Editorials

Primary care:

the sleeping giant of research delivery

A sustainable NHS requires a shift from reactive acute care to proactive ambulatory care, from secondary care to primary care, with a focus on health creation by empowering people and communities. This will require evaluation of transformed models of care to create a new evidence base, which in turn requires a strong primary care research delivery infrastructure.

PRIMARY CARE IS THE RIGHT PLACE TO UNDERTAKE RESEARCH DELIVERY

Primary care is the largest medical specialty, most of the UK population is registered with a GP and 90% of NHS consultations occur in primary care. Most prescribing occurs in primary care and most chronic diseases are managed in primary care, including people with multiple long-term conditions ('multimorbidity'). Primary care sites are physically located close to the communities they serve hence minimal travel and easy access. Over many generations GPs have built the trust of their patients.[1]

Primary care clinicians are expert medical generalists, their commitment is to the individuals on their list and not to a specific body of knowledge such as neurology or gynaecology.[2] The delivery of person-centred care requires interpretivist skills often emphasising the psychological and social aspects of a patient's life above the biological. Primary care is underpinned by long-term trusting relationships, 'relational continuity of care', the foundation of primary health care. The role of the GP is to assess an individual patient's needs, consider their circumstances, and weigh the relevant evidence. Primary care is a distinctive mode of delivering health care. It is not the same as secondary care, and many pitfalls and missed opportunities await investigators who think it is.

The traditional model of primary care, based on small-to-medium-sized GP practices is changing. Increasingly, practices work collaboratively within their primary care network (PCN), and in many areas GP practices have come together to create federations providing infrastructure and leadership. This allows growth in skills and capacity in data regulations, human resources, finances, and contracts. This expertise can be deployed into constituent practices, increasing consistency and reducing duplication. This complex system of interdependent layers of scale creates an ideal structure within which to operationalise research delivery projects.

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EPISTEMIC INJUSTICE OF SECONDARY-CARE ORIENTATED RESEARCH

Research delivery is secondary care dominated; most clinical academics in the UK work in NHS hospital trusts and very few work in primary care organisations. The National Institute for Health and Care Research's (NIHR's) Clinical Research Network (CRN) provides most of the funding for research delivery and it is 'hosted' by NHS trusts, which are mainly secondary care providers. Only a small percentage of the annual budget of local CRNs is invested directly into primary care organisations. This landscape inevitably biases the perspective of research delivery organisations, creating epistemic injustice against the primary care model of healthcare delivery.

The CRN does not consider most primary care sites as 'NHS organisations'. Most GP practices, PCNs, and federations are considered as independent contractors to the NHS and therefore are not entitled to partnership status on local CRN boards and do not have parity of esteem, or even a voice, when major decisions are made. Combined with falling GP numbers, huge workload pressures, and falling patient satisfaction because of difficulty accessing care, research in primary care is rarely seen as business as usual but instead as an unaffordable luxury.

In keeping with the structural imbalance between primary and secondary care, much research infrastructure, such as research and development (R&D) offices, resides within secondary care trusts. These staff usually have little or no experience working within primary care organisations, which makes operationalisation of patient identification and research delivery in primary care highly inefficient. One particular problem is the overly simplistic patient identification centre model, which generates very low conversion rates from written invitations to consents and is especially severe in disadvantaged groups, such as people who cannot speak/read English and those who are socioeconomically deprived. This contributes to the well-recognised deficit in representativeness among clinical trial populations.

Research delivery is complex and highly regulated.[3] Principal Investigators are required to understand and operate within complex legal and ethical frameworks. Entry level Good Clinical Practice[4] training can be completed and certified within a few hours, but a deeper and more comprehensive training requires experiential learning and support that historically has often only been available from within R&D offices of secondary care trusts and therefore has not been routinely available to primary care staff.[5]

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DEVELOPMENTS AND OPPORTUNITIES

The Health and Care Act 2022 has replaced clinical commissioning groups with integrated care boards, which have a statutory responsibility for research. The House of Lords,[6] the Academy of Medical Sciences,[7] the General Medical Council,[8] and the Department for Health and Social Care[9] have all recently issued reports emphasising the importance of research delivery, and the need for it to be considered core business for clinicians and not an optional extra. The COVID-19 pandemic focused minds and gave a clear demonstration of the imperative for a large skilled clinical research workforce in the UK. Two landmark COVID-19 clinical trials were conducted in primary care.[10,11]

The CRN recently published its Primary Care Strategy,[12] and subsequently it held two stakeholder workshops. The NHS Confederation's PCN was named as a partner in this, and it has formed a Research Working Group to identify areas of strength in primary care research across the UK to share best practice and support growth.

Academic primary care is represented by the Society for Academic Primary Care and the NIHR School for Primary Care Research. Both organisations are committed to working with NHS primary care organisations to support research delivery, and synergistic relationships between these three could be a catalyst for growth. There are many examples of individual GP practices that have built-up large research delivery portfolios leveraging large income streams from commercial research to support a portfolio of academic and commercial work.

The NIHR-Academy of Medical Royal Colleges (AoMRC) Clinician Researcher Credentials Framework (CRCF) was published in 2022.[13] Developed jointly by the NIHR and the AoMRC, and led by the Royal College of Physicians, working with Higher Education Institutions it provides a national framework for Master's level qualifications. The CRCF has the potential to provide high-quality and nationally recognised research training for primary care clinicians.

A SLEEPING GIANT

Primary care has a large and highly skilled workforce, which until now has made a relatively small contribution to research delivery in the UK. With national policy commitments to increase funding, local inititives to give primary care parity of esteem with secondary care, and with dedicated at-scale infrastructure, primary care could be a giant of the research delivery landscape. This would lead to a massive increase in the UK's capacity for complex research delivery projects and it would address the current deficit in the diversity of clinical trial populations. By incorporating research into the day-job, primary care would become a more attractive and sustainable career, mixing clinical sessions with research, innovation, and scholarship.

And most importantly, it would increase the evidence base with which to guide the care of our communities.

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