

Modernising Scientific Careers (MSC)

**A Consultation Analysis of:
Organisational, Individual and Deliberative Event
Responses (Conducted for Department of Health)**

September 2009

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Introduction

Introduction

Overview

This report, prepared by Ipsos MORI, contains a summary review of the responses received from organisations, individuals and (through two subsequent deliberative events) professionals to the 2008 / 2009 consultation document:

The Future of the Healthcare Science Workforce

Modernising Scientific Careers: The Next Steps

It has been produced to complement the UK Policy Document, which has itself been informed by the responses to the consultation and attendees at two deliberative events.

The deliberative events were held in Liverpool on the 22nd July and London on the 27th July 2009. They explored some of the key themes to emerge from the main consultation.

The consultation was available online (at www.dh.gov.uk/cso), and the target audiences were:

PCT Chief Executives, NHS Trust Chief Executives, SHA Chief Executives, Medical Directors, Directors of Nursing, Directors of HR, Employers across the UK, Trades Unions, Healthcare Science Departments and Healthcare Scientists, Healthcare Science Professional Bodies, Higher Education (HE) and Further Education (FE) Providers, Private Sector Healthcare Providers, Education Funders across the UK, Medical Royal Colleges, Health Boards, Regulatory Bodies and Patient Representatives.

In total, 980 responses were received to the main consultation, from groups / people associated with the Healthcare Science professions (comprising 185 replies from organisations, and 795 from individuals). The responses came in either online or in hard copy / written form.

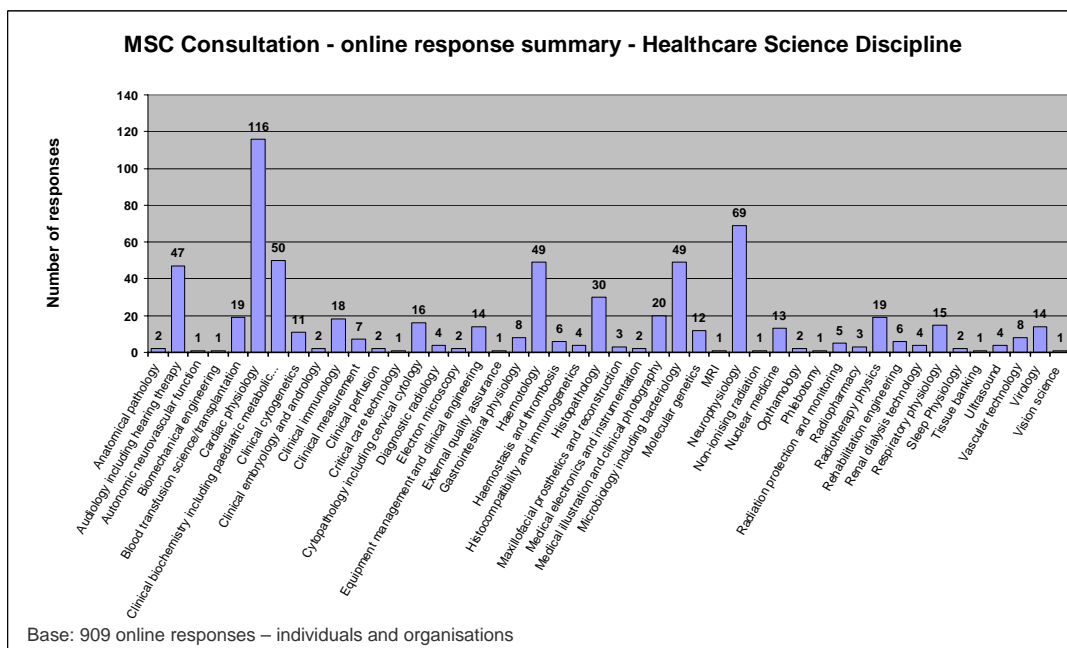
A total of 198 people participated in the two deliberative events.

Respondent Profiles

The 185 organisational responses represent around 145 *different* organisations (with some submitting more than one response).

Among individuals the disciplines represented were:

Who responded? – HCS disciplines



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In aggregate, 46% of individual respondents worked within Life Sciences, 14% in Physical Sciences & Engineering, and 40% in Physiological Sciences. Responses from England accounted for around 64%, Scotland 14%, Wales 6% and Northern Ireland 16%.

The deliberative events comprised 143 participants in London, and 55 in Liverpool. They encompassed a similar range of specialist and key audiences to the consultations: NHS Trusts and related bodies, universities and teaching hospitals, professional representative groups, legislators and trades unions. Patient groups and individual patient representatives also attended.

Content and Interpretation of the Report

The report is structured to reflect the UK Policy Document, with each main subject area discussed in turn and in each case the views of organisations and then individuals reviewed. (The outcomes of the deliberative events are summarised in separate text boxes).

The appendices contain a copy of the consultation questionnaire.

When reading this report, it should be noted that what is being reported is an account of people's responses, and of their views and perceptions – whether 'right' or 'wrong'. The report content has not been adapted to 'correct' or contextualise people's responses.

Such consultations seek views on specific proposal/s – and so those who choose to respond may not always share the same views / perspectives as those who do not.

Also, respondents will inevitably have a range of different *perceptions* which will colour their views. We cannot include the detail of everyone's views, but where applicable, have highlighted any broad differences in opinion between e.g. organisations and individuals – but again would caution that such views reflect those of respondents, not necessarily of the *entire* Healthcare Science workforce.

Having said that, the number of responses to the consultation – both from organisations and individuals – has been high, and so a good cross-section of opinion is represented.

Finally, we have been mindful of possible 'orchestrated' responses where several individuals from the same organisation have submitted very similar views. From our observations, the extent of these – whatever the motivation – has not been sufficient to markedly alter the overall findings. (Firstly, there is a very large overall number of respondents, secondly the interpretation of the findings has been primarily qualitative – and so numbers alone have not been the main focus – and thirdly, the points made by such groups are often broadly reflective of wider opinions [or if not, are making *additional* discipline-specific points, not contradicting the more generally-held view].)

Main Findings

Main Findings

1. Career Pathways

Organisations

There is general support – in principle – for the broad sweep of proposals on career development among organisations.

The current system is felt to be overly complex (all the more so with 50+ specialisms / professions falling under the Healthcare Science banner), and so attempts by the ‘Next Steps’ document to develop a more streamlined approach is welcomed.

However, the oft-repeated need for ‘seamless’ progression is not always seen to be met. In particular, there is fear that advancement from Practitioner to Scientist level will be blocked by a qualification ‘glass ceiling’ – or that those with ambitions to progress beyond Assistant level will be similarly frustrated by e.g. a lack of posts.

Furthermore, there is (as in so many areas of Modernising Scientific Careers / MSC) a need to strike a fine balance – in this case, between allowing suitable entry points for those *outside* the HCS field, but while safeguarding the positions of those already within it.

In particular, security of tenure is a recurrent issue, and organisations are looking for assurances that good candidates – whether external or internal – are not deterred by a need to resign and / or retrain as they progress.

This also then touches on the issue of equivalence in regards to qualifications, as is also evident in discussions about training regimes. One comment from organisations was that perhaps the use of titles – ‘Practitioner’ and ‘Scientist’ – can be divisive when in part, they cover the same role.

Finally, organisations make a plea (as do individual respondents) not to ‘throw the baby out with the bathwater’ in developing the new proposals: that existing systems which work well (whether in relation to career planning / progression, training or regulation) should not be sacrificed.

Individuals

Again, the current system's excessive complexity (and related lack of clarity and perceived lack of fairness) are viewed as barriers both to existing staff's motivation and retention, and to the recruitment of new people at all levels.

The potential to rectify this is seen by individual respondents as perhaps MSC's greatest strength.

Widening access though, is again a double-edged sword: the more this is pursued (and in principle it is generally welcomed) the more it may appear to threaten the position of existing staff.

This then is a key point of *communication*. Specifically:

- How are existing staff members' positions, entitlements and experience to be safeguarded / valued in relation to newcomers' under the MSC proposals?
- To what degree will / should new people be able to bypass existing training routes / qualifications?
- What safeguards will there be against a 'dumbing down' of skills, grades, and pay? For example, 'grandfathering schemes' are often cited by individuals as good practice in terms of practical aptitudes – but already in decline due to an ageing workforce.

Suggestions by individuals for career progression include:

- A review of current gradings and roles (e.g. amalgamating similar job roles)
- Establishment of clear roles and responsibilities on every rung of the career ladder
- Clarifying exact entry requirements for each role, for transparency of progression
- Supporting life-long learning and Continuous Professional Development (CPD)

Deliberative Events

Participants here also voice concern at the potential barriers to progression.

As a partial solution, they discuss two interim roles as potentially valuable: Associates (as a step up from Assistants), and Senior Healthcare Science Practitioners (as a stepping-stone to Scientist grades, or as the basis for more formal management training – perhaps aided by formal mentoring in this area).

A ‘Grow Your Own’ approach (albeit perhaps under a different name) is also advocated, as is Continuous Professional Development throughout what could be a 15+ year process.

2. Regulation and Revalidation

Organisations

In principle, regulation / registration is widely supported as a means of safeguarding patient care and formally laying out the requirements of those involved.

In the context of MSC, two key issues emerge: firstly, that any new regimes / bodies must safeguard the standards of those already in place, and secondly, that for those aspirant groups (such as Clinical Physiology) *not* so far regulated, this is an immediate priority.

There were mixed views in regards to some form of regulation of Assistant level grades. Some felt this was appropriate for patient safety, but others were concerned at the scope of HCAs to work independently. In general, enthusiasm for such regulation was greater among individual respondents (see below).

In general, more detail on regulation was called for by organisations – and the ‘Next Steps’ document raised several questions: who will be registered, and at what level? How will a potential second registration level (at HSST) sit with the ASE level? What will be the impact on current Protected Titles? Could a ‘preceptorship’ for HCSPs (Practitioners) usefully be introduced to mirror the arrangements in other clinical professions? What is the intended timetable for the process? Might there potentially be overlap in different regulatory bodies dealing with similar areas of people’s work?

In addressing some of these issues, people refer to the role of the Health Professions Council / HPC (in regard to Protected Titles), and to Accredited Prior Experiential Learning (APEL) for guidance on the equivalence that will be recognised. Again, there is an underlying desire to make best use of established procedures / bodies.

Finally, there is also a growing international dimension, with schemes and bodies now consciously linking into different countries to strengthen their positions. (The European Qualification Recognition Agreement is one such example.)

Individuals

The principle of regulation is also embraced by individual respondents; when asked to cite ‘other’ pressing issues they place it at number one.

In general, then, a move towards some form of regulation is welcomed – including that for HCSA posts - *as long* as it is seen to be a genuine step forward in terms of the improvement / maintenance / safeguarding of care standards, rather than simply adding to the complexities of the current system.

For example, some feel that the proposed Higher Specialist Scientist Training (HSST) programme should culminate in the establishment of registration at a level similar to medics and accreditation / membership of an appropriate professional umbrella organisation such as the Royal College of Pathologists – while other levels such as HCSPs and HCS should equate to registration by the Health Professions Council (HPC).

For others, statutory regulation is the goal. Those in Cardiac Physiology repeatedly note that their registration has been delayed since 2004.

There are also wider perceived logistical problems. Concern is raised (as with training) about the possible difficulty of matching supply and demand. Will the numbers of awarding bodies be sufficient to meet the likely demand for staff numbers under MSC, or conversely will the numbers of people coming through to registration exceed the number of available workplace posts?

Deliberative Events

Regulation is a key area here, and raises several questions:

- Would Associates be regulated to supervise Assistants?
- How do the proposals under MSC apply to private companies?
- What will be the role of Professional Bodies?
- How will regulation etc function in light of 24 hr working (eg out-of-hours operations at Pathology labs etc)?

Some also feel that training courses – as much as employment – need regulation.

3. Training and Education

This is probably the most complex area relating to healthcare science careers.

It combines the diversity of over 50 specialities / disciplines, with the obvious need for high standards, with the insistence by many that existing training, assessment and regulatory regimes are essential to the protection of patient safety.

The involvement of many other players – HE and FE institutions, other parts of the NHS, professional bodies and the private sector – complicates the situation further.

Organisations

One of the key questions is the ideal balance between broad-based and focused training.

Organisations have varying views on this. Some feel that a wider spread (implemented through the proposed rotations) promotes a richer mix of training experience - while others say that specialisation is the key to providing up-to-the-minute patient care at whatever staff level.

Broad-based / rotational training is most strongly supported for Healthcare Science Assistants (HCSAs) – and indeed there is wide support for generally more formal recognition and regulation of this grade. (HCSAs are valued in their own right, but also are often the Practitioners of the future.)

In terms of HCSA training, the role of Further Education is highlighted (NVQs etc) – but some ask whether a Foundation Degree would be intended as part of the mix.

Most organisations welcome the concept of a Healthcare Scientist Practitioner (HCSP) level - but there is uncertainty over the intended exit qualification/s. Consequently, they fear that progression from this level to Healthcare Scientist – or directly to managerial / leadership activities, if preferred - may be blocked. There is also concern about the intended time available for training (again, with the broad training rotations system being seen to allow very little focus on the intended core specialism).

By the Healthcare Scientist (HCS) stage, many people see rotations as less relevant – while others advocate a balance between that broader experience and unidisciplinary training on which to build higher specialist practice. Some combinations proposed by 'Next Steps' are seen as potentially useful (e.g. in regard to Blood Sciences) but others less so (e.g. Neurosensory).

The other point is that R&D needs to be more strongly emphasised – and indeed one commented that the proposals may help to ‘re-invigorate’ this area. This in turn calls for links with industry, and between hospital and research laboratories – and for any HCS qualifications to have ‘currency’ outside the NHS.

Beyond this, there is the HSST (Higher Specialist Scientist Training) and ASE (Accredited Specialist Expertise). These are broadly welcomed as potentially strengthening the resources and expertise of such higher level grades (e.g. in boosting both their research role and formalising their higher clinical practice role), but some organisations feel that clarity is needed on how these posts will complement - rather than duplicate – each other, as is an assurance of flexibility in meeting the varying needs across specialities. People’s security of tenure whilst training / studying is also a key issue that could ultimately determine people’s view of the HSST programme – as could the proposed shared funding model between educational and employer streams.

At all stages people point out the need to review and build upon existing *proven and successful* arrangements before any wholly new procedures are introduced.

Individuals

For individuals, the issue of training is given added urgency by the age profile of the current workforce – with large numbers aged 50+ due to retire in the coming years, and thus implications for skills mix / mentoring.

Otherwise, individuals raise many of the same issues as do the organisations:

- The inherent tension between specialisation and a more broadly-based approach (with preference for specialisation again strengthening with the seniority of the post)
- Lack of clarity in the necessary qualifications / skills / aptitudes at various levels
- Time pressures. A sense that training time is already often having to be found ‘on the hoof’ rather than formally ring-fenced, and that the MSC requirements (including rotations and reduced overall timeframes) may worsen this

However, individuals – like organisations – welcome the proposal for a strengthened basis for Healthcare Science Assistant posts’ qualifications.

Similarly, HSST reportedly has much to recommend it; over eight in ten feel it is a potentially important part of workforce development – often stemming from its more formalised approach, allied to clearer career pathways. HSST is also well-received in allowing people the option to stay within a more purely scientific field, rather than having to switch into management-based roles.

As ever though, there are calls for safeguards on existing staff members’ positions, and some wonder whether the potential length of training involved for HSST – in pursuit of a limited number of consultant posts – may deter applicants.

More generally, individuals (more so than organisations) worry that the MSC proposals will devalue practical qualifications in favour of more purely academic work. Again, the question arises as to what training ‘currencies’ there will be post-MSc. This of course has implications for the equity of internal vs. external candidates’ entry / progression – and for the morale / retention of existing staff.

Having said that, organisations and individuals broadly welcome competitive entry – so long as it is fair to both existing and new staff alike.

In terms of management / leadership skills, the view is that – although they are important, and conspicuous when absent – more relevant is the *balance* and *mix* of people’s broader skills set (both scientific / clinical and – where applicable – managerial).

Finally, respondents focus on the need for *international* standards to be borne in mind as the MSC programme is developed.

Deliberative Events

Participants align with organisations in being relatively open to broad-based / flexible training regimes – but with the need to find an optimum balance.

The desire for transferable skills / qualifications is highlighted (and Preceptorships are again mooted by some) – and people also want to see a broader range of aptitudes taught, such as business and communications skills.

This reflects the desire for HCS staff (especially at more senior level) to have the opportunity of patient-facing roles where appropriate.

HSST and its underlying criteria are generally welcomed by the participants, and

there is a strong desire to consult on the precise form the programme would take across various disciplines. (Again, flexibility is seen as one of the keys to HSST's success.)

Again, a strengthening of the Assistant (HCSA) role is welcomed – and at the other end of the spectrum the proposed Senior Healthcare Scientist grade is also endorsed (but with explanation needed of how it would differ from HSST / Consultant functions).

More detail is also requested across the board on *where* various training / education programmes will take place (workplace-based, university etc).

4. Employment

Organisations

Much of the discussion here – among both groups – is tied in with comments on training.

For organisations, there are perceived advantages in the potential to recruit more people at Band 4, so freeing up more senior posts to concentrate on technological and clinical scientific activity and R&D. Organisations also welcome the prospect of trainees being funded appropriately (which in some cases refers to the degree of funding, and in others, the source of it).

Again, though, there is concern that career progression (both from Assistant to Practitioner level, and then on to Scientist levels) will be interrupted – in this case by supernumerary stints. These are felt to both deter potential applicants, and to place additional burdens on remaining staff. One proposal is that Continuous Professional Development (CPD) would be suitable to bridge the progression from Practitioner to Scientist level.

This ties in with protection of employment issues, and also whether the proposals may disadvantage those wishing to take career breaks (e.g. women starting a family).

In general, many organisations feel that more information is needed: how will the old and new structures be assimilated? How will external recruitment be balanced with progression of existing staff? And what form will the ‘multi-disciplinary’ teams take?

Individuals

Individuals and organisations both cite the basic lack of new young recruits coming into science-based professions as a serious issue (see ‘Raising the Profile’).

In this context, the issue of how recruitment impacts on existing staff is key – with individuals particularly noting the potential time burdens that additional or new regimes may bring. (This relates to the process of recruitment itself, and to any subsequent workplace training.)

Many people feel that clarification is therefore needed on how existing staff members will be migrated over to the proposed new MSC arrangements – and how this process will benefit (not disadvantage) them.

Correspondingly, staff morale is a recurrent concern at the individual level (in part, given the apparent ‘reform fatigue’ brought on over recent years in the NHS generally).

Training is an integral part of HCS staff’s working lives over many years, and so *funding* of that training is also a key criterion (as are actual salaries) for job / career choice or satisfaction. As with organisations, individuals generally want to see a local input to this, albeit within a broader national framework as outlined by ‘Agenda for Change’.

Finally, suggestions for recruitment include:

- Earlier engagement of potential recruits (e.g. at school)
- Recruiting at the right level at the right time (e.g. in *expectation* of posts becoming available: ‘Proleptic’)
- Using more flexible recruiting criteria, so as not to exclude those who could train on the job or have a skill set that could be developed
- Targeting those who work outside the NHS or public sector generally, and thinking of innovative ways to make the job seem more attractive to them
- Reflecting the complexity of the workforce, and headhunting for specific positions rather than on a general recruitment drive

Deliberative Events

The need to encourage interest among potential recruits is also voiced here: participants want Accredited Specialist Expertise (ASE) to be made attractive to mature entrants, and want the benefits of the PTP made clear to employers.

Part of this process involves *broadening* the entry criteria (for example, allowing all those with a Life Sciences Degree to apply for Practitioner roles).

There is also the issue of attrition, with participants fearful that HCS may lose the best candidates to other professions or research programmes if training / employment arrangements are not strengthened.

5. Implementation

5.1 Workforce Planning

Organisations

Many comments are supportive of the broad thrust of the proposals; the potential for improved skill mix is noted, the simplification of roles and titles is welcomed, and allowing access for those from industry and academia is also a plus point.

There is some concern though, over how competitive entry will work in practice (again with the implication that existing staff members may be disadvantaged if academic rather than experiential qualifications are prioritised). There is also a question as to the basic numbers of Assistant, Practitioner and Scientist training posts that are envisaged.

Organisations are also mindful that the precise arrangements for planning will vary by discipline and by country, and so ask for greater clarity in that regard. Similarly, there is a desire to know exactly what role each level is expected to perform.

Finally, there are the lead times to consider. Trainees starting in post ‘now’ will take five years to achieve ‘fit for purpose’ status – and the full progression through to HSST level is predicted to take 10 years or more. With this in mind (and compounded by the ageing workforce) there is a sense of urgency in adding some detail to the basic framework.

Individuals

This is also true for individuals. For them (more so than organisations), the lack of clarity is generating unease about the implications for their day-to-day working lives.

As an example, the concept of ‘flexibility’ is often taken to mean that changeable short-term needs will predominate over longer-term planning (with attendant concerns about the demands on people’s time, job security, their degree of specialisation [and so quality of their work], the ability to plan longer-term, and the fairness with which people will gain entry or progress).

On a similar theme, there is also a perceived lack of succession planning. To some extent this is felt impractical where there is a simple lack of people. However, others feel that the situation could be better-managed – and that MSC has a role to play *if* it can establish effective structures and an environment in which they are allowed to operate and develop.

Other issues that bear on planning are:

- An ageing *population* profile, with ever-increasing demands on the NHS as a whole
- The need for funding to realise the MSC proposals' potential
- A current lack of co-ordination across all levels, and in the balance between local and national needs
- A poor understanding of roles and what is required of people
- Inadequate data collection regarding staff numbers
- The guidelines established by 'Agenda for Change' in relation to pay etc

Despite all the demands and complexities involved in workforce planning, training and career development, HCS staff remain firmly fixed throughout on the end objective – to provide high quality and safe patient care. This is a key criterion against which the MSC proposals are measured, and so a key context in which they need to be *communicated* going forward.

Deliberative Events

Two 'first principles' are highlighted here:

- Establish a culture of leadership, with e.g. mentoring in this area being more formally recognised (and moving away from the notion that staff have to be *either* a scientist *or* a leader).
- Assess the number of trainers needed (and their sources) to ensure effective training is part of long-term workforce planning – i.e. 15+ years.

Echoing comments from the other groups, participants bemoan the current lack of accurate workforce data – seeing this as a priority area to address – and want to know how existing staff will migrate over to the new MSC arrangements.

Again, there is a warm reception for the 'Grow Your Own' elements of staff planning / development. Many say that the proposals under MSC will yield the right skill mix in this regard, while ensuring equity for existing staff.

5.2 Education Commissioning

Organisations

Organisations are clear that adequate funding is essential in this area – and insofar as the ‘Next Steps’ document proposes this, it is welcomed.

The *source* of suggested funding, though, is perceived as unclear, and greater clarity is requested. Specifically, are the ‘fully-funded’ PTP and STP to be met by central government – and how will the ‘shared funding’ for HSST between educational funds and employers work? Questions are also raised over the funding of Schools of Healthcare Science.

In terms of *delivering* training programmes, special note is made of the difficulties for smaller and more specialised areas – for example in matching training demand and supply, and in keeping abreast of technical developments. One suggestion is that such areas should have a single lead body to commission training *nationally* (whether it be a specific SHA or some other ‘gold standard’ entity).

More generally, however, many refer to the need for a balance to be struck between local and national input to training - to combine transferable and recognised standards with tailored day-to-day solutions ‘on the ground’.

Overall, a cautious welcome is given to the proposal for an NHS School of Healthcare Science (albeit that it adds another layer) - although more detail is required to fully understand future arrangements.

Individuals

Individual respondents had less to say about the generic commissioning and funding of education programmes – but did offer a detailed list of key characteristics required of such programmes (including those in Further Education):

- The provision of ‘top up’ modules to fill gaps in current knowledge needed for ‘stepping up’ to the next grade, or to registration with the appropriate professional body
- Filling skills gaps of HCSAs, including literacy, numeracy, IT and basic science
- Enabling access to Higher Education on completion of workplace-based FE training for those who did not have this option as school leavers, by improving study skills

- Boosting aspirations to progress, job satisfaction and ‘self-worth’ among HCSA / HCSPs, by recognising their efforts to improve themselves
- Providing a structure to clearly show HCSA / HCSPs *how* to improve their work-based skills and prospects
- Providing access to new and different work placements and specialism modules which will help HCSAs / HCSPs to become aware of career options and decide which route they would like to take
- Developing a broader range of skills in HCSAs which will encourage employers / line managers to give them more extensive duties than in their current roles

The MSC proposals for Assistant (HCSA) roles potentially gel with many of these objectives.

Deliberative Events

Participants’ focus here is at a fairly high level – with discussion about the possibility of developing consortia to deliver education / training, and questions (familiar from the other groups) about ‘who will train the trainers?’

One specific suggestion is that HEIs be financially incentivised to collaborate with each other. Such bodies are seen as particularly key to the effective delivery of training – allied to the Professional Bodies’ role in registration.

Mention is also made of distance learning’s potential to broaden access and flexibility (and participants are also keen that training provisions of whatever kind be available *locally* if possible – albeit adhering to nationally-set standards).

Finally, a plea is made to account for the lead times – 12-15 months – needed for HEIs to develop appropriate courses.

5.3 Raising the Profile

Organisations

HCS's 'profile' applies at several levels: among existing employees in the field, within the wider NHS workforce, among potential external recruits, and among the public generally. Not all of these were considered in detail, but there is a general view among organisations and individual respondents that improvement is needed.

For example, both groups say that any external profile-raising of HCS starts with school-age pupils. Greater contact / outreach is widely advocated for these groups, and the prospect of it yielding more entrants to the Assistant (level 4) roles is particularly welcomed.

Allied to this (and raised at several points) is the need for greater *access* to the relevant fields, transparent training programmes, obvious workplace-valued and transferable qualifications /skills, and equity of treatment for internal and external candidates. (In general, a perception of simplicity and coherence is seen as desirable.)

Innovation is also a watch word: how to make HCS careers more appealing, and to embrace new models of working (e.g. competence-based). Needless to say though, this goes hand-in-hand with safeguarding the positions of *existing* employees.

Greater 'diversity' - it is implied - will follow from these measures.

Individuals

For individual respondents, the issue is not only one of raising the *profile* of science-based careers, but also in strengthening their broad-brush *image*. (The characterisation of '*mad boffins in white coats*' is one comment giving a flavour of the challenge faced.) On the other hand, the ability to draw parallels between careers in HCS and in medicine is seen as an asset in attracting the interests of new recruits.

Individuals say that a broader drive for engagement and image-building among younger groups will hopefully yield a more diverse and larger pool of potential recruits. More specifically, e-learning and distance learning can to a degree, overcome geographical boundaries.

Once potential recruits of whatever age / level have HCS on their 'radar screens', the task is again one of reassurance: that such jobs / careers:

- Are secure

- Offer the opportunity for clear career progression, with predictable, stable and nationally (and ideally internationally) consistent qualification requirements
- Are supported by appropriate, valued and well-funded training regimes
- Are accessible (where appropriate) to those with the right aptitudes, and not just the right certificates

Deliberative Events

As well as the familiar proposal to target schools in profile-raising, those in the deliberative events also suggest ‘champions’ outside the profession to promote it. (These might be trade unions, educational bodies or professional bodies.)

There is also seen to be a role for ‘early adopters’ – those who first take up the new MSC programmes – to promote the benefits to others. (The implication is that some groups will have progressed quite far with the transition [perhaps even completed it] before others have even started.) Web sites and newsletters are suggested as two means of dissemination.

With an eye on other professions, people also want to map the synergies across different fields (again, so that potential recruits can be helped to envisage the HCS structure more clearly).

And finally – coming full circle – there is a need for *clarity* on the range of opportunities available (whether to internal or external candidates, to new trainees or seasoned employees).

Appendices

Appendices

Consultation Questionnaire

Have your say!

The Future of the Healthcare Science Workforce Modernising Scientific Careers: The Next Steps A Consultation

The Future of the Healthcare Science workforce is a consultation document, launched jointly by the four health departments in the UK.

The vision for healthcare science is of a world class workforce integral to multi-professional teams delivering high quality innovative patient care, in a range of settings. The healthcare science workforce will also deliver excellence in knowledge creation, innovation and service improvement. It will lead and embrace research and development, continually evaluating clinical practice and care delivery models.

Achievement of this vision will require a transformation of healthcare science career pathways, supported by new education and training programmes, which will deliver improved benefits for patients, for employers and health commissioners, for the healthcare science workforce and for health services.

The consultation document sets out proposals to the future training and career pathways of the healthcare science workforce. A wide range of stakeholders, including healthcare scientists, NHS trusts, professional bodies, other clinical staff, trade unions, employers, and workforce planners (amongst others), have already been involved in shaping these proposals, but this consultation provides a further opportunity for key stakeholders to provide feedback in advance of further document, setting out implementation arrangements.

Please take a few minutes to give us your feedback on **The Future of the Healthcare Science workforce**, and tell us what you think about these proposals.

The responses will be analysed for the UK as a whole as well as by country, to enable this UK initiative to be taken forward by the four countries in partnership with all major stakeholders, including patient groups, to ensure that the healthcare science workforce is fit for the future in a rapidly changing and evolving healthcare environment.

If you have any technical (IT) issues related to completing this form please contact:

The Modernising Scientific Careers Team

Telephone: 0207 633 7405

Consultation Criteria

This consultation follows the Cabinet Office code of practice which is available from the Cabinet Office website. This requires government departments to:

- Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of policy
- Be clear about what proposals are, who may be affected, what questions are being asked and the timescale for responses
- Ensure that consultations are clear, concise and widely accessible
- Give feedback regarding the responses received and how the consultation process influenced the policy
- Monitor their effectiveness at consultation, including through the use of a designated consultation co-ordinator
- Ensure consultations follow better regulation best practice, including carrying out a regulatory Impact Assessment if appropriate

The Code also invites respondents to “comment on the extent to which the criteria have been adhered to and to suggest ways of further improving the consultation process”. For DH consultation, comments or complaints (but not your response to this consultation):



The Future of the Healthcare Science Workforce Modernising Scientific Careers: The Next Steps A Consultation

Please type in the text fields, click the radio buttons, tick boxes and use the drop down field that matches your answers. When you are finished hit the 'Submit your comments' button to provide your feedback.

Due to technical difficulties, the consultation document has been unavailable for a short period following the launch. As a result the closing date for the consultation period has been extended to 6th March 2009.

About You

Your Name

Age

Gender

Gender - Other

Ethnicity

Ethnicity - Other

Job Title

Job Role

Job Role - Other

Healthcare Science Division (if applicable)

Healthcare Science Discipline (if applicable)

Organisation

Email Address

Contact Details

Country

The Challenges of Modern Healthcare

1) Are there any other challenges that have not been outlined that the Healthcare Science (HCS) workforce face?

The Healthcare Science Workforce: The Case for Changing Training and Careers

2) Please rank the issues in terms of how pressing they are for you, where 1 = Important, 2 = Neutral and 3 = Least Important:

Workforce planning

1 2 3

Education and Training

1 2 3

Transparent Career Pathway

1 2 3

Other (please specify)

3) Are there specific problems in Workforce Planning which need to be addressed?

The Vision for Healthcare Science

4) Are there any other potential benefits that have not been outlined that can be achieved by modernising the Healthcare Science (HCS) workforce?

The Modernising Scientific Careers Programme

5) Are there any additional overarching principles you would add, in modernising the Healthcare Science (HCS) workforce?

The Proposed Training and Career Pathways

6) How can we make careers in Healthcare Science under Modernising Scientific Careers as attractive as possible for:

Healthcare Science Assistants (HCSA)?

Healthcare Scientist Practitioners (HCSP)?

Healthcare Scientists (HCS)?

7) Do these proposals enable sufficient flexibility for the workforce to meet the anticipated changes in:

Delivering high quality patient care Yes No

Please comment

Technology and scientific advances in the disciplines Yes No

Please comment

New models of care Yes No

Please comment

Skills mix arrangements Yes No

Please comment

8) Do you agree with the proposal for Healthcare Science Assistants (HCSA) to have the opportunity to gain formal awards and qualifications?

Yes No

Please comment

9) To support the Practitioner Training Programme (PTP), should there be greater provision of Higher Education / Further Education academic programmes with NHS-funded workforce placements aligned to the outcomes of the Practitioner Training Programme?

Yes No

10) How can Further Education contribute to the learning and development of Healthcare Science Assistant (HCSA) and Healthcare Scientist Practitioner (HCSP)?

11) In the Practitioner Training Programme (PTP) should trainees undertake workplace based training in one discipline (focussed PTP e.g. only in biochemistry) or in related disciplines (broad-based PTP, e.g. in biochemistry and haematology)?

Life Sciences

Focused PTP Broad-based PTP

Physiological Sciences

Focused PTP Broad-based PTP

Physical Sciences and Engineering

Focused PTP Broad-based PTP

Any comments

12) Do you agree with the broad indicative themes laid out for the Scientist Training Programme (STP)?

Yes No

Please comment

13) Do you agree with the proposals for Higher Specialist Healthcare Scientist Training (HSST) programmes?

Yes No

Please comment

14) Are there existing programmes that could be used for Accredited Specialist Expertise?

Yes No

Please comment



Implementation Issues

15) How important are the following areas for the development of the existing workforce, where 1 = Vitally Important, 2 = Important, 3 = Not Very Important and 4 = Least Important:

Leadership skills

1 2 3 4

Management skills

1 2 3 4

Further Specialist Scientist Expertise

1 2 3 4

Higher Specialist Healthcare Scientist Training (HSST)

1 2 3 4

Other (please specify)

Responder's Comments

Do you have any further comments?

Thank you for your comments, which will be considered by the Modernising Scientific Careers Team and will inform the future development of the Modernising scientific Careers programme.