

**UNIVERSITY CLINICAL  
PARTNERSHIP:**

**HARNESSING CLINICAL  
AND ACADEMIC RESOURCES**

**NUFFIELD TRUST WORKING GROUP ON  
NHS/UNIVERSITY RELATIONS**

Published by  
**The Nuffield Trust**  
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London W1M 7RD

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ISBN: 1 902089 46 4  
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## 1. FOREWORD

In 1981 the Nuffield Provincial Hospitals Trust published Sir Fred Dainton's *Reflections On The Universities And The National Health Service*. Dainton considered the interface between universities and the NHS to be 'the place where the future confronts the present' and the challenge 'to make this confrontation productive rather than cause sterile and destructive tensions'<sup>1</sup>. There has been an explosion of change in both the NHS and the universities since 1981, but these words are perhaps even more relevant today than when they were written. Establishing strategic links between research, education and health service provision (the tripartite mission) is a major challenge for a health service that strives to become a knowledge-based, learning organisation, and for universities to meet the changing demands of clinical education and research. The changing landscape demands that future aspirations confront the present situation.

This report does not address the totality of the NHS/university interface. It is principally concerned with the more limited topic of managing the tripartite mission in major centres, in which the complex components of health service provision, research and education are combined across organisational boundaries. It focuses particularly on the relationship between university medical schools and university teaching hospitals. However, the working group that prepared the report recognised that the NHS/university interface is now much broader than the specialist centre, with substantial teaching input not only from district general hospitals but also from general practitioners and community health centres in the primary care sector.

Since Dainton's reflections a body of work on the NHS/university interface has emerged. A chronological view reveals a widening scope and a change in focus over time, from concern about the ability of NHS teaching hospitals to support education, to a more general interest in managing the interface between research, education and health services.

The Croham report (1987) drew attention to the need for better co-ordination and planning of medical education at all levels. In November 1987, a conference involving all the stakeholders in medical education established a joint Steering Group on Undergraduate Medical Education. Four reports - and a change in title to the Steering Group on Undergraduate Medical and Dental Education and Research (SGUMDER) - indicates the shifting focus at the NHS/university interface. The Second Report (1990) laid out Ten Key Principles - rules of engagement - to govern the relationship between medical schools and university teaching hospitals. By the time of the Fourth - and most recent - Report (1996) the context had changed considerably. An NHS Research and Development (R&D) task force headed by Anthony Culyer (1994), had recommended the separation of the Service Increment for Teaching and Research (SIFTR) into an NHS R&D funding stream, and Winyard (1995) recommended changes to SIFT. The Higher Education Funding Councils established a Joint Medical Advisory Committee (JMAC) that reported to SGUMDER in 1995. The Fourth Report acted on JMAC's recommendation that the guiding principles should be revised and refocused<sup>1</sup>. The Fourth Report also acknowledged another key JMAC

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<sup>1</sup> SGUMIDER's (1996) Ten Key Principles are reproduced in appendix two of this report.

recommendation 'that there is a need for continued careful monitoring of clinical and academic work undertaken by university staff if the quality of teaching and research is to be maintained'. The House of Lords Select Committee on Science and Technology's report on 'Medical Research and the NHS Reforms' concurred, and the Department of Education sought the views of the Committee of Vice-Chancellors and Principals (CVCP). The CVCP established a task force chaired by Sir Rex Richards, whose deliberations were published as *Clinical Academic Careers* in July 1997. One of its recommendations was 'more work should be done to explore forms of governance that give greater weight to the academic mission of university hospitals'.

The Nuffield Trust became involved in this initiative following a meeting in June 1998 between Sir Alan Langlands and the Chairmen of the Council of Heads of Medical Schools and the Medical Committee of the Committee of Vice Chancellors and Principals. The meeting noted that relationships were not uniformly good and that the Ten Key Principles might be better facilitated by the development of supplementary guidance. It was decided to ask the Nuffield Trust to host a meeting to explore the matter in more detail.

A survey of heads of university hospitals and medical schools, undertaken to inform that meeting, in November 1998, confirmed a perception that relations between academic and clinical partners are not uniformly good. This report is the outcome of a decision at that meeting, held in November 1998, to form a smaller, collaborative working group with the aim of considering a joint strategic approach and to examine ways of developing the interface at a local level. The report should be read in the context of other work in this critical area, in particular, from JMAC on good practice in NHS/academic links<sup>iii</sup>, and from the Joint Department of Health/Higher Education Funding Council for England task group on developing a joint university/NHS planning culture<sup>iv</sup>. It is important that our work is not fragmented and is harnessed around mutual aims. This report is complementary to these reports and aims to lay out a strategic framework for local relations.

There is a need for a new framework to address joint working between university hospitals and medical schools, taking account of the key role of the primary and community care sector in the education and training of doctors and in medical research. The working group found that the Ten Key Principles are limited as a device to govern the NHS/academic interface. They lack a modern strategic context and are neither sufficiently broad nor detailed enough to address all the aspects of the shared agenda.

The management of the shared agenda is complex, with some medical schools working in partnership with many NHS teaching trusts. While the scope of this report is principally on specialist centres, the changing context is not ignored. It is important that networks are established to harness academic/clinical partnership across districts and regions, recognising that academic activity is growing beyond the confines of specialist centres.

Specialist centres have a particular role in the academic/clinical partnership. This role is emphasised by the introduction of a new term - University Clinical 'Centre'. The term seeks to capture the unique contribution of university teaching hospitals, medical

schools and other academic departments, for example Nursing, working in a partnership that embraces all providers of medical teaching and research. A University Clinical 'Centre' is a virtual body, and its composition, beyond the core membership of university hospitals and medical schools is flexible and will develop over time. The term 'centre' does not, in this context, relate to a centralised body nor necessarily imply physical co-location.

The organisational components of University Clinical 'Centres' have equal responsibility for the tripartite mission. They provide general professional education and specialised graduate training; lead in biomedical, clinical and health services research; and champion the application of new knowledge for the alleviation of suffering, rehabilitation of injury, and prevention of disease and premature death. These institutions are a national resource and are essential to accomplishing important national objectives. Tensions within the tripartite mission, unless mitigated, make them fragile in nature, despite their impressive size.

Local governance of University Clinical Centres should reflect a shared strategic vision. The philosophy of our approach supports the emphasis given by SGUMDER's Second Report: that 'liaison and consultation are not enough for effective collaboration. Both parties [should] recognise their unity of purpose and combine in a joint enterprise to achieve it'<sup>v</sup>. Local circumstances determine the detail of arrangements but a common framework should inform these choices.

A strong relationship between university hospitals, medical schools and other related academic departments is a key factor in determining the future quality of the nation's health<sup>vi</sup>. Success in service development, professional training and the production and development of knowledge are important performance measures for the NHS.

Academic Clinical 'Centres' make an important contribution to regional and national economies. Centres are major employers, and investment in academic clinical centres produce innovations that generate wealth and make a positive contribution to UK pic. In America, the Association of American Medical Colleges (AAMC) estimate that centres contribute \$186 billion directly and indirectly to the American economy. It is critically important that the potential of these 'centres' is fully harnessed and the maximum return made from the significant investment in health service development, research and training. Vital interests are served by Britain's place in medical science and the reputation of our health care services; health services benefit, as do our research and industrial base.

**John Wyn Owen,  
Secretary of the Nuffield Trust and Chairman of the Working Group**





## 2 RECOMMENDATIONS

### Local

1. The organisational components of University Clinical 'Centres' are jointly responsible for the tripartite mission. They need to adopt a common strategic approach and demonstrate this internally and externally.
2. Those leading University Clinical Centres should improve the understanding and communication of their pivotal role and think through ways of improving their contribution to health care.
3. University teaching hospitals should invite deans of medicine - or nominees of the Dean - to attend the Trust Board in an ex-officio capacity, and reciprocal arrangements should be established.
4. The relationship requires depth in commitment, and close working should be reflected at all levels of the organisation.
5. Local circumstances are the primary consideration when considering arrangements for managing the partnership between a university teaching hospital and medical school. Governance arrangements will necessarily differ, but a common framework should guide this approach.
6. The starting point for partnership at a local level is for partners to think through their shared objectives and to each sign a joint strategic commitment. This statement can be used to communicate purpose to a variety of stakeholders.
7. Signed frameworks of agreement between university and Trust are an essential mechanism for detailing the responsibilities of each party and should underpin the joint strategic commitment.
8. The most effective forums for developing joint working are those dedicated to specific shared tasks and functions. These are considered to be more effective than general liaison arrangements that are often difficult to focus on specific issues.

### Regional

9. A district and regional approach to planning and co-ordinating NHS/University relationships is important to maximise the contribution of academic activity. Academic clinical networks within regions, for service provision, research and education encourage and fully exploit the NHS/university partnership. Forums at a regional level help to provide opportunities for the co-ordination of service delivery, research and education policies.

10. Regional advisory groups for SIFT allocations should include NHS Trusts. Active engagement between the Region, medical school, and trusts should underpin service agreements.

#### National

11. The university/NHS relationship should be considered in its totality. While the Ten Key Principles emphasise the role of the NHS in supporting the academic mission, medical schools also have a role in supporting NHS responsibilities for delivering high quality service provision.
12. Ways of achieving greater financial transparency in the relationship of education, research and health service delivery remain a priority.
13. We welcome the recent emphasis on joined up policy. Government departments throughout the UK should ensure that there are effective mechanisms for the alignment of strategies for education, research and health services provision; this should be reviewed regularly interdepartmentally, and at the UK level to agree strategic policies and direction.
14. The third of the Ten Key Principles should be amended to read: 'The universities and the NHS have a shared responsibility for ensuring high standards are achieved and maintained in undergraduate medical and dental education, research *and service provision*'.
15. A UK forum for Academic Clinical Partnership is needed to bring together representatives of health service provision, education and research. It will identify bad practice and promote good practice; give a co-ordinated UK perspective on academic clinical partnership; allow NHS representation, and the totality of NHS/university relations to be addressed. It will also bring those who are operationally accountable together to facilitate the co-ordination and development of local strategies. A national forum will support a common framework for strategic development at the UK level.
16. The effectiveness of how local strategies and relations develop should be monitored and the Nuffield Trust survey repeated to measure progress in local governance.

### 3 INTRODUCTION

1. JMAC's report on good practice in university/NHS relations details the increasing tensions over recent years. For universities, the Research Assessment Exercise has highlighted and focused on the importance of research. During the same period medical schools have been addressing the recommendations of Tomorrow's Doctors with the need to develop and implement the new curriculum, including adaptation to changing patterns in health care and an emphasis on public health medicine, primary care and community medical services as well as specialist hospital-based services. Their NHS partners have been under pressure to meet growing service demands within national and local contract driven performance standards. Changes in postgraduate education have further increased the service delivery workload for Consultant Staff. The NHS has also seen an increased and changing emphasis on the approach to health service research following the implementation of the Culyer reforms.
2. The unique contribution made by medical schools and university teaching hospitals is in their dual and interdependent mission. Changes in the external environment have created incentives for organisations to pursue strategies that point in different directions. Both the NHS and universities are separately accountable and have differing priorities. The NHS is predominantly focused on service. Whereas in universities, the RAE, for example, has had a destabilising effect on NHS/university relations. At present, there are few incentives to align research, education and clinical service strategies. The RAE has shifted the emphasis between research and service and left the impression that the two missions are in conflict
3. The Nuffield Trust was invited to organise and host a meeting to discuss these tensions in more detail. To inform the meeting the Trust carried out a survey of relationships throughout the UK<sup>vii</sup> (the survey results are summarised in appendix four). The results confirm the perception that relationships are not uniformly good and highlighted a spectrum of relations more diverse than previously acknowledged. Meaningful cross representation is rare; half have no forum for consensual decision making, and a third have no mechanism for joint service review. Two thirds of respondents are considering ways to improve the relationship. The survey noted a number of initiatives to establish a joint approach, the strengths of which are perceived to be: better planning of the tripartite mission; more effective use of resources;~exploiting the full benefits of co-location - where this exists; to free up dedicated time; better planning of clinical provision. Representatives agreed that the NHS and Higher Education are interdependent and have a positive shared agenda. It was agreed to form a smaller, representative collaborative group<sup>2</sup> with the aim of considering a joint strategic approach and producing guidance for its translation into local relationships.
4. The group's natural reference for developing the interface was the Ten Key Principles. This report supports the emphasis given by SGUMDER's Second

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<sup>2</sup> The membership of the working group JS listed in appendix one


Report that 'liaison and consultation are not enough for effective collaboration. Both parties [should] recognise their unity of purpose and combine in a joint enterprise to achieve it'<sup>viii</sup>. It is a broader relationship than that implied by the Ten Key Principles. The NHS must support the academic mission, but the medical school also has an important role in supporting high quality NHS service delivery in university teaching hospitals. As such, joint planning should facilitate a shared strategy for research, education and health services. The Ten Key Principles need also to be considered in the changing context and priorities for Health and Higher Education.

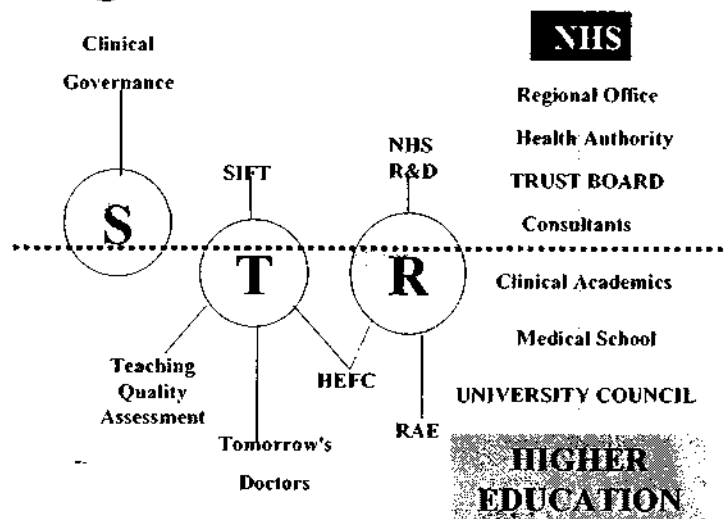
5. This report emphasises the rationale for joint planning for both internal and external constituencies. The interdependence of the two organisations requires the teaching hospital and medical school to plan and act together - in effect as one. They are partners with separate but overlapping agendas and with shared interests. The emphasis in this report is not a radical restructuring of local governance but on finding mechanisms to align clinical and academic objectives at local, regional and national levels.
6. The focus of this report is primarily on joint working between university teaching hospitals and medical schools. This cannot be achieved without an appreciation of the changing context. Of particular importance is the growth of academic activity beyond the confines of specialist centre and the need for medical schools also to work closely with providers of primary and community care. This report emphasises the importance of collaborative networks to harness academic clinical partnership and work across boundaries.
7. At the local level, the challenge for medical schools and university teaching hospitals is to develop the interface and establish an active dynamic between the components of the tripartite mission. The contribution of these centres is in providing a critical mass and integrated arena for research, education and health services.
8. This report makes some general assumptions based on the survey and our discussions. Partnership is essential. The performance and status of each is inevitably enhanced because of its close relationship with the other. Current arrangements for the interface do not adequately manage the tensions in the relationship, and change is required to facilitate a shared strategic and operational approach.
9. This report is divided into two parts, the first focuses on the managerial and cultural change required to support this vision and the second looks at the potential for a harmonised external context.

## PART ONE - EFFECTIVE LOCAL GOVERNANCE

### THE TRIPARTITE MISSION - COMPLEXITY AND INHERENT TENSIONS

10. Local tensions are inherent. Service provision, education and research compete for priority and are separately accountable. This makes the management of the tripartite mission an extraordinarily complex task. Figure 1 (overleaf) conceptualises the inevitable tensions in NHS/university relations. Either side of the dotted line, though tied together through a common mission, medical schools and university teaching hospitals are separately accountable. Effective governance will mean that partners jointly determine the appropriate position of the circles.

Figure 1  Tensions in NHS/University relations



## 5 THE VIRTUAL UNIVERSITY CLINICAL 'CENTRE'

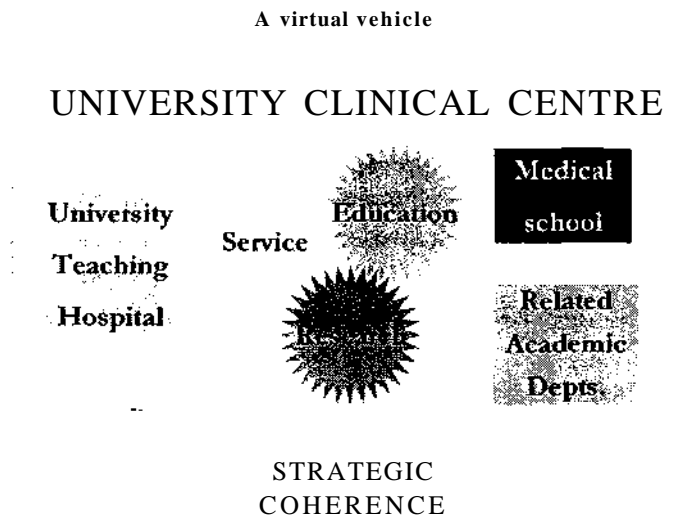
11. Medical schools and university hospitals are both independent and interdependent. This paradox is reflected by the introduction of a new term - Academic Clinical Centres. This term seeks to capture the pivotal contribution of university teaching hospitals, medical schools and other academic departments - for example, nursing - working in partnership. In order to manage the complexities of the tripartite mission, partners need to recognise their shared agenda and combine in a joint enterprise to meet it. The term is also introduced to capture the complexity and necessity of managing the tripartite mission across organisational boundaries.

12. Management of centres is complex, the tensions inherent in this environment rarely exist in other contexts. These tensions have been accentuated by an increased demand on the service contribution of clinical academics. At the same time, research has become more important to the financial position of the medical school. The level of service provided by clinical academics, the teaching contribution of NHS consultants, and the nature of interdependence is perhaps not

- widely appreciated. In its service provision a university hospital must take into account the impact on its day-to-day operations of clinical academic departments, which from time to time may have different priorities and special interests that may not always coincide. The close proximity of a university hospital and its medical school imposes managerial challenges that are different in character from those experienced by other NHS providers.
13. The complexity within the university clinical mission stems from the interdependence of the tripartite mission. Paradoxically, this is also the cause of the major value that they add. Education of high quality is possible where there is high-quality patient care. Innovation and improvement can only take place in an environment where existing care techniques are continually challenged by new knowledge and its applications. If the ability of university hospitals to provide quality service diminishes, this will inevitably harm the educational and research mission. Likewise, deterioration in the ability of academics to sustain leadership in education and research will inevitably undercut the quality and range of patient service that can be provided.
  14. University Clinical Centres have been at the forefront of advances in health services, translating laboratory and clinical research into advances in patient care and disseminating changes in clinical practice through their educational role. For example, many traditionally specialist services are now delivered at district general hospitals. Centres need to have a joint focus in terms of the best way of promoting their pivotal and unique contribution to the health sector. Centres, as a consequence of having a critical mass of expertise, have an important role to play in the *New NHS* quality agenda. Clinical governance, in particular, provides an opportunity to demonstrate added value.
  15. University hospitals working in partnership with medical schools contribute much through complex treatments and procedures, and in introducing and evaluating new technology. They provide important standby services such as emergency, burn and trauma care, and provide for patients with rare or complex diseases. They also make long-term contributions through research and development and through training programmes for the new generations of health professionals.
  16. Co-operation makes an important contribution to regional and national economies. Centres are major employers, and investment in university clinical centres produce innovations that generate wealth and make a positive contribution to UK pic. It is critically important that the maximum return is reaped from the significant investments made in service development, research and training
  17. Figure 2 (overleaf) conceptualises the University Clinical 'Centre' joint venture. A University Clinical Centre is a virtual body, and its composition beyond the core members of university hospitals and medical schools hospitals is flexible. The NHS is changing rapidly and it may be that other departments such as economics or epidemiology will become more active in centres. The term 'centre', should not, in this context, relate to a physical or centralised body. It is a virtual body and does not necessarily require co-location of its members, although in many circumstances this will be the case.


18. Conceptualising centres in this way allows the pivotal contribution and special character of these centres to be recognised both externally and internally. This is important for three reasons. 'Centres' will allow a recognition of the unique challenges of the tripartite mission: delivering high volume service with a complex case mix, training the next generation of clinicians and developing knowledge and the evidence base within the NHS. Secondly, it is an important cohesive concept for the components of the academic centre that will aid recognition of common purpose at all levels. The 'centre' will allow partners to speak with one voice on common strategic issues without prejudice to matters that are the prerogative of each organisation. Thirdly, it is important to formalise the management of academic clinical partnership to ease the linkages between the tripartite mission and catalyse innovation.

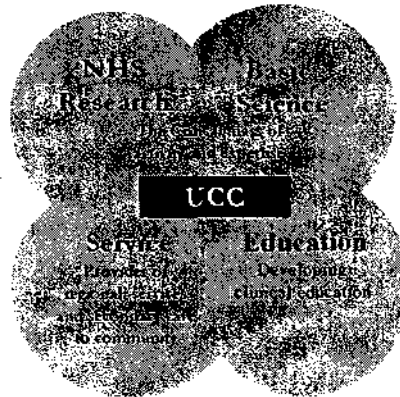
Figure 2  The University Clinical 'Centre'



19. University teaching hospitals and medical schools need to commit themselves to partnership and to get the relationship right to deal with tensions between the academic and clinical missions. Teaching hospital and medical school objectives are separate but interdependent; decisions taken by one organisation have an impact on the other. In partnership, they make a unique contribution as a university clinical centre by providing the primary site for education and research, comprehensive secondary care to the community, and tertiary care to the region and beyond. In partnership teaching hospitals and medical schools will be more effective if they can speak with one voice to the local health economy. It is imperative that University Clinical Centres establish partnerships with Primary Care Groups, and with Primary Care Trusts as they develop, to overcome interface difficulties between primary, secondary and tertiary care.

20. Figure 3 shows the contribution of the 'Centre' to the academic clinical network in its linkages and the dynamic between education, research - health services, clinical, and basic biomedical research - and health service delivery. The challenge is to integrate the circles where they overlap and to ensure a dynamic flow between them.

Figure 3  The contribution of the University Clinical 'Centre'




The challenge is to effectively manage the overlap between the circles, and to fully demonstrate the value added by a University Clinical Centre

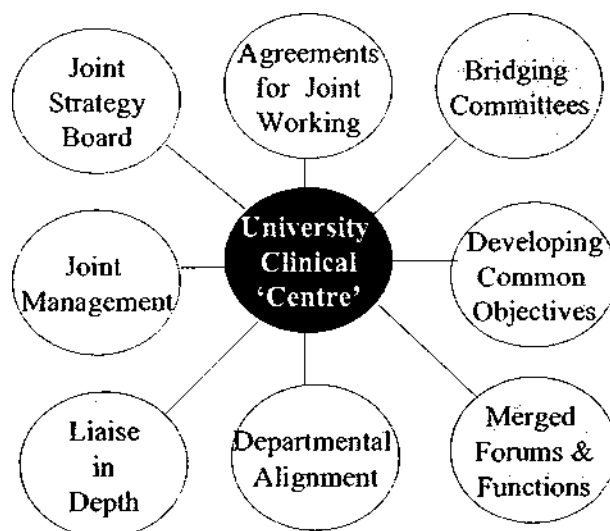
21. The overlapping interests of the medical school and teaching hospital require a delicate balance in protecting the individuality of the organisations, while recognising that objectives cannot be pursued without partnership. The key components of University Clinical Centres need to demonstrate unity, adopt a common strategic approach and demonstrate this internally and externally. The starting point of a joint approach should be to establish the shared agenda.

## 6 DEVELOPING JOINT WORKING

22. Local circumstances are the primary consideration when developing arrangements for consensual decision-making, but a common framework should guide these choices. Figure 4 shows a variety of mechanisms to support joint working. Elements might be combined and piloted, or change introduced unevenly. One possibility might be to consider joint activity in which both organisations have a shared interest. Another is to take a department by department approach.
23. It is not our intention to be prescriptive about the forms of local governance. Local circumstances and culture predominate. In the U.S. it is commonly stated that 'if you've seen one Academic Medical Centre, you've seen one Academic Medical Centre. The same might be said of centres in the UK, though there is a fundamental framework within which local relations should be strengthened.
24. A striking feature of the Nuffield Trust Survey is the correlation between good relations at the interface and the commitment to joint working and common objectives by individuals in leadership positions. A variety of successful mechanisms for effective governance can be identified, but each will only be as effective as the underpinning organisational culture promoted by senior management. Partners must recognise their unity of purpose and combine to achieve it.



Figure 4  Local options for supporting the vision



### **i. Cross Representation**

25. University membership at board level is the distinguishing feature of a teaching trust. The non-executive role is not 'narrow' as a university representative; it is a corporate responsibility representing the special interest of the partnership, bringing a particular set of skills to the NHS board. University teaching trusts should invite deans of medicine, or nominees of the Dean, to attend the Trust Board in an ex-officio capacity as observers, and reciprocal arrangements should be established. This is not simply a case of *quid pro quo* but reflects the need for discussions and the formulation of strategy to be enriched and improved by inputs from the partner perspective.
26. Relying solely on formal arrangements for cross representation at board level is unlikely to be sufficient. Effective cross representation requires forums for collaborative problem solving. Cross membership of decision making committees are needed at all levels, particularly executive management bodies.
27. Opportunities for reciprocal arrangements for the NHS to be represented in the university (eg: on curriculum committees) are few. The governance of the university should ensure that there are mechanisms for members of the NHS to be appointed.


### **ii. SIFT**

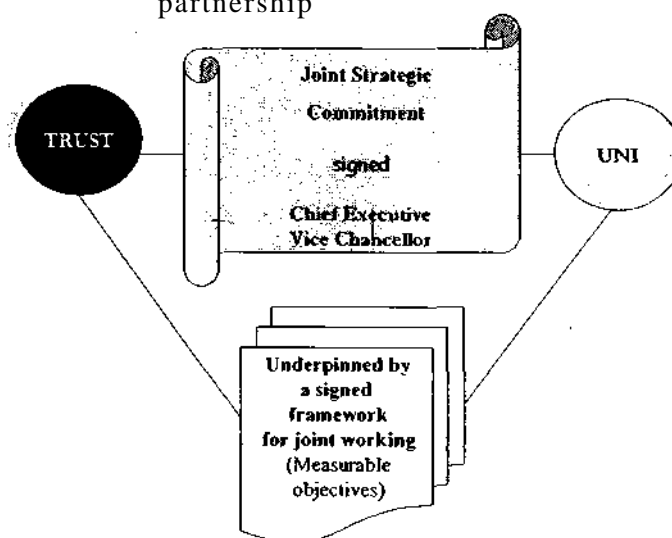
28. The significant costs incurred by university teaching hospitals through close association with medical schools have not been itemised. It has proved difficult to disentangle the financial components of knock-for-knock and SIFT. SIFT compensates the NHS teaching trust for the additional patient care costs of being a major teaching centre, it is not a payment for teaching - which is recovered

through knock-for-knock. There is a need for clarification of knock-for-knock and a tighter definition of the components of SIFT. Ways of achieving greater financial transparency should be explored. It is important to establish whether the excess service costs - including capital arising from teaching and research - incurred by university teaching hospitals are met by SIFT at its current level.

### iii. Developing common objectives

29. The absence of a common mission was the most commonly cited fundamental obstacle to developing closer working and partnership in the Nuffield Trust Survey. Partners need to think through their joint objectives. Statements outlining joint strategic commitments can be an effective managerial tool.
30. Figure 5 outlines the framework for the process of developing a shared objective. The purpose of a joint venture should be embodied in a statement of common strategic objectives or mission. In the Nuffield Trust survey, the absence of an explicit shared agenda was the most commonly cited fundamental obstacle to joint working. These statements communicate purpose to a variety of stakeholders including the local health economy, executive management, politicians and local communities. The statement needs to be clearly defined before considering governance arrangements to support it. In the US the development of mission statements has been an important process in the ownership and establishment of joint working. A mission statement is developed through active engagement with staff and regularly reviewed. The phrase mission management in the U.S. reflects a move from 'apple pie' statements to ones that are measurable and can guide a joint approach. Measures to monitor performance against the statement can also be developed from a signed agreement underpinning the statement. A framework agreement between the University of Birmingham and University Hospital Birmingham NHS Trust serves as a basis for joint working . The agreement is signed by the Vice Chancellor and trust's Chief Executive. It covers the breadth of joint service, teaching and research interests.


Figure 5  Developing and communicating partnership

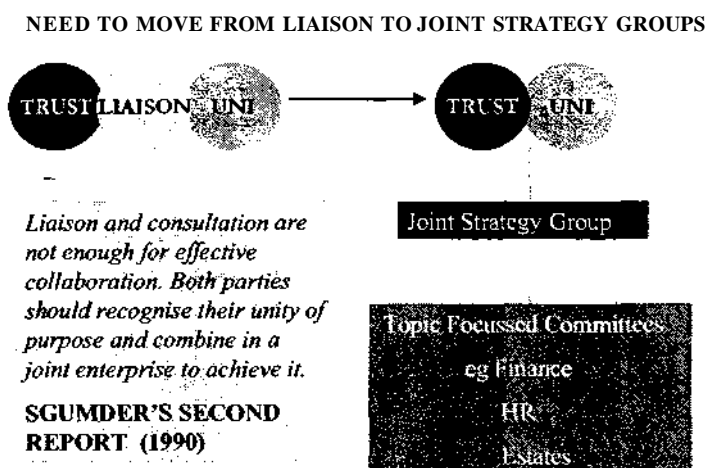


The framework for agreement at Birmingham is reproduced in appendix three

#### iv. Beyond liaison

31. Experience suggests that the most effective relationships result from building representation around specific tasks and functions. Functional and issue-based joint committees provide a more effective forum for a collaborative approach to strategy than one single all-embracing liaison committee. Liaison committees create an entity - or buffer zone - between the organisations and are difficult to focus on specific problems. Problems are more effectively addressed through joint forums serving as a bridge between the teaching hospital and medical school.
32. Figure 6 illustrates the transformation of liaison groups to a more direct managerial link by providing a strategic forum and developing direct 'bridging' links between the two organisations. Senior management serving in liaison groups can be an effective focus for strategic liaison. A regular meeting bringing together NHS and University staff from related speciality areas can help to prevent friction between the two sides. These groups should be representative and provide input into the general management structures. Direct bridging links, achieved through topic focused committees, can be created around common functions such as finance, estates or employment issues.

Figure 6  Depth in partnership - beyond liaison



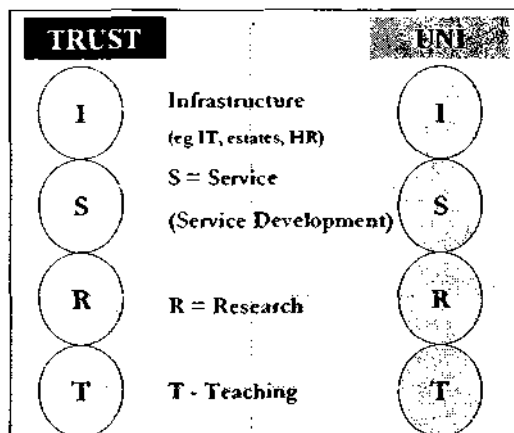
#### v. Bridging management structures

33. Figure 7 (overleaf) shows bridging committees between organisations focused around overlapping issues on the shared agenda. The challenge is to avoid impotent buffer zones. These committees should align strategy, priority and operational decisions. There are various successful examples of where this works effectively.
34. It is important to work towards gaining explicit recognition of responsibilities of staff to either mission. Clinical academics have a service obligation in their honorary contracts, but teaching sessions for NHS staff are rarely fixed sessions. Job plans should offer clarity of obligation while avoiding rigidity.

35. Forums focusing on a review of clinical service have been successful in gaining a better understanding of individual services, informing short-term strategic decisions and informing each other's strategy.

Figure 7  Aligning priorities

(Integral to the organisational structure, the committees share information and bring accountable individuals together)



36. There are some very good examples of collaboration in the management of research, through collaborative committees or joint offices for R&D. The Medical School has a real say in the allocation of funds and the Trust benefits from focused and dynamic research that is fed back into service. Where collaboration has been achieved so have effective systems of financial allocation.
37. Research Consortia facilitate multi-collaborative approaches to research between the NHS and the university. In Dundee, as part of the Tayside Consortium, the Trust attempts to recruit research-active clinicians. Additionally the Chief Scientist in the Scottish office annually issues guidelines to the NHS which assist in the objective of joint research. This approach offers the Trust and the University the opportunity to develop an overt plan, under the direction of the head of the research consortium, for the allocation of research monies.
38. Some Trusts have benefited from appointing full or part-time Directors of Clinical/Medical Education. Clinical Curriculum Committees can support this function through, for example, working parties in the various specialities, each of which has strong NHS representation. These play an important role in determining SIFT allocation within the Trust.

#### vi. Clinical and Academic Departments

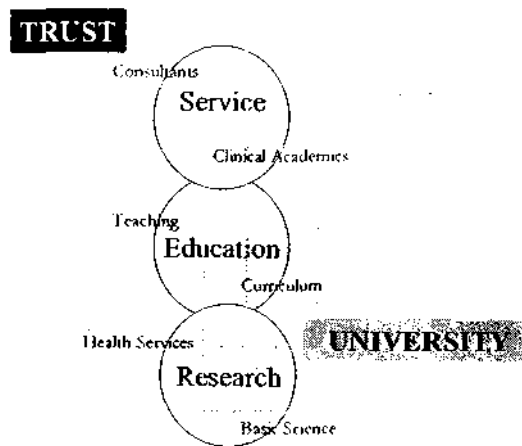
39. In some centres clinical and academic departments are merged. There should not be any rigid separation between clinical service departments and university departments in any one specialty, area but these departments are often not coterminous and separation can be beneficial. The departments interface over the common agenda. University staff should be full participants in the clinical service

department relevant to their sub-specialty. There is no 'one size fits all' model for internal governance, but consistency is needed between the university and NHS departments.

40. Figure 8 attempts to illustrate an alignment of clinical and academic interests. It shows the differing objectives between the two organisations, the challenge is to make the circles whole. Departments should organise according to their shared agenda. Objectives are complementary rather than merged. Individuals should be apportioned responsibility for feeding back the research and education agenda to the clinical department.

Figure 8  Aligning departments

(Interface over the shared agenda)



41. Perhaps departments will be less easily defined in the future, and groupings will be increasingly multi-disciplinary. The intention is to align clinical and academic resources for maximum impact, management should ensure that research, education and health service delivery is aligned at departmental level. It is important to recognise the differing objectives but to ensure mechanisms for joined-up management across the organisational boundaries. Departments should interface over the common agenda and ensure coherence between service provision, education and research priorities.

### vii. Aligning management functions

42. Bridging forums have the potential to create managerial forums that work across both organisations. Figure 9 (overleaf) shows these forums as developing and effectively taking management decision on behalf of the two organisations. Examples of aligned managerial forums include staff appraisal, the administration of research, or on an integrated site, estate management. There are good examples of joint working in research management. For example, there are gains to be made in commercial research. As with much of the shared agenda, partnership is incremental and should develop from this point. Developing an interface between pre-clinical and applied research is a very important step.



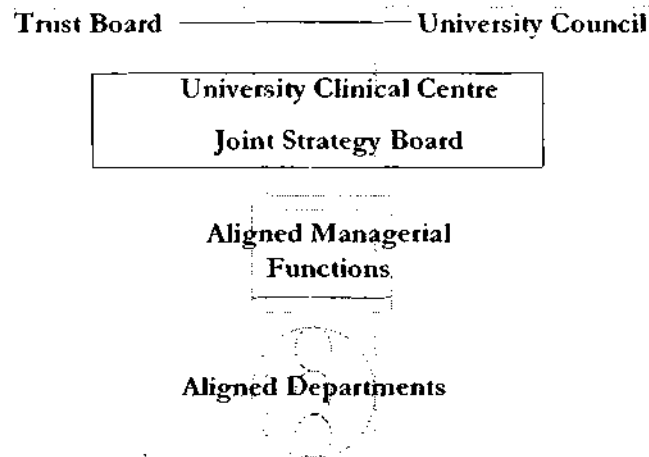
Administration	<u>Potential Collaborative                  Forums/Functions</u> <ul style="list-style-type: none"> <li>• Clinical Governance/Audit</li> <li>" Communications</li> <li>" Joint Appraisal</li> <li>• Estates</li> <li>• Information</li> <li>• Research Administration</li> </ul>
Education	
<b>UNIVERSITY CLINICAL CENTRE</b>	
Research	
Information	
Administration	

43. JMAC noted the success of the joint working group at King's College London. The SIFT contract developed at King's covers the requirements of the various specialities, the input from teaching staff required, accommodation needs, appropriate case mix, patient throughput and other support services such as library, diagnostic investigation facilities, medical records, information systems, educational services, clothing and equipment, and administrative structure. The monitoring of this service provision is currently undertaken by means of biannual questionnaires to teaching staff enquiring whether the service support for their teaching and data from the casemix office meets their needs. Any problems are dealt with through the SIFT contract manager of the Trust. Service agreements are being developed with each individual care group. There is also an agreement that the clinical placement SIFT revenue will be distributed to the care groups in proportion to their actual teaching activity so that resource follows the student.

**viii. Joint Strategy Board**

44. The establishment of a common strategy board is a mature point in establishing strategic coherence management, but can only effectively emerge once the culture has developed towards collaboration among a number of key functions. Separate accountabilities remain for the NHS and university, but strategic planning at this level may mitigate many of the tensions. There are clear divisions in responsibilities, and executive management bodies will remain separate. The joint strategy board is a unified body to jointly plan and manage the shared agenda. The bridging committees or aligned managerial functions will report to the strategy board who will oversee the development of joint working. Its principal aim is to ensure strategic coherence and effectively to manage a dynamic integration of research, education and health services.

Figure 10  Joint Strategy Board



#### ix. The matrix model

45. The majority of international examples of joint working are in North America where several approaches to joint management of the academic/clinical interface have been adopted. Examples were very useful for thinking about the UK situation, and offer some valuable perspectives, but they are not directly applicable to the British context. The matrix model approach in Amsterdam is an interesting and effective model of joint management, and operates within a nationalised health service.

46. The matrix model of joint governance has been introduced at the Academic Medical Center at the University of Amsterdam. It is cited here only as an example of an innovative attempt to harness destructive tensions into a positive dynamic. One of the key components of the successful introduction of the matrix model in Amsterdam was preparation. Both organisations restructured prior to the introduction of joint management to ensure a smooth transition. The structures were redesigned in each institution so that each of their functions could be fitted together into a matrix model of joint management. Figures 11 and 12 show the restructuring of the university hospital and faculty of medicine a year prior to the introduction of joint management. The hospital organised into 10 directorates and the faculty of medicine into seven research and three education institutes.

47..

Figure 11 The matrix model of joint management  
 (1) The Hospital

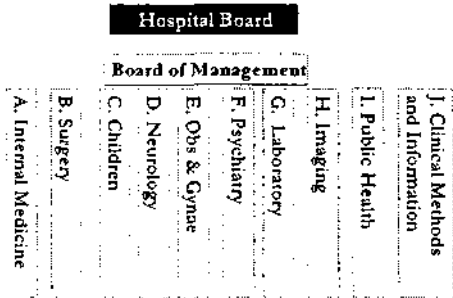


Figure 12 The matrix model of joint management  
 (2) The Faculty of Medicine

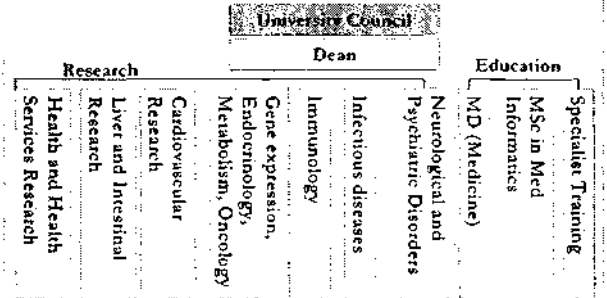

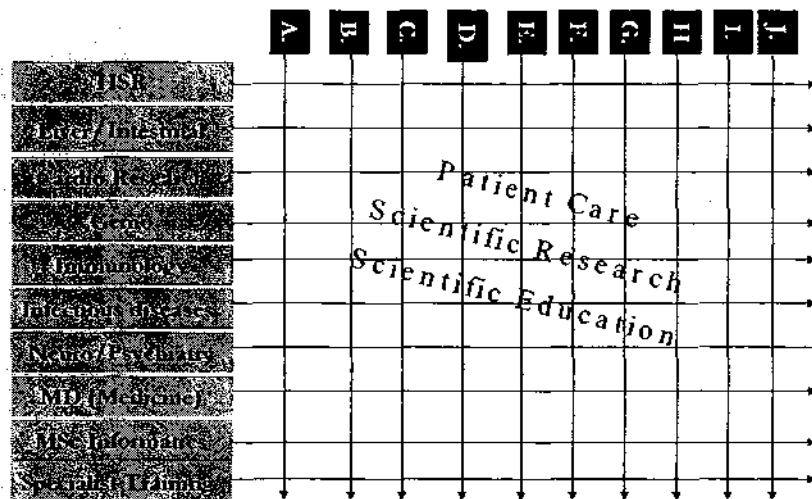


Figure 13  The matrix model of joint management  
 (3) Common Management Board





## **PART TWO - DEVELOPING A COMMON EXTERNAL FOCUS**

### **7 THE CHANGING ENVIRONMENT**

48. There are a number of changes in the external environment that offer both challenges and opportunities for the alignment of Academic and Clinical objectives.
49. There is a need to marry up the R&D (NHS) and RAE (University) objectives. At the root of increased tensions in recent years are the conflicting objectives of research strategies. In the competition for research funds, universities have adopted strategies that focus on their strengths, particularly basic science. This has had the effect of destabilising essential service provision by clinical academic staff. There have been few incentives to prevent separation between service and research priorities. There is a perception that the RAE has downgraded clinical research and there is a need to re-establish its credibility. How this is seen in the next RAE will be defining, it is an opportunity to align the two research agendas.
50. 'Centres', as a consequence of having a critical mass of expertise, large volumes and integrated academic and clinical missions, have an important role to play in the *New NHS* quality agenda and in developing the implementation of new initiatives. The emphasis in the *New NHS* is on continual quality improvement. The aspiration is to develop knowledge-based learning organisations with 'an open and participative culture in which education, research and the sharing of good practice are valued and expected'<sup>11</sup>. Increasingly, NHS providers will be accountable for the management of information and an evidence base. Accountability by NHS Trusts and specifically on Chief Executives for the quality of service will ensure that there are systems in place to assure appropriate care and access to, and systems to manage, evidence and information. University hospitals and medical schools working in partnership have a special contribution to the development of these systems and are standard-setting arenas for high quality clinical care. These centres have a leading role to play in a knowledge based NHS, as both a critical mass of expertise and activity, and as an arena in which there is a dynamic between education, research and health services
51. The aspiration of partnership requires a change in culture. There is a need to avoid fragmentation and harness the benefits of an academic clinical partnership through networks for service and research, along the lines of the educational networks that are developing following the diffusion of student placements.

### **8 DISTRICT AND REGIONAL ALIGNMENT: ACADEMIC CLINICAL PARTNERSHIP**

52. One of the consequences of the 1991 NHS reforms has been the creation of an environment in which there are few incentives to adopt a regional approach to planning. In effect, competition between providers has fragmented the concept of the NHS as a total entity.

53. There is a need to distinguish between NHS Regions and regional networks of activity. There is also a need for partnership at sub-regional level, but often across health authority boundaries. Although districts are no longer formally defined, they better describe the geographical boundaries of typical catchment areas. It is difficult to find a term that directly captures the situation across the UK. There is little uniformity in either regions or countries. In the Eastern region, for example, there is only one University Clinical Centre, and the networks will be essentially regional. In Wales the situation is more complex. The College of Medicine in Cardiff places its students throughout Wales, and its educational network is essentially national. Research networks in Wales are regional, though the College is involved with each, and its service network is district wide, predominantly within south-east Wales. In London, the situation is more complex with a number of centres within one region. In Trent, there are three medical schools (Sheffield, Leicester and Nottingham), although each has well-defined areas of activity, clearly some activity will flow across boundaries. The term *district* is not a 'catch all' term; it is used here to describe sub-regional catchment areas of service, research and educational activity.

54. Because health authorities no longer have discretion over the funding of SIFT and R&D money to providers, there is a perception that they are no longer directly engaged with the academic mission and are slow to appreciate university hospital roles in education and research. However, although they will no longer commission services directly, they will have strategic responsibility for planning the delivery of health care in their areas, working closely with NHS Trusts, Primary Care Groups and academic and research interests, and they will allocate resources to PCGSs. Indeed, Health Authorities that have Trusts with significant teaching responsibilities in their areas have university nominees on their Boards. They will therefore continue to have an important role in ensuring:


'That the contracting environment is meeting the longer-term needs of teaching and research whilst at the same time securing an efficient and cost effective service'

(JMAC Report on University/NHS Interactions, 1995)

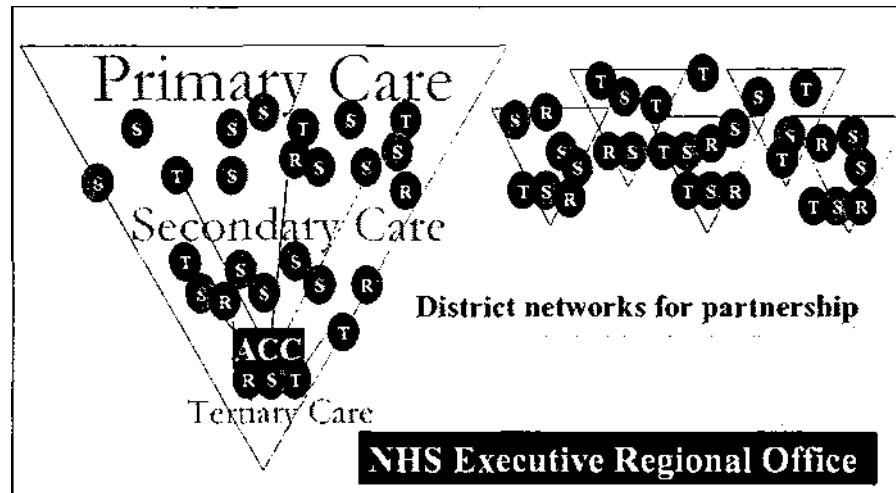
55. In Wales, Health Authorities have a clear strategic role in relation to training and research. For example, they distribute SIFT allocations and are co-signatories of the Educational Agreements. But even if health authorities have no discretion in the fund allocation process, the involvement of health authorities in academic clinical networks and regional discussions, is important to give a greater understanding of the various pressures competing for the time and resources of the Trusts to which they relate.

56. It is our view that the growth of academic activity outside university teaching hospitals and in the primary care sector should be both encouraged and better harnessed. There is a need for collaborative networks to harness these efforts. While academic activity is growing beyond the University Clinical Centre, these centres make an important contribution to the network as a critical mass.

57. There is a role for a forum that provides an opportunity for the co-ordination of strategy. District forums attended by health authorities, medical schools, NHS trusts and Primary Care Groups help strengthen NHS/university relations by promoting:
- Close working relationships
  - Joint working over R&D
  - Developing supportive relations over the curriculum
58. A regional perspective is important in understanding the unique role of the university teaching hospital/medical school mission. In some, but not all regions, a closer relationship with the Regional Office has been established to discuss and determine the allocation of SIFT, and to develop better consultation between the NHS teaching trusts and medical schools.
59. It is not our intention to be prescriptive about the managerial arrangements that exist at regional level. Each region will operate in ways relevant to its environment and circumstances. It is not necessary for Regional Offices to attempt to manage relations across the region. Regions should actively promote a culture conducive to a networked, joined-up approach across districts. The NHS Executive South East region, for example, encompasses both Southampton and Oxford, which clearly operate within different districts while sharing the same region. There should be a formally agreed mechanism for bringing together, within the region, the senior representatives of the major interested parties at least once a year.
60. Advisory groups for SIFT operate at Regional level. This ensures a discussion amongst all the key players: from the regional office, medical School, teaching hospitals and primary care groups. It is clear that such involvement of all the key groups is not uniform across the regions. Active engagement between Region, Medical Schools and Trusts should underpin the allocations. Contracts that are more prescriptive in ensuring that the resource is used for expenditure relating only to teaching create more transparency in the use of the resource.
61. Figure 14 lays out the framework for alignment at the district and regional level and the network relationship to the Regional Office. The Academic Clinical Partnership aims to harness regional activity in education and research. In many areas local networks will clearly not be as neat, nor in some cases as complex, as the one modelled. The intention-is to conceptualise partnership within networks of activity within the boundaries of the research, service and educational activity of any academic clinical centre. Postgraduate Deans have an important role in strengthening district-wide academic clinical networks and engaging with other providers.

Figure 14  A regional approach to Academic Clinical Partnership

Co-ordinating research, service and education




62. A planned network for service is a logical progression for a more planning orientated NHS. There are important reasons why a network view should be taken. Evidence is emerging that tertiary referrals to specialist centres in university teaching hospitals are increasing as clinical risk becomes a more important factor, the Audit Commission's report *Higher Purchase* recommends that specialist services should be mapped on a regional basis.
63. The continuing trend of placing students away from the main teaching hospital further reinforces the need for a holistic, network view, particularly in curriculum development and for SIFT allocation. There is also the potential for research networks and resources to be effectively harnessed.

### National Alignment

64. Government and interdepartmental alignment of strategies for health service provision, education and research should be reviewed annually at UK level to agree direction, and priorities. The partnership between the sectors of health and education should be reinforced at every level to mitigate the inevitable tensions between the university and NHS missions.
65. In this context, the group recommends that the third of the Ten Key Principles is revised to not only to reflect the responsibilities of the NHS towards education and research, but also the responsibilities of the university to support the provision of high quality health service provision.
66. A UK-wide forum for a University Clinical Partnership would help alleviate the pressures at local level. This body would bring together chief executives of university teaching hospitals, the NHS executive at a central and regional level,

and the heads of medical schools. The creation of a forum for chief executives of university teaching hospitals has provided a step towards its achievement.

67. A UK focus for the group is critically important. Many of the bodies concerned with aspects of NHS/university relation are in fact focussed on individual nations. The unique challenges of the academic clinical partnership require a problem sharing and solving forum that encompasses all parts of the UK. In our discussions, colleagues from Scotland, Wales and Northern Ireland have made it clear that, from their perspective, it is imperative to harness a UK focus.
68. Bodies that address NHS/university relations tend to focus on aspects of the problem. Issues around service provision, particularly, are less prominent in this agenda. There is a need for the parties who are operationally responsible for the successful management of the tripartite mission to take a strategic approach at UK level, to both guide and represent the development of local University Clinical Centres.
69. There is a need to review the overlaps and linkages of the current bodies whose remit is to address aspects of the NHS/university relationship (Appendix 5 contains a summary of current bodies whose remit is to consider aspects of the NHS/university relationship). There is a case for a UK forum for Academic Clinical Partnership and for considering whether there is a need to rationalise other existing bodies at the national level that address the NHS/university interface.

Figure 15  A UK forum for strategic  
and operational coherence

**NATIONAL FORUM FOR ACADEMIC  
CLINICAL PARTNERSHIP**

Provide a UK perspective to NHS/University relations


Share bad practice and promote good practice

Co-ordinate and promote development on the  
totality of NHS/University interactions

Give strategic coherence to joint working and bring  
operational partners together

70. The terms of reference for a national forum will be more fully informed following a review of how aspects of the relationship are currently managed by existing bodies. Figure 15 outlines the roles that exist for a national forum in: harnessing a UK approach, supporting a framework for strong local relations, providing a forum for identifying bad practice, and promoting good practice and to represent and develop Academic Clinical 'Centres'.

71. Figure 16 summarises the strategic direction proposed in this report. The figure conceptualises our aim to make education, research and health services strategically and operationally coherent. The box represents the connections between national, regional, district and local planning.

Figure 16  The vision  
Alignment of NHS/University Objectives



## 9 Conclusions

72. This report follows a meeting held at the Nuffield Trust in autumn 1998 to address tensions within NHS/University relations, and has been endorsed by a second meeting of this steering group. A survey of UK relations, undertaken to inform discussions, revealed that two-thirds of respondents were thinking about ways to improve relations. This report makes recommendations to align NHS and university strategies at national, regional and local levels. This report recommends national alignment of strategies and objectives to provide a framework and incentives for academic clinical partnership. At a local level it has not been the group's intention to identify a uniform model to fit every institution across the spectrum of NHS/university relations; relationships will vary for reasons relevant to the local situation. There are, however, common features of joint working that centres should demonstrate.

## References

- <sup>1</sup> Dainton, Sir Fred (1981) 'Reflections on the universities and the National Health Service', Nuffield Provincial Hospitals Trust, London
- "The UK higher education funding bodies' Joint Medical Advisory Committee (1995) 'University/NHS interactions', March 1995

<sup>III</sup> Report on good practice in NHS/academic links, (a study by the Health Services Management Unit, University of Manchester), Joint Medical Advisory Committee of the UK higher education funding bodies, March 1999

<sup>IV</sup> Joint Department of Health/Higher Education Funding Council for England task group (1999) 'Developing a joint university/NHS planning culture'.

<sup>V</sup> SGUMDER (1990) Second Report of the Steering Group on Undergraduate Medical and Dental Education

<sup>VI</sup> SGUMDER (1996) Fourth Report of the Steering Group on Undergraduate Medical and Dental Education

<sup>VII</sup> Nuffield Trust survey of teaching hospital Chief Executives and Heads of Medical Schools, The Nuffield Trust, November 1998

<sup>VIII</sup> SGUMDER (1990) Op Cit

<sup>IX</sup> NHS Executive (March 1999) 'Clinical Governance: quality in the new NHS'





## **APPENDIX ONE**

### **MEMBERSHIP OF THE WORKING GROUP**

John Wyn Owen (Chair)	Secretary Nuffield Trust
John Ashbourne	Chairman University Hospital Chief Executive Forum
Professor Colin Bird	Dean of the Faculty of Medicine Edinburgh University
Professor Sir Cyril Chantler	Vice Principal King's College, London
Alec Cumming	Chief Executive Aberdeen University Hospitals Trust
Tim Matthews	Chief Executive Guys & St. Thomas' NHS Trust
Dr Jonathan Michael	Chief Executive University Hospital Birmingham NHS Trust
Professor Eric Thomas	Dean of the Faculty of Medicine, Health and Biological Sciences Southampton University
Professor Stephen Tomlinson	Dean of the Faculty of Medicine, Dentistry and Nursing Manchester University
Michael Powell	Executive Office, Council of Heads of Medical Schools
Tom Smith	Associate Nuffield Trust



## **APPENDIX TWO**

### **THE TEN KEY PRINCIPLES**

#### Strategic principles

- i. The aim of undergraduate medical and dental education is to produce doctors and dentists who are able to meet the nation's present and future health and health care needs. To this end, doctors and dentists should be educated in an atmosphere of intellectual enquiry and innovation based on active research and development programmes.
- ii. The objective of medical and dental research is to maintain and improve the nation's health and health care by contributing to the promotion of health and the understanding of disease.
- iii. The universities and the NHS have a shared responsibility for ensuring high standards are achieved and maintained in undergraduate medical and dental education and in research.

#### Operational principles

- iv. The provision of undergraduate medical and dental education and research, guided by clearly defined and co-ordinated national policies, must be supported by effective joint planning at regional and local level.
- v. Universities, health authorities, trusts and, where appropriate GP fundholders, should share relevant information and consult one another about their plans. Once agreed, policies and plans should be disseminated locally and reviewed regularly.
- vi. The NHS and universities should consult one another about the special interests and contribution to service, teaching and research of senior medical and dental appointments.
- vii. Where agreement cannot be reached locally, the NHS Executive Regional Director and the Vice Chancellor of the University should confer.

#### Funding principles

- viii. The NHS and universities should ensure that undergraduate medical and dental education and research are undertaken efficiently and cost-effectively.
- ix. The universities and NHS should work closely together in funding research and development within the NHS in England.
- x. SIFT should be allocated on the basis of mutually agreed service plans to support teaching. Universities should be joint signatories to all SIFT contracts.



## APPENDIX THREE

### FRAMEWORK OF AGREEMENT FOR JOINT WORKING BETWEEN THE UNIVERSITY OF BIRMINGHAM AND THE UNIVERSITY HOSPITAL BIRMINGHAM NHS TRUST

The University of Birmingham and the University Hospital Birmingham NHS Trust agree to work jointly and collaboratively to achieve high quality clinical care, teaching and research in medicine, and where appropriate to the University Hospital Birmingham NHS Trust, in dentistry and health sciences.

These aims will be pursued through joint planning as proposed in the Ten Key Principles of the France Report (attached) and also in the context of the SIFT contract between the University of Birmingham, the NHS Executive West Midlands and the University Hospital Birmingham NHS Trust.

To this end:

1. The University of Birmingham undertakes to
  - (i) Identify the number of students each year to be allocated clinical placements at the Trust according to year, specialty, subject and location (Schedule 1).
  - (ii) Liaise with the Trust about any significant changes in student numbers, specialty and location, normally giving a notice period of twelve months.
  - (iii) Provide facilities for collaborative research projects as agreed with the Trust (Schedule 2).
  - (iv) Deploy an agreed number of University-employed clinical academic staff at the Trust to agreed levels of service, teaching and research, within clinical job plans agreed with the Clinical and Medical Directors of the Trust (Schedule 3). The latter will include a named individual responsible for ensuring that work patterns are properly covered, both annually and sessionally.
  - (v) Ensure that University-employed clinical academic staff observe Trust management arrangements, clinical standards, policies and procedures while involved in clinical duties.
  - (vi) Consult the Trust about changes in the establishment of University funded, University-employed staff that might affect clinical services. Where possible, a notice period of a minimum of three months will normally be given for departing staff, and six months for incoming staff or amendments to existing contracts.
  - (vii) Provide honorary University contracts to NHS clinicians in respect of agreed teaching commitments.

- (viii) In consultation with the Trust, keep under review the staff development and training needs of academic staff, and of NHS staff with regard to honorary teaching commitments, and take appropriate action where performance of these staff in clinical teaching is unsatisfactory (Schedules 4 and 5).
  - (ix) Provide for an agreed number of nominations by the University Hospital Birmingham NHS Trust to appointments committees and electoral boards for academic staff for whom honorary clinical contracts will be sought from the University Hospital Birmingham NHS Trust.
  - (x) Maintain a code of practice in relation to the conduct of clinical activity on University-premises by clinical academic staff.
2. The University Hospital Birmingham NHS Trust will:
- (i) Provide clinical placements for an agreed number of students according to year, specialty and location (Schedule 1).
  - (ii) Provide appropriate support facilities and a suitable clinical environment for research (Schedule 2).
  - (iii) Inform the University of any changes in service provision which may affect the education of undergraduate students or programmes of research (Schedule 6). Where practical a minimum period of three months notice will be given of such changes. .
  - (iv) Provide facilities to support clinical placements such as appropriate casemix, teaching space, and equipment (Schedule 6).
  - (v) In collaboration with the University, ensure that NHS staff involved in teaching have appropriate training and maintain jointly agreed standards of quality (Schedules 4 and 7).
  - (vi) Invite nominations by the University Trust Appointments Committees for consultant medical staff (one clinical member of University staff).
  - (vii) Identify teaching commitments for those consultants and junior staff involved in teaching undergraduate medical students..
  - (viii) In consultation with the University, take appropriate action where the clinical performance of University-employed staff is unsatisfactory (Schedule 3).
  - (ix) Undertake to maintain the agreed space requirements for standard teaching accommodation (Schedule 6).

3. The University of Birmingham and the University Hospital Birmingham NHS Trust will together:
- (i) Work in the pursuit of the highest possible standards of clinical patient care, undergraduate and postgraduate medical education, and research and development.
  - (ii) Agree annually a list of Trust-funded, University-employed staff. Any additions or amendments to this list will be made according to the procedures outlined in the Agreement for the Support of Posts (Schedule 8);
  - (iii) Agree job descriptions and the availability of clinical facilities for all University-employed staff for whom honorary clinical contracts are sought, before posts are advertised. The number of sessions available for clinical service, teaching and research will be specified.
  - (iv) Work with Purchasers to achieve the appropriate casemix to support teaching
  - (v) Provide a clear definition of the responsibilities of both University and University Hospital Birmingham NHS Trust staff with honorary contracts (Schedule 5).
  - (vi) Consult jointly on development plans for space and facilities required for teaching and research.
  - (vii) Consult jointly over patterns of service provision to ensure congruence of Trust and University needs.
  - (viii) Consult on issues of individual or combined interest by means of a Joint Liaison Group between the University and University Hospital Birmingham NHS Trust, and other such arrangements as shall be agreed. This will include joint planning of medical education and research and their delivery (Schedule 9).
  - (ix) Work together in relation to the planning of NHS research and development activity
  - (x) Establish a mechanism for the resolution of disputes that might arise in relation to the commitments of the University and the Trust outlined in this Framework Document and the associated Schedules (Schedule 10).
  - (xi) Ensure that the risks to employees and others from working or visiting each other's facilities are assessed, controlled and appropriately insured.
  - (xii) Ensure that appropriate indemnity is in place to cover clinical, teaching and research activity.

(xiii) Review this Agreement and the associated Schedules on a yearly basis.

Signed Vice Chancellor University of Birmingham  
Chief Executive University Hospital Birmingham NHS Trust

Dated



## APPENDIX FOUR

### SUMMARY OF THE NUFFIELD TRUST SURVEY, NOVEMBER 1998

#### 1. IS THERE CROSS-REPRESENTATION ON THE TRUST BOARD/UNIVERSITY COUNCIL?

The most common form of cross-representation is for a medical school representative to sit on the Trust Board as a non-executive director without any reciprocal arrangement. This is true for over half the respondents. Many institutions are considering ways to advance and formalise their joint relationship.

#### 2. WHAT MECHANISMS ARE THERE TO ENSURE THAT MANAGERIAL DECISIONS ARE TAKEN IN THE FULL CONTEXT OF YOUR NHS/ACADEMIC PARTNERS, IN RECOGNITION OF THEIR INTERESTS, AND THAT THOSE ISSUES ARE DISCUSSED?

3. The lack of a shared agenda, vision or mission was raised as a potential obstacle to joint working more than half the respondents. Many felt that a basic need is to develop an understanding of the perspective of their partner. A recurring theme was the idea that co-operation through good working relations was effective, but that more formal mechanisms were required. For most, regular meetings between Chief Executive and Dean are the only mechanism for ensuring that managerial decisions are taken in the context of their partner institution. Even with regular meetings, decision making is independent and often taken without consultation. A fifth have cross representation on decision-making committees, in addition to regular meetings at a variety of levels. Some institutions are making efforts to develop more collaborative decision-making, moving beyond representation and establishing shared decision-making bodies.

#### 4. MECHANISMS FOR JOINT SERVICE REVIEW?

A third have no form of joint service review other than informal discussions between senior NHS and university staff. It was acknowledged that this was an area that required development. While not specifically for service, other forums provide an opportunity to appraise service on a regular basis. These mechanisms include liaison groups, academically led directorates, and joint strategy groups. A number of institutions were just beginning to, or were considering, formal joint reviews of service.

#### 5. DO YOU HAVE MECHANISMS FOR JOINT RESEARCH REVIEW?

Collaboration in research is a developing area. One centre was discussing harmonising research grants and contracts across the university and the trust, with the university taking over the responsibility for administration. Research co-ordination is seen as a clear potential strength of joint arrangements. Although the divorce of the HEFCE Research Assessment Exercise and the Culyer Assessment Process was expressed as a potential obstacle "which can result in the same joint institution receiving completely different ratings on the same R&D portfolio".

#### 6. DO YOU HAVE ANY MECHANISMS FOR JOINT CURRICULUM PLANNING?

Half have committee representation, but perceptions around the success of this arrangement are varied. A common view within the NHS is that curriculum planning is driven by the university and takes little account of the NHS ability to teach and the impact on service. One Scottish trust was particularly concerned at the lack of

involvement with undergraduate curriculum planning, saying it is a big problem because of the fixed commitment required by NHS staff and its likely impact on service. Others have a more inclusive relationship in this area. A number have instituted specific joint reviews and two trusts have appointed a director of medical education

**7. WHAT PERSONNEL ARRANGEMENTS ARE IN PLACE TO ENSURE THAT THE BALANCE BETWEEN THE SERVICE AND ACADEMIC ACTIVITIES ARE APPROPRIATELY BALANCED?**

Almost 40% of respondents said that there were no specific measures to ensure balance in the activities of clinical academics. A common view was that clinical academics were working over and above their contracted service responsibilities. This was expressed as a particular problem and cited as a source of friction, particularly where an academic was the sole provider of a clinical specialty. Strategic groups, where they exist, play a positive role in this area. One centre had worked merged academic and clinical departments to achieve this balance and congruence between the three core activities of service, education and research. A need for a clearer understanding of the responsibilities and objectives of both partners in jointly and cross-funded posts was expressed.

**8. WHAT ARRANGEMENTS ARE IN PLACE TO ADDRESS THE QUALITY OF SERVICE PROVISION?**

The vast majority had no specific or formal joint quality review. Clinical Governance is likely to be the driving force for new systems to emerge, a large number of institutions said that they were examining systems in the light of the Government's consultation document on quality.

**9. WHAT SYSTEMS ARE IN PLACE FOR UNIVERSITIES TO AGREE THE SPEND OF SIFT AND R&D MONIES?**

No institution claims to operate an ideal system and the majority appear to be discontented. Financial allocation is seen as a major obstacle to joint working. Although most financial allocations require joint signature, this is not necessarily regarded as agreement. However, where dialogue does exist, progress has been made in making more allocation more transparent. For example, ensuring that spending is strictly on teaching related activity. Despite the intention of the Winyard Report to produce guidance to assist the NHS and the associated medical schools to manage SIFT in a more uniform way, no two medical schools or regions handle SIFT in the same way. Financial obstacles are the second most cited of perceived weaknesses for joint planning.

**10. ARE THERE PLANS TO ENHANCE JOINT PLANNING?**

More than two thirds of respondents are discussing plans to enhance their joint relationship in some way. Two institutions stated that they intended to do this without creating a plethora of committees~and that they were exploring models of Academic Health Centres. A quarter felt that the interface would evolve over time, structures were in place, and that it would be just a matter of making them more effective. A minority felt that there was little more that could be done, and tensions between each agenda seen as irreconcilable.

**11. WHAT, FROM YOUR PERSPECTIVE ARE THE STRENGTHS AND WEAKNESSES OF JOINT ARRANGEMENTS?**

Developing a better understanding of the objectives and perspective of partners is a major advantage of joint arrangements. With the aim of harmonising the agenda of each and reduce the 'them and us' attitude. Joint arrangements promote effective working and

a shared ownership of mission. The tripartite mission of service, teaching and research made institutions interdependent and can only be effectively delivered through partnership. Another key emphasis was the possibility of developing a shared agenda for research and the benefits this might provide to either side. Cited weaknesses include a potential for University and medical school relations to be weakened. Many made the point that provisions for personnel arrangements present a weakness to formulating a shared strategy, particularly the ability of clinical academics to devote appropriate time to research. There is also a perception from the NHS that clinical service has become less important to universities.

**12. WHAT DO YOU THINK ARE THE PRINCIPAL OBSTACLES TO BE OVERCOME IN RELATION TO ENHANCING A JOINT RELATIONSHIP?**

The lack of an explicit common agenda was the most commonly cited obstacle to developing joint working.

*'The strategies for patient care, teaching and research are pointing in different directions and driving the integrated ethos into history unless we strive for its preservation'.*

Financial allocation was raised by almost everyone as a further obstacle. There was also a feeling that the lack of formal mechanism for joint working meant that the capacity for joint working depended too much on personal relations between senior management. Organisational structures are not coterminous and joint working would require fundamental reorganisation, 'this would not be welcomed'. These arrangements are particularly difficult for universities that deal with a plethora of NHS trusts and the differing external indicators of success for the NHS and for universities. The divergence of external assessment was raised by a third who felt that unless some progress was made to harmonise, for example, research assessment, then inevitably the organisations would work according to their differing agendas. Delivering organisational change demanded from the centre creates little spare capacity to develop joint arrangements.



## APPENDIX FIVE

### CURRENT BODIES WHOSE TERMS OF REFERENCE ADDRESS THE NHS/UNIVERSITY INTERFACE

#### 1. STEERING GROUP ON UNDERGRADUATE MEDICAL AND DENTAL EDUCATION AND RESEARCH (SGUMNDER)

Chaired by the Permanent Secretary of the Department of Health, the group brings together representatives of the Association of Medical Research Charities, the CVCP, CHMS, CDDS, DH, CMO, GDC, GMC, HEFCE, MRC, NHS, DfEE, OST and Territorial Departments. Its terms of reference are to monitor developments in undergraduate medical and dental education and research, and to make recommendations where appropriate. The group meets twice yearly.

#### 2. JOINT MEDICAL ADVISORY COMMITTEE (JMAC)

Chaired by Professor Alasdair Breckenridge, the group brings together representatives of the universities, Higher Education Funding Councils and the NHS Executive. The four UK Funding Councils are advised on medical and dental education matters by their Joint Medical Advisory Committee (JMAC). A key JMAC function is advising on the maintenance and development of appropriate clinical environments for medical and dental education. Meets approximately three times per year.

#### 3. HEFCE/DH TASK GROUP I (R&D STRATEGY)

The group brings together representatives of the Higher Education Funding Council for England and the Department of Health, no formal chair is appointed. The Task Group was set up to consider how strategic objectives and priorities might be taken into account in HEFCE research assessment and resource allocation process. In particular to

- Consider how the RAE might best deal with health services in relation to: units of assessment, criteria for assessment; and to
- Consider whether special initiatives might be taken to encourage investment in developing area of Health Services Research, for example in primary care.

The group was established in 1998 when it met three times and prepared a consultation paper (RAE 3/98, August 1998) on "RAE 2001 and health-related research".

#### 4. HEFCE/DH TASK GROUP II (INTERDEPENDENCY OF SERVICE PROVISION, RESEARCH AND EDUCATION)

Chaired by Professor Alasdair Breckenridge, the group considered how best to take account of the interdependency between research, teaching and patient care in the funding of university medical schools. In particular to:

- Consider what practical steps, universities and NHS employers might agree locally to help reconcile the competing pressures on clinical academics in delivering research, education and patient care; and

- Suggest what practical arrangements might be put in place by HEFCE and the DH to anticipate and consider the potential impact of their funding decisions on university medical schools and NHS service providers.

A report by the Task Group, "Developing a Joint University/NHS Planning Culture" (HEFCE document 99/62) was published in November 1999.

## **5. HEFCE/DH MEETINGS**

Two informal liaison groupings bringing together HEFCE/NHS Director of R&D and; HEFCE/NHSE Chief Executive. These groups meet as required with no formal terms of reference.

## **6. NHS EXECUTIVE/CVCP LIAISON GROUP**

This group is a liaison body between the NHS and the Committee of Vice-Chancellors and Principals. It exists to discuss informally and openly issues concerning relationships between the NHS and universities in England across the medical, dental and non-medical areas of education, training and research. The group meets approximately twice a year.

## **7. ACADEMIC AND RESEARCH SUB-GROUP OF THE ADVISORY GROUP ON MEDICAL EDUCATION, TRAINING AND STAFFING (AGMETS)**

Professor J Temple chairs a group representative of: the NHS Executive/COGPED/ Committee of Vice-Chancellors and Principals/Council of Heads of Medical Schools/Medical Research Council/Association of Medical Research Charities/Medical Profession/British Medical Association/Academy of Medical Royal Colleges/Specialist Training Authority of the Medical Royal Colleges/Junior Doctors Committee/ the Universities.

The group meets approximately three times a year. Its remit is to advise the Advisory Group on Medical Education, Training & Staffing and the Specialist Workforce Advisory Group from time to time about the implications of wider NHS medical and staffing, education and training policies for recruitment and retention of clinical academic and research staff in universities and the NHS and for the effectiveness of education and training in academic and research techniques, methodologies and procedures.