

Survival of the biggest

THE purpose of the NHS is to improve the health of the population, so why does the NHS fund research? The reason, explicit on the Department of Health website, is to provide the knowledge base so that health and social care are based on evidence of needs and what works to meet those needs. However, at government level there has been disappointment at the failure of much NHS research-and-development funding to deliver what was intended. This article outlines the problems perceived at government level and the impact on researchers and the organisations that host research. Some solutions to these problems are being put into place, and I will outline these. Further changes are likely, and academic and applied psychologists with an interest in NHS research need to adapt to them.

Several reviews of the direction and outputs of NHS R&D are available (DH, 1999a; DH, 2002b). Mental health research (a subject close to the hearts of many psychologists) has been the subject of particular concern. The strategic review of mental health research (DH, 1999b) noted that the NHS at that point spent £129m per



ROGER PAXTON on changes and implications for academic and applied psychologists.

year on mental health research, and some strong partnerships and areas of great expertise and achievement were evident. However, problems were also pointed out. Nearly half the projects identified were small and without identified research funding. There were few systematic reviews, and important topics, including health promotion, access to health and social care services and supports for carers were neglected as topics for research inquiry.

Another facet of the problems is the decline in the number of randomised controlled clinical trials in the UK (Chalmers *et al.*, 2003). In the 2002 strategic review they constituted just 2 per cent of the projects. The decrease in numbers has not been accompanied by an increase in trial size. A major reason for this decline in the number of trials and larger-scale research is organisational changes in the NHS, and in particular the removal of the NHS regional offices (and their R&D departments), and the conclusion of time-limited national NHS R&D programmes. So from the standpoint of NHS researchers, it has become harder to obtain funding.

A third problem, again from a

researcher's viewpoint, is increased central control, and therefore reduced autonomy. As well as organisational and financial changes, there has been a change in the NHS research culture, with growing emphasis on research in topic areas that are centrally determined, and a related discouragement of individualistic 'own account' research. Another part of this change is the imposition of a single very thorough national set of procedures to ensure high standards of research governance (DH, 2001). This uniform approach, regardless of the scale and riskiness of the research, seems unnecessarily burdensome to many people, especially those with small projects with few evident risks (Warlow, 2004).

A fourth problem is the current uncertainty over possible shifting of NHS R&D support funding. Since the NHS funding tied up in research was first identified in 1997 there have been repeated promises (or threats, depending on your point of view) from the Department of Health to shift funding from poorly performing to high-performing Trusts. Changes so far have been small, probably because of the extent to which R&D funding is embedded in clinical services,

WEBLINKS

Department of Health Research and

Development: tinyurl.com/af370

UK Mental Health Research Network:

www.mhrn.info

and the consequent risk of destabilising these services. However, the new national health research strategy (DH, 2006), described further below, indicates that substantial financial changes will be made in the coming years.

Organisational solutions

The first response from the Department of Health to disappointing research outputs was the creation of new research funding arrangements, particularly the priorities and needs funding stream (DH, 2002a). This is to support NHS research directed at areas of identified national priority or clinical need. Priorities and needs funding is to support programmes of research in seven high-priority topic areas (cancer, mental health, coronary heart disease, ageing and older people, public health, genetics, and diabetes). A programme in this context is a coherent and continuing set of research projects carried out by a collaborative grouping of service provider organisations and universities. So to retain or access funding you need to be researching in the right topic areas within an appropriate research collaboration.

A further national development – another major attempt to improve the scale, quality and therefore impact of NHS research – is the establishment of national research networks. The Mental Health Research Network (MHRN) was recently established and is directed by Til Wykes (an academic clinical psychologist) – she was interviewed about the network in *The Psychologist* in May 2004 (see tinyurl.com/gh7c8). The national network is supported by eight regional hubs, each with a senior academic lead, and most with a deputy lead. Each has a full-time coordinator and now several full-time clinical studies officers and other part-time posts to ensure appropriate social care, primary care and service-user involvement in research. As well as a lead university or universities, each hub has an NHS base comprising nearby NHS Trusts covering a population of around three million. As well as organising and delivering large-scale research projects, the MHRN aims to broaden the scope of research, identify research needs in mental health and develop research capacity. Intended benefits for researchers are easy access to a number of clinical and academic centres, improved contacts between researchers and service providers, support and guidance on research governance matters, and improved

coordination of multicentre studies. Psychologists are already involved in several prominent positions in the MHRN, and more should become involved as the network develops further.

Now much greater changes, still in the same direction, are signalled by the publication of *Best Research for Best Health* (DH, 2006), the new national health research strategy. It aims to make the UK the best place in the world for health research, with more patients involved, large and high-quality studies, increased industry

'Quality may suffer if research becomes too much an externally directed process'

investment and less bureaucracy. Mechanisms to achieve all this include the creation of a virtual National Institute for Health Research, a small number of research centres of excellence, the continuing development of national research networks, continuing and strengthening the current national research programmes, new funding arrangements with incentives for NHS organisations to be involved in research, and new career opportunities for researchers. These major changes will occur over the next three years. It is unfortunate that the strategy contains little detail.

Shifting NHS R&D support funding was raised earlier as a possible problem, but depending on your point of view, it can also be seen as a solution. From a Department of Health perspective, part of the solution to the national disappointment is to shift funding from less to more productive research organisations.

Risks

The fact that much 'own account' research has been unproductive is not to say that it all has, and the first risk of the emerging organisation solutions is that innovation will be stifled. It seems obvious that the NHS needs research with applications that may not be felt or even predictable for some years.

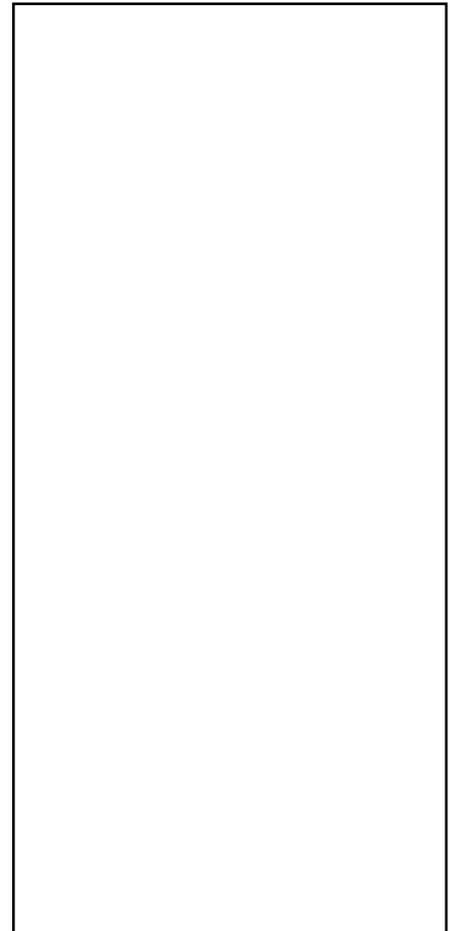
A related point concerns the motivation of researchers. Good research needs creativity and a deep interest in the subject matter. The quality of research and the quality of the people wishing to carry out research may both suffer if research becomes too much an externally directed

process. The most creative and able people may not wish to pursue research careers.

Thirdly, withdrawing money from relatively unsuccessful people or organisations would, of course, affect the organisations as well as the individual researchers, perhaps leading to a progressive centralising of research in a small number of centres. This would not just reduce R&D capacity in these organisations, but also damage the added value in terms of clinical quality that research active clinical staff bring. It might also lead to a narrowing of research approaches and research contexts, with a consequent reduction in the generalisability and applicability of research findings. The proposals in the new national health research strategy outlined above also seem to carry the same risks of centralising and narrowing research.

What should psychologists do?

Psychologists should be aware of these changes and seek wherever possible to engage in collaborative rather than isolated research in the NHS. The local R&D



department should be aware of current and possible research programmes in each Trust, and psychologists who are or wish to be active in research in the NHS should be in contact with their local R&D department. As Painter (2005) noted, in a practical paper on managing multicentre research, the NHS research governance standards are rigorous, and ensuring compliance with them is normally the responsibility of Trust R&D departments. This is another reason for researchers to make contact with their R&D department early on.

Linking with existing local research collaborations or networks is an effective way of getting started on research, and there are different kinds of research that are beneficially carried out through these groupings. For many psychologists a particularly attractive approach is practice research networks, such as the Psychological Therapies Research Network North jointly led by Michael Barkham and Glenys Parry, from Leeds and Sheffield Universities respectively (Audin *et al.*, 2001). Individual or organisational links are possible with projects of various sizes supported, and different kinds of involvement welcomed. Likely stages of involvement begin with routine collection of clinical outcomes data within a department to provide feedback to individual psychologists and on the whole service. These data and the systems for collecting them can then form a basis for local consensus on best practice, and clinical audits to support good practice. The third stage is using this information to evaluate the department's services. The fourth stage is using the network of organisations to compare participants, treatments and outcomes with those in other services as a means for larger-scale comparative research and evaluation.

DISCUSS AND DEBATE

Can the new world of bigger research be good for psychology?

How can we protect small-scale but good research, early stages research and research by novices?

How can we ensure that large RCTs do not squeeze out the other kinds of research that are needed to answer some questions?

Have your say on these or other issues this article raises. E-mail 'Letters' on psychologist@bps.org.uk or contribute to our forum via www.thepsychologist.org.uk.

A fifth stage is to use the extended network as a basis for a range of research designs including RCTs.

This is just one example of a research network that brings together researchers and service providers. Others of interest to psychologists are the MHRN networks on early intervention in psychosis and self-help for mental health problems (see www.mhrn.info).

By collaborating to form larger research groups and taking account of the national influences on the direction of NHS research, psychological research in health care can become bigger and better. Of course, novice researchers need to get started, and not all research should be large scale. However, there seems no doubt that more large-scale NHS research is needed, and psychologists must be involved and influential. And small-scale research should be connected rather than isolated. The networks that are developing to solve previous problems have much to offer.

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VISITING PSYCHOLOGISTS SCHEME 2006

The Research Board and Professional Practice Board invite nominations

Members of the Society are invited to nominate psychologists from developing countries who would like to make study visits to the UK. The scheme is specifically aimed at supporting psychologists early on in their careers to gain further experience and training not currently available in their home country.

- Four or five places are available, with up to £1000 per place.
- The scheme principally covers the cost of economy class air travel to and from the UK; standard class rail travel within the UK; and a contribution towards subsistence and accommodation expenses.
- The grant enables the visiting psychologist to undertake academic work or to carry out applied work.
- Proposers are expected to act as hosts for the visitor, or to arrange for a host to take responsibility for the practical arrangements of the visit, ensuring that all necessary facilities are available.
- Nominations must include an account of the visitor's academic / professional background and experience, a detailed provisional itinerary and the goals of the visit.
- An end-of-grant report must be submitted to the Boards for consideration at the end of the visit.

Nominations should be sent to the Chair of the Research Board c/o Lisa Morrison Coulthard (Scientific Officer) at the Society's Leicester office by no later than 29 September 2006.