Primary Health Care Research & Development 2013; **14**: 217–219
doi:10.1017/S1463423613000078

NETWORKING

SAPC hot topic: the changing primary care research landscape

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What do the extensive English NHS reforms mean for primary care research? How can we best take advantage of the new opportunities that will arise – and avoid being blindsided by any threats or confusions? One obvious imperative is to keep up-to-date with the changes and share ideas with colleagues and this Hot Topic aims to contribute to just those sorts of thought processes and conversations.

There are reasons to be cautiously optimistic. It seems clear that the government recognises the key role of research in the NHS. In November 2012, it published the first Mandate to the NHS Commissioning Board (Department of Health (DoH), 2012a), a mandate that the Board is legally required to follow. This contains a clear directive to promote and support participation by NHS organisations and patients in research. Importantly, particularly in the current climate, the Mandate spells out the significance of research not only for patient outcomes but also for economic growth. Making a success of partnership with public sector bodies, specifically including universities, is also stated as an objective for the Board.

Developments in terms of the NHS Constitution are also heartening. The Constitution is a 'declaratory document': it brings together the principles, values, rights and responsibilities that underpin the NHS. Because of its enduring nature, the Constitution is not amended without a 'clear and compelling' reason to do so (DoH, 2012b: 3). Nevertheless, the government is proposing to add not only a commitment to the 'use' of research (as well as its conduct and promotion) but also a new pledge to invite patients to participate in research. The new commitment to using research will be welcomed by members of the academic primary care community as an opportunity to further develop their knowledge exchange practices. Both the Board and clinical commissioning groups (CCGs) also have a duty to promote awareness of the Constitution among patients, staff and the wider public.

This raising of the profile of research in the Constitution is consistent with the unprecedented duties and powers, which the Health and Social Care Act (2012) gave to the Secretary of State and to CCGs that must now 'promote (a) research on matters relevant to the health service and (b) the use in the health service of evidence obtained from research'. Furthermore, research is no longer restricted to 'any matters relating to the causation, prevention, diagnosis or treatment of illness' but may also now encompass 'any such matters connected with any service provided under this Act as the Secretary of State, the Board or the clinical commissioning groups (as the case may be) considers appropriate'. Local authorities, too, can conduct, commission or help with the research 'for any purpose' connected with their work in relation to the health service. The NHS Outcomes Framework, which will be part of the accountability mechanism for the Board, also identifies research and the use of research evidence in the design and delivery of services at a local level as a 'vital area' (DoH, 2012c).

Therefore, both nationally and locally, the mood music is encouraging and opportunities for innovative research look likely to arise. However, no paranormal abilities are required to identify potential pitfalls. Major organisational upheavals and their accompanying staff migrations always bring with them the possibility of disruptive corporate memory loss and how such changes will

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play out at an individual level can never be fully predicted. For some, the opportunity to start again with new contacts and partners will be welcomed; others will regret the loss of productive and valuable relationships.

Until now, primary care trusts (PCTs) have led on supporting research involving primary care providers such as GPs and dentists. Therefore, safe transfer into the new system is essential to ensure the continued health of primary care research. In December, the DoH (2012d) issued a discussion paper intended to help local organisations achieve such a transfer. In future, independent providers will decide for themselves whether to be involved in research and both they and CCGs (who must use research to support their commissioning) will need advice and support. Current locally based PCT research services will need reviewing and the DoH is encouraging the retention of skilled teams, either as independent operators or hosted within a provider, commissioner, the National Institute for Health Research (NIHR) Clinical Research Network or an Academic Health Science Network (AHSN).

The NIHR Clinical Research Network's structure is changing in response to this new environment. Reflecting the expanded range and usage of health research envisaged under the new arrangements, the current 'topics' around which it organises itself will be replaced by 'themes' with a much broader scope. For the first time, figures show that more than half of all primary care sites in England have actively engaged with at least one NIHR portfolio study in the last five years – a level of participation that NIHR is keen to maintain and indeed develop. Therefore, primary care will remain a key theme and may well expand to include public health, prevention and health services research.

It is proposed that the 102 existing NIHR local networks will be replaced by just 15 integrated generic local clinical research networks. These will deliver a uniform service across the country, using standardised procedures contained in a nationally agreed operating framework. They will be coterminous with the emerging AHSNs, new bodies with which primary care academics will need to forge strong relationships, given the strategic role the AHSNs are intended to play in driving innovative research through partnership and engagement (DoH, 2012e).

Engaging the active interest and commitment of the plethora of new organisations in the field is obviously an urgent priority. NIHR, with one of its regular partners, Ashridge Consulting, is working on developing these strategic relationships. CCGs and the NCB's Local Area Teams (LATs) are being mapped against the NIHR's local research networks and a data set of research activity constructed to promote dialogue. A national meeting to promote research in the new NHS, targeted at lead players in the CCGs and LATs, is planned for 2013.

The situation remains fluid and fast changing. As we have suggested, the engagement of CCGs and individual providers with research may well enhance opportunities for newly 'in-demand' researchers. However, the complex new organisational structures may also pose new challenges for our academic discipline itself. Is there a risk of our methodological expertise becoming valued at the expense of our ability to contribute to shaping the conceptual landscape? Of us becoming regarded as technicians rather than experts, as is arguably the trend in generalist practice (Reeve *et al*., 2013)?

In this time of upheaval, it is not enough for us to inform ourselves. We must also take an active role in informing others, in demonstrating the unique contribution of primary care expertise, in communicating our vision and practice of patient-centred care, in seizing the opportunity to promote the relevance of curiosity-driven blue sky research. Share your ideas at http://www.sapc.ac.uk/index.php/future-directions, comment on the SAPC noticeboard, join the conversation on Twitter @sapcacuk.

Acknowledgements

Details in this report are correct at the time of writing (11 January 2013).

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