Report of a Working Party set up by the Executive Committee of the Association of University Departments of General Practice (AUDGP).

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Introduction

Departments of General Practice and/or Primary Care have been established in all medical schools in the United Kingdom and all now have at least one professorial chair in the discipline. These departments conduct substantial programmes of research, teaching and often service development. They are frequently linked with departments of community medicine and health services research and as well as attracting substantial research grant income, provide training environments for research fellows in academic general practice and primary care. The contribution of the departments to undergraduate teaching has risen sharply in recent years, so that they teach or administer between 10%-20% of the undergraduate clinical curriculum. There is often joint working with postgraduate general practice. Many departments are involved in service development and are developing close links with Primary Care Groups and Primary Care Trusts, particularly in relation to teaching, training, continuing professional development, clinical governance and audit.

In general terms departments of general practice have prospered over the last decade. They have enjoyed a modest increase in core funding from the universities, very significant increases in research grant income and support for teaching, following the successful SIFT/ACT negotiations for which the Winyard Report paved the way. There is, however, no room for complacency; mechanisms and funding are necessary to support a stable academic career path for those who will lead research, teaching and service general practice in the 21st century, and a number of outstanding problems remain to be tackled.

Most important of these is the lack of a coherent career structure that fully takes into account the range of disciplines involved in academic general practice and primary care, the variety of routes into academic general practice or the potentially complex inter-relationships between career development and progression in undergraduate and postgraduate general practice. These problems exist against a backdrop of a general concern about the future of clinical academic medicine in the UK, the subject not only of the Richards report but of a House of Lords Select Committee and a report published in March 2000 (http://www.acmedsci.ac.uk/) by the Academy of Medical Sciences. Notwithstanding the national picture, academic general practice has been chronically disadvantaged, in terms of recruitment and retention, because of an adverse comparison with salaries and career prospects in service general practice on the one hand and, on the other, the rewards,

including distinction awards, of a successful clinical academic career. These disincentives are even more sharply focused for non-medical academics pursuing a career in departments of general practice and primary care.

The consequences of these difficulties have become apparent in the last year or two, during which it has become evident that we still do not have a well-trained cadre of senior clinical and non-medical academics ready to take on leadership positions in the discipline. Inability to fill professorial chairs, for example, is an important indicator of this deficiency. The National R&D Clinical Scientist and Researcher Development award schemes are a welcome, but necessarily partial, antidote to this problem, and although the increased funding available for primary care through the MRC/DH programme is also timely, there are real concerns about the research capacity of the discipline and the depth and strength of its research leadership.

Finally, the interaction between academic and service general practice is an important and complex area. With the setting-up of primary care groups, the expansion of undergraduate teaching, the development of PRHO posts and the general rise in administrative tasks, the ability of service general practitioners to absorb these academic tasks is close to saturation. This has created a real manpower problem, felt acutely in terms of recruitment and retention of GP teachers in some areas, and having direct consequences on Medical Schools' ability to deliver high quality teaching programmes.

For all these reasons the Executive Committee of the Association of University Departments of General Practice (AUDGP) set up a working party during 1999 to further consider careers in university departments of academic general practice and primary care; the AUDGP has already produced and circulated working papers and position papers relating to this problem, and these and other relevant documents are summarised in appendix 1 of this report.

In this paper the term 'non-medical' refers both to those who are not medically qualified eg nurses, PAMS etc and to those who are not clinically qualified eg anthropologists, sociologists, economists, researchers, statisticians.

Challenges for the future

The working party identified a number of major challenges for the future, namely to:

1. Minimise inequalities in status and career prospects between medical and non-medical academics in the departments.
2. Establish and support a career structurefor General Practitioners in academic general practice, to encourage recruitment at an early stage of a career and to retain experienced and qualified academic GPs
3. Raise standards and expand capacity for teaching in general practice, and tobuild bridges between undergraduate teaching and postgraduate teaching and learning.

4. Further expand research capacity in primary care, including investment in research infrastructure, planning and support for specific programmes of research and longer-term funding for training and career development.

Further integrate service general practice and primary care with academic general practice (research and teaching), by bringing together, whenever possible, SIFT/ACT and Culyer funding streams.

Clearly solutions to the last three of these challenges, important as they are, lie beyond the working party and the AUDGP itself, and this report concentrates on the question of inequities and the lack of framework for academic careers in departments of general practice and/or primary care.

1) Minimising inequalities in status between medical and non-medical academics in the departments

The context for this statement is the shift from GP dominated and GP led general practice to multidisciplinary service primary health care. Academic primary health care is now an intellectually hybrid and eclectic discipline that encompasses sociology, anthropology, psychology, nursing, medicine and many other primary disciplines. This has resulted in both opportunities and threats for academic departments.

a) Progress 1993-99

i. Many departments of general practice have renamed themselves 'departments of primary care' to reflect the increasingly multidisciplinary nature of the teaching and research undertaken, and the expansion of the range of staff employed. We are cautiously optimistic that the status of staff from non-medical backgrounds in these departments is generally rising.
ii. There are now several chairs and senior positions held by non-medically qualified academics in departments.
iii. The proportion of named non-medics on published papers continues to increase.
iv. The Mant Report recognises the importance of multidisciplinary teams.
v. There are now National Primary Care Research Development Awards (from national R & D to support mid-career training and higher degrees in primary care).
vi. We welcome the inclusion of non-medical personnel in the RCGP accreditation process for primary care research and development in general practice.
vii. The proposed QAA levels would ensure that qualifications can be comparable.

b) Barriers to further progress

i. There remains disparity at all levels between medical and non-medical staff in terms of status and level of qualification required for appointment to particular posts eg senior lecturer. The need to attract service GPs to academia who unless they are appointed at senior lecturer level have to take a substantial drop in income, means

that relatively inexperienced individuals are being appointed at levels above non-medical career researchers.

ii. Cultural superiority within medical schools which tends to exclude non-medics from the decision making processes about research and teaching.

iii. Lack of clarity in defining roles.Although multidisciplinarity is now generally acknowledged to be a "good thing", we have so far fallen short of addressing the question of skill mix in detail.

c) Recommendations

i. Consideration should be given to innovative methods of assessing competency for both new appointments and promotion of academic staff to ensure equity in status between academics from all the disciplines working in the departments (see Appendix 2).

ii. The task of leading and co-ordinating primary care research should be recognised as requiring skills that are not doctor-specific. A professor of primary care might come from any of the primary contributing disciplines, and appointment of suitably qualified and experienced non-medical staff to the position of professor and/or head of department should be encouraged. However parity of pay is not currently a realistic recommendation for those medically and non-medically qualified.

iii. High quality research in and into general practice and primary care is impossible without non-medically qualified academics. Departments should check their systems and attitudes to ensure that non-medical academics are not viewed as support staff but are recognised as essential and equal partners in academic activities. The presence of these other fields in a Primary Care department provides a staff group whose time is not split between clinical service and academic life. They provide not only continuity, but also the more senior and visionary they are, the more powerful the group can become.

iv. Universities must be encouraged to use the standard terminology for research staff as suggested by CVCP for Best Practice for Research Contract Staff (www.cvcp.ac.uk). The 'Best Practice' document suggests that there are limited opportunities for career contract researchers in universities, but that where promotion is appropriate, standard academic routes may not be suitable. We have tried to incorporate their suggested model into the competency grid in Appendix 2.

2) The establishment and support for a career structure for general practitioners in academic general practice.

a) Progress 1993-1999

Since the publication of the first AUDGP report on this subject in 1993, a number of national schemes for career support for academic GPs have been established. These include:-

i. Bursaries (e.g. from R & D directorates of NHS regional offices to support students on short courses in research or Masters degrees);

ii. Fellowships (from the RCGP, MRC, and R&D directorates of regional offices, to enable GPs to work towards a higher research degree);
iii. National Primary Care Research Development Awards (from national R & D to support mid-career training and higher degrees in primary care);
iv. Career Scientist Awards (from national R & D to support promising postdoctoral academic GPs for a period of five years);
v. Academic trainee posts have been established for recently trained GPs; Associate academic GPs were appointed in several departments (though these posts have tended to remain ad hominem);
vi. In addition to individual award schemes, several local or regional trainee schemes have developed e.g. London Academic Trainees Schemes (LATS) has been running since 1995 in London, and HPTFS since 1996 in Scotland.
vii. Arrangements for prolonged study leave are in place but are relatively untapped perhaps because they do not cover locum costs.
viii. Since the working party met, the Academy of Medical Sciences produced in March 2000, the Saville report entitled "The tenure-track clinician scientist: a new career pathway to promote recruitment into clinical academic medicine" (http://www.acmedsci.ac.uk/). This recognises the lack of career structure in all branches of clinical academic medicine, including general practice, but offers no specific solutions. It suggests that solutions will depend on close working between academic and service GPs within the new system for managing the workforce linking primary care groups to regional education and teaching consortia.

b) Barriers to further progress

i. Funding. Career development grants are in short supply. In 1999, of 114 applications for the National Primary Care Research Development Awards, 56 applications were shortlisted and only 8 were funded. Clinical Scientist awards have also been heavily oversubscribed, with 32 applicants, 18 shortlisted and funded 6. Academic trainee schemes have never existed in some localities and face major funding shortages in others.
ii. Financial disparity. The financial disparity between the earnings of young GP academics and young GP principals, and between senior primary care academics and senior specialist academics holding honorary consultant contracts with distinction awards is resulting in a recruitment crisis for senior academic GPs. Experienced service GPs have a potential drop in income when they enter academia if they have limited research experience.
iii. Limitations of the 'career path' model. The 'Calman' model of a structured career ladder (with a formal training programme and defined milestones for academic attainment) has certain strengths. However, it fails to reflect the reality that most academic GPs continue to have an 'atypical' career path. The considerable variation in past experience, clinical expertise, special interests and personal qualities of aspiring academic GPs should be placed more centrally in the model. In particular, the following realities should be acknowledged and addressed:

iv. Some academic GPs, at all ranks up to and including professor, have spent long periods in full-time service general practice before entering academia;
v. The clinical and administrative commitments of GP principals are considerable;
vi. General practice may be taken up as a 'second career' following a planned change in direction from hospital medicine, public health, paediatrics, obstetrics and so on. These individuals bring valuable clinical and research experience, and may already have a higher degree, albeit not in the field of primary care. Given that primary care is by its nature a generalist and diverse discipline, the 'model career path' should be sufficiently flexible to meet the varied needs of second career recruits.
vii. The proliferation of departments of primary health care, isolated from medical schools may lead to differences in the academic career structure, but this should be discouraged.

c) Recommendations

i. A model or set of models for the career structure for GPs in academic general practice should be agreed so that an academic career is a realistic career choice from early on. These could be developed from existing models presented in earlier AUDGP reports. A variety of models would allow diversity and flexibility, which should be encouraged, and examples of successful variations should be publicised. Formal links with other clinical specialties (e.g. public health, obstetrics) should be explored to facilitate planned career changes to primary care.
ii. Consideration should be given to innovative methods of assessing competency for both new appointments and promotion of medically qualified academic staff. Various universities (e.g. Adelaide, Harvard) have developed competency grids. We have suggested a competency grid appropriate to our context and this is presented in Appendix 2.
iii. The RCGP, possibly through its career support forum, could continue to monitor, co-ordinate, support and evaluate the various research training opportunities for academic GPs. Currently this forum does not specifically mention the careers of academic GPs but possibly its remit could be explicitly expanded to cover career opportunities for: 1. junior 'career academic' GPs (i.e. those in vocational training who wish to become academic registrars, fellows, research scholars, and so on); 2. established GPs who wish to continue 'mainly' in service but forge links with - academic departments (associate fellows, clinical tutors); 3. established GPs who wish to change career and become 'mainly' academic, 4. clinicians from outside general practice (who may already have higher degrees) who wish to move into primary care.
iv. Financial incentives to recruit and retain senior academic GPs, as detailed in the Richards' report, should be pursued. In particular, pressure should continue to extend the distinction award system to academic GPs.
v. Different models for supporting an individual's commitment to an academic career (which may involve relinquishing the security of a 'tenured' clinical post) should be explored and evaluated.

Appendix 1:

Summary of previous work on academic careers in general practice and primary care AUDGP working party 1993

The AUDGP formally addressed the academic career structure in undergraduate departments in 1993. A specially convened working group produced a 10-page report, ratified by the Executive Committee of the AUDGP and the Heads of Department group. The chief recommendations were:

1. A core career structure for academic general practitioners was proposed, in which the stages from vocational trainee (now GP registrar) to professor through the acquisition of experience, training and academic qualifications were described. A high degree of flexibility around the "fast track" model was considered desirable (it was noted that most current professors of general practice in the UK had been 100% full time GPs in their early careers). The relationship between academic and service general practice was recognised to be crucial to the achievement of quality in both. Explicit criteria were proposed for Designated Academic Practices (DAPs) in teaching and research.
2. The links between undergraduate and postgraduate medical education were noted to be poor (largely for historical and organisational reasons). Building closer collaboration between these areas was seen as desirable, but was noted to be a potentially sensitive area since postgraduate GP education (vocational training and continuing professional development) has traditionally taken place outside academic departments.
3. The multidisciplinary nature of primary care as a research discipline was recognised, and the contribution of non-medical staff to teaching and research acknowledged. A range of career grades for "non-clinical" (i.e. non-medical) academics was proposed.

AUDGP Working Party Report 1997

The 1993 AUDGP working party report was put into a more up to date context by an AUDGP group in 1997. This acknowledged and incorporated several important policy documents, including the 1994 Culyer Report to the Minister of Health on R&D in the NHS (HMSO), the Mant Report on Academic General Practice http://www.epi.bris.ac.uk/rd/publicat/rdpcare, and the 1997 Richards Report on Clinical Academic Careers. AUDGP Working Party Report on nurses in departments 1997 A survey of registered nurses working in departments concluded that:

- Departments can provide an opportunity for nurses to develop their professional role
- Many nurses working in departments are highly qualified both clinically and academically

- On the whole, nurses want to remain clinically involved while working in academic departments
- Nurses need more support in developing research skills to enable them to conduct nurse-led projects

Paper for Advisory Group in Medical Education and Training 1998 Sean Hilton et al

In October 1998, Sean Hilton (representing AUDGP), David Percy (for COGPED) and Simon Smail (for UKCRA on Academic General Practice) wrote a paper for AGMETS (Advisory Group in Medical Education and Training chaired by the Chief Medical Officer). This outlined the necessity for a more clearly defined career structure to enable the research, education and teaching components of academic general practice to develop through convergence of the historically separated undergraduate and postgraduate departments, through liaison with general practice research networks and with interrelationships with service GPs. The report noted that current funding arrangements, levies, and monitoring processes are making progress slow. This is to be published in the College journal shortly. Academic capacity 1999 Roger Jones The specific concerns raised by Roger Jones in his 1999 paper were:

a. There is insufficient teaching capacity in general practice to cope with the projected expansion in medical undergraduate education.
b. Despite considerable work at executive level in the AUDGP and elsewhere, the existing career structure for academic general practitioners remains problematic, especially the issue of finding protected time for academic work within a full-time principalship with 24-hour commitment.
c. Research activity in general practice is increasing steadily as a result of new streams of funding, but it remains underfunded relative to the basic biomedical sciences and many clinical disciplines. In particular, the core infrastructure of primary care remains inadequate, and the capacity of research departments (number of research active staff) is so low that many have difficulty sustaining their research programmes.
d. There is a recruitment crisis at both professorial and senior lecturer level for academic general practitioners. This is partly due to the profound practical difficulties, financial constraints, and personal risk of combining academic and service commitment in this discipline. The individual who aims to become a "three stranded clinical academic" (research, teaching and service) is, in reality, likely to experience considerable role conflict and a high level of personal stress.
e. Recent service reconfigurations and contractual changes, in particular the new Primary Care Groups and their associated roles and responsibilities, has created new distractions for service general practitioners and potential new conflicts between service primary care and academic departments.

Academic status 1999 Pit Rink

The specific concerns raised by Pit Rink were that the non-medics are well aware of the need for more general practitioners to be involved in research, and the pay disincentives GPs face when entering academia, but that disparities in academic status are divisive.

There are three main reasons why there should be parity of status criteria for medical and non- medical personnel:

a. Equity - the principle of equal rank for work of equal value.
b. The academic credibility of general practice. If personnel at senior lecturer level and above do not have higher degrees or publications, this is likely to undermine the credibility of general practice as an academic discipline.
c. The Mant Report clearly identified the need to attract and retain 'non-clinicians' within primary care R&D. Departments of General Practice need incentives for the retention of non-medics. With more multidisciplinary working, it will be increasingly common for medics and non-medics to be working together in research teams, and in these situations disparities in status become particularly apparent and frustrating to non-medics.

Other reports

Richards Task Force Report July 1997 - Commissioned by Committee of Vice Chancellors and Principals

The Richards Report was an overall analysis of the academic medical career structure. Points specific to academic general practice included:

a) Remuneration of academic GPs

- The report noted that the MRC, NHSE and GMC have emphasised the need for an expanding programme of clinical and health services research, and of teaching in primary care and that the ratios of academics to principals in general practice show a big gap between expectation and capacity to deliver.
- Recognised the financial disadvantage of GPs in relation to other medical school colleagues;
- Recognised the resulting disincentives to GPs to enter or remain in departments of general practice as clinical academics;
- Recommended that the status of academic GPs should be brought into line with other clinical academic colleagues;
- Recommended the inclusion of part and full time academic GPs for eligibility of consultant status, allowing application for distinction awards.

b) Teaching and Training

- Acknowledged the lack of appropriate environments in general practice which combine clinical and research excellence;

- Regretted the historical separation of undergraduate and postgraduate education in general practice;
- Recommended that research findings would be put into practice more effectively if the two were brought together

c) Research

- Noted that GP contracts make no mention of a research commitment, unlike most consultant contracts;
- Noted the lack of clinically based training environments for research;
- Recommended that NHS R&D levy developments should be encouraged;
- Recommended a focus on training clinical academics with knowledge of and ability to work with disciplines of health services research.
- Noted the generally poor scores of academic departments of primary care in the Research
- Assessment Exercise, and suggested that this was understandable when GP academics are engaged in research for at the very best half of their time.

National Working Group Report on R&D in Primary Care (The Mant Report 1997)

Set out strategic principles and 23 recommendations to guide R&D in primary care to the provision of the sound evidence base required to improve the quality and value for money of primary care. Decisions in primary care need to be based on research evidence, but the capacity of primary care to undertake such evidence is currently limited. R&D leadership is in short supply, as is the number of clinical staff with research expertise. In addition there are disincentives for non-medical researchers to become involved, partly because of their lower status and salaries.. Consultation Paper on Qualifications Frameworks: Postgraduate Qualifications. QAA. 1998. The Quality Assurance Agency for Higher Education produced a consultation paper on qualifications frameworks (QAA 1998) on which the AUDGP Executive was invited to comment. The purpose of that paper was to produce a framework for postgraduate qualifications which would provide a clear and consistent nomenclature, an explicit means of locating the progression of learning achievements and a basis for quality assurance.

The proposed Higher Education Funding Council for England (NCIHE) levels are developed from postgraduate frameworks suggested in the Dearing and the (Scottish) Garrick Reports.

The key feature of the framework is the location of awards in terms of their level and volume of level-specific credit rather than their chronological relation to the undergraduate honours degree. The qualifications framework is therefore structured in terms of level, credit and character.

A level is an indicator of the relative demand, complexity, depth of study and learner autonomy involved in a programme. Postgraduate levels need to be described. A higher postgraduate level, for example, could be described in terms of the completion of a

substantial piece of research or advanced professional project in such a way as to make a significant and original contribution to a field of inquiry or practice. A lower postgraduate level might denote familiarity with complex and specialised areas of knowledge and skills.

The proposed NCIHE levels				
		Dearing proposals		Garrick proposals
	H8	doctorate		doctorate
	H7	MPhil		Masters / MPhil
	H6	Masters		Masters / MPhil
	H5	Postgraduate Diploma / Conversion		Higher Honours
	H4		Honours degree	
	H3		Bachelor degree	
	H2		Diploma	
	H1		Certificate	

Credit provides a measure of learning outcomes as qualified by the notional number of study hours required for achieving the outcomes.

Character

Qualifications that are composed of the same volumes of credit at the same levels may differ in character. Character describes the aim of a qualification e.g. 'research and scholarship', 'preparation for research and deepening subject knowledge', 'professional and practice-related', the nature of study involved and the method of assessment employed.

Three possible, and similar, models have been proposed for simplicity, one (Model 2) is described here. The key feature of this model is that it makes a distinction between standard masters and lower postgraduate awards (eg PGCert, PGDip). The model does not define level with regard to model of study but recognises that the difference between lower postgraduate awards and masters is more than one of volume of work and is reflected by a difference in the level of intellectual demand and achievement. The model would require

level descriptors to differentiate both standard and higher masters from other postgraduate awards.

	Proposed nomenclature	Typical duration		Character	Typical qualifications
PG4 PG3	doctorate higher masters	540 360	3 y f/t 2 y f/t	will contain a major research, constructive or reflective component	PhD, DEng, DMus, MPhil, BPhil
PG2	masters	180	1 y f/t	likely to contain a major research, constructive or reflective component	MA, MSc, MSocSci
PG1	diploma certificate	120 60	8 m f/t 4 m f/t	may contain a major taught element	PGDip PGCert

It is proposed that the nomenclature of postgraduate qualifications should be consistent across the UK. This means that, for example, a masters qualification should denote the same intellectual level and minimum volume of credit irrespective of discipline or awarding institution. Consistency will be achieved by the clear definition of levels, the use of criteria for the use of generic award titles (eg PhD, MSc) and the elaboration of additional criteria for variants (eg MEng). The QAA proposals do not mention the MD, which in Model 2 would appear to fit at level PG3. However, the use of 'Doctor' in the MD title allows an assumption of equivalence with PhDs. There is no national agreement on their comparative standards. Work carried out at doctoral level by medical academics could be prepared for either a PhD or a DMed according to these proposals.

Appendix 2

Suggested "competency grid" for academic staff.

Higher degrees are not included as requirements for particular grades; the competency grid allows for unusual circumstances where an individual will be considered to be suitably qualified without PhD, MPhil, MD etc. although Clinical Senior Lecturers and Senior Research Fellows should generally have a doctoral degree. The competencies listed are considered a minimum for appointment or promotion to that level.

TEACHING	Research assistant/associate/ clinical lecturer	Lecturer/	Senior lecturer	Reader	Professor
Performance	No formal teaching commitment unless funding body supports this. Opportunities	Regular teaching commitment on established degree courses.Some responsibility for course/module development	Major role in departmental teaching activity - e.g. departmental tutor, member of teaching quality committee.	Readership is essentially a research post. Excellence in teaching can enhance the case for promotion but is rarely adequate on its own.	Outstanding and sustained record of excellence in teaching at undergraduate and/or postgraduate level.
Knowledge/ reputation	N/A	Consistently good evaluation from	Excellence in teaching confirmed by	N/A	Excellence in teaching confirmed by student

		students and peers.	student assessments, peer review, and examination results.		assessments, peer review, or examination results.
Professional development	N/A	Evidence of systematic reflection and self development (e.g. through peer observation, formal training courses)	Teaching portfolio demonstrates wide range of high quality teaching activities, including innovation in curriculum development and teaching methods.	N/A	Record includes major innovation in teaching activity e.g. development of new degree programmes or units, introduction of new teaching methods, or evaluative research of educational methods, etc.

A head of department can be at senior lecturer/senior research fellow or above and in the context of teaching supports, enables and values the delivery and evaluation of teaching within a department through staff appraisal and development and will normally have a sound teaching performance and excellent reputation for supporting the teaching activities of others.

RESEARCH	Research assistant/ associate/	Lecturer/ Research fellow (RII)	Senior lecturer/ Senior Research fellow (RIII)	Reader	Professor/ Professorial fellow
Performance	1B:Assists with research 1A:Undertakes and assists in management of research	projects Plans and undertakes research projects.	Sustained record of high quality original research.	Sustained record of excellence in original research.	Outstanding and sustained record of original research.
Knowledge/ reputation	At 1B level previous knowledge of research not essential. Appointee may expect training in any aspect of research relevant to the project.	Basic knowledge of research methods, appropriate to own field of interest. Able to be submitted as research active to RAE	Sound knowledge of research methods in own field. Able to apply these to other fields.	Research performance recognised at national and international level. Evident potential for further research achievement.	Research performance recognised internationally by others in the field. Member of peer review bodies and committees. Leadership role in professional organisations.
Funding	1B:No involvement in	Writes	Evidence of successful	Successful record of	Outstanding record of

	applications for funding. 1A May collaborate in funding applications	applications for funding as part of a team	research grant applications in own field of interest.	securing major research funding through bodies such as MRC or large research charities.	securing funding for both individual projects and wider programmes of research.
Publication	May be involved in publication as co-author	Writes up research to publishable standard as part of a team	Established publication record of original research. At least one publication as first author of an original study in a major peer reviewed journal would normally be expected.	Outstanding record of publication, presentation at international conferences, and invited lectures.	Substantial output in the form of books, journal articles, commissioned reports, invited lectures, etc.

A head of department can be at senior lecturer/senior research fellow or above and in the context of research supports, enables & oversees applications for funding, supports, enables and co-ordinates publication of research within the department and has a sound knowledge of admin and organisation of research funding, and will normally have a sustained record of high quality research.

ENABLING	Research associate / fellow	Lecturer	Senior lecturer	Reader	Professor	Head of department
General departmental activities	Encouraged to attend meetings and contribute to all relevant activities.	Contributes to departmental activities e.g. attends journal clubs and presentations.	Makes substantial and regular contribution to departmental activities in research and/or teaching e.g. runs journal club or seminars.	Leadership in establishing and maintaining significant research programmes.	Plans strategically for the research and teaching activity of own unit or units.	Plans strategically for the research and teaching activity of the entire department.
Supervisory	None.	Student dissertations	Trains, supervises and co-ordinates other members of a research or teaching team	Established record of supervision of research students and research staff.	Established record of supervision and support of research and teaching staff.	Takes ultimate responsibility for supervision and professional development of all academic staff in own unit or department.

						Responsible for personnel issues.
Managerial	None.	None.	Conducts appraisals and deals with personnel issues for members of own team.	Conducts appraisals and deals with personnel issues for members of own team.	No major managerial responsibility beyond own projects unless head of department	Oversees management of administrative and financial issues in own unit or department.
Other	None.	None.	Providing an organisational framework that maximises the work of others.	Plays major role in supporting departmental research activity within own portfolio	Plays major role in supporting departmental research activity within and beyond own portfolio.	Leadership in securing major sources of capital or development funding.