

Review of UK Health Research

Response from the Research Forum for Allied Health Professions

General

The emphasis on health research is welcomed in the wording of the terms of reference, as is the statement that health research is a key priority for the NHS. It is obviously important to maintain the UK's world-class role in research into the basic science which underpins the delivery of healthcare advances but we also endorse the explicit inclusion of clinical and public health research and the recognition of translational research. The inclusion of economic benefit is also important, although the focus of such work should be widened to include all interventions and service developments and not just the application of new discoveries from the science base.

The scope of the award-making criteria of the Terms of Reference should be widened to include research from the allied health professions, to support and encourage emerging research and researchers and so help to build a robust foundation for future excellence. It is also noted that although the letter of invitation to comment makes reference to application of 'new discoveries and ideas to.....social care research' but little account is taken of contributions to health made by social care or other areas of practice. However, many allied health professionals (AHPs) such as occupational therapists work outside the NHS (eg. in social services, education, forensic, private practice) and in areas such as the work place/employment, physical environment and leisure. Approaches to preventing illness (p.2 of 4 May letter) are also likely to be developed outside of the NHS but will have significant economic benefits to the NHS in avoiding expenditure on medical and social care. It is hoped that these elements can be included in this review.

It is incontrovertible that funding should be on the basis of excellence but public funding of health research must also be directed to growing the research capability in those areas that are currently under-represented, and the development of flexible research career pathways to encourage clinical staff to become experienced researchers must be facilitated.

In addition to reform of the funding infrastructure, there is a need to simultaneously embed a culture of continuing positive change in UK health research systems by:

- requiring the remit of senior investigators in the NIHR Faculty to include demonstration of leadership and change
- involving patients and carers in all aspects of designing and undertaking research studies
- increasing the emphasis on the 'D' element of R&D to ensure research findings are actually implemented in practice

- promoting the role of outcomes-based research

Question 1 – What are the strengths and weaknesses of the MRC and NHS R&D programmes at present? How do each of these support the research and training needs of the NHS, social care, industry and academia? Does more need to be done?

Priorities and funding in the current MRC and NHS R&D programmes are so heavily biased towards medical research that it remains difficult for other types of research to ever make it to priority lists to be considered (e.g. the Health Technology Assessment lists). 'Other' types of research include nursing and allied health professions research (e.g. physiotherapy, dietetics, podiatry, arts therapy) and research relating to social care. As front line practitioners it is essential that research in these professional areas is recognised and supported in order to improve direct patient care.

The MRC has an enviable international reputation for scientific excellence but has a narrow focus (on medical, rather than health research). The current arrangements are strong when it comes to a rigorous approach to evaluation of research protocols. But they are weak in that they favour large, active research departments and do not therefore allow small emerging sites to grow. This timely review must consider how research-emergent professions such as nursing and the AHPs can be better supported. Such professional groups are crucial in delivering care to patients, and delivering the government's objectives, yet still have minimal evidence-bases for their interventions.

The NHS R&D programmes benefit from a much broader remit, including service delivery and organisation, but much of this funding is in the form of large, nationally-commissioned work programmes and cannot support investigator-led research, which is often generated from within clinical practice. The new response-mode funding stream announced in Best Research for Best Health is seen as a positive move to address this, but the indicative funding is disappointingly small. Some steps have been taken to address the training needs of allied health professionals and the research capacity development schemes have been welcomed. However, there were insufficient of these awards to meet demand and subsequent rounds have had far fewer applicants as it was perceived that the small chance of success did not repay the considerable effort required to put together a bid. Whilst these awards are still very welcome, they currently represent the highest level of capacity development for AHPs and are only available to those who already have considerable research expertise. There is still a dearth of funding for building the lower levels of research skills and experience.

Whilst there is a need to develop and maintain a cadre of researchers who undertake health research from within the Universities, the development of researching clinicians and clinical researchers who can identify and answer research

questions relevant to everyday clinical practice is vital for the promotion of a research and evidence-based culture in the NHS. This requires not only funding for capability building, but also access to research funding and a flexible career pathway which will recognise and reward this route.

Question 2 – What do you believe are the key scientific and organisational challenges facing health research, and underpinning training, in the UK over the next decade? How might the UK Government best help address those challenges? What do you believe should be the Government’s objectives for health research, and why?

One of the main challenges will be in providing high quality clinical research that is embedded in NHS practice and that the best, evidence-based practice is rolled out to all levels of NHS provision.

Changes in the delivery and organisation of healthcare in the UK will require different ways of working and a greater emphasis on care delivered by non-medical professionals in a variety of settings. It will be essential to have research leaders and a research-capable workforce in all clinical settings who are capable of providing evidence of benefit and of cost-effectiveness. Nursing and allied health professions now constitute the majority of the clinical workforce in the NHS yet have few opportunities to undertake research. Although new graduates in these professions undertake basic research training as part of their qualifying course, there is little encouragement or expectation that they will then use these skills once they join the NHS workforce, and if they have higher level research skills then there are no career paths for them within the NHS. This reinforces the problems caused by a low research-base and places such professions at a big disadvantage on the current competitive playing field. Researchers in these professions have few choices other than to move into higher education, which means research is taken away from the clinical situation. This is detrimental to developing transitional and applied research. The challenge is to support research in these groups and develop researchers without compromising on the quality of research undertaken.

Innovations in the way that services are delivered must be accompanied by evaluation for changes in the NHS to be truly evidence-based. There is a need for NHS staffing policy to recognise the pivotal role of research within the delivery of services and for sufficient flexibility of staffing to enable development and implementation of innovative practice. This requires both research skills and funding, at local as well as national level.

Government policy is still directed towards devolution of service planning to meet local needs. However, often local health and social care organisations do not have the skills, the capacity or the resources to undertake needs analyses and to evaluate their services. Funding should be made available for local research and evaluation requirements to support the delivery of these services.

Policy initiatives such as patient-led commissioning and closer working between health and social care mean that, increasingly, care will be delivered outside the

traditional NHS organisations. However, care delivered by other agencies (e.g. social care, voluntary and independent sectors) will have a direct consequence for the NHS and its operation and research into interventions and service delivery in these other agencies should also be Government funded.

Question 3 – What should be the Government’s priorities for health research? Is there anything it should stop doing or funding? What is it not doing or funding that it should do, and, in the absence of further sources of support, what can it lower in order to release the necessary funds?

The challenge for Government funding of health research will be in maintaining the excellence in bio-medical research whilst developing new and emerging research areas. By bringing together the MRC and NHS R&D programmes, there may be opportunities for the reduction of duplication in bio-medical research funding and infrastructure, releasing more funds for capability building and for funding research in under-represented areas.

The latter should include research into outcomes of existing common interventions which are not, as yet, based on research evidence. Many of the allied health professions use long-standing non-pharmaceutical therapies or interventions that have had little or no research undertaken to establish their efficacy, and finding funding for this work is extremely difficult. Similarly, the work of AHPs includes a strong focus on the prevention of illness and health promotion as well as actively working in areas such as housing, safe environments, lifestyle and occupation, all of which have a strong impact on health. However, in a health economy which is increasingly evidence-driven, not only are these areas of practice threatened, but this in turn threatens the whole basis for some professions. Funding is required for allied health professionals to rigorously research the evidence-base for their profession, enabling them to develop their therapeutic and preventative interventions and provide a sound evidence-base for their professional practice. This evidence could have cost-benefits elsewhere in the NHS as such interventions have low unit cost and could prevent more expensive interventions elsewhere.

The delivery of multi-professional health care often involves providing care and treatment for multiple problems and requires complex interventions. This necessitates a range of methodologies and research approaches outside the conventional bio-medical paradigms. In addition to wider acknowledgement of the value of existing alternative methodologies, there is a need for further methodological development to respond to new areas of research need.

As mentioned above (Q2), additional funding is also required for local needs analysis and evaluative research, including service development and operational research.

Question 4 – How should decisions be taken on the balance between the long-term economic and social benefits of a high quality biomedical research base; and the needs for research to improve healthcare and other public services? What is the appropriate balance between public funding for investigator-led and priorities led research? How do we balance funding for basic science, translational science and applied science? Is this something that should vary over time? What mechanisms should be used to make judgments about this balance?

It will be essential to retain sufficient flexibility in the system to allow the balance between bio-medical and service-led research to shift in response to, for instance, new public health issues (such as was the case for BSE/CJD) or the need for urgent NHS changes. However, all systems must be transparent and be seen to be equitable, with equal access to funding for all based on the quality of the proposal.

There should also be a balance between different research cultures and paradigms to enable social, environmental, and organisational research (for instance) to be funded alongside more medically-orientated work.

Similarly, priorities for nationally-driven commissioned research should be set after full and equitable consultation with the widest possible group of stakeholders, including patients, users and the voluntary sector in order for those whose voice is not often heard to have an opportunity of having research relevant to them prioritised (e.g. those with long-term neuro-disability).

Question 5 – In your experience, how have the results of publicly-funded health research in the UK been used, both in the development of new treatments and to influence / change wider policy and healthcare practices? What lessons can usefully be learned to improve the uptake of advances in science and medicine?

The transition from research results to practice change have been hindered by two main factors. Firstly, the Research Assessment Exercise and other esteem indicators required in both the University and NHS systems mean that research results are targeted primarily at academic journals which are not routinely read by practicing clinicians or service managers, and when the papers are made available, they are not in a format that can easily identify the main implications for practice. Secondly, changing practice usually requires additional resources, which are difficult to find from within service budgets. A greater emphasis on the responsibility of researchers to disseminate their findings to the practice community, in a form that is accessible and relevant, would go some way to improving the first point. Increased funding for translational research to provide the bridge between basic research findings and their application to practice would also help to produce better value for publicly-funded research money in terms of improved patient care. There needs to be a recognition of the cost of changing practice. In part, this could be achieved by an increased emphasis on health economic analysis of research results. If economic benefit (or improved outcome for similar cost) could be shown, then it enables

healthcare planners and managers to implement the innovations. Some start-up funding for putting research into practice may also be required for service areas to apply for.

There is a need to ensure that a positive climate exists for non-medical researchers in the NHS by noting the mechanisms that impede allied health professionals from accessing these funding opportunities, such as (a) poor applications due to lack of training, and (b) the requirement by clinical managers to meet clinical targets (i.e. number of patients seen)

Question 6 – How might better links be forged between ‘basic’, translational and applied researchers, working across the whole field of health research, from the laboratory bench to the front line of the NHS? How might better links be forged across disciplines, e.g. with engineers, physicists, and social scientists?

The Scottish model of funded health research consortia might be an excellent starting point for facilitating these vital links. Academic institutions and NHS Trusts need to establish permanent collaborative arrangements, rather than the ad hoc, bid-by-bid arrangements which are often produced at the last minute in order to produce credible funding bids. Such arrangements must encourage inter-disciplinary and multi-professional working and working collaboratively should be rewarded in both academic and NHS research quality indicators.

As mentioned above (q5), there is a need to ensure that applications for basic research contain within them a mechanism by which the researchers envisage transfer of results to a broader clinical forum where the efficacy/effectiveness can be tested. One mechanism for this could be a requirement of funding that follow-up clinical research is planned with identified NHS Trusts and colleagues specified in primary application for funding.

There are now examples of forging links across disciplines by the funding bodies, including the SPARC and New Dynamics of Ageing (NDA) initiatives. These are funded jointly by the Research Councils and bring together collaborative inputs from highly diverse research communities. These kinds of initiatives should be strengthened by further broadening the range of research paradigms and settings that can be included.

Question 7 – How can the Government encourage translation, entrepreneurship and innovation in health research to improve public services in the UK?

This is largely answered in the response to question 5. However, it should not be assumed that innovation and the translation of new basic science to clinical practice are the only routes to improvement of patient and client services. There is still much basic work to be undertaken on understanding the efficacy and health economics of

existing treatments and services and of understanding the inter-relationship of care between services and agencies. In particular, there is a paucity of research into the low-cost, high volume interventions which underpin much of primary, community and social care. Currently, this work is difficult to obtain funding for and is perceived as evaluation or service delivery work and hence of lower status than biomedical research. The methodologies that often underpin much work in this area are also not perceived to be valued and opportunities for funding support for methodological innovation is also required.

A greater emphasis on the requirement for outcome measures to be included in bids for clinical research funding would also help to smooth the transition to practice.

Question 8 – How can UK health research funding be most effectively used to provide the appropriate infrastructure for basic, translational and applied research, whether funded by the UK public sector or other sectors? How can UK health research funding be most effectively used to support the work of NICE, facilitate innovation and collaboration with industry, and address market failures in the application of healthcare?

The infrastructure should allow for several elements. Researcher development should be a vital element, particularly for those areas without a strong tradition of research, such as AHPs, social care staff and primary care. However, training without access to research funding and an attractive career pathway is counter-productive and wastes the talent that has been developed. As mentioned above, the establishment of permanent research consortia to encourage co-operation rather than competition would be highly beneficial.

The processes for allocation of research funding should be transparent and equitable. The perceived domination by the medical and academic biomedical communities should be replaced by a wider representation, including AHPs and social care researchers. There may be a need for ring-fenced development and pilot study funding for research-emergent professions as an interim measure.

Whilst NICE produces excellent clinical guidelines, there seems to be little research on the effects of implementing these in practice. The implications of implementation for clinical practice must be recognized in the funding of either research or service delivery (or both) as it requires service managers to be able to release clinical staff for research and development activities, resulting in lower productivity. This is basic conflict which will not be resolved without top-down support.

Question 9 – What lessons should the UK learn from other countries in making the proposed changes to the institutional arrangements for the funding of health research?

The Scottish initiative of establishing funded health research consortia is to be applauded, as are the close links that have been made in Scotland between clinical effectiveness (QIS) and the research community.

Question 10 – In implementing the single fund for health research, to what extent should the MRC and DH / NHS R&D be merged or brought together? And to whom should the single, ring-fenced fund be accountable? Please provide reasons and any supporting evidence for your response.

There are apparent benefits from this merger, not least by avoiding unnecessary duplication and enabling a more coordinated approach to biomedical research. However, any single fund must address the research, and research development, needs of the whole of the health community, including those areas which have not previously benefited from MRC support and have not been well represented in NHS R&D funding allocations.

Question 11 – To what extent does the success of recent innovations in health research (e.g. Clinical Research Networks) and the proposed structures rely on the new Connecting for Health NHS IT system, and to what extent should it do so?

Whilst some of the clinical research networks have worked well in the past (e.g. cancer networks) there is considerable unease at the way the new networks identified by Best Research for Best Health are being brought into play, and the central role that these networks will play. Such networks are perceived to be dominated by those who previously had strong connections and research-emergent professions are finding it difficult to find a place, or a voice in such structures.

The opportunities for research presented by Connecting for Health are potentially exciting and should allow researchers access to a wide variety of data for population and outcome studies. However, this enthusiasm is tempered by the acknowledged difficulties that are being encountered in the implementation of this system, and concerns over the quality and consistency of the data unless there is complete acceptance of the system by all of its users, with appropriate training in its use.

Question 12 – Given that NHS R&D is currently devolved, but that the work of Research Councils is not, how can these functions work best together to maximise the health and economic benefits to the UK?

A system of funding is required that is responsive to different needs (of nations, of local delivery of services, of patient/client groups, of health and social care professionals). This will involve far more than simple decisions about the extent of devolution of decision and budgets, but if successfully implemented will have benefits across the whole of the healthcare economy in the UK.