What are the tensions in research collaboration for NHS Trusts and HEIs?

FINAL REPORT

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Executive summary

Research active health and care organisations can have improved patient outcomes, though managing research at the 'clinical/practice coal face' at the same time as providing an excellent service can be challenging. One route to increasing NMAHP research capacity is to increase collaboration between the NHS and Higher Education Institutions (HEIs). Although we knew anecdotally there are some tensions for NHS-HEI research collaboration, through a survey to NHS and HEI colleagues (n = 323) we can now share the nature of these.

NHS and HEIs agree importance of evidence-based practice, staff development, education of students and staff at all levels, and person-centred care. Performance measures, patient experience and meeting targets were also generally agreed, though seen as more important to the NHS than to HEIs.

Clear differences, and thence potential tensions, for the NHS and HEIs relate to efficiency of services (very important to NHS); grants and publications (very important to HEI); diversifying income (important to HEI). Responses from those in joint appointments indicate they have some further and different tensions.

The vast majority of free comments expressed tensions and frustrations, even anger, maybe not surprisingly as the survey focused on "tensions", though these pessimistic views were not universal. NHS respondents spoke about the lack of time for research and the disconnect sometimes between senior management and what happens on the ground. There was also a sense that medical research was supported in contrast for NMAHPs. However, with some optimism for the future, respondents noted change in attitudes, a step-change on the focus and standing of research within Trusts.

These differences could explain the challenges for HEIs and NHS colleagues in bid/grant writing, and in developing joint clinical-academic posts. It appears important to acknowledge these differences as they are unlikely to go away, and instead adapt to working with and around these.

Acknowledgements: Thank you to all those who took time to complete the survey.

Background

The NHS has set an ambition to increase clinical research activity. It is known that a research active organisation produces better patient outcomes, in addition to delivering research as an end in itself. Many key UK-wide NHS documents reflect similar requirements for research education aiming to enhance practice and improve patient care and frame research and its benefits to patients and service delivery (1). Managing this at the 'clinical/practice coal face' at the same time as providing an excellent service can be challenging and is helped by a range of case examples, models of working, to help managers apply approaches that work at their level in their locality. This is especially important in the context of increasing financial constraints, a drive for outcome based commissioning and the widening of the healthcare provider market.

Research activity among nurses, midwives and allied health professionals (NMAHPs) has lagged behind medical research. One route to increasing NMAHP research capacity and activity is to increase collaboration between the NHS and Higher Education Institutions (HEIs), particularly in developing Clinical Academic Careers (2). A working group, initiated by the Department of Health and hosted by the Association of UK University Hospitals (AUKUH) comprises NHS and HEI representatives with an interest in clinical academic careers for NMAHPs, and aims to promote support for clinical academic career pathways.

We knew anecdotally that there are some tensions for NHS-HEI research collaboration. It is a current issue, routinely commented on and one that needs to be understood better. These challenges of research in practice have often been discussed, but with limited information on the nature of the challenges. We therefore decided to conduct a survey (Bristol Online Survey) to investigate the differing demands on HEIs and NHS using previously piloted, closed questions. We asked about issues, such as efficiency of services, performance measures and the value given to research activity. Comment boxes were associated with each question. The survey was distributed via the 31 members of the NMAHP CAC working group with a request for members to cascade to anyone they knew might be interested in participating (snowball sampling).

Findings

We received 323 responses. Of these, 68.1% (n = 220) were based in the NHS; 22.6% (n = 73) in HEIs; 5.8% (n = 19) had NHS/HEI joint appointments (most split 50:50) (Figure 1). A majority of NHS responses were from clinicians (31.8%, n = 102) and there were approximately equal responses from HEI lecturers (9.3%, n=30) and HEI researchers (7.2%, n = 23). 'Other' respondents (n = 5) included a professional body research lead, NHS Research Fellow, NIHR fellowship holders, one head of HE in a mixed economy college, one member of a consortium of an NHS and 3 HEIs. There were six incomplete responses which are excluded, and twelve where respondents had answered most of the 15 parts of the questions and their data have been included.

Respondents were asked about the importance to them and their organisation of a series of research related issues based on our experience and feedback from the working groups. The responses have been clustered to employment by NHS, HEI or joint appointment to help explore the tensions around research between the different organisations.

There were some areas where there was general agreement about being very important or of some importance - application of the evidence base to practice, staff development, education of students and staff at all levels, and person-centred care (Figure 2). Performance measures were also generally agreed although respondents indicated this as being more important to the NHS (71%, n = 154 said very important) than to HEIs (56.3%, n = 40).

There were differences in responses from NHS, HEIs and those in joint appointments in a number of areas (Figure 3). There are some responses clustered around 'some importance' and 'very important' but with clear differences for the NHS and HEIs such as efficiency of services (NHS); grants and publications (HEI); organisation values research (HEI). Diversifying income for HEIs is very important (50.7%) though for the NHS is notably less so (27.3% reported this as being very important, and 41.8% as of some importance). Within a research context, NHS respondents considered the patient experience and meeting targets as being very important (90.5%) whereas 24% of HEI respondents considered this 'not applicable', and though 45.2% HEI respondents also considered this 'very important', this is considerably less than NHS colleagues' response.

The importance of research findings being easily translated into practice, and research being immediately applicable to practice were asked as separate questions. It is curious that both questions are less important to NHS respondents than those in HEIs given the NHS focus on clinical practice, and the National Institute of Health Research explicitly having this focus (Knowledge Mobilisation). Figure 3 illustrates easy translation of research to practice as being very important to HEIs (62.5%, n = 45) whereas only 42.7% (n = 93) of NHS respondents consider this very important and 45.9% of some importance. Figure 3 shows a similarity in pattern of response to the immediate application of research to practice, in that this is less important to NHS respondents (35.5% very important) compared with HEI responses (52.6% very important).

As there were 19 respondents with joint appointments, their responses have been separated out, Figures 2 and 3. The data suggest some further or different tensions apply to this group with joint appointments, for example the majority (94.7%, n = 18) responded 'don't know' to – patient experience and meeting targets. For research targets as part of appraisal or annual review 57.9% (n=11) said this is 'very important' but for 26.3% (n=5) this is 'not important'.

Table 1 summarises areas of similarity and difference relating to research for NHS and HEI organisations. Where there are differences (blue and yellow), this may suggest these are main areas where tension can occur.

Table 1: areas of similarity and difference relating to research for NHS and HEI organisations
Blue = more important to NHS than HEIs
Yellow = more important to HEIs than NHS

Efficiency of services *More important to NHS*	Patient experience and meeting targets *More important to NHS*	Diversifying sources of income *More important to HEI*
Publications and grants *More important to HEI*	Research findings translate easily to practice *More important to HEI*	Research has immediate application to practice *More important to HEI*
Organisation values research *More important to HEI*	Expectations of research governance and time for ethics approval understood *More important to HEI*	Service users to have opportunities to be involved with research at any stage *More important to HEI*
Application of evidence base to practice *Important to all*	Education of staff and students at all levels *Important to all*	Person centred care *Important to all*

Free text comments

Of the 323 respondents, 114 chose to add a free text comment. Many talked about the lack of time for research in the NHS, the need to *"churn patients through as fast as possible"; "immediate clinical work takes priority" and "lack of research investment"; "it is not possible to do research in work time".* There appears to be a disconnect between senior organisation commitment to research, which may be strong, and what managers actually allow and value in clinical areas, with resources *"not necessarily commensurate with the stated importance"* and local managers' comments said to range from unsupportive to *"refer to academic activity as 'research rubbish'".* Others felt senior support was limited: *"senior management tend to want to rush out pieces of audit or "research" in order to look good to CQC etc".* One respondent summed this up as "*lack of infrastructure for research, lack of culture that values research activities, lack of support for nurses to engage in research activities".* Some felt large medically-led studies were the only type of research supported: *"only medical staff have the time".*

It was unclear if the culture of not valuing research is separate from, but exacerbated by, the high demand for the clinical service and staff shortage; possibly even if over-staffed and with few patients, research would still not be a valued activity: *"I feel research is not viewed*

as a core part of any clinical role by colleagues and managers It is seen as some kind of luxury on top when you have done your core clinical job and is the soft underbelly that can go when resources are stretched or capacity is limited". This contrasted to support for medical clinical academic careers: *"The NHS in our region is committed to integrated clinical/academic medical training and somewhat to integration of research into training and practice for medics. Conversely the NHS in our region is not committed practically to integrated clinical/academic training for NMAHP employees and has no manifest plan at all for integration of research and clinical activities for NMAHPs. The impression is given that NMAHPs' role is only to churn through patients as fast as possible and that any research/training/development activity is but a distraction from core business". "Research is extremely difficult for clinicians such as AHP's… IRAS system and the subsequent NIHR processes have made is a complicated, time consuming and stressful process that has definitely lead to myself making the decision not to do any more research. Also, being a clinical professional has meant that the research has been completed without support/ mentorship that one would get if completing research within a research department. The experience has been isolating". "Tensions +++ with senior clinical lecturer posts as the scheme funds 50%, NHS puts in 50% and HEI put in 0%. This is hugely impacting on the NHS supporting these posts and anything that can be done to rectify this is essential. In addition, funding for research grants predominantly goes to HEI and so they take the overheads too! Not surprising these posts do not have strong support within the NHS".*

The vast majority of comments expressed tensions and frustrations, even anger, maybe not surprisingly as the survey focused on "tensions". However, this pessimism about research potential was not universal from NHS respondents and there were signs of a change in attitudes: *"There has been a significant step change recently as to the focus and standing of research within the trust's strategic objectives. Included in this is a real drive to raise the profile of research and create opportunities for clinical staff to become more engaged in research activities".* But this did not always permeate the organisation to all levels*: "We find that there is commitment to research and service improvement at Board and Exec level but that it often gets diluted at middle management. It is at divisional/departmental level that service pressures impact capacity to deliver research".* Others spoke of clinical teams being encouraged to develop in their roles and apply evidence-based practice, having an AHP researcher to support others, and small grant funding from hospital charities.

There were relatively few comments from HEIs. *"As a nurse working in a HEI I feel that the biggest barrier to integration is the requirement for nurses to stop clinical practice in order to pursue an academic career and yet a successful career requires successful and meaningful research on patients with who they no longer have clinical contact".* The HEI imperative to obtain grants could be at odds with the relevance of clinical questions: "*NIHR espouse transformational approaches but criteria for judging research funding bids remains firmly traditional".*

Some joint posts generally work well but with their own procedural tensions: "*Having held a highly successful joint professorial appointment between HE and the NHS for the past 12 years I have not found these to be particular tensions in the role - or between the two*

organisations I work for. There are quite different tensions that I experience as an incumbent of a joint role, and between the two organisational cultures… For example, grant capture is important to both - the tension is where the grant is actually located in order to count in organisational metrics. The immediacy to deliver on the NHS agenda is often a tension with the comparatively slower delivery in HEI". "A lot of work has been done to develop a shared set of research priorities between my HEI and my local NHS Trust, but for the individual researcher, there is still a tension between identifying research priorities within the clinical setting (based on clinical problems) and finding a way to fit them into the existing research group activity/structure within HEI". There was some optimism about the future: *"The key drivers for both organisations are, at times, completely different. Clinical practice appears to place very little importance upon grants and publications, and rather is concerned with delivery of highest quality care at lowest cost. Recognition that research may be a funding revenue stream is increasing however, this has not readily translated into 'research in practice' and clinicians are generally unaware of how best to inform the research that is going on. Equally, I find there to be little meaningful engagement from researchers with the clinical community - inviting clinicians to meetings at the university site in the middle of clinic hours does not count! None the less, I am seeing some improvements with a modest, yet growing culture of clinical academia".*

Several people commented that while they valued research, their organisation or manager did not *"I do not feel my thoughts are the same as the department within the NHS I work for"*. Roles split between the NHS and an HEI seem to be at times problematic: *"very frustrating and caught between competing demands".* People expressed concern about re-integration after a fellowship and concern that their hard work, new knowledge and skills were largely wasted: ***"****In taking this scheme forward it is essential to address the tensions for clinically based researchers between service delivery and clinically based research. In working with NIHR funded early career researchers I hear time and again that on completion of their Masters or PhD no one in the Trusts know how to use their skills and expertise and that the focus is placed on service delivery. These students are not being linked into people or networks within their clinical setting who can help them to develop their research career, they are often managed and appraised by people with little or no understanding of researcher development".*

Discussion

The anecdotal impression of tensions for research collaboration between NHS and HEIs appear well founded. The response to our survey was considerably greater than anticipated, given that we snowball-disseminated only via our contacts through the Clinical Academic Careers Development Group (CACDG). The differences (table 1) are major in some instances and could explain the challenges for example of HEIs engaging NHS colleagues in bid/grant writing, and of developing joint clinical-academic posts, though of course there are a number of notable, effective collaborations across England. The important point would appear to acknowledge these differences as they are unlikely to go

away, and instead adapt to working with and around these.

There are however some areas where changes in either NHS or HEIs may be made. One such example is for the HEI emphasis on service user involvement in research at all stages to become more embedded within the NHS. This understanding may help reduce one of the areas of research-related tension between the different organisations.

The importance to the NHS respondents of the patient experience and meeting targets is encouraging and not surprising. However it is a surprise that easy translation of research to practice and expectation of immediate application of research to practice is more of a focus for HEI than NHS respondents. Evidence based practice is 'very important' to a large majority of all respondents: *'Knowledge is sticky and needs help across boundaries. It comes in many forms and often resists easy capture and sharing' (Nutley 2013)* so it is not yet clear why NHS colleagues' responses suggest research of immediate relevance to practice is not of more importance (2).

In addition to the challenges imposed by differing cultures related to research, there are the constant pressures of high demand for service delivery in an environment of staff shortages and economic constraint. The cumbersome bureaucracy that surrounds the governance and conduct of research is a further deterrent to clinical academic or research trainee staff who may have limited access to support and time to wait for study approval.

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(2) Finch report: http://www.researchinfonet.org/wp-content/uploads/2012/06/Finch-Group-report-FINAL-VERSION.pdf; Department of Health (2012) UK Strategy for Developing the Role of the Clinical Academic Researcher in the NMAHPs: https://www.gov.uk/government/publications/developing-the-role-of-the-clinical-academic-researcher-in-the-nursing-midwifery-and-allied-health-professions, AUKUH website: www.aukuh.org.uk

(3) http://blogs.lse.ac.uk/impactofsocialsciences/2013/02/25/practising-knowledge-mobilisation/

Figure 1. NHS Trust and HEI respondents' roles (n = 323)

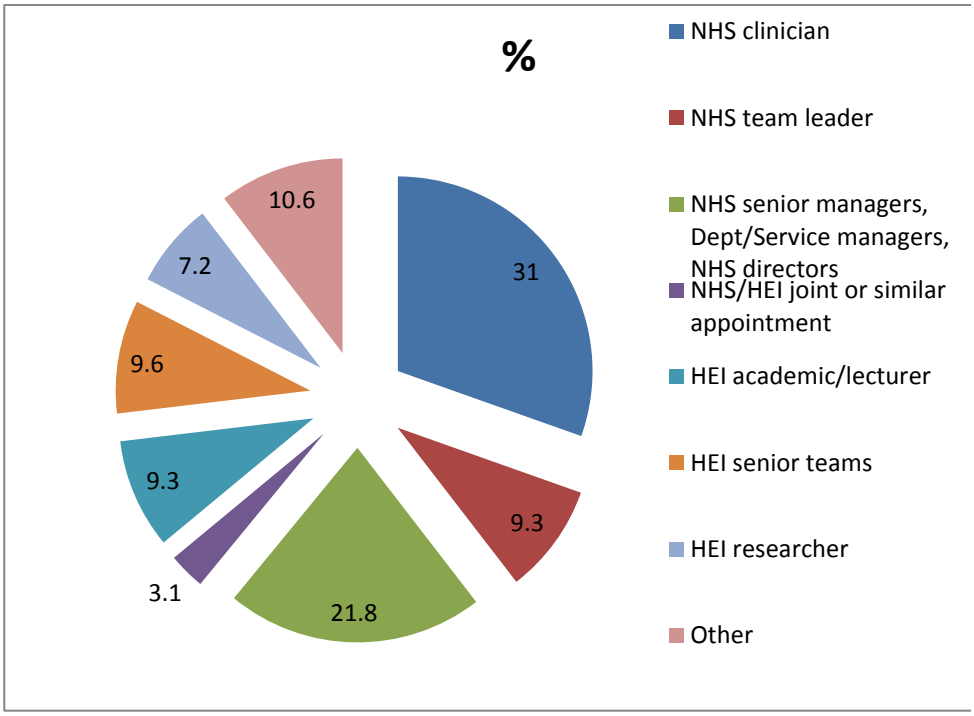
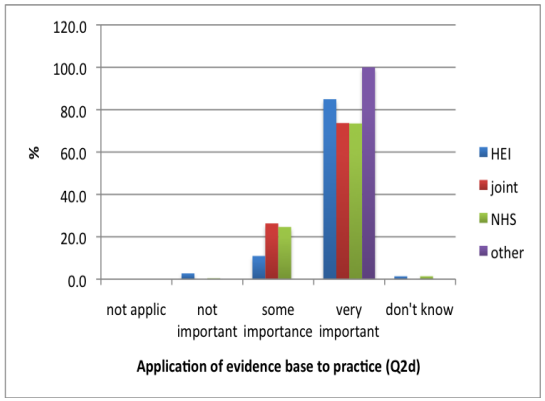
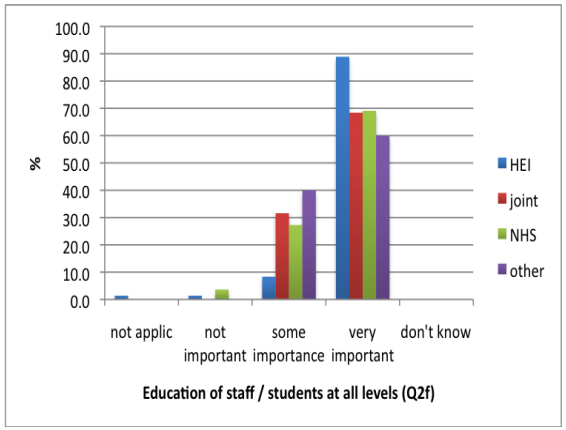
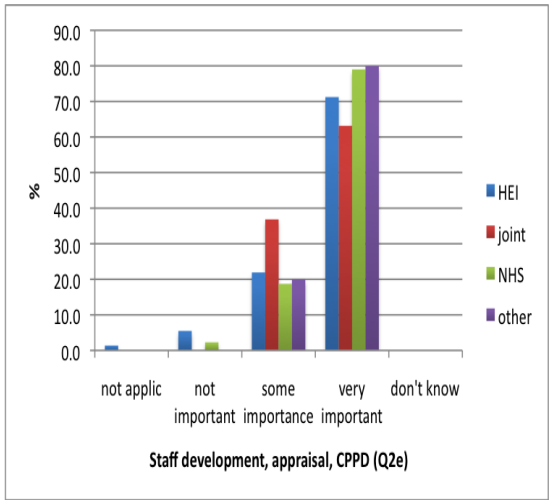


Figure 2. Areas where there is general agreement in NHS, HEI and joint appointment responses.







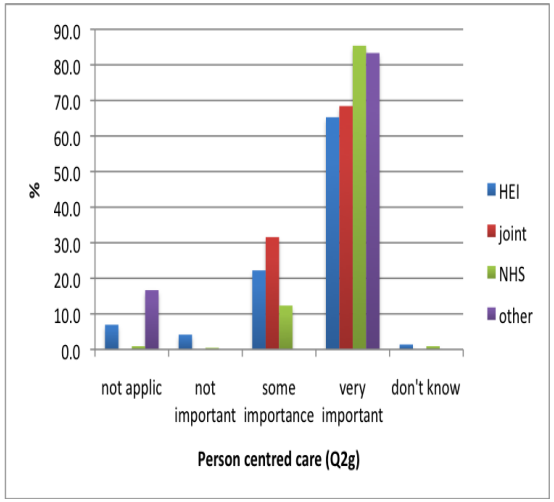
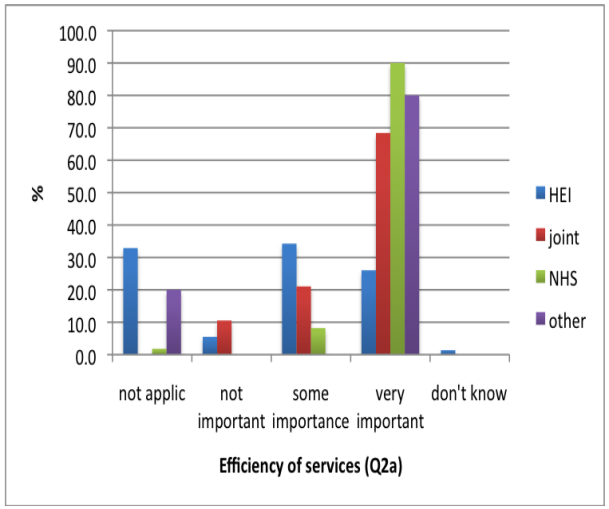
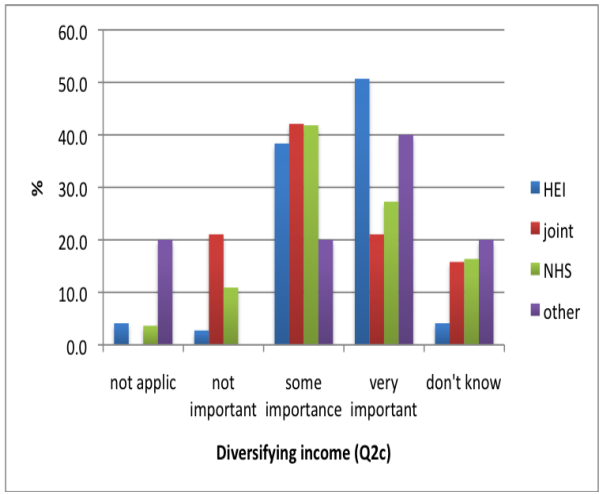
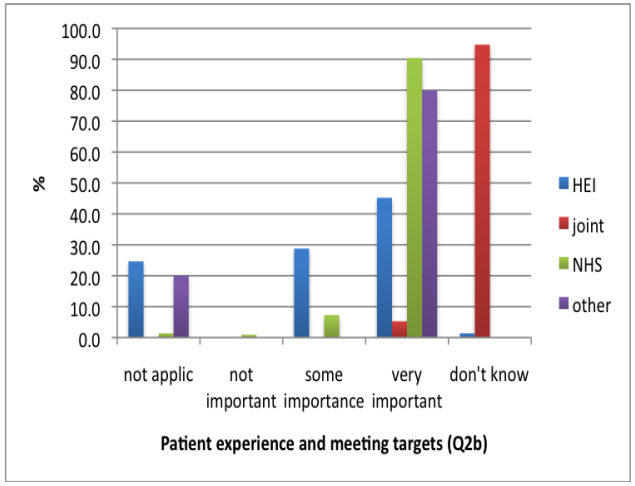
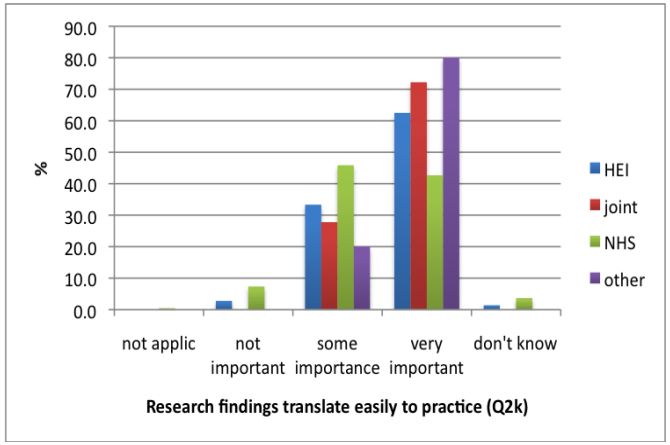


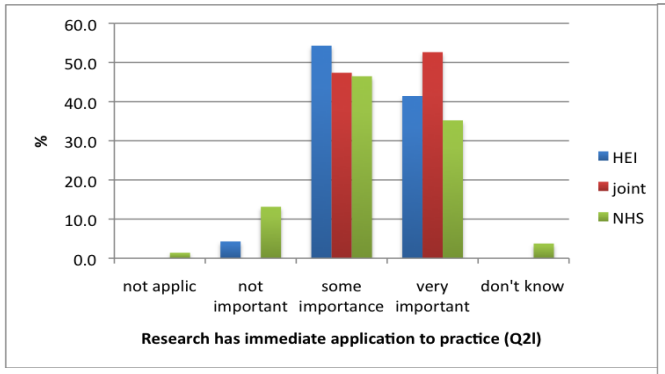
Figure 3. Areas where there is difference in NHS, HEI and joint appointment responses







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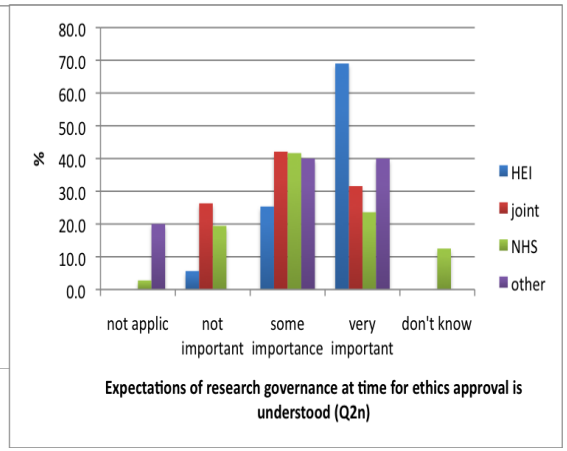
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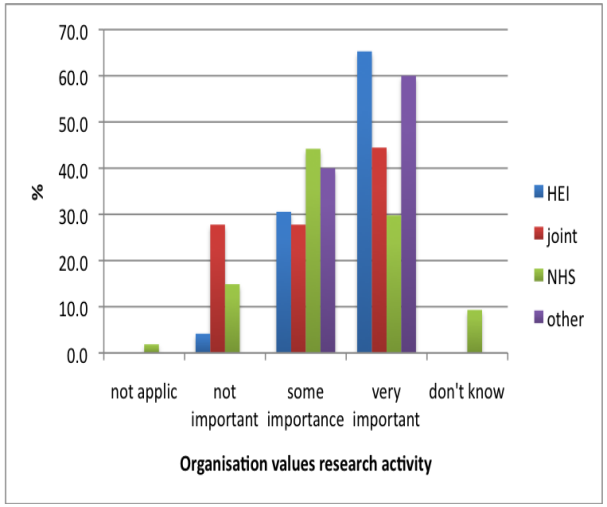
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