Royal Berkshire NHS Foundation Trust & University of Reading Strategic Partnership Evaluation

Final report and future strategy

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Contents

1. Executive summary and future strategy

1.1. Key findings

This report presents the findings of a 9-month Evaluation of the Strategic Partnership between the University of Reading (UoR) and the Royal Berkshire Hospital NHS Foundation Trust (RBFT).

The report describes a Partnership that has thrived in its early stages of development from 2018-24. In its current form, the Partnership comprises 5 pillars of strategic activity, spanning Research, Education, Advanced Analytics, Commercialisation and Estate. Through its broad-based initiatives to stimulate collaboration, a wide portfolio of early-stage collaborative links has been initiated. Collaboration has predominantly developed in the research pillar, but with elements of collaboration across all pillars to varying degrees.

There are examples of early-stage collaboration, initiated through the Partnership, which are already maturing. In total, the Partnership has leveraged over £9.3m from external funding sources, within which there are clusters of repeat success and high value awards. This gives confidence that the approach of the Partnership can lead to success at scale. However, beyond these early examples of success, the majority of the Partnership's portfolio remains early stage and is not yet maturing to the next stages of development. Looking ahead to the next phase of the Partnership, a key challenge is to scale and replicate the successes, and to support their further development as they mature into improvements in clinical practice and policy that benefit patients within and beyond RBFT.

At present, the Partnership initiatives and resources are oriented towards initiating new collaborative activity over the breadth of the two organisations. While this strategy of casting the net wide has served the Partnership well in its early phases, the challenge now is to build on this past investment and allow the Partnership to mature. At the heart of this Evaluation has been a central theme of how best to support the maturing of the Partnership? Should its' future strategy continue to be broad-based? Or should the emphasis shift towards building a depth of activity in defined areas of opportunity?

Based on the findings of the Evaluation, this report identifies a series of recommendations that will facilitate maturing of the Partnership and will drive an upturn in the pace of change and delivery. The recommendations describe a dual approach, in which the main emphasis should be to build depth that benefits patients in Areas of Shared Focus that have emerged to date, whilst in parallel maintaining a scaled-back element of support for new opportunities to emerge and mature as the potential focal points for the future.

1.2. Recommendations

The report identifies a series of recommendations, which group together to create the following strategic goals:

Overarching strategic goal: The future strategy for the Partnership should **emphasise building depth of collaboration**. The priorities for the Partnership should be focused on Research Innovation and Impact, and on Education and Talent. Collaboration in the form of Advanced Analytics should be repositioned as a cross-cutting underpinning activity that is interwoven into the two priorities (Recommendations A, K, P, R, T).

Research Impact and Innovation strategic goals: the focus for building depth should be to **provide strategic support to scale up activity where Areas of Shared Focus (ASF) have been established**. The Partners should take a strategic approach to development of these Areas, enabling each ASF to mature and develop a portfolio of collaborative impactful research with substantial external research income. The ASF should encompass both focal points of activity at RBFT and at UoR. For RBFT, a number of Departments have already been Recognised for Excellence in clinical-academic activity, within which there is a subset of 5 Departments that have also been awarded Joint Professorships. These 5 Departments should form the initial ASF for RBFT, building on their momentum and the investment in the Professorships. For UoR, the ASF should be defined by repeat successes in collaborating with RBFT. Over the course of the strategy period, the ASF approach could be extended to the other RoES Departments and emerging clusters at UoR (Recommendations A, D, E, F).

In parallel, **an element of activity to develop breadth for the future should be maintained** but at a scaled-back level. This should support new areas of collaboration where there is high potential, both targeted to specific opportunities identified "top-down", as well as responsive support where compelling opportunities arise "ground-up" (Recommendations B, C).

Maturing the Partnership's portfolio of past investments should be a focus for activity, with a reduced emphasis on initiating new collaboration. The Partners should continue to guide projects previously pump-primed through the Collaborative Innovation Fund (CIF) as they develop towards larger projects, impacts that benefit patients, or commercialisation. Many of these will form key strands of activity for the ASF, while others may represent emerging focus areas for the future (Recommendation C).

If the Partnership is to fulfil its potential to benefit the health and care of the people of Berkshire and beyond, the innovation enabled by this Partnership will need to be translated into impact within and beyond RBFT. This will require pathways that reach beyond the existing bilateral Partnership and connect to stakeholder organisations across the region, sector and wider NHS. To support this, the Partners should **make external engagement a strategic priority** for the next phase of the Partnership's development (Recommendation J).

Education and Talent strategic goals: the Partners should build depth by focusing on **innovation and student experience in existing collaborative programmes and courses**.

The Focus for activity in this priority should include **unlocking the potential of the Clinical Simulation Training Suite** to drive innovation in education and interprofessional training, building on the joint venture that has been established.

Enhancing clinical placement training should also be a Focus, by joining up, streamlining and optimising placements to form a foundation for innovation and improvement (Recommendations K, M, N).

The report also makes recommendations for the following *key initiatives*:

- Develop a package of practical hands-on support for joint clinical research (Recommendation H).
- Establish a virtual Joint Research Office that supports and facilitates all joint research between the two organisations (Recommendation I).
- Shift the focus of funding and Partnership Team activity towards maturing the pipeline of research within the ASF (Recommendation G). This includes establishing different modes for CIF (strategic-, targeted- and responsive-modes); shifting the emphasis of the Partnership Team towards strategic development and programme management; and rebalancing the Team across the two Partners.
- Increase transparency of decision-making for new educational programmes and courses to reduce mixed understandings (Recommendation L).
- Design elements of training for healthcare educators and for NHS leadership development that can be incorporated into education programmes for students, trainees and staff. This should draw on the successful RBFT-tailored Henley programme and the PGCert Healthcare Education (Recommendation O).
- Incorporate research-based estate development opportunities within the Research Pillar of the Partnership, using targeted-CIF to stimulate collaboration where opportunities are identified (Recommendation Q).
- Seek philanthropic, alumni, donor and corporate social responsibility investments to underpin CIF (Recommendation S).
- Incorporate health data analytics as a specific strand of research within the 5-year research strategies for the Partnership Areas of Shared Focus (Recommendation U).
- Explore opportunities for and feasibility of expanding UoR capacity in health data analytics (Recommendation V).
- Reconfigure the Partnership governance for the new strategy period (Recommendation W).
- Revisit the naming of the Partnership and consider whether the HIP name conveys a clear remit and identity (Recommendation X).

1.3. Future strategy

Based on the key findings and the recommendations, the report suggests the following strategy for the future (illustrated in Figure 1).

Our mission is to advance healthcare practice and policy through excellence and innovation in research and education, by working together in partnership and with stakeholders across the sector and region.

Our vision is to transform the health and care of the people of Berkshire and beyond by bridging university and healthcare environments. By creating a learning environment that drives continuous improvement, we will create a step change that informs national best practice in healthcare and prevention.

Our strategy focuses on two *strategic priorities*, through which we will achieve our mission:

- Research, Innovation and Impact
- Education and Talent

Our strategy is supported by a *cross-cutting theme* that underpins our strategic priorities:

- Advanced health data analytics

We work closely together to commercialise the outputs of our collaboration and to share elements of our infrastructure and estates, which contributes to the long-term sustainability of our Partnership.

Our strategy identifies a number of *strategic goals and key initiatives* through which we will develop a depth of collaboration in focused areas, leading to impactful research and education that benefits patients and informs clinical practice. This builds on the breadth of our collaboration developed in the earlier stages of our Partnership and will accelerate deepening of the Partnership as it matures to replicate and extend our early successes.

Defined *Areas of Shared Focus* are at the heart of this approach, around which we will focus resources and support to drive their development towards success at scale. As the initial wave of ASF mature, we will extend this approach to future waves as other focal points mature and emerge.

The initial wave ASF will include:

- 5 RBFT-based Departments, with Recognition of Excellence Status (RoES) and Joint Professorship: Cardiology, Critical Care, Emergency Medicine, Rheumatology, Radiology.
- 5 UoR-based clusters of collaboration: Cardiovascular Biology, Health Data Analytics, Health Inequalities, Nutrition, Pain.
- 2 Education and Training initiatives: building on the Clinical Simulation Training Suite to drive innovation and interprofessional education; and clinical placement excellence and innovation.

Subsequent waves of ASF could include other RoES Departments (current and potential future) and other emerging areas of activity at UoR that mature from past-CIF projects. It could also include other areas of innovation in education and training.

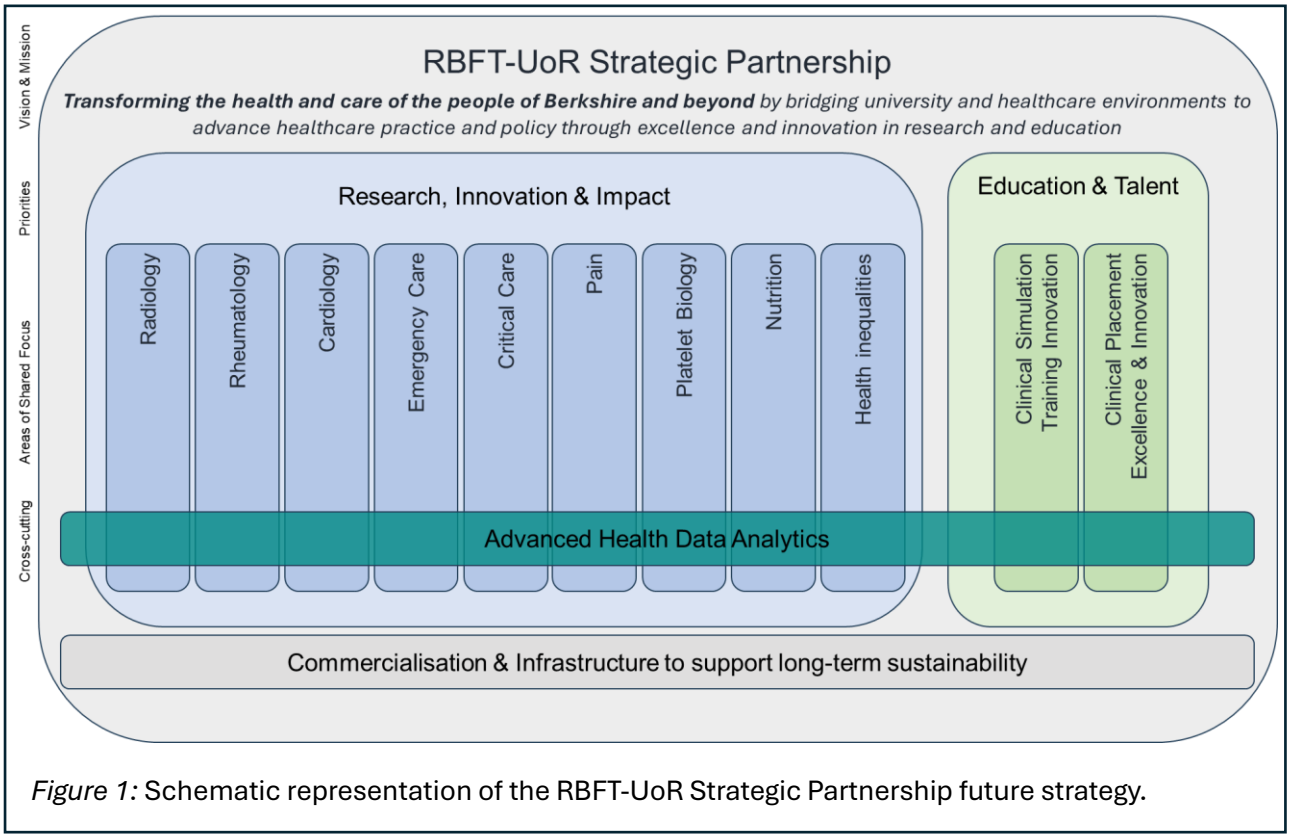


Figure 1: Schematic representation of the RBFT-UoR Strategic Partnership future strategy.

2. Introduction

This is the final report of the evaluation of the Partnership between the University of Reading (UoR) and the Royal Berkshire Hospital NHS Foundation Trust (RBFT). The Evaluation Exercise was conducted jointly on behalf of both partners and took place between 1 May 2024 – 31 January 2025. The final report presents the findings of the second phase of work, summarises the findings from phase 1 (as previously detailed in the interim report), and makes recommendations for the future strategy and initiatives for the Partnership in its next term (2026 onwards).

2.1. Introduction to the Strategic Partnership

The Partnership between UoR and RBF has evolved over the last 10 years and more. Prior to 2014, the collaborative links that existed were small in number and typically between specific individuals or were associated with specific taught programmes in Pharmacy and Clinical Language Sciences. Between 2014 to 2017, efforts were made to increase the breadth and depth of collaborative initiatives between the two organisations, including establishing a jointly funded Strategic Partnership Manager post to identify and facilitate new collaborative opportunities. The culmination of these efforts was a joint strategy meeting in November 2017, from which the formal Strategic Partnership grew. This included establishing a Joint Academic Board (JAB) in March 2018, tasked with delivering a 3-year programme of collaborative research and education innovation funding (the Collaborative Innovation Fund, CIF), worth £1.15m over 3 years (£575k from each partner). The JAB was also tasked with creating a scheme to recognise clinical and academic excellence (the Recognition of Excellence Scheme, RoES).

The initial form of the Partnership evolved in 2021 to become the Health Innovation Partnership (HIP). The HIP encompasses the second phase of CIF, with funding committed for5 years until 2026, and the continuation of the RoES initiative. The JAB evolved to form the HIP Board[1], with refreshed membership, and reporting into the Strategic Partnership Board (SPB) that oversees the Partnership as a whole[2]. The vision for HIP is *"to improve healthcare by building an environment and culture that fosters excellence in education, research and innovation in a sustainable, supportive and inclusive community"*.

In parallel to the formation of the Strategic Partnership, in 2017/18 exploratory work was underway to evaluate the possible formation of a joint medical school. This was prompted by the emergence of new medical schools elsewhere in the UK and by a government call for new medical schools in 2018 (Health Education England, 2018). Although the exploratory work resulted in a decision not to apply as part of that call, establishing a medical school remained a

[1] HIP Board reports to SPB. Membership: RBFT: Janet Lippett (Chair), Rebecca Cullen, Jill Ablett, Atul Kapila, Leslie Mokogwu, Elizabeth Flannery. UoR: Carol Wagstaff, Dan Grant, Phil Dash, Magda Kosmopoulou, Elisha Bird (secretary). Collaboration representatives: Jessica McKean and HIP Facilitator (vacant post).

[2] SPB reports to RBFT Executive Management Committee and UoR Executive Board. Membership: RBFT: Chief Executive (Steve McManus, Co-Chair); Chief Medical Officer (Janet Lippett); Director of Strategy (Andrew Statham). UoR: Vice-Chancellor (Robert van de Noort, Co-Chair); Deputy Vice Chancellor (Parveen Yaqoob); Research Dean for Agriculture Food & Health (Carol Wagstaff). Collaboration representative: Strategic Partnership Manager.

shared long-term ambition for several years. However, in spring 2023 the decision was made that a joint RBFT-UoR medical school was no longer a feasible ambition for the Partnership and would not be pursued further.

2.1.1. Current form of the Partnership

In its current form, the Partnership has grown to encompass 5 pillars of collaborative activity, spanning research, education, estates, commercialisation and advanced analytics (as shown below in figure 2).

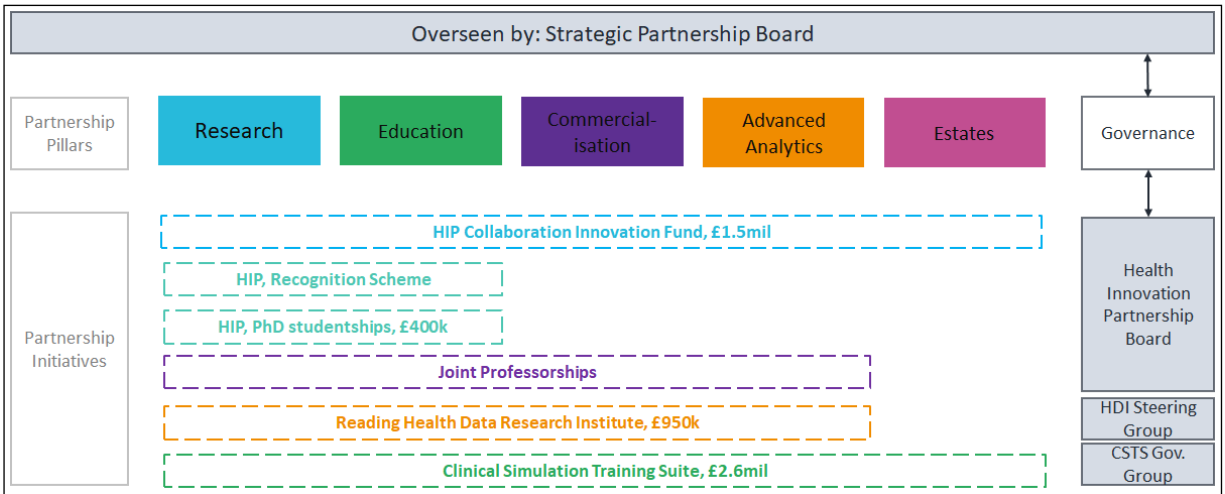


Figure 2: Schematic representation of the RBFT-UoR Strategic Partmership, illustrating the 5 pillars of collaborative activity, the initiatives through which activity is delivered, and the governance groups (with thanks to Jessica McKean)

The Partners have developed a number of initiatives to seed and drive collaboration, which include:

- The **Collaboration Innovation Fund** (CIF): provides funding of up to £60k over a maximum of 2 years to pump-prime collaborative projects in research, education and professional services engagement. Projects are evaluated on the basis of novelty, feasibility, rigour, potential for impact, timeliness and legacy, the team, value for money and strategic fit. Overseen and assessed by the HIP Board, usually open for applications once per year. Over the first 7 rounds of CIF £1.72m has been awarded to 47 projects[3].
- **Recognition of Excellence Scheme** for RBFT Departments (RoES): recognises clinical and academic excellence for RBFT Departments, conferring the title of "University Department". Applications to the scheme are evaluated against a framework of criteria demonstrating excellence in the core areas of clinical outcomes, research and innovation, and education and staff development. Evidence must align with the RBFT values (Compassionate, Aspirational, Resourceful, Excellent) and demonstrate how

[3] CIF round 8 took place during the periods of the Evaluation Exercise and has not been included in the analyses. Projects from CIF rounds 1-7 that were abandoned or had funding withdrawn have also been excluded from the analysis.

care is delivered in line with RBFT's strategic priorities and clinical service strategy. Successful Departments are awarded a Certificate of Excellence and plaque, use of the "University Department" title, half-funding for a 3-year PhD studentship (to be match-funded), and uplifted access to the CIF. Awards are reviewed every 3 years. 9 RoES Departments had been awarded at the commencement of the Evaluation Exercise, with a 10th Department successfully awarded during the Exercise[4].

- **RoES PhD studentships**: half-funding for 3-year PhD studentships have been awarded to successful RoES Departments, 5 of which have been taken up to date[5]. Matched funding has been awarded in most cases from the UoR host School, with one exception where UoR's BBSRC Doctoral Training Partnership grant was used to provide the co-funding.
- **Joint Professorships**: Joint Professorships were established in November 2024 to lead academic clinical research, taking the form of part-time secondments from RBFT to UoR. Secondment applications were invited from candidates within RoES Departments to further develop and enhance collaborative research with UoR. Five colleagues from RBFT were successfully appointed as Joint Professors from January 2025[6]
- The Reading **Health Data Institute** (HDI) was established as an RBFT initiative in 2023-24 with £750k investment from RBFT and in-kind support from UoR. The development of the HDI has progressed outside the structures of the Strategic Partnership, and its governance does not report to SPB. Nevertheless, it is a core component of the route through which joint health data analytics opportunities will be realised.
- **Clinical Simulation Training Suite** (CSTS) was established as a joint venture to provide a state-of-the-art simulation facility for training staff, students and trainees. The capital costs for the facility were funded by a grant awarded to UoR from the Office for Students (OFS) (£2.6m), with ongoing costs to be shared by UoR and RBFT.

The activity of the Partnership is facilitated by a small Partnership Team, comprising a Strategic Partnership Manager and a HIP Facilitator, both of which are employed through RBFT. Previously, the Team included a Strategic Partnership Director post, employed through UoR. This post was vacated in May 2024 and has remained on hold during the course of the Evaluation Exercise.

[4] RoES Departments at 1 May 2024: Cardiology, Emergency Medicine, Critical Care, Radiology, Rheumatology, Urology, Stroke, Elderly Care and Renal (Berkshire Kidney Unit). The 10th RoES Department, Ophthalmology, was awarded after the conclusion of the looking back element of the Evaluation and has not been included in the analyses.

[5] Active PhD studentships at the time of the Evaluation Exercise were: Emergency Medicine with Psychology & Clinical Language Sciences and Pharmacy; Radiology with Pharmacy; Stroke Medicine with Food & Nutritional Sciences (BBSRC co-funding); Critical Care with Biological Sciences; and Renal with Pharmacy.

[6] Joint Professors: Toni Chan, University Department of Rheumatology; Matthew Frise, University Department of Critical Care Medicine; Liza Keating, University Departments of Emergency and Critical Care Medicine; Mark Little, University Department of Radiology; Neil Ruparelia, University Department of Cardiology.

2.2. Introduction to the Evaluation Exercise

With the HIP more than halfway through its term, a mid-term Evaluation and Future Scoping Exercise was instigated by SPB in May 2024. The purpose of the Exercise was to evaluate what had been achieved since the formation of the Partnership in 2018, to understand what had worked well and what could be improved, and to guide the future direction of the Partnership. This included re-evaluating the long-term ambitions of the Partnership, taking into account the change of priorities relating to the previous ambition for a joint medical school.

The Evaluation Exercise comprised three elements:

- *Looking back*: Evaluated what had been achieved by the Partnership, across all pillars including research and innovation, education, commercialisation, estates and advanced analytics. Comprised approx. 60% of the Evaluation.
- *Looking out*: Considered examples of good practice from NHS-university Partnerships elsewhere in the sector to learn from in shaping the RBFT-UoR future strategy. Approx 15% of the Evaluation.
- *Looking forward*: Developed recommendations for the future strategy for the Partnership and key implementation initiatives (2026 onwards) based on a breadth of future perspectives from colleagues within the organisations and at Board levels. Approx 25% of the Evaluation.

Phase 1 of the Exercise (May-September 2024) focused on the *looking back* element. The findings of this phase were presented in detail in the UoR & RBFT Strategic Partnership Evaluation Interim Report (18 October 2024). The *looking out* and *looking forward* elements were completed in phase 2 (October – December 2024). The Evaluation methods are summarised in Appendix 1. This report presents the integrated findings from each of the 3 perspectives, along with recommendations that emerge from those findings, presented for each pillar and the overarching partnership.

The final section of this report presents a potential future strategy for the Partnership along with suggested implementation initiatives. This has been developed based on the recommendations identified in each section and informed by the looking back, looking out and looking forward perspectives. Following the conclusion of the Evaluation Exercise, the Partners will need to consider how they wish to respond to the recommendations and suggested future strategy, both jointly and as individual organisations.

3. Findings and Recommendations

This section of the report presents the integrated findings from the three perspectives for each pillar and the Partnership as a whole. Based on the findings, this section also identifies recommendations for the Partners to consider for the future.

3.1. Overarching Strategic Partnership

3.1.1. Looking back

The Evaluation identified strong and wide-spread support for the Partnership in both organisations. Colleagues identified that by working together, there should be opportunities for innovation and impact that are mutually beneficial, bringing together academic expertise and clinical expertise to tackle the healthcare challenges that clinicians see in the real world. Colleagues could also see the value to the Partnership in building reputation, attracting and retaining staff, and how both organisations are perceived as anchors in the region.

Colleagues noted a strong sense of positive intent within the Partnership, with individuals keen and willing to work together and overcome obstacles. Strong leadership from the top was frequently identified as a feature of the Partnership, with high-levels of buy-in and commitment at Executive levels. However, colleagues also noted that this can also bring challenges if the detail of implementation is not balanced with the top-down drive towards action.

Reflections from colleagues also formed a consensus that the Partnership lacks a clear strategic purpose. While colleagues could see the importance in principle, there was a lack of clarity about what the Partnership is trying to achieve and how this relates to the work of individuals and units. There were a range of issues that underpinned this view:

- **Activity spread wide and thin across many different areas**, with an emphasis on breadth of collaboration rather than depth and without a clear sense of priorities.
- **Lack of clarity about what has been achieved** and whether there is return on investment.
- **Changes in strategic direction**, with a sense of wasted investment and effort, primarily in relation to work towards establishing a medical school but also a previous attempt at establishing a joint Clinical Trials Unit (CTU).
- **Imbalances in the Partnership**. Colleagues in both organisations perceive a sense of imbalance, with individuals in both organisations feeling that their organisation was putting in more effort or resource while the other partner felt the benefits. This is compounded by tangible imbalances in the orientation of the Partnership initiatives (RoES-associated) and distribution of Partnership Team posts.

Collectively, these findings suggest the Partnership may be approaching a transition in its development. In the early stages, the Partnership's strategy was exploratory and sought to initiate a wide range of activity at small scale to see where opportunities would emerge. This has

led to a broad spread of activity across many possible areas, with some early examples of success already visible, some examples of activity that was not the right fit for the Partners that has been stopped, and a wide range of activity in between that may have potential for the future.

While this broad-based strategy has served the Partnership well in the past, the challenge now is how to build on this foundation and deliver at scale. The key question as the Partnership transitions into its' next phase (as identified in the Evaluation Exercise Interim Report) is: "*should the Partnership continue to build a broad base of activity across the two organisations? Or should the Partnership shift to building focused depth of activity in defined areas?*"

3.1.2. Looking forward

The key question above framed discussions within the looking forward perspective. Board level discussions supported the view that the Partnership is approaching a transition. They noted that the broad-based approach had allowed the Partner to learn how to work together, understand each other's cultures, and identify opportunities. Looking to the next term of the strategy, the Board discussions highlighted the need to focus on targeted areas where there is mutual opportunity and shared interest, and to scale up activity and income generation in those focused areas. While this view was most strongly expressed by UoR colleagues and Board, RBFT Board discussions also recognised that this direction of travel would be important if the current examples of success are to be replicated. The Strategic Planning Workshop gave further consensus for a transition towards depth in focused areas as the Partnership matures.

Board discussions also highlighted the importance of maintaining an element of breadth alongside developing depth in areas of shared focus, which would allow future areas of shared focus to emerge and develop. The Strategic Planning workshop echoed this, with consensus that a future strategy should allow a scaled, funnel-like approach that directs larger amounts of funding towards Areas of Shared Focus that are demonstrating success and maturing (such as the RoES departments), whilst also maintaining a smaller element of funding to support emerging opportunities that have potential as focus areas for the future. These emerging opportunities could continue to arise from "ground-up" activity, in which individuals in both organisations come together around a common interest that has potential to benefit patients. Alongside this, the Partnership might also seek to strategically seed new activity "top-down" where specific opportunities can be seen on the horizon.

This direction of travel represents the maturing and focusing of an established Partnership as it moves towards delivering success at scale from the foundations of its' earlier stages. Looking to the next phase of the Partnership, from 2026 onwards, the strategy should reflect this maturation. This Evaluation Exercise provides the transition point to move from the current broad-based early Partnership strategy to a future strategy that focuses on driving the pace of delivery and change in focused areas that have shown potential to benefit patients.

3.1.3. Looking out

Looking out across the sector, partnerships between the NHS and universities are commonplace and take a wide variety of forms. Partnerships can include a wide range of activities, such as healthcare education degree programmes, continuing professional development for healthcare professionals, research collaborations, joint staff and shared infrastructure. The majority of English universities now offer either medical or nursing programmes which rely on NHS partners to deliver the clinical placement elements of the teaching. Of 100 English universities (excluding specialist institutions), only 12 offers neither of these programmes[7], within which only a subset of 5 represent broad-based research-intensive universities (Cranfield, Loughborough University, Royal Holloway, University of Bath, University of Reading). All institutions within that subset are engaged in substantial collaboration with NHS organisations, although not all necessarily present this as a partnership on their websites.

Given the volume and variety of NHS-university partnerships in the sector, the looking out element of this Evaluation has focused on examples of good practice to inform thinking rather than a comprehensive review of the sector. In general, the information available is patchy and intended primarily for promotional purposes. However, in the example of the University of Portsmouth and Portsmouth Hospitals University NHS Trust, it has been possible to track down some of the partnership's milestones through press releases. It is notable that even this relatively recent partnership has developed over a timeframe of 10 years and more, while many other NHS-university partnerships have been developing over multiple decades and even centuries. This supports a view that partnerships in this sector tend are developed and sustained over long timeframes, with the RBFT-UoR Partnership seeming relatively early-stage.

Looking in more detail at the Portsmouth example, it is notable that the development has included similar elements to the RBFT-UoR partnership which have brought focus to the partnership and underpinned its future development:

- The formal partnership has been developing since at least 2009 when the first partnership agreement was signed. This was renewed and strengthened in 2019 with a new agreement which laid out a joint vision for 2025.
- The overall purpose of the partnership is "enhancing clinical and academic excellence to improve the health and wellbeing of people in the communities we serve".
- The partnership supporting a range of collaborative projects, with a specific emphasis on new healthcare technologies and their application. This has helped the partnership to develop a focus and definition to its work and reputation.
- The partners have established 3 clinical Chairs, in the fields of emergency medicine, stroke and dementia, and respiratory medicine. This is similar to the recently established Joint RBFT-UoR Professorships.

[7] English universities without medical or nursing programmes (excluding specialist arts and agricultural universities): Arden University, Bath Spa University, Bishop Grosseteste University, Cranfield University, Health Sciences University, Liverpool Hope University, Loughborough University, Royal Holloway University of London, University College Birmingham, University of Bath, University of Reading, University of Westminster.

- Education and training to develop skills for the future and address workforce challenges in the local healthcare system.

The partnership laid the foundations for the Trust to achieve its University Hospital status in 2020; an award of £1.7m from the European Regional Development Fund to provide support for small and medium sized enterprises developing healthcare technology products in 2019; and a branch campus medical school with King's College London. Levels of NIHR income to the Trust are similar in scale to RBFT, with both receiving £50k in 2024/25 via the Research Capability Fund.

3.1.4. Recommendations (A&B)

Recommendation A: The future strategy for the Partnership should **emphasise building depth of collaboration**, providing *strategic* support to scale up activity and income generation where Areas of Shared Focus (ASF) have been established.

Recommendation B: In parallel, continue a scaled-back strand of **support for new areas of collaboration** that have potential to be focus areas of the future. This should include *targeted* support where opportunities can be identified "top-down", such as through horizon scanning, unmet needs or strengths that have not yet been explored. It should also be *responsive* to "ground-up" opportunities where the case is compelling.

3.2. Outputs and return on investment

3.2.1. Looking back – return on investment

Consultation with colleagues identify a lack of clarity about the Partnership's achievements and return on investment. However, defining "return" in the context of the Partnership is open to different interpretations. It could be taken to mean the external income leveraged as a result of CIF pump-priming, or as a result of the wider Partnership. Returns could equally be viewed in non-financial terms, given that the purpose of the Partnership is to deliver research, innovation and education that benefits patient care rather than to generate income itself.

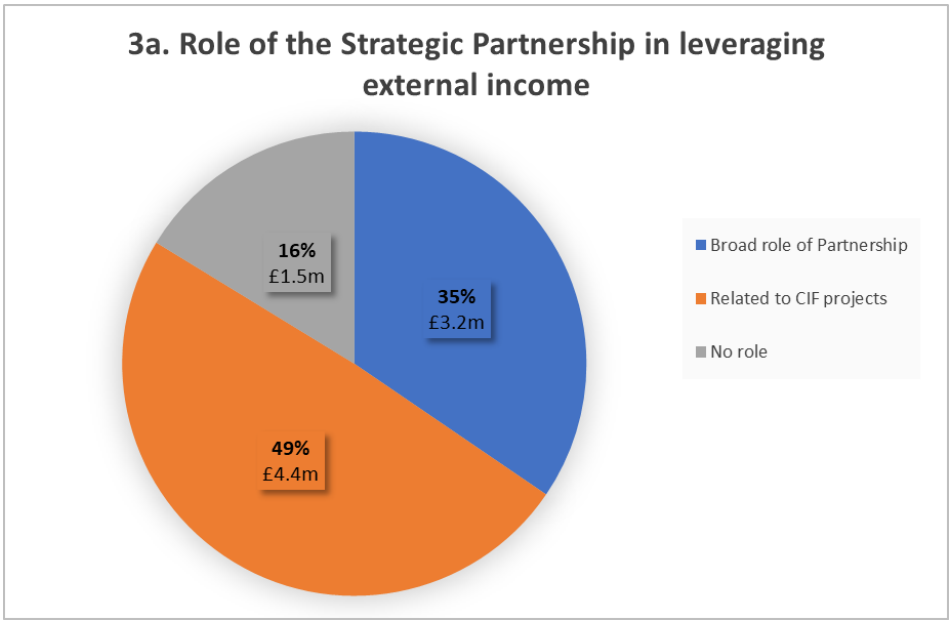
Nevertheless, income generation is a useful indicator for the growth of collaborative activity and to ensure that the Partnership and its investment fund are leading to purposeful activity that can attract external funding. For the purposes of this analysis, wider investment in the Partnership posts and in-kind costs such as the time committed by executive and senior leaders, investigators and professional services colleagues have not been taken into account. The analysis showed that:

- **Since the Partnership was formed, significant income has been jointly leveraged from external grants.** Since 2017/18 income of almost £9.3m has been generated from 23 joint external grant awards. The total value of grants applied for was almost £20m (49 applications), with an apparent success rate of 48% (Interim Report, section 4.3 for full analysis). Even taking into account the inflating effect of non-competitively won grants (e.g. from industry), this success rate compares favourably with UKRI Research Council rates (26%) (UK Research & Innovation, 2023) and stands up alongside NIHR Programme Grant success rates (44%) (National Institute for Health and Care Research, 2022).

- **The Partnership has played a significant role in facilitating joint income** (Figure 3a)**.** The income leveraged includes a mix of grants directly pump-primed by CIF, others in which the Partnership played a more general role in bringing people together, and some that the Partnership played no role in facilitating. To investigate this, income was sub-categorised by the role that the Partnership played in its generation. This revealed that of the total income leveraged, 49% (£4.5m) is directly related to CIF (although not necessarily a direct continuation of the same research) and 84% (£7.8m) can be attributed to the wider role of the Partnership.

- **Income generating activity is concentrated in a small number of successful collaboration clusters** (Figure 3b). 96% of income can be attributed to just 5 areas of activity: the Office for Students grant for the Clinical Simulation Training Suite (28%), Henley Business School (UoR) with Informatics (RBFT) (26%), Platelet Biology (UoR) with Cardiology (RBFT) (20%), Radiology (RBFT) with Psychology (UoR) (12%) and Rainer Cramer's grant to develop novel clinical diagnostics screening technology (10%). The success of these clusters provides evidence that income can be leveraged at scale when collaborations mature sufficiently. Alongside this there are also a substantial number of smaller grant successes, 13 grants accounting for 4% of the income in total. While these collaborations are at an earlier stage in their development, they have shown

ability to attract funding and have the potential to mature to deliver success at scale if appropriately supported to develop.



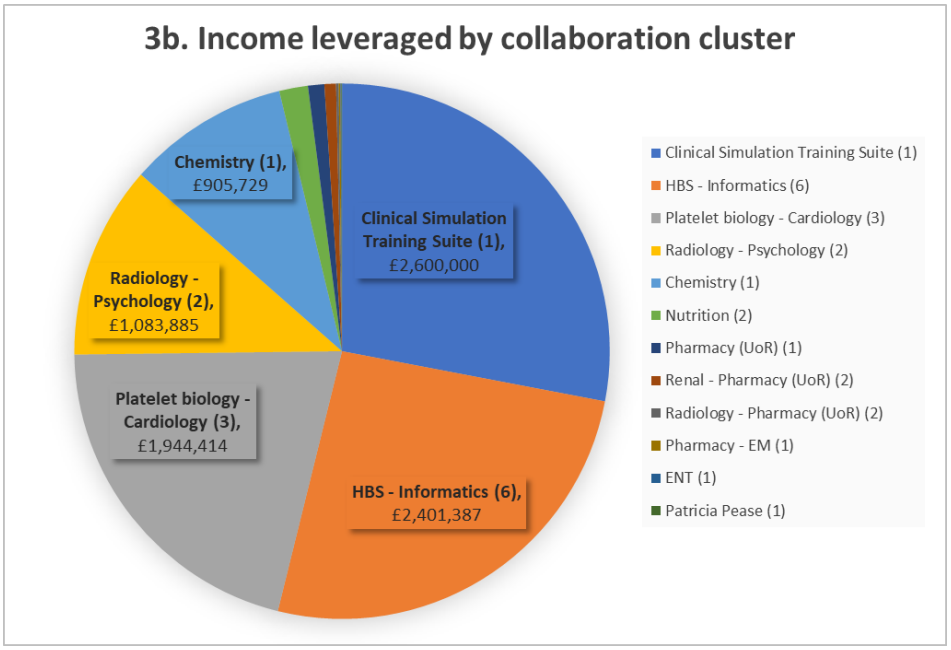


Figure 3. Analysis of external income. *Figure 3a* indicates the role that the Strategic Partnership has played in leveraging external income, either as a direct result of CIF investment, the wider role of the Partnership or has played no role. *Figure 3b* shows the distribution of leveraged income in collaboration clusters.

This analysis has revealed that there has been significant financial return on investment attributed to the Partnership. However, this has been highly reliant on a small number of successful areas of collaboration that have matured to leverage income at scale. The analysis also suggests a substantial number of earlier-stage clusters that have demonstrated ability to attract income at lower levels. This suggests that the portfolio may be skewed towards early-stage collaboration.

3.2.2. Looking back – Scholarly outputs

Peer-reviewed scholarly outputs are the core output of academic research, playing an important reputational role for both UoR and RBFT and as a means of research dissemination. Peer-reviewed outputs are essential for underpinning for subsequent grant applications, and for universities selected high quality research papers are a significant component of the submission to the Research Excellence Framework (REF)[8]. Whilst it is not possible to draw a direct line between scholarly output and financial return, without a healthy portfolio of outputs it would be extremely difficult to build a pipeline of future grants and follow-on funding.

Analysis of scholarly outputs using SciVal showed:

- **Collaborative research between UoR and RBFT results in publishable joint research outputs**. 71 co-authored outputs have been published in 10 years (2014-2024, analysis July 2024, shown in Figure 4) between authors affiliated with UoR and RBFT. In general, these papers have relatively few authors, which suggests these outputs reflect focused research rather than large multi-author, multi-institution clinical studies.
- **Research activity and output volume is dependent on a small group of authors and is vulnerable to declines if authors move or retire**. Annual output volume ranges from a peak of 13 publications per year (2014) to a minimum of 2 (2016), with a second peak in 2023 (noting the 2024 data were incomplete at the time of analysis). Three quarters of the initial high volume of publications are attributed to a small number of collaborating authors that are no longer publishing together (e.g. Danbury, Gosney, Horwood, McCrindle and Schafer). This illustrates the dependence of research activity and output volume on just a small number of investigators. From 2018 onwards, the volume of publications per year recovers steadily, which coincides with the formation of the Strategic Partnership.
- **The majority of joint outputs do not appear to be high quality publications**. Using Field-Weighted Citation Index as a rough proxy for quality, the average FWCI for RBFT-UoR co-authored papers is only marginally above the global average[9]. A low citation rate could be an indication that many of the joint publications are not likely to be considered high quality, with the exception of a few highly cited examples with FWCI >3 (Little, et al., 2021) (Wang, Li, Bradlow, Bazuaye, & Chan, 2023) (Malone, Hooker, Todman, Mohabir, & Jones, 2024) (Tidmarsh, Harrison, Ravindran, Matthews, & Finlay, 2022). However, publication quality assessment is complex and nuanced, with FWCI only a blunt indicator and taking 3 years post-publication to stabilise, so conclusions cannot be meaningfully drawn. It is also possible that the short-term nature of the pump-priming funding may be skewing publications towards smaller data sets and shorter timeframes, which are unlikely to result in high quality publications in top journals.

[8] The REF is a national assessment of UK research, held every 6-7 years to determine the quality of research produced by higher education institutions and used to allocate the proportion of quality-related funding each institution receives from Research England.
[9] RBFT-UoR FWCI = 1.11, compared with global average = 1.0

The bibliometric analysis confirmed that collaboration between the partners is resulting in peer-reviewed research publication outputs. Whilst many of the outputs may not be high quality publications, they should form a foundation of early published research that has the potential to mature and underpin subsequent larger studies and external income through grants. The level of published research output remains highly dependent on a small number of collaborating investigators and is vulnerable to decline if investigators move institution or retire. To mitigate the risk of such declines in research activity and volume in the future, efforts should be made to maintain an appropriate breadth of collaboration alongside increasing depth to drive higher quality, higher profile outputs. This supports Recommendation B, which outlines the need for a continuing element of breadth in the collaboration alongside the increased emphasis on building depth.

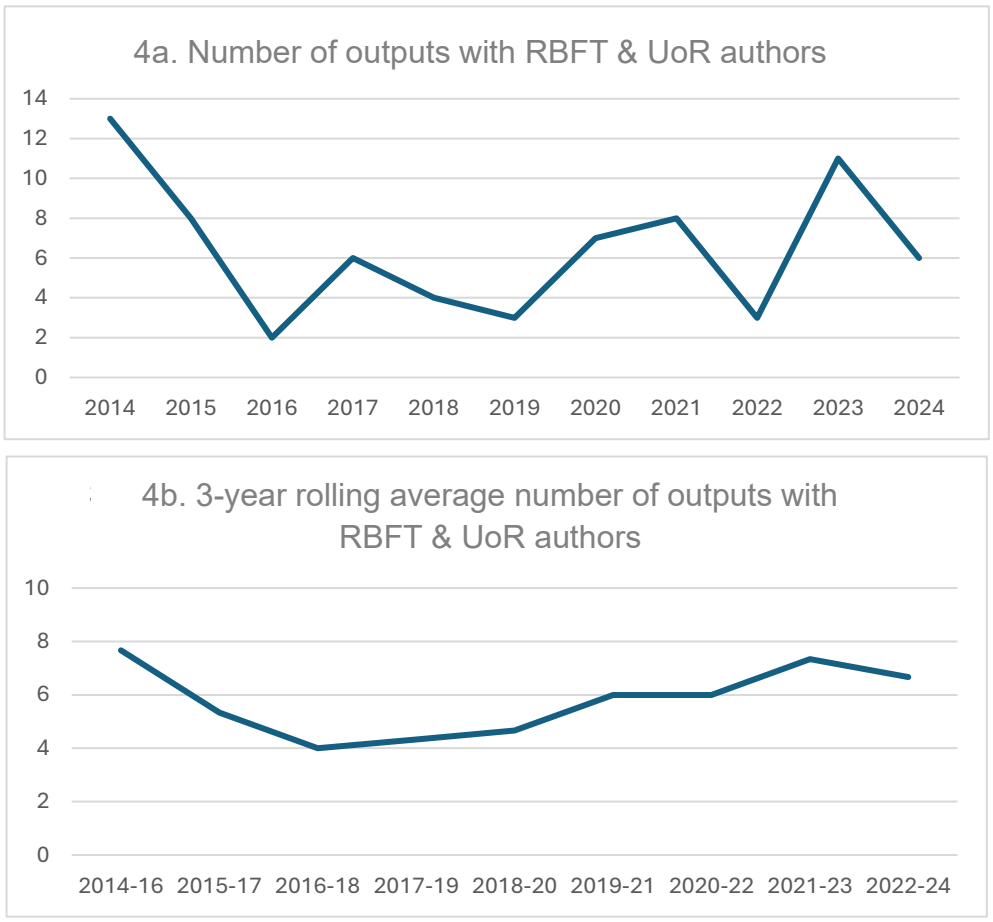


Figure 4 Co-authored RBFT and UoR output numbers 2014-2024 by year (a) and by 3-year rolling average (b). 2024 data in complete at the time of analysis (July 2024)

3.2.3. Looking forward

When considered together, the analyses of financial returns and research publication outputs support the view that the portfolio of RBFT-UoR collaboration is mostly focused at the early pump-priming stages. There are a small number of examples of success at scale that give confidence that RBFT-UoR collaboration can mature successfully. The current focus of the

Partnership's resources and support posts skews activity towards initiating new collaboration through the CIF mechanism rather than supporting existing collaborations to mature towards the next stages. To achieve more examples of success at scale, more emphasis needs to be given to supporting development of existing research collaborations. This would either require more resources, or current resources need to be pivoted to increase the emphasis on developing next stages and decrease the emphasis on initiation.

Ultimately, the strategic purpose of the Partnership is to benefit patients, so joint income and output publications should be viewed as indicators of activity that contributes to this purpose. There would be value in more closely monitoring these indicators as a measure of the Partnership's performance, but this should not detract from also monitoring how this activity is then applied in a healthcare context to the benefit of patients.

3.2.4. Recommendation (C)

Recommendation C: Support early-stage projects from **previous rounds of CIF to progress to the next stages of development** (where feasible). This should continue and expand work that is already underway to target support from the Project Team and Professional Services specialists to working with the Investigators of past-CIF projects. Examples of the support needed include: planning and pursuing next steps for follow on projects, identifying funding sources, developing grant proposals, and pursuing pathways to impact and commercialisation. Some of the maturing CIF projects will align with ASFs and become incorporated within their wider development, whereas others may represent potential future ASF that are at earlier stages in their development.

3.3. Research Pillar

3.3.1. Looking back

3.3.1.1. Priorities and purpose

Research-based collaboration has been at the heart of the collaboration, with 37 of 47 CIF funded projects focused on research[10]. The benefits of research collaboration identified by colleagues in both organisations included:

- Translation of research into clinical contexts and applying research expertise to clinical challenges.
- Improvements to patient care and effectiveness of clinical pathways.
- Creating pathways to impact from research, to contribute to future REF submissions (UoR).
- Commercial translation of research, generating a stream of income from commercialisation.
- Diversifying sources of research grant income, enhancing NIHR Research Capability Funding for RBFT and increasing income from clinical trials.
- Reputational benefit of a strong portfolio of investigator-initiated clinical translational research, which enhances ability to attract and retain high calibre staff.

These potential benefits arise as research matures beyond the pump-priming stage, which is consistent with Recommendations A and C.

There is a close connection between translation of research into clinical contexts (which was frequently identified by UoR colleagues) and improvements to patient care and clinical pathways (which was frequently identified by RBFT colleagues). Achieving these would provide crucial routes to impact for UoR, which is a core component of the REF, as well as reputational benefits for both organisations. However, for impact case studies to be high scoring and contribute meaningfully to a REF submission, the impact must be outstanding or very considerable in terms of the reach and significance i.e. influencing practice and/or policy beyond RBFT. Few, if any, examples of impact arising from the Partnership have yet matured to bring benefits beyond RBFT at scale.

3.3.1.2. Barriers and lessons learned

During the consultation with colleagues in both organisations, a range of barriers to collaboration were identified which inform lessons for the future. These included:

Gaining ethics approval for research and optimising study design is challenging, which is compounded by limited experience in both organisations of clinical translational research. This is explored in detail in the interim report. Contributing factors include a lack of detailed knowledge of how to successfully navigate the set up steps and processes for clinical research; a lack of practical hands-on support through these steps; bottlenecks in completing the necessary governance checks and steps; unclear processes that are not well aligned across the

[10] CIF rounds 1-7, excluding projects discontinued or abandoned.

organisations, inefficient and overloaded. Colleagues noted that the HIP Facilitator post had helped as a source of advice, but that there is still a need for practical hands-on support and help. More informative "how-to" guidance and a clearer sign posting of the process steps and contact points would also help, with the existing clinical research roadmap too complex to be useful. Colleagues also suggested drawing upon the experience that has built to date by enabling colleagues to learn from each other through buddying with colleagues that have previously set up clinical research studies.

Research can stall at the conclusion of pump-priming (CIF) phase. Consultation suggested that CIF projects have been too short in timescale and too low in value to enable research to develop to a scale sufficient to secure the next stage of funding. Whilst CIF is intended to pump-prime new collaborations, it is not designed to fund proof-of-concept in its entirety. There appears to be a gap in supporting research teams to plan and pursue the next steps in development beyond CIF. In some instances, this may be a financial gap; however, in many cases the gap could be bridged by better understanding of the steps needed and funding sources available to support the next stages.

Time for research is a limiting factor for colleagues in both organisations. Although the demands on time are different, colleagues in both organisations experience challenges in making time available for research. However, in both organisations this impact is mitigated to an extent where research is concentrated in clusters of sufficient scale for research-related posts to provide support across multiple projects (e.g. research nurses, PhD students and post-doctoral researchers). Limitations on time have significantly impacted the CIF portfolio, with many projects experiencing delays of 9-12 months or longer between award of funding and work commencing, largely due to the time taken to achieve ethics approval. Enhancing the specialist professional services expertise and practical hand-holding support for ethics and set up of clinical research projects would help ease the workload on investigators at the start of projects. A more recent development has been the establishment of 5 Joint Professorships at RBFT, for whom resources are made available to free up time and capacity for collaboration with UoR. A mid-point evaluation of this initiative would be valuable to assess the extent to which dedicated time and capacity for research can increase the scale and depth of collaboration. This could usefully inform the future development of joint academic-clinical posts as a means through which the Partnership matures.

Understanding and overcoming differences in culture, language and ways of working is a steep learning curve that takes time to navigate. Although the Partnership was established 8+ years ago, it has taken a long time for those at the heart of the Partnership to understand each other's organisations. For each new collaboration, this learning curve is repeated. The Partnership Team are able to support colleagues navigating this, however at present this support is based only at RBFT with no equivalent posts to support and drive from the UoR end.

3.3.2. Looking out and looking forward

3.3.2.1. Building depth in Areas of Shared Focus

Discussions at Board level and the Strategic Planning Workshop supported the view that the Research Pillar should continue as a key pillar of activity of the Partnership. The consensus was that there should be shift of emphasis towards driving a depth of impactful research in targeted areas where there are mutual interests and benefits. Discussions proposed that the RoES Departments at RBFT would be suitable as Areas of Shared Focus (ASF) around which to build depth, having already been evaluated for academic excellence as part of their accreditation. Moreover, the appointment of Joint Professors is an indication of the level of momentum and clinical-academic leadership that has developed in 5 of the RoES Departments. The consensus of the Workshop discussions was that these 5 RoES Departments should be the initial ASF, extending to other RoES Departments over time as leadership capacity develops.

The need for balanced development across both Partners was also discussed at the Workshop. If the Partnership is to benefit both organisations, there is a need to balance both the "pull" of clinical challenge-led research with the "push" of academic knowledge-driven research. At present, the Partnership is oriented heavily towards the "pull" of the RoES Departments. With resources already increasingly focused on the RoES Departments, this is creating an imbalance and has led to examples of limited alignment between these Departments and the UoR research base.

A future approach should counter-balance the clinical challenge "pull" from RBFT with focal points of UoR-led translational research "push". This could be achieved by defining ASF at UoR where there are clusters of repeat activity and success in collaborating with RBFT. This development would facilitate the Partnership's growth at the intersection of UoR's research excellence and RBFT's real-world healthcare challenges.

3.3.2.2. Strategic approach to research development

The ASFs should take a strategic approach to research and impact development. Each ASF should develop a long-term (5 year) research strategy that lays out the routes through which research will mature and grow to meet the expectations of the Partnership. This includes upscaling from successful pump-priming studies; developing longer and larger programmes of work funded by externally funded research grants; and seeing research through to impact that benefits patients in RBFT and beyond. The ASF would also be expected to seed new research opportunities, both with existing collaborators and new collaborations within the Partnership. Collectively, this would create a balanced pipeline of research for each of the ASFs, encompassing research at a range of stages of development from early stage through to mature and impactful.

Resources and support should be targeted towards the ASF, supporting the delivery of the ASF research strategies to build towards success at scale, fostering strong leadership and culture at the clinical-academic interface, and building outwards to allow successes and culture to permeate the Partnership more broadly. A substantial proportion of the CIF should be used in a

strategic-mode to overcome gaps or enable step-change elements of the ASF strategies that cannot be funded through other means.

The strategic approach to research development for the ASF will also require a shift in the emphasis of the Partnership Team. The Team should take the lead in facilitating development of the ASF research strategies. They should work closely with ASF leaders to drive a collaborative research planning process that brings together the research leaders, key investigators from both organisations, and relevant professional services specialists who support research innovation and impact to co-develop the 5-year research strategy for each ASF. The Team should continue to play a key role as the ASF strategies are delivered, working in partnership to facilitate delivery of the ASF research strategies, and forming an effective bridge between clinical, academic and professional services environments.

Effective facilitation of the strategic ASF approach will also require rebalancing of the Partnership Team. The current Partnership Team posts are both employed through RBFT, which results in the drive and facilitation for Partnership activity being unevenly distributed. While the post-holders have sought to work across both organisations, this is challenging in practice without authority, leverage and influence within UoR from an external position. If support is based only in one organisation, the barriers to access for the other organisation are higher and it is difficult to ensure outcomes are mutually beneficial for both Partners. A rebalancing of the Partnership Team would echo good practice elsewhere at UoR[11].

3.3.2.3. Maintaining a proportionate element of breadth

As explored in section 3.1.2, the looking forward perspective also highlighted the importance of maintaining an element of capacity for new areas of research to emerge, which may go on to form ASF for the future. This should be able to support both *targeted* opportunities that can be seen "top-down" as well as being *responsive* to ideas that emerge "ground-up" from academics and clinicians finding common interest that addresses clinical challenges.

Given constraints on resources, funding could be scaled appropriately to supporting new activity at a lower level than currently. For example, a future version of CIF be split 70% in *strategic-mode* towards the ASF and 30% for new opportunities in *responsive*- and *targeted-modes*. The Partners could also consider shifting the balance of this split over the timeframe of the strategy period, for example with a greater emphasis on the ASF in the initial phases and then moving to a greater emphasis on supporting new opportunities as the strategy progresses and the ASF are funded by a greater proportion of external grant income. During this time, the Partners should consider pausing future rounds of the RoES accreditation scheme while the first wave of RoES (with Joint Professors) are developed as ASF. A reduced emphasis on new collaborations via CIF and pausing RoES would substantially free-up capacity in the Partnership Team.

[11] The UoR-Natural History Museum Strategic Partnership is managed by paired posts, one in each organisation, who together support and drive the Partnership to the benefit of both Partners and form an effective bridge between the organisations.

3.3.2.4. Facilitating clinical research

Discussions at the workshop also highlighted the need to address the barriers to research if efforts to scale up are to be successful. In particular, the lack of specialist support and experience for clinical studies is already rate limiting for research. Past efforts to establish a CTU had been too early in the Partnership's development; however, the Partnership is now at the point when support needs to scale up to match the growing demand for academic clinical research studies. In the short term, developing a package of practical, hands-on support for setting up clinical trials was seen as vital. This should include specialist professional services to help navigate NHS ethics and trial design (for example, a Clinical Research facilitation post), along with peer-learning from more experienced investigators, and access to user-friendly guides and training.

In the longer term, colleagues suggested that being able to run clinical trials through a recognised CTU, registered with the UK Clinical Research Collaboration (UKCRC) remains an important step if the Partners are to be credible with funders and industry. A route to achieving this at lower risk could be to partner with an established UKCRC-Registered CTU elsewhere with complementary research strengths and feasible proximity. There are nine UKCRC-Registered CTUs in the South East[12].

3.3.2.5. Addressing barriers to joint research

Across all forms of joint research, the lack of alignment in processes and procedures pre- and post-award combined with disjointed communication creates substantial challenges for colleagues developing joint applications (as explored in detail in the Interim Report). In some cases, this has led to the investigators not pursuing opportunities for grants, working with alternative partners who are better equipped to support translational research, or insufficient costs being included in applications. These challenges are likely to escalate as the Joint Professors become established in their roles and stimulate growth in joint research grant activity; addressing these challenges will be vital if the shift towards strategic research development for the ASFs is to be successful.

Other NHS-university partnerships have addressed these challenges by establishing Joint Research Offices that bring together the Trust and university teams that support pre- and post-award research into a unified virtual or organisational structure and/or location. Examples exist at a variety of scales: from small teams such as the Plymouth Joint Clinical Research Office (3 people, established 2024)[13]; through to large teams at long established university–NHS

[12] UKCRC-Registered Clinical Trials Units in the South East region are: Brighton & Sussex Clinical Trials Unit; Comprehensive Clinical Trials Unit at UCL; 4 specialised CTUs at Oxford (Diabetes, Perinatal, Population Health, Primary Care), and the Oxford Clinical Trials Research Unit that spans multiple therapeutic areas; Royal Marsden Clinical Trials Unit (in partnership with the Institute for Cancer Research); and the Southampton Clinical Trials Unit.

[13] The University of Plymouth and University Hospitals Plymouth NHS Trust established a Joint Clinical Research Office in 2024 with a team of 3 (JCRO, Head and Senior Administrator). They provide an interface between multiple units within the University and Trust, as well as the NIHR Applied Research Collaboration and Clinical Research Network. The provide support at all stages of the life cycle for clinical and non-clinical research, from grant application to study set up ad project delivery.

partnerships associated with medical schools, such as the Newcastle Joint Research Office (established 2006, core team of 8) or Liverpool Health Partners Joint Research Office (team of 7)[14]. The importance of such Joint Research Offices was outlined in 2020 in a report by the Academy of Medical Sciences, which recommended that greater integration of academic and NHS research office functions was urgently needed to streamline processes, provide a single point of access and support for complex clinical research pathways, and encourage greater levels of academic-clinical collaboration (Lechler, et al., 2020).

In the short-term, the Partners could establish a virtual JRO by bringing together existing UoR and RBFT teams with the Partnership Team in a virtual structure. Joint leadership and management would be crucial to its success, ensuring that integration between the two institution's processes and priorities is evenly balanced. It would also be important to ensure that the vJRO priorities are driven by clinical and academic priorities, as well as by line management. This may require some reconsideration of governance structures to enhance the representation of clinical and academic leaders to ensure alignment of priorities.

3.3.2.6. Research and impact dissemination

If the Partners' joint research is to achieve its potential in terms of impact and reputation, there is a need for research and impact to be disseminated beyond the Partnership. At present, there is little Partnership activity that addresses this. Other NHS-university partnerships have taken a wider approach by engaging strategically with organisations that have remits to support adoption and spread of innovation. For example:

- The Sussex Health and Care Research Partnership was established in 2022 by the Universities of Brighton and Sussex, their joint Medical School, and the region's NHS providers (Brighton & Sussex Medical School, n.d.). The focus of the partnership includes "delivering high-impact research and driving improvements in population health, health and care services and outcomes for patients, service users and the broader community." Their strategy emphases the importance of wider partnerships with organisations across the region, including the ICB, Health Innovation Network, Applied Research Collaboration, and Research Delivery Network who collectively enable the partnership's research and impact to permeate across and beyond the region, along with the County and City Councils. The Health and Care Research Partnership, underpinned a recent award £3.5m for a Commercial Research Delivery Centre at University Hospital Sussex (Brighton & Sussex Medical School, 2024)
- The Health Innovation Alliance was established by the University of Plymouth and University Hospitals Plymouth NHS Trust, together with the region's Health Innovation Network, the City Council and Plymouth Science Park. The focus of the Alliance includes connecting the health innovation cluster in Plymouth, showcasing excellence

[14] The University of Newcastle and The Newcastle upon Tyne Hospitals NHS Foundation Trust formed the Newcastle Joint Research Office in 2006. It has grown to a core team of 8, and supports researchers in the development, implementation and delivery of world-class experimental, translational and clinical research. Liverpool Health Partners brings together 3 universities and 7 NHS Trusts, and incorporates the LHP Joint Research Office to support collaborative research between them. The team of 7 support researchers with setting up contracts and legal agreement, research grants research sponsorship and business intelligence.

and providing opportunities on a regional, national and potentially international scale (University of Plymouth, n.d.).

Looking ahead, the Partners should make external engagement across and beyond Berkshire a strategic priority in the next phase to support the spread and adoption of research, innovation and impact.

3.3.3. Recommendations (D-J)

Recommendation D: In keeping with a strategic shift towards building depth in the Partnership, the **Research Pillar should focus on strategic research development in Areas of Shared Focus** to enable a step-change in the Partnership. This approach should support each ASF to mature and establish a portfolio of collaborative impactful research, comprising a mix of mature long-term research programmes, impact development pathways, early and mid-stage research projects, and new exploratory research opportunities. Long-term (5 year) research plans should be developed for each ASF to layout the potential routes through which research will develop to build a depth of excellence and translation into impact for each ASF.

Recommendation E: Focus on the **RoES Departments with Joint Professorships** as the initial wave of ASF at RBFT. This builds on their established excellence and momentum in research at the clinical-academic interface, combined with the investment to further develop research leadership. The Partners should learn from the initial wave of RoES-ASF and Joint Professorships and consider how clinical-academic research leadership could be supported more broadly to support other RoES Departments in subsequent waves of the ASF approach. The Partners should consider pausing future rounds of the RoES accreditation process to allow focus on building depth in initial wave of ASF.

Recommendation F: Drive **balanced development of depth around focal points in both organisations,** such that clinical challenge-led approaches are balanced with translational research-driven approaches. UoR-led ASF should be established where there are clusters of UoR translational research capability to counterbalance the clinical lead of the RoES-ASF.

Recommendation G: **Shift the focus of funding and Partnership Team activity towards maturing the pipeline of research** within the ASF, and to enabling each ASF to deliver larger programmes of high-quality impactful research, with substantial external funding. This should include:
(i) Different modes for CIF. A *strategic-mode* of CIF should be used to support enabling elements of the ASF research strategies. An element of CIF should be maintained for pump-priming new collaboration in both a *targeted-mode* and a *responsive-mode*, but scaled back in proportion with the strategic shift towards depth.
(ii) A shift in emphasis of the Partnership Team towards strategic research facilitation and programme management to support ASFs as they develop depth. The reduced emphasis on initiation of new activity should support this by freeing-up aspects of the Partnership Team's capacity.
(iii) Rebalancing the facilitation and drive for the Partnership by addressing imbalances in the Partnership Team across the two organisations.

Recommendation H: **Develop a package of practical hands-on support for joint clinical research**. This should include:
(i) A specialist professional services post to provide hands-on support and facilitation for joint Clinical Research between the Partners. This post should support set up, study design and ethics for joint clinical research initiated between the Partners (CIF funded or otherwise), and be able to undertake specific elements of the process on behalf of the investigators.
(ii) A buddy-scheme to pair new investigators with experienced investigators, enabling colleagues to learn from each other. This could also include developing case study materials.
(iii) Joint mapping and alignment of the processes and steps for clinical research, allowing the steps to be mapped more accurately, develop suitable "how-to" guidance to support investigators as they follow the process, and identify bottlenecks that need to be addressed. This process should include investigators to ensure that the materials developed are fit for purpose.
(iv) Access to training materials to support investigators that are new to clinical research.
(v) In the medium to long term, explore opportunities to partner with a CTU where there are complementary research strengths and with feasible proximity to Reading.

Recommendation I: **Establish a virtual Joint Research Office** that supports and facilitates all joint research between the two organisations, including clinical and non-clinical research, funded through external grants and internal sources. It should bring together the relevant colleagues and processes, across both organisations, to work effectively and more efficiently together to support joint research pre and post award. This should be jointly developed and led by the relevant Directors in both organisations and held accountable through the Partnership governance. The vJRO would also facilitate the effective delivery of ASF research strategies by facilitating close working between the Partnership Team, UoR Research Services, RBFT Research & Innovation, and other relevant professional services.

Recommendation J: Support translation of research into impact that benefits patients beyond RBFT and **make external engagement across and beyond Berkshire a strategic priority for the Partnership in its next phase**. This should include developing key relationships across the region, sector and wider NHS landscape to encourage wider uptake of impactful research and allow benefits for patients to permeate beyond RBFT.

3.4. Education Pillar

3.4.1. Looking back

Education forms a significant core of the Partnership and is one of its' most enduring elements of collaboration. However, much of this has developed outside of the mechanisms and support of the Partnership, with only 6 of the 47 CIF projects in the education space (rounds 1-7). For both organisations, while UoR/RBFT is an important education partner, there are also several other education partners that are of at least equal importance.

RBFT-UoR Education collaboration takes several forms:

Future NHS workforce programmes: there are several UoR programmes that develop skilled allied health professionals for the future NHS workforce. These include programmes in Pharmacy, Speech & Language Therapy, Physician Associates, Dietetics (new for 2025/26) and Medical Sciences. These programmes include substantial components of learning on professional placements in NHS environments, including at RBFT to varying extents. In both organisations, the oversight and management of placements is different across the range of programmes. This results in a portfolio that is challenging for both organisations to manage consistently and effectively, which risks differing and less than optimal experiences for students on placement.

Professional development for existing staff:

- Accredited work-based programmes for healthcare practitioners: Non-medical prescribing, and Advanced Practice programmes for Pharmacy, Clinical and Healthcare practitioners, accredited by Professional Bodies[15]. These programmes are widely accessible to practitioners working across and beyond the NHS, with multiple past and current participants from RBFT.
- Bespoke development programmes for RBFT staff: most potential opportunities for bespoke development courses are too small in scale to be viable. One exception is the Postgraduate Certificate in Healthcare Education, which was co-developed to meet a need identified by RBFT. The programme continues to draw heavily on RBFT for ongoing teaching and recruitment of participants, provided as a substantial in-kind contribution to the programme. As a small niche programme, the PGCert only just achieves the student numbers to remain viable and is almost entirely reliant on RBFT to provide these students.
- Leadership and management development for RBFT staff: drawing on the expertise and brand of Henley Business School to provide leadership development through the Chartered Management Degree Apprenticeship route tailored to RBFT's needs. While RBFT is a key client for Henley, providing a substantial cohort of participants, this is as part of a wider programme with multiple streams of participants. This means the programme it is not reliant on RBFT to be sustainable. This collaboration is a win-win for both organisations as it provides RBFT will a valuable leadership development, allows

[15] Professional Accreditation Bodies include: General Pharmaceutical Council (GPhC), the Health and Care Professions Council (HCPC) and the Nursing & Midwifery Council (NMC).

future leaders to pilot improvement projects through the project-based learning, forms part of the recruitment offer to attract staff, and is a route through which the apprenticeship levy can be fully utilised.

These examples together illustrate the sweet spot for success in education collaboration, in which opportunities are of sufficient scale that programmes are sustainable without placing undue burden on either organisation to sustain them. Finding these opportunities is challenging; in the current context of financial constraints and limited capacity for new developments pursuing new opportunities for programmes is not a good use of resources unless the case is highly compelling. In the past, this has led to frustrations when new programme opportunities have not been pursued as they would not lead to sustainable UoR programmes.

Frustrations have arisen because the rationale for those decisions has not been communicated transparently to those involved with a perception of decisions being made unilaterally by UoR. The most notable example of this is the decision not to pursue a medical school, but there are many other earlier stage examples such as nursing, radiography, optometry, paramedic science, small bespoke Continuing Professional Development courses, and small-scale postgraduate programmes.

To avoid wasted effort and manage expectations, clear criteria should be developed that would allow ideas for new programmes to be evaluated jointly by the Partnership at an early stage and increase transparency for colleagues putting ideas forward. These criteria should reflect UoR's business case requirements for new education programmes, as well as considering NHS capacity for placements where relevant. The criteria should guide those making the early proposals to think broadly about all of the elements required for success. This reduces the risk of programmes being proposed by the Partnership that do not meet the University's requirements by acting as a pre-filtering stage, thereby ensuring that only programmes that are realistic possibilities are put forward for formal scrutiny under the normal UoR processes.

Education collaboration of a different form is seen in the Clinical Skills Training Suite (CSTS). This concept arose as an opportunity to both meet UoR's needs for simulation training infrastructure for students, as well as RBFT's needs for a more modern and fit for purpose facility than the current Trust Education Centre can provide. The initial set up costs were met through an external grant of £2.6m to UoR from the OFS, with the Partners jointly funding the ongoing costs as a joint facility. This area of collaboration shows considerable promise if the Partners can pool their expertise in education and simulation to develop innovative new approaches to training for students, trainees and staff. However, the current focus of effort is on overcoming the substantial teething problems associated with operational delivery, governance and effect of the CSTS as a joint facility whilst also balancing the differing priorities of the Partner organisations and the OFS as the funder.

3.4.2. Looking out and looking forward

Discussion at Board level highlighted a divergence in the institutional priorities of UoR and RBFT in relation to the Education Pillar. For RBFT, the priority for education is enabling a pipeline of

future workforce, maximising recruitment of healthcare professionals that have trained at RBFT during their studies and increasing recruitment from the local community. However, for UoR the long-term viability of educational programmes is the priority, in terms of likely student numbers, student demand, and financial sustainability.

Healthcare education programmes

Previously, the diverging priorities have led to a lack of clarity and differing interpretations about what the education is trying to achieve. Through this Evaluation Exercise, UoR has now clarified that establishing new healthcare education programmes is not a priority for the foreseeable future. UoR will not be in a position to develop new programmes unless there is a sustainable business case that combines existing UoR academic teaching capacity, sufficient student numbers per cohort, sufficient demand from potential students to give confidence of running courses at capacity, and sufficient capacity at RBFT and other NHS providers for placement-based clinical training.

Looking outside the Partnership, there is a huge volume and variety of university-NHS partnerships that have education at their core. These include 44 medical schools[16], 79 Nursing & Midwifery schools[17], and 30 Pharmacy Schools[18], as well as a broader range of universities that offer programmes for healthcare professionals. Many partnerships are responding strategically to the need for an uplift in healthcare professional training to meet the growing needs of the NHS, as outlined in the NHS Long-Term Workforce Plan (NHS England, 2023). Many partnerships have been preparing over the course of 5+ years to be ready for uplifts in training and have been awarded additional places in response[19]. Although, whether this will lead to sustainable success for these partnerships is not yet known.

Other partnerships are bringing together wider consortia of health and education providers over broad regional or city-wide footprints to collectively address the future health and care workforce needs for their regions and enhance employment opportunities for the local population. Examples include the Buckinghamshire Health & Social Care Academy, and the Leeds Health & Social Care Academy, both of which bring together higher and further education, with the NHS, County Council and a GP federation to focus on education, training and development for the healthcare professions[20].

[16] Medical schools | Medical Schools Council: 44 UK Medical Schools list
[17] Nursing & Midwifery Council: 79 Approved Education Institutions in England
[18] Pharmacy Schools Council | Study: 30 Registered Pharmacy Schools in the UK
[19] New medical schools (post 2015) to be allocated additional places for medicine in 2026/27 were: Brunel University London, Universities of Kent & Canterbury Christ Church, University of Surrey, Portsmouth Medical School (King's College London in partnership with University of Portsmouth), Aston University, Lincoln Medical School (University of Nottingham in partnership with University of Lincoln), Three Counties Medical School (University of Worcester), Anglia Ruskin Higher Education Corporation, University of Sunderland, Edge Hill University, University of Central Lancashire, University of Chester, and Pears Cumbria Medical School (Imperial College London in partnership with University of Cumbria) (Department of Health and Social Care, 2024).
[20] BHSCA Home; Home - Leeds Health and Care Academy

Interestingly, by operating over a larger geographical footprint, these partnerships bring together a range of different types of universities and further education providers, who can collectively deliver across a much broader spectrum of careers and education levels. A partnership of this breadth allows each organisation to play to its' strengths and business model whilst collectively meeting the workforce needs of its region and NHS partners. It is also consistent with the recommendations of Universities UK for education providers to play a stronger role in the regional skills and workforce agenda of the Integrated Care Boards (ICB) as a route to implementing the NHS long-term workforce plan (Universities UK, 2023). Broadening to engage a wider range of partners over a geographical and/or ICB footprint could be a valuable longer-term development of the RBFT-UoR Partnership. This adds further weight to Recommendation J, for the Partnership to make external engagement across and beyond Berkshire a strategic priority for its next phase of development.

Innovation and student experience within existing joint education activities

In keeping with the broader direction of travel for the Partnership towards a focused strategy that builds depth in areas of strength, consensus from the Looking Forward discussions recommended a more focused approach in the Education Pillar. This would also be consistent with UoR's position regarding new programmes. Discussions recommended that the Partners should together focus on innovation in teaching, learning and enhancing the student experience within the existing collaborative education programmes. This would focus joint efforts where there are opportunities to work fruitfully together, whilst also reducing the risk of frustration and wasted effort pursuing new activities that are unlikely to succeed.

The strategic planning workshop took this idea further and identified RBFT-UoR clinical placements as a key priority for enhancement and innovation. By addressing the dispersed and fragmented nature of placements in both organisations, there are substantial opportunities to enhance the quality, consistency and experience for UoR students on placement at RBFT. Bringing everything together on both sides, streamlining contact points and ways of working, and improving education training for healthcare educators would substantially improve provision on multiple programmes (Pharmacy, Physician Associate, Medical Sciences, and Speech & Language Therapy). Improvements to efficiency might also free-up capacity for clinical placement training, which could potentially create opportunities for growth. Many NHS Trusts face similar challenges in managing multiple streams of clinical placements from a variety of universities, particularly those Trusts that are not closely associated with universities that have large portfolios of healthcare programmes. For example, Berkshire Healthcare NHS Foundation Trust provide placements to students from 18 different universities. Responding to concerns about student satisfaction and low recruitment post-registration, the Trust has put in place a range of evidence-backed improve the experience of students on placements which may provide some examples of good practice to learn from (Rowland & Trueman, 2024).

Looking beyond the Partnership, with the projected growth in training the future healthcare workforce for the NHS, there is a consequent need for a sustainable and high-quality workforce of educators that can provide this training, both in academic and practice settings (NHS England, 2023). This need is set against a backdrop of declining capacity of healthcare

educators, driven by service pressures, lack of recognition and reward for educator activity and development, and the ageing demographic in the healthcare educator workforce (Baltruks, Cooke, & Tang, 2020). This may present an opportunity for RBFT-UoR to draw on its distinctive PG Cert in Healthcare Education and the RBFT-tailored Henley leadership training programme to incorporate elements of educator development and leadership into wider development offers for staff, trainees and students. This could contribute towards priorities 4 and 7 of the NHS educator workforce strategy (NHS England, 2023).

Examples of innovation in the sector suggest the Partners could find scope for innovation within clinical placement training and simulation training, capitalising on the Partners' joint venture. For example, Anglia Ruskin have developed a credit-bearing clinical placement for student nurses based entirely in a simulated environment using virtual reality – Hilda's home (Shaw, 2022). Bournemouth University and University Hospitals Dorset have developed a medical simulation game as a training aid for junior doctors that simulates the competing pressures and demands of working on a hospital ward – Admission Medical Ward Simulation (Bournemouth University, 2023). Health Education England, the University of Leeds and Fracture Reality have demonstrated the potential of extended reality in training healthcare professionals to deal with difficult and emotionally challenging conversations that can arise in consultations with patients that are experiencing mental health difficulties – digital patient Stacey (University of Leeds, 2023). This suggests that there may be fruitful space for the Partners to collaborate at the intersection of clinical simulation, emerging technologies and healthcare education.

3.4.3. Recommendations (K-O)

Recommendation K: In keeping with a strategic shift towards building depth in the Partnership, the **Education Pillar should focus on innovation and student experience in existing programmes**.

Recommendation L: **Increase transparency of decision-making for new educational programmes** and courses. Having set out its' position that new healthcare programmes are not a priority for UoR unless they are sustainable at scale, the criteria against which programme decisions are made should be made available through the Partnership. This would allow colleagues suggesting new programmes to self-evaluate their ideas at an early stage and avoid putting forward proposals for programmes that are unable to meet thresholds for sustainability.

Recommendation M: **Unlock the potential of the Clinical Simulation Training Suite** as a focal point for collaboration that drives innovation in existing education activities. In the first instance, efforts to resolve teething problems with the CSTS should be continued and strengthened, including reinforcing the governance of the CSTS, to facilitate joint problem-solving solutions. When this has been achieved and fruitful working relationships established, opportunities to develop innovative simulation-based education and training should be co-developed, combining the strengths of both organisations in simulation, education and healthcare training, incorporating innovative use of emerging technologies. This should include access to *strategic* CIF and the Partnership Team to pump-prime innovation. The Partners should review the CSTS progress annually and, if necessary, consider adjustments to joint venture arrangement.

Recommendation N: **Clinical training placement activity should be joined up, streamlined and optimised** across the two organisations, forming a foundation for innovation and improvement. This should aim to optimise the teaching, learning and experience for students, and to enhance the quality, consistency and efficiency across the placement components of different programmes. This work could potentially lead to additional capacity for placements at RBFT being identified, which could enhance provision of local placements for UoR students and may offer opportunities to expand programmes. This work should be supported by the Partnership Team and could be pump-primed by *strategic* CIF.

Recommendation O: Draw on the distinctive RBFT-tailored Henley programme and the PG Certificate in Healthcare Education to **design innovative elements of training for healthcare educators and NHS leadership development**. These elements could be incorporated into UoR education programmes, RBFT clinical placement and trainee programmes, and the staff development programmes of both organisations.

3.5. Estate Pillar

3.5.1. Looking back

The Estate Pillar was added to the Partnership in 2021 and includes ways of working together to share facilities, building spaces and meeting sustainability agendas. Examples of this form of collaboration have been few in number, only 2 CIF projects of 47 (rounds 1-7) were estate-based. Most of the examples of estate sharing and collaboration have arisen outside of the Partnership mechanisms and support. These include:

- **Small-scale tactical**: short-term access to space and facilities on a pay-per-use basis, such as Venue Reading spaces or use of equipment in the Chemical Analysis facility.
- **Large-scale tactical**: leasing building spaces such as the Harborne Building for RBFT clinical pathology or space within the Erlegh Building for RBFT Dingley Clinic. This is a relatively low-risk form of estate sharing as buildings or sections of buildings can be leased on terms that accommodate NHS access and legal requirements. This can be a tactical win-win for both organisations if needs and availability align, but it is difficult to drive this strategically.
- **Large scale and complex**: sharing space and facilities, in which both partners have shared access and use of space and facilities within it. The CSTS is the main example of this and illustrates the challenges. On the surface, this type of joint initiative may seem an effective way of sharing costs and risk. However, implementation issues can arise if the needs and requirements of the partners are not sufficiently mapped in advance. In the case of the CSTS, these unforeseen issues continue to cause frustration on both sides and prevent effective use of the facility. UoR experience with other NHS-shared access facilities suggests the issues experienced with the CSTS are not uncommon. However, external examples such as the Southampton BioImaging Unit suggest sharing of space and facilities can be effective in the right circumstances[21]. Although, this example is part of a broader partnership based on a medical school that is over 50 years old which includes multiple elements of shared estate, facilities and joint posts. Developing other shared facilities in this way could continue to be a medium-term aspiration for the Partnership, particularly in relation to large research infrastructure (e.g. imaging, chemical analysis etc). However, such opportunities should be carefully considered at the outset to ensure that the needs of both Partners can align at operational levels. Estates colleagues in both organisations should be involved early in the scoping process to ensure lessons are learned from past examples and that expectations are managed in relation to each organisation's priorities.
- **Research-based estate collaboration**: there may be promising opportunities to bring UoR's academic expertise to assist future planning at estate planning at RBFT. In particular, UoR's strength in climate and the built environment could help RBFT in

[21] The Southampton BioImaging Unit is based at University Hospital Southampton and is jointly funded by the University of Southampton and the University Hospital Southampton NHS Foundation Trust. The Unit comprises a mix of University and Trust employed staff.

understanding and planning for the potential impacts of the changing climate and extreme events on the local population health, the impacts on demand patterns, and the consequences for service planning and building requirements. This includes both the direct impacts of extremes on health and demand patterns (for example, the impacts for the elderly, those with chronic conditions, and socioeconomically deprived urban population groups), as well as indirect impacts on health that affect service provision, such as damage to facilities, power supply and communications (Issa, et al., 2024). There has been an example of this within the CIF portfolio (project 5-37). There is considerable scope for more research in this area applied to RBFT challenges, which could be strategically seeded by using a targeted CIF call for applications addressing this need.

3.5.2. Looking forward

Discussions at the Strategic Planning Workshop suggested that the Estate Pillar has struggled to find momentum. Many of the examples of success have been opportunistic rather than strategic, and where joint estate initiatives have been pushed strategically it has been challenging to implement (for example the CSTS). The mechanisms of the Partnership are not well suited to estate collaboration, in particular the CIF which funds projects of up to £60k whereas the costs for estate projects are orders of magnitude higher. In the current financial circumstances of both organisations, investing at this scale in joint estate projects is unlikely unless external funding is sourced. Similarly, the governance of the Partnership does not facilitate joined up thinking about estate opportunities or how to bridge the differing institutional and Partnership priorities in the context of estate strategies.

Discussions highlighted that there are opportunities to work collaboratively to apply insights from UoR's research expertise to inform the future development of RBFT's estate, as discussed above. The Building Berkshire Together programme may present more opportunities for this type of collaboration, but it relies of decision-making that is beyond the control of the Partners. Although the need for a new hospital has now been recognised, the timeline of at least 2037-39 for its development is problematic.

The consensus of the Workshop was that estate-based collaboration should be deprioritised. Rather than being a pillar in its own right, the discussions suggested estate collaboration could be reframed as a cross-cutting thread of activity. Alternatively, estate-based could simply continue opportunistically without being specifically identified as a substantial element of the overarching strategy. In either case, the Partners could remain responsive to opportunities when they arise, such as use of vacant UoR spaces to meet RBFT space needs when these align, but without proactively pursuing estate collaboration as a strategic priority. Opportunities for bringing UoR research capacity together with RBFT future estate development questions should be driven through the Research Pillar as a targeted activity.

3.5.3. Recommendations (P-Q)

Recommendation P: **Deprioritise estate collaboration** within the Partnership strategy. Reposition as an opportunistic activity that contributes to the broader Partnership but is not a strategic priority. The Partners should remain responsive to opportunities to work together in relation to the estate, facilities and infrastructure and use the Partnership as a forum for raising and exploring these opportunities as they arise.

Recommendation Q: **Incorporate research-based estate development opportunities within the Research Pillar of the Partnership**. Use CIF in a targeted mode to stimulate colleagues to respond to opportunities to apply UoR expertise to addressing key questions or challenges for RBFT's future estate.

3.6. Commercialisation Pillar

3.6.1. Looking back

Collaboration in commercialisation is defined in the Partnership strategy as "joint exploitation of new commercial opportunities and a pipeline of commercialisation of our research." This area of activity is at the early stages of exploration by the partners and is open to varying interpretations of what is meant by commercial opportunities and the reasons for pursuing them. For both Partners, financial sustainability of the Partnership is an important consideration, with the goal of the Partnership becoming self-sustaining through the returns it generates. Commercialisation has been viewed as a key route towards this goal.

Commercialisation of research

The focal point for commercialisation of research is the CIF portfolio. Work is underway to evaluate the commercial and impact potential of these projects, involving the Entrepreneur-in-Residence (Fiona Marston), and UoR's Knowledge Transfer Centre, Research Development and Impact Teams, and supported by the HIP Facilitator. Work to date has included mapping, commercial assessment and prioritisation of the HIP projects, which has identified a small subset of projects at different stages of the commercial translation pathway. These projects will be targeted for support by the Entrepreneur-in-Residence and UoR teams to facilitate their translation to impact and, where appropriate, commercialisation. However, the timeline for research to transition from discovery to market and patient benefit can vary widely, typically ranging from 5 to 10 years depending on the sector and the readiness of the technology. This is unlikely to contribute substantially to a self-financing Partnership in the short to medium term. Nevertheless, this work should continue as a key initiative of the Partnership (as outlined in Recommendation D), which may have potential to generate returns that can be reinvested in the Partnership in the long term, alongside its primary purpose as a route to impact and patient benefit.

As this stream of work to support further development of past CIF projects continues, consideration should be given to its ongoing management. It has been challenging to establish this workstream and maintain its momentum, requiring input from multiple colleagues who have relevant remits, predominantly in UoR business as usual teams. While the HIP Facilitator has supported this workstream, this post has no authority or influence at UoR, and no UoR line management escalation route. This is an example of the challenge of driving joint activity from a central resource based only in one Partner, as discussed in Recommendation G. Furthermore, the limited representation of UoR Research Services in the Partnership governance has made it challenging for the leadership to have sight of, and appropriately prioritise, workstreams such as this that emanate from the Partnership. These challenges permeate the UoR-side of the Partnership, but in this example, they created a barrier to realising the potential of its past investments.

Commercial opportunities

This Pillar has also aimed to drive other forms of new commercial, revenue-generating activity. This is not well defined and has considerable cross-over with the existing activities of the Partners. For example, use of the CSTS facility for commercial training courses is a pre-existing stand of activity at RBFT, previously delivered at the Trust Education Centre. Nevertheless, the CSTS should present opportunities to increase provision of courses and training facilities for external clients. However, there are challenges integrating the needs of commercial users alongside the needs of students, compounded by working within operational systems at UoR that are not designed for joint access and dual-purpose facilities such as this. Efforts to overcome the operational and governance challenges of the CSTS should continue and be strengthened within the Education Pillar, as discussed in Recommendation L.

3.6.2. Looking forward

Discussions at the Strategic Planning Workshop explored whether commercial return should be considered as an outcome of the Partnership rather than a priority in its own right. For example, commercialisation is a route through which research can have real-world impact and benefit patients through products, services and start-ups, but is can also potentially generate revenue to be reinvested in the Partnership. But if commercial return is viewed as a priority rather than an outcome, research that benefits patients through other means such as influencing policy, practice and preventative health might be out of the Partnership's scope. Similarly, if income from external courses and facility use were the priority for the CSTS, it is hard to see how this could have progressed as a joint venture and would not have attracted the £2.6m initial investment from OFS.

The consensus view from the looking forward discussions was that commercialisation, and commercial activity should not be positioned as a pillar in their own right. Instead, it should be viewed as a supporting activity that runs throughout the Partnership as one of the routes through which the Partnership can have real world impact and can move towards a financially sustainable Partnership.

As discussed in the previous section, the Partners have an ambition for commercialisation to provide a route towards a self-sustaining Partnership. With research commercialisation a long-term possibility, nearer term opportunities are more challenging. Other commercial activity, such as via the CSTS could potentially contribute in the short term, but this may not generate returns on a suitable scale. There would be value in exploring alternative approaches such as seeking philanthropic, alumni, donor and corporate social responsibility investment, particularly from companies and high net worth individuals in the region. This could take a form similar to the University's Imagine campaign, but specifically oriented to the Partnership and projects that benefit patients.

3.6.3. Recommendations (R-S)

Recommendation R: **Reposition commercialisation as an integrated element of activity within the strategic priorities of Research, Innovation & Impact and Education & Talent.** This should include continuing work that focuses on the portfolio of past CIF projects and supporting them to fulfil their commercial potential, driven through the Research Pillar (as described in recommendation C). In the medium term, the 5-year research plans for the ASF should also include pathways to impact and commercialisation, proactively supported by the Partnership Team and relevant professional services.

Recommendation S: **Seek philanthropic, alumni, donor and corporate social responsibility investments**. Initiate activity with UoR Campaigns & Supporter Engagement team to explore these opportunities, in partnership with RBFT colleagues and the Royal Berks Charity, and consider whether the Imagine Campaign could be extended or replicated for the RBFT-UoR Partnership.

3.7. Advanced Analytics Pillar

3.7.1. Looking back

Advanced analytics and AI have emerged as a significant strand of collaborative activity within the Partnership. 10 of the 47 CIF funded projects relate to advanced analytics and use of AI to augment clinical decision-making. Much of this activity is centred on inflammatory arthritis diagnosis and triage, but there has also been success in predicting patient non-attendance, as well as earlier stage work on kidney disease, diabetes and thyroid nodule diagnosis. Analytics has been a fruitful area of research and has secured over £2m funding since 2021 to develop commercial and patient benefit potential.

One of the key factors of success has been the ability to utilise RBFT's rich Electronic Patient Records (EPR) data to identify trends and correlations. RBFT has an exceptional wealth of historical patient data, having been at the forefront of adoption of EPR in the NHS. Recognising the potential of this data, the Reading Health Data Institute (HDI) was established by RBFT in 2023 to enable its' vast data resources to be utilised to produce impactful data research, improve patient care and safety, and address health inequalities. Crucially, this data is derived from the healthcare of real patients in real-world settings, which sets it apart from data resources elsewhere that are derived from clinical trials (Lam, Munoz, Davies, & Lasek, 2023).

In its early stages, the HDI's emphasis was on negotiating regulatory hurdles and establishing access, ways of working and governance. With this enabling work now complete, the Partnership can now look to capitalise on the exceptional data research opportunities that the HDI facilitates. The early successes with inflammatory arthritis and patient attendance validate the approach: the challenge for the future is to identify the sweet spots where this approach can be replicated.

3.7.2. Looking out

Data analytics is recognised as having the potential to revolutionise healthcare research. It can provide more rapid and adaptable routes to implementation of clinical advances than are possible with conventional clinical research, thereby speeding up pathways to impact. The health data resources of the UK are abundant, both via the NHS and an array of other sources. A recent report highlighted the vast scale of opportunity the UK has to harness the power of this data by linking the different data sources together to drive more powerful insights in shorter timeframes (Sudlow, 2024).

The Partners have a distinctive opportunity in this space, building on the examples of success already achieved. The structure of the Partnership could provide a short-cut to finding the sweet spots for replicating these success – working through the ASFs. This would bring together the Partners' clinical-academic research strengths, UoR's academic health data analytics expertise, and RBFT's exceptional real-world data and informatics via the HDI. This structure could support an approach that targets analytics research to addressing the challenges clinicians face in practice, and pump-prime the exploratory stages of the research via CIF (typically relatively low-cost). CIF has proved to be an effective means to pump-prime the early

stages of health data analytics research, which has demonstrated it can progress to external grants to support the clinical validation and upscaling.

At present, RBFT and UoR have a window of opportunity, but this is likely to be time limited. The HDI is ahead of the game, having found ways for researchers to overcome the barriers of accessing, linking and analysing data. But with a roadmap being developed, based on the Sudlow report, other NHS data sources will rapidly come on stream as the roadmap is put into action. The challenge for the HDI is to retain visibility and space to operate as development of the wider UK health data landscape takes shape at pace.

Similarly, other universities have well established research strengths and capacity in the health data analytics space[22]. While UoR has some excellent researchers in the health data analytics space, this is reliant on a small number of individuals. Given the pace at which this field of research is developing, there is a risk that UoR's limited academic capacity for analytics research creates a bottleneck for the Partners. Overcoming this bottleneck is challenging with limited financial resources available and UoR's lack of visibility in this field compared to competitors.

If the opportunities in health data analytics are to be realised, alternative routes to building UoR capacity through external funding may need to be pursued, for example, Research England's Expanding Excellence in England (E^3) fund[23]. Alternatively, it may be necessary to seek additional academic partners to overcome the bottleneck in UoR capacity.

3.7.3. Looking forward

Discussions with RBFT Board and at the Strategic Planning Workshop confirmed that a priority for the Strategic Partnership is to capitalise on the scale of RBFT's clinical data and as a means to advance clinical care. Looking ahead, if the Partners are to capitalise on their opportunity it is vital to avoid duplication and confusion between the remits of the Strategic Partnership and the HDI. The Partnership can provide a structure and focus to the HDI's efforts to seed new research opportunities, such that the two entities support and reinforce each other rather than duplicating efforts.

In keeping with the wider approach of the maturing Partnership, efforts to identify health informatics research should be focused on the ASF. Rather than sitting as a separate strand of activity, health data analytics research should be incorporated as a fundamental strand of the 5-year research strategies that each ASF develops. These strands should adopt the HDI's approach of reversing the translational paradigm that starts with a real-world clinical challenge

[22] UK research competitors in Health Data Analytics include: the Centre for Medical Informatics within the Usher Institute at the University of Edinburgh; the Christabel Pankhurst Institute for Health Technology Research & Innovation at the University of Manchester; Institute of Health Informatics, University College London; Institute of Global Health - Data Science & Analytics research area, Imperial College London; Centre for Health Data Science, University of Birmingham; and the Alan Turing Institute's Health & Medical Sciences Research Programme.

[23] Research England E3 funding: Provides funding for small and excellent research clusters to scale up and provide sustainability. Round 2 (2024-29) funded the Centre for Digital Innovations in Health & Social Care at the University of Bradford (£4.9m).

and working backwards to the underpinning science via healthcare delivery data. Proactive facilitation and pump-priming should be directed towards these opportunities to support rapid research and commercialisation, working in close partnership with the HDI data access committee. Through this approach, health data analytics could become an underpinning activity for the Partnership that develops as a cross-cutting and distinctive element of the Partnership's future identity.

There may also be potential in the Education Pillar, both in terms of developing the next generation of health data analytics researchers (e.g. PhD or Masters training) and supporting the development of current and future professionals to fully exploit the power of data analytics in the healthcare they provide.

3.7.4. Recommendations (T-V)

Recommendation T: **Reposition health data analytics as an underpinning approach** that will develop as a cross-cutting priority for the Partnership.

Recommendation U: **Incorporate health data analytics as a specific strand of research within the 5-year research strategies for the Partnership Areas of Shared Focus**. This will allow clinical challenge-led advanced analytics to develop as a distinctive underpinning approach of the RBFT-UoR Strategic Partnership. Direct the facilitation support of the Partnership Team and strategic use of CIF to pump-prime early research in close partnership with the HDI. Proactively pursue external funding for the next stages of development as research matures, in partnership with UoR Research Services and RBFT Research & Innovation.

Recommendation V: **Explore opportunities for, and feasibility of, expanding capacity in health data analytics**. This should include academic capacity building, either through external funding for UoR capacity building (such as Research England E3 funding), or through additional academic partnerships. Capacity building could also include opportunities for training future health analytics researchers (such as PhD or Masters programmes), and training for current and future healthcare professionals, if there is sufficient academic capacity to support these activities. Opportunities for wider partnerships that would strengthen the Partners reputation, visibility and capacity should also be explored, for example with other universities and technology companies based in the Thames Valley and beyond.

3.8. Governance

3.8.1. Looking back

The looking back consultations highlighted the high levels of commitment and direction from senior leadership as a strength of the Partnership. The consultations also suggested that this was not matched with buy-in and engagement at other levels of the organisations, with limited involvement of key mid-level leaders such UoR Heads of School, Department or Professional Service Functions and RBFT RoES leadership. In both organisations, these colleagues expressed willingness to be more actively involved.

The sense of disconnect is also a reflection of the wide array of collaborative activity on the ground, some of which is funded by the Partnership and some that is not. There are mixed understandings of what sits within the remit of the Partnership, with some colleagues of the view that only the specific mechanisms overseen by the HIP Board are considered to be part of the Partnership (i.e. CIF, RoES, the RoES PhD studentships and the Joint Professorships) while other colleagues considered all joint activity to fall within the Partnership. Collaborating through a variety of means is an indication of strength in the Partnership. It suggests that colleagues may be looking beyond the internally funded mechanisms (CIF, RoES PhD Studentships) and finding additional and creative ways to work together. The Partnership would benefit from taking a more holistic view of all collaborative activity and reducing the emphasis on the operational mechanisms of CIF and RoES.

Inconsistencies in the terms used to name the Partnership and its governing bodies contribute to confusion about remits. Colleagues are unclear whether the Health Innovation Partnership and the Strategic Partnership are the same entity, or whether HIP denotes a specific subset of activity. Externally, there are a wide array of partnerships and organisations that use "Health Innovation…" branding, for example: the NHS Health Innovation Networks[24], other university-NHS partnerships such as the Huddersfield Health Innovation Partnership[25], the Health Innovation & Transformation Partnership (Glasgow)[26], the Health Innovation Neighbourhood[27], and Lancaster's Health Innovation Community and Health Innovation Campus[28]. The transition

[24] Health Innovation Networks are the new name for the former Academic Health Science Networks, within which there are 15 local networks each with the Health Innovation… naming. Health Innovation Oxford and Thames Valley is the new name for Oxford AHSN.
[25] Huddersfield Health Innovation Partnership is a collaboration between the University of Huddersfield, 3M Buckley Innovation Centre, Business Kirklees, the NHS and other local and regional health and wellbeing partners. It connects businesses with its members, provides support and access to facilities for product development, grants for proof of concept in health innovation, lab and office space in the Innovation Centre, and events, mentoring and networking opportunities.
[26] The Health Innovation and Transformation Partnership is a collaboration between University of Glasgow with NHS Greater Glasgow & Clyde, AstraZeneca UK, Lenus Health & the Centre for Sustainable Delivery. It aims to create transformation in NHS Scotland through large scale programmes to improve the health of the population and expand clinical research.
[27] The Health Innovation Neighbourhood is a development of 1,250 new homes on that integrates health research and innovation, employment, people and community and sustainable placemaking. It is joint venture between the University of Newcastle, regeneration developer Genr8, and real asset developer Kajima.
[28] The University of Lancaster's Health Innovation Community is a membership and events organisation, which incorporates a business partnerships support team that provide access to funding, develop partnerships with the University and NHS. The Community is based at the Health Innovation Campus, which provides space for external organisations working on health challenges to co-locate on site with the University's Medical School and Division of Health Research.

into the Partnership's next phase presents an opportunity to re-evaluate whether the Health Innovation Partnership remains sufficiently clear to internal and external stakeholders and is an appropriately distinctive brand.

The governance structure for the Partnership would benefit from review and updating. For both SPB and HIP Board, the agenda and membership have evolved and in places moved away from the intended purpose or these Boards. Much of the SPB agenda is taken up by reporting, which detracts from its strategic purpose. Similarly, much of the HIP Board agenda is overly operational, which detracts from a more holistic view across the Partnership initiatives. Other significant initiatives within or associated with the Partnership, such as CSTS and HDI, either do not have clear governance or reporting routes into the Partnership or these routes are not adhered to in practice.

The recommendations of this evaluation could lead to a significant reconfiguration of the Partnership. Section 4 lays out a suggested strategy and key initiatives for the future that reflect the recommendations. If the Partners adopt the recommendations and strategy, this will trigger the need for a more extensive reconfiguration of the governance structure: a suggestion for which is also included in section 4. This provides an opportunity to ensure that the lines of accountability and cascade are clarified for all initiatives, that representation includes leadership of the Departments and Schools within which collaboration occurs, and leadership of the Professional Services that support and facilitate activity.

3.8.2. Recommendations (W-X)

Recommendation W: **Reconfigure the Partnership governance for the new strategy period**. The new structure should seek to improve the connection between top-level drive and on the ground activity and should increase representation at mid-levels. The remit of the governance bodies should be clarified, including the lines of accountability and cascade.

Recommendation X: **Revisit the naming of the Partnership** and consider whether it conveys an appropriately level of clarity of remit internally, and distinctive identity externally.

4. Strategy for the future

This section suggests how the recommendations and findings of the Evaluation Exercise could be incorporated into the Partnership's strategy for its next phase from 2026 onwards.

4.1. Vision and mission

Our mission is to advance healthcare practice and policy through excellence in innovation, research and education, by working together in partnership and with stakeholders across the sector and region.

Our vision is to is to transform the health and care of the people of Berkshire and beyond by bridging university and healthcare environments. By creating a learning environment that drives continuous improvement, we will create a step change that informs national best practice in healthcare and prevention.

4.2. Strategic priorities and cross-cutting themes

Our strategy focuses on two *strategic priorities*, through which we will achieve our mission:

- Research, Innovation and Impact
- Education and Talent

Our strategy is supported by a *cross-cutting theme* that underpins our strategic priorities:

- Advanced health data analytics

We work closely together to commercialise the outputs of our collaboration and to share elements of our infrastructure and estates, which contributes to the long-term sustainability of our Partnership.

4.3. Strategic goals and key initiatives

Our strategy will be delivered through strategic goals and key initiatives through which we will develop a depth of collaboration in focused areas, leading to impactful research and education that benefits patients and informs clinical practice. This builds on the breadth of our collaboration developed in the earlier stages of our Partnership and will accelerate deepening of the Partnership as it matures to replicate and extend our early successes.

Strategic goals - Research, Innovation and Impact:

- **Develop deep collaboration in Areas of Shared Focus.** Provide strategic support to scale up activity and build on existing momentum, which will drive the development of a portfolio of collaborative impactful research with substantial external research income for each Area. The ASF should encompass both focal points of activity at RBFT and at UoR. For RBFT, initial ASF should the RoES Departments with Joint Professorships. For UoR, the ASF should be defined by repeat successes in collaborating with RBFT. Over

the course of the strategy period, the ASF approach could be extended to the other RoES Departments and emerging clusters at UoR.

- In parallel, **maintain an element of activity to develop breadth for the future** by providing a scaled-back level of support for new areas of collaboration with. This should include both targeted support for specific opportunities that are identified "top-down", as well as responsive support where compelling opportunities arise "ground-up".
- **Maximise the further development of the Partnership's portfolio of past investments** and translation of previously pump-primed research to generate impact for patients, leverage external grant income, and enhance commercialisation.
- **Engage strategically** with organisations across the region, sector and wider NHS landscape to encourage wider uptake of impactful research and allow benefits for patients to permeate beyond RBFT.

Strategic goals - Education and Talent:

- Develop depth by focusing on **innovation and enhancing the student experience** within existing education programmes.
- Build on the potential of the CSTS as a shared resource for **innovation in simulation-based and interprofessional education and training.**
- Enhance the **experience of clinical placement students** from UoR at RBFT through a coordinated approach that optimises teaching and learning, and enhances quality, consistency and efficiency across all programmes with clinical placement education.

Key initiatives

- Develop a package of practical hands-on support for joint clinical research.
- Establish a virtual Joint Research Office that supports and facilitates all joint research between the two organisations, including clinical and non-clinical research, funded through external grants and internal sources.
- Shift the focus of funding and Partnership Team activity towards maturing the pipeline of research within the ASF. This includes establishing different modes for CIF (strategic-, targeted- and responsive-modes); shifting the emphasis of the Partnership Team towards strategic development and programme management; and rebalancing the Team across the two Partners.
- Increase transparency of decision-making for new educational programmes and courses to reduce mixed understandings.
- Develop elements of educator development NHS management and leadership development training that can be incorporated into education programmes for students, trainees and staff by drawing on the successful RBFT-tailored Henley programme and the PGCert Healthcare Education.
- Incorporate research-based estate development opportunities within the Research Pillar of the Partnership, using targeted-CIF to stimulate collaboration where opportunities are identified.

- Seek philanthropic, alumni, donor and corporate social responsibility investments to underpin CIF.
- Incorporate health data analytics as a specific strand of research within the 5-year research strategies for the Partnership Areas of Shared Focus.
- Explore opportunities for and feasibility of expanding UoR capacity in health data analytics.
- Reconfigure the Partnership governance for the new strategy period.
- Revisit the naming of the Partnership and consider whether the HIP name conveys a clear remit and identity.

4.4. Areas of Shared Focus

Defined *Areas of Shared Focus* are at the heart of our approach, around which we will focus resources and support to drive their development towards success at scale. This will allow the Partnership to build upon its' early successes and develop a depth of excellent research, innovation and impact in and between these Areas that have emerged as strengths. Figure 5 below illustrates the initial ASF.

As the initial wave of ASF mature, we will extend this approach to future waves as other focal points mature and emerge. Future ASF could include the other RoES Departments and other clusters at UoR that may emerge as current CIF projects mature.

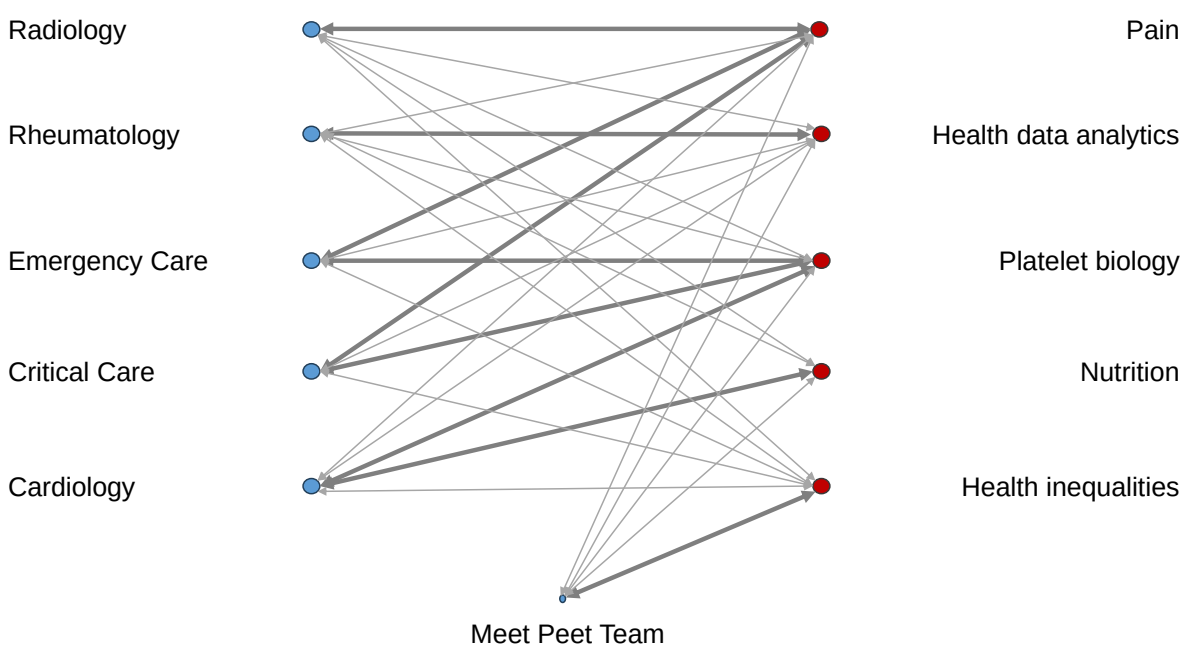


Figure 5: Schematic representation of the proposed AFS for phase 1. Thick grey lines indicate current collaboration, thin lines indicate potential future collaboration.

4.5. Future governance

As discussed in section 3.8, the recommendations of this Evaluation could lead to a significant reconfiguration of the Partnership, which would trigger the need for a revised governance structure. The diagram below suggests an alternative that would also address the disconnect between top-down direct and ground-level buy in and provides opportunities to strengthen and consolidate governance in the education domain.

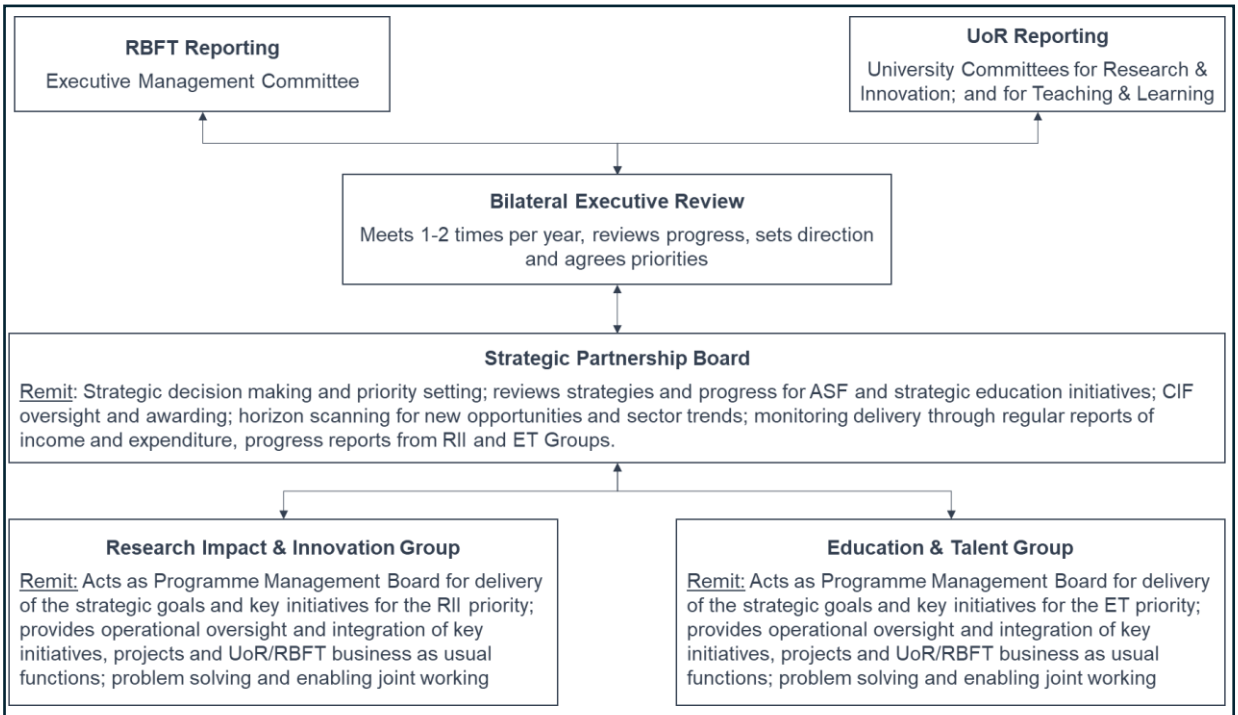


Figure 6: Schematic representation of a potential future governance structure, reconfigured to strengthen the Partnership governance, reduce the mid-level disconnect, and oversee the proposed strategic priorities, goals and key initiatives.

5. Concluding remarks and next steps

This report has summarised the findings of a 9-month Evaluation Exercise, undertaken jointly on behalf of both Partners as they look towards the next stage in the Partnership's development. The recommendations are based on the findings, with the future strategy and key initiatives designed to illustrate how these recommendations could be put into practice.

This Evaluation has taken place against a backdrop of growing financial pressure for both organisations. The recommendations have been made in the awareness of this context and predominantly describe shifts in emphasis and activity rather than adding additional activity. However, it will be for the Partners to now decide the extent to which they agree with the recommendations, how they could be implemented, and whether this is affordable. The Partners may wish to consider this both as a Partnership (through Strategic Partnership Board), and as individual organisations with input from their internal stakeholders.

Appendix 1 – Evaluation approach

Looking back element

This element gathered insights by exploring the main focal points of Partnership activity:

- RBFT Departments with Recognition of Excellence Status (RoES)[29] - to understand views on the purpose and value of the scheme and its future role in the Partnership, and to identify examples of success and lessons learned.
- The portfolio of CIF projects and PhD studentships - to understand the role that pump-priming projects plays in underpinning collaboration and identify examples of success and lessons learned.
- Education collaboration – to understand the future scope, opportunities and appetite for education collaboration.
- Examples of shared facilities and estate collaboration; analytics and AI collaboration; commercialisation – to understand the opportunities and challenges of these forms of collaboration within the partnership.

These focal points were explored through qualitative interviews with colleagues in both institutions (76 colleagues in total, 30 RBFT and 46 UoR as detailed in the Interim Report), qualitative reviews of key documentation (CIF applications and completion reports; RoES applications and supporting documentation), and quantitative analysis of co-authored publication data and joint funding data (SciVal analysis of the Scopus database[30]).

Looking forward element

This element gathered perspectives on the future direction and priorities of the partnership through:

Surveys: colleagues were asked to consider 3 questions, either via an open static survey or through live surveys conducted during meetings.

- Q1: Considering a future of 2035, how important do you consider the partnership between the University of Reading and the Royal Berkshire NHS Foundation Trust to be to the future success of your Department or Division?
  (1 = not important at all; 5 = extremely important)
- Q2: What are the most important things that you would like to see the Partnership deliver in the future? (Please organise the following suggestions based on existing priorities into the order of importance that you consider them to be, with the most important at the top of the list and the least important at the bottom.)

[29] At the time of evaluation, there were 9 RoES Departments: Cardiology, Emergency Medicine, Radiology, Stroke, Renal (Berkshire Kidney Unit), Critical Care, Urology, Rheumatology, and Elderly Medicine. Ophthalmology was awarded RoES status during the final phase of the Evaluation Exercise, after the competition of the looking back element, and was therefore not included in the qualitative analysis of RoES Departments.

[30] with thanks to Karen Rowlett, Research Publications Adviser, UoR

- Q3: How could the Partnership help your Department/Division to achieve its purpose and ambitions? (free text)
- Live surveys within pre-existing meetings: RBFT Clinical Leaders Development Half Day, 2 October 2024; UoR Agriculture Food & Health Theme Strategy Board 8 October 2024; UoR Health Strategy Group 27 November 2024; Reading Pathological Society Research Forum, 19 November 2024 (mixed audience of RBFT, UoR and external delegates).
- Static open surveys circulated to UoR Agriculture Food & Health email distribution list and via RBFT Chief Medical Officer blog, 15 October - 8 November 2024.
- Results of the survey are shown in appendix 2.

Discussions and workshop:

Strategic discussions were held, framed by the findings of the interim report and its' central theme: *should the Partnership continue to build a broad base of activity across the two organisations? Or should the Partnership shift to building focused depth of activity in defined areas?* Results of the looking forward surveys were also presented to incorporate the view of colleagues as part of the strategic discussion.

The following strategic discussions took place to inform the looking forward perspective:

- RBFT Board Seminar session, 30 October 2024: a discursive session was held with the RBFT Board, in which the Board were asked to take 10-year perspective and consider what the future priorities for the Partnership should be, and how those priorities might help RBFT achieve its purpose and ambitions.
- UoR Executive Board discussion, 18 November 2024: UEB was invited to discuss, taking a 10-year perspective, the future priorities for the Partnership and how UEB would like to see the Partnership develop.
- Strategic Planning Workshop with key representatives of the Partnership, RoES Joint Professors, and academic representatives from UoR[31], 4 December 2024. Participants were asked to consider the perspectives that had emerged from the Evaluation Exercise and consider how this should shape the future direction of the Partnership.

Looking out element

This element comprised desk research to gather examples of practice in other NHS-university partnerships. There is a wealth of partnerships in the UK, ranging from long established medical schools that are deeply entwined with their university partners, to other much newer partnerships that arose outside of medical school structures. This element is not intended to be an exhaustive review of the external NHS-university landscape. The purpose is to provide examples of practice from elsewhere to provoke thought. The insights have primarily been gathered from websites, alongside selected reports as listed in the bibliography.

[31] Workshop delegates: RBFT – Steve McManus, Janet Lippett, Katie Pritchard-Thomas, Andrew Statham, Jill Ablett, Atul Kapila, Toni Chan, Matthew Frise, Mark Little, Liza Keating, Neil Ruparelia. UoR – Robert Van de Noort, Parveen Yaqoob, Carol Wagstaff, Guy Hembury, Anne-Marie van Dodeweerd, Phil Dash, Richard Fraiser, Carmel Houston-Price, Jon Gibbins, Vicky Li. Facilitators – Kate Hough, Jessica McKean, Kirsty Withers, Tom Wright

Appendix 2

Looking forward survey – results

	AFH Strategy Group (9)	AFH Theme (25)	RBFT Clinical Leaders (16)	Reading Path Soc (36)	RBFT Open (4)
Q1: Overall importance (1 = not important at all; 5 = extremely important)					
Mean score	3.9	4.5	3.9	4.4	2.5

Q2: Ranking of Existing priorities (ranked 1 highest to 7 lowest	**Rank**				
Joint posts to share insight and knowledge, and deliver joint research, innovation and education	3	3	1	3	3
Consolidate and mature **existing areas** of collaborative research and education	1	1	5	4	2
Develop **new areas of synergy and opportunity** across the Trust and University that will deliver impact and value	4	2	3	2	5
Build, support and drive **digital developments** to improve patient care	6	5	2	1	1
Explore new collaborative opportunities within the **local borough and community**	5	4	6	5	4
Develop the **commercial potential** of previously funded projects to create return on investment	2	6	7	7	6
Support, enable and deliver net zero and sustainability agendas	7	7	4	6	7

Q3: Free text answers – how could the Partnership help your Department/ Division to achieve its purpose and ambitions?

UoR Responses (AFH Theme Strategy Board and open circulation to Theme
by enabling medical relevant research and by providing medical expertise to enhance current research
Within BSBE we focus of fundamental mechanisms of disease (and normal physiology). Partnership with RBFT offers the potential to translate these discoveries. Ideas do flow back in the other direction and this has led to the development of other HIP projects with teams within the Trust. Understanding the key questions for clinicians is important within this. Scientists and physicians ask different types of questions and RBFT colleagues have coal-face experience of working with patients and associated practicalities. So.....in my mind mixing them (scientists and doctors) altogether is a good thing - I therefore checked the joint appointments box below...
research collaboration and teaching on our modules
Yes. Since technology and healthcare is a key part of our research it is important to link to the medical community. RBH is the obvious choice and I have worked with consultants therein, but I have also

worked with U.Southampton NHS trust so I think it is important to consider regional partnerships as well
Facilitating collaborations between Uni and RBH research-active staff; providing pump-priming to get projects started; supporting co-supervised PhD studentships; facilitating access to participant groups - patients, new mothers/babies, etc
Make greater efforts to establish collaborations
This partnership can help translational research which often involves collaborations between laboratory and clinical researchers. The ultimate goal for the partnership will be to create more applicable results that directly benefit human health.
Research work with health care professionals within the NHS will enable us to pilot high impact research and increase our success rate for larger scale funding (i.e. NIHR), again improving impact and change that is far reaching within our community.
translation of our research into clinical practice with enhanced impacts but also better quality research and greater satisfaction for academics; perhaps even commercialisation opportunities
the partnership needs to work towards supporting key objectives of both institutions to help each institution excel in research, teaching and patient care. For my division, we need hospital support for our healthcare students.
By moving out gut microbiology intervention research into the clinical domain. This has already started but has much further to go.
Collaboration on large scale empirical projects that obtain external funding (e.g. NIHR).
An outlet for clinical and health-based research, a high potential for generating research with high impact, and an opportunity to engage with specialist funding streams (NIHR, Arthritis UK etc) that would otherwise be restricted
Opportunities to collaborate on clinical research projects that would improve our impact and increase funding opportunities available, make a difference to patient outcomes, allow us to maintain (and even expand) student numbers, supporting our ambition to train future healthcare professions that will support a safe and efficient healthcare system.
Need access to real patients- this would significantly elevate research quality.
Create more opportunities to meet researchers at UoR/RBFT (e.g. the Research Cafe, but maybe have themes)?
Collaboration with RBH would contribute significantly to impactful research and would help leverage larger research grants.
Increased relationships and deeper understanding of Physician Associate programme, and support for students in clinical settings. Evaluation of current impact of the 40+ Physician Associate staff and 50+ students currently working or gaining placement experience at RBH. RBH relationships are integral to the PA programme in terms of student placements and guest specialist lecturers. We support South East School of Physician Associates -their lead is RBH PA who trained as a postgraduate at UoR. SESPA use our clinical facilities to run clinical and academic training of PA staff across the South East Region.
It is our largest placement provider including offering consultant time to lecture the students
From an education partnerships standpoint we need to have a partnership that values UoR needs equally to those of RBFT - and is not geared predominantly toward keeping RBFT happy (which is the feeling at the moment). We need to create a regional partnership through student placement opportunities, curriculum enhancement, training of RBFT staff, etc. that recognises the value we can bring in working together. From a research context, there are opportunities from working with RBFT to enhance the impact of research.
Support our physician associate students in placement with clinical and work base skills, support clinical teaching, support employment and the wider physician associate profession
Student placements in the RBH are a key part of the Physician Associate and Pharmacy programmes

Working in partnership to support students and ensure placements.
Providing ongoing campus-based teaching and placement support for Physician Associate students
By allowing us access to patient populations which we have difficulty reaching. Also access to the specific clinical knowledge in depts such as cvd and neurology
Focus on key areas
Enhance clinically focus translational work. Focus on current clinical problems
Partnering on research where clinical or community healthcare expertise is needed
Joint appointments, ambitious large EXTERNAL grants, more interactions (e.g., joint research seminars, journal clubs in etc.)
By focussing on key areas of joint expertise rather than spreading resources too thinly.
Future collaboration opportunities for interdisciplinary/multidisciplinary funding calls
Scale up health-related research, RCTs, applications to NIHR
Clearer processes for collaborating in submitting grant applications

RBFT Responses – Clinical Leaders and Open Survey circulated via CMO Blog
Don’t think it would. Getting dept status and all the paperwork associated with it would be a distraction and time waster
I may not be as aware as others, but I don't fully understand the relationship with the university and how it impacts us at all. I don't think the partnership helps our department achieve its purpose.
closer cooperation between our ED and the University by having more events on university grounds to highlight the close connection to all staff members. another example would be the resus courses organised by RBH resus team, APLS, ATLS to use the sim suite at the University. As far as I know that has only happened once so far. Could the RBH use/buy in support from university tech know how to improve our status quo? Could there possibly some joint studies for medical students and digital medical networks?
Academic scrutiny and oversight of our strategic planning and operational objectives
Partnership - Gives purpose and direction to our work, goes beyond just routine clinical work, looking at how we can improve outcomes
Optimise Partnership-department -system horizon scanning opportunities
AI for clinical coding
Clarity of partnership strategy so any submission is aligned to its purpose
Improves the workings of the department Brings innovation to improve patient care ROES the process itself is just as important as the award. It has brought the team closer together We can now look into the future as a university department
Help attract workforce - give members of the team something else interesting to work on
Not obviously a link between HIP and Improving Together. Is there an opportunity?
Help with joint research projects. Funding for PhDs and other qualifications and opportunities. Maybe an MSc. Training in education.
Create more resources to invest in clinical techs which is essential to support research
Improved data use for designing peri-op medicine and rehabilitation.
Continue to help fund investigator led research and PhD studentships
Help with our activity data analysis and translate into modelling. AI applications for sexual health management
ROES - the work on this has benefited us hugely

RPS Research Day – mixed audience of RBFT, UoR and External Participants
Advisory board to help develop ideas
enhance the Trust's capacity by providing additional resources, expertise, and networking opportunities
Understand how to understand grants and increase reputation in academia
Grants
Research active trust has better patients outcomes…
Support the creation/development of AHP training. Creating and supporting the conditions for innovation to flourish.
Partnership = success through people. Support teams to appropriately resource their endeavours
Attracting research funding
More patients involvement in research
Encourage more engagement between UoR and RBFT
Support, expertise and a wider range of ideas
Utilise wider data sets some outside normal health data sets
Adding innovative approaches in healthcare from academic research
Leverage research, innovation, ideas from the university to create translational real world application. Improving the culture of excellence.
Grants
Anonymous focus on patients
Improve quality of care and clinicians capability for care
Improve innovation
Additional knowledge and expertise Broader horizon thinking
By encouraging innovation
Becoming more aware f the requirements for clinical research
Develop a critical mass of research and teaching excellence
More training
Expertise
Supports the aspirational and resourceful components of CARE values. Better patient outcome and experience through best clinical practice.
ease decision making
Improve reputation of the hospital as a health care innovator
Leveraging Advanced Analytics to enhance and create novel ways of improving clinical and operational tasks
Drive innovation, improve patient care.
Collaborative working should speed up process
More grants/funding
Collaborate on ideas
Aligned areas of interest, mutual development
Focus on patient outcomes
Innovation
Joint research governance office
Help unblock the operational pinch points
Formalise links
Improve patient care and clinical treatment pathways

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