Making the most of research opportunities for nursing


Summary
The Department of Health (2005) consultation document Best Research for Best Health: A New National Health Service Research Strategy offers both opportunities for the future development of nursing research and threats to its future. Lessons from the history of health research reforms in the UK suggest that it will take time for any benefits to become obvious and that only some members of the research community will receive funding. In the past few years the quality, potential leadership and skills base for nursing research have shown unprecedented improvements. Combined with a professional understanding of nurses’ careers in both practice and education, the proposed new strategy could work to the advantage of nurses and the patients who rely on their expertise. It is, however, essential that the experience and ambitions of as many nurses as possible now feed into this consultation process.

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Keywords
Nursing: research; Professional development; Research and development

These keywords are based on the subject headings from the British Nursing Index. This article has been subject to double-blind review. For related articles and author guidelines visit our online archive at www.nursing-standard.co.uk and search using the keywords.

Traynor et al (2002) found that the DH contributes about £3.4 million to nursing research (roughly 0.5 per cent of NHS funding). Although this sum seems modest, it is by far the major source of funding for nursing research in the UK (Traynor et al 2002). Therefore, whatever follows the consultation, we must ensure that nurses’ NHS research funds do not disappear during the forthcoming reforms.

There are precedents for vanishing research resources. When English health authorities were reformed into primary care trusts in 2002, all their previous area-based, health needs-related research funding evaporated (Caan 2000). However, the history of developments in the NHS identifies that there are also precedents for growth and innovation in research during NHS reforms.

A lesson from history
Reforms are not always as radical as politicians like to think. For example, in 1968, Jennie Lee, Labour minister for education and science, reflected on the National Health Service Act 1946: ‘Of course the health service in this country did not begin in the year 1948. Many of us have associations with the between-the-wars health service; a great patchwork, a good deal of good intentions, a great deal of inadequacies’ (Department of Health and Social Security 1968).

Similarly, the NHS has always had a national research strategy. The 1946 Act made allowance for a small number of postgraduate ‘special hospitals’ linked to the University of London to develop and evaluate care by doctors and nurses. Fundamental to these postgraduate teaching hospitals, for example, the Moorfields Eye Hospital, the Royal National Throat, Nose and Ear Hospital and the National Hospital for Nervous Diseases, was their focus on one
particular type of pathology – with the exception of the Hospital for Sick Children at Great Ormond Street.

The legacy of 1946 is still felt in terms of the concentration of current research in London which receives roughly three quarters of all available funding. Subsequent R&D reforms often occurred piecemeal for single specialist areas such as microbiology or cancer research. However, the 1991 strategy Research for Health (DH 1991) was a reform of a different magnitude. The first national director of R&D was Sir Michael Peckham. His vision for R&D coincided with the purchaser/provider split in health services following the NHS and Community Care Act 1990 and focused on aligning all the major sources of R&D money, including concordats between the DH and the Research Councils. The work of Tony Culyer (1994), professor of economics at York University, ensured that NHS research funding systems gradually became simpler and, at least in theory, more flexible.

The Royal College of Nursing (RCN) and other nursing bodies were consulted repeatedly by the DH about their potential contribution to research capacity. This reforming zeal culminated in the first international showcase conference for evidence-based practice entitled ‘Scientific basis for health services’, at which Alison Kitson (1995), the present executive director of nursing at the RCN, presented a framework for future nursing roles with a ‘scientific base’.

The ‘Culyer’ funding system was then evaluated in the NHS region with the biggest research spending. Arnold et al (1999) reported that ‘a key issue not tackled by the reforms is the type of research and development undertaken’. In terms of impact from the years of implementing reform: ‘Only the primary and community providers – who account for about 4 per cent of R&D support funding in the region – reported a significant positive impact on R&D performance’ (Arnold et al 1999).

Therefore, a pertinent issue to consider is why nurses did not capitalise on the opportunities that arose ten years ago. McMahon and Kitson (1997) found three stumbling blocks to increasing R&D in nursing. These were a shortage of resources, a lack of professional leadership and a lack of strategic planning. Sometimes other professions did not accept nurses as equals within the health research environment. At the last Research Assessment Exercise for universities, Traynor et al (2002) found that universities counted only 3.9 per cent of nursing academics as researchers. In 2000, the then Chief Nursing Officer for England Sarah Mullally recognised that to ‘strengthen the capacity’ of nurses to undertake research, ‘a new determination to tackle longstanding problems’ was required (DH 2000a).

Using evidence of increased outputs from nursing research and an increasing demand for nursing research, effective champions then arose for more resources for continued growth (Rafferty et al 2003). The RCN (2003) campaigned that excellent care necessitated outstanding new research leaders (Box 1).

Planning for research capacity (Dash et al 2003) then led to a new national Health Services Research Network which included health policy advisers, non-statutory funding bodies, health service managers and experienced academic researchers.

Simultaneous with the Academy of Medical Sciences (AMS) highlighting a catastrophic decline in clinical research across the UK (Bell and Working Group of AMS 2003), it was identified that academic medicine could only thrive if nurses could ‘contribute as partners (not handmaidens) to innovative research’ (Caan 2004).

The context of the current consultation

Reporting on the 2005 consultation, the British Medical Journal noted the historic weakness in DH strategies: ‘The way its funds are distributed has often been based on custom and practice rather than on the excellence of the research’ (Cole 2005). This strategy has prevented growth that responds to national needs, for example, new research capacity to affect health inequalities (Caan 2002). However, what could make a difference this year is the establishment of a new, rich stakeholder, that is, the UK Clinical Research Collaboration (UKCRC) 2005, which is committed to ‘reshape the clinical research environment’.

The UKCRC was developed as a consequence of recommendations of a report by Bell and the Working Group of AMS (2003) and pressure from the Office of Science and Technology (OST) – the

**BOX 1**

**Royal College of Nursing position statement on research and development**

Leaders with the necessary skills to fulfil complex roles, for example, nurse consultants in research and development, should be equipped through innovative curricula including, for example, professional doctorate programmes. Research and development leadership roles should be promoted across the UK, and underpinned by nurses engaged in integrated clinical academic career pathways.

(RCN 2003)
overseer of some £880 million spent on health research, in addition to the funds from the DH. The collaborating funding bodies of the UKCRC include all the UK health departments, the Medical Research Council and the pharmaceutical industry. Indeed, most of the ideas in *Best Research for Best Health* were foreshadowed in January by the UKCRC (2005), including:

- Consolidating R&D funding.
- Promoting disease-focused research networks (cancer, diabetes, stroke).
- Improving clinical academic careers.
- Enhanced facilities for experimental medicine (in the present consultation these are called Academic Medical Centres in premier research hospitals).
- Streamlining the regulatory and governance processes for clinical trials.

At the time the author (WC) questioned the UKCRC chief executive Liam O’Toole (January 19 2005), no nurses or midwives were contributing to this plan, which has been influential on the current NHS strategy.

**Using and shaping the emerging strategy**

The title of the consultation document calls for a ‘health’ research strategy. The research topics prioritised are preoccupied with disease. In contrast, the invaluable experience of health professionals is acknowledged within the NHS Plan (DH 2000b) that it wants a patient-centred health service.

In health research it has been midwives and nurses who have most mediated increased contributions from service users, and promoted wider recognition for their contributions, for example, in adopting patient-selected outcomes for intervention studies (Oliver 1997). Nurses have enabled the most voiceless people to lead research projects. In one case this was homeless mothers who then presented their findings to the Deputy Prime Minister (Houston 2004). This therapeutic alliance of patients and NHS nurses should be considered during the consultation process (Agnew 2005), as it not only fits with the ethos of nursing, but also applied patient-based research is acknowledged within the consultation document.

There is an added incentive for nurses in higher education to build on this relationship with patients as the next Research Assessment Exercise for universities wants to ‘encourage’ practice-based nursing research (Pearson 2005). Anglia Polytechnic University (APU) has completed a study of the nursing research skills base in the UK (McVicar and Caan 2005). In the last few years, the number of doctoral theses, the number of places able to supervise nursing research and the range of methodological capabilities has increased. In addition, there has been an increase in the capacity for clinical, experimental or patient-led research. UK nurses have never been in a stronger position to become full partners in applied health research.

The consultation proposes an initiative for clinical academic careers for nurses similar to one already being planned for doctors. The RCN, Nursing and Midwifery Council (NMC) and other interested parties must ensure that planning for this initiative begins as soon as possible, and is linked to existing efforts in individual institutions to promote a research culture for all academics (Jootun and McGhee 2003). The RCN PhD Students’ Network (www.man.ac.uk/rcn/rs/phd/index.htm) is also a key stakeholder, as the nurses involved are the potential future academic leaders of nursing (McVicar and Caan 2005).

*Best Research for Best Health* has proposed the creation of a National Institute for Health Research which would have new leadership funding for those people envisaged by the RCN (2003). It is essential that potential nursing research leaders have access to this funding. In addition, the organisations that employ these leaders-in-waiting must recognise that they have a responsibility to provide a culture that enables nurse researchers to introduce new practices and refine old ones (Cook 2005).

A major element of the proposed National Institute for Health Research will be a ‘Faculty’ to deliver the research needs of the NHS. This is the point at which the consultation explicitly mentions NHS nurses as potential ‘associates’ in trust-based research. Clearly, nurses have an interest in shaping the development of this Faculty right from the outset. It is important for nurses to be involved in deciding what research activity should be mustered quickly.

The National Research Register contains brief details of more than 100,000 research projects, old and new, including duplications where multiple centres are involved. It lists 13,487 ongoing projects entered by individual trusts. The search term ‘nurse’ or ‘nursing’ highlighted 620 projects, ‘midwife’ or ‘midwifery’ 139 projects and ‘health visitor’ or ‘health visiting’ 30 projects. There must be hundreds of NHS nurses involved in these projects registered by single trusts. Some nurses are the principal investigators on national projects that involve nursing practice funded by the NHS.

**Within the National Research Register we**
have identified at least 13 individual nurses holding this type of national grant. At the very least these national research leaders could form the nucleus of nursing within the new Faculty, to be followed by many more who are currently gaining experience of research at local trust level. McVicar and Caan (2005) could not trace the present job role of all postdoctoral researchers. However, it is likely that in the UK there are approximately 200 nurses, midwives and health visitors who have gained a PhD related to health practice, policy or professional development since 1983. There is also an additional population of nurses who have gained PhDs in other fields of research such as the social sciences or humanities. If their contributions could be co-ordinated, UK nurses with experience of research could make a decisive contribution to the current consultation.

The proposed strategy contains a number of other promising opportunities. There will be a revival of NHS grants that are responsive to practice-based ideas, and two types of innovation grant to encourage creative thinking with a ‘potential to make a difference to the NHS’. Research governance has become increasingly difficult for nurses to engage in because of its spiralling complexity (Appleton and Caan 2004). The strategy proposes cross-boundary research passports for academic researchers to work with several health trusts that should simplify NHS University collaborations. There is also a promise to make research ethics committees more user-friendly. Additionally, the Association of the British Pharmaceutical Industry is a key participant in this research strategy. Now that nurse prescribing is established, nurses should consider whether they should apply to the pharmaceutical industry for research money.

However, the biggest opportunity for nurses to shape the research agenda is noted in a subtle footnote to the consultation document that many readers may miss. ‘This part of the strategy relates to ‘clinical partnership working’. One of the consultation questions is ‘are there other important elements that we need to consider?’ Nurses currently undertake clinical work in many non-NHS organisations, including children’s trusts, hospices, local authority learning disability teams, nursing homes and prisons. As a profession, nursing could take the national lead in developing new research partnerships.

Nursing should take some encouragement from the consultation document. With the growth in recent years of research activity, and the continuing development of research leaders, the profession is ideally placed for an acceleration of research development. However, not all should be taken for granted as there are threats to the continued growth in nursing research activity.

**Threats**

The biggest threat to R&D in nursing from *Best Research for Best Health* is the concentration of research resources and leadership in a handful of selected research-intensive hospitals. Two medical schools likely to be selected for their ‘world-class’ research, according to the Research Assessment Exercise, are Imperial College and Oxford and yet these universities do not teach nursing. Concentration of resources on specific centres is likely to exacerbate regional inequalities. Also, at a time when the White Paper on health care outside hospitals (Hewitt 2005) is aiming to bring together all primary and community care services (Martin 2005), innovation in community nursing might be stunted by an exclusive focus on experimental medicine in teaching hospitals.

All the focus of the consultation is on clinical research of individual cases, but to solve some health problems a whole systems approach to research is needed, for example, in Health Action Zones for people living in a deprived locality (Plamping et al 1998). That broader view needs to be preserved within the culture of nursing.

To counter the potential threat to developments in health care outside hospitals, we need to highlight the unique roles of nurses in the community. The NHS Executive (1998) evaluated the experimental schemes for children with a life-threatening illness (that eventually became Diana Nursing in memory of the late Princess of Wales) and noted: ‘Clearly many nurses make excellent key workers and are often the practical instrument that gets something happening’. Innovation does not just happen in teaching hospitals. Nurses are currently breaking new ground in their communities in fields as diverse as enabling children to make judgements about their care (Moules 2004) or designing ecological interventions for mental illness (Burls 2005).

However, based on past mistakes, we need to be realistic about over-ambitious schemes for research. The hyperbole about the transformation that lecturer practitioners would bring to research was not matched by impact, mainly because individual nurses were only in these posts for short periods (Hollingworth 1997). This time academic nursing careers will need a much more strategic approach to their development. However, postgraduate nursing researchers are showing a remarkable perspicacity and creativity (Caan 2005) which bodes well for the future.
Conclusion

We stand at a turning point in the history of nursing research in Britain. The present consultation document on research funding in the NHS – Best Research for Best Health – is the latest development in funding reform (DH 2005). Nursing research must benefit from the proposals since the growth in research volume (capacity) and skills (capability) that has occurred in recent years means that nursing research is now better placed to affect patient care than at any other time. However, nurses must not be complacent. There are significant risks that nursing will once again be the poor relation.

If readers have any stake in the future of nursing research please add your views to this consultation before October 21. The consultation document and a ‘template’ for responses can be downloaded from www.dh.gov.uk/Consultations/LiveConsultation and responses can be emailed to RDconsultation@dh.gsi.gov.uk

Declaration of interest

All three authors declare an interest in the outcomes of this consultation: Woody Caan is a member of interprofessional regional and national groups looking at careers in public health and also chairs a social care research group for the NHS Research and Development Forum; Andrew McVicar is supervisor for many nursing research projects; and Valerie Shephard is about to complete her PhD thesis on obesity and primary healthcare nurses.

References


