

# ***Academy of learned societies for the Social Sciences***

***with the NHS R&D Forum social care research group***

**Response to the Department of Health Consultation**

**Best Research for Best Health:**

**A New National Health Service Research Strategy**

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## **Summary**

The Academy welcomes this opportunity, both to advise on Research Policy for Health and to share in the development of an important national asset, the NHS.

This Department of Health consultation offers both opportunities for the future development of social science research for health, and threats to that future. *Best Research for Best Health: A New National Health Service Research Strategy* contains proposals described as 'radical'. Lessons from the history of health research reforms in the UK suggest that it will take some time for any benefits to become obvious and that only some members of the research community will benefit. In the last few years the Academy for Social Sciences has brought together a spectrum of over 40 social disciplines and identified their contribution to a number of national priorities for health. The proposed new R&D strategy could work to consolidate the contribution of social scientists to the National Health Service and to the patients who rely on its expertise.

New transparent funding streams, especially when linked strategically to long-term investment in specified health topics, could draw more social scientists into

**partnerships with the NHS and also could promote world class social science skills among the wider health research workforce.**

## **An opportunity for new capacity and collaboration**

Research by the ESRC (Cairncross and Diamond, 2005) has found that the 'breadth and vitality of UK social science' is regarded as strong 'around the world'. The consultation *Best Research for Best Health: A New National Health Service Research Strategy* (Department of Health 2005a) seeks to promote 'world-class' research and development (*R&D*) for health. This consultation concerns how best to utilise the £680 million per annum allocated to the NHS, by the Department of Health, for R&D. The history of developments in the NHS since 1948 identifies that there are precedents for growth and innovation in research during NHS reforms. For example, 'new collaborative developments' *including social science contributions* helped provide a 'basis for improved services' during the last reform of Primary Health Care (Lupton and Saunders, 2000). Both the Academy for Social Sciences and the NHS R&D Forum were consulted directly by the Department of Health, and because there is a substantial overlap in both interests and membership, the Academy and the Forum's social care research group will respond jointly, here. The response will consider three dimensions of R&D for health:

- The potential for academic **social scientists** to enhance the new National Health Research Strategy
- The potential for **social science skills** to enhance the research capability of clinical academics
- The development of R&D applied to **social care practice**, especially practitioner research.

The Academy represents a broad spectrum of Learned Societies across the social science disciplines, including several professional groups directly involved in *social care* such as social workers, psychologists, housing officers, family therapists and managers in the public sector (Caan, 2000). The first publication of the Academy focused on *Health Inequalities* (Forbes, 2001) and at an early stage in scoping the potential of social science to shape the future, academicians identified the new NHS Primary Care Trusts as a most promising area for research partnerships (Commission on the Social Sciences, 2003). Contributions from the Academy to Sir Michael Peckham's *Foresight Healthcare Panel* (2000) led to their recommendations:

- To exploit the potential for health advancement **through social policy innovation**
- To provide advice to government on **the development and well-being of children**
- To integrate explicit **health objectives** within **international development policies, treaties and conventions.**

Teams of social scientists have responded to some of the most complex and unexpected challenges to health in the UK, for example recent work on the long-term effects on rural populations of epidemic *foot and mouth disease* involved insights from both social anthropology and geography (Mort et al, 2005).

### **International Developments**

In both the USA and Australia national bodies concerned with the social sciences have sought to contribute to health advancement (Division of

Behavioral and Social Sciences and Education 2004a, 2004b; Edwards, 2004). Many of the problems addressed are also familiar to British policy-makers e.g. preventing childhood obesity or reducing underage drinking. Where international social science collaborations have begun, these have addressed widespread concerns such as the impact of *globalisation* and *inequalities* (Pontifical Academy of Social Sciences, 2002). The UK presidency of the European Union has already stimulated ideas for R&D in areas as diverse as health and sexual tourism or migration, TB and healthcare for homeless populations in our big cities (Caan, 2005a).

### **A Lesson from History**

To improve the evidence base for NHS developments contained in *The Health of the Nation*, the 1991 strategy *Research for Health* was a reform of historic magnitude. Sir Michael Peckham's vision coincided with the Purchaser-Provider split in health services and focused on aligning all the major sources of R&D money, including *concordats* between the Department of Health and the Research Councils. To complement *Research for Health*, the Independent Review Group (1994) produced a strategy for R&D relating to social care. Unfortunately, this social care strategy was not implemented across *Social Services*, whereas thanks to the brilliance and perseverance of the economist Tony Culyer, *NHS* research funding systems were gradually reformed. Learned societies were consulted repeatedly about their potential contribution to research capacity. This reforming zeal culminated in the first international showcase for evidence-based practice, the conference *Scientific Basis of Health Services*, in 1995. Interestingly, during the Health Technology

Assessment section of that 1995 conference, social scientists present identified critical constraints on clinical trials involving sick children (to do with family dynamics): if these constraints had been addressed *then*, the Department of Health would not now be compelled (by the EU) to launch a catch up programme about Medication for Children.

The 'Culyer' funding system was then evaluated in the biggest-spending NHS Region. 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% of R&D support funding in the Region – reported a significant positive impact on R&D performance.' (Conclusions, page 65)

Reporting on the present R&D Consultation, the *BMJ* spotted the historic weakness in past Department of Health 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). Like the film *Casablanca*, a tendency to Round Up The Usual Suspects has prevented growth that responds to national needs, e.g. new research capacity to impact on Health Inequalities (Caan 2002). The Department of Health has recognised this unequal pattern of development: '*there has been a longstanding shortage of research groups with expertise in research on social care issues*', (DH, 2001) and this perpetuates a shortage of *research training opportunities* 'within small disciplines such as social work' (Social Care Institute for Excellence, 2004) and distorted 'postdoc prospects' for academic *career pathways* in the applied social sciences (Lipsett, 2005).

## **The current context of Reform in health and social care services**

The imminent White Paper on health care outside hospital (Martin, 2005) and the proliferation of potentially competing providers from both public and private sectors promised by the Secretary of State from December 2005, will impact on both service users and staff across the Community, in fundamental ways. Already, a year ago Government policy directed that 'social care will be further integrated with health services' (Department of Health, 2004). In terms of existing service development,

*'The question of what is health and what is social care is one to which we can find no satisfactory answer, and which our witnesses were similarly unable to explain in meaningful terms. The policy division between health and social care lags far behind practice in a number of areas, where, born of necessity, health and social care professionals have commendably developed innovative joint working practices.'* (Department of Health, 2005b).

In this context of converging practice, it is not surprising that 86% of social care professionals now say their relationship with health professionals is 'good or excellent' (Community Care, 2005). However, in the academic disciplines for social care, there is profound concern that the major service changes in progress *build on evidence* of best practice (Ferguson, 2005).

Today, the recommendation of the Independent Review Group (1994) has become even more urgent, that a criterion for an R&D Strategy is that: *'it crosses the boundaries of social care, health and other related services, such as education and housing'* (Recommendations, page 6).

## **The Academic context**

The report by the Academy of Medical Sciences (Bell, 2003) resulted in the UK Clinical Research Collaboration which is committed to 'reshape the clinical research environment'. The many collaborating funding bodies include all the UK Departments of Health, the Medical Research Council and the Economic and Social Research Council. Indeed, most of the ideas in *Best Research for Best Health: A New National Health Service Research Strategy* were foreshadowed in January (UK Clinical Research Collaboration 2005) including

- consolidating R&D funding,
- disease-focused research Networks (e.g. 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.

Within some medical schools, there has already been concern about the **concentration of resources** on five Academic Medical Centres (Fazackerley, 2005).

For the social sciences, both the ESRC and the Commission on the Social Sciences have found expertise is much more geographically *dispersed* than in biomedical sciences, and there is no evidence that concentrating social researchers in fewer units leads to higher quality research. Research on 42 social care projects for the Wales Office of R&D found that 'local', solitary research was typical (and utilised). Rather than attempting to

aggregate these independent researchers, the recommendation was for national support :

*'to develop transdisciplinary initiatives that met cross-sector practitioner research interests in health, social care, teaching and housing services'*

(Keane et al, 2003, page 13).

Philosophically, this is similar to the response of Banatvala et al (2005) to the adverse structural impact of the Research Assessment Exercise on academic medicine - to value 'the interdisciplinary approach to medical research' with a 'mixed constituency'. Perhaps the potential of the diverse *social science* constituency to enrich the proposed *Health Research Strategy* is illustrated best by the 2005 *Lancet Lecture*. Nobel laureate Daniel Kahneman (economist and psychologist) grappled with the implications for international Health Policy of seeking the elusive condition '**Well-being**'.

### **Best Research for Best Health: the big challenge ahead**

This was summarised by the Deputy Director of Research and Development for a NHS Research and Development Forum meeting (19 September 2005):

**'Social Care research is not in there'.**

Secondary challenges relate to the Strategy's exclusive focus on experimental medicine. Within each of the strategic, disease-focused priorities (e.g. mental illness), how will corresponding social research priorities be agreed (NIMHE, 2005)? Within NHS structures geared to facilitate more clinical trials, how will qualitative or participatory approaches to evidence fare (Gelling, 2005)?

Finally, in making Research for Health 'more responsive to the needs of patients, the public, healthcare professionals and policy makers' (Department of Health, 2005a), will the future NHS be able to synthesise 'evidence from diverse research designs' (Social Care Institute for Excellence, 2003)?

*Best Research for Best Health* aims to strengthen areas that are 'currently neglected or underfunded' (Department of Health, 2005a, page 7). Is neglected, social research the X Factor that could help this Strategy succeed?

### **The added ingredient of social scientists**

Before Academicians identified primary healthcare as a specially promising area for research partnerships (Commission on the Social Sciences, *ibid.*), the NHS had already concluded that purchasing 'social science support' (Temple, 1998) was a high priority for additional resources within primary care R&D. Within clinical research (e.g. breast cancer treatment, Liberatti, 1997) one of the most persistent disappointments has been in engaging service users, in the research process. Social researchers even enabled the most voiceless people, like homeless mothers, to lead research projects: these same women then presented their findings to the Deputy Prime Minister (Houston, 2004). As well as social scientists helping R&D to engage hard-to-reach groups, support from such non-clinical academics can help evaluate clinical care in complex social environments (e.g a neonatal intensive care unit: Caan, 2005b; a special school: Caan et al, 2005).

Some health interventions do not just act at the level of the individual patient, but affect their households and communities. Sometimes a whole

systems approach to research is needed (e.g. across a Health Action Zone: Plamping et al ,1998) or an awareness of the interplay of the physical environment, social networks and health (e.g. for Vocational Rehabilitation: Burls and Caan, 2005).

McVicar et al (2006) demonstrated the value of inter-professional training for research leaders in health and social care, specifically where research findings had a direct application to practice. The Strategy contains a welcome proposal to develop future research *leadership*. The Social Care Research Group has identified a shortage of emerging researchers able to take leading roles in the future of R&D. One hundred million pounds has been pledged to develop 'new blood' for academic medicine (Fazackerley, 2005). A complementary scheme to develop academic social scientists with expertise in health would be highly desirable.

Finally, research at the British Library (Lee et al, in progress) has already identified that the health researchers (both clinicians and social scientists) who produce high-impact original research are those that work synergistically with diverse collaborators. The Strategy contains a welcome proposal to offer *innovation* funding, as well as *responsive mode* funds for people with unpredictable, original ideas. Strengthening collaborations between the new Academic Medical Centres and academic departments of social science may help to stimulate the innovation that is so vital to the UK economy.

### **The added ingredient of social science skills**

Undergraduate medical students are increasingly being introduced to social science skills (UCL, 2005). Understanding community and lifecourse determinants of illness appears to help such students relate to their patients' lives (Booth and Caan, 2005). Postgraduate medical education involving social science skills (Wills, 2005) seems to translate directly into improved problem-solving (Hillier and Caan, 2005). The vast majority of postgraduate nursing students choose social research methods for their research projects (McVicar and Caan, 2005) with a wider and wider range of social science methods appearing in their theses, over the last 20 years. Not all health professionals that complete postgraduate degrees subsequently move into full-time academic careers. However, all the General Practitioners described by Bateman and Kinmonth (2001) developing new, academic careers, chose to improve their skills in social science research methods.

### **The added ingredient of social care practitioner research**

The theoretical framework for the practitioner-researcher is attributed to the educationalist Lawrence Stenhouse (1975):

‘It is not enough that teachers’ work should be studied:  
they need to study it themselves.’ (page 143)

The Academicians include both practitioners and academic researchers. Keane et al (2003) found that practitioners undertook a high proportion of Welsh research applied to social care. The recent emergence of Professional Doctorates (McVicar et al, 2006) should help improve the quality of research done within practice, and its dissemination. Ian Diamond AcSS, now director of the ESRC, is a supporter of a range of practitioner research, to parallel

traditional research council development of capacity in Universities. However, realistically, the funding from the ESRC (Social Care Institute for Excellence, 2004) or the HEFCE Research Capability Funding, for professions like social work or occupational therapy, will always be modest and will predominantly be won by researchers in Higher Education.

Potentially, the Department of Health and individual service providers are much more likely to provide resources for practitioners who are contributing to the knowledge base for care. The Strategy proposes that the new National Institute for Health Research includes a *Faculty* for practising doctors and nurses who make an important contribution to research within their Trusts. It would be highly desirable for the development of practice if social workers, occupational therapists, learning disability nurses and other professionals employed by social care providers, could also become part of this Faculty. The Social Care Research Group is in contact with a number of small research networks (e.g. for parenting, or learning disabilities, or improved employment after mental illness). Networks form an important strand of the Strategy, and given the concentration of resources in the five Academic Medical Centres, these Networks are crucial for ensuring that Regional inequalities are not exacerbated. Innovation does not just happen in teaching hospitals. Networking that includes a critical mass of social care practitioner-researchers will ensure that innovative 'best practice' is recognised and widely adopted.

## **Research infrastructure**

For community practitioners, Research Governance has become increasingly difficult to comprehend (Appleton and Caan 2004) but the Strategy's proposed Research Passports should simplify NHS-University collaborations and there is a promise to make research ethics committees more 'user-friendly'. The proof of the pudding will be the way new mechanisms for ethical scrutiny of student research in fields like social policy are implemented (Doyal, 2005). If Masters students (e.g. for MA Child Protection) do find the Department of Health systems 'user-friendly', then there is hope that the Strategy's intention to improve careers could extend to, say, the new Consultant Social Worker roles that combine research and practice development.

## **Conclusion**

The Strategy was clearly influenced by other stakeholders like the Academy of Medical Sciences and the Pharmaceutical Industry. We stand at a turning point in the history of social research for Health in the UK. The present consultation document on research funding in the NHS is the latest development in a series of funding reforms.

Social science could make a strategic contribution to Best Research for Best Health since the growth in research volume (capacity), skills (capability) and trans-disciplinary working (networks) that have occurred in recent years means that it is now better placed to impact on patient care than at any other time. As healthcare outside hospital evolves in the next few years, social care practitioners could also contribute to the knowledge base for practice.

The critical factor for success will be the quality of the **partnerships** that develop between clinical and social research communities.



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