Strengthening Health Services Research

A record of a joint meeting hosted by The Academy of Medical Sciences and the Health Services Research Network held at 10 Carlton House Terrace on 6 September 2005

Contents

Section 1: Introduction and background: A perspective from The Academy of Medical Sciences'

Section 2: Introduction and background: A perspective from The Health Services Research Network

Section 3: Feedback from the break-out Groups

Section 4: Potential areas for action

Annex 1: Meeting attendees

Annex 2: Meeting programme

Section 1: Introduction and background: A perspective from the Academy of Medical Sciences'

Sir Andrew Haines, FMedSci

1.1 The chairman of the meeting welcomed participants (see annex 1) and provided some brief background to the meeting, which had come about as a result of discussions over some months between the secretariat and Officers of the Academy and those involved in the establishment of the Health Services Research Network. Both the Academy and the Network share a common concern that high quality health services research should flourish in the UK and that the resulting knowledge should be translated into an improving health care system, through better practice and policy-making.

1.2 The question to be addressed was how best to take forward this common concern. Where might advances be made by working together and where might it be better to pursue initiatives independently, but informed by a better understanding of each other's activities?

1.3 A further desired outcome of the meeting was the promotion of communication and networking between the members of the two associations. However, the meeting was not intended to be a purely bilateral event, as evidenced by the number of participants present from other organisations with an interest in health services research.

The Academy of Medical Sciences and health services research

1.4 The Academy was formed in 1998 to act as an authoritative body to promote medical science across traditional disciplinary boundaries. The authority that it commands comes largely from the eminence of its membership, from its independence and from the quality of its outputs.

1.5 The Academy has always seen influencing public policy as part of is core activities. It exercises this influence in a number of ways: through networking, through hosting meetings and seminars, through the work of expert committees, through consultation responses and through the publishing of reports. Recent influential reports have included those on clinical research and alcohol.

1.6 The Academy's values are entirely compatible with undertaking policy activity in health services research; many fellows would describe themselves as both medical scientists and health services researchers. However, based upon the Academy's records, those who describe themselves first and foremost as health services researchers represent a minority of the Academy's 800 Fellows.

1.7 To ensure that the Academy would add most value through activity in this area a Working Group meeting was held to explore the issues further. The background briefing note in annex 3 reflects the areas discussed at this meeting. The Working Group decided that lengthy discussions of definitions were unlikely to add value and that the Academy was content to work within the definition offered by the Health Services Research Network. However, it is important to note that there are varying views as to where the boundaries of health services research lie, especially in relation to population health sciences and clinical sciences.

1.8 Establishing the exact amount spent in the UK on health services research is problematical, not least because of the boundary issues. However, of the £650m spent by the Department of Health (DH) on R&D (the largest spend on R&D of any civil department), around £150m is spent on programmes that could be regarded as health services research. Approximately another £65m is spent by sources, mainly the Medical Research Council (MRC), although this is almost certainly an upper estimate.

1.9 The Working Group had identified four areas where the Academy might be interested in further work:

Methodological Challenges

1.10 Health services research as a field of enquiry is both multi-disciplinary and multi-professional. The consequence of this is it must accommodate a wide range of paradigms, methodologies and disciplines. This means that there are barriers to be overcome in terms of career disincentives to multidisciplinary work and cognitive barriers for researchers.

1.11 Within medical science there is a widely accepted 'hierarchy of evidence'. Some health services research can sit securely within this, for example health technology assessment, but many other research questions are not amenable to this approach and can only be approached by using methodologies that are less familiar to the bioscience community.

1.12 The evidence-based medicine 'movement' rests upon systematic reviews as the preferred method for evaluating and integrating data from different sources so as to inform clinical decisions. But this is a practice that requires reasonable consistency in methods and a well-ordered literature. Health services research presents substantial challenges in synthesizing evidence, especially that which is relevant to management and policy-making, because of the range of methodological approaches used and the importance of contextual factors in determining whether a particular strategy works in a given setting.

1.13 The 'hierarchy of evidence' can all too easily translate into a 'hierarchy of esteem' in which health services research drawing on social sciences are sometimes looked down on as 'second-rate' research using soft methodologies. Yet it may also be true that some health services research could be more methodologically rigorous.

Creating an evidence-seeking and evaluative user community

1.14 The extent to which research is translated into improvements in both practice and policy is partly determined by research strategies, commissioning processes and quality assurance mechanisms. But it is also determined by the extent to which the user community is able and motivated to access and apply the knowledge produced.

1.15 Theory, and a growing body of evidence, suggests that 'linkage and exchange' is the best model for promoting research relevance and utilisation. This suggests that attention must be paid to the development of organisational mechanisms to link the research community with policy-makers.

Capacity building and Leadership

1.16 Various models for assessing the strategic commissioning of research were available, for example those developed by the National Audit Office. The extent to which the deployment of health services research funding is informed by this sort of strategic analysis remains uncertain.

1.17 The Academy is interested in careers in academic medicine and the extent to which clinically trained researchers are entering careers in health services research.

1.18 There has historically been an absence in the UK of a national institutional or intellectual home for health services researchers. This may be a gap that the new Network is well positioned to fill.

International comparisons

1.19 The Canadian Health Services Research Foundation has been influential in developing thinking about mechanisms for engaging researchers and research users in long-term collaborative relationships, or 'linkage and exchange'.

1.20 In the context of discussion of medical careers and leadership, the 'Academy Working Group was impressed by the model of the Robert Wood Johnson Clinical Scholars Programme (USA). This starts from the premise that competence in health services research is the clinician's route to leadership in health services. This programme has now produced over 1,000 clinical scholars, many of whom are now in leadership positions in health care delivery organisations, in government and in academic medicine.

Conclusion

1.21 The main themes to have emerged from the preliminary discussions of the Academy Working group were used to shape the agenda for the event and, in particular, the topics for the break-out groups.

Section 2: Introduction and background: A perspective from the Health Services Research Network

Professor Nick Black, Chair HSRN Governing Board

2.1 The Health Services Research Network (HSRN) has been set up with the primary aims of encouraging policy-makers and managers to make better use of health services research and to ensure that research priorities reflect the needs of the public, policy-makers and those responsible for the management of the system.

2.2 The Network has the secondary aims of campaigning for secure funding for health services research and measures to improve careers in the field as well as providing a collective voice for health services researchers in policy debates. It aims to act as a collective voice in areas of common concerns to researchers, such as the Research Assessment Exercise (RAE) and research governance and it wants to promote dialogue between health services researchers, clinicians and managers.

2.3 Activities include: representing the health services research community to various interest groups, including managers, government, funding bodies and other professional and scientific bodies; organising events; building international links with equivalent bodies; producing and disseminating briefing papers; responding to consultations; keeping members informed and promoting networking.

2.3 Membership included health services research units and departments in universities, NHS Trusts, the independent sector, the charitable sector and professional associations. It is also open to both NHS and private health care organisations that are members of the NHS Confederation.

2.4 The Governing Board comprises four elected health services researchers, three NHS Confederation representatives and three representatives of sponsors (DH, Health Foundation and Nuffield Trust). As well as funding from these sponsors the Network is also funded by subscriptions from members. At present membership is on a corporate basis only but it was possible that individual membership might also be adopted in the future.

Section 3: Feedback from break-out Groups

Group 1: How can we further improve the quality and relevance of health services research?

3.1 Most health services research questions being tackled are important. There is always a need to pay close attention to context.

3.2 Health services researchers should seek answers to the 'best' questions that have wider relevance than the immediate locality in which the research in undertaken.

3.3 Health services research is not always internationally transferable.

3.4 The current status of health services research was discussed and it was concluded that the scientific community often sees health services research as being of lower standing than biomedical research. There may be incomplete understanding of the relevance of qualitative methods in some quarters. This warrants more exploration of relationships between academic standing, quality measures and relevance.

3.5 The group debated the nature of health services research and how it relates to clinical and basic science. A comparison was made with engineering because it is applied, and what counts is the process by which knowledge is made use of.

3.6 What is important is making research fit for purpose and this might lead processes like the RAE to need different paradigms for assessment.

3.7 All health services research needs to be of high quality and action is needed to promote continued improvement, especially in methodology. There should also be mechanisms for stopping poor health services research. It was suggested that there may be a strategic window for talking about resources needed for health services research methodology with the MRC.

3.8 Good health services research can include relevant international comparisons and can force users of research to re-examine problems from a fresh perspective.

3.9 Better timelines are needed for health services research: it is concerning that in order to move policy forward, policy-makers can demand unrealistic (e.g. three month) timetables for work. By comparison MRC has made proposals for funding 10-year research groups

3.10 There should be more emphasis on health services research in programmes that are developing new frameworks for clinical academic careers

Group 2: How can we increase the impact on policy and practice of health services research?

Challenges

3.11 Lasting relationships help health service researchers and policy-makers exchange information more fruitfully. It is more difficult to form these bonds if the DH is in a continuous state of flux. A central clearinghouse that consistently directs health service researchers to appropriate policy-making contacts in the DH would facilitate interaction. The importance of interactions between health service researchers and policy-makers in other government departments should not be overlooked.

3.12 Policy-makers are often more interested in results than methodology so do not find most scientific papers useful. Conversely, health service researchers often devote as much attention to how results were obtained as to their consequences. Information needs to be communicated in a format useful to its audience. On a similar note, there is concern that there is excessive focus within the health sector, and government more broadly, on action rather than thoughtful consideration. For example, those undertaking diplomas in healthcare receive larger bursaries than those undertaking academic degrees.

3.13 To make a convincing case for health services research to government it will be necessary to map current activity so strengths and weaknesses can be identified. Whilst this has been achieved by some other disciplines in the biomedical sciences the health service research landscape in the UK is not well understood. Moreover, without a clear definition it is hard to determine whether particular work is health services research.

Crossing the divide

3.14 Some policy-making bodies such as the DH and number 10 Strategy Unit have expressed an interest in research. The Health Services Journal presents awards to managers and policy-makers who support research, while the Service Delivery and Organisation R&D Programme (SDO) Chief Executive's Forum considers research questions on a quarterly basis. The government initiative, Policy Hub, also provides a rich resource.

3.15 To facilitate communication further, policy-makers should be on research commissioning groups while researchers should be on policy-making committees. Researchers can also influence policy indirectly through partnerships with patients and clinicians. Furthermore, heath service researchers should disseminate results through the media.

3.16 Health service managers and policy-makers need to be equipped to access health services research evidence. It is likely that these managers and policy-makers will be most interested in research that directly applies to their day job. Whilst it has been argued that a cadre of managers and policy-makers should achieve the necessary research skills through formal academic qualifications such as MSc's, there is also a need for more of them to learn more fundamental skills such as how to interpret research findings. It would be interesting to see what could be done at a middle as well as senior management level.

Communicating health services research

3.17 Historically PhD's have not been effective in teaching researchers to communicate. The NHS Service Delivery and Organisation R&D Programme use expert writers to provide four to five page summaries of research that focus on results rather than methodology. That said, there is a clear case for policy-makers and health service researchers to communicate directly. However, whilst some researchers are very enthusiastic and able communicators others are much less so. The Health Foundation might be able to offer a funding stream to support communication between researchers and policy-makers. Such activity should be undertaken in partnership with others.

International comparisons

3.18 In the US, where scientific knowledge is often more valued, it is easier to move between academia and policy-making. There are also fewer barriers between academics and clinicians. This may be in part because of the Robert Wood Johnson programme and the work of the Institute of Medicine.

Group 3: How can we ensure that innovations in health care and health systems are properly evaluated?

3.19 The group focused its discussion on innovations in policy, management initiatives and systems re-design, rather than innovations in health care interventions at the individual patient level where it was considered that regulatory and legal requirements meant that innovations were more likely to be evaluated, and the mechanisms for so doing, for example health technology assessment, were better established.

3.20 In policy-making, it was possible to find good examples of policy development from a basis of research and evaluation, for example the quality and outcomes framework in general practice. However, a common perception persisted that many policy initiatives were not subject to rigorous evaluation on either an *ex ante* or an *ex post* basis. This was despite the fact that the DH policy research programme commissioned £32m of policy-related research last year and builds an evaluation requirement into all contracts.

3.30 The mismatch between short political lifecycles and research timescales was noted as a major impediment to getting research into policy-making. Other challenges were the 'fuzzy nature' of many policy innovations and the preference for novelty in the policy-making dynamic of Whitehall and Westminster.

3.31 The timescale problem may not be as intractable as it is often portrayed. For example, it is possible to undertake integrative synthesis to a short time-scale. In this respect, it may be a strength of health services research that it is pluralistic in its methodology. Politicians and civil servants are more relaxed about methodology than academics.

3.32 The NHS as a large, and until recently, standardised managed care system provides a superb environment for health services research but this is not fully taken advantage off. Researchers are too often leaden footed in positioning themselves to take advantage of these opportunities. Politicians and civil servants are too hasty in their desire to roll-out new policies, missing opportunities for (quasi-) experimental studies in the process.

3.33 How far the management community remain interested in systematic evaluation remained uncertain, not least because it was unclear how much scope managers have for individual innovation. The centralisation of innovation, and of judgements about what works, may have largely crowded out managers' scope to be innovative but this is set to change with increasing decentralisation. However there are few mechanisms to ensure that important innovations are adequately evaluated in the 'new' health care environment.

3.34 Possible areas for action:

- Both The Academy and HSRN should concern themselves with capacity building and with defining the infrastructure needed to make the most of the NHS as a laboratory for health services research.
- The Academy should embrace health services research more enthusiastically than it has done hitherto, not least because the boundaries between clinical research and health services research may be less well-defined than is sometimes assumed. The Academy's report on strengthening clinical research had been very influential and perhaps it was now time to say something on health services research. The English R&D strategy consultation provided a good starting point.
- The Academy could also take a lead in making health services research more attractive to those with a medical background.

Group 4: How can we create a more supportive environment for health services research careers?

3.35 The discussion focused on what aspects of the current environment need to change in order to increase support for health services research.

3.36 It was felt that the community should work through existing channels in order to take advantage of the new opportunities as they arose.

3.37 There is a need to improve articulation of the research questions.

- If the quality of health services research is improved, recognition from other parts of the academic community will follow. The whole research community has an interest in the improvement of the quality and relevance of health services research.

- Clinical researchers should communicate with health services research researchers to establish the research problems and information needs of health services research. The output of this will shape the future of clinical research.

- It was felt important for the wider research community to be informed of the day-to-day of activities of health services research and understand the associated tensions etc.

- It was noted that the Select Committee report on Science of Ageing sent a strong message of what is wrong in the research environment and where the problems lie.

- Some of the poorer quality research coming out of health services research may be due to the poor commissioning of research. 'Soft money' may be problematic in that it is not as highly competitive as money from funding bodies.

3.38 There is a need to work through the UKCRC research networks, to ensure these reflect the needs of health services research and not just areas such as clinical trials.

3.39 Training was considered to be very important. Together with the recommendations of the Walport Report, a mechanism is needed whereby young clinicians are exposed to health services research, in order to spark their interest. Initiatives for nurses and professions allied to medicine are also needed within health services research.

- Training programmes are needed for young clinicians so that they are educated about what the current world of research is like. There should be opportunities for people to look outside their own environment, and to instil the need to be sensitive to other professionals operating around them.

- It was felt that the current exciting developments should be harnessed, e.g. using the network to explore opportunities such as those arising from the Walport Report.

- Compared to clinical academic scientists, the nursing profession is more difficult to define in terms of training and research. There is no model of nursing training, so this needs to be achieved and then the research component built in. In order to make this happen, lots of subgroups would need to be brought around the table.

- If one looks at all the players working in and researching a single disease, such as diabetes, many of them will be found at the delivery end, far away from the bench scientist. The chain is: Bench scientists – translational scientist – health services researcher – policy researcher. How could the latter end be provided with incentives?

- A career path for managers needs to be developed, as academic managers are not represented.

- Currently, people who choose to work in health services research and clinical research usually have to take part time jobs in both camps to achieve this. These people are not looked at in a unified way.

- It was discussed how to interface the two environments of health services research and conventional clinical research. This was considered a challenge, however it may be achieved by setting the culture right from the start.

3.40 Funding is crucial. There is a need to work with funders in order to obtain more investment in health services research.

- It was questioned how investment could be generated in patient research. Medical charities want to concentrate on the practical end of research, in part to show the contributors some short-term benefit. Therefore, they may be looking to invest in health services research issues.

- How can Chief Executive Officers, Trust Managers and Finance Managers be influenced so they understand the need for research? This could be achieved by creating a stronger voice for the need for research. This voice should not just be from health services research, but from the NHS and industry, therefore creating a demand for research. This voice will generate funding and then researchers will follow. It was felt that secured funding was necessary to attract researchers.

- What are the funding streams available? DH, R&D funding strategy – aimed at answering problems within the NHS. Charities and Research Councils may be interested in the applied end of the business. However it was emphasised that funding would only be awarded if the importance of the questions was clear and the research was of high quality.

- The peer-review of research such as health services research and translational research is harder, or perceived, as harder compared to conventional research. This may deter major funders such as the MRC awarding grants in these areas.

- The funding councils may want to fund health services research, however, the applications do not get through the rigours of review. A fitness for purpose approach should be taken, e.g. if the research answers a relevant question, then it should be seen as high quality research.

- A database is being compiled of all the health services research being funded in the UK.

3.41 Regarding the Research Assessment Exercise: the developments within the RAE were welcomed; however, further work needs to be done to attach importance to health services research.

- A broad research environment was thought to very important, however, there were issues surrounding this with respect to the RAE. For example, if a researcher were working with both health and social care agencies on areas such as governance, would this work be returned to the RAE? Is health services research taking account of circumstances such as this?

- In terms of measures of esteem for research, policy, health and social care research should be included.

- Examining the new process of the RAE, there is a mechanism to ‘make things work’. However, it is up to the panel to make it happen. It was suggested that NHS Confederation representatives could sit on the health

services research sub-panel. These representatives would have a different brief and alter the dynamic of the panel.

- It was noted that beneficial changes in the RAE had occurred for other disciplines, such as the clinical craft specialities, who were not previously given sufficient time to submit material to the RAE. Therefore, the next step would be to encourage the RAE to pick up the issues particular to health services research.

- Researchers in health services research find it difficult to place their research in high profile journals, due to its interdisciplinary nature.

- Regarding the possibility for universities to make their own choice between a health services research panel or a conventional panel, it was felt that universities would be guided by monetary concerns rather than strategic importance of health services research.

Section 4: Potential areas for action

4.1 In final plenary session the meeting identified a number of possible areas for action, drawing together the issues arising from the working groups. These are set out as follows, including a suggested allocation of lead organisation.

- **hosting high level seminars on methodological issues in health services research (AMS)**

- **celebrating and publicising examples of high-quality health services research leading to demonstrable improvements in health care (HSRN)**

- **promoting a better understanding of the roles of health services research, including answering specific questions and providing a different framework for thinking about health services. (HSRN)**

- **producing a report on 'strengthening health services research' (AMS)**

- **take forward specific proposals for encouraging more people with a background in all the clinical professions to train in health services research – 'clinical scholars programmes' – and link to NHS interest in leadership development (AMS/HSRN)**

- **provide a forum to promote researcher networks and overcome isolation (HSRN)**

- **take advantage of international developments, e.g public health theme in British presidency of EU (HSRN/AMS)**

- **respond to consultation on new national R&D strategy for England, stressing the importance of health services research (AMS/HSRN)**

- **engage with Academic Careers Sub-Committee of Modernising Medical Careers (MMC) and UK Clinical Research Collaboration to ensure that career paths for health services researchers from both clinical and non-clinical backgrounds are attended to (HSRN/AMS).**

Annex 1: Meeting Attendees

NAME	ROLE	ORGANISATION
Dr Stuart Anderson	Senior Lecturer	London School of Hygiene & Tropical Medicine
Ms Jane Austin	Policy Manager	NHS Confederation
Professor Deborah Baker	Professor of Public Health	Institute for Public Health Research and Policy
Ms Pamela Baker	SDO Programme Manager	NCCSDP
Mrs Kim Beazor	Deputy Secretary	Nuffield Trust
Professor Nick Black	Professor of Health Services Research	London School of Hygiene & Tropical Medicine
Ms Wendy Buckley	Assistant Director	Health Foundation
Professor Tony Butterworth	Director of Clinical and Academic Workforce Innovation	University of Lincoln
Professor Mike Calnan	Honorary Professor of Social Medicine	University of Bristol
Dr Suzanne Candy	Senior Academic Careers Officer	Academy of Medical Sciences
Mr Keith Chantler	Associate Medical Director	Central Manchester and Manchester Children's University Hospitals NHS Trust
Dr Michael Clark	Manager for Mental Health R&D Portfolio	Department of Health
Professor Angela Coulter	Chief Executive	Picker Institute Europe
Professor Martin Eccles, FMedSci	Professor of Clinical Effectiveness	University of Newcastle-Upon-Tyne
Professor Ray Fitzpatrick	Chair, RAE Health Services Research Panel	University of Oxford
Mr Tim Freeman	Lecturer	University of Birmingham
Sir Andrew Haines, FMedSci	Director	London School of Hygiene and Tropical Medicine
Professor Richard Hobbs, FMedSci	Head of the Department of Primary Care and Occupational Health	University of Birmingham
Professor George Kernohan	Professor of Health Research	University of Ulster
Dr Val Lattimer	Reader in Nursing and Head of Health Services Research Group	Health Services Research Group, University of Southampton
Professor Karen Luker, FMedSci	Health Services Research Group, University of Southampton	University of Manchester
Mrs Mary Manning	Executive Director	Academy of Medical Sciences
Sir Peter Morris, AC, FRS, FMedSci	Head, Clinical Effectiveness Unit	Royal College of Surgeons of England
Professor John Newsom-Davis, CBE, FRS, FMedSci	Professor Emeritus of Clinical Neurology	University of Oxford
Dr Liam O'Toole	Chief Executive	UKCRC

Sir Keith Peters, FRS, PMedSci	President	Academy of Medical Sciences
Professor John Pickard, FMedSci	Professor of Neurosurgery, and Chairman Wolfson Brain Imaging Centre	University of Cambridge
Professor Martin Roland, CBE, FMedSci	Director, National Primary Care Research & Development Centre	University of Manchester
Professor David Rowbotham	Director of Research & Development	University Hospitals of Leicester NHS Trust
Sir Michael Rutter, FRS, FBA, FMedSci	Vice-President	Academy of Medical Sciences
Professor Trevor Sheldon, FMedSci	Pro Vice Chancellor	University of York
Professor Bonnie Sibbald	Deputy Director	National Primary Care Research & Development Centre
Mr Laurie Smith	Policy Officer	Academy of Medical Sciences
Mr Peter Sneddon	Head of Research Programmes, R&D	Department of Health
Professor Charles Wolfe	Director of R&D	Guy's, Kings & St Thomas School of Medicine

Annex 2: Meeting Programme

Strengthening health services research

6th September 2005 2pm to 5pm
The Reading Room, The British Academy
10 Carlton House Terrace
London SW1Y 5AH

Programme

1.40 Coffee and Registration

2.00 Chairman's welcome and purpose of the event

The Academy of Medical Sciences' perspective

Sir Andy Haines FMedSci
Director, London School of Hygiene and Tropical Medicine

2.20 The Health Services Research Network perspective
Professor Nick Black
Chair, Health Services Research Network

2.40 Introduction to topics for small group discussion

1. How can we further improve the quality and relevance of HSR?
2. How can we increase the impact on policy and practice of HSR?
3. How can we ensure that innovations in health care and health systems are properly evaluated?
4. How can we create a more supportive environment for HSR careers?

2.45 Small group discussions

3.30 Tea

3.50 Report back and plenary discussion

4.40 Closing statements
Prof Nick Black, Sir Andy Haines

4.55 Chair's closing remarks

5.00 Close

You are invited to stay for continuing informal discussion over drinks after the formal close of the meeting.

Annex 3: Background briefing paper

Health Services Research in the UK

Background Information

Stephen Davies

Definitions of Health Services Research

'Health services research' is a term used to describe a field of enquiry which is characterised by i) its applied nature ii) its multi-disciplinary and multi-professional nature and iii) its ambiguous boundaries. It occupies a territory bounded by fields which include public health research, population health sciences, health systems research and clinical research.

The Health Services Research Network has adopted the following definition:

> Health services research is defined as any research underpinning improvements in the way health services are organised, planned and delivered, including health technology assessment and health policy research

The Academy of Medical Science working group accepted this as a serviceable definition and does not wish to offer an alternative.

Some other perspectives are provided in annex 1 to illustrate that perceptions of health services research are varied, nationally and internationally. The lesson of this may be that it is important not to assume more uniformity of perception than is found in practice.

The uses and users of Health Services Research

Health services research is an applied field of enquiry. Its rationale is usually presented in terms of producing knowledge that can lead to the improvement of health policy, health systems and health care delivery (The Health Foundation 2003). The users of this knowledge will thus include policy-makers and managers as well as clinicians.

The paradigm of evidence-based practice is well-established at the level of individual patient care but attempts to extend this to embrace 'evidence-based management' and 'evidence-based policy making' have been criticised as 'highly contestable and misguided'(Klein 2000). Others have analysed why this might be the case, exploring different understandings of the nature of knowledge and evidence in the domains of the researcher, the clinical practitioner, the manager and the policy-maker (Walshe and Rundall 2001) (Black 2001).

A dominant concept in this literature is that of 'knowledge transfer'. Research is seen as filling gaps in knowledge which are then adopted by decision-makers in a one-way process. This model has been increasingly challenged in theory and in practice by the concept of 'knowledge exchange', which emphasises the importance of longer-term linkage and bi-directional influencing between the three domains of researchers, practitioners and policy-makers (Lomas 2000). From this perspective, building an environment in which knowledge exchange can occur will be seen as more important than tactics for bringing research to the attention of 'decision-makers'.

A related area of uncertainty is the responsibility for the 'D' in R&D. Although national R&D programmes have always placed a strong emphasis on the practical application of research findings the way in which the research community should involve itself in development remains unclear (Black and Mays 1996).

The UK Environment for Health Services Research

The environment in which research is commissioned and produced will determine the scale, quality and impact of health services research. Only limited information on the field is readily available, but it would be possible with research to establish some basic facts. These might include the identification and quantification of funding streams; an identification of where health services research is produced; a quantification of outputs and an overview of the principal channels of dissemination. Annex 2 provides an overview of funding streams for health services research, mostly in England but with some lines of the analysis relating to the UK.

The environment for health services research is shaped by the structures, incentives, institutions and relationships that determine what research is produced, the quality of that research and how it is utilised. This is an area of discussion where international comparisons may be particularly helpful. The Health Foundation proposed the Canadian Health Services Research Foundation and Academy Health (USA) as useful exemplars.

The academic environment for health services research, and in particular the questions of incentives and career structures, could also be examined. Earlier rounds of the RAE were criticised as undervaluing clinical and health services research and as disadvantageous to multidisciplinary research, although 2008 guidance explicitly addresses these concerns. The 2008 RAE also includes a separate panel for health services research for the first time.

There is also a wider context of accountability for health services research. The government wishes to see value for money obtained from all public R&D expenditure and the Office of Science and Technology has a cross-departmental role in identifying and encouraging good practice in all aspects of the research process, from commissioning through to application (NAO, 2003). As can be seen from annex 2, the Department of Health is the largest single commissioner of health services research, and is also the civil department with the largest spend on R&D – some £630m pa (although a large part of this sum is the R&D levy).

The Organisation of Health Services Research in the UK

Health services research in the UK has not hitherto had a national institutional or intellectual home. There has been no national academy or research foundation, in contrast to the situation in the USA and Canada. The establishment of the Health Services Research Network may represent a first step in making good this deficit. There have also been plans to develop a Scottish Academy for Health Policy and Management, although progress with this appears somewhat stalled at present (Scottish Executive 2004).

The historical absence of any organisation comparable to Academy Health in the USA has meant that many elements of health services research infrastructure and support have been absent. There has been no annual research meeting, no careers support, no membership networks, and so on. There are organisations that provide a forum for health services research but they do so either from a particular perspective (e.g. Society for Social Medicine) or from a single-disciplinary base (e.g. the medical sociology group within the British Sociological Association) and have not sought or achieved a more over-arching role.

Within the universities, centres for health services research appear quite heterogeneous in their origins and character. Some are associated with business

schools, some with medical schools and some with schools of public health whereas others have sprung from a particular academic discipline.

Commercial research organisations, consulting firms, charities and other bodies beyond the universities also have a role in health services research which has yet to be described.

The Health Services Research Workforce

Health services research is not a discipline in its own right, but rather a field of enquiry in which there are a number of participating disciplines. It adopts theoretical perspectives, traditions and research methods from the clinical sciences, epidemiology, anthropology, history, operations research, management science, economics, individual and organisational psychology and sociology. Some work may be conducted from the viewpoint of a single discipline whereas other work may be interdisciplinary. To add to the complexity, it is also a multi-professional activity and is often undertaken by research-active clinicians.

These characteristics create a number of challenges and tensions within health services research that may have implications for the workforce. Firstly, interdisciplinary work comes complete with its own challenges which may drive the researcher back to the relative comfort of single discipline work (Giacomini 2004). Career structures may be less likely to reward those who venture into multi-disciplinary work. There is an implicit issue about the 'hierarchy of evidence' and the fact that some methodologies are held in higher esteem than others. So, for example, much methodological development appears to have been driven by the quest to extend the 'gold standard' of the RCT to health services research, in the expectation that only this will confer legitimacy in the eyes of the medical community (Selby 1993). However, many of the concerns of HSR will not be amenable, for practical and ethical reasons, to deductive and experimental methods (Raine 1998).

The challenge of creating a health services workforce that is fully engaged in learning and research has been recognised by the Strategic Learning and Research Advisory Group (StLaR): a high-level forum to improve the interface between health and education sectors at central government level. Included in this forum's terms of reference is a brief 'to take an overview of the interplay between service, research and learning issues'. This forum has commissioned work that examines issues of career pathways and incentives and their impact upon the development of research-active and research-aware practitioners (Strategic Learning and Research Advisory Group 2004).

Another notable aspect of the UK from an international perspective is the extent to which participation in health services research is not part of a mainstream career path for medical doctors beyond the traditional route of public health medicine. In the USA, in contrast, competence in HSR is seen as the clinician's route to leadership in health services. This is the logic behind the Robert Wood Johnson Clinical Scholars Program, which 'aims to produce scholarly physician leaders with the understanding and skills necessary to have a major influence on health care policy and to help create and build the field of health services research'. As of 2003, the programme had produced over 1,000 clinical scholars, many of whom are now in leadership positions in health care delivery organizations, in government and in academic medicine.

In contrast, recent recommendations on training for academic medicine in the UK still treat the area of academic interest for those who are medically qualified as confined to the biomedical sciences, including for this purpose clinical

epidemiology and public health. (Modernising Medical Careers, 2004). These are fields which are either dominated by the medical profession or rest upon methodologies more highly esteemed by the medical profession

There appears to be no quantification of the number of health services researchers available in the UK, although this may be problematical given the multi-disciplinary nature of the field. Nor, in contrast to the USA, does there appear to be much concern about a workforce strategy for HSR, although the StLaR report is a step in this direction.

Annex 1

Perspectives on health services research

Health services research is defined as any research underpinning improvements in the way health services are organised, planned and delivered, including health technology assessment and health policy research.
Health Services Research Network
http://www.nhsconfed.org/influencing/health_services_research_network.asp

The central research question is:
"How can we make best use of advances in health care and health technology so that individuals with health problems, as well as the whole of society, will benefit?"
The HSRC will work to develop new research methodology, and will concentrate on chronic health problems, and the health of older people. The emphasis will be on multi-disciplinary research:
The MRC Health Services Research Collaborative
http://www.hsrc.ac.uk/Current_research/res_agenda.htm

There is a substantial body of research that needs to be undertaken to ensure the successful operation of the many components that make the NHS function effectively. This includes a whole set of issues relating to activities within both hospitals and general practice and includes the activities of medical and paramedical staff at all levels within the health services. A rigorous approach to health services research could have profound implications and is an essential component of the NHS managerial function (The Academy of Medical Sciences 2003)

Health services research is concerned with problems in the organization, staffing, financing, utilization and evaluation of health services. This is in contrast to biomedical research, which is oriented to the aetiology, diagnosis and treatment of disease. Health services research subsumes both medical care and patient care research (Flook and Sanazaro 1973)

Health services research is a multidisciplinary field of inquiry, both basic and applied, that examines the use, costs, quality, accessibility, delivery, organisation, financing and outcomes of health care services to increase knowledge and understanding of the structure, processes, and effects of health services for individuals and populations.(Institute of Medicine 1995)

The integration of epidemiologic, sociological, economic, and other analytic sciences in the study of health services. Health services research is usually concerned with relationships between need, demand, supply, use, and outcome of health services. The aim of the research is evaluation, particularly in terms of structure, process, output, and outcome.
World Health Organisation
http://www.who.int/topics/health_services_research/en/

Annex 2

Health Services Research Funding 2004/5

		£m	£m
Department of Health	National Research Programmes		
	HTA, SDO, NEAT, Cancer etc	99	
	Policy Research Programme	32	
	UKCRC support	20	
			151
MRC	Health Services and Public Health Research		62
Charities	Health Foundation		1
	Nuffield Trust		2
Total			216

References

Black, N. (2001). "Evidence-based policy: proceed with care." British Medical Journal **323**(275-279).

Black, N. and N. Mays (1996). "What is 'development'?" Journal of Health Services Research and Policy **1**(4): 183-4.

Flook, E. E. and P. J. Sanazaro (1973). Health Services Research: Origins and Milestones. Health Services Research and R&D in Perspective. E. E. Flook and P. J. Sanazaro. Ann Arbor, Health Administration Press.

Giacomini, M. (2004). "Interdisciplinarity in health services research: dreams and nightmares, maladies and remedies." Journal of Health Services Research and Policy **9**(3): 177-183.

Institute of Medicine (1995). Health Services Research: Work Force and Educational Issues. Washington D.C, National Academy Press

Klein, R. (2000). "From evidence-based medicine to evidence-based policy?" Journal of Health Services Research and Policy **5**(2): 65-66.

Lomas, J. (2000). "Using 'linkage and exchange' to move research into policy at a Canadian Foundation." Health Affairs **19**(3): 236-240.

Modernising Medical Careers (2004). Academic Careers Sub-Committee of Modernising Medical Careers and the UK Clinical Research Collaboration.

NAO (2003) Getting the Evidence: Using Research in Policy Making. Report by the Comptroller and Auditor General. National Audit Office HC586-1 Session 2002-3

Raine, R. (1998). "Evidence-based policy: rhetoric and reality." Journal of Health Services Research and Policy **3**(4): 251-153.

Scottish Executive (2004). Scottish Academy for Health Policy and Management - Position Paper: March 2004

Selby, P. (1993). "Health Services Research in Oncology." British Journal of Cancer **67**: 639-640.

Strategic Learning and Research Advisory Group (2004). Developing and sustaining a world class workforce of educators and researchers in health and social care.http://www.stlarhr.org.uk/consultation

The Academy of Medical Sciences (2003). Strengthening Clinical Research. London

The Health Foundation (2003). Increasing the impact of health services research on service improvement and delivery. London

Walshe, K. and T. G. Rundall (2001). "Evidence-based management: from theory to practice in health care." The Milbank Quarterly **79**(3): 429-457.

The Academy of Medical Sciences

The independent Academy of Medical Sciences promotes advances in medical science and campaigns to ensure these are translated as quickly as possible into benefits for patients. The Academy's 800 Fellows are the United Kingdom's leading medical scientists from hospitals, academia, industry and the public service.

The Academy's Officers are: Sir Keith Peters, FRS, PMedSci (*President*); Sir John Skehel, FRS, FMedSci (*Vice-President*); Sir Michael Rutter, FRS, FBA, FMedSci (*Vice-President*); Sir Colin Dollery, FMedSci (*Treasurer*) and Professor Patrick Vallance, FMedSci (*Registrar*).

The Academy's Executive Director is Mrs Mary Manning.

The Academy of Medical Sciences
10 Carlton House Terrace
London SW1Y 5AH
Tel.: ++44 (0) 20 7969 5288
Fax.: ++44 (0) 20 7969 5298
E-mail: apollo@acmedsci.ac.uk
Web: www.acmedsci.ac.uk
Registered charity no.: 1070618
Registered company no.: 3520281

The Academy of Medical Sciences is a company limited by guarantee.

The NHS Confederation

In consultation with health services researchers and funders, the NHS Confederation has established a new network for the health services research (HSR) community in the UK.

The Health Services Research Network has been supported by the Department of Health, the Health Foundation and the Nuffield Trust.

The network aims to connect all universities, commercial and professional organisations, charities and NHS bodies with an interest in HSR. It defines health services research as all research that underpins improvements in the way health services are financed, organised, planned and delivered, and includes health technology assessments and health policy research.
The network also complements existing organisations such as the Society for Social Medicine and the Health Economists Study Group. It works with these bodies to bridge the divide between users, funders and researchers.
The Health Services Research Network aims to:

- influence policy makers and managers to support better use of research and to ensure that research priorities reflect the needs of the public, policy makers and those responsible for the management of the system
- campaign for secure funding for HSR and measure to improve HSR careers
- promote interchange between health services research, clinical work and management
- provide a collective voice for researcher in the wider policy debate

- promote issues of common interest to funders, universities and government.

The network will do this by:

- representing the HSR community to government, funding organizations, the management community and other professional bodies by initiating and leading discussion and responding to policy issues
- organising events to promote HSR and provide opportunities for dialogue between researchers and with managers
- building international inks with equivalent bodies, the EU and other international agencies with an interest in HSR.

For more information, please contact Jane Austin, Policy Manager, on 020 7074 3212 or at jane.austin@nhsconfed.org

ACKNOWLEDGEMENTS
The Academy is most grateful to Sir Andrew Haines, Professor Nick Black and Mr Stephen Davies for preparing this summary. The Academy would also like to thank the Fellows and Officers of the Academy, members of the NHS Confederation's Health Services Research Network Board and Academy Working Group, as well as the secretariat of both organisations for their helpful contributions.