Consultation on the second Research Excellence Framework (REF)

Council for Allied Health Professions Research

March 2017

Contents

Introduction

The Council for Allied Health Professions Research (CAHPR) is the representative voice of the 12 AHP professions on research matters. Our member organisations include:

- British and Irish Orthoptic Society
- British Association of Art Therapists
- British Association of Drama Therapists
- British Association for Music Therapy
- British Association of Prosthetists and Orthotists
- British Dietetic Association
- College of Paramedics
- College of Podiatry
- College of Occupational Therapists
- Chartered Society of Physiotherapy
- Royal College of Speech & Language Therapists
- Society and College of Radiographers

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1. Executive Summary

- We recommend maintaining an overall continuity of approach with REF 2014. We believe that the assessment burden should not be increased.
- Generally, UOA3 is acceptable. However, there are issues that need to be taken into consideration when assessing allied health profession (AHP) research. AHPs are a diverse group, leading to a broad range of research in the allocated UOA. There is a risk that high-impact research in small professions may get lost, or be assessed by people with inadequate knowledge of a specialist field. We recommend an AHP sub-profile within the UOA or 'tagging' and indexing submissions by discipline at submission stage.
- We do not support the proposal to use HESA cost centres to map research-active staff to UOAs. HESA codes do not align with REF UOAs. Mapping in this way could inhibit multi- and cross-disciplinary work and lead to "pigeon-holing" of academics according to cost centre, which could be highly detrimental. We suggest that staff are instead allocated to the most appropriate UOA based on their research outputs, impact and a genuine assessment of the environment.
- We recommend that a full equality impact assessment is undertaken on the implications of implementing Lord Stern's recommendations. There are potential risks clinical academics will be moved from teaching and research contracts to teaching-only contracts so that their work does not need to be included in the REF. Safeguards would need to be put in place to weight research equally within less teaching-intensive disciplines. We recommend that the proportion of staff time allocated to research should be recognised and output volume weighted accordingly.
- We support proposals to use acceptance for publication as a marker for identifying outputs.
- We recommend that early-career researchers and staff on fixed-term contracts should be exempt from non-portability.
- We support the proposed definitions of impact and believe broadening the definition provides greater opportunities to demonstrate impact.
- We are concerned that creating an overall quality profile for each submission could introduce an alternative ranking dimension to a system that already results in numerous rankings. We would recommend including scores within individual quality profiles.

2. Overall approach

1. Do you have any comments on the proposal to maintain an overall continuity of approach with REF 2014, as outlined in paragraphs 10 and 23?

We agree that an overall continuity of approach with REF 2014 should be maintained. Key considerations for CAHPR are:

The assessment burden should not be increased.

Metrics should be carefully devised and only used where appropriate as there is a risk some allied health professions (AHPs) will not be treated equally.

A consistent approach to the assessment of research impact should be maintained for two reasons. Firstly, considerable resources have been used to train and develop staff to make REF submissions which include impact. Secondly, AHP research often focuses on impact outside academia; therefore the concept of impact is considered particularly valuable.

Equity in the assessment of all types of research is supported; a process that values the role of qualitative and mixed methods research is to be commended.

3. Unit of assessment structure

2. What comments do you have about the Unit of Assessment structure in REF 2021?

Generally, we feel that the current UOA3 is acceptable. However, our members have raised a number of issues:

AHP research may not necessarily be inter-disciplinary, but may well be across UOA boundaries.

AHPs are a diverse group, leading to a very broad range of research in the allocated UOA. This requires that the expert panel is able to equitably assess the variety of outputs in terms of research design, approach and also the environments and impacts of such research.

Many allied health professional's research could be returned under a number of different UOAs. UOA3 is often the best fit, but is a wide category. There is a risk that high-impact research in small professions may get lost altogether, or just as significantly, be assessed by people with little or no knowledge of a specialist field.

While it is recognised that it is possible for an HEI to make multiple submissions to the UoA, it is felt that the size of UoA3 negatively affects relatively small professional groupings.

For AHPs, a solution could be to have AHPs as a sub-profile within the UOA; although they are very different fields, they share many common themes.

We would also find it valuable to look at ways of 'tagging' and indexing submissions by discipline at submission stage. This would ensure that diverse UOAs record information that is sufficiently nuanced to improve the REF results search function and allow interrogation of the REF results by individual disciplines.

This would increase the value of REF data for future discipline-based policy-making and research. This would be particularly valuable for allied health professions groupings, and be helpful to identify interdisciplinary research.

4. Expert panels

3a. Do you agree that the submissions guidance and panel criteria should be developed simultaneously?

We support this as long as there is expert input from all professions included for submission. We are concerned that small professional groupings could be disadvantaged if expertise on the Main Panel A is not suitable. For example, a strongly quantitative, positivist approach to science could disadvantage returns to UoA3 and from AHPs in particular.

3b. Do you support the later appointment of sub-panel members, near to the start of the assessment year?

We are concerned that appointing sub-panel members later would cause challenges for those appointed. It may have the effect of less engagement in the earlier stages of the process. There would also be fewer people to influence the shape of the assessment criteria and limit sub panel members' inability to influence criteria if these have already been set. It is considered, that later appointment would reduce involvement and ownership.

Based on feedback from REF 2014, diverse professional groups need time to understand the respective research contexts. This will need to be factored in to REF 2021, especially if panels change significantly.

4. Do you agree with the proposed measures outlined at paragraph 35 for improving representativeness on the panels?

We agree that the measures are appropriate for improving representativeness however we would like to know what long-term plans are in place if data analysis shows an unacceptable imbalance.

5a. Based on the options described at paragraphs 36 to 38, what approach do you think should be taken to nominating panel members?

We support nominations being invited from a range of bodies as undertaken in REF 2014. We do not support nominations by HEIs. If carefully managed, self-nomination could increase the representativeness of the candidate pool. As detailed in the consultation, evidence of experience and support would need to be available. To ensure balance and a workable nomination process, it could be appropriate to develop a 'mixed economy'; i.e. with some traditional nominations from nominating bodies, plus the option for a proportion of additional panellists to be self-nominated.

Good governance of the nomination process is essential. There is a risk of imbalance being created by politically or commercially motivated bodies. It will be imperative to be clear about how final decisions are to be made about appointments.

As the peer review process is fundamental to research, it would seem reasonable to continue to use it here. We recommend that the influence and opinions of other bodies are considered in the development of impact case studies.

5b. Do you agree with the proposal to require nominating bodies to provide equality and diversity information?

We support taking equality and diversity into account in the nomination process in order to increase and monitor representativeness. However, the practicalities of this process need to be considered. Some nominating bodies may not have access to the required level of detail about equality and diversity of their membership.

We suggest that equality and diversity information is sought about each individual nominee, rather than at organisational level.

Nominating bodies could also be asked to provide an overview of how equality and diversity has been taken into account when making the nomination.

6. Please comment on any additions or amendments to the list of nominating bodies, provided alongside the consultation document.

We believe the Council for AHP Research (CAHPR) would be a suitable addition as nominating body. We represent all 12 allied health professions' interests in research.

5. Staff

7. Do you have any comments on the proposal to use HESA cost centres to map research-active staff to UOAs and are there any alternative approaches that should be considered?

We do not support the proposal to use HESA cost centres to map research-active staff to UOAs for the following reasons:

This could inhibit multi- and cross-disciplinary work and lead to "pigeon-holing" of academics according to cost centre, which could be highly detrimental.

To date, HESA data has been primarily concerned with teaching rather than research. Consequently, the current HESA "architecture" is a much better reflection of the organisational structures associated with teaching (faculties and departments), rather than the University Centres and groups around which research activities are structured and presented.

HESA codes do not align with REF UOAs.

The use of HESA cost centres could lead to potentially artificial representations of research, and would lead to great difficulties in describing and presenting the research environment.

We suggest that staff are instead allocated to the most appropriate UOA based on their research outputs, impact and a genuine assessment of the environment. We acknowledge the risk that some HEIs will strategically allocate staff to UOAs to promote success. However, the converse risk of automatic allocation of staff to specific UOAs could lead to more negative consequences for academic disciplines, particularly in areas where there has traditionally been a strong focus on teaching. It is important, however, that any approach prevents manipulation in terms of recruiting, moving or realigning staff for REF purposes.

8. What comments do you have on the proposed definition of 'research-active' staff described in paragraph 43?

We support the proposed definition in principle and the proposed measure of independence in the definition of research-active staff. We would like to know how post-doctorates working on personal fellowships fit in. It is also important to note that, in a number of AHP disciplines research is carried out without or with minimal funding.

We support the principle that returning all staff research outputs as part of the REF if it stimulates AHP research. Some AHP bodies have reported that their members were under-represented in REF2014 returns and would welcome the opportunity to be included. However, we are concerned that the definition of “research-active” staff and the pressure on HEIs to perform well in the REF will have unintended consequences for AHP researchers. This will be to the detriment of AHP research and professional development beyond academia as follows:

It is likely clinical academics will be moved from teaching and research contracts to teaching-only contracts so that their work does not need to be included in the REF.

Many clinical academics roles are very teaching-intensive and they have small research portfolios.

The proportion of time across research and teaching can also vary greatly between individuals; this flexibility should not be removed.

Many AHP academics have additional duties in addition to teaching, such as pastoral care of students and liaison with practice placement education.

Safeguards would need to be put in place to weight research equally with less teaching-intensive disciplines; one suggestion is that recognition should be made of the proportion of staff time allocated to research and output volume be weighted accordingly.

As HEIs seek to obtain prestige and funding through the REF, there is a danger that early career researchers will be stifled. It is likely that “REF returnable research” will be at 3*/4* level. Early-career research is unlikely to be at this level and AHP research may also be more clinically-focussed at this point (e.g. service evaluations). This research is, however, of value to the allied health professions and building research capacity. There is a danger that very few new researchers will be able to progress in their careers.

We would recommend that there is a full equality impact assessment undertaken of the implications of implementing Lord Stern’s recommendations.

9. With regard to the issues raised in relation to decoupling staff and outputs, what comments do you have on:

9a. The proposal to require an average of two outputs per full-time equivalent staff returned?

The average number of outputs per FTE as the metric to calculate the total number of outputs required for a submission makes sense. If practicable, the FTE should be calculated on the time nominally allocated to research rather than employed by the HEI. This will allow account to be taken of teaching contracts and staff with clinical or industry caseloads. Implementing decoupling should encourage collaborative working. This will be beneficial for AHP research.

Some of our members are concerned that calculating an average of two outputs per FTE would result in a larger number of returns and a larger burden for HEIs and panel members.

9b. The maximum number of outputs for each staff member?

It has been difficult for our members to reach a consensus on this point. The majority agreed six would be a reasonable maximum number.

9c. Setting a minimum requirement of one for each staff member?

The majority of our members disagreed with this proposal for the following reasons:

Setting a minimum requirement of one output for each staff member does not decouple staff from outputs and could mean that public funding is effectively wasted on supporting staff to produce outputs of variable quality, rather than letting individuals get on with what they are good at; e.g. practice-informed teaching, translation of research etc.

It would also not take account of individual staff circumstances for largely female professions in clinical, teaching-intensive disciplines, or where teams work together.

Lack of one output in one cycle might lead to removal of the research component of contracts.

Allowing zero as a minimum would enable staff on long-term sick leave, maternity leave, part-time contracts and early-career researchers to be supported into a REF return without unnecessary pressure.

10. What are your comments on the issues described in relation to portability of outputs, specifically:

10a. Is acceptance for publication a suitable marker to identify outputs that an institution can submit and how would this apply across different output types?

The majority of our members support this. However, it may be challenging for some AHPs in arts therapy.

10b. What challenges would your institution face in verifying the eligibility of outputs?

Our members believe verification for existing staff would not cause any issues. For new staff, institutional affiliation would need to be verified to prevent manipulation.

10c. Would non-portability have a negative impact on certain groups and how might this be mitigated?

We believe that non-portability could have a negative impact on early-career researchers and staff on fixed-term contracts.

Non-portability could create a stasis in movement of workforce within 2-3 years leading up to the REF and another approach should be considered. For example, if a member of staff moves, their outputs could be split between their former and new HEI employer based on a weighting for the number of years spent at each.

In addition, non-portability should not apply to first lecturer posts, or to within 5 years of commencing any lecturer post.

Non-portability could potentially disrupt the coherence of the narrative around the research environment, whereby an individual's current and future contribution to research groups is disconnected from (some) of their publications.

10d. What comments do you have on sharing outputs proportionally across institutions?

We are in favour of this suggestion and have the following comments:

Outputs could be shared between the institution where the data was collected and where the work was submitted for publication, rather than the institution where an individual was working when the output was accepted for publication.

There could be a small element of “double-counting”. However, this goes on in the existing system. It would be important to be consistent with the scoring of outputs and this could potentially be a way of reducing panel workload. Caution may need to be exercised around sharing the underpinning research for impact case study production. It is also worth noting that some contributors could have a minor role.

11. Do you support the introduction of a mandatory requirement for the Open Researcher and Contributor ID to be used as the staff identifier, in the event that information about individual staff members continues to be collected in REF 2021?

The majority of our members support this, although there is also a perspective that this does not support decoupling.

12. What comments do you have on the proposal to remove Category C as a category of eligible staff?

Although there is an argument for removing category C to streamline, this seems to reduce the recognition of collaborative working. We consider that Category C should remain. This could enable submission of work from NHS-based researchers who are undertaking research with universities. While it is likely that there will be a co-author that is University staff, it would be better to keep the category open. Removing this category could disadvantage AHPs who are developing clinical academic profiles.

13. What comments do you have on the definition of research assistants?

We recommend that independence should be the primary consideration here. Guidance should include examples of what is and what is not considered to be independent research. This could be modified by main panels (or even sub-panels) to take into account accepted disciplinary norms.

14. What comments do you have on the proposal for staff on fractional contracts and is a minimum of 0.2 FTE appropriate?

This is an area that needs to be carefully considered. We are concerned that it is open to game-playing and that some organisations can be very creative/adept at presenting persuasive statements.

The majority of member feedback supported 0.2 FTE. However, there were some concerns:

“Sub-panel determining eligibility” could be cumbersome and perhaps inconsistent.

An institutional cap on the proportion of staff submitted on fractional contracts may be appropriate, particularly in disciplines associated with Main Panels A, B and C.

Staff appointed on fractional contracts in the final years of the assessment cycle could be excluded from the submission, to combat game-playing.

6. Collaboration

15. What are your comments in relation to better supporting collaboration between academia and organisations beyond higher education in REF 2021?

We are in favour of supporting better collaboration. This is likely to be a big issue for health-related research where many people move in and out of HEI-related projects. If information about these collaborations could be easily collected, it would be beneficial as a marker of good practice in research.

Modification of the guidance for the environment narrative to require HEIs to describe internal and external staff mobility is welcomed. This would be easier following decoupling of individuals from outputs. It would be beneficial for HEIs to be able to include honorary research appointments (normally NHS staff) in submissions.

We recommend the following in defining substantial collaboration:

- Peer-reviewed charitable funding / CRN portfolio acceptance
- Evidence of HEI involvement with study design / conduct / analysis
- We recommend collecting data on the following:
- Numbers of joint appointments
- Numbers of research Internships and clinical academic award holders
- Support systems for clinical academic careers
- Levels of patient/ public and organisational involvement in research developments and research activities.
- Developing collaboratively mechanisms for capturing research impact
- HEI staff inputs to research developments in NHS trusts, the private sector and industry.

7. Outputs

16. Do you agree with the proposal to allow the submission of a reserve output in cases where the publication of the preferred output will postdate the submission deadline?

We welcome flexibility in the submission of outputs as long as it does not unfairly advantage or disadvantage particular types of institution.

17. What are your comments in relation to the assessment of interdisciplinary research in REF 2021?

We are in favour of these proposals as an interdisciplinary approach is essential for high-quality AHP research. Inter-disciplinary champions on each panel is a positive step and we support strengthening the interdisciplinary identifiers. The provision for cross-referencing outputs across sub-panels is also welcomed.

Enhancing the environment template to give “points” to multi-disciplinary working might hinder specialist research of equal or higher value.

As found in analysis of routes to impact for REF 2014, the impact case studies are a natural way to reward interdisciplinary research.

18. Do you agree with the proposal for using quantitative data to inform the assessment of outputs, where considered appropriate for the discipline? If you agree, have you any suggestions for data that could be provided to the panels at output and aggregate level?

The continued use of peer review is supported and the usefulness of metrics such as citation impacts is recognised, provided sub-panels deem it appropriate to use that data. It is useful that these may be field-weighted. However, in UOAs with diverse constituencies (UOA3, for example), there will be marked differences in citation rates. A granular, potentially discipline-specific approach to the use of such metrics is required. Otherwise specific groups will be notably disadvantaged.

We would recommend ensuring panel members are guided to use metrics appropriately.

We do not support the inclusion of social-media in citations (e.g. counting the number of tweets or re-tweets) as this is not a measure of research quality.

8. Impact

19. Do you agree with the proposal to maintain consistency where possible with the REF 2014 impact assessment process?

We agree with this to minimise disruption and workloads, providing impact is decoupled from individuals. We fully support maintaining the impact narratives in a similar form.

20. What comments do you have on the recommendation to broaden and deepen the definition of impact?

The definitions of impact provided are suitable and it is useful to differentiate between academic impact and wider impact.

The broadening of the definition of impact provides greater opportunities to demonstrate impact over a range of disciplines, with a range of research approaches and cultures.

Impact cannot be assessed purely on the basis of reach or scale, as impact can still be significant even when the number who benefit is modest. Impact can/should take many forms. Specific elements of change and how this is evidenced need to be highlighted.

21. Do you agree with the proposal for the funding bodies and Research Councils UK to align their definition of academic and wider impact?

If yes, what comments do you have on the proposed definitions?

We agree with this in principle but have the following comments:

It would be useful to include the institution in which the researcher is based.

We prefer the term economic and societal impacts; as wider impact suggests academia is the centre of research impact and everything else is undefined.

22. What comments do you have on the criteria of reach and significance?

Criteria for reach and significance would be helpful. It would also be useful to understand the emphasis on significance.

Both reach and significance are important concepts/criteria within impact. However, these are not always fully understood. For research in relatively small professions, research may have limited reach in terms of audience, but may have huge significance in terms of change in practice and impact on patients/clients care and outcomes.

Both reach and significance need to be considered; neither should be more or less important than the other. Significance is more challenging to identify and describe than the concept of reach.

23. What do you think about having further guidance for public engagement impacts and what do you think would be helpful?

Further guidance would be helpful/valued including an indication of appropriate means of genuine engagement. Indicators of the different levels of reach and significance would also be important. Guidance on how public engagement requires two-way communication both from and to the public would be helpful. It is important to avoid a “box ticking” approach to public engagement in ways that have limited impact. Targeted impact on intermediaries dealing with the public e.g. health services would be a more important metric.

24. Do you agree with the proposal that impacts should remain eligible for submission by the institution or institutions in which the underpinning research has been conducted?

We agree that impact should remain with the institution, to avoid manipulation of staff transfers / recruitment for REF purposes. However, this could act as a disincentive to researchers to drive further impact once they leave the institution where they did the research.

25. Do you agree that the approach to supporting and enabling impact should be captured as an explicit section of the environment element of the assessment?

We agree with this approach in order to avoid necessity for a separate template and perhaps reduce work required in preparation. However, as with all parts of the REF submissions, there is a balance to be struck between what can be written in the specific word counts. This can be especially challenging for specialist groups working in much larger UOAs; e.g. healthcare clinical research within psychology, or basic science departments. The nature of impacts requires extra explanation to be intelligible for assessors who may be minimally aware of the issues in a field towards the “periphery” of a UOA.

If impact is merged with the environment narrative, the ability for HEIs to give an overall summary of the strategy and processes used to develop impact will be needed. This should form part of a larger environment template.

26. What comments do you have on the suggested approaches to determining the required number of case studies? Are there alternative approaches that merit consideration?

The proposal to allow one case study for smaller submissions is supported, as is the suggestion that a system is required for defining the number of case studies depending on the number of staff returned. We agree that the total number of case studies should not be greater than in REF 2014.

27. Do you agree with the proposal to include a number of mandatory fields in the impact case study template to support the assessment and audit process better (paragraph 96)?

We support the proposal to enable better comparison between impact case studies. While the underpinning research is clearly important and could be listed, the large majority of the template should remain focused on the narrative of impact. In REF2014, some institutions also used evidence such as policy generation and other outputs that were not submitted to the REF in their own right, but helped to explain the impact of the underpinning research. We support a continuation of this approach. In such cases, a field could be added to identify additional outputs not directly returned.

We are concerned that including role at the time when the associated research was conducted would create an unnecessary administrative burden. Individual roles change throughout careers and impact evolves throughout an individual, or group of individuals' careers.

28. What comments do you have on the inclusion of further optional fields in the impact case study template?

We support this on the whole. These fields need to be genuinely optional, as not all research is funded.

We suggest also allowing non-research funding, that has been secured to be recorded in order to maximise how impact is reported.

29. What comments do you have in relation to the inclusion of examples of impact arising from research activity and bodies of work, as well as from specific research outputs?

We strongly support being able to include impact from a body of work. We consider that this will support disciplines where there are smaller numbers of researchers and where research culture is developing as it may allow a greater range of opportunities to demonstrate impact. It will also prevent the distortion that was caused in REF2014 by trying to work case studies into specified outputs when this has not always been the best fit.

30. Do you agree with the proposed timeframe for the underpinning research activity (1 January 2000 to 31 December 2020)?

We support the window of 20 years to enable impact of work to be clearly demonstrated over time.

31. What are your views on the suggestion that the threshold criterion for underpinning research, research activity or a body of work should be based on standards of rigour? Do you have suggestions for how rigour could be assessed?

We support the suggestion that individual pieces of work that may lead to real and tangible impact may not be the same as research outputs that would be considered of international quality. While the methodological rigour of the underpinning research is important, small-scale research (2*) could be more likely to lead to real local impact that should be valued. We suggest that impact should consider the range of outputs, that not all need to be submitted and many may be of smaller scale.

We suggest that peer review is recognised as a measure of rigour.

32. Evaluation of REF 2014 found that provision of impact evidence was challenging for HEIs and panels. Do you have any comments on the following:

32a. The suggestion to provide audit evidence to the panels?

We agree that evidence should be available to assessment panels. However, we have a number of concerns about how this would work:

If not carefully managed, this process could become overly onerous.

In healthcare, audit evidence may not be held by the HEI and may even contain sensitive data.

If an online repository were used, security/privacy would need to be guaranteed. Provisions would need to be made for confidential/classified information. Without these assurances many commercial organisations, especially, are unwilling to disclose key assessment and/or audit evidence or to engage with institutions in supporting case study development.

The burden on HEIs is already substantial, so this should be minimised.

32b. The development of guidelines for the use and standard of quantitative data as evidence for impact?

Guidelines need to be clear but we also request that researchers are able to make their own judgement as to the most appropriate way to evidence impact. Much audit data in healthcare is not held centrally, or by the HEI, and may be in many formats. Quantitative data may not be appropriate for all professions and research approaches.

Guidelines should provide a list of suggested impact indicators, and clarify that they are for illustrative purposes only and that there is no hierarchy of evidence. Comparison between impact case studies should not be a factor in their assessment and metrics relating to reach/significance should be assessed on the individual merits of a case study.

32c. Do you have any other comments on evidencing impacts in REF 2021?

The development of the REF's approach to impact is still in its relatively early stages. Another round of impact case study assessments in 2021 would form a better basis for future consideration of assessments, including whether metrics are suitable for use.

The value of being able to compare across case studies is useful in order to obtain a robust picture of the impact of UK research (but not for the assessment of individual case studies). We suggest that this would be a welcome area for further analysis and research around methodologies for comparing impact measures. There should also be work to begin to standardise impact metrics into both

research and business development practices through policy and development of professional practice (e.g. using a standard set of commercial indicators as part of licensing deals, including a standard set of measures in clinical trials etc.).

Following recent Digital Science studies from the REF2014, impact case study data set (http://blogs.lse.ac.uk/impactofsocialsciences/2016/04/04/what-impact-evidence-was-used-in-ref-2014/), there is evidence of a hierarchy of evidence/panel bias. Guidelines need to clarify the acceptability of different sources of evidence; e.g. written testimonials of reach and/or significance from individuals/beneficiaries.

Where institutions gather data from numerous third parties and public data sources to build up arguments for reach/significance. Consideration needs to be given to how this should work and how any subsequent estimates would be evidenced. It needs to be clear whether evidence can include a dossier of data; e.g. calculations with assumptions, rather than taking up valuable word counts to explain methodologies (e.g. estimating market penetration, global sales etc.).

There are difficulties in keeping evidence of impact current; e.g. guidelines and websites get updated.

33. What are your views on the issues and rules around submitting examples of impact in REF 2021 that were returned in REF 2014?

We agree with this approach as long as the rules are clear and the impact stated in 2021 is demonstrably different or enhanced from that reported in 2014. Evidence of further dissemination / publication of ongoing research/ evaluation impact capture would need to be included in the case study.

9. Environment

34a. Do you agree with the proposal to change the structure of the environment template by introducing more quantitative data into this aspect of the assessment?

We support this and recommend collecting existing data in order to reduce burden. We welcome the link to the Forum for Responsible Metrics.

34b. Do you have suggestions of data already held by institutions that would provide panels with a valuable insight into the research environment?

We suggest the following:

Research links with local communities, professional bodies, private practice, industrial partners, NHS Trusts, private hospitals, local councils and government.

35. Do you have any comment on the ways in which the environment element can give more recognition to universities' collaboration beyond higher education?

We suggest the following:

- Collaborative research conferences / research fora
- Joint appointments with NHS Trusts and professional bodies
- Joint grant applications and publications (to recognise collaboration between clinicians, professional bodies etc.)

- Joint activities and developments in facilitating research awareness and research capacity; e.g. joint research development with the groups mentioned in 34a / support for local Council for AHP Research hubs

36. Do you agree with the proposals for providing additional credit to units for open access?

We agree with this proposal as long as it does not unfairly disadvantage smaller, more specialist institutions that may not have either the output profile, volume or the levels of resource required to support Open Access. We agree that the environment statement (potentially at an institutional level if this is introduced) could usefully include some comment on the approach to open access.

We are also concerned that this may severely limit submissions of unfunded or post-graduate research for these reasons, it is essential that the criteria for Open Access publication are inclusive of all Open Access routes.

37. What comments do you have on ways to incentivise units to share and manage their research data more effectively?

We support the inclusion of an institutional statement on research data management alongside a statement on compliance with open access. In health-related subjects, there would be a number of ethics and governance issues that would need to be addressed.

10. Institutional level assessment

38. What are your views on the introduction of institutional-level assessment of impact and environment?

We see benefits of this and believe it could encourage interdisciplinary working and collaboration in research. However, we also note concerns about the increased burden of producing institutional impact case studies and whether smaller institutions will be disadvantaged.

We consider the contribution to the wider academic community and to under and post graduate research education to be a particularly important metric.

39. Do you have any comments on the factors that should be considered when piloting an institutional-level assessment?

This needs to take account of the relationship with unit-level assessment.

11. Outcomes and weighting

40. What comments do you have on the proposed approach to creating the overall quality profile for each submission?

We are concerned that this could introduce an alternative ranking dimension to a system that already results in numerous rankings. We would recommend including scores within individual quality profiles.

41. Given the proposal that the weighting for outputs remain at 65 per cent, do you agree that the overall weighting for impact should remain at 20 per cent?

We support this.

42. Do you agree with the proposed split of the weightings between the institutional and submission-level elements of impact and environment?

The majority of our members support this.

12. Proposed timetable for REF 2021

43. What comments do you have on the proposed timetable for REF 2021?

We consider the timetable appropriate, although the extent of changes to the rules around REF 2021 might make some of the operationalisation more difficult.

13. Other

44. Are there proposals not referred to above, or captured in your response so far, that you feel should be considered? If so, what are they and what is the rationale for their inclusion?

Evaluation of REF 2014 found that provision of impact evidence was challenging for HEIs and panels.

For this to be successful, organisations need to be informed very soon about any changes in the criteria so that they can begin to forward plan.