Primary care research after the Act: why commissioners and academia need to work together

The Health and Social Care Act 2012 is driving the biggest shake-up in the NHS for a generation. The Act proposes a complete change in the NHS commissioning architecture, an increased emphasis on competition and choice, and a move of public health services to local authorities. From April 2013, primary care trusts (PCTs) and strategic health authorities will be abolished with their commissioning functions taken over by clinical commissioning groups (CCGs) and the NHS Commissioning Board (NHS CB).

These changes represent very significant challenges for those within the NHS, particularly as they are coupled with the NHS' number-one priority of making £20 billion in productivity improvements to avoid a reduction in service quality. So how might these changes impact on research in primary care? And what opportunities could emerge from such a shake-up?

THE TRANSITION FROM PCTs

First, we need to identify, describe, and evaluate important existing roles of PCTs so they are not overlooked during the transition. Secondly, we need to think about how these changes could be made to work from a research and evidence perspective for the benefit of the academic community, the new commissioners, and most of all their patients.

PCTs have a number of research-related roles which successor bodies need to take on. The list of potential roles is long and includes:

- being responsible for compliance with the Research Governance Framework for Health and Social Care;
- holding research contracts with the Department of Health and with universities;
- deploying Research Capability Funding earned through hosting research grants;
- paying excess treatment costs of research;
- hosting of some National Institute for Health Research (NIHR) Clinical Research Networks; and
- leading service evaluation and influencing local research policy, in particular as partners of a local Collaboration for Leadership and Applied Health Research

and Care, Academic Health Science Centres, and the forthcoming Academic Health Science Networks.

With the exception of excess treatment costs, which will remain the responsibility of commissioners, it is far from clear which organisations will take responsibility for these roles from PCTs.

GROWING RESEARCH

While not providing specific central guidance on these roles, the Department of Health makes it clear that CCGs and the NHS CB have a duty 'to promote research, innovation, and the use of research evidence'¹ and that CCGs will have to demonstrate how they will address this duty to be authorised by the NHS CB.² Yet because of the many demands on the nascent CCGs, research is initially likely to be perceived as a relatively low priority despite the presence of this duty, and their leaders will often have had limited contact with researchers. To maximise the opportunities for researchers and commissioners arising from these changes, the academic community needs to engage promptly with CCGs. They can help them to see the value of promoting research and the use of evidence in informing their commissioning decisions for the benefit of their patients.

Being involved in research and evaluation brings many benefits to organisations and their patients.³ For example, research-active organisations achieve improved patient outcomes compared to non-research-active organisations.⁴⁻⁶ And where research, innovation, and evaluation are encouraged, benefits arise from a wider culture of asking critical questions and seeking out best practice. Also, patients have a right to be involved in research if they wish, with those participating in studies tending to do better than patients who are not.⁷ In addition, greater participant numbers improve the generalisability of research findings and strengthens their

power to form conclusions.

Importantly, CCGs have the opportunity for greatly increasing patient participation by routinely specifying in their tender documents and contracts that providers should have systems and processes in place to promote recruitment of patients into studies. Performance in this area could be easily monitored using existing data collection mechanisms by the NIHR Clinical Research Network. Working with the Primary Care Research Network, CCGs could also have a role in overseeing the recruitment of patients in their own member practices in a similar way to current referral rates and prescribing behaviour. Research has become progressively professionalised over the last 5 years, so patient recruitment is now recognised by many NHS trusts and GP practices to be an increasingly reliable source of income. This is especially true considering that health research is the only part of the public sector to have received increased funding in the 2010 Comprehensive Spending Review.

The formation of new organisations is a great opportunity to develop a commissioning-driven culture of research and evidence across the NHS, and the academic community has a pivotal role in making this happen. So what might a mutually productive interaction and collaboration between academics and clinical commissioners look like?

EVIDENCE INFORMED COMMISSIONING

There are clear benefits for CCGs. Commissioners face enormous challenges to develop innovative care pathways that provide good quality care to their patients within a reducing budget. To do this, they need access to the latest evidence in a manageable format and an ability to evaluate whether their services are delivering what is expected of them. The academic community has a considerable repository of such skills that could be mobilised to the advantage of effective commissioning decisions while meeting the

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ADDRESS FOR CORRESPONDENCE

Peter Brindle

NHS Bristol, South Plaza, Marlborough Street,
Bristol, BS1 3NX.

E-mail: peter.brindle@nhs.net

requirements of the Research Excellence Framework.

But there are also benefits for the academic sector. Through greater contact with healthcare decision makers, researchers will benefit from exposure to a rich source of potential research ideas and new collaborations. By including commissioners in developing research proposals, requests for excess treatment costs may be more easily managed. Recruitment of participants becomes more efficient and the findings of research are more likely to be implemented enabling researchers to have a greater impact on patient health. Successful NIHR grants arising from these collaborations and hosted by the NHS would bring in Research Capability Funding which could then be used to support further the combined research effort.

EVIDENCE HUB

The lack of specific guidance on how commissioners should promote research and use evidence for developing and improving services, is a powerful incentive to find innovative local or regional solutions. One strategy could be the formation of 'Evidence Hubs', with access to expertise in research management and governance, evidence synthesis, and in evaluation and audit methodology. These Hubs could support the research and evidence needs of an NHS CB local office and several CCGs, while being the effective link between local universities and clinical commissioners. Key to the success of this model is for CCGs to

identify a research and evidence lead to advocate research issues and guide the direction of the Evidence Hub, while also being the point of contact for the wider research community.

The NHS is going through turbulent times, and the impact of the impending changes on research have not yet been widely explored, so it is important that the existing research and evaluation roles of PCTs are not lost during the transition. But beyond keeping 'business as usual', there are considerable opportunities for commissioners and academics arising from the Act. For these to be fully realised, local research leaders need to approach their local CCGs and offices of the NHS CB, and together deliver a vision of how they can meet the needs of patients, their own organisations, and the wider NHS.

Peter Brindle,

Research and Development Programme Director,
Directorate of Strategic Planning, NHS Bristol,
South Plaza, Bristol.

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