Research for commissioners:

filling a black hole in the NHS White Paper

The NHS White Paper *Equity and Excellence: Liberating the NHS* heralds many changes in the way that decisions about health services are made.¹ Some are clearly spelled out; for example, whereas currently services are commissioned by primary care trusts (PCTs) working within a framework set by strategic health authorities, these bodies will be replaced by GP consortia with slimmed down management structures. Other aspects of the reforms are less well developed, particularly with regard to the role that PCTs currently play in facilitating health research.

The government's commitment to health research appears clear. Indeed the White Paper emphasises that:

'Supporting and promoting research and development will be a core function of the future Department of Health, and the Government remains committed to providing the right environment for innovation to flourish.' (para 3.46)

At a national level, the new NHS Commissioning Board will have duties to promote involvement in research and the use of research evidence, but it is less clear how these responsibilities will be met locally. It seems likely that, along with a host of other activities, responsibility for research will fall to GP consortia.

There may be several advantages in GP commissioners taking a lead role on research locally. As clinicians who are familiar with evidence-based medicine, GPs understand the importance of research. Individual practices are often asked to help with recruitment to clinical research so most have ways to assess these requests. They have a sense of whether a study will fit with their everyday work and whether the arrangements proposed are sound. Taking the east of England as an example, 98 of the 812 practices are currently accredited under the Royal College of General Practitioner's Research Ready scheme: 318 (39%) of the practices assisted in recruiting 13 655 participants during 2010.

THE ROLE OF GP COMMISSIONERS IN RESEARCH

Before a study can begin within the NHS, research management and governance

approval is needed to ensure that patients' interests are protected and NHS resources used appropriately. Currently these arrangements are coordinated by comprehensive local research networks, (a part of the National Institute for Health Research; NIHR), but final approval is currently given by the NHS trust. These arrangements have been criticised as burdensome for researchers.

As a result, the Academy of Medical Sciences (AMS) has recommended centralising and simplifying the process.² Disappointingly, the AMS review gave little thought to the implications of the NHS reforms that are set to abolish the bodies now responsible for NHS permission for research in primary care. Despite the lack of recommendations on this, it seems likely that GP consortia will need to review studies planned in their areas, not least because of the potential impact of research on the services they commission.

MEETING THE COST OF RESEARCH

In the UK, the costs of undertaking health research are met through three different routes:³ (1) research costs, such as researchers' salaries, are met by the funding body awarding a grant; (2) service support costs, such as the time NHS staff devote to recruitment are met by the NIHR networks; and (3) excess treatment costs, (if for example additional referrals were required) are met by NHS budgets; although most studies do not incur these excess costs, some PCTs have been cautious about approving studies that might.

FACILITATING RESEARCH

Since its inception in 2006, the NIHR Primary Care Research Network (PCRN) has transformed opportunities to undertake research in the NHS.⁴ This has been achieved by helping researchers access a much larger number of practices, by helping those practices develop as research sites, by ensuring that studies are

properly resourced and fit with everyday work, and by taking on some of the work involved in recruiting individual patients. As a result, 31% of all participants recruited to NIHR accredited studies in 2009/2010 were recruited through primary care.⁵ To date, most local PCRN staff have been employed by PCTs, but if arrangements can be made for these to pass to GP consortia, this would ensure the network remains closely integrated with primary care.

PRIORITY TOPICS

If the NHS reforms are to deliver the heralded £15–£20 billion 'efficiency savings' that the government seeks, there will need to be major changes in the way that services are delivered. Simply cutting back may increase the pressure on hospitals, as more people require the treatment of last resort — a hospital admission to pick up the pieces. Preventive strategies, community-based treatment, intelligent management of referrals, and greater use of new technology all need investment and evaluation. Commissioners who grasp the opportunity to collaborate with researchers in developing and testing their services will attract the best staff and bring new resources and insights to their work. There is an ethical imperative to identify changes to services that are worthwhile and stop those that are not.

LOCAL IMPLEMENTATION

Despite the various reasons why GP consortia may wish to promote research, the practical aspects may seem daunting, given the range of other responsibilities they are asked to shoulder. There is a strong case for local partnerships to share this work, bringing together the different functions of governance, hosting PCRN staff, and coordinating projects that member consortia develop with academic partners. This would not mean that GPs needed to get bogged down in the detail of research management; instead, they would bring their understanding of a topic's

"Preventive strategies, community-based treatment, intelligent management of referrals, and greater use of new technology all need investment and evaluation."

importance, and whether particular studies might, or might not fit into everyday practice.

Some of the most devastating critiques of the health reforms highlight the lack of evidence for what is proposed, the government's lack of a mandate for these changes, and the dangers of wrecking a national treasure: the provision of universal health care that people can depend on.^{6,7} Despite understanding these worries, many GPs see an opportunity to reshape services in a way that is less bureaucratic and more focused on the core business of improving health. The same potential exists if GP commissioners grasp the opportunities to support and use health research as a core part of their work.

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