

# **Review of UK Health Research**

## **The NPSA response to the consultation**

### **The NPSA**

The NPSA is keen to be a “research literate, evaluative organisation”, and so ensures that its work is evidence-based, that it promotes research and development in patient safety and that it evaluates its own work. The NPSA believes it is vital for the NHS to understand the issues of patient safety and is strongly supportive of a knowledge service that is useful to clinicians, healthcare providers and patients. The NPSA already provides a knowledge service in the field of patient safety, ensuring that the information provided on patient safety is accurate, evidence-based and easily available.

The NPSA’s Research and Development Strategy (2004) came into being after a national listening exercise. It set out a broad framework for prioritisation and delivery of a wide-ranging R&D agenda. The NPSA works with academic researchers and funders to increase the amount and quality of patient safety related research, and makes patient safety research and knowledge available via its publications, its own website and the NPSA funded website *saferhealthcare.org.uk*.

The NPSA collects data from all Trusts in England & Wales about the safety of their patients via incident reports submitted to the National Reporting and Learning System, set up in 2004. The NPSA is in the process of extracting knowledge from this database and feeding it back to NHS Trusts and other organisations involved in clinical care, for example particular issues related to specialties, and so has experience in providing accessible information to healthcare staff and stakeholders.

The NPSA has recognised that its staff need accessible knowledge, support and training in critical appraisal and other research skills, and includes an R&D section that supports this.

### **The consultation**

The Review of UK Health Research, as described in this consultation document, asks important questions about the future arrangements of a proposed new single fund for health research described in the March 2006 Budget.

The consultation asks for input into possible institutional arrangements for best managing this large health research programme encompassing the “full spectrum of health research”.

The NPSA has the following comments to contribute to the discussion as part of the external consultation.

### **NPSA comments on consultation**

#### **General comments**

It is very important for the NPSA that the combining of programmes promotes the development of quality research and quality researchers in areas across academia and the healthcare service. The aim should be to ensure that research funded results

in clear-cut benefits to patients and the public health, and in particular improvements in the quality and safety of healthcare.

Some Departments and Universities and others who work on basic research may be worried that this will decrease the spend on molecular and other basic sciences, where they have traditionally been excellent. Others will have the opposite concern, that traditionally under-resourced and under-skilled areas of research, particularly health services research and public health research, will be disadvantaged. However, this budget change should not reduce or dilute the quality of molecular or basic research, but should be seen as an opportunity to ensure that programmes encompassing applied research are able to step up, be seen to be first class and prove their quality, judged appropriately on merits. Both concerns reflect a fundamental challenge of a single centralised budget retaining the organisational arrangements to appropriately fund and support diverse research, with a commitment to redressing perceived imbalances. These imbalances exist at all stages of research from skills development through to implementation of research outputs. There is a pressing need to enhance applied multidisciplinary and multi-method research.

Specific comments related to particular questions

Q1. The combined fund can be seen as positive for patient safety research. Traditionally, patient orientated research has not done well at MRC boards, and the NHS R&D funds are often also compartmentalised as “not suitable” for some researchers to apply for, and left for purely NHS staff (and not necessarily high flying academics) to apply for. Health services researchers, for example on patient safety research, should not be acting in isolation within departments, but should have the opportunity to engage widely with their research in local NHS Trusts for example. Any blurring of these boundaries may help the quality of patient-orientated research, such as that needed to increase patient safety.

Q2. The NPSA appreciates that basic and molecular research provides the backbone of much research that ultimately will benefit patients, and the funding should be maintained. However, there is an opportunity to translate certain advances more quickly by linking this with patient benefit and patient safety. How should this be best done? Through the combining of the research budget, there could be opportunity to engage and train quality researchers to focus on research that would have clear impacts on patient safety.

It seems important to have routes whereby motivated young clinicians (including frontline staff from nursing, allied health professions and doctors) could be drawn into research that has a patient-orientated research outcome. At what point might these be engaged? Some more concrete undergraduate work may be necessary to ensure NHS workers understand how research relates to their work, but there should also be opportunity later, so that experienced frontline staff are able to access quality training for themselves. This may be different for different sorts of clinicians. Trained researchers, working and collaborating as necessary, would then be able to act as mentors to the next generation of patient-orientated researchers. Excellent research training of younger clinicians of all types should be available, targeting appropriately, and with excellent mentors, preferably cross-disciplinary in training. Research should be seen as underpinning much of what is improving in the NHS and social care.

One of the current key challenges is that nurses are not involved in research in the same systematic way that other health professions are - while this is improving it is not seen as a day to day objective - more an objective to achieve an aim such as an MSc. This should be made simpler to get started and link with good academic

centres experienced with this sort of research, giving consistently high standard of training of research methods for selected staff to access at an early or later stage. There is need to get the balance right between high quality academic research on the one hand and research literacy on the other. The quality of research will not necessarily be enhanced by expecting large numbers of NHS staff to undertake research, but the quality of implementation and translation will be enhanced by improvements in dissemination of findings and by enhancement of the skills of research literacy and evidence based practice. This will help address a second key challenge of the implementation of solutions that research indicates are good and could improve healthcare (see also Q5).

Q3. Priorities for research should include the kind of research needs arising from patient safety that may not be well met by existing channels, especially with the arguably premature demise of the NHS R&D Patient Safety Research Programme.

Evaluating the effects of changing the way that services are delivered to improve quality and safety should be a key strand of the funding, to ensure that future healthcare needs are based on evidence that we are doing the right thing, and to ensure that clinicians trust the guidelines and recommendations that come from agencies such as the NPSA. One example is the evaluation of the NPSA's *cleanyourhands* campaign that is being undertaken after commissioning research into this area. Research should also include research to support current policy objectives e.g. NSF areas and Standards for Health (where safety is the first domain). Research is needed to understand safety issues; to review the effectiveness and cost-effectiveness of potential solutions; and to evaluate the impact of solutions which are implemented.

There also needs to be the ability to fast track important research, where rapid information and scoping of an issue that emerges, for example, from the National Reporting and Learning System is needed before solution development can go ahead. There is also a need to ensure that research is adequately reviewed, whilst still providing fast and immediate tracks for these funding streams, where the funds are available more quickly. There is the opportunity to rethink the way that peer review is used by funders of this sort of research, and to learn from the experiences of organisations such as the MRC, who have used prior identification of willing reviewers to do this.

Q4. Increased engagement of key frontline staff in the issues that affect patient care and health outcomes is important in taking decisions on the benefits of research. How is research training and funding to be accessed? At present it can be sponsored, or by a motivated individual with the support of a sponsor. Could there be a need for more funding to be allocated generally to a quality researching organisation (NHS or academic) bidding for the funding? There would need to be a process for ensuring quality of the bid, with clear and robust decision criteria used transparently for approving and providing funding, but it should be as simple as possible, particularly for seed corn funding.

There is also a chance to get patients and the public involved with recognising the type of research that is already funded, how it benefits the public, what could and should be funded, and in taking part in research (participants, steering committees, etc). This could all take place locally, with the local public and patients engaged and supportive of the particular research expertise available locally.

Q5. The NHS should be a research-aware organisation, and this should be embedded in the culture both at the frontline and at the top of NHS organisations,

and in Trusts and universities supported by local initiatives involving patients and the public. However, currently, this is not always recognised. In the future, research should be seen as not only for the academics; instead, there is opportunity to give all in the NHS a chance to become involved at an appropriate level. Not all will be leaders, clearly, but many will be able to collaborate, working to recruit, advise and consider research implications within their daily practice. This would embed research for patient benefit into the NHS culture.

Incentives for Chief Executives of NHS Trusts are probably necessary to ensure that they consider research to be intrinsic to the working of their organisation. There should therefore be some thought on how this might work in practice, for example researchers may need to build these costs for NHS Trusts into grant applications, in terms of releasing and engaging staff to work on a project, ensuring that grant-giving committees understand these costs and the appropriateness, and giving CEs a say in funding certain types of work etc.

To communicate the results of publicly-funded health research to healthcare staff, there should be dedicated routes that are trusted, and in some way seen to be owned, by staff. Recognition that staff need a respected and responsive IT service to achieve this should be a key part of the CfH programme, but this aspect should be one of the fastest achievements to maintain trust at the frontline (see also Q11). In the same way, results that are seen to come from local work (good news stories), and relate to patients will be better supported by patients and the public.

The link between research published resulting in action/change is poor. There are a few limited studies which show how things could be improved in implementation: Bero, L.A., Grilli, R., Grimshaw, J.M., Harvey, E., Oxman, A.D. & Thomson, M.A. (1998). 'Closing the gap between research and practice: an overview of systematic reviews of interventions to promote the implementation of research findings', British Medical Journal, 317, pp. 465-468

Fraser, S. W. (2002). Accelerating the Spread of Good Practice: A Workbook for Health Care. Bodmin, Cornwall: Kingsham Press

Gagnon, M.P., Sanchez, E., & Pons, J.M.V. (2006). 'From recommendation to action: psychosocial factors influencing physician intention to use Health Technology Assessment (HTA) recommendations', Implementation Science, 1, pp 8

Q6. Just as NHS staff need to understand research, and how it is used, in the same way, researchers need to understand the NHS. There could be more use of funds for secondment of quality researchers within NHS agencies and other organisations. There may be opportunities to create networks across specialties by using funding mechanisms to ensure that collaborations are part of healthcare research; particularly where learning from other disciplines and industries will be crucial.

Q7. Translation might be better achieved by promoting collaborations between basic and more patient-orientated research in certain streams of funding, enabling new researchers in the field to benefit from dual training, and facilitating a generation of translational researchers who can see the big picture. Maybe all programme grants should have to build in an aspect of patient orientated work and collaboration via a percent of their budget. Clever programme leaders funded by NHS R&D and from the MRC would have to think laterally and finally become engaged with each other.

Q11. There should be a clear strategy for linking up the proposed structures with CfH now.

