

The Health and Care Act 2022: key challenges and priority actions for embedding research in the NHS

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The Health and Care Bill received Royal Assent and became an Act of Parliament on 28 April 2022.¹ Aimed at rebuilding the NHS following the impact of COVID-19, the Act incorporates some valuable lessons learnt from the pandemic. One of those lessons is the extraordinary value a research-active NHS can deliver. Embedding research in the healthcare system to improve outcomes for patients is now on a statutory footing.

Others have noted that the absence of commitment to regular workforce forecasts within the Act will be problematic because of existing shortages, which will leave the government struggling to deliver across its ambitions, including for research.² A key challenge is the pressure of dealing with rising demand following the pandemic by an exhausted workforce, which will leave little room to do more despite the opportunity that research brings to improving patient outcomes and reducing inequalities.

Even before COVID-19, there was growing evidence that research-active NHS trusts benefitted from delivering improved survival rates, providing better care experiences, and finding it easier to recruit and retain.^{3,4} Surveys have also shown that clinicians value research as important to their job satisfaction but are hampered by a lack of time, an NHS culture that disregards research as core business despite research being a key part of the NHS Constitution, and an increasing research skills gap.⁵ These barriers are most acute for women, those working less than full time and those in non-teaching hospitals. Patients also report added satisfaction when involved in research studies aligned with their clinical care.⁶

What will not work is simply adding research to an already congested job plan. The normalisation of research in clinicians' everyday practice will challenge NHS trusts to rebalance priorities - in job planning and appraisals; in creating supportive research infrastructures and incentives; and in shifting the emphasis of quality improvement from applying knowledge that we already have to

addressing many aspects of care where reliable evidence is absent and where current practice might even be harmful.^{7,8}

Research also needs to be made easier for patients and clinicians. In a health system that will remain overwhelmed for some time, the focus on clinical trials that are simple to recruit to and aligned to clinical practice is even more valid now, especially as COVID-19 research was a singular focus during the pandemic. Rapidly practice-changing research through large, inclusive and pragmatic clinical trials, such as RECOVERY, is a lesson learnt from COVID-19 and an opportunity going forward to address many conditions that are under-researched.⁹ Trial regulation also needs to change in parallel to focus on the scientific principles of randomized controlled trials (RCT) in a risk-proportionate way. The added value is the opportunity for increased global collaborations in NHS research efforts and for the Good Clinical Trials Collaborative to improve RCTs globally.¹⁰

The increase in accessible data linkages during COVID-19 needs to accelerate to enable electronic health and administrative records to be safely made available for research. Such routinely collected data provides an opportunity to re-design trials to be both higher quality and more efficient.

Increasing interoperability between information technology (IT) systems and rationalising information governance processes would optimize reusability of data to shift the NHS towards evidence generation and proficient, data-informed change.¹¹ Beyond the benefits of developing successful treatment and innovations, trusts can better recognise what is not working and tailor services accordingly to meet the needs of patients.

If research is designed carefully, it can have a light touch on the operation of the NHS, but this requires everyone to contribute and for it not to be just the preserve of the few. All staff will need to be aware of the opportunities that research presents to them and their patients. But research governance needs to be proportionate and existing schemes to encourage research in diverse professional groups and trainees, many of which have been developed by the National Institute for Health and Care Research (NIHR), should be more easily accessible. The challenge of increasing research capacity and capability also requires joined-up contributions from multiple stakeholders, including research funders, professional regulators and royal medical colleges.

If the UK government is to also achieve its ambition of 5 years extra healthy life expectancy by 2035 when current life expectancy is worsening for some groups, this is a timely opportunity to embed research while rebuilding services, especially in areas with the highest disease burdens and levels of deprivation.¹² COVID-19 research took place in teaching and non-teaching hospitals alike across the country and with implementation of integrated care systems (ICS) within the Health and Care Act, a truly integrated and equitable delivery of research could reduce health inequalities. Embedding

research properly into NHS clinical practice requires significant changes but these will be justified by the sustainable benefits to the health and care system – most importantly, its staff and patients.

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