Annex A

Consultation questions and response form

1. Responses to the consultation should be made by completing the form below, and returning it by e-mail by **midday on Wednesday 16 December 2009**.

2. All responses should be e-mailed to ref@hefce.ac.uk. **In addition**:

   a. Responses from institutions in Scotland should be **copied to** Pauline Jones, Scottish Funding Council, e-mail pjones@sfc.ac.uk.

   b. Responses from institutions in Wales should be **copied to** Linda Tiller, Higher Education Funding Council for Wales, e-mail linda.tiller@hefcw.ac.uk.

   c. Responses from institutions in Northern Ireland should be **copied to** the Department for Employment and Learning, e-mail research.branch@delni.gov.uk.

3. We will publish an analysis of responses to the consultation. Additionally, all responses may be disclosed on request, under the terms of the Freedom of Information Act. The Act gives a public right of access to any information held by a public authority, in this case HEFCE. This includes information provided in response to a consultation. We have a responsibility to decide whether any responses, including information about your identity, should be made public or treated as confidential. We can refuse to disclose information only in exceptional circumstances. This means responses to this consultation are unlikely to be treated as confidential except in very particular circumstances. Further information about the Act is available at www.informationcommissioner.gov.uk. Equivalent legislation exists in Scotland.

Respondent's details

Are you responding: (Delete one)	On behalf of an organisation
Name of responding organisation/individual	Mental Health Nurse Academics (UK)
Type of organisation (Delete those that are not applicable)	Mental Health Nurses Academics (UK) is an academic association that brings together representatives from all UK Higher Education Institutions engaged in mental health nursing research and education.
Contact name	Alan Simpson
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Consultation questions

(Boxes for responses can be expanded to the desired length.)

Consultation questions

(Boxes for responses can be expanded to the desired length.)

Consultation question 1: Do you agree with the proposed key features of the REF? If not, explain why.

Mental Health Nurse Academics (UK) (MHNAUK) in general agrees with the proposed key features of the Research Excellence Framework (REF). However, we have some concerns mainly relating to the assessment of impact which we shall outline below.

Mental Health Nursing research can lead to direct and indirect impacts on the economy, social relations and well-being, university teaching and learning, workforce development, international, national and local mental health policy, guidance and clinical practice. However, impacts derived from even the most focused programme of research can take ten or more years to emerge and the methods for identifying and appraising any such impact is not well developed or understood.

Additionally, mental health nursing research frequently requires involvement of and responsiveness to a wide range of stakeholders including policy makers, service providers across several sectors, service users, families and the public. Identifying and appraising impact across these disparate fields will require considerable effort and creativity with significant resource implications.

Moreover, as a relatively new research discipline, the research infrastructure and interdisciplinary relationships required to ensure maximum impact are still being developed within mental health nursing research and we are concerned that strong but relatively new teams and programmes of research stand the risk of being curtailed in their adolescence if impact receives an undue weighting within the REF.

So, whilst we welcome the inclusion of impact and firmly believe that mental health nursing can demonstrate actual or potential impact in various spheres, we are concerned that it is poorly defined, its assessment is untested, it may handicap newer research teams, and it is likely to lead to a proliferation of creative writing on the part of HEIs. We would much prefer that outputs are assessed largely on research excellence and more closely follow the definition of those allowed in the 2008 RAE.

We would assert that impact should be measured separately from “excellence” since (as noted on p.17 of the consultation) impact includes the economic and social benefits that result from “research of the highest quality (in terms of originality, rigour, and significance)”.

In our view, the REF should focus on:
a) Research excellence as evidenced by quality outputs (50%)
b) How the research environment effectively promotes excellent research (30%); and the
c) Impact of the research on society, the economy, health and quality of life and on informing best practice (20%).
The proposed REF spreads impact across all three elements (outputs, environment, and impact). Our view is that it should be assessed – but independently.

Consultation question 2: What comments do you have on the proposed approach to assessing outputs? If you disagree with any of these proposals please explain why.

Comments are especially welcomed on the following proposals:

- that institutions should select research staff and outputs to be assessed
- for the categories of staff eligible for selection, and how they are defined
- for encouraging institutions to submit – and for assessing – all types of high-quality research outputs including applied and translational research
- for the use of citation information to inform the review of outputs in appropriate UOAs (including the range of appropriate UOAs, the type of citation information that should be provided to panels as outlined in Annex C, and the flexibility panels should have in using the information)

and on the following options:

- whether there should be a maximum of three or four outputs submitted per researcher
- whether certain types of output should be 'double weighted' and if so, how these could be defined.

It appears that the intention is to sample the highest quality work from a sample of staff from the total profile in a unit. MHNA(UK) is in broad agreement with this principle and accept this is an efficient system of allocating resources.

The proportion of staff selected should not be a factor in assessing quality. We agree that staff employed by the institution on the census date are included and that others should be included only if the research is based in the submitting unit. HEIs should have the freedom to select which staff and outputs will be returned for assessment. All types of high quality research outputs should be returnable, with each assessed in its own terms.

For any other categories of staff the connection between their work and the submitting unit must be clear. Explicit criteria for this may need to be produced. It would also be useful to have further guidance on the eligibility of research-only staff, for example contract research staff. It should be explored whether such staff would have to be a principal investigator or a fellowship holder in order to be included.

We would welcome further guidance on the definition of acceptable Category C staff; in particular, NHS staff whose work is done in close collaboration with a submitting department (co-supervision of students, co-publication of outputs), and who have no other means of submitting to the REF, but who are not, or not primarily, physically based in the department.

The use of citation data at the level of individual papers may not be helpful given time-lags etc. Additionally, in developing research fields such as mental health nursing, previous, poor quality papers are often cited for purposes of criticism to justify current research. Given all the caveats listed in the REF consultation document we do not agree that citations will be all that helpful in informing the panel in the broader health field. As evidenced by the 2008 outcome, nursing, midwifery and AHPs are producing quality research but, as in the social sciences, bibliometric

indices are not sufficiently robust to be acceptable in these disciplines; if used at all they should simply inform the peer review process - not dictate it.

There should be a maximum of three outputs submitted per researcher. This will reduce the burden of assessment and takes into account the shortened timeframe. Nonetheless, the proposal to double-weight some outputs could lead to confusion. We believe that three outputs should be achievable to a research active member of staff in the timeframe. Monographs should be double weighted.

Consultation question 3: What comments do you have on the proposed approach to assessing impact? If you disagree with any of these proposals please explain why.

Comments are especially welcomed on the following:

- how we propose to address the key challenges of time lags and attribution
- the type of evidence to be submitted, in the form of case studies and an impact statement supported by indicators (including comments on the initial template for case studies and menu of indicators at Annex D)
- the criteria for assessing impact and the definition of levels for the impact sub-profile
- the role of research users in assessing impact.

The proposal that impact is assessed at the level of the submitted unit is appropriate. Using key indicators and case studies that follow a set template is also appropriate.

There needs to be recognition that impact operates at many levels i.e. local, regional, national and international and that each level is equally important. Impact assessment is likely to favour those forms of impact that are more readily quantifiably evidenced and so fail to recognise and reward ‘softer’ impacts such as impact on quality of life and well-being.

Mental health nursing research is potentially able to show impacts at many levels; however even the ‘best’ programmes of research can take 10 years or more to significantly impact policy, guidelines or practice. Impact on teaching and learning and workforce development should be included.

Additionally, mental health nursing research frequently requires involvement of and responsiveness to a wide range of stakeholders including policy makers, service providers across several sectors, service users, families and the public. Identifying and appraising impact across these disparate fields will require considerable effort and creativity with significant resource implications. Addressing this issue alongside those proposed may avoid issues of time lag and attribution, since evidence about 'impact' can be triangulated and seen to evolve over time.

Because of the devolution into four countries it is important that local impact is valued. For example, Scottish research that influences policy in the Scottish parliament can be meaningful. In other words impact should not just be respected on a UK or an international basis.

There are serious issues to address including time-lags, attribution and corroboration. The definition of 'attribution' in the consultation document does little to clarify the position and could possibly discriminate against certain disciplines where impact routes are more difficult to determine.

It is not clear how 'impact' can be graded on the same 4 point scale as outputs. The methodology does not appear to very well developed, and certainly not sufficiently well developed to justify a 25% weighting.

There are very real challenges for HEIs in providing demonstrable impacts and panels are likely to face challenges in corroborating claims. This will add to the burden of the submission, which appears to contradict the original aims of REF.

It is going to be complex to present research themes if these have changed over time – as outputs and current activity may focus on different thematic areas than work which has produced impacts.

The proposal to run a pilot exercise in 2010 is sensible, but the timescales for the exercise will allow little time for HEIs to prepare for these changed requirements. For example, these changed requirements signal the need to keep routine data on the impact of work which was undertaken outside the assessment period. Furthermore, would an impact be eligible for inclusion if the researcher responsible no longer worked in the department? What about work undertaken by a researcher in a department who had undertaken research whilst employed elsewhere which was now having an impact? As the translation of research into impacts could be undertaken by non-research returnable individuals, how would this be accommodated in REF?

Using income from government departments as indicator of impact is questionable: this is evidence of potential, but not actual, impact.

Each panel should provide guidance relating to the impact indicators it deems to be most appropriate for assessing quality in this area. The pilot exercise is going to be very important here in terms of defining the impact indicators as well as the construction of the case studies. Commentary on how these were assessed is crucial in allying concerns about this element of the assessment process.

There is an issue around research collaboration and impact. The nature of collaboration is that it is inter-dependant and relies on relationships to be successful. What evidence will be required to support claims of impact when the research is multi-centred and how will this be presented?

In addition, we have difficulty understanding what is meant in para. 68, p21 by "*We do not envisage that a unit could claim credit for impact which was based on research undertaken in the unit but which was exploited or applied through the efforts of others, without a demonstrable contribution by the unit to that exploitation*." If our understanding is correct, this could mean that a research study may have been carried out in a university and published and presented in 1999 and the team have moved on to another study. If in 2009 an interested clinician or manager came across the findings and used them to change practice or policy, then the original unit/team could not claim the impact or use this as a case study. This appears excessive and we would appreciate some clarity on this issue.

In nursing, midwifery and the allied health professions there are some small departments eligible to submit. In the proposed model where there is one case study per ten individuals, a submission of 20 researchers will only have two opportunities to demonstrate the impact of their research. We recommend one case study per five researchers up to a maximum of 20 people, then one per ten beyond that.

We are concerned that the menu of indicators appears to value industry more than public service. The "delivery of highly skilled people" makes no mention of the public sector or third sector. Additionally, mental health nursing research is increasingly undertaken and disseminated with full involvement of mental health service users, with capacity building and research training/development a core component of the research enterprise. Such involvement has significant impact on individual and community quality of life and well-being and wider social impacts on employment and social inclusion. Such impacts need to be recognised and included in any criteria.

We are also concerned about how impacts such as "changes to public attitudes to science" will be measured. But equally, we would welcome the addition of wider criteria such as 'changing public attitudes to mental illnesses' (amongst workforce or wider public).

We would welcome service users as panel members but this needs to follow good practice guidelines on public involvement to ensure the meaningful and constructive contributions to the process. We would stress that impacts such as preparing the future health care workforce and enhancing productivity through improving health should be highly regarded.

There are real tensions for those involved in policy related research, in which many funding streams explicitly state that researchers should not make policy recommendations e.g. NIHR PRP. REF appears to suggest that in order for impact to count researchers should also be responsible for its exploitation. This is clearly inappropriate in policy-related research where it is not in the gift of researchers to undertake such translation.

Consultation question 4: Do you have any comments on the proposed approach to assessing research environment?

The three key areas identified as being relevant for the assessment of environment are appropriate. We believe that impact also permeates this section under the heading of engagement. We would ask that this element of the assessment be focused on creating an environment in which top class research occurs. This could reasonably include engagement with the discipline but, if so, must include *international* as well as national engagement.

MHNA(UK) suggest the need for greater recognition of involvement of public, workforce, and specifically patients/service users and families and carers of patients. In mental health nursing research, research funders require widespread stakeholder involvement *at all stages* of the research process, which is much less evident in most other areas of research. This requires significant investment of resources, time and skill to be consistent and effective and should be incorporated and rewarded through the REF process.

There appear to be no quality definitions for environment and no clarity about how this will be assessed within these proposals. It is intimated that panels could decide on the relevant weightings of various environment elements; we would be nervous if this occurred at sub-panel level as it would be an opportunity to tweak the system so as to retain the status quo.

Consultation question 5: Do you agree with our proposals for combining and weighting the output, impact and environment sub-profiles? If not please propose an alternative and explain why this is preferable.

MHNA(UK) agree in relation to the process for combining the sub-profiles. Having the same weightings across units of assessment will allow some degree of consistency across the panels.

As alluded to above, we feel that 25% is too high of a weighting for an untested assessment mechanism. Given the limited reliability of impact, we would suggest something more like:

a) Research excellence as evidenced by quality outputs (50%);
b) How the research environment effectively promotes excellent research (30%);
c) Impact of the research on society, the economy, health and quality of life and on informing best practice (20%).

Combining the weightings for outputs, impact and environment is tricky, primarily because of the under-development of impact. The proposals for assessing impact set out in the consultation exercise follow a scientific model and thus application of similar weightings to disciplines which operate differently could see them penalised.

The criteria for environment will need some thought and could, for example, include areas of clinical practice where these have been supported and developed to provide a supportive infrastructure for further research and research dissemination.

Consultation question 6: What comments do you have on the panel configuration proposed at Annex E? Where suggesting alternative options for specific UOAs, please provide the reasons for this.

The proposed REF Unit of Assessment 'Allied Health Professions, Dentistry and Nursing' is the fourth largest proposed UoA (2,939, FTE in RAE 2008) after Engineering (4459), Clinical Medicine (3568) and Business/ Management (3501). Although we recognise there is similarity in some of the methodological approaches and scope of work in AHP, pharmacy, dentistry, nursing and midwifery, there are also some clear distinctions (e.g. applied sciences versus biological sciences, affecting both the nature of the research undertaken and the means of demonstrating impact). There is also concern that from the evidence of the last RAE, the research progress of Nursing and Midwifery may not be evident in the proposed new UOA.

Therefore, in order to ensure appropriate recognition of the distinctiveness of the groups, we would propose that this Unit of Assessment be treated in the same way as the other three large ones, with the establishment of four informal sub-groups (AHPs, pharmacy dentistry, and nursing and midwifery).

Some members of MHNA(UK) wonder whether nursing would sit better with public health, health services research and primary care. However, we would also express caution about nursing being coupled with disciplines in which the academic culture is one in which it would be expected that citations are likely to be used substantially by panels as assessments of quality.

Consultation question 7: Do you agree with the proposed approach to ensuring consistency between panels?

There should be consistency of the application of assessment of quality, weighting and use of standardised data across all UOAs.

Consultation question 8: Do you have any suggested additions or amendments to the list of nominating bodies? (If suggesting additional bodies, please provide their names and addresses and indicate how they are qualified to make nominations.)

MHNA(UK) agrees with these proposals with regards to the nomination of the main and sub-panel chairs.

Consultation question 9: Do you agree that our proposed approach will ensure that interdisciplinary research is assessed on an equal footing with other types of research? Are there further measures we should consider to ensure that this is the case and that our approach is well understood?

Broader panels should avoid the need to refer out to other panels; we feel that this did not work as efficiently or effectively as it could have done in RAE 2008.

We agree that interdisciplinary research should be assessed on an equal footing.

Consultation question 10: Do you agree that our proposals for encouraging and supporting researcher mobility will have a positive effect; and are there other measures that should be taken within the REF to this end?

We support the proposals for encouraging and supporting researcher mobility.
With increasing pluralisation of health and social care providers, we can expect the 'faculty' to grow to be an increasingly wider organisation than more traditional groupings within higher education. This may involve increasingly diverse arrangements between the university and local health/social care organisations.

There are a range of issues concerning conflicting HR policies, pay, pensions and conditions between health and higher education. To attract staff there is a need to secure greater flexibility and complementarity between health and higher education to reflect both the different functions and changes in employers that may occur during a clinical academic pathway

Consultation question 11: Are there any further ways in which we could improve the measures to promote equalities and diversity?

We welcome in particular the proposal to have a centralised approach to assessing individual circumstances.

Consultation question 12: Do you have any comments about the proposed timetable?

The time for panels to consult and publish criteria through to actual HEI submission in 2012 is unrealistic. The rules for REF will not be available until midway through the assessment period. Therefore, Institutions may be disadvantaged.

Consultation question 13: Are there any further areas in which we could reduce burden, without compromising the robustness of the process?

We think the assessment of impact could be a greater burden than reading peer reviewed papers. The case studies and impact material could be very time consuming to analyse.

Consultation question 14: Do you have any other comments on the proposals?

The transfer of knowledge from research through to practice can be very protracted and we think that demonstrating impact over 5 years could be difficult – even if it is from research published in the previous RAE. Ten or even 15 years is much more realistic.