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An NHS fit for the future

The urgent need to prioritise university health partnerships now to deliver for the long term

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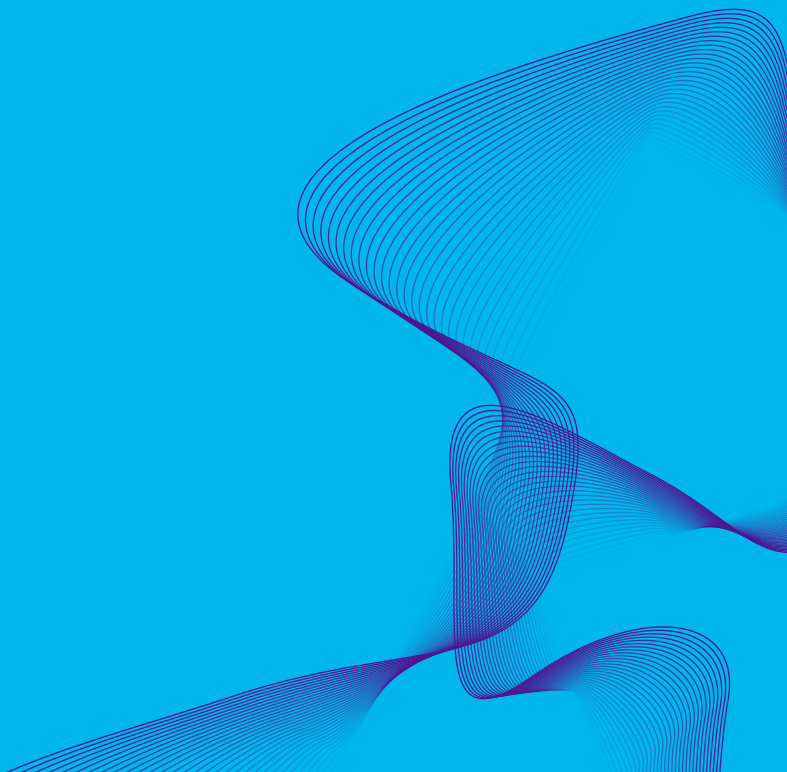

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Contents

Executive summary

After 76 years, the NHS now struggles to keep pace with both demand and the advances in medical knowledge that could transform health. 7.4 million people in England are waiting for hospital treatment, and despite more knowledge about what works, chronic illness is rising, health inequalities are widening, and 2.8 million people are now economically inactive due to long-term sickness, all contributing to worse outcomes for patients and populations. At the same time, universities – critical to driving health research and innovation, improving outcomes and training the healthcare professionals of the future – are under intense financial strain.

The COVID-19 pandemic demonstrated the power of NHS, university and industry partnerships when faced with an urgent, common goal. However, these partnerships – built through decades of investment – now risk fragmenting just when they are needed most. Policy incentives are not always aligned, and the proportion of clinical academics (health professionals combining research with patient care) making up our medical workforce has declined by 27 per cent since 2012.

Yet the opportunities are huge. University health partnerships have driven immense benefit to society by accelerating health innovations, offering fulfilling careers and training generations of health professionals. They are now at the forefront of harnessing AI and unlocking data with the potential to transform health. Hospitals with high research activity consistently report lower mortality rates and improved patient survival. Medical research drives economic growth, delivering an annual return of 25p for every £1 invested. The UK is ranked third worldwide for research outputs in life sciences and MedTech innovation.

Partnerships will play a critical role in delivering the NHS 10-Year Health Plan, by providing the evidence and environment to test what works (and what doesn't) as the government seeks to implement the three shifts of care to community, analogue to digital and treatment to prevention.

However, research is at risk of slipping off the national NHS 'to-do' list: the 2025/26 NHS operational planning guidance, the most recent annual guide to national priorities, targets and financial frameworks for all NHS organisations to follow, does not mention research once.

With health and research prioritised in UK government investment plans, now is the time to recognise that **university health partnerships are both urgent and vital, by aligning policy incentives and taking local action** to embed research and education at the heart of health and care, securing a resilient, high-impact system fit for the future.

... now is the time to recognise that university health partnerships are both urgent and vital, by aligning policy incentives and taking local action

To recognise university health partnerships as urgent and vital we recommend:

Table 1 Recommendations

National policy actions: aligning long term planning and incentives to support collaboration	Local actions for university health partnerships: Universities	Local actions for university health partnerships: Healthcare providers
1. Make research visible, measurable and accountable by embedding research activity in the NHS Performance Assessment Framework and NHS staff survey. 2. Invest in workforce development, expanding fellowships and securing long-term research funding. 3. Remove structural barriers between universities and NHS employers, protecting pay, pensions and leave for staff engaged in research. 4. Put healthcare data to work by enabling secure, structured access for research – supporting discovery, innovation testing, next-generation trials, and improved care delivery.	5. Draw on the breadth of expertise to deliver research that's evidence-based and impactful, working with NHS providers, patients and communities to ensure innovations can be easily adopted. 6. Recognise and champion NHS staff and public contributions to research, education and innovation. 7. Evolve healthcare professional education curricula to drive new models of people centred, digitally enabled, preventative care.	8. Support research inclusion to enable equitable access for patients and communities. 9. Support the health and care professionals of the future by fostering a research-driven culture. 10. Expand research participation across health and care providers, ensuring smaller institutions benefit from university health partnerships.

University health partnerships are not a luxury – they are a necessity. By embedding research, education and innovation into NHS strategy and delivery, we can create a healthcare system that is resilient, equitable, and fit for the future. The time to act is now. Healthcare and universities must work together, with the communities they serve, to deliver real impact for people – patients, populations and the next generation of healthcare professionals.

Introduction

The NHS transforms lives every day, but after 76 years, its original model no longer meets the demands of modern healthcare. The system is stretched beyond capacity – demand far outpaces supply, creating unsustainable pressure. And despite more access to evidence-based interventions, patient and population outcomes still fall short of where they should be.

The COVID-19 pandemic demonstrated the power and impact of NHS, university, and industry partnerships in responding to urgent healthcare challenges. Collaborative efforts accelerated vaccine development, advanced large-scale clinical trials like RECOVERY,[1] and mobilised population-level data systems. Yet, these strengthened partnerships, built through decades of commitment and investment, now risk drifting apart, at a time when society needs them more than ever before.

Research-active healthcare organisations consistently deliver better results, with many of these advances driven by partnerships between universities and healthcare providers. However, both sectors are facing immense financial and structural challenges,[2] risking a perfect storm where universities are less able to support an NHS under strain.

As health, and research, emerge as clear priorities for the UK government, with the 2025 Spending Review committing £22.6 billion per year by 2029–30 for research and development, and £226 billion for the NHS by 2028–29,[3] it is both **urgent and vital** to ensure that the right policy levers and local partnerships are in place to maximise the benefits of this investment.

Research, education and innovation will be essential to delivering the three shifts in the NHS 10-Year Health Plan – from hospital to community care, analogue to digital systems, and reactive treatment to proactive prevention. Strengthening NHS partnerships with universities and wider system collaborators will be critical to delivering and sustaining these changes.

Looking ahead, AI, MedTech and biomedical innovations, together with understanding of systems engineering and applied health research, present an opportunity for data-driven transformational change at an unprecedented rate, if we have strengthened partnerships that can innovate quickly and test locally at scale.

To secure our ambitions for the future, urgent action is required. Aligning incentives, strengthening partnerships, and establishing supportive policy, regulation and local organisational frameworks will enable the NHS and universities to weather financial pressures while driving innovation. By embedding research and innovation at the core of health, we can ensure a resilient and high-impact healthcare system fit for the challenges ahead.

The outlook

Today

- **7.4 million people in England were waiting for hospital treatment** at the end of April 2025, and the 18-week treatment target has not been met since 2016.[4] Waiting for treatment can be stressful, painful and result in poorer outcomes and higher healthcare utilisation.[5]

- Rising chronic illness and widening health inequalities aren't just damaging our nation's wellbeing – they're harming our economy, with **2.8 million people now 'economically inactive'** due to long-term sickness in the UK.[6]

- **Chronic conditions are hitting the poorest hardest**, deepening regional disparities in life expectancy and further straining an already overwhelmed system.[7]

By 2030

- **Mental health will remain inseparable from physical care.** By 2030 at least a third of people with one or more chronic conditions are likely to also experience mental health challenges, compounding the impact on their physical and psychological wellbeing.[8]

- **The global workforce crisis will worsen.** The World Health Organization (WHO) projects a global deficit of 10 million healthcare and social workers by 2030.[9] The workforce we do have are under strain – in the UK, they are 50 per cent more likely to experience chronic stress than the general population,[10] with 30 per cent of NHS staff reporting frequent or constant burnout in 2024.[11]

By 2040

- **Health inequalities will deepen dramatically.** People in the 10 per cent most deprived areas of England will be diagnosed with serious illness a decade earlier than those in the 10 per cent least deprived areas[12] – a gap rooted in childhood, as UK children experience some of the worst health outcomes in Europe and around 4.3 million are living in poverty.[13]

- **An aging population will strain the system further.** Annual deaths are projected to rise to 635,814 in 2040 – up from 501,424 in 2014. 53.6 per cent of those who die will be aged 85 years and over, and more will do so in hospital rather than at home.[14]

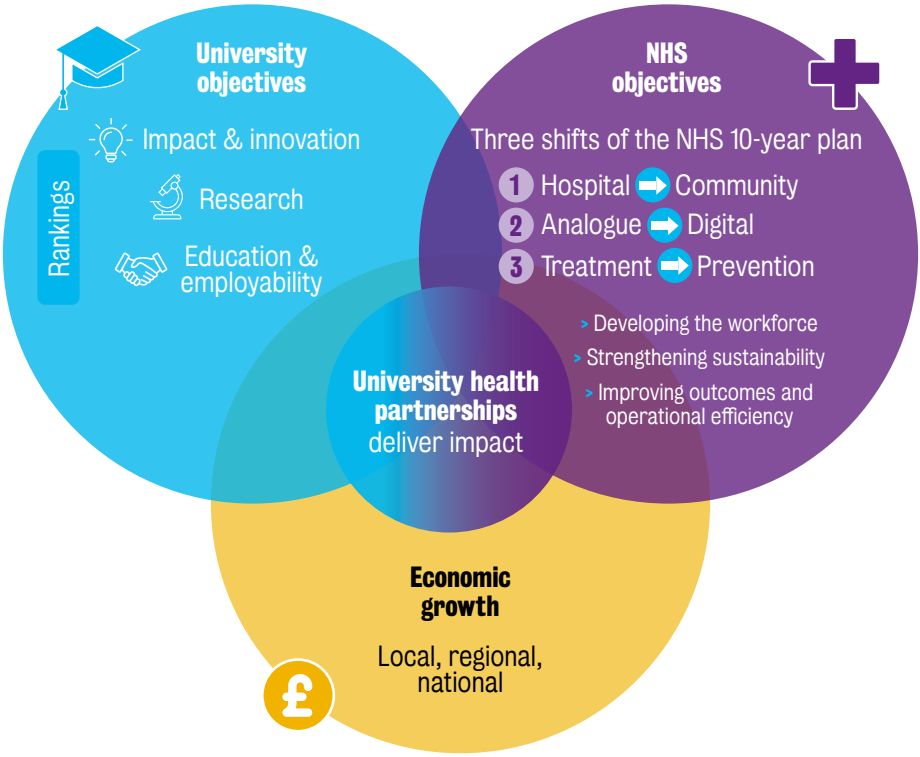
An urgent and vital part of the solution: university health partnerships

The NHS isn't alone. Despite rising healthcare spending worldwide,[15] all systems grapple with surging chronic conditions like diabetes, heart disease and stroke.[16] Globally, barriers to accessing care are widening inequalities for the most vulnerable, further exposing the limitations of conventional healthcare models.[17]

Healthcare's complex challenges demand a shift in thinking. University health partnerships, and the clinical academics who work in them, have a vital role to play in achieving this.[18]

University health partnerships unite world-leading expertise from universities and healthcare organisations in enduring long-term partnerships committed to getting the latest evidence into frontline care faster, inspiring innovation, training future leaders, and attracting large-scale investment in the process.

Figure 1 Through partnerships, universities and NHS organisations can achieve their organisational priorities



The model of partnerships is evolving, together with the terminology.[19] These partnerships have their foundation in clinical medical schools, locating academic teaching and training within technologically advanced hospitals.

University health partnerships accelerate the translation of scientific discovery into patient benefit for local, national and global populations. They have the capacity to answer questions across healthcare delivery, from investigating how to personalise psychological treatments and

evaluating the impact of population-level maternal health interventions, through to answering systemic questions on how to provide equitable healthcare.[20]

Breakthroughs often come as a result of longstanding and resilient partnerships. There is an urgent need to prioritise them now in order to realise the benefits for the NHS, so that it delivers the very best in cutting-edge care, in 10 years' time. To disrupt and innovate, we need research-active workforces supported through these partnerships in every part of the NHS.

The impact of university health partnerships

When they work in collaboration with the communities that they serve,[21] university health partnerships have the potential to reimagine healthcare for the long term, by:

- **Leading discovery and translational research:** by developing and implementing cutting-edge treatments and healthcare innovations, improving outcomes today, and investing in personalised care for the future.

- **Providing the evidence for what works (and what doesn't):** including understanding and addressing the root causes of inequalities, preventing and managing chronic ill health of patients and populations, and tackling waiting lists by keeping people out of hospital.

- **Unlocking the potential of healthcare data:** through bringing the wealth of data collected by healthcare providers with the research and analytical expertise to interpret and structure data in universities.

- **Accelerating digital health:** including working with industry to develop the devices and technology needed to support people to live well at home in their communities, without the need to come to hospital.

- **Enhancing career development:** with only half of NHS staff reporting they have the opportunity to develop their career in their organisation,[22] university health partnerships also provide the means to diversify career development, and the opportunity for fulfilling, flexible careers at the cutting edge of practice.

- **Educating healthcare professionals of the future:** university health partnerships work to advance medical, nursing, midwifery, and allied health professional curricula, equipping the workforce to meet changing health needs.

Key features of university health partnerships[23 24]

Purpose

- Delivering a tripartite mission of producing high-quality health research, health education and clinical care, with international recognition for excellence.
- Translating basic and clinical research into new treatments and interventions, and implementing this new evidence in clinical practice and policy.

Model

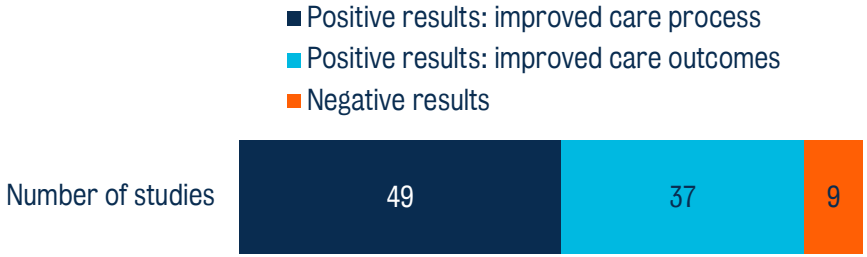
- Enduring long-term partnerships between healthcare providers and universities with integrated governance such as an oversight board.
- No 'one-size-fits-all' model, best defined by uniting missions.
- Joint programmes combining research and clinical care.
- Integrated clinical-academic career paths and leadership.
- Commercial capabilities to translate research into practice.

The opportunities of university health partnerships

Improved care

Research is at the heart of what university health partnerships do, and research-active healthcare organisations lead to better health outcomes. Research activity is associated with reduced mortality and better outcomes, not just for those taking part in clinical trials, but from the 'spillover' effect of higher-quality care associated with research-active organisations.[25]

Figure 2 If health organisations and staff engage in research, does healthcare improve? A systematic review identified 95 academic studies evaluating this question, 86 of which saw improved healthcare outcomes or care processes



Source: Boaz A, Goodenough B, Hanney S, Soper B. If health organisations and staff engage in research, does healthcare improve? Strengthening the evidence base through systematic reviews. Health Res Policy Syst. 2024 Aug 19;22(1):113

A large 2017 study of hospitals in the UK demonstrated evidence of a dose effect: the more research activity that takes place in a healthcare provider, the better the outcomes.[26] This study, using colorectal cancer as an example, found patients treated in UK hospitals with high levels of research participation had lower mortality risk and lived longer, with a 3.8 per cent improvement in five-year survival rates. An effect size of this magnitude is comparable to the population impact seen following the introduction of any new, highly effective (and expensive) treatment.

Another study, of 140 English NHS Trusts, found those with significant involvement in research had lower risk-adjusted mortality for acute admissions than those that didn't, and this was independent of other factors including teaching hospital status.[27]

Likewise, in the US, a 2022 study of more than 4,000 acute hospitals showed that research-active hospitals lead to lower risk-adjusted mortality rates for a range of conditions, as well as better patient satisfaction.[28]

Economic benefit

The Office of Life Sciences demonstrates the role the NHS plays in improving the nation's wealth, as well as its health, not only by keeping people well and in work, but also through catalysing growth in the life sciences industries.[29] University health partnerships are key to this: they attract investment from global industries into the UK economy. A 1 per cent increase in public sector expenditure in biomedical research is associated with a 0.75 per cent increase in private sector expenditure.[30]

As leading health research institutions, university health partnerships make a strong economic contribution: a 2018 study demonstrated that 'every £1 invested in medical research delivers a return equivalent to around 25p every year, for ever.'[31]

The globally competitive clinical academic infrastructure, coupled with the unique breadth of our NHS datasets and the talent of our clinical academics, makes UK university health partnerships incredibly attractive for investment.[32] The UK is third in the world for clinical academic research outputs.[33] 91 per cent of clinical medicine research, 89 per cent of biological sciences and 92 per cent of public health, health services and primary care research in the UK is rated world-leading or internationally excellent.[34] University health partnerships collaborate with industry to translate new discoveries into practice. Global industries choose to have their research bases in the UK because of its academic power.[35] This clinical academic prowess is enabling new enterprise in life sciences and MedTech industries.[36]

The UK is third in the world for clinical academic research outputs. We must not miss the opportunity to capitalise on our globally renowned university health partnerships.

Workforce development

University health partnerships are global leaders in developing and delivering healthcare professional education, from undergraduate medical education through to continuous professional development for health policy professionals. Curricula are developed across university health partnerships to advance clinical and professional practice and ensure the future workforce is equipped to manage future need.

The Digital Health Competencies in Medical Education framework illustrates how university health partnerships are driving forward global workforce development. The framework was developed by education and digital health experts from world-leading university health partnerships in the UK, Singapore and the US, and seeks to prepare future physicians for digitally transformed healthcare.[37]

The evidence is clear: research participation leads to better health outcomes and to economic growth. University health partnerships can provide the leadership, culture and long-term, stable environment needed to realise the full potential of our workforce, and the full benefits of research and innovation. Nurturing our globally recognised partnerships, and our clinical academic workforce, will protect the nation's health and its financial wellbeing.

The risks to university health partnerships

It is well established that research, education and innovation are important for driving improvements in health. However, faced with operational targets and waiting list pressures we risk sidelining activities that typically have longer-term pay-off. The 2024 Darzi report on the state of the NHS in England summarised the phenomenon: research infrastructure such as university health partnerships are seen as 'important but not urgent'. However, to transform the NHS, we need to recognise university health partnerships as both urgent and vital.

The UK government's upcoming 10-Year Health Plan[38] will seek to address the challenges set out in Darzi's report through three shifts: hospital to community, making better use of technology, and focusing on preventing sickness, not just treating it. Research, education and innovation, focussing on people, need to be at the heart of delivering an NHS fit to meet the changing needs of our population, ensuring we are not managing the same spiralling challenges in 10 years' time.

Research activity will always be sidelined if NHS targets are not used to shift research, education and innovation out of the category of 'important but not urgent' and into 'urgent and vital'.

The 2022 Health and Care Act introduced new legal duties for Integrated Care Boards to promote research, and the subsequent NHS planning guidance reiterated the importance of NHS organisations embedding 'innovation and research in everyday practice'.

This new ICB requirement solidified research as 'important' in national health policy. However, research and university health partnerships appear to be slipping off the national 'to-do' list: **the 2025/26 NHS operational planning guidance, the most recent annual guide to national priorities, targets and financial frameworks for all NHS organisations to follow, does not mention research once.**[39]

Similarly, other national levers that help drive direction of travel for NHS providers, like the annual NHS staff survey or the planned 2025/26 NHS Performance Assessment Framework, do not track research activity or clinical-academic participation. This creates a significant risk for frontline staff trying to carve out clinical-academic careers, and for partnerships trying to align strategically across multiple large organisations, which often feel pulled in different directions.[40] Crucially, it is also a significant missed opportunity for patients: **embedding research in the NHS is one of the most cost-effective interventions we can make to improve health outcomes everywhere.**

Effect on staff

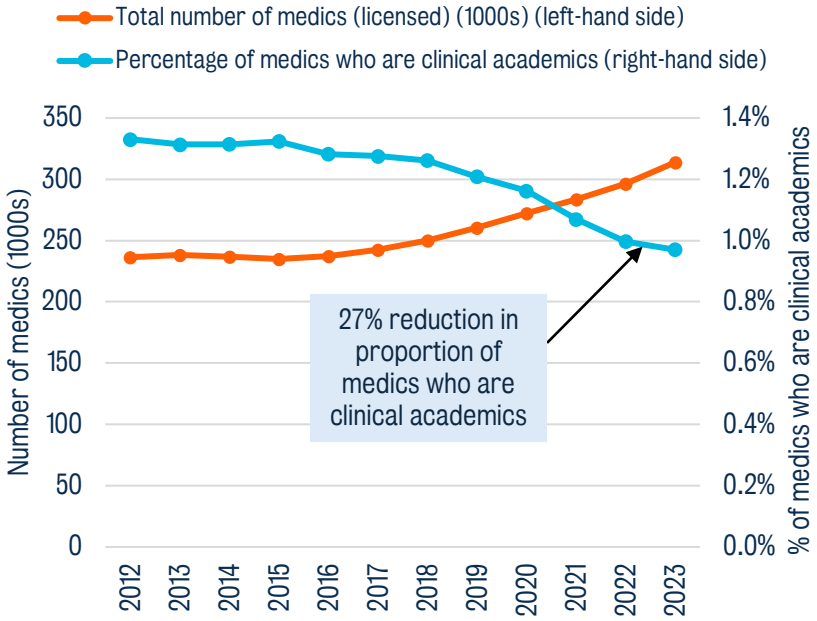
The deprioritisation of research is impacting staff. Clinical academics are the driving force behind the integration of research and practice. They deliver world-leading research,[41] get the latest evidence into care faster, and make sure that research focuses on things that matter to the NHS and the patients and communities it serves. Having an academic component to clinical roles also enhances staff satisfaction, recruitment and retention.

Worryingly, the number of clinical academics practising in the NHS is falling. Earlier this year, a report commissioned by the Office for the Strategic Co-ordination of Health Research found that between 2012 and 2022 there was decrease in the total number of full-time equivalent clinical academic doctors. It also found that, for the first time, the number of clinical academic doctors at state retirement age (66 and over), exceeds those joining the workforce aged 35 and under. The workforce is ageing and not being replaced at a rate that will maintain current levels.[42]

A respondent to a recent survey of frontline staff in a university health partnership goes some way to explaining this decline, saying: 'clinical commitments always take priority and research is often asked to be dropped as demand grows'.[43] The 2025 report found that clinical research capacity and capability has not kept up with the expansion of the NHS and is not being supported through current national policy. A culture shift that sees research as 'core business' is called for.[44]

Our analysis of the latest data from the General Medical Council and Medical School Council indicates that between 2012 and 2023 there was a 3 per cent decline in the absolute number of clinical academic doctors in the UK: in 2012 there were 3,143, and in 2023 3,044. Over the same period, the total number of doctors has grown by 25 per cent, which means clinical academics are a shrinking proportion of the medical profession: they were 1.33 per cent of the total profession in 2012 and now make up 0.97 per cent – a 27 per cent reduction. There is also a way to go in supporting nurses, midwives and allied health professionals to be involved in research – although increasing, numbers are still well below those of doctors.[45]

Figure 3 Number of medical academics compared to total number of medics



Source: The General Medical Council List of Registered Medical Practitioners (data only available from 2012), and Medical School Council Clinical Academic Survey.

Notes: table shows number of licensed medics compared to number of medical academics since 2012. During this time period the total number of medical academics has fallen by over 3 per cent, while the total number of doctors has risen by nearly 25 per cent, leading to a 27 per cent reduction in the proportion of medics who are also clinical academics.

Tension in investment decisions

There is an urgent need to re-prioritise embedding research in NHS delivery. Any level of research engagement is beneficial from a health perspective: wherever there is research activity, outcomes improve.[46] However, there is a tension between decisions to invest in well-established university health partnerships and a geographically equitable spread of investment, across the full breadth of health and care organisations.

Funders are currently following a policy of spreading investment, including beyond the 'golden triangle' of centres in London, Oxford and Cambridge.[47] For example, in 2022 the National Institute for Health and Care Research (NIHR) channelled a substantial portion of its £800 million investment into biomedical research centres (BRCs) in the North and Midlands.[48]

With growing geographical socioeconomic inequalities, a policy of spreading research investment is well understood. However, a critical mass of skilled people is needed to generate scientific discovery, provide peer and supervisory support to a research-active clinical workforce, and provide a sufficient number of people with the health concern of interest to rapidly innovate, especially in early-stage research. This critical mass is also necessary to attract global investment, bolstering the economy.

With finite resources, explicit choices must be made. The solution will need to be nuanced and networked[49]: larger partnerships are likely best placed to develop early-stage and discovery science, with later-phase, observational and implementation research supported across the whole NHS. Larger partnerships must ensure geographical equity in research participation opportunity and career development – for example, through supporting clinical academics and research recruitment in networked smaller providers.

Wherever there is research funding, infrastructure is needed to support staff to develop their clinical academic careers, and realise the full potential of investment.

Case studies

University health partnerships provide the evidence for decision-making at every level of healthcare, from personalised treatment choices through to policy decisions.

Rapid responses to global crises

The success of the **Oxford–AstraZeneca COVID-19 vaccine exemplifies the importance of investing in longstanding university health partnerships**. In 2020 the Jenner Institute was able to draw on its well-established clinical-academic research base, expertise in virology and vaccine technology, and existing infrastructure to respond rapidly to the global crisis. Thanks to this university health partnership, the first clinical trial batch of vaccinations was produced in April 2020, just four months after the discovery of COVID-19. Through industry partnership, the vaccine was then produced at scale, saving more than six million lives in its first year of use.[50]

Industry partnerships driving efficiencies and improved care

The UK's **first industry-funded whole-body positron emission tomography (PET) scanner is being used to assess patients in St Thomas' Hospital**. This new technology illustrates how university health partnerships, collaborate with industry, to deliver cutting edge innovations to improve diagnosis and treatment.

The total-body PET scanners create detailed images of the entire human body. The scanners are two to three times faster and up to

40 times more sensitive than existing machines. As they produce half the radiation it is also feasible for use in children for the first time. This new technology creates more detailed images than other PET scanners revealing subtle, early warning signs of cancer and other neurological, cardiovascular and musculoskeletal conditions.

The new scanners will build a bank of data which will help improve diagnoses and aid researchers' understanding of disease. This new technology improves NHS efficiency, and quality of care now, whilst helping us develop better informed evidence-based care for the future.[51] For example, researchers at King's Health Partners are using the scanners to test a new imaging tracer for people with cancer.[52]

Data-driven cancer care: PharosAI

Researchers and clinicians at **King's Health Partners, Queen Mary University of London, and Barts Health NHS Trust**, are demonstrating how university health partnerships are **leading the way in responsible AI enabled care**. The partners have received £18.9 million UK government investment to support development of a powerful AI platform to transform cancer care by refining decades of NHS cancer data and creating an unprecedented 360-degree profile of each patient. This rich data platform is empowering researchers, developers, and innovative companies to responsibly and ethically develop the next generation of sophisticated AI models, shaping the future of personalised medicine.[53]

Improving mental and physical health; shifting care to the community

Research, education and implementation support led by the **King's Maudsley Partnership for children and young people's mental health** has **helped shift eating disorder care out of hospitals and into the community**. Research undertaken in 2012 demonstrated the efficacy of specialist services in improving quality of care and reducing rates of inpatient admissions for young people with eating disorders.[54] Specialist eating disorder services for children and young people were adopted into national policy in 2014, with substantial investment to aid national rollout.[55] In 2017 the university health partnership was funded by Health Education England to support implementation in training 77 specialist children and young people's eating disorder teams across England.

Investing for the future: pandemic preparedness

The **NHS Clinical Respiratory Metagenomics Programme** is rolling out groundbreaking genomic technology to 30 NHS sites, **helping ensure the sickest patients in intensive care units receive rapid diagnosis and treatment now, while also helping to protect the UK population against future pandemics**.

Metagenomics is the study of the entire genetic material in a sample. A new metagenomic test has been developed over the last four years at the Centre for Clinical Infection and Diagnostics Research, part of King's Health Partners. It can identify any known infectious organism in a patient sample and is therefore much faster at diagnosing disease compared to existing approaches, where microbiologists culture specimens over several days and take a 'best guess' approach based on a patient's symptoms.

Metagenomic testing will enable rapid results in response to any future infectious disease threats. Real-time test data is being

provided to the UK Health Security Agency, creating an early warning system to protect against future outbreaks. The programme is also providing a critical platform for NHS and industry collaborations, supporting the UK as a leader of global solutions in infectious disease management and biosecurity.

Improving population health: from treatment to prevention

The success of **BRUSH: optimising toothbrushing programmes in nurseries and schools** illustrates the role university health partnerships play in preventing ill health. A quarter of five-year-olds in England have tooth decay, disproportionately affecting the least well off. Treatment of decay is the leading cause of planned hospital admissions and avoidable surgery for young children, costing the NHS more than £50 million a year. The NIHR Applied Research Collaboration (ARC) South West Peninsula and NIHR ARC Yorkshire and Humber undertook rapid applied research to understand the evidence base for successfully implementing oral heath interventions to address this challenge. Their work led to a **national early years toothbrushing programme, launched in 2025 with £11 million of funding targeted at the most deprived areas in England**.

Recommendations

National policy actions

To fully harness the power of research in delivering the 10-Year Health Plan, national incentives must be aligned to encourage strong research partnerships.

To shift university health partnerships out of the category of important but not urgent, we need better national incentives and coherent investment, with long term planning and sustainability at the core of the approach:

1. **Make research visible, measurable and accountable by embedding research activity in the NHS Performance Assessment Framework**[56] for 2025/26 and beyond, and measure research participation through the NHS staff survey by asking all staff: Are you offering patients the opportunity to take part in research?

2. **Invest in workforce development**, expanding research fellowships across all professions and commit to multi-year secure funding aligned to 10-year research and development budgets and ring-fencing of research funding in the NHS.[57] Support with dedicated infrastructure for clinical academics in and beyond the major centres, enabling access to excellence in education, training, supervision and peer support.

3. **Remove structural barriers between universities and NHS employers**, protect pay, pensions, and leave entitlements for healthcare professionals engaged in research and education to enable seamless clinical-academic careers. This enables retention of talent and smoother cross-sector collaboration.

4. **Put healthcare data to work** by enabling secure, structured access for research – supporting discovery, innovation testing, next-generation trials, and improved care delivery

Local actions for university health partnerships

To deliver for our NHS, university health partnerships must evolve. We need to continue the shift to responsive research, education and innovation that aims to improve population health and equity, co-produced with communities and frontline staff to ensure activity meaningfully addresses real-world challenges.

Universities need to:

5. **Draw on the breadth of expertise to deliver research that's evidence-based and impactful**, prioritising diverse and inclusive lived experience, and working with NHS providers, patients and communities to ensure innovations can be easily adopted, and are most likely to lead to positive change in outcomes.[58] Providing meaningful evidence, education, implementation support, and evaluation to inform how the 10-Year Health Plan is delivered in local integrated care systems, and broader national geographies.

6. **Recognise and champion NHS staff and public contributions to research, education and innovation**, making participation easier through honorary contracts, affiliations, supervision and peer support.

7. **Evolve healthcare professional education curricula** to modernise the workforce to deliver a new model of digitally enabled, preventative healthcare.

Healthcare providers need to:

8. **Support research inclusion to enable equitable access for patients and communities** – through promoting research opportunities, monitoring access to research participation and appointing research champions across services.

9. **Support the healthcare professionals** of the future by fostering positive training environments and a **research-driven culture.**

10. **Expand research participation across health and care providers**, ensuring smaller institutions benefit from university health partnerships, improving geographical equity for staff and communities.

Conclusion

The challenges facing healthcare systems are profound: rising demand, chronic illness, widening health inequalities and workforce burnout threaten to overwhelm them. At the same time universities, vital engines of discovery, innovation and professional training are under increasing strain. Yet, at the intersection of these two sectors lies one of our most powerful and underutilised solutions – university health partnerships.

These partnerships have repeatedly proven their value, delivering faster innovation, better outcomes, stronger workforces and economic return. They are not an academic luxury, they are essential infrastructure for a healthcare system that must adapt, modernise and lead.

The evidence is clear – research-active organisations achieve better patient outcomes. Embedding research and education into NHS delivery is one of the most cost-effective, high-impact interventions that we can make. But, unless we act now, embedding research into performance frameworks, securing clinical academic careers, and strengthening collaboration between universities and healthcare providers, we risk losing critical momentum and capacity.

We have the blueprint, the evidence and the policy window. What's needed is resolve.

To secure a resilient, equitable, and innovation-led NHS, we must stop treating university health partnerships as important but a second-order priority, and start treating them as urgent and vital.

References

1. Recovery Trial. (n.d.). *Home.* https://www.recoverytrial.net
2. King's College London. (2030). UK universities trapped in 'triangle of sadness'. https://www.kcl.ac.uk/news/uk-universities-trapped-in-triangle-of-sadness-kings-vice-chancellor-says
3. GOV.UK. (2025a). *Spending review*. https://www.gov.uk/government/publications/spending-review-2025-document/spending-review-2025-html
4. NHS England (2025) Statistical Press Notice NHS referral to treatment (RTT) waiting times data. April 2025. https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2025/06/Apr25-RTT-SPN-publication-PDF-420K-77252-1.pdf
5. NIHR. (2024). People on long waiting lists use more healthcare resources. https://evidence.nihr.ac.uk/alert/people-on-long-waiting-lists-use-more-healthcare-resources-than-others
6. ONS. (2025). Economic inactivity by reason (seasonally adjusted). https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/datasets/economicinactivitybyreasonseasonallyadjustedinac01sa
7. Institute of Health Equity. (2024). *England's widening health gap: Local places falling behind*. https://www.instituteofhealthequity.org/resources-reports/englands-widening-health-gap-local-places-falling-behind/read-the-report.pdf
8. Mathers, C. D., & Loncar, D. (2006). Projections of global mortality and burden of disease from 2002 to 2030. *PLoS Medicine, 3*(11), e442.
9. World Health Organization. (2016). *Global strategy on human resources for health: Workforce 2030.* https://www.who.int/publications/i/item/9789241511131
10. Wall, T. D., Bolden, R. I., Borrill, C. S., Carter, A. J., Golya, D. A., Hardy, G. E., Haynes, C. E., Rick, J. E., Shapiro, D. A., & West, M. A. (1997). Minor psychiatric disorder in NHS trust staff: Occupational and gender differences. *British Journal of Psychiatry, 171*(6), 519-523. https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/abs/minor-psychiatric-disorder-in-nhs-trust-staff-occupational-and-gender-differences/A10DFBFA99C3CC597C392F5BA9538F44
11. King's Fund. (2025a). What does the NHS staff survey 2024 really tell us? https://www.kingsfund.org.uk/insight-and-analysis/blogs/nhs-staff-survey-2024-tell-us

12. The Health Foundation. (2024). *Health inequalities in 2040: Current and projected patterns of illness by deprivation in England*. https://www.health.org.uk/reports-and-analysis/reports/health-inequalities-in-2040

13. King's Fund. (2025b). *Ten actions the government can take to improve children's health.* https://www.kingsfund.org.uk/insight-and-analysis/briefings/ten-actions-government-improve-childrens-health

14. Bone, A. E., Gomes, B., Etkind, S. N., Verne, J., Murtagh, F. E. M., Evans, C. J., & Higginson, I. J. (2018). What is the impact of population ageing on the future provision of end-of-life care? Population-based projections of place of death. *Palliative Medicine, 32*(2), 329-336.

15. World Health Organization. (2024). *Global spending on health: Emerging from the pandemic*. https://iris.who.int/bitstream/handle/10665/379750/9789240104495-eng.pdf?sequence=1

16. Bloom, D. E., Cafiero, E. T., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L. R., Fathima, S., Feigl, A. B., Gaziano, T., Mowafi, M., Pandya, A., Prettner, K., Rosenberg, L., Seligman, B., Stein, A. Z., & Weinstein, C. (2011). *The global economic burden of noncommunicable diseases*. World Economic Forum. https://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf

17. Martin, S., Siciliani, L., & Smith, P. (2020). Socioeconomic inequalities in waiting times for primary care across ten OECD countries. *Social Science & Medicine, 263*, 113283. https://www.sciencedirect.com/science/article/abs/pii/S0277953620304494

18. Higginson, I. J., Shand, J., Robert, G., Boaz, A., French, C., Carvalho, N'Djai, A., Malone, M., Wolfe, I., Normand, C., & Hotopf, M. (2024). Reimagine health and care to tackle the rising tide of inequality, multimorbidity, and complex conditions. *NEJM Catalyst, 5*(6). https://catalyst.nejm.org/doi/full/10.1056/CAT.24.0266

19. Dzau, V. J., Balatbat, C. A., & Ellaissi, W. F. (2021). Revisiting academic health sciences systems a decade later: Discovery to health to population to society. *The Lancet, 398*(10318), 2300-2304. https://doi.org/10.1016/S0140-6736(21)01752-9

20. European University Hospital Alliance. (2024). *Rethinking healthcare systems in Europe: A call for urgent, Europe-wide and EU-funded research and collaboration*. https://www.euhalliance.eu/wp-content/uploads/2025/02/EUHA-RHCS-Position-Paper.pdf

21. Forsythe, L. P., Carman, K. L., Szydlowski, V., Fayish, L., Davidson, L., Hickam, D. H., Hall, C., Bhat, G., Neu, D., Stewart, L., Jalowsky, M., Aronson, N., & Anyanwu, C. U. (2019). Patient engagement in research: Early findings from the Patient-Centered Outcomes Research Institute. *Health Affairs, 38*(3), 359-367.

22. NHS Staff Survey. (2025). *National results briefing 2024*. https://www.

nhsstaffsurveys.com/static/c1a573e95b1a49428676ef4b24f5efe7/National-Results-Briefing-2024.pdf

23. French, C. E., Ferlie, E., & Fulop, N. J. (2014). The international spread of Academic Health Science Centres: A scoping review and the case of policy transfer to England. *Health Policy, 117*(3), 382-391. https://doi.org/10.1016/j.healthpol.2014.07.005

24. Ovseiko, P. V., Davies, S. M., & Buchan, A. M. (2010). Organizational models of emerging academic health science centers in England. *Academic Medicine, 85*(8), 1282-1289.

25. Boaz, A., Goodenough, B., Hanney, S., Soper, B., & King, S. (2024). If health organisations and staff engage in research, does healthcare improve? Strengthening the evidence base through systematic reviews. *Health Research Policy and Systems, 22*, Article 88. https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-024-01187-7 Boaz, A., Hanney, S., Jones, T., & Soper, B. (2015). Does the engagement of clinicians and organisations in research improve healthcare performance: A three-stage review. *BMJ Open, 5*(12), e009415. https://pubmed.ncbi.nlm.nih.gov/26656023/

26. Downing, A., Morris, E. J., Corrigan, N., Sebag-Montefiore, D., Finan, P. J., Thomas, J. D., Chapman, M., Hamilton, R., Campbell, H., Cameron, D., Kaplan, R., Parmar, M., Stephens, R., Seymour, M., Gregory, W., & Selby, P. (2017). High hospital research participation and improved colorectal cancer survival outcomes: A population-based study. *Gut, 66*(1), 89-96. https://pubmed.ncbi.nlm.nih.gov/27797935/

27. Ozdemir, B. A., Karthikesalingam, A., Sinha, S., Poloniecki, J. D., Hinchliffe, R. J., Thompson, M. M., Grahame-Clarke, C., Holt, P. J., Loftus, I. M., & Thompson, L. (2015). Research activity and the association with mortality. *PLOS ONE, 10*(2), e0118253. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0118253

28. Shahian, D. M., McCloskey, D., Liu, X., Schneider, E., Cheng, D., & Mort, E. A. (2022). The association of hospital research publications and clinical quality. *Health Services Research, 57*(3), 587-597.

29. GOV.UK. (2024). Life sciences competitiveness indicators 2024: Life sciences ecosystem. https://www.gov.uk/government/publications/life-sciences-sector-data-2024/life-sciences-competitiveness-indicators-2024-life-sciences-ecosystem

30. This report also found that the return of investment in biomedical research centres or units is estimated to be between 29 per cent and 58 per cent (total rate of return) which is 'well in excess of the cost of capital set for the public sector and that adopted by the private sector' demonstrating a very strong return: University of York & The King's Fund. (2020). *Estimating the economic value of NIHR biomedical research centres and units*. https://www.york.ac.uk/media/healthsciences/documents/Estimating%20the%20Economic%20

Value%20of%20NIHR%20Biomedical%20Research%20Centres%20and%20Units.pdf

31. Health Economics Research Group, Office of Health Economics, & RAND Europe. (2008). *Medical research: What's it worth? Estimating the economic benefits from medical research in the UK*. UK Evaluation Forum. https://wellcome.ac.uk/sites/default/files/wtx052110_0.pdf

32. Clinical academics are 'critical to securing the UK's position as a global leader in the life sciences sector' taken from: Medical Research Council. (2025). *Clinical researchers in the United Kingdom: Reversing the decline to improve population health and promote economic growth*. https://www.ukri.org/wp-content/uploads/2025/01/MRC-290125-ClinicalResearchersReversingTheDecline.pdf

'The extraordinary richness of NHS datasets is largely untapped either in clinical care, service planning, or research' taken from: Department of Health and Social Care. (2024). *Independent investigation of the NHS in England*. https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

33. Office for Life Sciences. (2024). *Life sciences sector data, 2024*. https://www.gov.uk/government/publications/life-sciences-sector-data-2024

34. REF 2021. (2022). Results and submissions. https://results2021.ref.ac.uk/unit-of-assessment-summary/1 The Academy of Medical Sciences. (2023). *Future-proofing UK health research: A people-centred, coordinated approach*. https://acmedsci.ac.uk/file-download/23875189

35. PwC in collaboration with ABPI. (2022). *Life sciences superpower: Growing the global hub in the UK*. https://www.abpi.org.uk/media/0bfpf3wb/revised-pwc-report_ls-superpower_abpi_v4.pdf

36. A 2025 report commissioned by the Office for the Strategic Co-ordination of Health Research found that clinical-academics are central to high quality care and economic growth by attracting major investment from global industries. Medical Research Council. (2025b). *Clinical researchers in the United Kingdom: Reversing the decline to improve population health and promote economic growth*. https://www.ukri.org/wp-content/uploads/2025/01/MRC-290125-ClinicalResearchersReversingTheDecline.pdf

37. Car, J., Ong, Q. C., Erlikh Fox, T., Kwan, B., Lau, S. T., Sim, K., Lim, T. Z., Marusic, A., Flottorp, S., Car, M., Sheikh, A., & Digital Health Competencies Consortium. (2025). The digital health competencies in medical education framework: An international consensus statement based on a Delphi study. *JAMA Network Open, 8*(1), e2453623. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2829788

38. GOV.UK. (2025b). Change NHS: Help build a health service fit for the future. https://www.gov.uk/government/publications/change-nhs-help-build-a-health-service-fit-for-the-future

39. NHS England. (2025a). *2025/26 priorities and operational planning guidance*. https://www.england.nhs.uk/long-read/2025-26-priorities-and-operational-planning-guidance/

40. Researchers have demonstrated that the incentives between healthcare providers and academic organisations do not align with the former focussing on productivity targets, and the latter on research outputs and student recruitment. See: Edelman, A., Taylor, J., Ovseiko, P. V., Larkins, S., & Topp, S. M. (2022). The population health role of academic health centres: A multiple-case exploratory study in Australia and England. Health Policy, 126(10), 1051-1061, and Ovseiko, P. V., Heitmueller, A., Allen, P., Davies, S. M., Wells, G., Ford, G. A., Darzi, A., & Buchan, A. M. (2014). Improving accountability through alignment: The role of academic health science centres and networks in England. *BMC Health Services Research, 14*, Article 24. https://doi.org/10.1186/1472-6963-14-24

41. The Academy of Medical Sciences. (2020). *Transforming health through innovation: Integrating the NHS and academia*. https://acmedsci.ac.uk/file-download/23932583

42. Medical Research Council. (2025c). Clinical researchers in the United Kingdom: Reversing the decline to improve population health and promote economic growth. https://www.ukri.org/wp-content/uploads/2025/01/MRC-290125-ClinicalResearchersReversingTheDecline.pdf

43. King's Health Partners. (2025). 'Clinical commitments always take priority, and research is often asked to be dropped as demand grows': An exploratory study of the barriers and enablers for professions allied to healthcare engaging in research activity within an academic health science centre in the UK. *[Manuscript under peer review]*.

44. Marzo-Ortega, H. (2025). Research at the centre of UK health-care delivery to fix clinical academia, *The Lancet*, 405(10488). https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(25)00493-3/fulltext

45. Jones, D., & Keenan, A. (2021). The rise and rise of NMAHPs in UK clinical research. *Future Healthcare Journal, 8*(2), 195-197. https://www.sciencedirect.com/science/article/pii/S2514664524005289#:~:text=Currently%2C%20there%20are%20more%20than,NIHR%20Clinical%20Research%20Network%20alone

46. Downing, A., Morris, E. J., Corrigan, N., Sebag-Montefiore, D., Finan, P. J., Thomas, J. D., Chapman, M., Hamilton, R., Campbell, H., Cameron, D., Kaplan, R., Parmar, M., Stephens, R., Seymour, M., Gregory, W., & Selby, P. (2017). High hospital research participation and improved colorectal cancer survival outcomes: A population-based study. *Gut, 66*(1), 89-96. https://pubmed.ncbi.nlm.nih.gov/27797935/

47. University of York & The King's Fund. (2020). Estimating the economic value of NIHR biomedical research centres and units. https://www.york.ac.uk/media/healthsciences/documents/Estimating%20the%20Economic%20Value%20of%20

NIHR%20Biomedical%20Research%20Centres%20and%20Units.pdf

48. NIHR (2022). *NIHR announces nearly £800m to turn research into new treatments* https://www.nihr.ac.uk/news/nihr-announces-nearly-ps800m-turn-research-new-treatments

49. Research networks have been established internationally to improve access to clinical research and its benefits for more patients. In the United States the Community Clinical Oncology programme is an early example of this.

50. The Jenner Institute. (n.d.). The Oxford/AstraZeneca Covid-19 vaccine. https://www.jenner.ac.uk/about/the-oxford-astrazeneca-covid-19-vaccine

51. NPIP. (2024). Patient and Ministers Unveil NPIP's First total-Body PET Scanner. https://npip.org.uk/news/patient-and-ministers-unveil-npips-first-total-body-pet-scanner/

52. King's College London. (2025). Groundbreaking Cancer Imaging Trial Begins Using Advanced PET Scanner. https://www.kcl.ac.uk/news/groundbreaking-cancer-imaging-trial-begins-using-advanced-pet-scanner

53. King's College London (2025). AI minister visits King's to celebrate £18.9 million funding. https://www.kcl.ac.uk/news/platform-research-drug-discovery-ai-powered-cancer-care

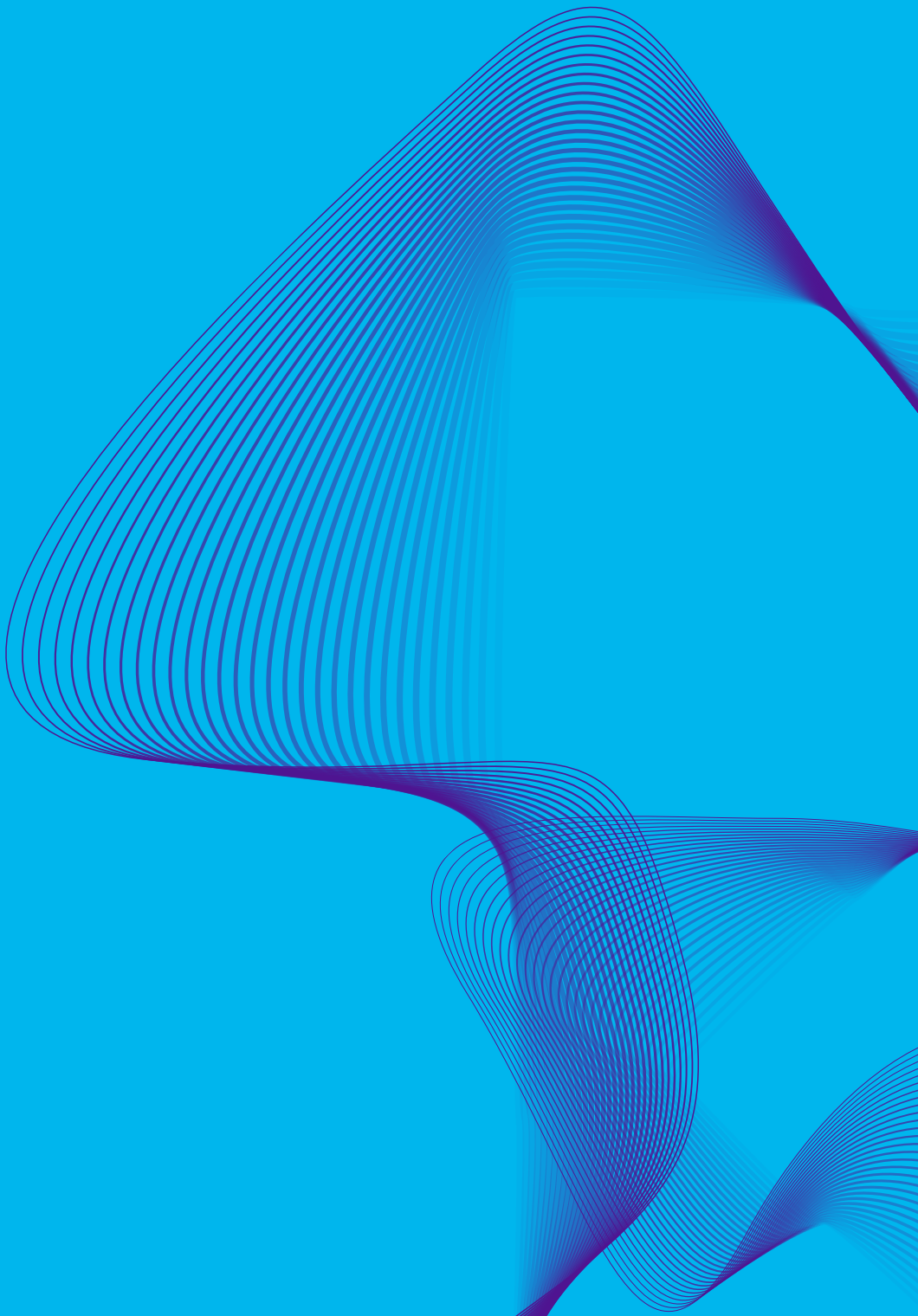
54. House, J., Schmidt, U., Craig, M., Landau, S., Simic, M., Nicholls, D., Hugo, P., Berelowitz, M., & Eisler, I. (2012). Comparison of specialist and nonspecialist care pathways for adolescents with anorexia nervosa and related eating disorders. *International Journal of Eating Disorders, 45*(7), 949-956. https://onlinelibrary.wiley.com/doi/full/10.1002/eat.22065

55. GOV.UK. (2014). Deputy PM announces £150m investment to transform treatment for eating disorders. https://www.gov.uk/government/news/deputy-pm-announces-150m-investment-to-transform-treatment-for-eating-disorders

56. NHS England. (2025b). *The NHS performance assessment framework for 2025-26*. https://www.england.nhs.uk/long-read/the-nhs-performance-assessment-framework-for-2025-26/

57. NHS England. (2025c). *Board oversight and staffing of NHS clinical trials*. https://www.england.nhs.uk/long-read/board-oversight-and-staffing-of-nhs-clinical-trials/

58. Chinekezi, O., Andress, L., Agonafer, E. P., Massick, S., Piepenbrink, S., Sutton, K. M., Alberti, P. M., de la Torre, D., Guillot-Wright, S., & Lee, M. (2023). From the national to the local: Issues of trust and a model for community-academic-engagement. *Frontiers in Public Health*, 11, 1068425. https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2023.1068425



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