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Editorial

Are primary care research networks up to the challenge?

How swiftly things change! It does not seem so long ago that primary care research networks (PCRNs) were espoused within the NHS Research and Development (R&D) programme, with the Mant Report (NHS Executive, 1997) recommending network arrangements for all localities and co-ordination at a national level. The initial remit was to facilitate research and to promote the acceptance of a culture of research in primary care. These now sound rather old-fashioned sentiments. Increasing 'research capacity' has been the more recent adage, and we know well how great a need there is for this in primary care, but is there a possibility that a still newer priority is approaching?

Networks are currently under intense pressure to deliver. The current climate suggests that PCRNs have to be seen to be part of the national and regional R&D initiatives, including the carrying through of new policies and priorities, rather than acting as independent initiatives. Funding changes have sharpened the view that PCRNs have to respond and conform to the strategic intentions of the Department of Health in order to survive (Department of Health, 2000a). The shift of balance from Regional R&D funding towards Culyer, and now the Support for Science and the Priorities and Needs Funding streams, potentially leaves PCRNs somewhere between the cracks, in danger of being squeezed or, in some cases, squeezed out altogether. The priorities of networkers themselves may in future need to run parallel or be subservient to the changing administrative and management requirements within the new NHS research ethic. Add to this the shifting ground in relation to national R&D requirements, especially research governance, and network leaders can't be blamed for asking themselves what they are supposed to be doing, for whom, or whether it is worth it.

Nowhere is this more apparent than in the challenges faced by primary care in responding to the proposed requirements of research governance. This emergent concept, detailed in the current consultation draft and aimed at all managers and staff, in all professional groups, no matter how senior or junior, defines mechanisms to deliver standards in research and describes monitoring and assessment arrangements (Department of Health, 2000b). It lays down the responsibilities of researchers, especially the principal investigator (including the stipulation that the principle investigators must have suitable experience and expertise), and the requirement that research will be open to monitoring and assessment. Care providers (including practitioners) may only themselves take on the role of 'sponsor' if they have 'systems in place' to discharge the responsibilities of governance. Crucially, all research sponsors must have systems in place to undertake expert independent review of proposals to ensure their scientific and ethical standing, strategic relevance and value for money. Much (probably the majority) of research in primary care is so-called 'own account' research, i.e., without direct external support, management or sponsorship, and these proposals create a special challenge for the PCRNs who support these researchers.

Primary care researchers, whilst becoming more team oriented, remain driven by personal initiative and enthusiasm. Applying mechanisms of research governance which assume the nature of 'sponsorship' and accountability could have an enormous negative effect on the level of research activity in primary care and on its capacity development, even though this must run counter to the aspirations of the Department of Health.

Will research governance represent a new opportunity for PCRNs or an added task for their often small and overstretched teams? Networks are certainly capable of meeting these challenges providing they adapt to functioning beyond their original remit of training and support. They are

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well placed to assist with research governance in primary care, a task that requires sensitivity and a light touch in a developing environment. They cannot now afford to be associated with dubious research, and network leaders will have the responsibility of indicating when proposals do not measure up. When help is sought with completed or near completed projects, some may not reach the requisite requirements and could place PCRNs in a difficult position. Primary care organizations are likely to seek ways of independently ensuring that local research governance guidelines are conformed with – ironically this represents an excellent opportunity for PCRNs to liaise with such organizations.

PCRNs can also facilitate research teams based on their knowledge of local and outside resources. For example, a study on the management of heart failure, whilst based in primary care, might comprise a multidisciplinary involvement of hospital specialists, practice nurses, GPs and public health physicians. The ability to resource such teams is almost unique to networks, and represents an effective method of responding to the research needs of PCGs. In particular, clinical or health services research in primary care alone may be too narrowly focused to be conducive to improvements in care and for influencing management across the health boundaries.

R&D in primary care has made huge strides in the last 10 years. Far from being considered a superfluous activity, it is now thought to be integral to the enhancement of quality care and for revitalizing the academic base of primary care. Nearly all PCRNs commenced with enthusiasm and commitment, often at grass-roots level. To keep pace with the changing requirements of the NHS, networks may need to reset their sights. They also need to recognize the national clinical priorities (and therefore the research priorities), such as those in the national service frameworks, and to demonstrate work in them. It may be unreasonable to expect PCRNs, often delicately placed in an environment of fiercely independent practitioners, to respond to these new challenges without reassessing their aims and capacity for response. That they will have to respond is almost inevitable.

This does not mean that the fundamental nature of PCRNs needs to alter. They are in essence research facilitation bodies and not professional research units. However, the networking function lends itself to the creation of partnerships, and there is now an opportunity for closer liaison with professional groups which would not have previously associated themselves with research. There is no reason why networks should not increase their stake in the research arena beyond their current functions. It is time perhaps to promulgate the culture of manifestly robust research in primary care as opposed to merely the culture of research. If we are to be judged on the basis of measured outputs and bibliometric evaluations, this may be the most effective way of demonstrating success. Is your PCRN thinking about these new challenges?

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