society for Academic Primary Care (SAPC) website. The SAPC is the organisation for academic general practice in the UK and holds annual scientific meetings and regional conferences, and attendance at one of these would give excellent insight into the kind of research and teaching work being carried out in the university departments. Career options and local opportunities may be discussed informally with your local professor.

In England, the Department of Health and NIHR websites provide information on training opportunities, particularly the research fellowships and the in-practice fellowship awards. An MSc (part time or full time) in general practice and primary care is a further option. Some primary care organisations still have prolonged study leave funding to allow this to happen and some deaneries are now integrating an MSc into the third and fourth years of an extended 'post-Tookey' vocational training period. For information on Scotland, please refer to the section on *Medical training in Scotland* on page 25.



Information

Society for Academic Primary Care: www.sapc.ac.uk

National Institute of Health Research: www.nihr.ac.uk

Master's courses in primary care include:

King's College London: www.kcl.ac.uk/gppc/msc

Bart's and the London: www.smd.qmul.ac.uk/postgraduate/primarycare

University College London: www.ucl.ac.uk/openlearning/pged

Scotland: www.pcmssc.scot.nhs.uk

Royal College of General Practitioners: www.rcgp.org.uk/clinical_and_research/circ.aspx

Hastie A & Stephenson (2008) *Choosing general practice: your career guide*. London: Blackwell. ISBN 978-1-4051-7070-3

Scottish Chief Scientist Office – dedicated page on research in primary care in Scotland, including funding opportunities:

www.sehd.scot.nhs.uk/cso/

Recommendations for Medically and Dentally-Qualified Staff: Recommendations for training the researchers and educators of the future (2005) – also known as the Walport Report:

www.ukcrc.org/pdf/Medically_and_Dentally-qualified_Academic_Staff_Report.pdf

Working in the private sector and for pharmaceutical companies

The pharmaceutical industry and the private sector represent an important part of medical research in the UK. Collectively the pharmaceutical industry in the UK spends more than 20 per cent of gross output on Research and Development, carries out approximately a fifth of all industrial R&D in the UK, and is the largest investor in UK medical research (Cooksey, 2006).

More focus has been given to effective collaboration between the NHS and industry in recent years. The *Best Research for Best Health* strategy in 2006 set out plans to strengthen the research environment in England with stronger links to industry. A main priority of the Office for Strategic Co-ordination of Health Research (OSCHR) is to encourage a stronger partnership between Government, health industries and charities, following recommendations from Sir David Cooksey's report, *A review of UK health research funding*.

To achieve the desired partnership it is important that there are effective links between researchers and industry, for which the mobility of researchers between and within the sectors is considered crucial.

It is becoming increasingly common for doctors in industry to hold joint appointments with either the NHS or academia. Usually the industry part of the post is the larger commitment but this is not always the case. Such posts can be a good way to get an introduction to the field. They can also help to make sure the clinician maintains credibility with their constituent peer group in mainstream medicine.

Opportunities for medical academics to be involved with and work in the private sector are numerous and are not limited to the pharmaceutical industry. Resources on further career possibilities in areas such as biotechnology, devices, diagnostics, informatics and services can be found at:



Information

Association of British Healthcare Industries:

www.abhi.org.uk

UK Clinical Research Collaboration:

www.ukcrc.org

Health Technologies Knowledge Transfer Network:

<http://healthtech.globalwatchonline.com>

The Bioindustry Association:

www.bioindustry.org/

Perceptions of the pharmaceutical industry

Despite the Government's emphasis on collaboration with industry as the means of achieving the best outcomes in translational research, the number of doctors working in the sector remains fairly low, at approximately 1,000 pharmaceutical physicians. Furthermore, in UK universities the number of studentships and postdoctoral grants conducted in collaboration with the pharmaceutical industry has fallen in recent years.

Underlying reasons for the declining level of activity include escalating costs and the increasing difficulty in negotiating contracts, including the issue of intellectual property ownership. For clinical and medical industry roles, research shows further reasons for this:

- a lack of communication about the opportunities for academics within the industry
- commitment of academic researchers to university careers
- academics are concerned that by working in industry they would lose touch with academic networks
- some academics consider a move from academic-based research to industry to be a career failure.

Career options

Given the complexity of modern pharmaceuticals and the push for the UK to be a world leader in bioscience, there is a real demand for researchers with relevant experience such as a medical degree and BSc, MSc, PhD, MD or equivalent. The roles available to a medical academic are varied: these can include medical strategist, clinical pharmacologist, clinical research physician and medical adviser. Particularly in larger companies there are also opportunities in areas such as medical economics, vaccines, pathology and pharmacovigilance.

Professional requirements

Doctors working in the pharmaceutical industry must be registered with the GMC or its equivalent and should have at least two years' general professional training following registration. Postgraduate qualifications (eg royal college membership or PhD or MD) will also be useful. Pharmaceutical medicine became a listed specialty in the UK in 2002 and progression to senior roles usually requires further study such as an MSc in Pharmaceutical Medicine and/or the Diploma in Pharmaceutical Medicine awarded by the Faculty of Pharmaceutical Medicine.

Further information can be found at the Faculty of Pharmaceutical Medicine website: www.fpm.org.uk/hmtpmst/hmt_pmst_faqs

How to find a job in the industry

- Keep an eye on the weekly BMJ Careers section
- Contact companies directly to find out about opportunities and possible vacancies
- Recruitment agencies deal with many appointments
- The British Association of Pharmaceutical Physicians also posts vacancies: www.brapp.org.uk/holding_jobs.html

Public or private?

Salary and benefits

Remuneration in the private sector can be attractive, especially to young researchers. However, it is not so clear for clinicians, as consultants' NHS contracts will be competitive.

In smaller biotechnology companies, there might be incentives such as company shares, as well as the opportunity to influence the company's direction.

Working conditions in industry may be considerably better, for example, in terms of office space, activities and research.

Job security

Particularly in larger pharmaceutical companies, the industry can offer good job security, especially for researchers early in their career, with more stability than academic short-term contracts.

However, it is not possible for private businesses to guarantee that roles will be available every year, especially in times of economic recession.

Leave and flexible working

In industry the need for a work-life balance is acknowledged and there may be more support for those taking maternity leave.

It can be the case that in academia, researchers will be expected to put in longer hours, work at weekends and travel abroad to conferences. On the other hand academic work can offer the researcher more flexible working hours and the option to work at home.

Professional development and progression

Academia offers a clear career progression and this may not be the case in the private sector: decision-making can be slow and employees can be affected by company changes and reorganisations.

Many companies will encourage employees to pursue higher medical training, as well as day-to-day professional development. See *Professional requirements* above.

Travel and opportunities to move into broader fields, such as public affairs, health policy, health economics and regulatory affairs are potentially available for doctors in industry. Many of the skills developed in the private sector, such as management and leadership, are transferable and can be well-received in the public sector.

Industry can also provide an excellent grounding for those looking to branch out on their own. This is especially the case for those looking at careers in biotechnology where small start-up companies may require a broader skill-set than that provided by traditional academic research work.

In industry there are clear targets to achieve and as such there are defined objectives and performance management to ensure that they are achieved.

Revalidation requirements in the UK also make it harder to move from a job in industry back to a clinical role

Publishing work

There is less pressure to maintain a publication record in industry as it is not a priority and researchers are not having to constantly apply for funding.

While some researchers welcome this and are glad to be free of the 'publish or die' mentality in academia, others are concerned: fewer publications may make it harder to return to academia and it may affect a researcher's profile in the sector.



Information

The role of the pharmaceutical physician:

www.bma.org.uk/ap.nsf/content/PharmaceuticalPhysician

Sustaining the skills pipeline in the pharmaceutical and biopharmaceutical industries – ABPI, 2005:

www.abpi.org.uk/publications/pdfs/2005-STEM-Ed-Skills-TF-Report.pdf

An insight into careers for doctors with the British pharmaceutical industry – ABPI, 2002:

www.abpi.org.uk/publications/pdfs/careers_for_doctors.pdf

Academy of Medical Sciences (2007) Research careers in the biomedical sciences: promoting mobility between academia and industry:

www.acmedsci.ac.uk/download.php?file=/images/page/Careersi.pdf

Cooksey Review: A review of UK health research funding:

www.hm-treasury.gov.uk/cooksey_review_index.htm

OSCHR Chairman's first progress report (November 2008):

www.nihr.ac.uk/files/pdfs/OSCHR_Progress_Report_18.11.08.pdf

Best research for best health: a new national health research strategy (2006):

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127127

Association of the British Pharmaceutical Industry (ABPI):

www.abpi.org.uk

ABPI careers website:

www.abpi-careers.org.uk

Faculty of Pharmaceutical Medicine:

www.fpm.org.uk/

British Association of Pharmaceutical Physicians:

www.brapp.org.uk/

UK Clinical Research Collaboration:

www.ukcrc.org

New policy developments

Developments in recent years have recognised the significant opportunities to be had from a stronger and more focused investment in health research in the UK, with new organisations and initiatives set up to realise this. Meanwhile there are real concerns about recruitment and retention of medical academics and that, until this problem is addressed, there will be insufficient staff to educate and train doctors for the NHS.

Reports

Science and innovation investment framework 2004-2014

The proposals in the *Science and innovation investment framework 2004-2014* set out a long-term vision for UK science and innovation, together with the ambition for public and private investment in R&D to reach 2.5 per cent GDP by 2014. The document followed on from the earlier 2002 *Investing in innovation strategy and the excellence and opportunity* white paper.

Recommendations for medically and dentally-qualified staff: recommendations for training the researchers and educators of the future – also known as the Walport Report

Published in March 2005 by the UK Clinical Research Collaboration and Modernising Medical Careers, the report set out a clear and integrated academic training pathway for interested junior doctors and dentists. The plans sit well with the revised structure for postgraduate medical education (Modernising Medical Careers), allowing medical academic staff to combine research and education with a clinical career. The recommendations led to the establishment of integrated training schemes. In England, this resulted in the launch of the ACF and CL phase of the training pathway, as well as a scheme for clinical senior lectureships. In Scotland, this resulted in the SCREDS (Scottish Clinical Research Excellence Development Scheme), including the introduction of NHS funded clinical lectureship posts.

Best research for best health

The Department of Health's research and development strategy set out the direction for health research: to establish the NHS as a recognised centre of research excellence at an international level; attract, develop and retain the best research professionals; streamline existing systems for research management and governance and, commission research to improve health and social care.

Sir David Cooksey's report into UK health research

The report proposed structured coordination between the NHS, the MRC and the healthcare industry to ensure more research is translated into real benefits for patients. From the recommendations of the report came the Office for Strategic Coordination of Health Research (OSCHR), which oversees the research strategy and budget division for the Medical Research Council and the NIHR. The report also recommended that the NIHR (then a virtual organisation) should become an executive agency of the DH from April 2009.



Information

Science and innovation investment framework 2004-2014 (2004):

www.berr.gov.uk/dius/science/science-funding/framework/page9306.html

Walport Report (2005):

www.ukcrc.org/pdf/Medically_and_Dentally-qualified_Academic_Staff_Report.pdf

Best research for best health (2006):

www.dh.gov.uk/en/Researchanddevelopment/ResearchAndDevelopmentStrategy/DH_4127109

Cooksey Report (2006):

www.hm-treasury.gov.uk/media/56F/62/pbr06_cooksey_final_report_636.pdf

Structural change

UK Clinical Research Collaboration

The UK Clinical Research Collaboration (UKCRC) was set up in 2004 to reform the clinical research environment in the UK by bringing together key stakeholders in health research to improve the health and wealth of the nation. The stakeholders include the NHS, funding bodies, academics and industry. The UKCRC is making progress in areas such as infrastructure (see clinical research networks), developing the research workforce (see Walport Report) and improving the regulatory and governance environment.

National Institute for Health Research (NIHR) in England

The establishment of the NIHR has been an important development as it provides a framework for maintaining research, research staff and a research infrastructure in England, and focuses on meeting the needs of the research community, patients and the public. It also offers funding for high quality clinical research in the NHS.

Since it was set up in 2006, the NIHR has overseen the creation of 12 Biomedical Research Centres formed between leading NHS Trusts and universities. These partnerships have led to progress in innovation and translational research in biomedicine and contribute to the UK's international competitiveness. It is expected that these centres will take up early adoption of new technologies, techniques and treatments for improving health. The centres, in London, Oxford, Cambridge, Liverpool and Newcastle, are set to receive £450million between 2007-12. Comprehensive and Specialist Biomedical Research Centres are located at the following NHS and university partnerships:

*Comprehensive biomedical research centres***NHS organisation Academic partner**

Cambridge University Hospitals NHS Foundation Trust	University of Cambridge
Guy's & St Thomas' NHS Foundation Trust	King's College London
Hammersmith Hospitals NHS Trust & St Mary's Hospital NHS Trust	Imperial College London
Oxford Radcliffe Hospitals NHS Trust	University of Oxford
University College London Hospitals NHS Foundation Trust	University College London

*Specialist biomedical research centres***NHS organisation Academic partner Specialism**

Great Ormond Street Hospital for Children NHS Trust	Institute of Child Health, University College London	Paediatric/Child Health
Central Manchester & Manchester Children's University Hospitals NHS Trust	University of Manchester	Genetics and Developmental Medicine
Moorfields Eye Hospital NHS Foundation Trust	Institute of Ophthalmology, University College London	Ophthalmology
Newcastle upon Tyne Hospitals NHS Trust	Newcastle University	Ageing
Royal Liverpool & Broadgreen University Hospitals NHS Trust	University of Liverpool	Microbial Diseases
Royal Marsden NHS Foundation Trust	Institute of Cancer Research	Cancer
South London and Maudsley NHS Trust	Institute of Psychiatry, Kings College London	Mental Health

Twelve biomedical research units are also being established in areas of high disease burden and clinical need that are under-represented in the existing biomedical research centres:

NIHR biomedical research centres

NHS organisation	University partner	Priority area
Leeds Teaching Hospitals NHS Trust	University of Leeds	Musculoskeletal Disease
Nottingham University Hospitals NHS Trust	MRC Institute of Hearing Research & University of Nottingham	Deafness & Hearing Problems
Nottingham University Hospitals NHS Trust	University of Nottingham	Respiratory Disease
Nuffield Orthopaedic Centre NHS Trust	University of Oxford	Musculoskeletal Disease
Royal Brompton & Harefield NHS Trust	Imperial College London	Cardiovascular Disease
Royal Brompton & Harefield NHS Trust	Imperial College London	Respiratory Disease
Sheffield Teaching Hospital NHS Foundation Trust	University of Sheffield	Musculoskeletal Disease
Sheffield Teaching Hospital NHS Foundation Trust	University of Sheffield	Cardiovascular Disease
Southampton University Hospitals NHS Trust	University of Southampton	Nutrition, Diet & Lifestyle
Southampton University Hospitals NHS Trust	University of Southampton	Respiratory Disease
United Bristol Healthcare NHS Trust	University of Bristol	Cardiovascular Disease
University Hospital Birmingham NHS Foundation Trust	University of Birmingham	Gastrointestinal (including Liver) Disease

Office for the Strategic Coordination of Health Research (OSCHR)

While the NIHR leads on applied research in the NHS and the MRC on biomedical research, they together comprise the single research fund provided by the OSCHR. Through OSCHR there is a new focus on the transparency of research funding and on funding translational research underpinning the UK research infrastructure.

OSCHR's role was to facilitate agreement between the Department of Health in England and the Department of Innovation, Universities and Skills and the MRC on the allocation of over £1.7 billion of the single, ring-fenced health research fund and the overall strategy for UK health research, as set out in the Cooksey report in 2006 – see above.



Information

UK Clinical Research Collaboration:

www.ukcrc.org/

National Institute for Health Research (NIHR) in England:

www.nihr.ac.uk/Pages/default.aspx

BMA note on NIHR:

www.bma.org.uk/ap.nsf/Content/maschnihr0908?OpenDocument&Highlight=2,NIHR

Office for the Strategic Coordination of Health Research (OSCHR):

www.nihr.ac.uk/about_oschr.aspx

Clinical research networks

In England clinical research networks have been established across the country to facilitate patient and health professional involvement in clinical trials and other high-quality research. Initially, topic-specific networks were set up to provide dedicated staff and support to clinical teams to encourage participation in clinical studies in cancer, diabetes, dementias and neurodegenerative diseases, medicines for children, mental health and stroke. There is also a primary care network to focus on disease prevention, health promotion, screening, early diagnosis and the clinical management of long-term conditions.

Further, a NIHR Comprehensive Local NHS Research Network for England was set up in 2007 to provide the infrastructure to support research in areas not covered by the topic-specific networks.

In the devolved nations, the UK Clinical Research Collaboration has set up networks to cover key areas.

- In Scotland, the Scottish Executive Chief Scientist Office (CSO) is leading the establishment of clinical research networks to complement the existing Primary Care and Cancer Networks.
- The Clinical Research Collaboration in Wales brings together thematic networks, research infrastructure and technical support groups, trial units and the coordinating centre.
- The Northern Ireland Clinical Research Network aims to provide a local research network to support the Health and Personal Social Services R&D community engage with larger UK research networks and help generate high quality local clinical research.



Information

England: www.ukcrn.org.uk/index.html

Scotland: www.sehd.scot.nhs.uk/cso/

Wales: www.wales.nhs.uk/sites3/home.cfm?orgId=580

Northern Ireland: www.nicrn.hscni.net/

Academic Health Science Centres (AHSCs) in England

An AHSC is a healthcare organisation that brings together the governance and management of service delivery, teaching and research to promote new discoveries and their application in the NHS and across the world. International examples include Johns Hopkins in Baltimore, Harvard/Massachusetts General in Boston and Karolinska in Stockholm.

The Next Stage Review final report *High quality care for all*, published in June 2008, made a formal commitment to foster a number of the centres in England. In March 2009 five designated AHSCs were announced, following peer review by an international panel of clinicians and researchers. The centres designated, that partner world-class universities and leading NHS organisations, are:

- Cambridge University Health Partners
- Imperial College
- King's Health Partners
- Manchester AHSC
- UCL Partners.

It is hoped that this new status will enable the centres to speed up the process of taking research breakthroughs into NHS patient care – the aim is to improve treatments and promote the NHS across the world. Universities and NHS organisations will work together to deliver world-class research, education and patient care for the benefit of local communities and the NHS. Designation is for five years and the successful centres will be subject to review and there will also be a re-application process.

Health Innovation and Education Clusters (HIECs)

Announced as part of Lord Darzi's review in 2008, HIECs will be partnerships between NHS, higher education, industry and other public and private sector organisations in England. With initial investment from the Department of Health of £10 million, it is hoped that HIECs will support the spread and adoption of innovation locally and strengthen professional education and training. The first wave of HIECs is due to be announced in December 2009.



Information

Academic Health Science Centre:
www.ournhs.nhs.uk/?page_id=296

Application and guide to HIECs:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098887

NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRCs)

Nine NIHR CLAHRCs were established in October 2008 and are collaborative partnerships between a university and the surrounding NHS organisations. They aim to undertake applied health research that focuses on the needs of patients and to support the translation of research evidence into practice in the NHS. This focus on the 'second gap in translation' was identified by Sir David Cooksey's review of UK health research.

The nine CLAHRCs are:

Name of CLAHRC	Lead NHS organisation	Academic partner(s)
NIHR CLAHRC for Birmingham & Black Country	University Hospital Birmingham NHS Foundation Trust	University of Birmingham
NIHR CLAHRC for Cambridgeshire & Peterborough	Cambridgeshire & Peterborough Mental Health Partnership NHS Trust	University of Cambridge
NIHR CLAHRC for Greater Manchester	Salford Teaching Primary Care Trust	University of Manchester
NIHR CLAHRC for Leeds, York & Bradford	Leeds Teaching Hospitals NHS Trust	University of Leeds University of York
NIHR CLAHRC for Leicestershire, Northamptonshire & Rutland	University Hospitals of Leicester NHS Trust	University of Leicester
NIHR CLAHRC for North West London	Chelsea & Westminster NHS Foundation Trust	Imperial College London
NIHR CLAHRC for Nottinghamshire, Derbyshire & Lincolnshire	Nottinghamshire Healthcare NHS Trust	University of Nottingham
NIHR CLAHRC for South West Peninsula	NHS South West	University of Exeter University of Plymouth Peninsula Medical School
NIHR CLAHRC for South Yorkshire NHS Foundation Trust	Sheffield Teaching Hospitals	University of Sheffield Sheffield Hallam University

**Information**

www.nihr.ac.uk/infrastructure/Pages/infrastructure_clahrcs.aspx

Incentivising medical academic careers

The Government commissioned two major initiatives to increase recruitment and retention in academic medicine.

- 'Modernising Medical Careers/UK Clinical Research Collaboration (UKCRC) Academic Medicine Subcommittee', which produced proposals for improved career pathways for medical researchers and educators (also known as the Walport Report see page 49).
- Joint DfES/DH-sponsored 'Strategic Learning and Research Advisory Group (StLaR) Human Resources Project Plan for the future learning and research workforce in health and social care'.

Both initiatives saw stakeholders in academic medicine working together to achieve effective solutions, and the BMA fully supported the work. The challenge now is to ensure that the agreed diagnosis is properly acted upon. Moreover, many issues critical to recruitment and retention remain unaddressed.

The introduction of the MTAS medical recruitment system as part of Modernising Medical Careers led to unprecedented disruption to the recruitment of thousands of doctors and widespread protests, ultimately leading to a highly critical House of Commons Select Committee report. Many of the reforms to academic training described above were introduced at the same time and have been badly impacted on by the continuing disruption leading to lower than expected recruitment to academic training places.

The BMA has been strongly supportive of the MMC Programme Board for England and its counterparts in the devolved administrations, playing a full role as members of these bodies contributing to the formulation of policy recommendations for ministers. Nevertheless, there are still concerns about the need for continued vigilance over clinical academic careers and more needs to be done to maintain the alignment and appeal of clinical academic training pathways with purely clinical ones.

Arrangements for quality assessment of research and funding in higher education

In March 2006 the Government announced plans to reform higher education research assessment and funding. The existing Research Assessment Exercise (RAE) is to be replaced in 2009 with a Research Excellence Framework (REF), an assessment system based on metrics (numerical indicators).

Research Assessment Exercises (RAEs)

The Research Assessment Exercise (RAE) was the process set by the Government to assess the research quality and output of a university in comparison with international competitors, and to award the university its funding on the basis of this assessment. The universities are thus in competition and the losers are financially threatened. The RAE covers all fields of scholarship, not just medicine, and clinical medicine which generates outcomes in a long time frame has been disadvantaged. Quality was judged by peer review of a number of research outputs including a limited number of publications in high impact journals and measures of esteem, such as the number of masters and doctoral students, editorships, and invitations to be a keynote speaker at international meetings.

Since 1986 RAEs have been held in the UK to provide a comprehensive process for assessing the quality of research in Higher Education. Subsequent RAEs were held in 1989, 1992, 1996 and 2001. The last UK RAE was published at the end of 2008.

The RAEs were conducted jointly by the Higher Education Funding Council for England (HEFCE), the Scottish Funding Council (SFC), the Higher Education Funding Council for Wales (HEFCW) and the Department for Employment and Learning, Northern Ireland (DEL).

The primary purpose of the RAE 2008 was to produce quality profiles for each submission of research activity made by institution. The four higher education funding bodies intend to use the quality profiles to determine their grant for research to the institution, which they fund

with effect from 2009-10. Any higher education institution (HEI) in the UK that is eligible to receive research funding from one of these bodies is eligible to participate in the exercise.



Information

Research Assessment Exercise:

www.rae.ac.uk/

Research Excellence Framework (REF)

Preparation and consultation for the REF is currently being coordinated by the Higher Education Funding Council for England. Within the REF's overarching framework, there will not be a clear distinction between the arrangements for science-based subjects and those for all other subjects. For all subjects the assessment will include some combination of metrics-based indicators, including bibliometrics where appropriate, as well as input from expert panels.

It will make greater use of quantitative indicators in the assessment of research quality than the present RAE system, while taking account of key differences between the different disciplines. Assessment will combine quantitative indicators – including bibliometric indicators wherever these are appropriate – and light-touch expert review. Consideration is also being given to assessing impact and user-value. Measures of impact on health practice could include: impact on health service guidelines and international treatment guidelines; evidence of improvements in patient outcomes; reducing costs in the acute care sector and community; and service user involvement. Which of the elements are employed, and the balance between them, will vary as appropriate to each subject.

Pilot studies for the REF have indicated that medical academics are going to be as difficult to fit into this system as they have been with respect to the RAE because of their diverse nature, practices and publishing patterns. This is in part due to the propensity of medical academics to move between different employers, making it more difficult at any one time to define which medical academics are eligible for REF evaluation.

The REF will be developed as a single unified framework throughout 2008 and 2009. Aspects of the framework will be phased in from 2011-12, and it will fully drive research funding for all disciplines from 2014.

Bibliometrics pilots exercise

As part of developing the REF, HEFCE has run a pilot exercise in the construction of bibliometric indicators of research quality. The pilot exercise will develop and test the process and run from summer 2008 to spring 2009, when the findings will be used to establish proposals for consultation.



Information

RAE: www.rae.ac.uk/

REF: www.hefce.ac.uk/research/ref/pilot/

Who's taking part?: www.hefce.ac.uk/research/ref/pilot/inst/

Contracts, terms and conditions

Introduction

It should be noted that there are differences between the contracts for NHS consultants between the four nations of the United Kingdom and further differences in their application to clinical academics. There are also some differences in the way the UK junior doctor contract has been applied to clinical academics in training. Every effort has been made to highlight these differences in the text of this section, but members moving between nations of the UK are advised to check any points of concern with their new employer and to seek advice from colleagues and, if necessary, from *askBMA*.

Medical academics – Outline of contracts

Medical academics will ordinarily hold a substantive contract of employment with a university, a medical school, a Research Council or other institution engaged in medical research. Even where academics are funded by grants from research organisations (such as the MRC or the Wellcome Trust), the employment contract tends to be issued by the university or medical school.

Employment terms in higher education can vary from those offered in the NHS and between higher education institutions (HEIs). This is because HEIs are incorporated under independent statute which governs their operations. Older universities have freedoms granted under Royal Charter and others operate under Acts of Parliament such as the Higher and Further Education Amendment Act 2002. The extent to which terms and conditions vary depends on the grade of doctor, whether they undertake clinical work and the institution of employment.

Clinical academics are those medical academics that also undertake clinical sessions, or who are engaged in academic work for a limited period of time (for example trainees undertaking a period of research that intend to return to the NHS). Such academics should have an integrated contract comprising the substantive contract with the university or HEI employer and an honorary contract of employment from an NHS Trust/health board. The academic employer is

responsible for paying the total salary, including any supplements payable, for example, from undertaking out-of-hours work in the NHS, and CEAs.

NHS doctors planning to move into the academic sector should note that an honorary contract with an NHS Trust/health board should be offered jointly with the contract with the substantive university employer. Retaining an honorary contract while working in a university provides for some important employment protections, especially if the doctor returns to the NHS.

The BMA recommends that all those working in the higher education sector, especially junior doctors undertaking a period of research out of programme, hold honorary contracts with the NHS where possible.

Contact *askBMA* for more information.



Information

BMA (2008) *University employment good practice guide*. London: BMA.

www.bma.org.uk/employmentandcontracts/employmentcontracts/UniversityEmploymentGuide2008.jsp?page=1

Institution policy

Medical academics who do not undertake clinical work

Medically qualified academics who do **not** undertake clinical work will be subject entirely to the terms and conditions of the HEIs. This includes junior doctors who have secured grant funding for research (including from the MRC or the Wellcome Trust) but who hold a contract of employment with an academic institution. Such academics should carefully review the policies in place at the individual institution before accepting a post or funding to complete a research grant.

All institutions should provide information about their human resource policies to prospective employees. Academics are encouraged to

review this information carefully and contact *askBMA* to have their contract checked before signing. In addition, the MASC has produced detailed information about the human resource policies at many HEIs that employ medical academics in the *University employment good practice guide*. Review the *University employment good practice guide* and contact *askBMA* before signing your contract.

Always contact *askBMA* for employment advice before signing your contract and to check how terms and conditions might vary from an equivalent level post in the NHS.

Consultant clinical academic contracts – General

Clinical academics with consultant contracts will usually hold a form of the joint integrated academic consultant contract, which was introduced in England in 2003. This contract was negotiated to integrate NHS and academic practice and should be treated as an integrated document which follows the principles outlined in the Follett Review (see page 67). Contract holders are generally employed jointly between the NHS and an HEI with both institutions contributing towards employment. Pay for the clinical academic is determined by the number of sessions undertaken and comprises academic and clinical components. These posts are jointly appointed between the NHS and HEIs and are subject to joint annual job planning and appraisal.

Under these contracts the funding of the post may come from the NHS or the HEI or jointly but payment is generally made by the HEI. The component parts of this contract are:

- i. a contract of employment with the HEI, often called the substantive contract
- ii. a contract of employment with the NHS often called an honorary contract; and
- iii. a set of guidance notes
- iv. the principles of the clinical academic contract.

It should be emphasised that the clinical academic consultant contract was developed and is still seen by the BMA, UCEA and NHS Employers for England as an integrated contract, not two separate contracts. This position was reinforced by the agreement of memoranda of understanding in England, Scotland and Wales regarding the employment of joint staff of universities and the NHS (see page 69).

National versions of the clinical academic contract exist in Scotland, Wales and Northern Ireland. These contracts reflect to a greater or lesser extent the arrangements agreed for England. Details of the various national contracts are set out below.

Clinical academics on other contracts (such as those pre-dating the new consultant contracts of 2003 and 2004) may have two separate contracts of employment or an honorary contract with the NHS and a substantive contract with the HEI.

Schedule 23 of the 2003 Consultant Contract in England and section 13 of the 2004 Consultant Contract in Scotland outline those parts of the NHS consultant contract(s) that do and do not apply to clinical academics.



Information

Schedule 23 of the 2003 consultant contract in England:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123989

Section 13 of the 2004 consultant contract in Scotland:

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/TC5acadconscontract2004.jsp

Follett Review Principles

All medically qualified academic staff working for both the NHS and a higher education institution should be employed subject to the principles recommended by Professor Sir Brian Follett in September 2001 in his *Review of appraisal, disciplinary and reporting arrangements for senior NHS and university staff with academic and clinical duties*.

The recommendations are broadly accepted by both sectors and are known as the Follett Review Principles. The key principle is for NHS and university organisations involved in medical education and research to work together jointly to integrate the separate responsibilities. In practice this should mean:

- there should be joint strategic planning bodies, with joint subsidiary bodies that are responsible for staff management
- for staff with both clinical and academic duties there should be procedures that are articulated clearly, and which cover all aspects of their work
- staff should be made fully aware to whom they are accountable for all aspects of their work
- honorary and substantive contracts of employment should be cross referenced, consistent and issued in a single package
- joint appraisal and performance review for clinical duties should be based upon the system that is used for NHS consultants
- honorary and substantive contracts should be interdependent, with an obligation on both parties to inform the other about any issues relating to appraisal, job planning, discipline and dismissal.

Good practice for the employment of clinical academic staff recognises that both the honorary component and the substantive component are distinct contracts of employment, but that they may be perceived in holistic fashion, whereby performance of clinical duties under an honorary NHS contract may be necessary for performance of duties under a substantive academic contract.

Joint working of handling concerns about doctors with both an honorary and a substantive contract is expected in four areas:

- appraisals must be undertaken jointly
- permission of the doctor must be obtained for the exchange of sensitive personal data, such as medical records, between the honorary and substantive employers
- honorary contracts should contain an 'interdependency clause' stating that the honorary contract is based on a substantive contract of employment with a university being held and if the university post is terminated for any reason, the NHS organisation reserves the right to review the continuation of the honorary contract
- the university and the NHS organisation develop co-partnership relations with each other and ensure jointly agreed procedures are in place for dealing concerns about doctors with honorary contracts.



Information

A review of appraisal, disciplinary and reporting arrangements for senior NHS and university staff with academic and clinical duties:

www.academicmedicine.ac.uk/uploads/follett.pdf (also referred to as the Follett Report)

Maintaining high professional standards in the modern NHS, 2003 (not applicable in Scotland):

www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4065697

Agreed guidance associated with clinical academic consultants under the Scottish consultant contract Section 13:

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/guidancescotclinicalacademics.jsp

Scottish Executive Health Department letter (28 October 2002). Clinical academic staff (consultants) appraisal scheme (Scotland only):

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/AappraisalScotClinicalAcademics.jsp

Memorandum of understanding on joint academic and clinical staff

The memorandum of understanding was developed in response to the University of Glasgow – v – HM Revenue and Customs VAT tribunal ruling (EDN/03/109) released on 29 April 2005. In this case the VAT Tribunal found that there had been a supply of staff from the university to the NHS, where university-employed clinical academic staff provided patient care in NHS organisations. Such supplies it stated were liable to VAT at the standard rate. However, the Tribunal did not fully consider the question of the precise contractual arrangements and whether ‘joint working’ arrangements existed.

In March 2007, the MASC together with other unions agreed a memorandum of understanding for joint staff of universities and the NHS with the University and Colleges Employers Association (UCEA), the DH and NHS Employers. The memorandum covers staff engaged in both teaching/research and patient care in England and Wales.

The memorandum of understanding outlined the employment and joint working arrangements that usually apply in the case of staff engaged in both teaching and/or research as well as the delivery of patient care. Its purpose, therefore, was to:

- set out the NHS and university understanding of the role of joint staff of NHS organisations and universities who are engaged in both teaching and/or research as well as the delivery of patient care
- clarify selected duties and responsibilities of their employers
- document established practice in respect of those staff
- confirm that such arrangements are outside the scope of VAT.

A similar memorandum of understanding was developed by the Scottish government with stakeholders, including the Scottish MASC, and published as CEL 22 (2008) on 7 May 2008.

The memorandum provides that a joint integrated job plan will encompass both NHS and university commitments covering relevant

aspects of teaching, research and patient care, amongst other things. Such arrangements are covered by honorary and substantive contracts of employment, which constitute two or more contracts of employment.

Both employers should discharge their duties and responsibilities as an employer. Both should follow their own procedures, but also work jointly with the other employer and employee to ensure that the integrated contract approach is fair and appropriate in terms of the employee experience.

Employees should be made aware of their duties and responsibilities to both of their employers.



Information

The memorandum of understanding on joint working for England and Wales:
www.bma.org.uk/ap.nsf/Content/Memorandum150307

UCEA Update 07:20 VAT: Memorandum of understanding: joint staff of universities and NHS organisations

Memorandum of understanding: joint staff of universities and NHS organisations (Scottish government) CEL 22 (2008): www.sehd.scot.nhs.uk/mels/CEL2008_22.pdf

Consultant clinical academic contract England

In 2003, MASC negotiated with the relevant stakeholders – the UCEA, the DH and other unions – for the 2003 consultant contract to apply to consultant clinical academics working in England. This resulted in a joint integrated contract, which is issued as a substantive university contract and an honorary NHS contract. The university ordinarily acts as the paymaster for the consultant clinical academics, regardless of how the post is funded.

In accordance with Follett Review Principles the components of the academic contract for consultant clinical academics are interdependent. There are rights and obligations for the NHS employer as well as the university employer built into the contractual arrangements, including in instances where the NHS employer wishes to terminate the honorary contract. In particular, integrated job planning and joint appraisal should be undertaken jointly by both employers in accordance with Follett Review Principles.

A snapshot of the contents of the clinical academic contract can be found in *Principles for applying the consultant contract to clinical academics*. The core principles found in this document are as follows.

- There is a commitment to the principle of parity in arrangements, including pay, between clinical academics and substantive NHS consultants.
- Any new arrangements for clinical academics will be based on the terms and conditions produced for substantive NHS consultants.
- Follett Review Principles will be incorporated into arrangements for consultant clinical academics.
- If a national agreement is accepted for substantive NHS consultants in England, the aim will be to reach an agreement for clinical academics in England, incorporated into the terms and conditions of the national agreement (as a stand alone annex or schedule).
- Clinical academics will retain an honorary NHS contract and a separate substantive university contract of employment unless they were/are to be contracted under the 'A+B' arrangements (which consist of two distinct part-time contracts with separate employers).
- These arrangements will apply to full-time and part-time clinical academic appointments.
- A shorter model honorary NHS contract will be produced for individuals who are not at consultant level or who have limited access to patients.

In addition, see NHS terms and conditions relevant to academic consultants on page 75 and terms and conditions that may differ from the NHS on page 82 for the specific terms and conditions that relate to each employer.



Information

Principles for applying the consultant contract to clinical academics (England):

www.bma.org.uk/ap.nsf/Content/mascprinciples1003?OpenDocument&Highlight=2,Applying,Consultant,Contract,to,Clinical,Academics

Guidance notes for the employment of consultant clinical academics (England):

www.bma.org.uk/ap.nsf/Content/ProcedureforagreeingAcademicContract?OpenDocument&Highlight=2,Employment,Consultant,Clinical,Academics

Consultant clinical academic substantive contract suggested clauses (England):

[http://uk.sitestat.com/bma/bma/s?RH2MASCcontractDocs&ns_type=pdf&ns_url=www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFSubstantiveClauses/\\$FILE/SubstantiveClauses.pdf](http://uk.sitestat.com/bma/bma/s?RH2MASCcontractDocs&ns_type=pdf&ns_url=www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFSubstantiveClauses/$FILE/SubstantiveClauses.pdf)

Honorary consultant contract (England) December 2003:

www.bma.org.uk/ap.nsf/Content/MASCcontractDocs?OpenDocument&Highlight=2,Honorary,Consultant,Contract

Scotland

In Scotland, clinical academics' terms and conditions are covered by Section 13 of the 2004 Scottish consultant contract. The arrangements are similar to those in England, in that they recognise the Follett Review Principles, integrated appraisal and job planning.

The core documents are:

- a) Terms and conditions of service of the Scottish consultant contract 2004, section 13:

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/TCSacadconscontract2004.jsp

- b) Guidance associated with section 13 agreed with BMA Scotland:
www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/guidancescotclinicalacademics.jsp
- c) Clinical academic staff (consultants) appraisal scheme Scottish Executive Health Department letter 28 October 2002:
www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/AppraisalScotClinicalAcademics.jsp
- d) Clinical academic section of the *Consultant Handbook for Scotland*, May 2006:
www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/ScotConHandbookIntroduction.jsp?page=15
- e) Job planning for the new consultant contract in Scotland: guidance from BMA Scotland, December 2004:
www.bma.org.uk/ap.nsf/Content/jobplanconsscotdec04
- f) New consultant contract (Scotland) – managing the job plan review: guidance from BMA Scotland, January 2006:
www.bma.org.uk/ap.nsf/Content/jobplanconsscotjan06
- g) NHS Circular PCS(DD)1999/7, paragraph 7 of the annex regarding honorary contracts

Northern Ireland

In Northern Ireland medical academics with a clinical component to their job will be employed part time by the NHS and part-time by the university. These are known as A+B contracts (see page 84).

Clinical academics terms and conditions are covered by Schedule 23 of the consultant terms and conditions of service (Northern Ireland) 2004.

Clinical academics in Northern Ireland hold joint-appointment contracts with the university and a hospital Trust and are paid in line with the

new consultant pay scales (available at www.bma.org.uk/ni/employmentandcontracts/pay/doctorspaysupp.jsp). Salaries and pensions are handled by the university.

The relevant documents are:

- a) TCS (NI) 2004, schedule 23
- b) The Consultant Handbook for Northern Ireland:
www.bma.org.uk/ni/employmentandcontracts/employmentcontracts/NIconhandbk.jsp

Joint appointments

In Northern Ireland joint appointees hold a contract of employment with their relevant Trust, which outlines their commitments to both the Trust and the university (five PAs).

Wales

Clinical academic consultants may be employed under one of two possible types of contract.

- (i) *Honorary contracts* where the consultant is employed by a medical or dental school, by a university without a medical or dental school, or by the MRC (usually through the university) and has an honorary (unpaid) appointment with a Trust.
- (ii) *A+B contracts (see page 84)*. In Wales, like their NHS colleagues, clinical academics are all now employed under the 'new' 2003 amended consultant contract, which is a revised version of the 'old' contract and so differs from the 'new' consultant contract agreed in England. However, the new clinical academic contract for Wales was not signed off, though it has been agreed locally in Cardiff. Hence, the arrangements are effectively local ones but which follow the agreement of the new consultant contract for Wales.

NHS terms and conditions relevant to academic consultants

An NHS employing organisation has rights and obligations in respect of clinical academic consultants that hold an honorary contract with them.

England

Terms and conditions of the 2003 contract for NHS consultants that apply to consultant clinical academics are set out below.

- Continuous employment for the purpose of the calculation of seniority (NB Continuous employment **only** applies nationally to the **calculation** of seniority, though there may be other local arrangements regarding its applicability).
- Clinical and professional responsibility for patients, tasks incidental to job plans and deputising for colleagues.
- Job planning must be according to *Follett Review Principles* and take place in an integrated fashion. Both the NHS and university employer should be party to the job planning process, including the recommendation on pay progression. Both the honorary and the substantive employers are able to propose an amendment to the job plan, where the clinical academic's duties or responsibilities have changed during the year.
- Recognition of emergency work arising from on-call work as counting toward direct clinical care PAs.
- Additional PAs and spare professional capacity.
- Recognition of premium time.
- On-call rotas.
- Private practice and fee paying work (although academics are also subject to the substantive employer's rules about private practice).
- Fee paying services and additional fees (except where it relates to services for the substantive employer).
- Other conditions of employment such as financial interests, private residence, health assessment, research, publications, confidentiality, public interest disclosure, travelling time.

- Pay supplements (although London weighting is paid by the substantive employer).
- Pension arrangements. Continuing contributors can remain part of the NHS scheme although there is the option to contribute to the University Superannuation Scheme). See the *Pensions* section (page 122) for more information.
- Termination of employment (see page 102 onwards for the termination of employment and redundancy sections).
- Expenses for duties under the honorary contract including mileage allowance.
- Locum consultants.

See schedule 23 of the consultant terms and conditions for more information.

If employed prior to October 2003 in England, academic consultants may also be employed in an honorary capacity under the pre-2003 contract, if they elected not to transfer over the clinical academic contract.



Information

Guidance notes for the employment of consultant clinical academics (England)

Honorary consultant contract (England) December 2003

Terms and conditions – Consultants (England) 2003 especially Schedule 23 *Application of terms and conditions of service for NHS consultant clinical academics*

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123989

Scotland

For details of NHS consultant terms and conditions as they apply to consultant clinical academics, please refer to the following documents:

a) TCS of the Scottish consultant contract 2004, Section 13:

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/TCSacadconscontract2004.jsp

b) Guidance associated with section 13 agreed with BMA Scotland:

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/guidancescotclinicalacademics.jsp

c) Clinical Academic staff (consultants) appraisal scheme SEHD letter 28 October 2002

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/AppraisalScotClinicalAcademics.jsp

d) Clinical Academic Section of the Consultant Handbook for Scotland, May 2006

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/ScotConHandbookIntroduction.jsp?page=15

Contracts for senior academic GPs

England

In 2004, the MASC negotiated with the DH, the university employers and the relevant unions for the English arrangements for clinical academic consultants to apply to clinical academics, at senior lecturer level and above, specialising in general practice who undertook duties and responsibilities commensurate with consultant clinical academic staff in England. Amongst other things, the contract gave these GPs access to the clinical excellence awards scheme.

Academic doctors on the GP register who undertake clinical duties in the NHS at the level equivalent to a consultant should therefore be employed on the 'new' consultant/Senior Academic GP contract which has an emphasis on:

- programmed clinical and academic activities
- integrated job planning; and
- joint appraisal.

Apart from the NHS terms and conditions listed below, the employment arrangements for senior GP clinical academics will be determined by the policies at the individual institution. The principles

for applying the new consultant contract to clinical academics are listed on page 70 above.

The contractual arrangements are based on the consultant clinical academic substantive contract suggested clauses (England) and honorary consultant contract (England) December 2003 and other associated documentation. They were introduced in 2005.

Registered GPs that are practising clinicians normally based in an undergraduate medical school and are employed at senior clinical lecturer or above should be appointed under these arrangements. Other GPs employed by HEIs at a level below senior clinical lecturer, such as clinical teachers are employed on local contracts.



Information

[Principles for applying the consultant contract to clinical academics](#)

[Guidance notes for the employment of senior academic GPs in \(England\) 2005](#)

[Senior academic general practitioner substantive contract suggested clauses \(England\) 2005](#)

[Honorary contract for senior academic general practitioners \(England\) 2005](#)

Scotland

Similar arrangements were agreed for senior academic GPs in Scotland in June 2007. The implementation circular, PCS(DD)2007/2, includes the terms and conditions, additional guidance and a table detailing transitional pay arrangements.

For the purposes of the contract, a senior academic GP is defined as a clinical academic specialising in primary care who has a substantive contract of employment with an HEI or other organisation at senior lecturer level or above and is considered to be undertaking duties and responsibilities commensurate with clinical academic consultants. It is also expected that the individual will be a registered GP and practising clinician.

The new terms and conditions are based on Section 13 of the 2004 Scottish consultant contract. The effective date for the terms and conditions is 1 February 2007, with pay arrangements backdated to 1 April 2004.



Information

Implementation circular:

[www.sehd.scot.nhs.uk/pcs/PCS2007\(DD\)02.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2007(DD)02.pdf)

Northern Ireland

Senior academic GPs hold a contract of employment with the university and are also paid in line with the new consultant contract. However, they are still on the terms and conditions of the old consultant contract:

www.bma.org.uk/ni/employmentandcontracts/employmentcontracts/NIconhandbk.jsp?page=3

GPs are often employed on A+B contracts. See page 84 below.

Staff grade and associate specialist academics

A number of staff grade and associate specialist doctors and dentists are employed by HEIs. As there is no nationally agreed contract for such doctors they will almost invariably be on local terms and conditions of service. With the roll-out of the new specialist doctor contract, it is suggested that clinical academics on such local contracts check the new contract to see if it would be beneficial to them and, if so to try and seek to move this new contract. It is suggested that members speak to *askBMA* for advice. At present, however, the BMA is not aware of any such doctors being offered the new contract.

Academic trainees

The academic training pathway is covered in detail in the Careers in academic medicine section. It starts with the foundation academic programme, which gives trainees a taster of academic medicine. The terms and conditions of these posts will be no different to those of other foundation trainees.

The BMA would argue that the Follett Review Principles (noted above) should apply even from FY1 level. ACFs in England should, therefore, hold honorary university contracts, and the BMA advises that an honorary contract may also be useful for juniors on academic foundation programmes. These, however, are by no means automatically forthcoming.

Academic clinical fellows (ACFs) (England)

ACFs will normally be employed by the Trust in which their clinical training takes place. They are expected to hold a substantive contract of employment with the trust, which follows model guidance and the national terms and conditions for junior hospital doctors (agreed by the BMA Junior Doctors Committee).

After lobbying by the BMA, the NIHR, in *Best research for best health implementation plan 3.2c*, now recommends that all ACFs also hold honorary contracts with their host academic institution. The honorary contract should outline the rights and responsibilities of the trainee in their research capacity. Despite this a number of ACFs have contacted the BMA indicating that they have not been given honorary academic contracts. Trainees in this position should seek the advice of *askBMA*. Some suggestions regarding the content of an honorary contract can be found on page 107.

The BMA supports the policy of the employment of ACFs by the NHS. It is possible that ACFs who are offered a contract of employment with a university may be employed under terms and conditions that are not in line with that offered by the NHS junior doctors' contract. Members are, therefore, advised to contact *askBMA* for advice if offered a substantive contract of employment with a university.

Clinical lecturers (England) and clinical lecturers and other academic trainees (Scotland)

Clinical lecturers are expected to have a substantive contract of employment (which sets out salary and other basic entitlements) with the university and an honorary contract (which sets out your clinical working arrangements) with the relevant NHS organisation.

In England, the basic salary for NIHR clinical lecturer posts is provided via a ring-fenced research and development budget held by the DH. Salaries should be up-rated in line with each of the Government's decisions following publication of the DDRB's recommendations. The paymaster for employment purposes is likely to be the university. They are responsible for paying the total salary (including banding supplements). With the university being the substantive employer, some terms and conditions will be subject to the particular university policy as they operate under independent statute.

To ensure the maintenance of pay parity, pay banding for work above 40 hours per week and in out-of-hours time should apply. Nonetheless, some academic trainees have had difficulty with getting information about the pay banding they will be entitled to in their university contract. The funding for this comes from the NHS organisation but forms part of the total salary. Academics should seek to ensure that this information is included in the substantive contract from the university (see 'joint working' below). It is up to the university as the substantive employer to liaise with the NHS organisation on this.

Incremental date

Employees should be made aware of their incremental and continuous employment dates. For junior doctors working in the NHS the incremental date is the date of taking up the post in a new grade, except where previous service is counted or in other specific circumstances. The BMA believes that there should not be a financial penalty if there is a difference between the incremental date of the substantive and the honorary employer on moving to a university post.

Joint working

We expect that employment will be conducted according to the Follett Review Principles, which called for joint working between employers to integrate the separate responsibilities of clinical academics. This should mean that the contracts from both the university and the NHS are issued as a single package and that there is clarity as to what the responsibilities are for both the clinical and the academic parts of the job. The Follett Report also outlines some arrangements with regard to discipline.

For instance, the substantive contract could outline the work undertaken during academic time and the honorary contract should outline the work carried out during clinical time. The description for the post should contain sufficient detail, but if there is doubt about the exact nature of the work, you should ask to see a copy of the application for the post as sent to the UK Clinical Research Collaboration Clinical Academic Careers Panel.

Role of postgraduate deaneries

We fully expect postgraduate deaneries to be involved in ensuring the clinical element of training accords with national standards. The deanery office can be approached for advice and we would urge trainees to establish a good relationship with clinical and education supervisors early on.

Terms and conditions that may differ from the NHS

Some terms and conditions can differ in universities from the NHS. Look out for:

- pension schemes – you should be able to (if you choose) join the University Superannuation Scheme or retain contributions to the NHS pension scheme. See the section on pensions from page 122.
- annual leave – this is often set locally and can even be down to the department individuals are working in. At a minimum there should be the same entitlement as that offered in the NHS for an

equivalent junior doctor post in the NHS. See the *Junior doctors' handbook* for this but it is likely to be between five and six weeks.

- maternity leave – some universities have reciprocal recognition arrangements with local trusts with regard to continuity of service for maternity leave and pay entitlement but many do not. Members are advised to ascertain what the university policy is as there can be minimum periods of employment before entitlement to additional leave starts. More detailed information is available in the BMA's *University employment good practice guide*.

European Working Time Directive (EWTB)

The EWTB has applied to doctors in training since 1 August 2004 and a 48-hr average working week will be implemented from August 2009 for the vast majority of rotas, though some may be subject to local derogations. We believe that the number of hours junior clinical academics can work in a week and the rest breaks that are needed are therefore prescribed by the directive and are a legal requirement. The BMA believes that all time spent working either in the NHS or at the university (aggregated) should count towards the weekly hours limit and rest requirements. However, members should be aware that universities have been resistant to local application of the EWTB for academic work. See page 94 for more information. Further information on the EWTB can be found on the BMA website.

Intellectual property

Both employers will have rules about intellectual property, which are normally agreed between the university and the Trust. Whatever rules apply must be made explicit to the clinical academic trainee, in all cases.



Information

Junior doctor terms and conditions of employment

Junior doctors' handbook: www.bma.org.uk/ap.nsf/Content/jdhandbook

NIHR Implementation plan

www.academicmedicine.ac.uk/uploads/folletreview.pdf

www.bma.org.uk

A+B contracts

Some medical academics are employed on 'A+B contracts'. They are either employed:

- jointly on a full-time basis. Doctors are employed on a full-time basis either by the NHS with sessions subsumed to the university and work done in these sessions directed by the university; or employed on a full-time basis by the university and sessions subsumed to the NHS and work done in these sessions directed by the NHS; or
- on a part-time basis with both a medical and dental school or MRC and an NHS organisation (in which case the consultant will be treated as part time by both the university and the NHS employer).

Medical academics appointed before 2003 in England or 2004 in Scotland on A+B style contracts can decide whether they wish to be treated either as if they were employed jointly on a whole time basis, or as though they were employed on a part-time basis with each employing authority. Those holding honorary appointments in these circumstances are entitled to travel and other expenses incurred in respect of their NHS duties. They are also eligible for local and national clinical excellence awards (see section on *Clinical excellence awards* on page 116).



Information

Pre-2003 terms and conditions of service for hospital doctors paragraphs 78, 81, 86

Less than full-time working

There is no absolute right to work less than full time or job share. However, employers have an obligation to consider requests for flexible or part-time working, though they may with justification refuse such a request. The MASC has focused on this area and of the 33 institutions that participated in its 2008 survey on human resource policies in HEIs, only 16 reported a formal policy to support less than full-time working. However, in a follow-up survey in 2009 only three of the 30 HEIs that responded did not report having a formal policy on flexible working. Further information is available in the University employment best practice guide published by the BMA on its website. It is also suggested that academics (and prospective academics) contact the individual HEI to review the institution policy. The BMA Junior Doctors Committee has produced detailed guidance on flexible training available via the BMA website.



Information

Flexible training:

www.bma.org.uk/careers/training_trainers/flexible_training/index.jsp

Short-term or fixed-term contracts

Medical academics can sometimes be offered short-term or fixed-term contracts by higher education institutions. Because of the relative vulnerability of their position, the BMA advises that senior academics should resist taking up such appointments unless there are compelling reasons to do so. Nonetheless, doctors who are employed on short-term contracts (or more accurately, fixed-term contracts) have certain rights under the law. These are enshrined in the Fixed-Term Employees (Prevention of Less Favourable Treatment) Regulations, 2002.

A 'fixed-term employee' is defined as a person with a contract of employment, which is due to end when a specified date is reached, a specified event does or does not happen or a specified task has been completed. For example clinical lecturers and clinical research fellows will be on fixed-term contracts. The length of the contract will depend on factors such as funding, (ie a time limited research grant or fellowship) or training requirements. Normally these types of fixed-term contracts are never less than a year's duration. In some cases, a fixed-term contract may be offered to clinical academics to cover maternity leave or a clinical academic who is on secondment or sabbatical.

It is not uncommon for senior lecturers/principal Investigators to be offered contracts with three-year or even five-year probationary periods. However, this is a permanent contract not a fixed-term contract.

Under the Regulations, fixed-term employees cannot be treated less favourably than comparable permanent employees unless the different treatment can be objectively justified. Less favourable treatment can occur when a fixed-term employee does not get a benefit, whether it is contractual or not, that a comparable permanent employee gets. In practice, fixed-term medical academics should have the same rights and benefits as their comparable permanent colleagues, including resources, equipment, contractual benefits, training, remuneration, appraisal, access to information and job opportunities.

The Regulations provide that period of service qualifications or benefits relating to particular conditions of employment must not be different for fixed-term employees as for permanent employees except where justified on objective grounds. For example, employees may be entitled to increased holiday allowance depending on length of service. This should not be denied to a fixed-term employee if they achieve the same length of service as a permanent colleague. Fixed-term employees should also have access to occupational pension schemes.

Fixed-term employees who have been continuously employed for two years or more have a right to redundancy payments if they are made redundant at the end of their contracts. However, the expiry of a fixed-term contract may not always be a redundancy – this will depend on the circumstances of the case, such as whether the funding for a particular project was time-limited or the employee was covering for a colleague on maternity leave for example.

After a period of four years' continuous employment the employee has a right to a permanent contract unless objectively justified by the employer. In addition, the Regulations ensure that fixed-term employees must have the same opportunity as their permanent colleagues to secure permanent vacancies in their establishment.

If fixed-term employees believe that their rights under these Regulations have been infringed, they should contact *askBMA*. A BMA adviser will discuss their case and they may have sufficient grounds to make a claim to an Employment Tribunal. However, before any legal action is considered, employees are advised to raise the matter internally, at first informally and then, if the matter is not resolved, via an internal grievance. BMA members will receive support and representation throughout.

If you require any further advice or support, please contact *askBMA*.

Annual, sick and special leave

For academics (other than foundation trainees and ACFs employed by NHS Trusts) leave entitlements are determined by the university employer. The entitlement should, however, be no less favourable than that available to substantive NHS employees. NHS consultants are entitled to six weeks' annual leave. In England, two days' extra leave is awarded to consultants on the 2003 contract following seven years seniority, to recognise sustained commitment to the NHS.

There is no agreed definition in the NHS of how many days constitute a week. Some employers regard a week as seven days (to include weekends) giving 42 days of annual leave per year; others include Saturdays but not Sundays, providing a six-day week, giving 36 days; others define a week as five weekdays, giving 30 days. Some employers add on statutory holidays to form part of the overall leave entitlement. As long as an employer's policy on the definition is clear and consistently applied, then any one of these options may be applied locally. Any proposals to change the definition or the standard leave year should be agreed locally.

The timing of annual leave should be agreed in advance and should not be unreasonably denied by either employer. Ideally arrangements for the taking of annual leave should be agreed as part of the integrated job planning process. In Scotland consultant clinical academics are expected, in planning and taking annual leave, to take into account the impact of the timing of annual leave on his/her clinical service and academic commitments.

Public holidays

Consultant clinical academics are entitled to 10 statutory and public holidays each year. These consist of eight public or bank holidays plus two additional days' paid holiday as determined by the employer.

Study and professional leave

Study, sabbatical and other leave are determined by the substantive employer in consultation with the NHS where there may be an impact on clinical services.

Sick leave

The policies concerning sickness absence (including any qualifying period of service that may apply) are determined by the university employer who should be informed immediately according to local arrangements. If the illness lasts longer than three calendar days, a self-certificate must be submitted within the first seven days of absence. Further statements in the form of a medical certificate provided by another practitioner must be submitted for any absence extending beyond the first seven days.



Information

Institution policy

Guidance notes for employment of clinical academic consultants

BMA guidance on annual leave:

www.bma.org.uk/employmentandcontracts/leave/index.jsp

Parental leave and pay

Honorary contract holders are subject to the maternity and parental leave provisions laid down by individual universities. Previous continuous service within the NHS does not normally count towards continuous service for maternity and parental leave purposes in university contracts. However, there is reciprocity when moving from the university to the NHS as the main employer.

Since 20 April 1983 doctors in academic posts who have held honorary NHS contracts may, on their return to the NHS, count service under that honorary contract when assessing their eligibility for maternity/parental leave and pay. A+B contract holders are subject to NHS maternity leave entitlements.

Maternity leave

Maternity leave and pay arrangements vary across the higher education sector. The right to take 26 weeks' ordinary maternity leave followed by 26 weeks' additional maternity leave **does not** require any qualifying period of employment. However, the right to statutory maternity pay often requires a qualifying period, and entitlement to a higher education institution's enhanced maternity pay scheme may also require a qualifying period of employment with that institution.

The BMA advises members to check the individual policy at the institution prior to taking up a post. Universities should provide copies of their maternity benefit scheme prior to an employee accepting a post. In particular, doctors should check whether there is a minimum qualifying period for leave and pay before signing a contract of employment with a particular HEI. Some institutions have a reciprocal agreement with their NHS partners which recognises work in the NHS as continuous employment for the purposes of maternity leave. If that isn't the policy of your institution then it would be worth asking for it anyway. Should this approach prove to be unsuccessful contact askBMA for assistance on 0300 123 123 3 or via support@bma.org.uk

The BMA is aware that the following institutions have recognised service in the NHS as counting towards university employment for the purposes of their maternity schemes. Members are, however, advised to confirm this.

- Bristol
- Dundee
- Imperial College London
- Institute of Cancer Research
- Liverpool
- St Andrews
- Sheffield
- Swansea
- Warwick.

This list will be updated on the *University employment good practice guide* pages of the BMA website as further information is received.

Where there is no formal policy of reciprocity there are no legal means of forcing HEIs to take into account previous work undertaken in the NHS or in another HEI for the purposes of continuous employment.

Members who are concerned about access to enhanced maternity benefits after they have signed a contract should seek further advice from the BMA, as progress can be made by pressure being brought, especially where the head of department supports the case for recognition of previous employment in the NHS. Approach your head of department directly or contact askBMA by emailing support@bma.org.uk or telephone 0300 123 123 3 (Monday to Friday, 8.30am to 6pm) to see if the situation cannot be resolved informally.

There is, however, reciprocity with regard to maternity arrangements when moving from the university to the NHS as the main employer. The period of employment with the university will not constitute a break in service, and, although the time at the university cannot be counted towards service for the purposes of further maternity leave, doctors will still be able to access the benefits under the NHS maternity scheme.

Therefore, in summary, although the period of time holding an NHS honorary contract (ie period of employment with the university) will not actually count towards NHS service, it will not be considered a break in service if the doctor returns to the NHS.

Paternity leave

The General Whitley Council (GWC) introduced a set of principles on which to base locally negotiated schemes for parental, paternity and adoption leave (among others) further to the implementation of the Maternity and Paternal Leave Regulations 1999. However, this section of GWC conditions of service, along with the current GWC scheme for maternity leave and pay is likely to be subject to further change. Members are strongly advised to consult askBMA for advice about their entitlements at the earliest opportunity.



Information

Institution policy

BMA (2008) *University employment good practice guide*. London: BMA.:

www.bma.org.uk/employmentandcontracts/employmentcontracts/UniversityEmploymentGuide2008.jsp?page=1

Qualifying periods for other terms of employment

Some other terms of employment have minimum qualifying periods that are set out in statute where institutions do not recognise previous employment in the NHS. For example:

- the qualifying period for the right to claim unfair dismissal is one year
- the qualifying period for redundancy compensation is two years
- the right to claim parental leave has a one year qualifying period
- the right to request flexible working in relation to a child or adult dependant has a 26-week qualifying period
- the right to be paid up to 39 weeks' statutory maternity pay requires 26 weeks' service by the end of the 15th week before the expected week of childbirth (and average weekly earnings not less than the lower earnings limit)
- the right to paternity leave and pay also requires 26 weeks' service by the end of the 15th week before the expected week of childbirth (and the same provisions on earnings in order to qualify for paternity pay).

Local variations from the statutory arrangements that may enhance entitlement are possible.

No qualifying period of employment is required for protection against discrimination on the grounds of gender, pregnancy, race, ethnic origin, disability, age, sexual orientation, religion or belief, or trade union membership.

The right to equal pay for work of equal value does not require any qualifying period of employment.



Information

Institution policy

Employment Rights Act 1996 and other current statutory regulations as appropriate

Accommodation and removal expenses

There is no national policy for the provision of removal expenses for clinical academics by university employers. However, many individual universities do provide some reimbursement for removals expenses. In the NHS this is also locally agreed.

All 33 institutions that responded to the BMA's 2008 survey of human resource policies in Higher Education Institutions pay some removal expenses. Contact the individual institution for more information.

Before accepting an appointment, doctors who have to move to take up that appointment should contact the new employer as soon as possible to ascertain whether or not they are eligible for removal expenses. It is important that any negotiation of removal expenses takes place *before* the post is accepted.

For academic trainees, the BMA believes that arrangements for the provision of accommodation (where necessary), removals/associated travelling expenses and other expenses should be no less favourable for academic trainees than for NHS junior doctors. See the *Junior doctors' handbook* for this information.



Information

BMA guidance on removal expenses:

www.bma.org.uk/employmentandcontracts/pay/removal_expenses/index.jsp

Institution policy

BMA (2008) *University employment good practice guide*. London: BMA.:

www.bma.org.uk/employmentandcontracts/employmentcontracts/UniversityEmploymentGuide2008.jsp?page=1

Junior doctors' handbook: www.bma.org.uk/ap.nsf/Content/jdhandbook

European Working Time Directive (EWTG)

All clinical academics are covered by the EWTG for the clinical aspects of their work.

At the present time clinical academics are not included under the terms of the senior hospital doctors' agreement on working time. This is because they are employed by universities who hold responsibility for applying these regulations.

University employers have refused to implement the terms of the Directive as they take the view that clinical academics have control over the hours they work. Clinical academics are therefore not entitled to receive rest periods or to have restrictions placed upon their average hours worked per week. The BMA has challenged this view and has promoted the application of the senior hospital doctors' agreement. The BMA argues that clinical academics undertake similar duties to their NHS colleagues and have an obligation to provide continuity of care for patients throughout the entire working week, regardless of other teaching and research commitments.

Junior academic doctors with a substantive NHS contract should be covered by the working time directive where they undertake academic work on a day release basis. They have the same obligation to provide continuity of care for patients as their junior doctor colleagues.



Information

BMA web pages on the EWTD:

www.bma.org.uk/employmentandcontracts/working_arrangements/hours/index.jsp

Private practice

Definition of private practice

Private practice is defined for consultants and other hospital doctors in both sets of terms and conditions of service as ‘the diagnosis or treatment of patients by private arrangement’. A private patient is defined in the NHS Acts as a patient who gives (or for whom is given) an undertaking to pay charges for accommodation and services. The definition of private practice does not apply to any other activities, for example, writing textbooks, articles and giving lectures.

England

Schedule 9 of the terms and conditions – consultants (England) 2003 governing the relationship between NHS work, private practice and fee-paying services applies to consultant clinical academics, as does the Code of Conduct for Private Practice. They may however be supplemented by the substantive employer’s rules about undertaking private practice.

The key points from Schedule 9 are as follows.

- The consultant is responsible for ensuring that the provision of private professional or fee-paying services for other organisations does not:
 - result in detriment of NHS patients or services
 - diminish the public resources that are available for the NHS.
- The consultant will inform their clinical manager of any such regular commitments as part of the job plan review. The information to be noted in the job plan will include the planned location, timing and broad type of work involved.
- In the case of any conflict or potential conflicts of interest, NHS commitments must take precedence over private work. If emergency work for private patients regularly impacts on the

delivery of PAs, the consultant will make alternative arrangements to provide cover.

- If an employer proposes a change to the scheduling of NHS work it will allow a reasonable period of time to rearrange any private commitments.
- A consultant may not undertake private practice when on-call unless the rota frequency is one in four or more frequent, the on-call duties are regarded as category B (where the consultant can typically respond by phone or return to work later) and the employer has given prior approval.
- NHS staff and facilities may not be used for private work except with the employer's prior agreement.
- Any procedures taking place in the employer's facilities should not impact on normal services for NHS patients.
- Consultants should not initiate discussions with NHS patients about providing private services.

The further rules that could apply to clinical academic staff, especially at consultant/GP level, are complex because of the myriad possible combinations of arrangements that could apply, ie partial or total remittance of private income or fees to the university department, shared arrangements among a number of interested parties or income being retained by the individual.

There may be occasions where undertaking private practice or providing fee-paying services is a requirement or an expectation of your substantive employer. Any such commitment should be identified in your job plan. The provisions regarding spare professional capacity (see page 98) shall not apply in such cases.

Members with a query about this are advised either to speak to more senior colleagues in their department or obtain their institution's policy from the HR department. If you are unable to resolve the problem within your institution it is recommended that you contact askBMA for further advice.

The provisions for clinical academic staff who intend to undertake private practice are outlined in Annex C of the Substantive University Contract and the code of practice on private practice for NHS consultants.

Scotland

As in England, the rules around private practice apply equally to clinical academic consultants as to NHS consultants. While those rules are generally similar to those that apply in England, they are not always identical. In particular, section 6 of the Scottish NHS consultant terms and conditions of service is much less detailed than its English equivalent referred to above. For example, it does not have the same specific rules regarding private commitments when on call. The principal relevant document in Scotland is the Code of Conduct for Private Practice: Recommended Standards for NHS Consultants, which is included as Appendix 8 to the Scottish NHS consultant terms and conditions of service.

Where a clinical academic consultant wishes to undertake private practice, and this is permitted by the university's regulations, the impact on the university and NHS components of the consultant's working week should be a matter for local determination by the university, in consultation with the NHS employer. This will take into account the need to achieve a fair balance between the individual's NHS and university commitments.



Information

See references on page 99.

Spare professional capacity

England

Where a clinical academic, working up to 10 PAs also undertakes privately remunerated work outside the terms of his or her substantive contract, they may be asked by the honorary or the substantive employer to undertake up to one additional PA. If asked to do so, agreeing to undertake an additional PA will form part of the criteria for pay progression. Where an additional PA is undertaken it will be remunerated at the standard NHS rate applicable to the time of day.

The requirement to offer an additional PA because a clinical academic undertakes private practice does not apply where a clinical academic undertakes private practice, but the profits are retained by, or used for the benefit of, the substantive employer.

Scotland

There are provisions in the Scottish NHS consultant terms and conditions of service, which mean that consultants who undertake private practice may, in certain circumstances, put their eligibility for pay progression at risk if they do not first offer to undertake an extra PA for the NHS. This also applies to those full-time clinical academic consultants who are contracted for five clinical service weekly PAs or less within a total equivalent to less than 12 weekly PAs in the integrated job plan, except where:

- the individual does not personally profit from undertaking private practice (eg the profits are retained by the university); or
- the separately remunerated work is undertaken explicitly on behalf of the university.

For further details, see paragraphs 4.4.6 to 4.4.12 of the Scottish NHS consultant terms and conditions of service.



Information

Honorary consultant contract (England) December 2003

Consultant clinical academic substantive contract suggested clauses (England)

Code of practice for NHS consultants in England

Section 13 of Scottish consultant contract 2004:

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/TSacadconscontract2004.jsp

Appendix 8 of Scottish consultant contract:

[www.sehd.scot.nhs.uk/pcs/PCS2007\(DD\)11.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2007(DD)11.pdf)

Disciplinary issues

Follett Review Principles should be adhered to with respect to discipline.

Wherever possible disciplinary matters should be identified and resolved without recourse to formal procedures. If a disciplinary action is taken, either the substantive employer's disciplinary procedures or the honorary employer's disciplinary procedures may be used, depending on which is most appropriate to the circumstances. A revised model statute for universities on dismissal, discipline and grievance procedures for academic staff was approved by the Privy Council in 2003. In the NHS in England a framework for the initial handling of concerns about doctors and dentists in the NHS was agreed with the BMA in 2005.

Regardless of which employer contemplates disciplinary action, the clinical academic should be given the opportunity to respond to the matter as part of a preliminary investigation. If it is subsequently deemed necessary after appropriate investigation to proceed to a disciplinary hearing, the substantive employer should inform the honorary employer and keep the honorary employer informed at all stages. Similarly if the honorary employer proceeds to disciplinary hearing, the honorary employer should inform the substantive

employer and keep the substantive employer informed at all stages of the process thereafter.

The involvement of one employer in disciplinary procedures in respect of a clinical academic may not necessarily obviate the need for the other employer to initiate a disciplinary process of its own however a 'double jeopardy' situation must not occur and both employers must work with the employee and their representatives in this regard.

Joint working is the of handling concerns about doctors with both an honorary and a substantive contract is expected.

- Appraisals and job planning must be undertaken jointly.
- The university and the NHS organisation should develop co-partnership relations with each other and ensure jointly agreed procedures are in place for dealing with concerns about doctors jointly appointed and with integrated contracts.
- Honorary contracts should contain an 'interdependency clause' stating that the honorary contract is based on a substantive contract of employment with a university being held and if the university post is terminated for any reason, the NHS organisation reserves the right to review the continuation of the honorary contract.
- Permission of the doctor must be obtained for the exchange of sensitive personal data such as medical records between the honorary and substantive employers.



Information

England

A review of appraisal, disciplinary and reporting arrangements for senior NHS and university staff with academic and clinical duties:

www.academicmedicine.ac.uk/uploads/follett.pdf

The Memorandum of understanding on joint academic and clinical staff:

www.bma.org.uk/ap.nsf/Content/Memorandum150307

Maintaining high professional standards in the modern NHS, 2003:

www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4065697

Also see:

Guidance notes for the employment of consultant clinical academics.

Consultant clinical academic substantive contract suggested clauses (England).

Honorary consultant contract (England) December 2003.

Scotland

NHS Education for Scotland operational framework on management of trainee doctors in difficulty:

www.nes.scot.nhs.uk/documents/publications/classa/031108_Operational_Framework.pdf

Paragraph 13.8 of Section 13 (clinical academic consultants) of the Scottish consultant contract 2004:

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/TSacadconscontract2004.jsp

Paragraphs 20-22 of guidance associated with Section 13 of the Scottish consultant contract 2004:

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/guidancescotclinicalacademics.jsp

NHS circular 1990 (PCS)8(Scot), updated by PCS(DD)1997/7, PCS(DD)2001/9 and HDL(2001)60

Termination of honorary or substantive contract

Academics should be wary of attempts to vary or terminate either the honorary or the substantive contract as, due to the interdependent nature of the contracts, it may lead to redundancy (see page 104).

Contact askBMA for advice as soon as there is a suggested change to your employment arrangements either with the NHS **or** the university.

England

Interdependency provisions are built into the contractual arrangements for clinical academic consultants following a recommendation from the Follett Report and agreement between the DH and the UCEA outlined in *Maintaining high professional standards in the modern NHS (2003)*. In practice this means that where there is a move to terminate one contract, there will be implications for the other contract as a review of the other contract will be triggered.

Nevertheless, both employers must follow the proper procedures when seeking to terminate either a substantive or an honorary contract.

The jointly appointed clinical academic with an integrated contract will go through an integrated job planning process (see page 130 onwards) and it is through this process that changes to the contract should be discussed. There should be, at the earliest point, discussion involving both employers and the employee. Aside from an annual review of the job plan, a job plan review can be requested by either employee or employer at any stage when circumstances change.

A decision taken by an NHS employer is not a decision that can be taken in isolation but must be taken within the spirit of integrated working which is fundamental to the integrated nature of the new joint integrated academic consultant contract

Where termination of the honorary contract is under consideration, the NHS organisation must give the consultant academic three months' notice in writing, although shorter or longer notice may

apply where agreed. The provisions governing termination of employment for honorary contract holders are outlined in Schedule 19 of the consultant terms and conditions of service.

In respect of termination of the substantive contract of employment the statutory arrangements and the procedural arrangements at the individual institution will apply.

Where the NHS organisation undertakes a review of the honorary arrangements following suspension or termination of the substantive contract, this must occur in accordance with employment law.



Information

Maintaining high professional standards in the modern NHS (2003):

www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4065697

Scotland

In Scotland, specific guidance for clinical academics is contained within Section 13 of the 2004 consultant contract. As noted above, clinical academics are reminded that any change to one part of the contract will trigger a review of the other. While this does not necessarily mean that termination of the university contract will result in termination of the NHS contract or vice versa, members are advised to contact *askBMA* immediately upon any change or proposed change to either contract.



Information

What to do if things go wrong (page 167)

A review of appraisal, disciplinary and reporting arrangements for senior NHS and university staff with academic and clinical duties:

www.academicmedicine.ac.uk/uploads/follett.pdf (also referred to as the Follett Report)

Honorary consultant contract (England)

Terms and conditions – consultants (England) 2003, Schedules 23 and 19

Scottish consultant contract (2004) section 13 and Annex C:

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/TSacadconscontract2004.jsp

Redundancy

For medical academics employed by a university terms and conditions are determined by the type of contract they have. Universities are independent employers and will have their own policies dealing with the possibility of redundancy in relation to all staff. You will have the same statutory entitlements as any other worker but your contractual entitlement may differ from those with contracts with another employer or with the NHS.

The Privy Council approved a revised model statute for adoption by institutions in respect of dismissal, discipline, grievance and related matters that many institutions have incorporated into their procedures.

Medical academics are advised to contact their human resource department for information and for further advice and assistance contact askBMA on 0300 123 123 3 who will refer the case to BMA Regional Services if representation is required.

Definition of redundancy

Redundancy is a specific situation defined by Section 139 of the Employment Rights Act 1996 (ERA 96).

A redundancy situation is defined as one where:

- the employer has ceased, or intends to cease, to carry on the business for the purposes of which the employee was so employed; or
- the employer has ceased, or intends to cease, to carry on the business in the place where the employee was so employed; or
- the requirements of the business for employees to carry out work of a particular kind has ceased or diminished or are expected to cease or diminish; or
- the requirements of the business for the employees to carry out work of a particular kind, in the place where they were so employed, has ceased or diminished or are expected to cease or diminish.

A redundancy can still occur even if there is a demand for the work or service that is being provided. An employer can decide for business reasons that they wish to reduce or stop providing a particular service. While there may be a strong moral argument that this is not desirable, if the correct procedures are followed a service can be closed or reduced and dismissals by reason of redundancy take place.

The withdrawal of external funding would be one situation which, after following an appropriate process to terminate both employments and making appropriate payments due, is likely to be in law a 'fair' dismissal. It is important that advice is sought from the BMA at the earliest point, if withdrawal of funding is a possibility, in order that all possible support can be given. In particular the possibility of suitable alternative employment with either employer should be explored.

Rights of employees

Establishing a redundancy situation confers two important legal rights: to be consulted on the proposal and to receive redundancy payments if the individual qualifies for them. Where there are more than 20 proposed redundancies there is also a legal obligation on the employer to consult with the recognised representatives of the employees. The BMA is not always recognised by higher education employers for such purposes, but, nonetheless, can still assist members on an individual basis. Local BMA industrial relations officers and assistant secretaries will also seek to establish good working relations with the recognised trades unions.

Avoiding redundancies

This consultation, which must be genuine and seek to reach agreement, should include ways of avoiding and reducing the redundancy situation or dismissals and mitigating the effects of the dismissals.

Measures for minimising or avoiding compulsory redundancies may include for example:

- natural wastage
- restrictions on recruitment
- retraining and redeployment to other parts of the organisation
- reduction or elimination of overtime could include reduction in PAs and SPAs
- retirement of those employees already beyond normal retirement age
- seeking applicants for early retirement, or voluntary redundancy; and
- termination of the employment of temporary or contract staff.

Selection criteria

Under the ERA 96, dismissal for redundancy comes within one of the 'fair' reasons for dismissal. Where the selection was unfair, an individual can pursue an unfair dismissal claim. This may occur where the employee has been:

- selected contrary to the criteria set down in the agreed policy
- selected for trade union reasons
- selected because they have been, or stood as, an appropriate employee representative
- been the victim of discriminatory selection
- selected because they are pregnant or on maternity leave.

This list is not exhaustive.

There is further guidance on redundancy on the BMA website but redundancy is a complex area of law and each situation needs to be considered on its own merits. It is important to obtain advice from the BMA as early as possible in any situation which might result in a redundancy.



Information

What to do if things go wrong (page 167)

BMA guidance on redundancy:

www.bma.org.uk/employmentandcontracts/redundancy/index.jsp

Honorary academic contracts for NHS consultants and juniors

Doctors working primarily in the NHS who also undertake research and/or education at a higher education institution should have an honorary academic contract which outlines the rights and responsibilities of both the employee and the employer in respect of the academic work carried out.

Doctors needing this type of contract include:

- NHS consultants who provide undergraduate teaching for UK medical schools; and
- ACFs in England who undertake academic work for 25 per cent of their post.

Consultants

Together with the UCEA, the MASC has agreed a model honorary academic contract for NHS consultants delivering education and research in academic institutions. The provisions of the contract are broadly based on the honorary contract for clinical academic consultants and are intended for consultants undertaking at least one PA per week of teaching and research. While it is based on the contract in England, every effort has been made to ensure that it can also be used in the other nations of the UK.

The framework for an honorary academic contract for consultants working in the NHS was agreed in response to the need to ensure that honorary contractual terms and conditions of employment are robust within the HEI and fully support Follett Review Principles. It addresses the commitment enshrined in Follett to joint working between the NHS and higher education to integrate the separate responsibilities. It also addresses the particular need for both substantive and honorary contracts for senior NHS staff posts with academic duties to be explicit about separate lines of responsibility, reporting arrangements and staff management procedures.

In March 2009 an update was sent to UCEA's subscribers alerting them to the fact that the framework contract is now available on request. The intention being to ensure that those who use the contract are fully briefed about its use. In addition, UCEA would also be able to monitor which HEIs have a copy. It is important also to note that the contract is a framework model contract rather than a nationally negotiated agreement and the autonomy of HEI employers means that they do have the flexibility to adapt it for local circumstances when appropriate. UCEA have undertaken to ensure that the BMA's comments are passed on to the Scottish universities for their information when they request a copy of the contract.

Contact your HEI for a copy of the model contract and guidance on its use.

ACFs in England

While ACFs are expected to hold a substantive contract of employment with an NHS Trust and be employed under the national contractual arrangements for junior doctors working in the NHS they should also have an honorary contract with the university, not least to give them ready access to the university library and other facilities.

There is no agreed model honorary contract for ACFs, though the National Institute for Health Research in *Best research for best health implementation plan 3.2c* agrees with the BMA that ACFs should have one. The BMA suggests that an honorary contract for ACFs should cover:

- date of commencement of the post
- whether remuneration is attached or confirmation of the paymaster for the basic salary and any supplements
- name of the academic supervisor
- general expectations of the post
- any expectations with regard to academic work, eg contribution toward research projects, completion of research grants, taught modules, delivery of education during the contracted period
- duration of contract and expected hours of work (including applicability of EWTD for those on day release from clinical duties)
- arrangements for joint working between the institution, the deanery and the NHS in respect of the trainee, including for assessment of academic competence
- entitlement to the reimbursement of expenses incurred during honorary employment
- responsibilities and entitlements with respect to access to university facilities, intellectual property, research governance and any health and safety arrangements in place.

Copies of the institution's intellectual property, research governance and any other policies relating to honorary employment should be appended to the contract.

See page 141-154 for more information about the arrangements for academic training.



Information

Honorary academic consultant contract

NIHR Implementation plan 3.2c *NIHR Integrated Academic Training Pathway for Academic Clinical Fellowships and Clinical Lectureships (England only)*

Pay and pensions

General provisions

Salary arrangements differ depending on whether clinical work is undertaken as an ordinary part of the post. Clinical academics, whether in the training grades, staff and specialty grades or consultants, should have pay parity with their NHS colleagues. This includes equivalent payment for on-call or out-of-hours work of equal weight.

Research conducted by the BMA, together with the Medical Women's Federation, indicates that there is a gender difference in the raw salaries for medical academics with women earning on average 17 per cent less than their male counterparts. The Gender Equality Duty places a responsibility on employers to ensure equality of treatment in the workplace. The BMA is encouraging institutions to conduct gender pay audits to ensure compliance with legislation. In addition it will support women in their salary negotiations.



Information

WAM/Asset data set – academic and gender pay difference in HE/NHS

Medical academics who do not undertake clinical work

Medically qualified academics who do not undertake clinical work will be paid on the same pay scale as applies to other academic staff in the university. Some higher education institutions (HEIs) offer market supplements, especially for professors, which are over and above the standard university pay scales, as a way of attracting the best academics to their institution. Medical academics are encouraged to consider the academic skills and experience they bring to an institution in negotiating a starting salary.

The salaries for medically qualified staff that do not undertake clinical work are based on a single national pay spine on which local grading arrangements are made. For academic and academic related staff this is based on a library of national role profiles setting out the nature of the roles within each of the grades.

Basic salary for clinical academics

The Doctors and Dentists Review Body (DDRDB) recommends to Government the annual salary increases for doctors and dentists working in the NHS. Following a Government commitment, this pay award is essentially automatically translated to the HE sector. The MASC, therefore, submits evidence to the DDRB each year calling for academic pay to keep on a par with pay for doctors in the NHS, and the DDRB does take an interest in maintaining the supply of clinical academics. The translation process takes place between the University and Colleges Employers Association and MASC secretariats. Rates are normally uplifted from 1 April or shortly thereafter on an annual basis.

Clinical academics who experience problems in being awarded the annual DDRB uplift or who want salary information should contact askBMA for advice.

In setting the starting salary the higher education institution is expected to take into account all previous NHS service and any equivalent experience in another state in the European Economic Area. The salary should be agreed between the substantive and honorary employer.



Information

Paragraph 28, guidance notes for the employment of consultant clinical academics (England)

The latest information about the salary scales for clinical academics can be found in the *Doctors' pay supplement* on the BMA website:

www.bma.org.uk/employmentandcontracts/pay/doctorspaysupp.jsp

Supplements for on-call or out-of-hours work

These should be paid by the substantive employer according to the amount of work undertaken in exactly the same way as for NHS doctors. The Follett Principles on joint working should mean that both employers work together to ensure the clinical academic is paid the total salary due and the reimbursement of monies owed to the substantive employer in respect of on-call/out-of-hours work undertaking in the NHS.

Consultant clinical academics participating in a rota on the same basis and as frequently as their full-time NHS colleagues, will receive the same percentage supplement on their basic salary as their colleagues. However, if they participate in the rota on a different basis they will receive the percentage supplement that a consultant on an equivalent rota would have received.

In Wales, where on call is worked, this will be remunerated on the same basis as an NHS consultant.

Clinical academics experiencing problems with receiving their total salary (including supplements) from the substantive employer should contact askBMA for advice.



Information

England

Consultant clinical academic substantive contract suggested clauses (England)
Schedule 16 terms and conditions – consultants (England)

Wales

Amendment to the national consultant contract in Wales

Scotland

Scottish consultant contract 2004. Section 13 (clinical academic consultants):
www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/TCS_acadconscontract2004.jsp

Northern Ireland

Consultant terms and conditions (Northern Ireland) 2004:
www.dhsspsni.gov.uk/consultants-terms-conditions-of-service-revised-may-2008.pdf

Pay progression

Pay progression for clinical academic consultants and senior GPs is based on the same arrangements as for NHS consultants, and follows an integrated job plan review. A joint recommendation for pay progression is submitted by the university manager and NHS clinical manager to the dean of the medical school or their nominee. The final decision on pay progression is made by the university in consultation with the NHS employer. In England the mediation and appeals framework set out in annex B of the honorary consultant contract applies (see page 133).

Pay progression can only be deferred where the clinical academic has not met the criteria outlined in annex D of the substantive university contract and annex A of the honorary NHS contract in England. The criteria for pay progression include that the clinical academic has made reasonable efforts to meet the time and service commitments and personal objectives in the job plan, participated in a joint appraisal and that the academic has met standards of conduct, including with regard to the undertaking of private practice.

Clinical academics should not be penalised if objectives cannot be met for reasons beyond their control.



Information

Annexes D and E of the substantive contract

Annex A of the honorary NHS contract

Scotland

Similar arrangements apply in Scotland, and are set out in Section 13 of the NHS consultant grade terms and conditions of service.

Wales

Similar arrangements apply in Wales and are set out in Chapter 4 of the amendment to the national consultant contract in Wales

Incremental dates

Incremental dates are fixed by some universities at a specific date across the institution and some may suggest that incremental dates do not apply during a probationary period.

The BMA's view is that individual university policies should not result in clinical academics salaries falling behind those of their NHS counterparts. Any gaps in incremental progression that arise from fixed incremental dates or limitations from a probationary period should be minimised.

For example, if incremental progression is denied during a nine-month probationary period, the first increment should be received immediately after the probationary period with the next increment received on the due date so university trainees do not fall behind.

Doctors experiencing difficulties with receiving incremental progression should contact *askBMA* for assistance.

Pay progression on return to the NHS

As long as they hold an honorary contract with the NHS, doctors who work in universities are entitled to incremental pay progression on return to the NHS as if they had not left. The date on which pay progression shall take place should remain unchanged. The relevant paragraphs from the junior doctors terms and conditions of service are:

Starting salaries and incremental dates

121. Except as provided elsewhere in these terms and conditions of service practitioners shall on appointment be paid at the minimum point of the scale for a post in the grade to which they are appointed; and their incremental date shall be the date of taking up their appointment

Interpretation

135. For the purposes of paragraph 121 to 134:

'b. service in a part-time or honorary appointment shall count in exactly the same way as service in a whole-time appointment'

For consultants NHS organisations should take into account all previous experience as a consultant, including equivalent experience in another EEA state. The terms and conditions of service for consultants in England add that these provisions specifically apply to clinical academics.



Information

Junior doctors terms and conditions paragraphs 121 and 135

Terms and conditions of service (consultants) England 2003, Schedule 1 and Schedule 23

Clinical excellence awards (CEAS)

England

Clinical academic staff, including senior academic GPs, are eligible for local and national clinical excellence awards.

The proportion of the award that they receive is determined according to how much of the work in their job plan is of benefit to the NHS, as outlined below.

Pre-2003 contract, discretionary points and distinction awards

Paragraphs 81 and 82 of the pre-2003 terms and conditions provided that clinical academics were eligible for distinction awards and discretionary points according to the average time per week for which they were engaged in clinical work per week as follows. No new awards are made.

Average number of hours per week	Proportion of award of clinical work
21 or more	Full amount
17.5 or more but less than 21	80%
14 or more but less than 17.5	65%
10.5 or more but less than 14	50%
7 or more but less than 10.5	35%
3.5 or more but less than 7	25%
An assessable amount but less than 3.5 hours	15%

2003 contract, discretionary points and distinction awards

Average number of PAs worked	Proportion of award per week of benefit to the NHS
5 PAs	100%
4 PAs	80%
3 PAs	60%
2 PAs	40%
1 PA	20%
An assessable amount but less than 1 PA	15%

Academic consultants on pre-2003 contract who receive CEAs

The entitlement to full eligibility for an award will be based on five PAs (or equivalent) in the jointly agreed job plan being devoted to activities beneficial to the NHS including teaching and clinical research.

Average number of hours per week	Proportion of award
20 or more	100%
16 or more but less than 20	80%
12 or more but less than 16	60%
8 or more but less than 12	40%
4 or more but less than 8	20%
An assessable amount but less than 4 hours	15%

Consultants on 2003 contract who receive CEAs

The entitlement to full eligibility for an award will be based on five PAs (or equivalent) in the jointly agreed job plan being devoted to activities beneficial to the NHS including teaching and clinical research.

Average number of hours per week	Proportion of award
5 PAs	100%
4 PAs	80%
3 PAs	60%
2 PAs	40%
1 PAs	20%
An assessable amount but less than 1 PA	15%

BMA group to support CEA applications

Clinical academics thinking about applying for a clinical excellence awards (CEAs) award should note that every year a BMA group meets to consider applications to support applicants for the annual national CEAs round. The group will then provide citations to support a small number of applicants for higher CEAs who have made a substantial contribution to the work of the BMA.



Information

Advisory Committee on Clinical Excellence Awards (ACCEA):

www.advisorybodies.doh.gov.uk/accea/2008round.htm

BMA guidance on CEAs:

www.bma.org.uk/ap.nsf/Content/GuidetoCEAforms161107

Clinical excellence awards in the nations

Scotland

In Scotland, clinical academic consultants are eligible for clinical excellence awards. The proportion of the award/point that they receive is determined according to how much of the work in their job plan is of benefit to the NHS, as outlined below. Academic GPs are eligible for awards under the 2007 terms and conditions for senior academic GPs. The proportion of the award/point that they receive is determined according to how much of the work in their job plan is of benefit to the NHS. A National Group has been tasked with reviewing the current scheme and is likely to report its recommendations to the Scottish Government in 2009.

The information below, therefore, is based on the current scheme but may be subject to change.

2004 contract, clinical excellence awards

Average number of hours of clinical work per week	Proportion of award payable
20 or more	Full amount
16 or more but less than 20	80%
14 or more but less than 16	65%
10 or more but less than 14	50%
6 or more but less than 10	35%
4 or more but less than 6	25%
An assessable amount of clinical work but less than 4 hours	15%



Information

BMA Scottish consultant handbook:

www.bma.org.uk/ap.nsf/Content/ScotConHandbookIntroduction~ScotConHandbook2004Contract

Scottish Advisory Committee on Distinction Awards:

www.sacda.scot.nhs.uk/

Wales

Subject to satisfactory job plan reviews, clinical academic staff in Wales are eligible for CEAs and commitment awards in line with the provisions that apply for consultants. The awards are paid on a pro rata basis to part-time staff.



Information

www.wales.nhs.uk

Clinical excellence awards scheme 2009:

<http://wales.nhs.uk/page.ctm?pid=3928>

Northern Ireland

Clinical academics in Northern Ireland have joint appointment contracts with Queen's University Belfast and the Health and Social Care Trust (HSCT). It is the HSCT part of their contracts that allows them to be eligible for CEAs. To be eligible for full CEAs, clinical academics must have at least five clinical PAs/sessions. The same applies to joint appointees.

Average number of hours per week	Proportion of award
5 PAs	100%
4 PAs	80%
3 PAs	60%
2 PAs	40%
1 PAs	20%
An assessable amount but less than 1 PA	15%



Information

www.dhsspsni.gov.uk/index/hss/clinical_excellence_awards_scheme/cea_guidance.htm

www.bma.org.uk/ni/employmentandcontracts/employmentcontracts/Nlconhandbk.jsp?page=85

Staff grade clinical academics

At a minimum clinical lecturers and other medical academic equivalent staff grade doctors should look to agree contracts that are broadly reflective of terms and conditions offered in the NHS.

Clinical academics below the level of consultant and who are not in the training grades, will normally be paid on the clinical lecturer or senior clinical lecturer pay scale published by the Universities and Colleges Employers Association (UCEA). These are usually available on the websites of individual institutions.

Doctors are advised to compare the pay for their equivalent grade in the NHS with that offered by the university and if necessary contact *askBMA* for further advice.



Information

Staff and associate specialists – contract information and guidance:

www.bma.org.uk/employmentandcontracts/employmentcontracts/staff/index.jsp

Junior academics

It is agreed that junior academics should have pay parity with their NHS colleagues. This means that they should be paid equivalent to a specialty trainee, with pay banding for work above 40 hours per week and in out-of-hours time. Clinical academics below the level of consultant are paid on a clinical lecturer and clinical senior clinical lecturer/reader scales. The scale drew on the pay scale for specialist registrars working in the NHS. The BMA has been urging the UCEA to translate the pay scale for specialty training to the university sector since the closure of the specialist registrar grade and discussions have begun on this.

Until formal translation takes place, doctors should be guided by the most recent NHS pay circular and arrangements for appointment to specialty training in discussions on their university starting salary. Appointment to the specialty registrar pay scale is determined by one of two things:

- what a doctor was paid in their previous FY1/2 post immediately prior to appointment as an StR; or
- if they have not moved directly into an StR post, how many years they have spent in a StR-equivalent role.

In order for parity to be maintained with the NHS, additional experience, for example completion of a higher degree, should also be taken into consideration when determining the starting salary.

There are separate pay arrangements in Scotland, though the amounts paid are the same.

For more experienced trainees, it may be more appropriate to use the UCEA salary scale below the level of consultant as it contains a number of additional points on the scale.

Junior doctors taking time out of a training programme to complete a period of research will be paid according to university pay scales or in accordance with grant funding. Often junior academic researchers will undertake locum work to reduce salary shortfalls that may arise from not working the same level of intensity as their NHS colleagues.

Doctors are advised to compare the pay and terms and conditions for their equivalent grade in the NHS with that offered by the university and contact *askBMA* for further advice.

See page 115 for advice on pay on return to the NHS.



Information

HSC on NHS pay scales in England in Scotland separate pay circulars apply which can be accessed from SJDC useful web links page:

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/junior_doctors/usefulweblinks.jsp

The Universities and Colleges Employers Association (UCEA) publishes pay scales for clinical academics below the level of consultant at clinical lecturer and senior lecturer:

www.ucea.ac.uk/en/

Junior doctor contract:

www.bma.org.uk/employmentandcontracts/employmentcontracts/junior_doctors/index.jsp

BMA *Junior doctors' handbook*:

www.bma.org.uk/employmentandcontracts/employmentcontracts/jdhandbook.jsp

Personnel Memorandum (81)30 Annex A

Pensions

The pension arrangements open to medical academics will depend on what establishment they are working for. The two most common options are the Universities Superannuation Scheme (USS) or the NHS pension scheme (NHSPS), under a direction arrangement. A direction (by the Secretary of State) is a concession which allows continued membership of the NHSPS while not being employed directly by the NHS.

Members may also join the Medical Research Council Pension Scheme or other arrangements such as the Superannuation Arrangements of the University of London (SAUL). Members can choose not to pension their income in any of these arrangements and instead take out private provision, for example a personal pension plan or stakeholder arrangement.

The majority of medical academics working in UK universities and other higher education and research institutions will pension their income in USS. Those who take up short-term appointments are more likely to remain in the NHS pension scheme under a direction.

Universities superannuation scheme

USS is the principal pension scheme for employees of UK universities and other higher education and research institutions. USS is one of the largest private sector pension schemes in the UK with over 390 participating institutions. The USS is a final salary scheme. Retirement is permitted from age 65 or in accordance with your contract of employment or if you satisfy one of the conditions for permitted early retirement. The minimum retirement age is 50, increasing to age 55 on 6 April 2010. The standard retirement benefits are:

- a pension for life commencing on retirement at the annual rate of 1/80th of pensionable salary for each year of pensionable service; and
- a tax-free lump sum of 3/80ths of pensionable salary for each year of pensionable service.

USS rules allow for the early payment of pension benefits on the grounds of redundancy and ill-health. Further details of the benefits payable under USS are available on the scheme's website.



Information

www.usshq.co.uk

NHS pension scheme

Generally speaking membership of the NHSPS is available only to those employed by an NHS employer. However, there are occasions where membership may be extended to those who work outside the NHS. Direction status will allow an employee of a medical school in England, Wales, and Northern Ireland to remain in the NHSPS providing the following criteria is satisfied:

- your employer must have direction status
- you must make an application to remain in the scheme within three months of commencing employment
- you must have contributed to the NHSPS at some time during the 12 months leading up to the direction employment.

Direction arrangements are also available to doctors working in medical schools in Scotland. The arrangements in Scotland apply to:

- doctors who are purchasing added years or the unreduced lump sum in the amended NHS pension scheme and who take up a position in a medical school within three months of leaving the NHS; and
- to lecturers and clinical researchers whose contract, which must begin within 12 months of leaving NHS employment, is for no more than five years.

You should take note that if you remain in the NHSPS under a direction arrangement you will not be covered under the NHS Injury Benefits Scheme and cannot receive benefits under the transitional NHS redundancy arrangements.



Information

A detailed explanation surrounding the rules covering direction arrangements can be found in the BMA factsheet entitled *Leaving the NHS* which is available on the BMA website.

The NHSPS was amended on 1 April 2008. From this date a new NHSPS was created for members joining NHS employment for the first time after 1 April 2008. Doctors who are not presently working in the NHS

who were previously a member of the NHSPS, will be able to re-join this scheme (known as the amended NHSPS) if they rejoin the NHSPS within five years of leaving. If the break in service is more than five years, future NHS service will be in the new NHSPS (known as the new NHSPS).

Transfers of pension rights between schemes, including from the amended NHSPS to the new NHSPS, are permitted.

Doctors currently working in the NHS will have the opportunity to move to the new NHSPS during a choice exercise which is due to start in 2009.

In the amended NHSPS retirement is permitted from age 60, although members can claim benefits from age 50* with actuarial reduction.

The standard retirement benefits will be:

- a pension for life commencing on retirement at the annual rate of 1/80th of final pay for each year of pensionable service; and
- a tax-free lump sum of 3/80ths of final pay for each year of pensionable service.

*The NHSPS minimum pension age is moving to 55 from 6 April 2010 except for members who have continuous NHS membership from 5 April 2006, or who left the NHSPS with deferred benefits prior to 31 March 2000.

Members of the new NHSPS will have a normal retirement age of 65 and a minimum retirement age of 55. Benefits are calculated on the basis of pensionable service and reckonable pay: the pension is 1/60 of reckonable pay for each year of scheme membership. Lump sum benefits are not automatically provided in this scheme, but can be taken on the basis that £1 of pension commuted will provide £12 of tax free lump sum.

Further details of the benefits payable under the NHSPS are available in a series of factsheets produced by the BMA Pensions Department which are available on the BMA website at www.bma.org.uk The NHSPS is administered nationally, for members working in England and Wales, by the NHS Business Services Authority (www.pensions.nhsbsa.nhs.uk), for

members working in Scotland by the Scottish Public Pensions Agency (www.sppa.gov.uk) and for members working in Northern Ireland by the Health and Social Care Pension Scheme (www.dhsspsni.gov.uk).

Doctors considering moving pension rights between the NHSPS and USS may wish to consult the BMA document *Moving between NHS and university* appointments which is available on the BMA website at www.bma.org.uk

In reality many medical academics may have time working in various establishments both in the UK and overseas, which provide access to a number of alternative pension schemes through their career.

Care must be taken when deciding what action to take with accrued pension rights.

If moving between posts in the UK should I transfer my pension rights?

There is no firm answer to this question. Factors which you may wish to consider are:

Time restrictions

To retain the right to transfer benefits between pension providers you should inform your new scheme administrators of any previous pension rights as soon as you commence employment. In many pension schemes time limits operate which restrict the receiving scheme from accepting transfers of pension rights after the first year (NHSPS, SAUL) or first two years (USS) of scheme membership. The receiving scheme may refuse to accept a transfer of pension rights outside of this time frame.

Application of the public sector transfer club

The NHSPS, USS, MRC and SAUL are all members of the public sector transfer club. Transfers of pension rights between club schemes is normally calculated on a preferential basis as all club members use a set of transfer factors calculated using common actuarial assumptions.

It may not be a clear-cut decision whether to transfer benefits between pension schemes. Members may be advised to take independent financial advice.

Treatment of service if it is transferred

The amount of service which is credited by the receiving scheme is not necessarily the same as the amount of service which has been transferred. Adjustments to the amount of service credited will depend on the actuarial assumptions underlying the calculation of the transfer value, whether the public sector transfer club applies, the scheme normal retirement date, salary differentials and numerous other factors. You should ask for independent advice on this before transfer. The credited period will normally provide benefits in a manner determined by the scheme rules of the receiving scheme (with reference to final salary or perhaps to salary subject to the earnings cap) and are payable at the normal pension age in the receiving scheme.

Treatment of service if it is not transferred

Providing you have accrued sufficient service in the pension scheme to satisfy the preservation requirements (in USS, the NHSPS and SAUL this is two qualifying years) and then you leave the scheme, you will receive a preserved benefit. Your pension and lump sum are calculated up to your last day of service, including any service which may have been previously transferred in. Preserved pensions are increased annually and the amount of increase applied is normally determined by the pension scheme rules. In the public sector increases in benefits are generally determined by changes in the Retail Prices Index (RPI) but some increases may be discretionary. The benefits remain subject to the rules which apply to this pension scheme.

If moving between a post in the UK and a post overseas should I transfer my pension rights?

Transfers of pension rights are permitted between pension schemes in the UK and overseas pension schemes which are Qualified Recognised Overseas Pensions Schemes (QROPS). A list of QROPS is available at www.hmrc.gov.uk

Pension coverage varies considerably between countries, and the form of benefits and the tax relief which apply on contributions and pensions can be very different to those available in the UK. Care must be taken when considering transferring pension rights overseas and it may be advisable to seek independent financial advice.

Moving overseas for a short period of time

Members of the NHSPS may be able to remain in the NHSPS under a direction arrangement. The BMA Pensions Department factsheet entitled *Leaving the NHS* explains this option fully. If a direction does not apply, or is not available and members fully intend to return to the UK after a short period overseas then it would be advisable to seek independent financial advice when considering a transfer.

Moving overseas permanently

Due to the diverse nature of pension arrangements it is recommended that members seek independent financial advice when considering a transfer.

If you do not transfer your pension rights from a UK pension scheme it is possible that your UK pension provider will pay your pension overseas; the NHSPS and USS both offer this facility. In other cases please check the scheme rules to ensure that this option is available.

The BMA Pensions Department is not registered under the Financial Markets Act 2000 to offer members financial advice. This advice is available through the BMA via BMA Services (BMAS) who can be contacted on 0845 609 2008. There may be a charge for advice received from BMAS.

Further information is available on the BMA website at www.bma.org.uk/pensions

For further assistance please contact the BMA Pensions Department on 020 7383 6166/6138 or at pensions@bma.org.uk



Information

Working Abroad (page 30)

Doctors working for the MRC can find further information on their pension scheme at:
www.nimr.mrc.ac.uk/employment

Members of SAUL can find out further information on their pension scheme at:
www.saul.org.uk

Job planning, appraisal and revalidation

Integrated job planning

A job plan is a detailed description of the duties and responsibilities of a doctor and of the supporting resources available to carry them out. Job planning has been a responsibility for all consultants in the NHS since 1991, but the 2003 consultant contract has placed a renewed emphasis on ensuring that job plans are accurate and up to date. A new job planning system has been developed in the NHS that is based on a partnership approach between consultant and clinical manager.

Standards of best practice for job planning were agreed between the BMA and the Department of Health (DH) in England as part of the documentation in support of the new consultant contract in September 2003. However, these standards represented recommended guidance on best practice in relation to job planning, both for consultants on the 2003 contract and for those who remained on their existing contracts. The CCSC has produced extensive guidance on this issue for members and MASC has also produced additional advice for clinical academic staff drawing on the Follett Review Principles of joint working.

For consultant or GP clinical academics, both the substantive and the honorary employers will be party to a joint, integrated job planning process and the recommendation on pay progression for the academic will be a joint recommendation, agreed between the joint employers. Where the clinical academic's duties or responsibilities have changed during the year the employers will also be able to propose amendments to the job plan. There should be appropriate application of the Follett Review Principles in the agreement of clinical academic integrated job plans, outlined in the accompanying guidance.

The purpose of the job planning process, as set out in the standards of best practice, is to:

- enable better priority setting of work and reduce excessive workload
- agree how the individual or their team can most effectively support the wider objectives of the service and meet the needs of patients

- agree how the NHS employer can best support the delivery of these responsibilities
- provide the doctor with evidence for appraisal and revalidation
- comply with Working Time Regulations; and
- reward activity above the standard commitment.

Job planning can therefore be of great benefit. Clinical academics are encouraged to prepare for and participate actively in job planning on an annual basis. For those on the 2003 consultant contract, participation in the process will be a factor in informing pay progression and for all, adherence to the principles of job planning will be a factor in decisions on CEAs.

England

In broad summary:

- clinical academics will have a commitment to the university/academic employer and the NHS employer. This will typically be five programmed activities (PAs) of academic work and five PAs of NHS work, although these proportions can be varied according to the needs of the job (for example, 6:4, 3:7)
- within the NHS commitment, there should be a typical ratio of three direct clinical care PAs to one supporting PA. Supporting PAs may include teaching and research activities if agreed with the NHS employer
- the integrated job plan should be agreed between the academic employer, NHS employer(s) and the clinical academic staff member
- additional PAs can be agreed with either employer, according to the needs of the job. Clinical academics should find it useful to keep a workload diary for a reasonable period in order to support the case for additional PAs and the BMA consultants' committee has produced a spreadsheet for this purpose. Any work undertaken in additional PAs could be agreed on a separate short-term contract
- a key feature of the 2003 contract is flexibility. Consultants may decide to annualise their job plan rather than keep a weekly or fortnightly timetable, so that attendance at conferences, exam periods or research projects can be incorporated into the job plan more easily

- service level agreements between a university and an NHS organisation to outline a defined amount of clinical service in a particular speciality with the aim of providing flexibility and continuity of services. These service level agreements can be implemented via individual integrated job plans.

Many of the principles of job planning can and should be applied to the pre-2003 contract.



Information

The clinical academic consultant contract (England) 2003, BMA advice on integrated job planning.

Guidance notes for the employment of consultant clinical academics/senior academic GPs

NHS Employers guide to contracting for additional programmed activities:

www.nhsemployers.org/SiteCollectionDocuments/Guide_to_Contracting_for_APAs_180208_aw.pdf

CCSC consultant job planning and workload diary:

www.bma.org.uk/employmentandcontracts/working_arrangements/job_planning/jobplanningdiaryversion6.jsp

Scotland

The arrangements for job planning in Scotland are similar to those in England. However, it is important to note that under the Scottish consultant contract the split between academic work and NHS work is typically six PAs of academic work (five core and one extra) and five PAs of NHS work for a full-timer. There are differences in the agreed NHS commitment as well. In Scotland there should be a typical ratio of 3.5 direct clinical care PAs to 1.5 supporting professional activity PAs (SPAs).



Information

BMA guidance on job planning on 2004 consultant contract in Scotland which has a section on job planning for clinical academic consultants (section 10):

www.bma.org.uk/sc/employmentandcontracts/working_arrangements/job_planning/jobplanningscotdec04.jsp

Official guidance for clinical academic consultants which accompanies Section 13 of the 2004 consultant contract in Scotland:

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/guidancescotclinicalacademics.jsp

Section 13.2 of the terms and conditions of the 2004 consultant contract in Scotland which can be found at:

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/TCSacadconscontract2004.jsp

Wales

The arrangements for job planning in Wales are similar to those in England in that NHS employers in Wales will work with universities to agree the commitments with those on honorary contracts and build a job plan accordingly. Job plans for clinical academics will recognise that their role encompasses their responsibilities for teaching, research and the associated medical services.



Information

More information is available in Chapter 8 of the amendment to the national consultant contract in Wales.

Mediation and appeals

Subject to informal attempts at reaching a resolution having failed, a clinical academic may appeal about a dispute arising from the integrated job planning process or a decision about pay progression. Appeals will be conducted jointly by both the substantive and honorary employer with the clinical academic nominating a member of the appeal panel. The clinical academic is entitled to representation in the formal appeal and the BMA is able to support and represent members.

England

The mediation and appeals framework is set out in annex B of the honorary contract and annex E of the substantive contract. In summary it states that if there is a dispute over a job plan or a decision relating to pay progression, there is a process of mediation and appeal that can be followed.

Mediation

In the first instance, the clinical academic, the university manager or the clinical manager should refer the matter to the dean in writing within two weeks of the disagreement arising, setting out the nature of the dispute. The dean will consult with the NHS medical director (or another designated person if the medical director is one of the parties to the initial decision). The other party should then set out their position on the matter. There will then be a meeting, usually set up within four weeks of the referral, involving the relevant manager, the clinical academic and the dean working with the medical director. If agreement is not reached at the meeting, the dean in consultation with the medical director will take a decision or make a recommendation to the vice-chancellor, copied to the NHS Trust/board chief executive. The medical director must inform the clinical academic and clinical manager of the decision or recommendation in writing. Where the dispute is over pay progression, the vice-chancellor should write with his/her decision to the clinical academic, the dean, the medical director and relevant managers. If the clinical academic is not satisfied with the outcome, a formal appeal can be lodged.

Appeal

The clinical academic must lodge the appeal in writing to the vice-chancellor (copied to the NHS Trust/board chief executive) within two weeks. The appeal should set out the points in dispute and the reasons for the appeal. The vice-chancellor, in consultation with the NHS chief executive, will then convene an appeal panel. The membership of the panel is a chair nominated by the university/HEI, a representative nominated by the honorary employer and a representative nominated by the clinical academic and two independent members from a list

approved by the BMA/BDA and the strategic health authority (SHA) – one each chosen by the university and the clinical academic. The clinical academic can object on one occasion to the independent member who would then be replaced with an alternative representative. The parties to the dispute will submit written statements of case to the appeal panel one week before the hearing and may make oral submissions on the day. The panel may hear expert advice if required. The clinical academic can either present his or her own case at the hearing or he or she can be assisted by a representative, who may be a member of BMA Regional Services, but may not be someone acting in a professional legal capacity. The panel then makes a recommendation to the vice-chancellor, copied to the board of the NHS employing organisation, usually within two weeks of the hearing. The recommendation will normally be accepted and the vice-chancellor's decision is final.

Scotland

The mediation and appeals process is set out in section 13.4 of the terms and conditions of service for the new consultant contract.

Contact *askBMA* for assistance with mediation and appeals.



Information

[Annex E substantive contract \(suggested clauses\)](#)

[Annex B honorary academic contract](#)

[Section 13 of the terms and conditions of service \(Scotland\)](#)

www.bma.org.uk/sc/employmentandcontracts/employmentcontracts/medical_academics/TCS_acadconscontract2004.jsp

Joint appraisal

Appraisal is separate from, but informs, the job planning process. As with job planning, the appraisal process should include input from both employers as well as the clinical academic. Therefore the appraisal should be a joint process between the clinical academic, the NHS organisation and the university employer.

The objectives of the appraisal scheme are to enable the university/NHS employer and the clinical academic/NHS staff with honorary academic contracts to:

- review the contribution of the individual to education, research and patient care
- review the contribution of the individual to academic leadership of the discipline and to innovation locally, to the NHS, and nationally and internationally
- review annually an individual's work and performance, utilising relevant and appropriate comparative performance data from local, regional and national sources
- optimise the use of skills and resources in seeking to achieve the delivery of service priorities with respect to research, teaching and clinical practice
- consider the clinical academic's contribution to the quality and improvement of services and priorities delivered locally within higher education and the NHS
- set out personal and professional development needs and agree plans between the two sectors for these to be met
- identify the need for the working environment to be adequately resourced to enable any objectives in the agreed job plan review to be met
- allow consultants to discuss and seek support for their participation in activities for the wider NHS and HE sectors
- use the process to meet the requirements for GMC revalidation.

The BMA is aware that some HEIs require a separate appraisal from the joint appraisal with the NHS. Of the 33 HEIs that responded to the BMA's 2008 survey on human resource policies 10 indicated they require an appraisal in addition to the joint appraisal.



Information

BMA advice on clinical academic staff (consultants) appraisal scheme:

www.bma.org.uk/employmentandcontracts/doctors_performance/1_appraisal/Cliniacadstaffconsultantsappraisalscheme.jsp

BMA (2008) *Annual appraisal for clinical academic consultants in Scotland*. London: BMA.: www.bma.org.uk/employmentandcontracts/employmentcontracts/UniversityEmploymentGuide2008.jsp?page=1

Revalidation

Following the publication in February 2007 of the chief medical officer (CMO) for England's white paper, 'Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century', fundamental changes will take place to the way in which the UK medical profession is regulated. Under the white paper and the subsequent report by the CMO (see below), revalidation will be required for doctors to demonstrate their continuing fitness to practise. Revalidation will be a single process with two potential outcomes: relicensing for all doctors and, for those doctors on the GP register or the specialist register, relicensing plus specialist recertification. Annual appraisal will be a key vehicle by which it will be confirmed that a doctor is progressing satisfactorily and that any issues of concern are being managed effectively.

Revalidation will be a requirement for all doctors wherever they work: doctors in the NHS, academic departments, public companies, and those who are self-employed will have to demonstrate their fitness to practise every five years. Plans are underway and the GMC will introduce the licence to practise in the autumn of 2009.

Details of how revalidation will be implemented over the following two years were also set out in the CMO's report *Medical revalidation – principles and next steps* published in July 2008. To meet the requirements of revalidation it is likely that a portfolio of evidence will be needed including:

- confirmation of participation in CPD
- results of appropriately tailored Multi-Source Feedback (MSF)
- outcomes-based assessment of performance
- robust audit data
- peer review of departments (and not individuals).

Currently arrangements for revalidation for medical academics are not yet fully agreed. The arrangements will need to be compliant with the Follett Review Principles. They will need to take account of the varying work patterns and responsibilities of medical academics. In both 2007 and 2008 CMO reports there was an acknowledgement that there would need to be careful consultation with all employers to ensure appropriate without prejudice arrangements for academic doctors; and that, therefore, specialist standards would need to be adapted accordingly.

The GMC has noted that 'there will be no legal requirement to hold a licence for activities such as teaching, medical management, medical journalism, medico-legal work and some types of research. Nevertheless, holding a licence will demonstrate that you are up to date and fit to practice'. Hence, since some medical academic (as opposed to 'active clinical') activities will not need licensing, as they are outwith the 'licence will require periodic renewal by revalidation' regulations (subject to the caveat that all revalidation will have a 360° aspect to it and this does include teaching).

Responsible officers

As part of revalidation process, the 2007 white paper and 2008 Bill also set out plans to create responsible officers. It proposed that senior doctors will take personal responsibility for evaluating the conduct and performance of doctors and making recommendations on their fitness to practise.

At the time of writing, final details of how to progress with plans for a responsible officer had not been published. However, there are some key issues for medical academics that have been highlighted by the BMA:

- as NHS organisations issue honorary contracts for clinical academics for their clinical work (which is the activity covered by revalidation), the relevant NHS organisation should be seen as the employer for the purposes of revalidation and should provide the responsible officer function without any charge to the higher education institution for which the clinical academic undertakes academic work

- clinical academics employed by HEIs but undertaking sessions in the NHS should relate to the responsible officer in the NHS organisation in which they undertake their clinical work or most of their clinical work if there is more than one. Whilst their academic work does not need to be covered specifically by the revalidation process, nonetheless responsible officers will have to be cognisant of such work in order to make sure that the process is compliant with the Follett Review Principles.



Information

Follett Review Principles (page 67)

BMA statement of principles on revalidation:

www.bma.org.uk/employmentandcontracts/doctors_performance/professional_regulation/revalidationstatement0708.jsp

Revalidation factsheet – meeting the demands:

www.bma.org.uk/employmentandcontracts/doctors_performance/professional_regulation/revalidationfactsheet1008.jsp

Trust, assurance and safety – the regulation of health professionals in the 21st century,

February 2007:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946

Medical revalidation – principles and next steps, CMO's report – July 2008:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086430

Training, career progression and support

Introduction

In preparation for the introduction of the specialty training phase of Modernising Medical Careers (MMC) in 2007, consideration was given as to the best way to continue to provide access to academic medical training within run-through training programmes. A joint Academic Careers Sub-Committee of MMC and the UK Clinical Research Collaboration was set up under the chairmanship of Dr Mark Walport to bring together key stakeholders from across the UK. The subsequent report produced by this committee is now often referred to as the 'Walport Report' and was published in March 2005.

The report made a number of recommendations for the future training of medical researchers and educators, including the development of an explicit specialist training pathway during the specialist training of doctors with the creation of dedicated academic training programmes.

The Walport Report acknowledged that its recommendations might well be implemented differently in each of the devolved nations and this has indeed been the case. In England and Wales, the National Institute for Health Research has developed the Integrated Academic Training Pathway (IATP). In Scotland, the Scottish Clinical Research Excellence Development Scheme (SCREDS) was established in 2007 and is operated by Scottish Universities in partnership with NHS Education for Scotland (NES).



Information

Recommendations for medically and dentally-qualified staff: recommendations for training the researchers and educators of the future (2005) – also known as the Walport Report: www.ukcrc.org/pdf/Medically_and_Dentally-qualified_Academic_Staff_Report.pdf

Academic training in England

Academic foundation programmes (AFPs)

Academic foundation programmes (AFPs) are a new initiative arising from the Walport Report. They offer a unique training opportunity for those interested in a career in academic medicine. Under the scheme medical school graduates are able to get the training required of them as part of their foundation programme, and receive a comprehensive introduction to academic medicine. There are currently around 350 AFPs and they are offered by all foundation schools across the UK.



Information

Rough guide to the academic foundation programme (UKFPO):

www.foundationprogramme.nhs.uk/download.asp?file=Academic_Rough_Guide.pdf

NIHR academic clinical fellowships (ACFs)

Academic clinical fellows (ACFs) are allocated to medical schools in England and are managed through partnerships between postgraduate deaneries, medical schools and NHS Trusts. ACFs are NHS employees and spend 75 per cent of their time in clinical work and 25 per cent in academic work. How the proportions of time are allocated varies from post to post.

To help ensure that the best candidates are attracted to ACF posts, the Medical Programme Board has to date stated that there will be a recruitment round before the recruitment process for national speciality training takes place. However, posts do not necessarily have to be made available each year, and to allow a greater degree of flexibility for both deanery and trainee, the recruitment process can take place at any point within the year in which the post was allocated.

Prospective applicants are therefore advised to contact the relevant deanery in the first instance to check for availability and the specific application timetable. A list of deaneries with ACF programmes and allocated posts is available through the NIHR Trainees Coordinating Centre website, along with the contact details for further enquiries. The MMC website and local deaneries provide more detailed information.

The recruitment process is led by postgraduate deaneries, and panels ensure that applicants meet both clinical and academic standards. To this end, additional components are built into the standard specialty training application process to assess an applicant's potential as an academic. Applications can be made to non-academic specialty training alongside those to ACF programmes.

Eligibility and entry points

ACFs are aimed at individuals who display a commitment to academic medicine and have outstanding potential for success in the field. They are open to all applicants who meet the requirements for entry into specialty training as well as existing specialty trainees.

The level of clinical experience required for individual ACFs is determined by the deanery in question and entry can be up to four levels of training: ST1, ST2, ST3 and/or ST4 for psychiatry and paediatrics. If successful, trainees will be awarded an academic National Training Number (NTN(A)).

Entry points into specific specialties are dependent on whether they have a core training period.

For ACFs which specify a specialty with a core training period, the trainee would be entered onto a core academic programme – even if appointed at ST1 or ST2 – and then progress onto the specialty in question. Progression is dependent on the trainee achieving the core competencies and assessment by a selection panel.

For specialties without a core training period, entry will be directly into the specialty programme.

Trainees on ACFs which are not specialty specific, eg 'medicine' or 'medical education', enter an academic core training period for two to three years during which clinical and academic specialisation is decided. Medical education ACFs can be based on either specialties with a core training period or those without. Decisions regarding specialty area are

based on the individual preferences of the trainee and the academic opportunities available locally.

Part-time opportunities

The standard length for an ACF is up to three years, or four years for GP programmes. For part-time posts this can be extended up to a maximum of five years (six years for GPs), provided this includes the standard 25 per cent academic component. The duration and specific arrangements of a part-time post will need to be made clear on monitoring forms both at the start and throughout the training programme.

Completion of an ACF and early exit from the programme

Success in obtaining a research training fellowship or a place on an educational programme which leads to a higher degree is usually seen as the end of the ACF period. At this point trainees, with the agreement of their postgraduate dean, will take time out of their clinical programme to complete the MD, PhD or equivalent higher degree. After this has been completed, they will return to their clinical programme and will be able to apply competitively for clinical lectureships (CLs) at ST4/5, provided they meet the eligibility criteria (see below).

Trainees who hold a PhD or equivalent higher degree are eligible to apply but will be expected to further their postdoctoral research experience. These include:

- MB PhD graduates
- graduates with an intercalated PhD gained during an undergraduate medical degree
- doctors who have undertaken an MD or PhD and have a commitment to academic medicine
- medical graduates who have obtained a PhD prior to medical undergraduate training.

Early exit from the programme

In circumstances where a trainee decides not to continue with a career in academic medicine or where they have been unsuccessful

in obtaining a training fellowship, he or she would relinquish their NTN(A) for an NTN and join a standard clinical programme and specialty training. This is dependent on achieving the required clinical competencies and the availability of a suitable placement. As it could take up to 12 months before a suitable training opportunity becomes available, the trainee should contact his or her postgraduate dean at the earliest opportunity. Where a trainee has no determined choice of specialty, it will be necessary for them to compete for entry at ST3 (or ST4 in psychiatry and paediatrics).

NIHR Clinical Lectureships (CLs)

As with ACFs, CL programmes are allocated to medical schools in England and are managed through deanery/Trust partnerships, together with the medical school.

Clinical lectureships comprise an equal split of clinical and academic training for up to four years. The recruitment process to CL programmes is by application form and is led by the postgraduate deaneries. A list of participating deaneries with CL programmes and allocated posts, along with a detailed person specification framework, is available from the NCCRC website. Clinical lecturers will be employed by the higher education sector.

It is not necessarily the case that programmes will offer posts every year and there are no constraints on when the process has to take place. Prospective applicants are therefore advised to contact the named academic lead for details regarding availability and the specific application process. These details can be found through the NCCRC and local deaneries.

Eligibility and entry points

CL programmes are aimed at doctors who are advanced in their specialty training, hold an MD, PhD or an equivalent higher degree and who show outstanding potential for continuing a career in academic medicine. All those who have an NTN and a higher degree are eligible to apply, including:

- specialist registrars (SpR) or specialty registrars (StR)
- doctors with speciality experience (as an SHO, LAT or equivalent) who meet the entry criteria for specialty training
- GP trainees that have completed both their clinical training and have obtained a higher degree.

Candidates who are about to begin specialty training are not excluded from making applications but these will only be granted in exceptional circumstances. As a CL programme can last up to a maximum of four years, a period of dedicated clinical training is considered appropriate, completed either before or during the programme.

Part-time opportunities

Those wishing to take on a part-time CL would be able to extend the period of the programme up to a maximum of six years and would have input into how the balance between clinical and academic training is arranged.

Completion of a Clinical Lectureship

The CL phase will normally end with the attainment of a Completion of Clinical Training (CCT). It is expected that a number of trainees will apply for external funding to support further postdoctoral research (such as the Clinician Scientist Award) or for further training as an educationalist.



Information

NIHR Trainees Coordinating Centre:

www.nihrtcc.nhs.uk/

BMA Medical and Academic Staff Committee (2006) *A career in academic medicine*.

London: BMA.:

www.bma.org.uk/ap.nsf/Content/careeracademicmedicine

Other academic training posts

Other academic training posts that are not funded from the NIHR are also available. These posts, such as anatomy demonstrators, clinical research fellows, research fellows and clinical lecturers, are advertised in the medical press, including the *BMJ*, and on the medical academic website. The recruitment and employment arrangements for these posts will be determined locally by the employer.

There are also a small number of non-NIHR ACF posts attracting NTN(A) and funded jointly by The Wellcome Trust and the pharmaceutical industry. Recruitment for these posts is flexible but some were advertised alongside the 2009 NIHR ACFs.

Successful applicants to these posts, especially those who intend to return to the NHS, should seek to ensure that they hold an honorary contract with the NHS during medical school employment.



Information

Clinical academic jobs website:

www.clinicalacademicjobs.org/

www.wellcome.ac.uk/News/Media-office/Press-releases/2008/WTX049865.htm

Training and arrangements for NIHR posts in England

Training structure and supervision

NIHR funded trainees are automatically granted membership of the NIHR Faculty. There is a recognition that this excludes some trainees and consideration is being given as to how non-standard ACFs and the like can be brought into the fold, possibly through a system of 'kite-marking' such posts.

Each ACF should have a personalised training plan and timetable, which balances the academic and clinical components to meet the overall training goals of the programme. The timetable should establish protected training periods for the research and taught modules, either through day and/or block release.

Clinical training and clinical performance are the responsibility of the educational supervisor and clinical supervisor respectively. Both positions are based within the relevant NHS Trust. An academic supervisor, appointed by the university, is responsible for the assessment of academic progress and is responsible for drawing up the training programme with the ACF. The integration of the clinical and academic components is the responsibility of the deanery training programme director.

Personalised training plans for each trainee must be agreed by the four members of the Trust/deanery partnership, that is: the educational supervisor, the clinical supervisor, the academic supervisor and the deanery training programme director.

ACFs are encouraged to keep a copy of their training programme for future reference. Should difficulties with their clinical or academic training programme arise, ACFs should discuss this with their local ACF programme director and either seek to resolve the matter informally or approach the deanery programme director.

Problems arising from clinical or academic training

It is expected that the medical school, deanery and the Trust will work in partnership to deliver ACF training and resolve any issues arising from clinical training that affect academic training and vice versa. The BMA can also assist where difficulties arise across clinical and academic training or where problems appear intractable. Contact the BMA on 0300 123 123 3 or email support@bma.org.uk

Training content and qualifications

Along with the research and clinical content of the ACF programme, trainees should have access to relevant modules in other fields to support inter-disciplinary knowledge and enquiry in research.

If the focus of research is educational, a trainee should also have access to appropriate teaching and learning opportunities. In addition, all ACFs are eligible for a national annual bursary of £1,000 a year which is held

by the medical school and can be used to enable trainees to attend conferences and training courses which would be beneficial to their academic development and research awareness.

Those appointed to ACF posts from 2009, will undertake a taught research training programme, provided by the medical school, which is designed to equip trainees with knowledge of:

- research skills (statistics, trial design, project management etc); and
- the basics of research practice (patient involvement, diversity, ethics, research governance).

From 2010 the course will be credit-bearing and the content of an ACF post should be sufficient to lead to a Masters degree (MRes or MEd) or be recognised as part-fulfilment of a corresponding qualification, especially where this is a precondition to pursuing research leading to a PhD.

Clinical lecturers

Clinical lecturers will be employed primarily by the university in which they hold a post. They should also hold an honorary contract with the NHS Trust to cover their clinical duties. Like ACFs, they will be classed as trainee members of the NIHR Faculty.

As the clinical academic timetable is split 50-50, a clinical lecturer should also hold an honorary contract with the NHS. There is no standard structure regarding the supervision of CLs that the Trust/deanery partnerships must follow. It is expected though that most will adopt a similar system as that which applies to ACFs, with the clinical training and performance managed by the Trust by educational and clinical supervisors, and the research/educational components overseen by an academic supervisor employed by their university.



Information

National Institute for Health Research (NIHR):

www.nihr.ac.uk

NIHR – Implementation plan 3.2 – Integrated academic training pathway for academic clinical fellowships and clinical lectureships:

www.nihr.ac.uk/about_implementation_plans.aspx

Medical academic training in Scotland

Academic Foundations Programmes (AFPs) in Scotland

AFPs in Scotland provide the opportunity for foundation doctors to develop research and teaching skills in addition to the current basic competencies outlined in the curriculum. They are intended to be beneficial for both those who plan to pursue a career in academic medicine and those who may wish to gain further experience in research before pursuing a different medical career. There are different approaches to providing academic training within foundation programmes across the UK. Some programmes will provide separate blocks of pure academic training, while others will have an ongoing element with regular ‘protected time’ for academic input.

There are around 40 AFPs available each year in Scotland, with varying numbers of programmes available in each of the four regions. Academic programmes are advertised on the NES website (see below) in June and July each year. Any vacancies that arise for individual year long programmes are also advertised separately on the NES website.

Further information on AFPs in Scotland can be found at the UK Foundation Programme Office (FPO) website and from NHS Education Scotland (NES) website.



Information

UK Foundation Programme Office:

www.foundationprogramme.nhs.uk/pages/academic-programmes

NES Scottish Foundation School:

www.nes.scot.nhs.uk/medicine/foundation/academic/

Academic opportunities during specialty training

The Scottish Clinical Research Excellence Development Scheme (SCREDS) was established in 2007 in response to Walport Report recommendations and is operated by Scottish Universities in partnership with NHS Education for Scotland (NES).

SCREDS was introduced to support doctors to develop their skills and experience in medical research and education, with the aim of producing trained doctors (and dentists) to attain both their CCT and research experience at doctoral or post-doctoral level. It allows clinicians to pursue academic and clinical training in the NHS either concurrently or sequentially. There is also a post-CCT element to SCREDS – the Scottish Senior Clinical Fellowship Scheme.

Unlike England, all medical academic training posts at specialty level are university contracts. We strongly advise any trainee offered a university contract to contact the BMA for advice as academic trainees may be offered terms and conditions that are less than those offered by the junior doctor contract. It is also important to secure an honorary NHS appointment for the duration of any university contract to ensure continuity of employment and other provisions.

Unfortunately there is no one site or body through which universities are required to list vacancies for medical academic training posts in Scotland, nor is there a fixed timetable for recruitment. This does make it challenging for individual trainees to monitor possible vacancies to which they could apply. The Medical Schools Council have now established a website (www.clinicalacademicjobs.org) which hopes to provide a central resource to advertise clinical academic jobs at every level across the UK and the BMA is keen to encourage universities to advertise available posts on this site. Posts are also advertised on the NES website, individual university websites and the medical press such as *BMJ* and *The Lancet*.

Although attempts have been made to clarify the arrangements and opportunities for doctors who wish to pursue research and academic

interests during specialty training, the majority of the posts available are highly individual in nature and the following information is provided as a guide only.

At present, there are three main types of post available for those in specialty training:

- CL (including SCREDS NES funded CL posts)
- clinical fellowships (out of programme research posts)
- intermediate fellowship (for those who have attained a higher degree in research).

Clinical Lectureships

The aim of these posts is to integrate mainstream specialty training with an element of research training. As such, they normally allow for 20 per cent research training and 80 per cent clinical training. The posts are usually available from ST2 and above for the duration of specialty training and are available through direct competition as they become available. Some of these posts fall under the SCREDS scheme and are funded by NES, others are funded directly by the universities. The posts funded by NES have some tighter restrictions on time spent allocated to research.

The time provided for research training in these posts is intended to facilitate a more extended period of research leading to either a higher degree, or, for those already holding a higher degree, post-doctoral research. Appointed by the universities, with the support of the relevant postgraduate dean, trainees would hold a substantive contract with the university and an appropriate honorary NHS contract. They are funded directly by the university or by NES. In 2008 there were approximately 125 NES clinical lectureship posts in place across Scotland.

Clinical fellowships

These have also been referred to as academic training fellowships. The aim of these posts is to allow for out of programme research, primarily leading to either a PhD or MD. There may be scope for a small amount of clinical work. The posts are funded from a variety of sources,

including universities, the Scottish Government, research councils and grant-awarding bodies (eg the Wellcome Trust). They are advertised separately and are usually of between three and four years in duration. More information on these can be found on page 157 – out of programme experience.

Clinical scientists/intermediate fellowships

These posts are aimed at those who already hold a higher degree but who have not yet attained CCT. These are funded from a variety of sources, including MRC, medical charities, the Chief Scientist Office (CSO), NES or by individual universities.

Scottish senior clinical fellowships

This scheme represents the post-CCT element of SCREDS, the Scottish response to the Walport Report, and aims to provide an entry point to a permanent clinical academic career for those who have recently attained their CCT. Launched in September 2008 with the intention to create 20 permanent posts over the subsequent five years, these posts are funded by a partnership between SFC and the universities. Applicants are required to have postdoctoral research experience, a strong publication record and should have won competitive research or fellowship funding at some point prior to application to this scheme. Further information can be found on the relevant page of the NES website.



Information

NES and Board for Academic Medicine (2009) *SCREDS: A guide to the scheme*.

www.mmc.scot.nhs.uk/documents/SCREDSFINALRevisedGuidetoScheme16thJanuary09.pdf

Edinburgh Clinical Academic Track scheme (E-CAT):

www.ecat.mvm.ed.ac.uk/scheme.html

Medical academic training in Wales

In 2006/07, Welsh Office for Research and Development (WORD) made £400k available on a non recurrent basis to enable Wales to join the Walport Scheme. Recruitment has been difficult and it was felt that the

scheme lacked a secure funding base and a strategic approach to meet the needs of Wales.

In response to the acknowledgement of the need for a new direction, WORD established a policy forum for clinical academic careers and, as a result of this policy forum, a new model for clinical academic careers in Wales has been agreed, similar to the E-CAT model utilised in Edinburgh (see above for further information). The scheme ensures completion to a position where they can apply for senior lecturer posts or for external funding for intermediate or senior fellowships.

It is proposed that 10 candidates are appointed for placement throughout Wales in the first two years, reducing to five candidates each year from year 3. This will result in a maximum of 50 places by year 8 plus the 'new blood' clinical lectureships starting in year 5. The posts are fully funded for the duration of training including the PhD years. By winter 2008 Wales had 16 Walport posts.

The scheme will include a formal assessment/interview on completion of the PhD to permit entry into the lectureship training (years 5-8). The scheme will be administered by the medical schools via the postgraduate deanery. The proposed scheme is similar to the Walport Scheme (which proposes to allocate five Fellowships per annum to each medical school) but it also incorporates a complete academic training pathway.

The Welsh assembly has confirmed funding for the initiative that will cover all of Wales and it is expected that the deanery will receive applications from academic institutes across the UK for these posts.

In Wales an exit strategy for promising candidates is essential in the proposed scheme to retain the candidates that have been trained locally. Fully funded senior lecturer posts, available throughout Wales after open competition, will be introduced using a phased approach, beginning with three posts starting in August/September 2014 and rising to 18 posts each year from August/September 2017.

Medical academic training in Northern Ireland

Queen's University of Belfast in partnership with the Northern Ireland Medical and Dental Training Agency (Northern Ireland Postgraduate Deanery) and Belfast Health and Social Care Trust has developed a pathway of academic clinical training opportunities under a similar system to that suggested by the Walport Report.

New posts have been created as part of MMC/National Co-ordinating Centre for Research Capacity Programme of Integrated Academic Training and offer candidates a comprehensive experience in clinical academic medicine alongside international clinicians and researchers.

AFPs in Northern Ireland

Academic programmes are integrated into the FY2 year. Students will normally complete two four-month specialty attachments, and another four-month academic attachment. The academic attachments vary yearly, but at present specialties involved in these are:

- renal
- ophthalmology
- paediatrics
- respiratory medicine
- there are also clinical skills placements.

Academic opportunities during specialty training

There will be recruitment to academic clinical lectureships (ACLs) annually in the spring. In the first instance these posts are recruited internally from trainees at ST3 level and above. In the event of being unable to fill these with local candidates, the posts will be advertised externally. The following disciplines will be included:

- old age
- paediatrics
- respiratory
- cardiology
- epidemiology

- ophthalmology
- renal
- oncology.



Information

More information is available from the Northern Ireland Medical and Dental Training Agency (NIMDTA) website: www.nimdt.a.gov.uk

National Clinician Scientist Awards Scheme in England

Launched in 2001, the National Clinician Scientist Award Scheme in England was set up to support the development of the leading clinical academics of the future. All funding bodies must meet the national standards agreed by the National Clinician Scientist Monitoring Committee to run approved Clinician Scientist Awards, but each award will differ slightly according to the individual objectives of the organisation. At present there are thirteen funding bodies that run recognised Clinician Scientist Awards:

- NIHR
- MRC
- Cancer Research UK
- Leukaemia Research UK
- Wellcome Trust
- Academy of Medical Sciences
- The Health Foundation
- GlaxoSmithKline
- Institute of Child Health
- Arthritis Research Campaign
- British Heart Foundation
- National Kidney Research Fund
- Institute of Thrombosis.

The duration of awards can vary although they are normally between three to five years. All provide personal remuneration for the award holder, at least equivalent to the basic salary they would be entitled to if

employed within the NHS at a similar level. Further support for the research programme may be provided but can vary in extent for each award. Applicants will usually hold an NTN in their chosen specialty and clinician scientists funded through one of the 13 bodies which meet national standards will be eligible to apply for an NTN(A).

Applying for an award

Funding bodies normally expect applicants to have either obtained a higher research degree or submitted it for examination. Entry points can be up to and including CCT holders. The level of experience required depends on the criteria laid out by the funding body.

All awards are decided through competition. Along with assessing the scientific merit of research proposals and their relevance to improving human health, panels will be looking for applicants who have demonstrated their independence as a research scientist and who have the potential to become a research leader in their chosen field. Application timetables differ for each funding body and not all run consecutive annual award schemes. Prospective applicants are therefore advised to contact each funding body for more information:



Information

National Coordinating Centre for Research Capacity and Development:

www.nccrcd.nhs.uk/natclnsciencescheme/standardcsawards

Academy of Medical Sciences: www.acmedsci.ac.uk/index.php?pid=143

NHR: www.nccrcd.nhs.uk/natclnsciencescheme/index_html

Medical Research Council:

www.mrc.ac.uk/Ourresearch/Resourceservices/RCaH/Opportunities/index.htm

Cancer Research UK: www.cancerresearchuk.org

Leukaemia Research UK: www.lrf.org.uk

Wellcome Trust: www.wellcome.ac.uk

The Health Foundation: www.health.org.uk

GlaxoSmithKline: www.gsk.com

Institute of Child Health: www.ich.ucl.ac.uk

Arthritis Research Campaign: www.arc.org.uk

British Heart Foundation: www.bhf.org.uk

National Kidney Research Fund: www.kidneyresearchuk.org

Thrombosis Research Institute: www.tri-london.ac.uk

Out of programme experience (research)

Doctors that are interested in pursuing academic research but do not want to compete for, or are unsuccessful in securing, an integrated programme may apply to take time out of their clinical training. Such periods can be very valuable. Trainees may discover an emerging significant interest in academia and many find a break from the routine of clinical work invigorating. Regardless of whether undertaking a period of research leads to a career in medical academia, completing a period of research and being able to translate the skills gained to the clinical environment can enhance a clinical curriculum vitae.

All applications to undertake out of programme research (OOPR) must be agreed by the postgraduate dean. Unlike integrated programmes, trainees undertaking OOPR are not allocated an academic NTN(A). However, if an application is successful and agreed to by the postgraduate dean, the trainee retains their NTN for the duration of the research and their re-entry into clinical training, subject to annual review. The *Gold guide* to specialty training outlines the requirements for OOPR (see pages 160-2).

Trainees should seek a contract with the NHS for the period of OOPR to maintain continuity of employment. See pay progression on return to the NHS on page 115.

Usually OOPR is only granted for trainees who wish to pursue a registered higher degree (eg MRes, MD or PhD) and normally only once they are in possession of an NTN or NTN(A). The duration permitted will not usually exceed three years. Applications for OOPR will not normally be accepted from trainees in their final year of training.

It is also possible for trainees to defer the start of run-through clinical training if they have either:

- been accepted onto a higher degree programme at the time of being offered their clinical placement; or
- are already undertaking research towards a registered degree when their clinical placement is due to start.

Trainees who are required to compete for entry into specialties at ST3 or ST4 and who hope to take time out of clinical training are advised to secure their specialty placement first. If a trainee has successfully competed for a grant and has a desire to pursue academic research, it is advised that they engage with the ST3 (or ST4) recruitment process. This gives an individual the option of rejecting an unsatisfactory placement offer, taking up their research post and then reapplying in subsequent years through open competition. In this case though, trainees need to be aware that they would lose their NTN until they are accepted back into specialty training.

The PMETB will recognise research as contributing to the award of a CCT where it is relevant and appropriate to the curriculum in question. The medical royal colleges and faculties are responsible for determining whether research sufficiently contributes to training and whether it has been satisfactorily completed in their recommendations to the PMETB regarding the award of the CCT. It should be noted, however, that the Tooke Report recommended that PMETB merge with the GMC, a recommendation that the Government accepted. At the time of writing, how this was to be done was being discussed by the two organisations. A consequence of this change may be that some of the functions of PMETB, such as the award of CCTs, will be handled differently in future.

Where there is prospective approval from the faculties/royal colleges that OOPR can count towards a CCT, formal assessment documentation must be submitted annually to the review panel along with the relevant section of the OOP document. If a trainee retains a clinical element whilst carrying out research, the extent of this will

guide decisions on whether time spent on OOPR can count towards a CCT. As such it is advised that those considering OOPR discuss the proposed amount of clinical exposure with their training programme directors.

For trainees undertaking OOPR, the research programme will have been outlined in the documentation supplied as part of the initial application to the postgraduate dean. Formal assessment and monitoring then follows a similar structure to integrated training programmes. Similar documentation and evidence should be provided to the Annual Review of Competence Progression (ARCP) panel along with a report from the academic supervisor. The panel will then award an out of programme outcome recommending either the continuation of the OOPR or its termination.



Information

MMC – *A reference guide for postgraduate specialty training in the UK 2008* (The 'Gold guide'): www.mmc.nhs.uk/default.aspx?page=457

Examples of OOPR opportunities

Medical Research Council – Clinical Research Training Fellowship Scheme

These can be awarded for a minimum of two years and maximum of three years and are designed to accommodate up to 20 per cent continuing NHS clinical work. These are aimed at those at pre-doctoral level and those taking up these posts are required to register for a research degree, normally at PhD, based on research undertaken during the fellowship.



Information

www.mrc.ac.uk/Fundingopportunities/Fellowships/Clinicalresearchtraining/index.htm#P20_1174

Wellcome Trust – Clinical PhD Programme

There are seven of these programmes in the UK. The aim of the programme is to provide structured research training in basic laboratory sciences for those who have completed foundation programme training

and who wish to pursue a career in academic medicine. Those undertaking the programme are expected to register for a PhD with the university.



Information

www.wellcome.ac.uk/Funding/Biomedical-science/Grants/PhD-programmes-and-studentships/WTD037337.ht

Academic and clinical progression

The progress of all trainees who undertake postgraduate specialty training is formally assessed through the Annual Review of Competence Progression (ARCP) which reviews evidence both for a trainee's progression and the appropriateness of their clinical and academic training programmes. Progress in postgraduate medical training is judged against the specific standards of knowledge, skills and behaviours set out in the postgraduate curriculum for the relevant specialty.

The assessment structure is competency-based and has three key elements: appraisal, assessment and work planning. Although separate processes, together they contribute to the ARCP and on the basis of the evidence provided, the ARCP panel will award an outcome for the progress achieved on the following scale.

- (1) – Progress has been achieved and an individual has developed the competencies expected
- (2-4) – A trainee's level of progression is lacking or insufficiently evidenced to varying degrees
- (5) – Incomplete evidence has been submitted to the panel and they are unable to make a judgement

Each trainee will be formally assigned a separate educational supervisor for the clinical and academic components of the training. On the clinical side, the supervisor is responsible for the educational and work-based appraisals and is there to provide feedback on performance and assistance in career progression for the trainee outside of the formal assessment structure. Full details regarding the monitoring of clinical progress and the roles and responsibilities of both trainee and supervisor

are set out in the MMC's *Reference guide for postgraduate specialty training* in the UK, known as the 'Gold Guide'.

An academic supervisor will work with the trainee to identify generic and specific goals for the academic programme and will monitor their progress in achieving key competencies. Academic progress is assessed across three generic domains.

- Generic and applied research skills – eg grant applications, developing research proposals
- Research governance – eg clinical trials legislation, research ethics, human tissue storage
- Communication/education – eg writing skills, verbal presentation skills, teaching skills

The academic supervisor will determine which aspects of each are relevant to the individual trainee and develop a suitable training programme and personal development plan (PDP) around these. The PDP will outline the key objectives for academic trainees against which their progress will be judged. In addition it is recommended that trainees should seek to take part in and provide evidence of research and teaching activities where appropriate. These can be identified in advance by the supervisor and the trainee and laid out in PDPs. These can include: presentations at research meetings, grant or fellowship applications, delivering lectures or seminars, and publishing a peer-reviewed article. Other evidence which can be listed and created for submission to the ARCP panel includes log and case books, reports from colleagues and training programme directors and any examination results or certificates for courses attended.

For English trainees

For ACFs, academic supervisors will plan the training programme to incorporate the basic skills required for trainees to secure a research training fellowship or educational training programme. These are: the development of skills to define a research question in the first year and those to develop a research proposal in the second year of the ACF. The ARCP will judge the progress of an individual specifically against these

two objectives. Similarly, for CLs the training programme should be built around the attainment of the specific skills and attributes expected of academics with higher degrees. As such, individuals would be expected to develop a publication record during their appointment and demonstrate their ability to supervise and teach. Again the ARCP will judge the progress of a Clinical Lecturer against these criteria.

For Scottish trainees

NHS Education for Scotland is currently adapting the guidance from the Academy of Medical Sciences *Supplementary guidelines for the ARCP for speciality registrars undertaking joint clinical and academic training programmes* to ensure that this it is applicable to Scotland.



Information

MMC – A reference guide for postgraduate speciality training in the UK 2008 (The ‘Gold guide’):
www.mmc.nhs.uk/default.aspx?page=457

Academy of Medical Sciences – Guidelines for monitoring academic training and progress (2007):
www.acmedsci.ac.uk/index.php?pid=99&puid=110

Specialist and GP registers

All doctors must be registered with the GMC before they can work in the UK.

To take up an NHS consultant post in a medical or surgical speciality (other than a locum consultant appointment) or a GP post, doctors must apply to the GMC’s specialist register or general practice register respectively. Although not a legal requirement, doctors wishing to work, unsupervised, in private hospital practice in the UK will also, generally, need to hold specialist registration.

Being on the specialist register indicates that a doctor has completed specialist training to the satisfaction of the Postgraduate Medical Education and Training Board (PMETB), which has an important role ensuring that doctors are qualified and certified to apply for the specialist or GP register.

There are various routes to the specialist and GP registers.

- Option 1 – for doctors who have completed a full PMETB approved training programme. These doctors are eligible to apply for a Certificate of Completion of Training (CCT) or GPCCT.
- Option 2 – open to doctors who have not followed a full PMETB approved training programme and wish to have their training, qualifications and experience assessed for eligibility for entry to the specialist or GP register.

Doctors who have not followed a full approved training programme are eligible to apply for a Certificate of Eligibility for General Practice Registration (CEGPR) or a Certificate confirming Eligibility for Specialist Registration (CESR). Set out under Articles 11 and 14 respectively of *The general and specialist medical practice order*, CEGPR and CESR assess applications from doctors who have not followed a traditional training programme but who may have gained the same level of skills and knowledge as CCT holders.

This may apply to doctors working in academic medicine or those who have undertaken training outside the United Kingdom in a specialty not recognised by the current arrangements under PMETB. It should be noted that PMETB is due to merge with the GMC and that this may affect how certain PMETB functions are handled in future.



Information

PMETB provides separate guidance and application forms for those in academic medicine:
www.pmetb.org.uk/index.php?id=407

Frequently asked questions (FAQs) about CESR/Article 14 applications and the specialist register: www.pmetb.org.uk/index.php?id=cesrfaq0&textsize=#c1031

BMA guidance on PMETB:

www.bma.org.uk/careers/training_trainers/postgraduate/PMETBguidance.jsp

The general and specialist medical practice order:

www.opsi.gov.uk/SI/si2003/20031250.htm

Further information on registration:

www.bma.org.uk/ap.nsf/Content/checkingdocreg

Supervisors

For all research projects, but particularly for PhD studies, the role of the more senior member of the academic community who is your supervisor is critical. Thus the choice of a supervisor is one of the key steps.

The compatibility of student and supervisor is very important: although the supervisor is not a mentor at this stage, the best supervisors are those who emerge as 'natural' mentors after you complete the PhD process.

The primary responsibility of a supervisor is to ensure that you undertake a project which contributes to knowledge, and that you complete it and present it as a thesis. As part of this process the supervisor has a duty to report on your progress regularly to the University. Detailed arrangements vary from place to place, but good supervisors will support your creativity at the same time as having a practical approach as to how to deliver.

At a practical level, after the joint selection process has taken place, in most places the supervisor is expected to:

- introduce and induct you into the place where you are doing your research, and introduce you to your colleagues
- ensure that you have access to all the facilities of the institution, both general (eg libraries, information technology) and those that are needed specifically for your project
- ensure that all issues about liability, risk assessment, ethics, and intellectual property rights have been discussed and fully resolved in advance
- ensure that you have the opportunity to attend any taught or training courses necessary for your research
- establish the framework for regular meetings and discussions
- contribute constructively to your progress, helping to refine objectives in view of practical issues as well as of new developments in publications from other groups

- provide you with prompt comments on any written material
- encourage you to present and publish your research
- be responsible for ensuring the smooth administrative running of your project, from the initial registration phase, to the upgrading from MPhil to PhD, leading to the appointment of examiners and arrangements for thesis submission and examination.

The supervisor will have a multitude of other tasks and responsibilities, and a tight timetable. Thus it is best to define the student and supervisor expectations clearly, and for both parties to decide upon and meet deadlines. Mutual expectations are important, and perhaps the key shared objective is that both parties have an investment in joint publications in peer-reviewed journals.



Information

Vitae: www.vitae.ac.uk/

Mentoring

Most academics, if asked how they became established, will pay tribute to a key person who supported and encouraged their ambitions at an early stage in their career. Given the long duration of academic training and its coupling with higher specialist training, early career medical academics particularly need support in developing a career. Also mentoring is not only beneficial to those at the start of their career and many academics find that they benefit from mentoring at different stages of their careers.

Until recently, supervisors were the major source of career support and planning. However, in recent years, mentoring has become an important issue on the medical education agenda and organisations such as the Academy of Medical Sciences (see below) have developed formal schemes for adding value to academic training through mentorship. Unlike a supervisor, a mentor is not involved in the management or content of the trainee's research and does not provide references or collaborate in research. Instead, he or she encourages the mentee to explore research and career options, and

advises on access to other sources of information, whether people or networks.

Although good supervisors can and should fulfil these roles, a key benefit of the mentor-mentee relationship is that it allows reflection on priorities in a confidential context that is separate from the working relationship. A mentor can also offer support in areas such as managing work/life balance and identifying short and long-term goals in medicine or other spheres of life. This allows the trainee to put aside everyday priorities, potential conflicts of interest and hidden agendas, and enables him or her to focus on major issues of wider academic development. This process can both enhance the relationship with the supervisor, and help the trainee to move beyond it. Mentoring has been found to improve motivation and job satisfaction and can also have a positive impact at an organisational level.

For a mentoring relationship to be of maximum benefit, it is important that clear expectations are set in terms of frequency of meetings, and the role of the mentoring relationship. Both parties need to take time to prepare for meetings, and to make reflective notes which can be reviewed later on. Mentoring schemes should be as flexible as possible and should allow either party to seek an alternative partner should they feel the mentoring relationship is not working.

Notable schemes include:

Academy of Medical Sciences (AMS)

The Academy set up a mentoring scheme in collaboration with the Department of Health in 2002 to support the National Clinician Scientist Awards Scheme (see page 155). The programme is now available to all researchers with a higher degree (PhD or MD) who are on a funded fellowship or project grant and are looking to become a research-based clinical academic. This scheme is currently only available to those working in England but there are moves to ensure funding to extend it to those working in Scotland.

The AMS also runs an outreach programme aimed at helping researchers find mentors and to use them effectively, both through formal and informal routes and this is aimed at pre-doctoral trainees, such as the academic clinical fellows, clinical training fellows, academic foundation fellows and MB PhD students.

NHS London Deanery

The deanery provides a very useful resource on mentoring, which includes information for the mentor and mentee, as well as resources and further information, including FAQs. It also discusses the skills necessary for mentoring and the associated benefits.



Information

Academy of Medical Sciences:
www.acmedsci.ac.uk/p55.html

Department of Health guidance:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089395

London Deanery website on mentoring:
<http://mentoring.londondeanery.ac.uk/>

BMA (2004) *Exploring mentoring*. London: BMA.:
www.bma.org.uk/ap.nsf/Content/Mentoring?OpenDocument&Highlight=2,mentoring

South West Peninsula Deanery on mentoring:
www.peninsuladeanery.nhs.uk/index.php?option=com_content&task=view&id=178&Itemid=295

Northern Deanery on mentoring:
<http://mypimd.ncl.ac.uk/PIMDDev/news/mentoring-in-the-northern-deanery/>

Research governance

What is research governance?

Research governance is the set of regulations and principles which aims to uphold the standards of good practice across all aspects of healthcare research. Healthcare research in this context can consist of any form of research which involves humans, their tissue or medical data. Research governance applies to all those who host, conduct, participate in, fund and manage health and social care research whether medically qualified or not.

The aim is to maintain consistent high-quality research by ensuring that it is conducted to a high methodological standard, meets the legal obligations which apply, and thereby prevents bad practice and misconduct. Adherence to its basic principles ensures that the rights of any human participants are protected and that findings are published openly and honestly with any unexpected or adverse results reported immediately. Subsequently, the research will be seen to meet local, national and international ethical approval.

Its fundamental principles are derived from Good Clinical Practice (GCP) an international ethical and scientific quality standard set out by the Tripartite International Conference on Harmonisation (ICH) and made law in the UK under the Medicines for Human Use (Clinical Trials) Regulations 2004. These regulations, in conjunction with The Human Tissue Act 2004 and the Mental Capacity Act 2005, form the legal obligations applicable to all clinical research which takes place in the UK.

The Department of Health Research Governance Framework

The Research Governance Framework for Health and Social Care (RGF) was originally published in 2001 and is now in its second edition. Although not law itself, it incorporates the key legislation listed above and sets out the core requirements and standards with which all research (clinical and non-clinical) relating to the responsibilities of the Secretary of State for Health must comply. This includes any research which is associated with or conducted on behalf of the Department of Health, the NHS or social care agencies

and any research which is concerned with the protection and promotion of public health. Equivalent frameworks are in place for Scotland, Wales and Northern Ireland.

The RGF is broad in scope and applicable to all healthcare sectors: primary, secondary, tertiary, social and public. It exists to safeguard the rights of participants while protecting all those undertaking research by providing clear guidance on all elements of research practice, thereby aiming to minimise risk and enhance the ethical and scientific quality of clinical research.

The RGF lays out the specific responsibilities of all those associated with research, from the chief investigator and research team members through to those funding and/or sponsoring the research, along with the core standards and the mechanisms by which these can be realised. The core standards it describes cover five domains.

- Ethics (use of human tissue, informed consent, animal rights etc)
- Science (awareness of existing research, approval of regulatory bodies etc)
- Information (accessibility of information for participants, beneficiaries and critical review etc)
- Health and safety (prioritisation of the safety of participants and staff, Control of Substances Hazardous to Health (COSHH) appraisals etc)
- Financial and intellectual property (transparency and accountability of the use of public funds etc)

Universities and funding bodies

Universities, university associations (eg the Russell Group) and funding bodies (eg Medical Research Council) set out their own guidance in relation to research governance and good research practice. Universities have dedicated committees for both ethics and/or research governance which ensure compliance with the legislative standards and with the RGF where applicable. Many universities and NHS organisations run good clinical practice in records training workshops.

Procedure for investigating misconduct in research

In August 2008 the UK Research Integrity Office (UKRIO), which is hosted by Universities UK, published guidance on their Procedure for Investigating Allegations of Misconduct in Research. This is aimed at all research organisations, where funds come from Research Councils and Government bodies, charities, overseas funding bodies and the commercial sector.

It sets out the investigation process in full, providing information and a standardised protocol to ensure that investigations are carried out thoroughly and fairly. The procedure also contains a clear definition of what is misconduct in research. The guidance draws on best practice in UK universities and as such institutions will also have their own policies for dealing with research misconduct.

There is also a programme of education and training to accompany the procedure for managers, administrators and other research staff involved in investigating research misconduct or promoting good practice. Check the UKRIO website for course information.

Patient records

Patient records are a unique resource that can help researchers improve their understanding and improve patient care. There is however considerable uncertainty about the processes that should be used when information from patient records is required for research. To assist with this the Wellcome Trust has produced guidance, developed with the assistance on the BMA and other organisations. The Trust describes it as 'the first step in a process to ensure that patients and GPs have confidence in the processes used to access patient information.' The guidance emphasises 'the overriding importance of safeguarding patient confidentiality and privacy and the need to clearly define the processes and procedures for the use of data'.



Information

Department of Health Research Governance Framework (second edition):

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108962

Research Governance Framework for Scotland:

www.show.scot.nhs.uk/cso/Publications/ResGov/Framework/RGFEdTwo.pdf

Research Governance Framework for Wales. The 2001 version is currently being updated by the Department of Health and a link to the new edition will appear here:

www.dh.gov.uk/en/Researchanddevelopment/A-Z/Researchgovernance/DH_4002112

Research Governance Framework for Northern Ireland:

www.dh.gov.uk/en/Researchanddevelopment/A-Z/Researchgovernance/DH_4002112?

UK Research Integrity Office: www.ukrio.org

PDF: [www.ukrio.org/resources/UKRIO%20Procedure%20for%20the%20Investigation%20of%](http://www.ukrio.org/resources/UKRIO%20Procedure%20for%20the%20Investigation%20of%20)

The Wellcome Trust:

www.wellcome.ac.uk

What to do if things go wrong

Just like NHS clinicians, individual clinical academics may be affected by service reconfiguration, changing strategic priorities of their institution or many other issues. This can be very unsettling and potentially damaging for their career. In such instances the BMA can provide advice, support, and legal advice and representation if necessary and appropriate. If any BMA member needs such advice, they should in the first instance contact *askBMA* who will put them in contact with an industrial relations officer (IRO) to discuss their options in detail. In addition, it may be useful to take stock by taking informal advice from colleagues outside the institution. The IRO will keep an individual doctor's circumstances entirely confidential. However, once alerted, the BMA can also provide more general support and organise meetings through different routes, eg LNCs, MSCs and central BMA MASC.

In the event of large-scale changes, such as closure of a department or service reconfiguration, IROs will work with other trade union representatives whose members are affected to generate with the employer a 'package' for staff who may become redundant. The IRO can accompany staff to meetings with employers (often colleagues) and assist in drafting documents, letters etc that staff may wish or be

required to write. Where there is a dispute between staff and the employer and legal action is contemplated, the BMA (like many other organisations and trade unions) will usually only consider support if the likelihood of winning is judged by legal advisers to be greater than fifty percent. Before the BMA will support the case the 'package' for staff made redundant will often have been discussed with NHS managers and colleagues in case there is the opportunity for staff to move to the NHS. For this a formal appointments process may be required.

The BMA has advisors who support staff during this process. A number of methods to mitigate these activities are available:

- contact askBMA
- compare information with other staff
- ask for information and attend/organise meetings
- have a personal email and avoid using institutional email systems for personal use
- keep copies of all relevant documentation
- take care to comply with all governance issues.

Bullying and harassment

A questionnaire survey by Stebbing et al about bullying (*Postgraduate Medical Journal*, 2004), of 259 doctors undertaking research found that 112 (43%) had experienced bullying, 194 (75%) felt isolated and 150 (58%) felt overworked. Over two thirds of the sample were men.

Feedback from all grades of staff suggests that bullying and harassment are quite common, but may not be recognised at an individual level either by the perpetrator or by the victim. Where one particular staff member is behaving in a manner considered by others to be bullying and harassing, this requires documenting and then action taken by a line manager.

There are times when the bully is unaware of their behaviour. A 360° appraisal or multi-source feedback may reveal this and generate immediate change. The bully may not be a doctor but another healthcare worker so an employer should have a robust reporting system.

Bullying can also lead to stress, poor health, poor decision making and low morale. It can lead to feelings of unworthiness, low esteem and lack of empowerment and the victim may rationalise the situation to be of their own making. It may, therefore, be useful to discuss what has happened with supportive colleagues. It also has financial effects through time off work, sick leave and even doctors leaving medicine to avoid the culture. The BMA has an Equal Opportunities Committee that investigates conditions at work and the BMA's doctor adviser service and BMA Counselling can provide support. Many NHS organisations also have similar support for staff and an occupational health service may provide consultations. To aid discussions you may want to consider questions such as:

- how has a person made you feel?
- have you experienced a threat to your personal status?
- have you experienced a threat to your professional status?
- do you feel isolated?
- do you feel overworked?
- do you feel supported?

When choosing a post it may be helpful to ask previous incumbents how they were treated as well as consult the MASC *University employment good practice guide* on issues of gender balance and ethnicity of staff.



Information

Also see *Redundancy* – page 104

BMA Counselling (08459 200 169)

www.bma.org.uk/doctors_health/index.jsp

BMA (2008) *University employment good practice guide*. London: BMA.:

www.bma.org.uk/employmentandcontracts/employmentcontracts/UniversityEmploymentGuide2008.jsp?page=1

BMA (2006) *Bullying and harassment of doctors in the workplace report*. London: BMA.:

www.bma.org.uk/ap.nsf/content/bullying2006

BMA Equal Opportunities Committee:

www.bma.org.uk/representation/pro_committees/equal_opportunities_committee/index.jsp

BMA Doctors for Doctors Unit:

www.bma.org.uk/doctors_health/index.jsp and on 08459 200 169

HR policies in force in each UK university

Terms and conditions may vary from institution to institution. This is because HEIs are incorporated under individual statutes, which governs their operations. Older universities have freedoms granted under Royal Charter and others operate under Acts of Parliament such as the *Higher and Further Education Amendment Act 2002*.

With universities in the UK operating their own HR policies as a result, the BMA Medical Academic Staff Committee has created the *University employment good practice guide* as a service to clinical academics.

The document aims to provide a clear guide to the employment environment in UK medical schools and contains a wealth of information. This includes key facts on each medical school, detailed statistics on the staff breakdown and in-depth information on employment terms and conditions, such as honorary contracts, leave and pay arrangements, mentoring provision and interaction with the NHS.

Furthermore the guide provides information about good employment practice, allowing each of the HEIs to promote areas of excellence. These include teaching and research, staff development, facilities and training.



Information

University Employment Good Practice Guide

www.bma.org.uk/ap.nsf/Content/UniversityEmploymentGuide2008?OpenDocument&Highlight=2,good,university,guid

Appendix 1

Sources of research funding

Association of Medical Research Charities (AMRC)

Although the AMRC does not undertake any medical research, it plays a key role in representing the interests of charities involved in medical research. Medical research charities fund a large proportion of health research undertaken in UK universities. A wide range of medical charities support medical research in the UK, from dedicated research institutions to smaller external research teams. Details of the AMRC member charities and the research funding available can be found at:

AMRC homepage: www.amrc.org.uk/homepage/

The AMRC website also provides a searchable directory of its members with information on available funding schemes:

AMRC member directory:

www.amrc.org.uk/homepage/Default.aspx?Nav=479,536

Biotechnology and Biological Services Research Council (BBSRC)

The BBSRC offers a number of different collaborative research and research training schemes: www.bbsrc.ac.uk/business/collaborative_research/index.html

The Industry Fellowship Scheme (a collaboration between the BBSRC, the Royal Society, the Engineering and Physical Sciences Research Council, Rolls Royce and AstraZeneca) offers academics the opportunity to work in industry:

www.bbsrc.ac.uk/business/people_information/industry_fellowship_scheme.html

Industrial Partnership Awards:

www.bbsrc.ac.uk/business/collaborative_research/industrial_partnership_awards.html

British Medical Association (BMA)

The BMA offers a range of grants for medical research through the Association's Board of Science. These are awarded for prospective or current research and the funding is available for up to three years.

Applying

A list of grants is published in January each year, both in the *British Medical Journal (BMJ)* and on the BMA website. The deadline for applications is in March. Successful applicants will be notified by June and funding will be available from September onwards.

Eligibility

Funding is not normally granted solely to cover travelling expenses, and funding for computer hardware, training courses and further education is also excluded. However, grants may be used to cover salary costs.

Further information, FAQs and details of grants which have been available in previous years can be found at the following link:

www.bma.org.uk/ap.nsf/Content/HubAwardsAndGrants

European Union

The European Commission provides funding through its Research Framework, FP7. Information on this is on the European Commission Cordis (Community Research and Development Information Service) website: <http://cordis.eu/>. This describes itself as an information space for European research and development. FP7 was introduced in 2005 and will run from 2007-13. Details on the funding of grants can be found at: <http://cordis.europa.eu/fp7/home>

An annual work programme is confirmed for each theme of the FP7 which includes a schedule of 'calls for proposals' (calls) which will be announced throughout the year. These can be found at the following link: <http://cordis.europa.eu/fp7/dc/index.cfm>

National Contact Points have also been established to help applicants access FP7 calls: http://cordis.europa.eu/fp7/ncp_en.html

Eligibility

Information on participating in FP7 can be found at:

http://cordis.europa.eu/fp7/participate_en.html

Those eligible to participate in a collaborative project include any company, university, research centre, organisation or individual from a member state, associated country or third country. It is a specification however, that applicants form a consortium which meets the minimum standards specified by the FP7 Rules for Participation, covered in the general provisions on the above web page.

Applying

After having identified a relevant call for proposal, applicants should identify partners with which they will be able to build an eligible consortium. The European Commission website, CORDIS has a search facility and further guidance on finding appropriate partners:

http://cordis.europa.eu/fp7/partners_en.html

Once an eligible consortium has been built an application can be submitted. This is done via the Electronic Proposal Submission Service (EPSS). Further details on EPSS and guidance on how to apply via this method can be found on the Preparation and Submission of Proposals (EPSS) page of: <http://cordis.europa.eu/fp7/dc/index.cfm>

Guides for applicants can also be found for each call for proposal made. These will provide detailed information regarding the call for the proposal and the application, submission and evaluation procedure for that call.

Proposals are evaluated by the European Commission with the assistance of independent external experts.

Further guidance on FP7 can be found in the BMA guide to the European seventh research framework programme at: www.bma.org.uk/careers/careers_academic_medicine

Industry

There are opportunities for academics involved in medical research to take part in collaborative work with industry. There are a number of medical charities working in collaborative schemes with industry.

The Academy of Medical Sciences document *Research careers in the biomedical sciences: promoting mobility between academia and industry* explores the benefits of collaborative work and provides some examples of the ways in which medical academics can become involved in industry. The document can be found at:

www.acmedsci.ac.uk/download.php?file=/images/page/Careersi.pdf

Below are some examples of collaborative projects with industry.

The Royal Society

Industry Fellowship Scheme which allows academics to work collaboratively with industry: <http://royalsociety.org/funding.asp?id=1125>

The Medical Research Council (MRC)

The MRC has incorporated into a number of its fellowships the opportunity for researchers to undertake a period of time carrying out research in industry: www.mrc.ac.uk/Fundingopportunities/index.htm

Association of British Pharmaceutical Industry (ABPI)

The ABPI is the trade association for pharmaceutical companies in the UK and also represents companies involved in the research and development of medicines for human use. Details of members can be found at: www.abpi.org.uk/links/Members/full_members.asp

Medical Research Council (MRC)

The MRC funds research through a range of different grant schemes. Researchers can apply to a scheme best suited to their research and funding needs. The MRC has produced an *Applicants handbook* which provides comprehensive guidance on the application process, including who is eligible to apply, how to apply and preparing a case for financial support. The handbook can be found in the funding opportunities

section of the MRC website: www.mrc.ac.uk/ApplyingforaGrant/ApplicantsHandbook/index.htm

THE MRC funds a number of grants. These include collaboration grants; the Developmental Pathway Funding Scheme and the New Investigator Research Grant. It also awards programme grants, providing renewable funding over a longer period of time, and research grants, the most widely used grant within the university and NHS sectors. Applications are assessed initially through a triage system carried out by independent expert reviewers and then by the MRC research boards/panels against a set of core criteria.

NIHR Trainees Coordinating Centre (NIHRTCC)

The NIHRTCC offers funding for research through its National Institute for Health Research (NIHR) Research Fellowship Scheme. Funds are for salary costs and secondarily for contributions to the cost of research.

Eligibility

Applicants should be employed by an English institution and involved in scientific work with the aim of improving health or healthcare services. The research for which the funding is required should also have clear outcomes, which would be of benefit to health and healthcare services within five years of the completion of the research project. Funding will not be made available to cover research involving animals and/or animal tissues.

Applying

The NIHRTCC has produced comprehensive guidance notes for those wishing to apply for any of their funding schemes. Further information on the four stages of the fellowship and application forms can be found at: www.nihrtcc.nhs.uk/nihrfellow/

For devolved nations applicants, please see:

www.nccrcd.nhs.uk/nihrfellow/informationforprospectiveapplicantsfromdevolvedcountries

NIHR funding streams

There are a number of funding streams covering a wide range of different projects. These include Research for Patient Benefit, Invention for Innovation Research Programme, Research for Innovation, Speculation and Creativity (RISC) Programme, Health Technology Assessment Programme, Public Health, Research Methods, Service Delivery and Organisation which either put out calls or accept new ideas. Check out the information on their website: www.nihr.ac.uk/programmes_research_programmes.aspx

Wellcome Trust

Funds biomedical, scientific and technological research which aims to 'protect and improve human and animal health'.

Eligibility

Individuals at all stages of their career who currently work in a research institution or HEI in the UK, the Republic of Ireland or a developing country are eligible to apply for research funding from the Wellcome Trust. In some instances eligibility can vary and applicants should check the details of the scheme they are considering.

Applying

Throughout 2008 all applications for research funding should be made via the Wellcome Trust 'e-grant' system; an online application service. A new application system is currently in development and potential applicants should monitor the Wellcome Trust website for further information and updates.

Full details of the funding offered by the Wellcome Trust and the application process can be found at:

www.wellcome.ac.uk/Funding/index.htm

The Wellcome Trust and the Academy of Medical Sciences (AMS) have developed a joint funding programme for clinical lecturers which will run for four years: starter grants will provide funds for clinical lecturers involved in research to prepare for applications for long-term funding schemes.

The grant can be used to cover both current and new research costs, although it cannot be used to cover salary costs or staffing costs. Applicants are invited to apply for a sum of up to £30,000 which is available over a period of two years.

Eligibility

Clinicians who have an MD or PhD and who currently hold a clinical lecturer post in which they are/will be undertaking research for at least half their working time.

Applying

Information on applications can be found at:
www.acmedsci.ac.uk/p176.html

Other sources of research funding

For a list of other sources of research funding including BUPA and the UK research office please go to www.bma.org.uk/researchgrants

Appendix 2

Organisations relevant to academic medicine

Academy of Medical Educators

Web: www.medicaleducators.org

The Academy of Medical Educators is the professional standard setting organisation for medical educators in the United Kingdom. Established in 2006, it brings together educators from all professions who are involved in teaching medical students or doctors. It covers all stages of medical education from undergraduate through postgraduate medical education to continuing professional development. It looks to provide leadership, promote standards and support all those involved in the academic discipline of medical education.

Membership is open to clinical and non-clinical individuals regardless of their professional background or subject discipline. It aims to provide a registered qualification to members through a process of accreditation to an agreed national standard.

Academy of Medical Royal Colleges

Web: www.aomrc.org.uk

The Academy was set up in 1974 as The Conference of Royal Colleges and Faculties and now has 21 permanent members drawn from the medical royal colleges. It has a role in the areas of doctors' revalidation, training and education. There are also a number of subcommittees, which look at issues such as education, postgraduate education and continuing professional development.

Academy of Medical Sciences

Web: www.acmedsci.ac.uk

Set up in 1999, the Academy of Medical Sciences promotes internationally competitive medical science in the UK and campaigns to ensure these are translated into healthcare benefits for society.

Furthermore it looks to engage with the public about medical science and to support those working in biomedical science.

The Academy runs a number of initiatives for medical academics. The National Clinician Scientist Award Scheme supports a number of research-led clinical academics with funding opportunities, access to academic mentorship and flexible academic career development together with clinical specialist training. The Clinical Research Champions scheme (in collaboration with the Medical Research Society), teams up younger doctors with senior clinical academics, to promote the academic medicine pathway as an attractive career route. The Academy's Mentoring Scheme supports 'mentees' with their personal and professional development through independent mentors. This service is available to all young researchers with a higher degree (PhD or MD) who are on a funded fellowship or project grant with the intention of becoming a research-based clinical academic.

Association for the Study of Medical Education

Web: www.asme.org.uk

The Association for the Study of Medical Education (ASME) is a forum for debate and exchange of information. It looks to promote knowledge and expertise in medical education. It is a membership organisation, made up of doctors, health professionals and medical educators from all specialties and levels. Members receive the monthly journal *Medical Education* and the quarterly journal *The Clinical Teacher*, regular mailings and news updates from the Association. ASME also supports grants and fellowship schemes, details of which can be found on the website.

Association of Medical Research Charities (AMRC)

Web: www.amrc.org.uk/homepage/

AMRC is a membership organisation of medical and health research charities in the UK. The Association works with member charities and partners to support the sector's effectiveness and advance medical research by developing best practice, providing information and

guidance, improving public dialogue about research and science, and influencing government. AMRC was established in 1987 and has 114 member charities.

Biotechnology and Biological Sciences Research Council (BBSRC)

Web: www.bbsrc.ac.uk

Funded by the Department for Business, Innovation and Skills, the BBSRC is one of seven Research Councils that work together as Research Councils UK. With a budget of £400 million, the BBSRC supports approximately 1,600 scientists and 2,000 research students in universities and institutes in the UK working on high-quality basic, strategic and applied research. The Council also supports postgraduate training relating to the understanding and exploitation of biological systems. Areas funded include biochemistry, cell biology and biomolecular sciences; there are also opportunities for new investigators, longer and larger grants (LoLas), and multidisciplinary research. Full details can be found on their website.

Department of Education and Learning, Northern Ireland

Web: www.delni.gov.uk

In Northern Ireland, because of the relatively small size of the sector, the Department for Employment and Learning not only has responsibility for policy and for securing funding but also stands in place of a funding council, disbursing funds directly to institutions.

Department of Health National Coordinating Centre for Research Capacity and Development (NCCRD)

Web: www.nccrd.nhs.uk

The Centre manages several programmes that fall under the National Institute for Health Research umbrella.

The Research Capacity Development Programme makes research awards to individuals who show the potential to become research leaders and where research is patient-focused and relevant to the NHS.

The NIHR Fellowship Scheme has replaced the previous Personal Awards Scheme (PAS) and provides flexibility and continuity between different levels of award. Four levels of Fellowship are available on an annual basis. Fellowships are designed primarily to buy out salary costs with a contribution to research costs.

The centre manages the Academic Clinical Fellowship and Clinical Lectureship phases of the Integrated Academic Pathway, as recommended by the Walport Report.

The NIHR Clinician Scientist Award is open to individuals in medicine and dentistry and looks to support a group of research-led clinical academics capable of leading research in their discipline by providing up to five years' postdoctoral training.

Higher Education Funding Council for England (HEFCE)

Web: www.hefce.ac.uk/

Set up in 1992, HEFCE is a non-departmental public body and distributes public money to universities and colleges in England that provide higher education. Funding supports the 130 universities and higher education colleges in England and higher education courses in 124 directly-funded further education colleges.

Higher Education Funding Council for Wales (HEFCW)

Web: www.hefcw.ac.uk/

HEFCW, which was set up in May 1992, is responsible for distributing public funds, set by Welsh Assembly Government budgets, for higher education in Wales. Its aim is to promote internationally excellent higher education in Wales for the benefit of individuals, society and the economy in Wales and more widely.

The Leadership Foundation for Higher Education

Web: www.lfhe.ac.uk

The Leadership Foundation has been set up by Universities UK (see below) to develop and improve the key skills of Higher Education leaders. Through a number of events, programmes and networking forums, LFHE offers support and advice on leadership, governance and management. Institutional membership of the Foundation is open to higher education institutions and related organisations and benefits include access to grant and investment schemes.

Medical Research Council (MRC)

Web: www.mrc.ac.uk

Established in 1913 the Medical Research Council (MRC) is a publicly-funded organisation dedicated to improving human health. By providing grants, training and research facilities, the Council supports research in all areas of medical sciences in the UK and Africa. In 2006/07, the Council spent £537 million on these activities. There are five MRC Research Boards responsible for deciding which scientific proposals the MRC funds, while a Training and Development Board distributes funding for training scientists.

Approximately 3,300 researchers are supported by MRC-funded programmes in universities and hospitals and the grants available are numerous in their range and scope: they include awards for collaborative and trial research, grants for new investigator research, work with industry and for translational stem cell research. Full details and information on how to apply are comprehensively listed on the Council's website.

Medical Women's Federation

Web: www.medicalwomensfederation.org.uk

Established in 1917, the Medical Women's Federation was set up to represent all medical women and their interests. Current issues include

concerns over workforce planning and flexibility, as well as the lack of opportunity for part time work and financial constraints. A membership organisation, the MWF is represented on major national committees and provides regular communications, local support networks for members and also holds national meetings twice a year.

National Institute for Health Research (NIHR)

Web: www.nihr.ac.uk

As part of the Government's strategy for Research and Development the NIHR was set up in 2006 to oversee the direction for publicly funded health research in England. The NIHR ensures that public research money follows activity and, as such, grant proposals must qualify for inclusion in the NIHR portfolio of programmes (designed to benefit patients, society and the NHS). As well as focused research and work to improve systems and infrastructure in UK research, the Institute has established the NIHR Faculty. This supports those individuals carrying out and participating in research and employed by the NHS or by a university.

Postgraduate deaneries

Web: www.copmed.org.uk

Training for doctors who have completed their pre-registration year is coordinated and delivered through the local postgraduate deanery. There are 22 deaneries throughout the United Kingdom and details of these can be obtained from the Conference of Postgraduate Medical Deans via their website.

Local deaneries provide a range of information and advice on: the availability of training opportunities by specialty and the challenges facing each speciality. As well as general careers information, they will be able to advise on arrangements for flexible training and for overseas doctors and provide career management information. Individual deanery websites also include information about interview schedules for the first round of national recruitment to specialty/GP training, as well as local training opportunities and rotations.

Scottish Funding Council (SFC)

Web: www.sfc.ac.uk

The Scottish Funding Council was formally established in October 2005 to bring together funding and support for Scotland's colleges and universities under a single body. It funds 43 colleges and 20 higher education institutions. One of its strategic objectives is to support Scottish Universities to provide 'a high quality and internationally competitive research base'.

UK Clinical Research Collaboration (UKCRC)

Web: www.ukcrc.org

The UKCRC brings together key organisations, which include the main funding bodies, academia, NHS regulatory bodies, industry and patients, to coordinate the clinical research environment through the National Health Service more effectively and to make the UK a world leader in this field.

To achieve this, UKCRC activity is focused on five key areas:

- develop comprehensive research infrastructure in the NHS
- build expert research workforce
- develop incentives for research in the UK
- streamline regulation and governance
- develop coordinated research funding.

Universities UK

Web: www.universitiesuk.ac.uk

Universities UK is the representative body and membership organisation for the higher education sector. Working with Higher Education Wales and Universities Scotland, the organisation represents Vice Chancellors and Principals of universities and colleges of higher education. Through policy and advocacy work, Universities UK seeks to represent the interests of all 132 of its members and also to encourage and share best practice between the institutions.

University and College Employers Association (UCEA)

Web: www.ucea.ac.uk

University and College Employers Association (UCEA) provides UK higher education institutes with a framework for discussion, advice and guidance on a range of pay and employment matters. UCEA aims to be a valued representative of, and advisor to, HE employers on the delivery of excellence in HR management.

The Wellcome Trust

Web: www.wellcome.ac.uk

Founded in 1936 the Wellcome Trust is the largest charity in the UK and funds research to improve human and animal health. With an endowment of around £15 billion, the Trust spends over £600 million every year to support and promote biomedical research in the UK and abroad. Funding is awarded to research in universities and other UK academic centres in the UK and to Wellcome Trust initiatives. To promote biomedicine, the Wellcome Trust also focuses on other activities, such as conferences and courses, extensive web resources and the Wellcome Library.

For academics, the Wellcome Trust website should be noted as an excellent resource for funding advice and other professional resources. Please see *Sources of research funding* on page 175 for further details.

Appendix 3

Acronyms

AAC	Advisory Appointments Committee
ABPI	Association of the British Pharmaceutical Industry
ACCEA	Advisory Committee on Clinical Excellence Awards
AME	Academy of Medical Educators
AMRC	Association of Medical Research Charities
ARCP	Annual Review of Competency Progression
AVC	Additional Voluntary Contribution
BBSRC	Biotechnology and Biological Sciences Research Council
BDA	British Dental Association
BMA	British Medical Association
CCSC	Central Consultants and Specialists Committee (of the BMA)
CCST	Certificate of Completion of Specialist Training
CCT	Certificate of Completion of Training
CEA	Clinical Excellence Award
CEGPR	Certificate of Eligibility for General Practice Registration
CESR	Certificate of Eligibility for Specialist Registration
CHRE	Council for Healthcare Regulatory Excellence
CL	Clinical Lecturer
CLAHRC	Collaborations for Leadership in Applied Health Research and Care
CNST	Clinical Negligence Scheme for Trusts
CPD	Continuing Professional Development
DCC	Direct Clinical Care
DDRB	Doctors and Dentists Review Body
DH	Department of Health (in England)
EC	European Commission
E-CAT	Edinburgh Clinical Academic Track
EWTD	European Working Time Directive
FSAVC	Free Standing Additional Voluntary Contribution
GDC	General Dental Council
GMC	General Medical Council
GPC	General Practitioner's Committee (of the BMA)
GWC	General Whitley Council
HA	Health Authority

HC	Health Circular
HEFCE	Higher Education Funding Council for England
HEI	Higher Education Institution
HIEC	Health Innovation and Education Cluster
HMSO	Her Majesty's Stationery Office
HSC	Health Service Circular
HSE	Health and Safety Executive
HSG	Health Service Guideline
ICAS	Independent Complaints Advocacy Service
IRO	Industrial Relations Officer (BMA)
ISTC	Independent Sector Treatment Centre
JMCC	Joint Medical Consultative Council
JNC(S)	Joint Negotiating Committee (Seniors)
LAC	Local Awards Committee
LNC	Local Negotiating Committee
MAC	Medical Advisory Committee
MASC	Medical Academic Staff Committee (of the BMA)
MHO	Mental Health Officer
MRC	Medical Research Council
MSC	Medical Staff Committee
MSF	Multi-Source Feedback
MWF	Medical Women's Federation
NCAA	National Clinical Assessment Authority
NCCRD	National Coordinating Centre for Research Capacity and Development
NCSSD	National Counselling Service for Sick Doctors
NHD	Notional Half Day
NHSLA	National Health Service Litigation Authority
NHSPS	National Health Service Pension Scheme
NICE	National Institute for Clinical Excellence
NIHR	National Institute for Health Research
NIMASC	Northern Ireland Medical Academic Staff Committee (of the BMA)
NPSA	National Patient Safety Agency
OSCHR	Office for the Strategic Co-ordination of Health Research
PA	Programmed Activity

PCT	Primary Care Trust
PFI	Private Finance Initiative
PHLS	Public Health Laboratory Service
PMETB	Postgraduate Medical Education and Training Board
PPP	Personal Pension Plan
RCSC	Regional Consultants and Specialists Committee
SCREDS	Scottish Clinical Research Excellence Development Scheme
SFC	Scottish Funding Council
SHA	Strategic Health Authority
SIFT	Service Increment for Teaching
SMASC	Scottish Medical Academic Staff Committee (of the BMA)
SPA	Supporting Professional Activity
SpR	Specialist Registrar
StR	Specialty Trainee
TCS	Terms and Conditions of Service
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
UCEA	Universities and Colleges Employers Association
UCU	University and College Union
UKCRC	UK Clinical Research Collaboration
UUK	Universities UK
USS	Universities Superannuation Scheme
WMASC	Welsh Medical Academic Staff Committee (of the BMA)

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