

Joint Funding Bodies' Review of Research Assessment British Dental Association

Central Committee for University Dental Teachers and Research Workers

1. The Central Committee for University Dental Teachers and Research Workers (CCUDT&RW) is an autonomous committee of the British Dental Association. It is concerned with all matters that affect university dental teachers and research workers, who are dentally clinically qualified, and with dental education and research. Clinical academics in dentistry are based in the university schools of dentistry of which there are nine in England, one in Wales, two in Scotland and one in Northern Ireland. In addition, clinical academics are based in the Eastman Dental Institute in London and Edinburgh Dental Institute, both of which are concerned with postgraduate education and research. In addition a small number of dentally qualified academic staff are employed in universities without dental schools. Dentally qualified research workers are also employed in research units and in industry.
2. We are pleased to have the opportunity to contribute to this important debate. This is the agreed statement of the Executive Committee of CCUDT&RW. We are happy for it to be published. Enquiries should be directed to:

Sue Martin 020 7563 4138 or s.martin@bda-dentistry.org.uk

Introductory Comments

3. Dentistry as an academic discipline came out well from the last exercise, with a considerable lift in grades achieved across the country, with two 5* institutions, 5 institutions rated 5, 5 rated 4 and two rated 3a. This has proved a considerable boost to morale, and augers well for the future. However there is much disappointment and cynicism that this has not lead to real increases in funding for most schools, and a considerable loss to some. The process undoubtedly has benefits, but rewards have to follow, and a growing cynicism headed off in future exercises. Also we are deeply concerned about disincentives in the present system for collaborative research.
4. We recognise that the dual support system will continue and therefore endorse the continuation of some form of RAE. This should follow the principles of transparency, accountability, proportionality, consistency and targeting as recommended by the Better Regulation Task Force.
5. The funding algorithms that will be driven by the outcome of an RAE should be published at the beginning and, to minimise gamesmanship, institutions should be required to return **all** HEFC-funded staff.

Specific comments addressed to the requested headings follow.

Group 1: Expert review

6. Expert panels should continue and include peers and consumers. For dental research the latter must involve the NHS, the industrial/pharmaceutical base and the increasing private sector for health care. International experts must be included, and their time will have to be paid for.
7. The pressures on research time of dental academics created by the intensive nature of teaching and clinical care, especially with the possibility of new Consultant Contracts, do argue for a joint approach to research and teaching assessments. These might be done by different teams, at about the same time, with *joint reporting* so that a balanced view is taken.

a. Should the assessments be prospective, retrospective or a combination of the two?

8. We recommend retrospective assessment based against the stated aims/plans from previous exercises: in effect this makes assessments both prospective and retrospective. This would help to overcome the "short termism" that has been a damaging feature since the RAE process started.

b. What objective data should assessors consider?

9. postgraduate student numbers and completion rates for degrees.
publications: but overuse of journal impact factors is unfair and misleading in a small subject like dentistry where specialist journals have a modest global readership.

research income. All sources of funds are of value and the quality of outcome should be the arbiter, rather than perceived quality of income source.

c. At what level should assessments be made? and d. Is there an alternative to organising the assessment around subjects or thematic areas?

10. Within dentistry we recommend agglomeration of clinical and pre-clinical science in a single grouping. Methods ought not to be significantly different from other health sciences, and methods of recognising, encouraging and rewarding transdisciplinary research found.

Group 2: Algorithm

a. Is it in principle acceptable to assess research entirely on the basis of metrics?

11. No. This will always need a subjective measure, hence the importance of wide national and international input.

b. What metrics are available? and c. Can the available metrics be combined?

12. See comments in paragraph 9 on Impact Factor, degree completion rates and wider recognition of sources of research income.

13. Other measures of reputation should be considered, e.g. research prizes, editorial work, participation in governmental and NGO expert groups.

d. If funding were tied to the available metric, what effects would this have upon behaviour? Would the metrics themselves continue to be reliable?

14. Any metric is open to abuse and should be regularly reviewed to compensate for gamesmanship.

e. What are the major strengths and weaknesses of this approach?

15. Strengths would be of openness and transparency, particularly if the algorithm were published at the outset. A weakness would be vulnerability to units playing the game, hence the importance of regularly reviewing it.

Group 3: Self-assessment

a. What data might we require institutions to include in their self-assessments?

16. The same data groups as outlined in paragraph 9.

b. Should the assessments be prospective, retrospective or a combination of the two?

17. A combination, for the reasons given in paragraph 8.

c. What criteria should institutions be obliged to apply to their own work. Should these be the same in each institution or each subject?

18. The criteria should be the same for a given Unit of assessment, but it may not be possible to apply this to all Units.

d. How might we credibly validate institutions' own assessment of their own work?

19. By external appraisal of a random subset, emphasising those with a substantial change from previous assessments

e. Would self-assessment be more or less burdensome than expert review?

20. This would depend on the nature of the validation process. Bibliographic algorithms could be used as a crosscheck.

f. What are the major strengths and weaknesses of this approach?

21. A strength could be reduced workload for panels. A weakness might be deliberate fraud.

Group 4: Historical ratings

a. Is it acceptable to employ a system that effectively acknowledges that the distribution of research strength is likely to change very slowly?

22. No, institutions can make strenuous efforts to change within an assessment period. This approach would reduce the motivation of the less good to improve/develop and encourage complacency within highly rated units.

Group 5: Crosscutting themes

a. What should/could an assessment of the research base be used for?

23. to identify strengths within the research community,
to foster continued development of research programmes and identify areas of emerging strength for support
to inform strategic decisions about research funding methods, particularly on behalf of the research councils and to encourage international collaborative efforts.
to provide management tools for individual institutions

b. How often should research be assessed? Should it be on a rolling basis?

24. Every 5-7 years: institutions must have an opportunity to respond to or work with the benefits of the previous exercise without artificially sustaining the status quo.
25. A rolling programme would be less disruptive.

c. What is excellence in research?

26. Excellence must relate to the current best; e.g. excellence in genomics now is not the same as it was 10-years ago.

The best research is that which others seek to emulate or validate.

In a clinical discipline, research which has an impact on patient care and on public and personal health should be valued and rewarded.

d. Should research assessment determine the proportion of the available funding directed towards each subject?

27. Not unless there is a radical change in the HEFCs' policy. Society and politicians have to determine the relative merits of fields of endeavour, not quality judgements reached by separate panels, with a limited ability to be consistent.

e. Should each institution be assessed in the same way?

28. Yes

f. Should each subject or group of cognate subjects be assessed in the same way?

29. Yes, basically, but with recognition of special criteria, such as teaching load in dentistry and health outcomes in all health sciences.

g. How much discretion should institutions have in putting together their submissions?

30. We believe that institutions should be required to return a standard data set for **all** HEFC funded staff. Due recognition within the process should be given to those who are not involved directly in research as their contribution to the research effort will take the form of extra teaching or administrative load. However the process should have a record of all staff and how they contribute. This will get away from one form of gamesmanship where institutions choose to submit a small number of high quality research staff to achieve a 5* grade at the expense of research numbers. There is an underlying assumption in this that the kudos of a 5* rating is worth more to an institution than achieving a 5 with a larger number of staff submitted.

h. How can a research assessment process be designed to support equality of treatment for all groups of staff in Higher Education?

31. Staff who contribute to the research effort through administration or teaching **would** be recognised if there was a return involving all staff. They would then feel that their efforts **had** contributed to the overall research rating.

i. Priorities: what are the most important features of an assessment process?

32. Transparency.
Robustness.
Equity of application.
33. Minimising the burden on both research workers and their institutions (the institutional burden could be Spread by phasing assessments over a time period between disciplines rather than having one big bang)
34. An outcome that resulted in a continuous sliding scale of reward rather than specific bands would also be an advantage as small changes in output / quality that might be expected on a cyclical basis then would not have a huge impact (for example an institution that oscillates between 5 and 5* would have potentially dramatic shifts in their funding base).

Group 6: Have we missed anything?

35. The model should encourage collaborative research, between dental schools, with medical schools and with other scientific and humanity disciplines, both in the UK and abroad. At present it seriously mitigates against all of these, particularly within the UK.