REF2014: Impact template

Institution: Queen Mary University of London

Unit of Assessment: A2 (Public Health, Health Services Research and Primary Care)

1. Context

Queen Mary, in London's East End, has a strong tradition of doing socially relevant research at local, national and international level that contributes to the wider knowledge base. The College's research strength has grown rapidly in the past 15 years; it was admitted to the Russell Group in 2012. Collaborative links with industry and the public sector have increased significantly. The School of Medicine and Dentistry (SMD) was established in 1995 when The London Hospital Medical College ('The London', founded 1785) merged with St Bartholomew's ('Barts', 1123) and they were incorporated into the newly formed Queen Mary. This submission reports work from groups within SMD (chiefly the Centre for Primary Care and Public Health and the Centre for Psychiatry) that undertake community based research covering a range of themes including risk behaviour, the psychology of behaviour change, self management in chronic illness, mental health and wellbeing, women's health, and the organisation and delivery of health services.

2. Approach to Impact

SMD's approach to research impact is underpinned by four guiding principles. First, links between research, innovation, practice and policy are complex and multidirectional: they follow an organic rather than linear model of causality. For maximum impact, researchers need to be fully engaged with potential users and in active dialogue with them in all six stages of the research life cycle (Figure 1). Secondly, the knowledge, skills and techniques needed for achieving world-leading research *impact* are different from those neeeded for undertaking world-leading *research*. Hence we need new expectations and rewards for academic staff; new training opportunities and changes to research infrastructure. Thirdly, the impact agenda, linked as it is with closer ties to policymakers and industry, raises numerous potential biases and conflicts of interest, hence robust governance procedures are essential. Fourthly, world-leading impact activity demands an ongoing programme of learning and improvement, informed by systematic audit of performance.

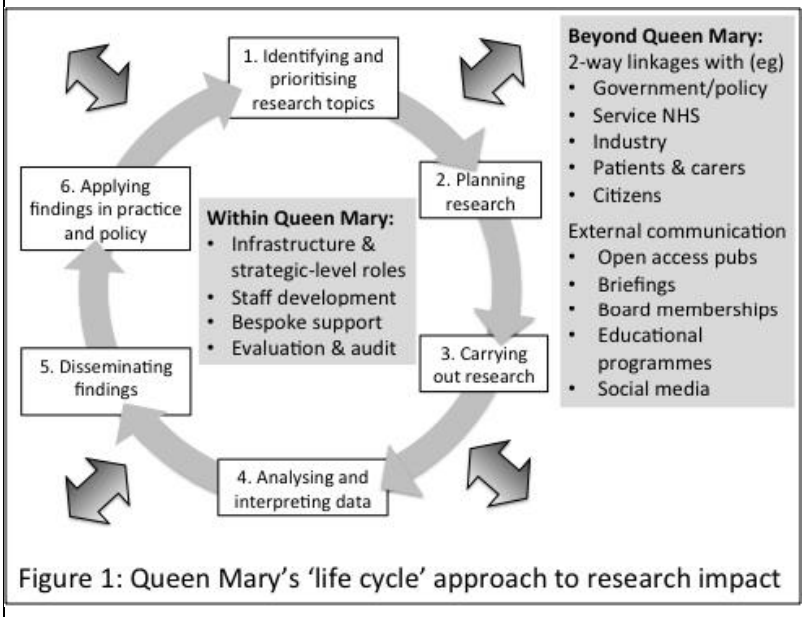

Figure 1: Queen Mary's 'life cycle' approach to research impact

Drawing on these principles, we have created opportunities for impact using six key approaches. *Beyond Queen Mary*, we worked to (a) build **links with stakeholder communities** who may use our research and (b) develop broad, diverse **external communication channels** to reach our audiences. *Within Queen Mary*, we set up (c) **infrastructure and strategic roles** for delivering on impact; (d) **staff development** to build capacity for impact; (e) **bespoke suport** for specific projects; and (f) **evaluation and monitoring**.

Our numerous links with external stakeholders include:

- **Government and national policymaking.** Of 22 academics in this submission, 14 have been represented on national-level policymaking and related groups in 2008-13 including NICE guidelines (Robson, Bhui, Khan), NICE implementation groups (Khan, Greenhalgh, Russell), NHS RightCare (Khan), Department of Health and Public Health England (Cardiovascular Risk: Robson, Pandemic Flu: Greenhalgh, Mental Health: Bhui), Medicines and Healthcare Devices Regulatory Agency (Greenhalgh); select committees (Mental Health:

Bhui) and advising a wide range of other government departments and groups including the Airports Commission (Clark); Ministry of Defence Advisory Group on Chronic Fatigue in the Military (White), Department for Environment, Food and Rural Affairs (Stansfeld), Department of Work and Pensions (Stansfeld) and Working Group on High Speed Train link (Stansfeld).

- **Local policymaking and NHS services.** Our researchers link closely to the local health economy. More than half of the submitted researchers also work as NHS clinicians; Griffiths, Priebe and White are non-executive directors of NHS trusts; and we are widely represented on Clinical Commissioning Groups and/or local implementation groups for clinical services (Greenhalgh, Griffiths, Khan, Robson, Swinglehurst, Taylor, Thangaratinam). Particularly through NIHR and Department of Health funding, we have built a strong portfolio of studies whose research questions emerge from clinical practice and whose outputs have immmediate and direct application to local patients as well as generating wider lessons, many with colleagues in secondary and tertiary care to address questions of service delivery and organisation across the full patient pathway. Clinically embedded programmes are ongoing, for example, to improve services for disadvantaged and/or minority ethnic groups with HIV (Eldridge, Griffiths), viral hepatitis (Bhui, Greenhalgh), asthma (Griffiths), domestic violence (Eldridge, Griffiths), cardiovascular risk (Robson), pelvic pain (Khan), pregnancy care including obesity and epilepsy (Khan, Thangaratinam), mental health problems (Priebe, Bhui), and diabetes (Greenhalgh). The recent award of £9M CLAHRC funding (see 'Networks' below) will strengthen and extend these NHS links.
- **International.** We actively promote links to international organisations. SMD's Unit for Social and Community Psychiatry became a World Health Organisation Collaborating Centre in 2012, the only WHO centre in the world specifically for Mental Health Services Development. In his role as Director of the Centre, Prof Priebe wrote parts the WHO European Mental Health Action Plan. Taylor is Advisor to World Health Organisation on Self Care of Non Communicable Diseases, and Stansfeld is Adviser on Noise and Health.
- **Industry.** SMD has extensive industry links. Via a Technology Strategy Board grant (Greenhalgh), we link with manufacturers of telehealth and telecare (Philips, Tynetec, Graphnet) and have secured knowledge transfer funding from QMI (see below) to work with them to inform design of new products. Robson has longstanding links with GP computer supplier EMIS; see CS2 for exammples of how his research has informed system upgrades.
- **Service users and charity sector.** Our academics have close links with patient and third sector organisations, especially Patient Advice and Liaison Services in our partner NHS trusts and and local faith-based organisations, notably the East London Mosque, with whom we have collaborated closely in research on access to services in minority ethnic groups (e.g. Greenhalgh, Griffiths, Bhui). In 2008-13 our academics have held board-level positions at Macmillan (cancer charity, Russell), British Lung Foundation (Taylor) and Care-If (an international charity on mental health and well-being for young people, Stansfeld, Bhui).

Increasingly, knowledge translation work involves multiple stakeholder communities linked in **networks** (reflecting the 'organic' model of research impact described above). In particular, Queen Mary is an active partner in the **Collaboration for Leadership in Applied Health Research and Care (CLAHRC).** Themed programmes apply research findings in mental health, self-management and engagement in chronic conditions, and child and adolescent health. There is a cross-cutting workstream on methodology and another on 'Innovation in Systems and Models of Care'.

We offer a broad and **multi-modal portfolio of communicative activity** to go beyond conventional academic outputs, including tailored messges to policymakers and industry (eg briefings, web updates, short summary articles). Queen Mary's **Centre for Public Engagement**, led by the **Vice-Principal for Public Engagement**, aims to set a new international standard for the ways HEIs engage with the public. Using a c£300K grant from RCUK and £1 million HEIF5 funding for 2011-5, it provides support and funding (> £100K pa) for public engagement activity by academics. **Queen Mary Public Relations** directs research with relevant audiences via press releases, Twitter and RSS feeds, podcasts, iTunesU and a Youtube channel. We run a range of **specialist postgraduate courses** for user audiences including a unique and innovative MSc in Transcultural Mental Healthcare and a modular MSc programme with qualifications in global public health, primary care and health systems. Individual modules may be taken as short CPD courses.

Queen Mary Innovation (QMI) is the College's technology transfer office, advising on intellectual

property and knowlegde transfer activities; the Business Development Unit provides suport for commercialising research discoveries. SMD houses the East London branch of the **London Research Design Service** (RDS, http://www.rdslondon.co.uk), providing support to research teams including techniques for engaging users and the **Pragmatic Clinical Trials Unit** (PCTU, http://blizard.qmul.ac.uk/research-groups/225-pragmatic-clinical-trials-unit.html) which supports trials whose research question relates to whether an intervention works *under real conditions of use*. SMD is (to our knowledge) unique among UK medical schools to have created a post of **Dean for Research Impact**, whose role is to promote, support and help evaluate knowledge translation and research impact across all Institutes. Queen Mary's **key performance indicators** (KPIs) for impact include the annual budget for translational research activity; number and range of inventions; and number and range of professional courses that disseminate our findings.

3. Strategy and plans

Our **strategic objectives** are SMD-wide and also cover our wider submission to UoA1 and UoA3:

1. Beyond Queen Mary, to continue our ongoing work to:
   a. Extend and strengthen strategic-level links with key user audiences;
   b. Optimise activity in our networked collaborations, particularly with the CLAHRC for UoA2;
   c. Develop and pursue collaborative ventures with industry and the third sector;
   d. Attract research users from all stakeholder communities to our postgraduate courses;
   e. Identify and incorporate examples of best practice from other HEIs and elsewhere.
2. Within Queen Mary, to continue our ongoing work to:
   a. Develop and refine our infrastructure for research impact;
   b. Ensure that every researcher receives a personalised programme of training, support, incentives and rewards to develop the personal capability for world-leading impact activity;
   c. Identify and support particular individuals to become leaders in knowledge translation;
   d. Promote organisational and team learning about research impact;
   e. Improve our performance systematically year on year.

To achieve these strategic objectives we will implement the following **specific plans**:

3. Plans for developing our externally-facing impact activity:
   a. Establish a strategic level Advisory Board on Research Impact with external representation;
   b. Incentivise and reward high-impact external appointments for academic staff;
   c. Prioritise and reward networking activity in applied research eg via CLAHRC;
   d. Increase CASE studentships and secondments to industry where appropriate;
   e. Rationalise and expand our specialist postgraduate courses and the marketing of these;
   f. Organise exchange visits to other higher education institutions, industrial partners, policy think tanks and so on to capture ideas for best practice in research impact.
4. Plans for further developing our internal structures and processes include:
   a. Build themed collaborations, thereby increasing potential for large-scale impact;
   b. Review and revise in-house training opportunities;
   c. Work with the Human Resources Department to maximise staff development opportunities;
   d. Increase the overall resource available for researcher-led impact activity;
   e. Introduce, deliver and evaluate a programme of activities to raise awareness of research impact, including an annual showcase event to share best practice among research teams.
   f. Extend, refine and apply key performance indicators in a continuous quality cycle.

4. Relationship to case studies

Our three case studies (on chronic fatigue, cross-cultural mental health and cardiovascular risk) illustrate four key elements of our 'life cycle' approach to research impact. First, the **research was clinically led** by academics who held NHS appointments and sought to explore questions emerging in practice; they were opinion leaders in their clinical field hence their colleagues were aware of their work, followed it as it unfolded and took notice of the findings. Second, there was **strong patient and public involvement** that began at the design stage in all cases so as to maximise relevance and acceptability of findings to users. Third, **lead researchers were members of, or advisors to, key policymaking groups** including NICE, Department of Health, Scottish Chief Scientist's Office and Parliamentary Reviews. Finally, **proactive engagement of lay media** ensured that the messages being put out by the press on these potentially controversial topics were clear, accurate and targeted appropriately.