

Clinical Academic Posts for Nursing: NHS Lothian Case Study

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Building Knowledge Exchange:
Clinical Academic Posts for Nursing and
Recognition of Knowledge between Health and
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report for

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Executive summary

1. Background and objectives

With the support of the Chief Nursing Officer and NHS Education Scotland, Dr Annie Weir, Centre for Educational Sociology (CES), University of Edinburgh, and Professor Jenny Ozga, University of Oxford (formerly at CES) advised by Professor Brian Williams, Chief Scientist Office (CSO) Nursing, Midwifery and Health Professions (NMAHP) Unit, University of Stirling are conducting a research project entitled “Building Knowledge Exchange: Clinical Academic Posts for Nursing and Recognition of Knowledge between Health and Higher Education Systems”.

The research aims to identify and understand the barriers to and facilitators of the development of senior clinical academic posts in nursing in Scotland in the context of the implementation of NHS Education Integrated Principles and Career Framework for Clinical Academic Research Careers.

For the purpose of this research, clinical academic posts are defined as those that involve clinical practice as well as university based research and teaching. In Scotland, current developments put the emphasis on clinical academic research careers. There are currently numerous clinical teaching arrangements in place.

The investigation involves a review of international and Scottish literature as well as case studies of partnerships in three selected health boards in Scotland NHS Lothian, NHS Greater Glasgow and Clyde, and NHS Tayside and their partner universities.

2. Methodology

The case studies use a variety of methods including (i) documentary analysis of relevant background materials, (ii) interviews (up to 15) with key actors involved in clinical partnerships at a strategic level in universities and health boards, and (iii) three focus groups (up to 10 participants in each nominated by each NHS Board) with representatives of key players.

The case studies draw on the key concepts identified in the literature review as contributing to barriers to recognition/development. These include issues of power and gender, as well as differences in knowledge practices and processes. These concepts have been tested in the case studies, including through the interview questions and observations. The case studies focus on the *National Guidance for Clinical Academic Research Careers for Nursing, Midwifery and Allied Health Professions in Scotland* (NHS Education for Scotland, 2010) and build the enquiry around responses to it and investigation of its implementation.

The following key issues are explored:

- strategies for career development/enhancement; support for/barriers to career development;
- strategic priorities for patient care/knowledge building;

- alignment/synergy between health boards and universities in relation to evidence-based practice, and to quality improvement in health and knowledge exchange;
- the existence of different kinds of knowledge and their different statuses;
- the need for ‘translation’ of different knowledge-based processes and practices;
- power relations and status in the environments of practice and in HE.

Acknowledgements

We would like to thank the senior managers and clinical academics who took part in this study for their valuable contribution to developing knowledge and understanding of the barriers to and facilitators of enhancing clinical academic careers.

3. Executive summary

Investigation of NHS Lothian Clinical Academic Research Career (CARC) pilot suggests that the following key factors are significant in enabling the development of CARCs:

- (i) Congruence in the strategies of all the key actors: The ‘Clinical Academic (Research) Careers Scheme for Nurses, Midwives and Allied Health Professionals in NHS Lothian’ and the ‘Lothian NMAHP Research Framework 2010-2015’ are congruent with other career frameworks for health, for example, the Agenda for Change (AfC) and with the NHS and the Chief Scientist Office (CSO) strategic research direction of translational research. It is also aligned with NHS Education for Scotland’s National Guidance for Clinical Academic Research Careers for Nursing Midwifery and Allied Health Professions (NMAHP) in Scotland.
- (ii) High level strategic commitment: NHS Lothian, the universities’ senior management groups (University of Edinburgh, Queen Margaret University and Edinburgh Napier University) and NHS Education for Scotland are all highly supportive of the CARC pilot initiative.
- (iii) Publically demonstrated convergence between key actors: the Executive Nurse Director is the Executive Sponsor and provides leadership and oversight. The Research & Development strategy developed in conjunction with the pilot is closely aligned with Board priorities and is endorsed by the Board.

In addition, the following organisational arrangements are important:

- a) Formal agreements covering key aspects of the partnerships in order to ensure effective management of strategic priorities and operational processes between NHS Lothian and the universities;
- b) Familiarity with clinical and research priorities across all actors/sectors;
- c) Integration of clinical academic posts with the NHS Lothian workforce strategy (the implementation of CARC resulted in integrated policies, resource allocation and practices aimed at supporting and embedding research careers);

- d) Formation of a management group representing all the partners and a steering group of key stakeholders to oversee strategic direction and advise on implementation;
- e) Sharing of funding to support the infrastructure, management and operational processes required for implementation;
- f) Securing of employment conditions: Post-holders (3 PhD and 3 postdoctoral) are employed by NHS Lothian and contracted to spend 50% of their time in clinical practice and 50% of their time at the university;
- g) A longer term aim is to create a professorial clinical chair post to provide clinical leadership focused on achieving an evidenced-based practice culture, and is expected to hold PI researcher status.

4. Key findings

4.1 Building on past initiatives

There has been progress over time in enhancing the status of nursing knowledge and in supporting the development of clinical academic careers.

However, the CARC scheme is relatively new and it is not yet fully embedded in the NHS or the universities.

Developments include:

- strategic investment in nursing research at PhD and Post Doctoral levels;
- building relationships between the different partners involved.

4.2 Where is there scope for improvement?

Barriers to the development of clinical academic careers are still considerable for those clinical academics currently in post who sit outside the current pilot. Some overarching themes emerged relating to areas for improvement. These are:

- the need to build on the developing partnerships between NHS Lothian and HEIs with attention to strategic and operational constraints (there are very small numbers in the pilot and there is a need to create a sustainable future and expand to offer greater support for those outside the pilot);
- the need to mainstream the CARC by embedding a clear career path from undergraduate to leadership status, with more developed infrastructures of support in NHS and HEIs to sustain greater numbers beyond the current pilot;
- the need to attract and retain clinical academic leaders with professorial status (some nursing professors have retired and have not been replaced; there are no clinical academic chair posts);
- closer and more visible alignment of research priorities in nursing with health policy priorities while allowing 'blue skies' research to also flourish;

- enabling clinical academics at all levels to have sufficient authority to implement their research findings to support practice and make quality improvements;
- the need to build on ideas of knowledge exchange and translation to support clinical academic careers in nursing, for example by integrating a knowledge exchange plan at the research proposal stage and monitoring the outcomes.

4.3 Recommendations

Key implications for the development of Clinical Academic Research Careers for nursing in NHS Lothian are identified as follows:

- to increase investment in leadership roles such as clinical chairs and clinical academic professorships;
- to build on the synergy between health policy priorities, the quality improvement agenda and the development of clinical academic careers;
- to fill gaps in the evidence base, especially in relation to the impact of clinical academic posts in nursing on the translation of research knowledge into improved patient outcomes;
- to develop a stronger focus on the potential of the 'translation' role in clinical academic posts.

Section A: Introduction

The relationship between health and higher education is complex and is characterised by differing strategic objectives and reporting requirements. An opportunity for productive policy convergence occurs through the establishment of clinical academic posts that create and embody partnership between the two worlds and offer scope for effective collaborative use of resources in an environment of constrained finances. Collaboration is dependent on understanding of the value of clinical academic posts in evidence-based practice, to the quality improvement and knowledge translation agendas in the NHS as well as to the nursing research and knowledge transfer agendas of universities. Shared understanding is vital to achievement of the mutually desired goal of improving outcomes for patients and the quality of the patient experience, central to government policy (Weir and Ozga, 2010: 56).

There are significant benefits to NHS Lothian and Scotland in harnessing academic nursing research to better inform health care and health services and to improve the quality and outcomes for patients. The NHS Lothian Board, and three universities (University of Edinburgh, Queen Margaret University and Edinburgh Napier University) and NHS Education for Scotland have together supported the development of the 'Clinical Academic Research Careers (CARC) Scheme for Nurses, Midwives and Allied Health Professionals in NHS Lothian' and the 'Lothian Nursing, Midwifery and Allied Health Professional (NMAHP) Research Framework 2010-2015'. They are both significant steps on the journey to embedding CARC as a viable career option for nurses.

This case study builds on the findings of the review of literature on the barriers to and facilitators of clinical academic careers in the UK and other countries (Weir and Ozga, 2010) by testing out whether similar factors apply in NHS Lothian. The case study of the NHS Board and partner HEIs provides an opportunity to explore at first hand how a developing partnership has been operationalised and the potential for knowledge exchange.

The CSO research strategy for Scotland's health has translation at its heart (The Scottish Government, 2009). Clinical academic nurses are ideally placed to facilitate research translation in order to enhance Scottish patient care and the nation's health.

Dame Janet Finch (author of the influential policy document 'Developing the best research professionals' (UKCRC, 2007)) highlights the importance of clinical academic careers in nursing the UK and outlines below a vision for the future. This vision is relevant to Scotland and shared by those who were interviewed in this study.

That vision must be that being a "clinical academic" becomes a recognised and supported career route for nurses and allied health professionals. Within this route, it must become the norm to combine clinical practice with research (and education also, where that is appropriate), at various different career stages. It must also be much easier to move from one to the other, concentrating for a while on clinical practice, then moving to a research-oriented role, then back again. But the creation of the clinical academic route is not an end in itself. The goal must be to build up, and continually to refresh, a robust evidence base for nursing and health care practice. In order to do that, the aim must be to have nurses and allied health practitioners involved in many types of research projects at all levels. Eventually it must become routine to have clinical academics

undertaking not simply small-scale studies—important though these are—but also being the leaders of large scale, multi-method, and multi-disciplinary projects with funding from prestige sources (Finch, 2009).

1. Background

Although there have been significant developments in NMAHP research (e.g. NMAHP research consortia and NMAHP Training Scheme, 2003) as well as progress in implementing clinical academic careers since *Choices and Challenges* (2002) there are still challenges to overcome. In the area of developing research awareness and research usage it is noted that NMAHP exposure in undergraduate studies to evidence-based practice and research modules is variable (NHS Lothian, 2010a:5). Relatively small numbers of NMAHPs are involved in post-graduate studies. NMAHPs do not have a tradition of engaging with research pertinent to their field. PhD candidates are usually self-funded and work part time, with a minority supported by research fellowships (ibid). Post-graduate study may involve a degree of sacrifice where there is salary difference between the lower paid fellowship and the NHS salary. Typically post-graduate study is driven by individual interests and not related to clinical service priorities. At the same time, the NHS rarely utilises the research skills gained by staff in a strategic way, thus losing the opportunity to benefit clinical Services (p5). Many academically qualified NMAHPs are faced with career opportunities which are either entirely clinical/managerial or entirely academic (p5). The NHS Lothian initiative described below is designed to help overcome some of these perceived barriers to the successful implementation of clinical academic research careers and to further developing a culture of evidence-based practice.

Some interviewees commented on the need to establish CARC:

Some nurses have completed Post-docs and come back into service others have remained at their universities and become academics. Clinical academics won't have to choose.

There are so few joint appointments and they have all had to work through significant HR issues.

How do we make the most of them in service and the academy?

Individuals who work part time and self fund their PhDs and Post-docs have to work too hard.

2. Implementing clinical academic posts from 1998

Currently there are 22 clinical academic posts. Between 1998 and 2011 24 clinical academics posts relating to specialist areas were created mostly on an ad hoc basis in NHS Lothian. The most recent appointments are part of the NHS Lothian NMAHP CARC pilot discussed below. Post holders' titles vary: they include Nurse Consultants/Consultant Nurse and Honorary Nurse Consultant (13); Research Lead/Facilitator (1); Senior Nurse-Research/Lead Practitioner Research (1); One post holder held the following posts from 2002 -2011: part time Staff Nurse/part time Nurse Researcher, part-time Research Fellow & part-time Clinical Research Specialist, full-time Clinical Research Specialist and Honorary Fellow; Band 7 Nurse (1); Joint Appointment Senior CNS/Lecturer (1); Lead Nurse/Clinical Researcher (1); Joint Appointment Nurse Specialist/ Lecturer (1); There is one Advanced Practitioner Clinical

Research post currently with three more posts to be appointed to by the end of 2011. There is one Senior Practitioner Clinical research post currently with three more posts to be appointed to by the end of 2011; and the highest status post currently is Clinical Reader of which there is one post holder.

Since 2008 two specific initiatives have been implemented: 1. The 'Clinical Academic (Research) Careers Scheme for Nurses, Midwives and Allied Health Professionals in NHS Lothian' 2. Lothian NMAHP Research Framework 2010-2015. These are discussed in Section B and see Appendix A: NHS Case Study Questionnaire for more detail.

Employment arrangements

Employment arrangements are varied; for example most post holders hold their substantive post and HR matters are covered by the NHS. In addition they hold honorary appointments with HEIs with the time spent at each location varying depending on individual contracts. Other post holders have joint appointments that are partly funded by NHS and HEIs with HR matters being shared depending on the weighting of time allocated to each location. The most recent appointments have a 50/50 split between the NHS and HEI with the NHS being the employer and covering HR matters. Yet other post holders have a full time post with the HEI being the employer and covering HR matters and an honorary post with NHS.

Engaging in teaching and research

Of the current pool of clinical academics seven hold doctorates. In addition a nurse and a midwife hold doctorates but are not working as clinical academics. Of the current pool of clinical academics, six are involved in teaching only, 10 are involved in both teaching and research and five are engaged in research only. One Nurse Consultant is currently not involved in teaching or research. Of those engaged in research eight hold Principal Investigator status and four hold Co-Investigator status. Research is currently being undertaken by clinical academics in the following areas: Community Nursing; Facilitator Cancer Nursing; Substance Misuse; Learning Disability; Cardiology; PSI Psychosis; Sexual Health Compassionate; Care Long term conditions; Neonatology; Critical Care Palliative Care. Cancer, substance misuse, learning disabilities and critical care are example of areas where outcomes from research have been put into practice (see Appendix A: NHS Case Study Questionnaire).

Section B: Implementing clinical academic research careers in NHS Lothian (NHS views)

This section presents the findings of the interviews with NHS senior managers and clinical academic post holders (focus group).

The NHS Lothian CARC scheme aims to utilise and develop clinical and academic research competencies simultaneously and is trying to establish academic and clinical ‘homes’ for researchers (Lothian, 2010a:3). This is in keeping with NHS workforce development policies such as *Modernising Nursing Careers* (Department of Health, 2006) and ‘*National Guidance for Clinical Academic Research Careers for Nursing, Midwifery and Allied Health Professions in Scotland*’ which describes a CARC framework and accompanying set of principles (NHS Education, 2010).

1. Overview of the NHS Lothian pilot

The ‘Clinical Academic (Research) Careers Scheme for Nurses, Midwives and Allied Health Professionals in NHS Lothian’ was launched in May 2010. NHS Lothian and NHS Education (NES) in partnership with three universities (the University of Edinburgh, Edinburgh Napier University and Queen Margaret University) have developed a five year pilot scheme aimed at establishing research career pathways for a small number of NMAHPs. This NHS Lothian partnership model is embedded in clinical practice and involves collaborating academic partners in providing research training and supervision.

2. NHS Lothian NMAHP research framework

In 2010 NHS Lothian and its three partner universities launched the ‘Lothian Nursing, Midwifery and Allied Health Professional (NMAHP) Research Framework 2010-2015’ which articulates a vision and guiding principles that underpin their collaborative approach to research and presents a five year plan (NHS Lothian, 2010b). Both the pilot and the research framework are aligned to NHS Education for Scotland (NES) national approach to NMAHP Clinical Academic Research Careers in Scotland (NHS Lothian, 2010:6).

3. Strategic overview and priorities

High level strategic commitment from NHS Lothian, the senior management groups of the three universities and NHS Education for Scotland was essential for the five year pilot to proceed. The Executive Nurse Director took on the role of NHS Lothian Executive Sponsor for the pilot thus providing high level leadership and oversight. The Research & Development strategy developed in conjunction with the pilot and which was closely aligned to Board priorities was endorsed by them. The clinical academic posts are part of the NHS Lothian workforce strategy and therefore integrated into their policies, resource allocation and practices at least for the duration of the pilot, although the intention is to embed clinical academic posts into the NHS infrastructure in the long term depending on the success of the pilot and on securing a sustainable funding base.

High level clinical and academic leadership is viewed as important to the pilot and to the future of CARC in NHS Lothian and there is the intention to further consider how to create Clinical Chair posts. The Clinical Chair is a professorial post providing clinical leadership focused on achieving an evidenced-based practice culture within NHS Lothian. The Clinical Chair is expected to identify strategically important clinical priorities for research and is expected to hold PI researcher status thus bringing in funds to academic partners for research, contributing the REF and raising the status of nursing research.

One senior manager commented:

I would love to see a Professor of Nursing Chair established around this key nursing issue. The universities need to work more with us (NHS) and think how we might create them (Clinical Academic Posts) in these hard financial times.

Interviewees noted that strong leadership is the key to the implementation of CARC:

A typical comment:

The Executive Nurse Director and Nurse Leads have made the posts more visible. They have backed initiatives from the top.

4. Special arrangements between NHS and partner universities

Funding arrangements were worked out by identifying two separate funding streams; the clinical component to come from NHS Lothian's general budget (it was essential for the success of the pilot to ring fenced funding) and the research component secured through investment by NHS Lothian R & D Office, the university partners and NES. An equal contribution of funding was secured from all partners to support the infrastructure, management and operational processes required for implementation. It is anticipated that some the research activities may be eligible for CSO doctoral and post doctoral fellowships. NHS Lothian manages the overall funding arrangements. Sustainability of funding is clearly a key consideration for the future, with long term commitment needed to grow a critical mass of NMAHP clinical academics.

There is a legal agreement with regard to the pilot between NHS Lothian, partner universities and NHS Education for Scotland.

QA is under the umbrella of Health Services Development Unit (HSDU) which supports all research.

5. Establishing partnership synergy

Familiarity with each others' organisational priorities, with the clinical priorities of NHS Lothian and with the research strengths of the three universities were all viewed as important for establishing progress with the pilot. It was noted that the strategic priorities and operational processes of NHS Lothian and the three universities are at times divergent and could inhibit progress although the partners were able to build on past working relationships. Indeed developing synergy for the NHS with the universities was much easier than had been anticipated. As one interviewee stated:

The HEIs have had a history of coming together with NHS Lothian and they were keen to set something up again. Financial times are hard and there is a sense that better we are all in it

together. The HEIs are aware that they need clinical partners. There is a big health and higher education agenda to work on together.

To promote shared understanding of priorities and perspectives facilitated sessions were held between the universities and NHS from summer 2009 onwards. Dialogue at the early sessions was informal and relaxed with a focus on establishing whether the potential partners had a shared agenda. It was noted that the relationship between the NHS and partners would be tested at all levels.

A Project Management Group was established with representatives from the partner organisations to develop the Lothian CARC pathway and operationalise the pilot report reports to a Steering Group. The establishment of a Project Steering Group made up of key stakeholders whose tasks include overseeing the strategic direction of the project and providing advice on its implementation was seen as essential to ensure commitment to the pilot. The group comprises representatives from NMAHP management, local HEIs, NMAHP Consultants, NHS Lothian R & D Office, NHS Education for Scotland, Continuing Professional Development Department, and HR Department (NHS Lothian, 2010a:9). NHS Lothian leads on communications about the project and consults with partners which has been effective, for example communication and publicity for the launch event in May 2010.

6. Operationalising the partnership

The NHS Lothian partnership model is embedded in clinical practice and involves collaboration with academic partners in providing research training and supervision. Key features of the scheme include: establishing a total of six clinical academic research appointments, three at senior practitioner level (with a part time PhD focus) and three at advanced practitioner level (clinical research fellows) across three clinical demonstration areas, selected in relation to strategic research priorities, local Service plans and established research groups with supportive infrastructures (ibid). Each university will register one of the three PhD students. Three NHS Lothian appointments will be given formal honorary status at Clinical Research Fellow level - one at each of the participating universities.

There has been an attempt to overcome employment issues such as those identified above and in the Finch Report (2007) by offering positions only to existing NHS employees who will remain in their clinical post for 50% of their time. The remaining 50% of their time will be available for research activities. Perceived benefits of the model include defined research outputs in terms of research training, career development and succession planning, mentoring, completion of relevant clinical research studies, publications and positive evidence-based impact on clinical Service delivery. It is also expected to enhance a culture of enquiry and research-mindedness within the NMAHP professions in the region (NHS Lothian, 2010a).

It is intended to evaluate the clinical academic initiative through a longitudinal study involving data collected using a variety of methods to gather views and experiences from a range of stakeholders at years one, three and five (the end of the pilot). It is noted that comprehensive evaluation of the pilot will be important for attracting sustainable funding and establishing clinical academic careers as a mainstream option.

In 2010 NHS Lothian and its three partner universities launched the 'Lothian Nursing, Midwifery and Allied Health Professional (NMAHP) Research Framework 2010-2015' which articulates a vision and guiding principles that underpin their collaborative approach to research and presents a five year plan (NHS Lothian, 2010b). Both the pilot and the research framework are aligned to NHS Education for Scotland (NES) national approach to NMAHP Clinical Academic Research Careers in Scotland (NHS Lothian, 2010: 6).

Section C: Benefits of implementing clinical academic posts (NHS views)

1. CARC quality healthcare improvement potential

There is a widely held belief among those interviewed that there is significant quality and healthcare improvement potential in establishing and maintaining clinical academic posts for nursing in NHS Lothian. It is felt that clinical academics can make a significant contribution to research and quality practice in patient safety, care and treatment. Clinical academics are in position to influence Service, in both organisational development and evidence into practice. Clinical academic posts are not particularly new to NHS Lothian as various initiatives have resulted in a small number of positions being created. Clinical Academic posts are considered by those interviewed to be essential for the ongoing care for patients and research is an essential part of that. Clinical academics can help to change views on how Service is delivered. There is also a widely held view that frontline nurses do not always realise that there is a need to use evidence to support their practice.

2. Efficiency and improvements in service delivery

Clinical academics can influence practice through their research findings and are well placed to note areas where service improvements are needed and also note outdated and inappropriate practices. In line with the Cooksey (2006) review of health research recommendations, current clinical academics in NHS Lothian act as knowledge transfer champions, using and disseminating evidence to influence its uptake and adoption to improve the quality and safety of patient care.

3. Benefits to patient

An important aspect of the pilot is the intention to involve patient/service user representatives in the selection process in research study proposals where they have experience (Lothian, 2010: 13). There is also the intention to involve them in the project steering group. It is hoped patients will benefit from their involvement in research through the pilot.

4. NHS may become a more attractive place to work

By implementing clinical academic posts for nurses, the NHS may become a more attractive place to work. Nurses will know that they are able to pursue a clinical academic career and know that the posts are essentially geared towards clinical work and research. The CARC scheme's ultimate goal is that nurses are able to pursue a clinical academic career by undertaking a PhD and moving on to become Research Fellows who lead research and gain sustainable funding and that some move on to become Clinical Chairs. Whatever future models are developed for CARC the interviewees note that flexibility is the key for the post holder in order to balance their clinical and academic commitments. Current post holders have struggled to maintain their flexibility and a clinical academic career.

Indeed one person in post since the 1970s created her own clinical academic career through taking the decision to work part time in both jobs but was forced by lack of flexibility with clinical shifts to abandon this strategy.

5. Bridging the theory-practice gap

There is a widely held belief among those interviewed that clinical academics posts can contribute to bridging the theory-practice gap. The posts provide evidence that clinical academics are competent and credible in both the environment of HE and in clinical work. They are able to utilise and translate evidence to inform practice. They are able to identify areas where there is a lack of evidence and understand that some areas such as emergency medicine are well researched. Those interviewed who hold clinical academic posts noted that when setting up a research project it is essential to get the right mix of academics and clinical staff in order to access knowledge of processes and of people. It is important to note that clinical academics are engaged with the literature base. They have knowledge of who is researching in their area and are able to establish national and international links to research in their specialist areas.

Clinical academics know their field of research: they can help point clinicians in the right direction to gather evidence and they can also offer an assessment of research quality, avoiding the transfer of weak research into practice. Clinical academics are active in sharing research findings face-to-face on the wards. Some interviewees reported that their own research is not directly applicable to practice or that transfer into practice may take some time.

Some senior clinical academics have a strategic role and are able to influence policy and practice at local and national levels. Some interviewees reported that they have been asked to develop clinical guidelines and so can weave their own research findings and information into guidelines thus shaping them as they see fit. Clinical academics are often consulted by clinical colleagues because they are seen as experts in their specialism.

6. CARC scheme changed research dynamic

Some interviewees noted that the CARC scheme has changed *“the dynamic a bit”* in that there is more infrastructure support and research is more aligned to the NHS Board’s strategic direction. It was noted that clinical academic careers are more accepted and integrated as part of clinical services, but it was also noted that the scheme is in its early stages. Interviewees who are clinical academics enjoy having their own research agenda based on their experiences and knowledge of their field. They were able to pursue their own interests in research terms. Interviewees described research as not just a job but as needing to be driven by a strong desire to move a particular specialist area/agenda forward.

For some their research has helped to shape the research strategy in their areas of expertise especially where their research areas reflected national health priorities. The clinical academics explained that they were used to *“being mavericks”*: that is doing their own research. They expressed some uncertainty about being part of a bigger team if this meant that their research priorities were set elsewhere. They do not want to be controlled by the

NHS agenda. They were concerned to make sure their voices are heard in shaping the research agenda.

7. Thinking about the future

One interviewee suggested that building a critical mass of clinical academics could be achieved by every ward having staff nurses at band 6, one for education and one for research. Another interviewee suggested that more use could be made of the Cochrane Nursing Network in order to encourage others to look at evidence.

Section D: Barriers to establishing and maintaining clinical academic posts for nursing (NHS views)

1. CARC is new and not yet fully understood

CARC is new therefore is not yet fully understood by NHS or universities. In the past attempts have been made to implement clinical academic posts but they have tended to be at a more junior level. Some interviewees noted that some university managers may feel that it is better to have a full time academic position than a joint post. Some NHS managers may prefer full time positions within Service rather than a joint post with universities.

One interviewee commented:

We are at early stage of introduction and it is not surprising that CARC is not understood. It is driven by the Executive Director of Nursing so it should happen. However, it is not necessarily a priority for NHS Service Managers. It is not a priority when they have to deal with day-to-day clinical services although they are not necessarily against research. Under financial constraints, the priority is to cover clinical services. Just covering clinical services is such a challenge.

2. The need to develop a research culture

Interviewees believe that key to encouraging evidence into practice is to create a research culture within the NHS. There are no precedents for research and only a few individuals available as role models. Many clinicians do not see the relevance of research to their role. This underlines the need for research facilitator roles in the NHS so that a supportive infrastructure and leadership with dedicated time to facilitate research is provided.

Two interviewees commented:

The research facilitator roles enable us to think about research as part of our daily routine.

There needs to be a realisation that we need research and that it is a service priority and relevant to driving efficiency. In terms of being receptive to research – even if managers are positive, above all they will maintain provision.

3. The need for clear definition of clinical academic posts

A number of interviewees noted that clinical academic posts were not clearly defined: there were a number of versions of the role and debate about whether all three components of the role needed to be carried out in order for the post holder to be considered a clinical academic.

4. Challenges in managing the research process

Finding time to complete the preparatory work before a research project can be undertaken is challenging and often deters potential researchers. Researchers find the practical support from NHS Lothian Research Facilitators helpful. Interviewees noted that it takes years to build from a small research project to larger projects involving a team. Part of the role of facilitators is to help bring people together to form a research group for proposal writing and conducting the research.

5. Lack of continuity of established research groups

Some interviewees stated that a major barrier to research is the lack of continuity of established research groups: the maintenance and development of a line of enquiry is dependent on individual and local circumstance. For example, there are circumstances when a researcher in the NHS is interested in pursuing a research project, but there is no matching expertise or interest at the university.

6. Lack of leadership

The numbers of clinical professorial chairs in nursing are being reduced through early retirement, and the positions are not being replaced, resulting in a lack of leadership. Compared to the medical profession the number of established chairs is small. The Royal College of Nursing research group commissioned research to look at the dwindling professoriate.

Interviewees commented:

We need to look at where the future professors are coming from and look at succession planning for clinical academic chairs and work on getting people with the right skill set. Within the NHS Lothian framework there is the ambition at the end of the five year pilot to establish a Clinical Academic Chair. CARC should be embedded in NHS after five years.

Currently there are no clinical academic chairs in Lothian NHS.

There is a problem with the supply of people at Post Doc level to develop. The current pilot is limited to NHS Lothian this is an artificial barrier to growing numbers.

There should be professorships, clinical chairs and career pathway like Medics have.

A clinical chair would have both clinical practice and academic credibility and be able to influence both worlds.

7. NMAHP consultants and research leadership

There are 15 NMAHP consultants that sit outside the Lothian CARC scheme. The interviewees believe that not many of the consultants could lead research. The consultants are strong clinical leaders but most do not necessarily have well developed research capabilities.

One interviewee commented:

The potential leader pool is small. Only one consultant in NHS Lothian has a PhD.

8. Feeling invisible and isolated

A few interviewees had experienced feeling invisible and isolated, although they believe this is slowly starting to change. The clinical academics noted that they were usually the only person in the Clinical Directorate or field that is research active and also felt isolated from the wider clinical academic community. They noted that there were a nurses with Masters level and PhD level research training qualifications who did not go on to become research active beyond their training and that more needs to be done to tap into this potential pool of clinical academics.

9. Obtaining research funding

A few interviewees believe that there is very little academic investment in nursing research, however there is significantly more investment in teaching which has a different funding stream.

Clinical academics spend a significant amount of their time writing grant proposals. Sometimes they secure only small amounts of research funding and this obviously affects what they can achieve and the impact of the research. Small-scale studies with small sample sizes may mean that the findings are not reliable and cannot be submitted for publication.

Interviewees commented:

There is limited grant funding available, sometimes you need a large grant to get reliable answer.

With clinical trials the number of patients to research on is limited and you are limited by the finances.

10. The banding issue

Clinical academics were concerned that their current NHS banding did not recognise the complexity of their roles, in particular their research role, and they considered this to have a significant negative impact on their career development.

Interviewees commented:

Doing research does not help our banding. It is not recognized and you do not get extra points.

We do not get credit for our PhDs and there is no financial recognition, whereas the Docs get credit.

The NHS needs to recognize the achievement of a PhD in the AFC (Agenda for Change) which requires staff to achieve additional qualifications such as Masters and PhDs. We should start on Band 8A like the Medics.

11. Heavy workloads

Interviewees reported high clinical workloads along with academic pressures to be research active that involved writing proposals and publishing for the upcoming REF. Some have added administration pressures associated with teaching. They are expected to participate fully in the life of both the NHS and the university. They are keen to keep the clinical element of their post and consider patient contact very important. In order to cope with the pressures of different parts of their work (Service, research and teaching) they have developed key contacts in each area who can help provide them with essential information and identify priorities. They constantly juggle work commitments within and across their different responsibilities and need maximum flexibility to make the post work.

Interviewees commented:

One needs to be able to juggle workloads. People do not understand what you do particularly in clinical settings. Both academic and clinical have different expectations of you and they only know their world and they expect you to meet all the work demands.

If one is going to be a clinical academic then you need to accept that you will be working until midnight on marking and writing journal articles, it is just how it is.

You work hard to achieve status. We would like to be recognized at Nurse Consultant level.

We have to cope with processes and bureaucracy. We need to know the academic systems and clinical systems. I tend to use key contacts for each part of the job so that I can cope. They will help you to keep up with academic demands and clinical demands and particular administration requirements.

I am keen to keep the clinical part of job because having patient contact is most important.

The interviewees also commented on the heavy workload experienced by those undertaking a PhD and that although one noted the personal satisfaction gained, when the doctorate was completed it was not recognised in Service beyond “a tick in a box for Service”.

As one interviewee summarised views around doing a PhD:

Doing a PhD is a huge commitment, you need to sustain your research interests and this does not necessarily do anything for your career. Often nurses do a PhD in mid career and they have to make a lot of sacrifice and just end up back in post and nothing has changed but they have. NHS should highlight the potential international research opportunities.

12. The NHS is a barrier

Some clinical academics believe that the NHS is a barrier to successful implementation of clinical academic careers because people working in the NHS do not understand these posts. Difficulties were reported in working with HR around banding, pay agreements and general HR issues. Historically universities have been the grant holders which meant that they had control over contracts and researchers were given relative freedom to get on with their research. The interviewees are concerned that the NHS does not have in place robust systems ~~to~~ that work for clinical academics.

HR is a complete nightmare to work with supervision and management – it takes months to get banded and to get an agreement to pay.

Colleagues have not been given contracts through bureaucratic problems.

Historically universities are the grant holder. The NHS needs to address this issue (appointing clinical academic researchers). The fact they do not know how to work with clinical academics is a recipe for disaster.

The logistics of joint appointments are very difficult. The statement below summarises the issue:

I used to do a 12 hr shift on the roto, it's hard to cut back on clinical. The roto offers no flexibility. I stopped doing clinical work to concentrate on research.

Section E: Facilitators of the successful establishment and maintenance of clinical academic posts (NHS views)

1. Funding sustainability

There is the issue of sustainable funding for clinical academic posts beyond the current pilot and also to build a critical mass. Interviewees suggested as a way forward that there needs to be much greater investment in infrastructure. The universities have FEC and REF money – the next re-distribution will be after the REF in 2014 with funding allocated in 2015 that could be invested in clinical academic posts and nursing research.

2. Maintenance beyond the five years

The pilot scheme has clear outcomes and outputs and there is an expectation that the post-doc posts will generate research income in the future. It is very important for those in the scheme to secure grants from recognized funders and achieve academic outputs. Interviewees believe that there should be investment in support of developing researchers' grant writing skills. The scheme must demonstrate its success by ensuring PhDs are completed and post docs have established a secure funding base.

Interviewees commented:

As far as maintenance into the future beyond the five years is concerned it's like stepping into a void.

3. Ongoing need to develop research capacity

The interviewees believe that while there may be reasonable levels of interest in research by some in the NHS, there are only a few clinical academics who have the capacity to attract research funding. They believe that the NHS needs to see research as important in the quality improvement culture and invest in its future.

4. Work to do with non CARC demonstration sites

Interviewees noted that there is work to be done with non CARC demonstration sites. The idea of Service Clusters has been developed to facilitate clinicians and academics working together on joint research projects. Cluster members will be helped by the NHS Lothian Research core research team to develop research questions and they will provide expertise and time to help with forming research groups and with proposal writing to attract funding. They hope to capture the enthusiasm of potential researchers who do not necessarily have the appropriate skills for these tasks and help them to move forward on their research ideas.

5. Key senior management support and buy in is crucial – can make or break

Interviewees strongly believe that top down support is essential for the establishment and maintenance of clinical academic careers. They stated that a commitment to nursing research and CARC needs to be part of strategic objectives with appropriate resourcing

committed on an ongoing basis.

Two interviewees commented:

Key senior management support and buy in is crucial to the successful implementation of the pilot and its future, it can make or break it.

How clinical academic posts are played out through management structures will be telling. Is there real support for these positions?

Interviewees stated that line manager support is crucial to the support of the post and that they let researchers get on with their research. They need to work with the clinical academics to prioritise workload and to support those priorities.

One interviewee commented:

NHS managers could be like the one I worked with ten years ago, the local manager freed up time for research from the clinical budget.

Section F: Changes needed to make it easier to establish and maintain clinical academic posts (NHS views)

1. Mainstream CARC as a career option

Interviewees stated that for the majority who want to do research *“have to want to do it, to step off the career path, loose points and live on a stipend”*. What needs to happen is to mainstream clinical academic careers so they are seen as a viable career option from early research training through to professorial clinical chairs.

2. Demonstrate to the NHS the value of doing nursing research

There is a need to demonstrate the value of doing nursing research to the NHS. There is a need to achieve the agreed outputs from the pilot. Interviewees believe the key to this is getting the right candidates and the right demonstration sites to show the benefits of research and demonstrate the translation of evidence into practice thus illustrating an impact on health as well as publications and an impact on the REF.

3. Improve understanding of what research is

Some interviewees believe that the NHS Managers are keen to have numbers of Academic Service Evaluators to evaluate schemes such as LEAN rather than support research. Some interviewees were concerned that not all managers understand the difference between a service evaluation and research. The interviewees were also concerned that many managers are not aware of what nursing research is.

4. Medical staff have a well established career pathway

Typically those interviewed made comparison between NMAHP's experiences and those of the medical profession. Some of those interviewed noted that doctors have a well established career pathway where research is integral and that it is centrally funded. They regretted that the model is not the same for nursing. Also unlike nursing there is, for example, a funded doctors' journal club where lunch is provided and there is the opportunity to discuss journal articles. Doctors have time allocated for research reading and for writing journal articles. Doctors have flexibility in that they have specific time allocated to teaching research and clinical practice.

5. Knowledge priorities are different in the NHS and the universities

Some interviewees noted that the workforce is changing as a result of the increasing numbers of graduate nurses whose knowledge may reflect their university experiences and who are more knowledgeable than some of their counterparts in clinical practice about the importance of drawing on the evidence base to support clinical practice. In university hospitals in particular there is an expectation that nurses will use evidence to inform their practice. They express the view that graduate nurses need to work in clinical practice before going on to a clinical academic career so they get a good grounding in the NHS and develop their 'emotional IQ' which is regarded as essential to nursing. They argue that it is important

that in developing clinical academic careers that tacit knowledge is not devalued and the role of the 'Expert Nurse' is valued.

Some interviewees believe that the differences between health and higher education are diminishing. In particular, they state that CHIR brought Service and HEIs together in their focus on developing NMAHP research. Some interviewees stated that they would be surprised if universities worked in isolation and developed research areas without first approaching the NHS. Some HEIs are calling their research applied research to demonstrate their connection with Service.

Interviewees commented:

The issues for HEIs are the REF, teaching v research tension, voluntary redundancy, and pressure for individuals to make time for research. The pressures from clinical are immense and clinical will win out.

The HEIs come from a different philosophical base and a different funding base. Service is much more practical and needs answers more quickly to problems.

For the pilot scheme we acknowledged different perspectives and worked with them.

The partnership with HEIs is working but I think that they could have been more proactive, it (the pilot) feels NHS led.

Section G: Implementing clinical academic research careers in NHS Lothian (HEI views)

This section presents the views of senior academics in nursing and of university senior managers.

1. Strategic fit of clinical academic posts in universities

The university managers stated that the establishment of clinical academic posts fit well with the strategic plans for their university. The creation of the posts was consistent with their strategy to enhance nursing research and education. The managers saw the posts as a useful bridge for building a closer relationship between the universities and the NHS. They understood the importance to the universities to have research informed by practitioners as part of an iterative process with educators/researchers that has been in process for many years. However prior to the current pilot, posts had been ad hoc and arrangements varied depending on the individuals concerned. Attempts in the past to formalize joint appointments between NHS and some universities did not work well. Interviewees thought that under the present economic constraints clinical academic positions will be challenged. The university will look at the income that clinical academics are generating through research grants in order to be sustainable and make judgements on viability informed by these considerations.

Some interviewees commented:

I believe that two publicly funded bodies should cooperate in knowledge transfer in partnership.

A change in funding has meant that positions became closely aligned to strategic plans.

In the past clinical academic posts were called joint appointments and they were not very successful. The clinical side wins out. They were a great strain on the individual and turned out to be tales of martyrdom. The posts were largely set up by individuals. They were not set up by institutions or linked to strategic plans.

2. Key tasks to be achieved prior to establishing the posts

There was a growing recognition by the universities that in the current financial climate there was a need to collaborate with one other and the NHS. The universities needed to think strategically about how to use the positions and how well they fit with their research strategies. One of the key tasks for universities was to agree their financial commitment to the pilot. In principle the pilot seemed straightforward to the senior managers and they were committed to it, however, they all thought 'the devil was in the detail'. Different tasks sit with different groups who had to work on the detail which took 9 – 12 months. The current pilot required considerable effort to establish correctly and there were many drafts of the Lothian Career Framework before agreement was reached. The NHS had their agenda and the universities each had their own and at times the universities' clinical research priorities did not match with those of the NHS.

Some interviewees commented:

The universities and NHS have different concerns and priorities. We had to talk through our various agendas.

Over the last few years we have been working towards greater recognition of joint posts.

The CHIR (Centre for Integrated Health Care Research) earlier project laid the ground work for future collaborations, prior to this we did not talk to one another.

The National NHS Education framework and the NHS Lothian framework were developed concurrently. NHS Lothian did use the national framework to inform its framework.

We need to work on NHS and university partnership to encourage graduate work in research to reflect the interdisciplinary experience of patient care.

New posts are tailored they have been built up over time and we are hoping that the boundaries will be fuzzy and not too rigid.

Usually with a joint appointment there is an emphasis on one part of the business more than another. To help mentors are to be appointed in an attempt to try to get the balance reasonable and not to have too rigid expectations, there is a need to blur the boundaries.

3. Special arrangements

Special arrangements were made for establishing legal agreements around funding and quality assurance between universities and NHS Lothian. There were group discussions between the NHS and HEIs about arrangements. The universities sought HR and Academic Registrar perspectives on the agreement. Collaborators offered £100,000 over five years, that is, £20,000 per annum. NHS administers the fund and NHS salary costs for post holders. The universities conducted due diligence on accounts. NHS/HEI contract sets out responsibilities and funding arrangements.

One Interviewee commented:

Within the university there was a debate over our investment, in particular how would these appointments help the REF. We were hoping for a 60%/40% split for our senior fellow to do research.

4. Establishing partnership synergy

The partnership with NHS Lothian was considered to be an evolving one and took approximately a year to set up. Each university nominated representatives to the management group. One of the tasks was to work out how the collaboration would work in practice, how the universities would work together and how they would work with NHS. Each university has its own agreement with NHS.

Interviewees commented that the NHS's agenda and theirs did not necessarily match:

From the start of the process the NHS agenda and ours did not necessarily match. In particular the part that applied to post docs NHS agenda did not necessarily map with our research profile and strength.

There are 14 post docs in NHS Lothian and there are not many post docs to choose from that match the universities' strategic plan.

We may not be in a position to advertise the positions in time to fit with timetable of the pilot.

The people available may not match our needs and there is a potential for mismatch.

5. Power sharing between the university and partner NHS

Power was divided on an equal basis between the universities and the NHS. The NHS is a constant factor, and there is no dominant HEI: chairing of the meeting and note taking rotates among the HEIs. The parties are fairly comfortable with what has been achieved in the partnership and they are developing levels of trust. The posts are administered and held within the NHS. The university's role is mentoring, career planning and professional development.

Interviewees commented:

The HEIs are paying partners. We still need to work out how applications will develop and move forward, although the clinical areas thought they could do it on their own without consulting us.

There is a power imbalance emerging between NHS and HEIs, I am not sure how the partnership will work out.

The pilot is to be monitored and independently evaluated and funds have been set aside for this.

Having a named person at NHS to work with the university has helped to build strong relationships.

6. Human resource issues

The Human Resources department of each the universities looked at any issues with employment that arose during the process of developing the pilot. The post holders are NHS employees on a single contract and NHS take care of HR issues. Post holders in the pilot are in honorary positions within the universities for 50% of their time where they have defined research outputs and supervision.

Interviewee commented:

That we agree on one model is a miracle.

Another benefit to spin off from the pilot is that we have managed to arrange four PhDs with other universities where we will share supervision.

Through the new initiative we have formalized working relationships with NHS and other universities.

If the model is successful it will pave the way for greater collaboration.

Line management is through the Dean.

7. Aligned communication processes between HEIs and NHS

The representatives on the pilot management group at each university regularly communicate with each other and with other staff within their universities and to their PR team about the pilot. The universities believe that aligned communication across the NHS and each university is important and to get it right can be difficult. There is no formal communication strategy between the partners. To date NHS has drafted communication

about the pilot to be shared publicly and this went to the universities for approval to ensure that they were comfortable with what was being used.

8. Previous attempts to establish clinical academic posts

The interviewees all noted a long history of ad hoc appointments with mixed success as previous systems had been very fragmented and usually when post holders left post they were not replaced.

Interviewees commented:

The university has had a long history of joint appointments and there has been a number of problems such as clinical duties being overwhelming, lack of authority to implement research into practice, it is difficult to take someone from full time NHS into academia.

In the past we had lecturer practitioner posts.

Clinical academic posts have not really worked for us.

There has never been a scheme or framework like the pilot in Lothian.

The earlier posts were ad hoc and tended to be informal.

9. A question of ongoing support

The interviewees noted that in principle they would like to keep the pilot going beyond five years however there is no commitment and continued funding is dependent on the evaluation of the pilot. It is hoped that the positions will have developed so that the post holders will have attracted their own research funding from other sources.

The post holders will need to achieve research grants and bring money to the university.

Dubious - we will look at the pilot financially.

Section H: Benefits of establishing clinical academic posts for nursing (HEI views)

1. Quality improvement potential in establishing and maintaining clinical academic posts

Universities consider that having an evidence base for clinicians is important and that it should ultimately lead to improved patient care. A culture of evidence based practice is developing, research is becoming more embedded in practice but this is still variable. Research undertaken has resulted in positive impact on practice e.g. NICE guidelines being developed.

Interviewees commented:

Universities meet regularly with NHS staff in their areas of research expertise and these meetings have helped to inform the development of their research strategies.

I hope there will be quality improvements. It is good to combine theory and practice.

There is a challenge for HEIs to be relevant to clinical.

Clinical ask different questions.

HEIs think of research more broadly.

NHS do not necessarily move from their point of view, position. There are tension and gaps between clinical and academia.

Both the NHS and the university want quality, there are different view of what this means.

2. Benefits to the post holders

Interviewees consider the main benefit for individuals holding clinical academic posts is the chance for them to develop expertise in a research area relevant to clinical practice. Post holders are able to maintain a clinical footing and combine this with research training (e.g. PhD) or as a Research Fellow. In identifying the benefits some interviewees also noted that it may be difficult for post holders to reflect on and use research findings in practice or to have a very significant impact on clinical practice, however the experience may help with their teaching. Some interviewees noted that the potential of the clinical academic posts is yet to be realized as it is difficult for the post holder if they are not in a senior post with authority to implement their findings.

Interviewees noted that there is no clear pathway from a post-doc to a clinical academic career and that post holders may end up returning to the NHS full time or become academics.

Interviewees commented:

It is easier for clinicians to come into academia than the other way around.

It would be indulgent for me as an academic to work in clinical practice once a week. It would be difficult to make a difference.

3. Benefits to the universities

There is political pressure from the Scottish Government and the Scottish Funding Council (SFC) for collaboration in research. Clinical academic posts provide opportunities to collaborate with other universities and the NHS and provide the bridge between the universities and the NHS. It was noted that by working with the NHS Lothian on CARC and the Research Framework universities became familiar with one another's priorities and those of the NHS. It was also noted that NHS may retain staff who are ambitious and research orientated and that Service will be enhanced by their contributions to evidence into practice. Post holders help to build the capacity to use research of the whole team.

A key benefit to the NHS is that the academy rather than tempt NHS person away from NHS, they can re-orientate themselves to a new career where they can stay in Service.

We are under pressure from SFC to work creatively in research collaborations with other universities and NHS. The creation of these posts (clinical academic) clearly shows we are working together.

Some interviewees questioned whether the “right people were being targeted with enough authority to implement evidence into practice”. One university as a result of closer collaboration with NHS has modified its approach to PhDs.

Over the last four years we have moved away from the scatter gun approach with PhDs, in the future we will be going for a narrow approach. We will be operating in strategic niches within our HEI and focus on publications.

4. Knowledge exchange potential of clinical academic posts

The interviewees consider that knowledge exchange is a key area of development in their university, in higher education and internationally. While there is no agreed definition most commented on the two-way flow of people and research ideas between the Academy and Service. They stated that KE fits with government priorities and with research funding and that maximizing the benefits of health research is a key area for knowledge exchange.

Interviewees commented:

Clinical academics can act as a conduit between NHS and HEI, but this needs to be put into perspective and agree on achievable outcomes.

NHS management will need to support the dissemination of knowledge. Post holders will need support to go to conferences, although you can end up meeting the same people because of the small research community.

Post holders should be able to draw together the threads of research outcomes and translate them into practice.

Section I: Other comments (HEI views)

1. Knowledge priorities are different in the health authority and the university

Interviewees noted that the NHS and each of the universities have different knowledge priorities and different areas of research and foci. The NHS may want a post-doctoral appointment in a particular area where a university does not have the expertise. Universities have a different view of what counts as evidence and a different philosophical position from the NHS and the university has a bigger picture of the research environment.

Interviewees commented:

NHS has a positivistic approach to what counts as evidence, they are more interested in systematic reviews.

NHS is looking for answers to questions, quick fixes and answers to questions that are financially driven.

NHS has competing discourses of cuts and efficiencies can be at odds with research agenda.

2. Nursing research

Interviewees reported that It is not very common to do a PhD and that nurses tend to do it mid career. Many nurses do not want to leave the security of the NHS employment so consequently there is not a big pool of candidates willing to develop as clinical academics. One interviewee identified three different types of nursing research: *“Those doing their own thing, and a cadre of nurses doing data collection for doctors as well as a group of non nurses involved in nurse research as part of multi disciplinary teams.”*

All interviewees thought that nursing research journals have been a good way “to get new knowledge out there”. They are in no doubt that nursing research is helping to create an evidence base for nursing that should be utilised. They acknowledged that nursing research has grown up around individual interests and expertise and in the past it was not necessarily lined to any strategic plan.

Some interviewees believe that the problem for nurse specialists is how to translate specialist knowledge and research findings into mainstream nursing.

3. Nursing policy

Some nursing academics are able to influence nursing policy through regularly attending meetings with their counterparts in the Scottish Government CNO department and NHS Education and their local NHS Boards. The establishing and implementing of clinical academic posts have been discussed at Council of Deans meetings.

4. Leadership

Leadership for clinical academic posts is considered by interviewees to be very important because they believe that post holders need to have the power and authority to implement

their research findings. The establishment of clinical academic chairs could “give clout from the top and act as change agents”.

Section J: Summary and conclusions

We now turn our attention to the question: how well do developments in NHS Lothian sit with national and international efforts to establish and sustain clinical academic careers?

1. The National Guidance and NHS Lothian

The 'National Guidance for Clinical Academic Research Careers for Nursing, Midwifery and Allied Health Professions in Scotland' (NHS Education for Scotland, 2010) provides guidance for NHS Boards and the academy to support the implementation of CARC. The guidelines provide a brief overview of developments since 1994 to date in building a NMAHP research infrastructure for Scotland and note a number of different initiatives and funding models that have been tried over the years (pp 2-4). Although strategic collaborations have been established it was noted that they were not consistent in their approach to clinical academic posts and consequently there were limited pathways available to promising clinical academics. The guidelines also noted the importance of establishing a sustainable approach to NMAHP research leadership and to creating consistency and transferability for clinical academic posts across the NHS career framework (p4).

The "purpose of creating a national approach to NMAHP clinical academic research careers (CARC) is to strengthen research capacity and capability across NHS Board/University/Research Academic Centre partnerships through the generation and translation of research for population and patient benefit" (NHS Education for Scotland, 2010: Appendix 2). The 10 principles are viewed as being broadly in line with developments in the other UK countries: with a strong focus on NHS-academic partnerships while capitalising on multi-disciplinary collaborations. The principles also cover protected time for clinical practice and research to be conducted concurrently, the importance of research mentoring and addressing HR issues along with local adherence to the National Framework to ensure consistency and parity to enable career mobility (p14).

The NHS Lothian collaborative pilot was designed to help overcome some of the perceived barriers to the successful implementation of clinical academic research careers and to further developing a culture of evidence-based practice. The 'Lothian Nursing, Midwifery and Allied Health Professional (NMAHP) Research Framework 2010-2015' articulates a vision and guiding principles that underpin their collaborative approach to research and presents a five year plan (NHS Lothian, 2010b). Both the pilot and the research framework are aligned with the NHS Education for Scotland national approach to NMAHP Clinical Academic Research Careers in Scotland discussed above. For those clinical academics who sit outside the pilot there are still many challenges in working across the NHS and the Academy such as heavy workloads, obtaining research funding and concerns about the NHS banding for clinical academic posts.

2. International perspectives

The first part of this research project reviewed literature on the barriers to and facilitators of clinical academic careers in Scotland and five international comparators: England, Northern Ireland, Australia, United States and Canada (see Weir and Ozga, 2010).

Internationally governments, health authorities and nursing sector professional bodies have commissioned reports and developed policies that support the enhancement of quality, capacity and capability in nursing research, teaching and scholarship. Establishing and maintaining clinical academic posts is an essential part of this wider nursing policy agenda as these posts involve clinical practice, teaching and research and offer an effective route to bridging the gap between the academy and clinical services. Putting these policies into operation has presented a number of significant challenges to countries including identifying barriers to, and facilitators of establishing these posts. Common barriers to emerge in the literature are clustered around the recognition of the differences in clinical and academic strategic priorities, policy drivers, funding bases and reporting structures. Those responsible for implementing policies acknowledged the need to work through these organisational barriers and as well challenges faced by individual post holders moving between two worlds. Common barriers in the NHS Lothian pilot echoed those mentioned in the literature and were addressed through several months of negotiation culminating in formal written agreements on the way forward. For clinical academics outside the pilot significant challenges still exist, in particular with HR issues.

Common facilitators identified in the literature and in the NHS Lothian pilot are clustered around securing targeted funding to support research training initiatives and fund joint appointments up to the level of clinical chair (at the level of aspiration for NHS Lothian) and securing formal agreement across the academy and health services.

NHS Lothian and partner universities recognise that clinical academic nurses are ideally placed to facilitate research translation in order to enhance patient care. However, without strong clinical academic leadership many of the 'bottom up' initiatives may lead to future disappointment. The time is right to exploit the value of establishing clinical academic posts for nursing leaders as pivotal in developing partnership between health (knowledge users) and higher education (knowledge producers) with a more recent shift towards co-production of knowledge: this partnership may also now be constructed around shared goals that promote learning across all the players involved, in pursuit of improved patient outcomes.

3. Conclusion

There are approximately 14,000 nurses in NHS Lothian and only a small number of clinical academics. If a clinical academic career route is mainstreamed as an option within a modernised career framework AfC for nurses then there are key potential barriers to be overcome. These are:

- Sustainability of funding: in the medium to long term further funding will needed if future sustainable CARC are to implemented.

- Quantifying investment for NMAHP research for example through the REF, knowledge exchange activities and evidence of the take up of nursing research into practice.
- Integration of the CARC role into the organisational structures and processes of the partner health organisations and the university.
- Gaining and sustaining high level visible organisational support to drive for sufficient resources to ensure post holder integration into both clinical practice and the academy.
- Developing and agreeing clear lines of responsibility and accountability between partner organisations to ensure the development and continuation of clinical academic posts and their inclusion within quality enhancement processes.
- Securing clinical chairs and other senior clinical academic posts to provide leadership and influence the research culture of both the academy and clinical practice. Clinical chairs can effectively engage with clinical staff and academic staff at all levels to facilitate the co-production of knowledge to jointly achieve better outcomes and quality for patients.

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Appendix A: NHS case study questionnaire

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NHS Case Study Questionnaire November/December 2010

Building Knowledge Exchange: Clinical Academic Posts for Nursing and Recognition of Knowledge between Health and Higher Education Systems

This research aims to contribute to the agenda of quality improvement in health and to knowledge transfer theory in higher education by identifying and theorizing policy, strategic and operational barriers and facilitators to partnerships between higher education and health boards for the development of senior clinical academic posts in nursing.

We would like to have accurate information for the case study and we are hoping you will help out by answering this questionnaire. All questions relate to nursing clinical academics.

- 1. Do you have records that track clinical academics appointed over the past decade (2000 – 2009)?** If so, can you table them by year and job title

Date	Positions–job titles	Total numbers of each for each year
1998	Research Lead/Facilitator for Community Nursing	1
2001	Consultant Nurse Sexual and Reproductive Health	1
2001	Senior Nurse-Research (University Hospitals Division)	
2007	Lead Practitioner Research (NHS Lothian)	
2002 – 2008	Part time Staff Nurse ICU/Part time Nurse Researcher	1
2009	Part-time research fellow (University Edinburgh) & Part-time Clinical Research Specialist	
	Full-time Clinical Research Specialist NHS Lothian and UofE	
2010	Honorary Fellow	
2003	Nurse Consultant Learning Disability	1
2004-2007	Band 7 Nurse, Substance Misuse Directorate	1

2007-present.	NMAHP PhD Clinical Research Training Scheme – 3 year full-time secondment Band 7 Nurse, Primary Care Facilitator Team, Substance Misuse Directorate.	
2005	Cardiology Nurse Consultant	1
2005	Consultant Midwife	1
2005 2010	Joint appointment as Senior CNS Palliative Care/ Lecturer Lead Nurse Palliative Care/Clinical Researcher	1
2006	Joint Appointment Diabetes Nurse Specialist/Lecturer	1
2006	Nurse Consultant Child Protection	1
2007	Nurse Consultant Interventional Cardiology	1
2008	Nurse Consultant Cancer	1
2008	Nurse Consultant Keeping Childbirth Dynamic (Midwifery)	
2008	Nurse Consultant for Intensive Home Treatment Teams and Mental Health assessment Service	1
2008	Nurse Consultant Children Palliative Care	
2009	Nurse Consultant Psychosocial Interventions Psychosis	
2009	Consultant Nurse Single gene complex needs Service	1
2009	Clinical Reader Neonatology (formerly Research and Practice Development Facilitator Neonatology since 2002)	1
2009	Honorary Nurse Consultant Acute Mental Health	1
2009	Consultant Nurse Alzheimer's	1
2011	Advanced Practitioner (Clinical Research) Critical Care Senior Practitioner (Clinical Research) Critical Care	1 1

The following questions are to do with your current situation 2010 -2011

1. How many clinical academic positions do you have at present?

Partly depends on definition of clinical academic positions.

If include all Nurse Consultants (13) and other posts (9) = 22

But if look at the Nurse Consultants who really fulfil a strong research role (3) = 12

2. What are the titles of the different posts that fit into the category of a senior clinical academic and how many of each of these posts do you have at present?

It depends what you define as senior clinical academics. We have only one at Clinical Reader level, which is probably the only senior one.

- Clinical Reader Neonatology – 1

3. What are the titles of the non senior clinical academic positions you have and how many of each category do you have? For example:

Title	Total numbers
Nurse Consultant	13
Lead Practitioner Research	1
Community Nursing Facilitator	1
Research Manager Capacity and Capability	1

Lead Nurse / Clinical Researcher in Palliative Care	1
Primary Care Facilitator Substance Misuse	1
Clinical Research Specialist	1
Diabetes Nurse Specialist/Lecturer	1
Advanced Practitioner (Clinical Research)	1 (3 by end 2011)
Senior Practitioner (Clinical Research)	1 (3 by end 2011)

- 4. What kind of employment arrangements do the clinical academics have and how many are in each category? For example, joint appointment 50% funded by NHS 50% funded by HEI and HR responsibilities shared between with NHS and HEI (5 posts); Substantive position with NHS and honorary position with HEI 30% and HR sits with NHS (3 posts).**

Date	Positions–job titles	Employment Arrangements
1998	Research Lead/Facilitator for Community Nursing & Health Visitor	2 Separate contracts both NHS
2001	Consultant Nurse Sexual and Reproductive Health	WTE NHS Honorary appt HEI
2001 2007	Senior Nurse-Research (University Hospitals Division) Lead Practitioner Research (NHS Lothian)	WTE NHS
2002 – 2008 2009 2010	Part time Staff Nurse ICU/Part time Nurse Researcher Part-time research fellow (University Edinburgh) & Part-time Clinical Research Specialist Full-time Clinical Research Specialist NHS Lothian and U of E Honorary Fellow	WTE NHS
2003	Nurse Consultant Learning Disability	75% NHS 25% HEI (Senior Lecturer)
2004-2007 2007-present.	Band 7 Nurse, Substance Misuse Directorate NMAHP PhD Clinical Research Training Scheme – 3 year full-time secondment Band 7 Nurse, Primary Care Facilitator Team, Substance Misuse Directorate.	WTE NHS – 0.2 WTE for research
2005	Cardiology Nurse Consultant	WTE NHS
2005	Consultant Midwife	WTE NHS
2005 2010	Joint appointment as Senior CNS Palliative Care/ Lecturer Lead Nurse Palliative Care/Clinical Researcher	0.5 WTE NHS/0.5 WTE HEI HR NHS
2002	Nurse Consultant Child Protection	NHS Part funded HEI
2006	Joint Appointment Diabetes Nurse Specialist/Lecturer	0.5 NHS/0.5 HEI HR NHS
2008	Nurse Consultant Cancer	WTE NHS (although first 2

		years 0.5 WTE funded by Scottish Government)
2008	Nurse Consultant Keeping Childbirth Dynamic (Midwifery)	WTE NHS
2008	Nurse Consultant for Intensive Home Treatment Teams and Mental Health assessment Service	WTE NHS
2008	Nurse Consultant Children Palliative Care	WTE NHS
2009	Nurse Consultant Psychosocial Interventions Psychosis	WTE NHS
2009	Consultant Nurse Single gene complex needs Service	WTE NHS
2009	Clinical Reader Neonatology (formerly Research and Practice Development Facilitator Neonatology since 2002)	1
2009	Honorary Nurse Consultant Acute Mental Health	WTE HEI
2009	Consultant Nurse Alzheimer's	WTE NHS
2011	Advanced Practitioner (Clinical Research) Critical Care Senior Practitioner (Clinical Research) Critical Care	0.5 WTE CARC funding/0.5 NHS funding* 1

* CARC funding made up of NHS R&D, NHS Education for Scotland, University of Edinburgh, Edinburgh Napier University & Queen Margaret University

5. Do you know how many clinical academics currently employed have a doctorate? 7

We also have one nurse and one midwife with doctorates who are not working in clinical academic roles currently.

6. How many of the current pool of clinical academics are engaged in

- a) Teaching only 6
- b) Teaching and research 10
- c) Research only 5
- d) Neither – 1 (one of Nurse consultants)

7. Of the total number of clinical academics who are currently engaged in research?

- a) How many hold Principal Investigator status? 8
- b) How many hold Co-investigator status? 4
- c) How many hold Research Fellow status? Not sure
- d) How many hold Research Assistant status? None
- e) Other – please specify

8. What areas of research are currently being undertaken by clinical academics?

Post/Field	Research
Community Nursing Facilitator	Studies all relating to community nursing practice and Service development, e.g. assessment of vulnerability to determine health visiting support needs, evaluation of introduction of new model of community nursing practice
Cancer Nursing	<ul style="list-style-type: none"> – Evaluation of pelvic function following treatment for rectal cancer – Evaluation of pelvic function following treatment for anal cancer – Evaluation of early assessment and intervention to manage pelvic dysfunction following treatment for rectal cancer – Programme for Clinical Nurse Specialist sustainability
Substance Misuse	Parenting issues for drug users
Learning Disability	Access to healthcare and improving health and wellbeing areas of research
Cardiology	Chest pain management
PSI Psychosis	Impact of staff training/delivery of psychological interventions
Sexual Health	Identifying and reacting to cause for concern arising from early sexual activity amongst teenagers Exploring stakeholder views for the MMR and HPV Vaccines
Compassionate Care	Embedding compassionate care in practice: realistic evaluation of Leadership in Compassionate Care Programme
Long term conditions	Role of telehealth in management long term conditions in the community
Neonatology	Parenting support Communication – IT systems
Critical Care	Quality of Life following prolonged critical illness Temperature and its measurement and management in brain injury and stroke Human brain cooling in health and illness
Palliative Care	End of life care in non-cancer illnesses

9. Do you have evidence and record of how research carried out by clinical academics has influenced practice? Can you provide examples of how research carried out by clinical academics has influenced practice?

Some examples:

Cancer – In the aforementioned research projects (1-3) – data from project 1 has identified that patients with rectal cancer can experience ongoing pelvic problems for many months/years following treatment. This data has informed the design of project 3 to introduce and evaluate an early assessment and intervention in practice for this group of patients.

Substance Misuse – Translation of evidence into practice has been through seminars, development of in-house training programmes, good practice guidance/inter-agency protocols and practice development toolkits, development of clinical practice documentation and templates and membership of Lothian-wide and Scottish-wide policy groups related to the management of children and families affected by problem substance use.

Learning Disability – Acute liaison nursing research across South East Scotland is a good example of practice-based research that is the first in the world to be undertaken and is informing service development and patient care.

Critical Care – research on brain cooling has contributed to knowledge and understanding of the physiology of heat loss from the head and is contributing to the development of non-invasive brain temperature measurement. This has been translated into evidence-based protocols for temperature management in critical care including shivering detection and treatment and traumatic brain injury management protocol.

10. What initiatives were in place to support clinical academic positions in your NHS prior to the Finch Report in 2007?

No specific initiatives as such although ad hoc appointments. These were largely historical from the NHS Trust organisations that had existed pre-2005 reorganisation.

11. What new initiatives were put in place to support clinical academic positions in your NHS since 2008? How many positions have been created and at what level?

Two specific initiatives:

1. Lothian NMAHP Research Framework 2010-2015

The NMAHP Research Framework exists to establish and sustain a Lothian NMAHP research community. It represents collaboration between NHS Lothian and its 3 principle academic partners for NMAHP research:

- School of Nursing, Midwifery and Social Care, Edinburgh Napier University
- School of Health in Social Science, University of Edinburgh
- School of Health Sciences, Queen Margaret University, Edinburgh

The aim of the Framework is to create and embed a shared vision that will strengthen the contribution of the NMAHP professions to the delivery of applied health services and clinical research that impact on patient/client care and position Lothian as a place with a vibrant NMAHP research culture.

The goals of the Framework are to:

1. Enhance research awareness and evidence based practice within all registered NMAHP roles.
2. Establish and develop clinical academic research careers for NMAHPs including those with established research training (doctoral level), NMAHP consultants, those appointed to the Lothian Clinical Academic Careers (CARC) Scheme, new and early career

researchers. It will also include a focus on joint appointments focussed on research including those at Clinical Reader/Professor level.

3. Embed the concept of 'clinical' and 'academic' homes for research active academics and NMAHPs as a way of strengthening collaboration, developing programmes of research, dissemination and utilisation of research findings.
4. Improve the monitoring and dissemination of NMAHP research activity including studies, publication and examples of impact.
5. Identify and work collaboratively with service clusters to develop local NMAHP research plans that will support overall R&D Strategy and local delivery priorities.
6. Enhance the management, professional support and career development for clinical research nurses.
7. Increase research activities (joint funding applications, publications and the development of shared agendas) between NHS
8. Enhance the role that Lothian NMAHP researchers make in shaping research policy, priorities and funding nationally.
9. Contribute towards each university's Research Excellence Framework (REF) submission.
10. Develop and sustain Lothian's reputation for NMAHP research within the UK.

2. Lothian Clinical Academic Research Careers (CARC) Scheme

NHS Lothian has developed a model for developing clinical academic career pathway that is firmly embedded within clinical practice whilst involving full collaboration with academic partners and placing an emphasis on supervision and training. It is aligned to the national career framework for health. Key features of the model are:

- 6 clinical academic research appointments at senior and advanced practitioner levels across 3 clinical demonstration areas.
- Clinical demonstration areas will be selected in relation to strategic research priorities, local service plans and supportive infrastructure especially the existence of well-established, active and successful research groups (of whatever professional mix)
- Defined allocation of clinical and research time embedded within clinical Service setting (0.5/0.5 WTE Split)
- Team organisation of the post holders with clear operational management, supervision and support arrangements
- Funded clinical research training relevant to each career stage (PhD and Clinical Research Fellow)
- Principle of separation of funding stream for research from clinical budgets with research training and infrastructure investment of circa £157,000 per annum over a 5 year pilot period (clinical parts of posts are already establishment and funded from current general budgets therefore incurring no additional cost to NHS Lothian).

The benefits of the model include defined research outputs in terms of research training, career development and succession planning, completion of relevant clinical research studies, publications and positive evidence-based impact on clinical Service delivery.

The first demonstration site is Critical Care and the advanced and senior practitioners came into post January 2011. The two other demonstration sites will be appointed in early March 2011 with a view to the four remaining post holders being in place by summer 2011.

12. What is the total number of nurses employed in your NHS of them what percentage of them are clinical academics?

Approximately 6,500 registered nurses (CHECK) – estimate 22 posts = 0.3%

Is there anything that you would like to share that has not already been covered in this questionnaire?

Thank you for taking the time to complete this questionnaire.

Please email your responses by 23 December 2010 to Dr Annie Weir, University of Edinburgh Annie.Weir@ed.ac.uk

Appendix B: Interview schedule: NHS Senior Managers

Building Knowledge Exchange: Clinical Academic Posts for Nursing and Recognition of Knowledge between Health and Higher Education Systems

This research aims to contribute to the agenda of quality improvement in health and to knowledge transfer theory in higher education by identifying and theorizing policy, strategic and operational barriers and facilitators to partnerships between higher education and health boards for the development of senior clinical academic posts in nursing.

Key questions:

Health Board Interview Schedule Topics:

1. How have clinical posts for nursing been incorporated into strategic overview and priorities? Do your plans include establishing senior clinical academic posts for nursing (post doctoral to professors)?
2. Have any special arrangement been made with regard to establishing legal agreements around funding and quality assurance between NHS and your partner universities?
3. How have you gone about establishing partnership synergy – working out how to work with potential HEI partners?
4. How have you gone about understanding partner's priorities and perspectives?
5. How has the partnership been operationalised between the NHS and partner HEIs?
6. Have there been human resources issues that have had to be worked on? Please explain
7. How have you aligned communication processes between the NHS and your partner universities?
8. Do you think there is quality/healthcare improvement potential in establishing and maintaining clinical academic posts for nursing?
9. What kind of benefits do you think there are in establishing these posts for a) individual post holders b) the NHS c) the universities?
10. What kind of ongoing support is there for the post(s)?

We are also interested in your views on whether you think that knowledge priorities are different in the health authority and the university.

Is there anything that you would like to share that has not already been covered in this interview?

Appendix C: Interview schedule: Senior Managers (Universities)

Building Knowledge Exchange: Clinical Academic Posts for Nursing and Recognition of Knowledge between Health and Higher Education Systems

This research aims to contribute to the agenda of quality improvement in health and to knowledge transfer theory in higher education by identifying and theorizing policy, strategic and operational barriers and facilitators to partnerships between higher education and health boards for the development of senior clinical academic posts in nursing.

The following questions will be used to guide the discussion:

1. How does the establishment of the posts fit with strategic plans for the university and department and how might the positions be sustained into the future?
2. What were the key tasks that had to be achieved prior to establishing the post(s)?
3. Have any special arrangement been made with regard to establishing legal agreements around funding and quality assurance between your university and partner NHS?
4. How have you gone about establishing partnership synergy – working out how to work with potential NHS partners?
5. How have you gone about understanding NHS priorities and perspectives?
6. How has power sharing been operationalised between the university and partner NHS?
7. Have there been human resources issues that have had to be worked on? Please explain
8. How have you aligned communication processes between your university and the partner NHS?
9. Do you think there is quality improvement potential in establishing and maintaining clinical academic posts for nursing?
10. Has the possibility of clinical academic posts been previously explored? What were the outcomes?
11. What kind of benefits do you think there are in establishing these posts for a) individual post holders b) the NHS c) the universities?
12. What kind of ongoing support is there for the post(s)?
13. What do you consider is the knowledge exchange potential of this position?

We are also interested in your views on whether you think that knowledge priorities are different in the health authority and the university.

Is there anything that you would like to share that has not already been covered in this interview?

Appendix D: NHS focus group meeting agenda

NHS Focus Group Meeting February 2011

Building Knowledge Exchange: Clinical Academic Posts for Nursing and Recognition of Knowledge between Health and Higher Education Systems

This research aims to contribute to the agenda of quality improvement in health and to knowledge transfer theory in higher education by identifying and theorizing policy, strategic and operational barriers and facilitators to partnerships between higher education and health boards for the development of senior clinical academic posts in nursing.

Agenda

1. Introductions and research project overview
2. Focus Questions
3. Discuss the findings from the literature review (accuracy and insight)
 - a) Findings on Scotland
4. Future Focus

Interview schedule

1. What are the benefits if any in establishing and maintaining clinical academic posts for nursing?
2. What are the barriers if any in establishing and maintaining clinical academic posts for nursing?
3. What facilitates the successful establishment and maintenance of clinical academic posts?
4. What would have to change to make it easier establish and maintain of clinical academic posts?
5. Clinical academic posts span universities and Health Boards, in your opinion, do universities and nursing staff have the same objectives in producing knowledge through research and are there any conflicts, differences in priorities?

Is there anything that you would like to share that has not already been covered in this focus group?