Briefing for House of Lords short debate on the Association of Medical Research Charities' report *Our vision for research in the NHS* – 27 June 2013

The Royal College of Surgeons (RCS) supports the Association of Medical Research Charities' (AMRC) vision of an NHS which: encourages patient participation in research; communicates the importance of research to all its staff; and conducts high-quality research and adopts new treatments.

The College has welcomed the Government's commitment to accelerating the adoption and diffusion of innovation in the NHS through the implementation of *Innovation, Health and Wealth*.

We have also supported the Government's decision to give Health Education England (HEE) a duty to promote research, and have welcomed the establishment of the Health Research Authority (HRA) and the move to place it on a statutory footing.

However, there are a number of areas where we feel the Government should focus its efforts to further stimulate innovation and research.

In particular, the **College would like to see:**

- Increased funding for surgical research and innovation.
- A reduction in research bureaucracy.
- The Department of Health improve its monitoring of the roll-out of new technologies and techniques.
- Clarity around how CCGs will be held to account where they are failing to fund NICE-approved drugs and devices.
- Time for Supporting Professional Activities (SPAs), including for research, safeguarded.
- The benefits of nationally commissioned training preserved under the new funding system for education and training.
- More NHS staff encouraged to participate in research.
- Greater use of clinical ethics committees by Trusts to make decisions around the use of innovations.

These recommendations are set out in further detail in the following briefing note. While we have primarily focused on surgical research, we agree with the AMRC that promoting interdisciplinary research in the NHS is key.

The RCS' role in research

New technology and innovations from research have the capacity to improve surgical practice and standards of patient care. This is why the RCS has made promoting research and innovation one of its key priorities for 2013.

Earlier this year, the RCS launched plans to set up a nationwide network of surgical clinical trial centres, with the aim of revolutionising the delivery of surgical care for thousands of patients. The College has put in £2.5m over the last 18 months to support this initiative and hopes to contribute more over the coming years.

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Working with partners, including the NIHR, Rosetrees Trust and Cancer Research UK, the College has established a network of surgical trials units across the UK where surgical research can be pioneered and effectively developed. The units will enable surgeons to learn more about how to deal with a range of conditions, assess new surgical techniques and discover surgical breakthroughs.

In partnership with our specialist surgical associations and affiliated charities, we have also appointed 11 national Surgical Specialty Leads with the specific remit to develop new trials, establish clinical networks and to work with their patients to develop and deliver new and innovative trials across the numerous surgical disciplines.

Lastly, the initiative facilitates the work of trainee research networks across the country. These networks encourage surgical trainees to collaborate by 'pooling' their patients and creating large-scale surgical trials, which help to gather evidence on existing procedures. The initiative helps to overcome one of the biggest obstacles to surgical trials: recruiting enough patients. It also encourages trainees to engage with research at an early stage of their career and has the potential to change the future research culture within surgery.

More funding is needed for surgical research

One third of hospital admissions involve surgery, but less than two per cent of Government funding for medical research goes into surgical areas.[1]

There have been some positive moves towards increasing funding – for example, last year the National Institute for Health Research (NIHR) issued a call for research on the evaluation of technology-driven implanted or implantable medical devices, surgical procedures or surgical services.

However, there is still a long way to go to address the underfunding of surgical research, and some medical charities are concerned that the development of clinical research in surgery has lagged behind that of non-surgical disciplines.[2]

Example case studies

High-quality surgical research has been instrumental in expanding the range of procedures that can be performed safely. It has made operations safer, less invasive and more effective.

For example, recent surgical research looked into the viability of donor kidneys, examining outcomes for patients who received donations from patients who had experienced a 'controlled cardiac death' (i.e. death from major heart failure after being withdrawn from life-support following brain trauma). Traditionally, kidneys from these donors were thought to be inferior to those taken from patients who had experienced a brain-stem death. However, the research showed that the kidneys were equivalent. This has the potential to effectively double the rate of viable kidney donations.[3]

[1] http://www.rcseng.ac.uk/publications/docs/priorities-for-2013
[2] http://www.rcseng.ac.uk/news/investing-in-surgical-research-2013-the-way-forward-for-leading-healthcare-organisations
[3] http://www.rcseng.ac.uk/news/docs/theory_to_theatre_2011_web.pdf

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You may also be interested to watch a recent video from the College details research led by surgeon Mr Richard Shaw, which is looking into treatments for tumours of the tonsils and back of the tongue.

Reducing research bureaucracy

The RCS feels that reducing research bureaucracy will help to foster a culture that encourages medical professionals to participate in research. We are therefore pleased to note that the AMRC has highlighted that the complexities inherent in the current system "act as a disincentive to conducting research".[4]

As outlined in our recent briefing on the Care Bill, we believe that the HRA will play an important role in helping to streamline the current system. However, we would welcome further clarification from Ministers about what the Government is doing to support this.

We encourage Peers to ask the Government:

- What is the Government doing to help reduce bureaucracy in research?

Monitoring the uptake of innovation

We are also pleased to note the AMRC's recommendation that the NHS establish a set of metrics to measure how well it is delivering research. We also feel that there needs to be some measure to monitor the *uptake* of innovation, particularly within secondary care.

The Department of Health could improve its monitoring on the extent to which new proven technologies and techniques have been adopted in clinical practice, and set out what steps will be taken to address any barriers in their roll-out. The Government has a key role to play in encouraging the spread of surgical innovation.

We encourage Peers to ask the Government:

- Can the Government clarify the roles of the Department of Health and NHS England in monitoring the uptake of innovation in secondary care?

Compliance with NICE technology appraisals and guidance

NICE technology appraisals are "recommendations on the use of new and existing medicines and treatments within the NHS in England and Wales".[5] They encompass medicines, medical devices, diagnostic techniques, surgical procedures (such as hernia repairs) and health promotion activities.

The College welcomes the fact that clinical commissioning groups (CCGs) are required to publish their level of compliance with these appraisals. Primary care trusts (PCTs) were not required to

[4] http://www.amrc.org.uk/news-policy--debate_our-vision-for-research-in-the-nhs
[5] http://www.nice.org.uk/guidance/index.jsp?action=byType&type=6

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publish this information proactively. However, NHS England needs to clarify what it will do where CCGs are not commissioning NICE technology appraisals.

NICE technology appraisals also only cover a small proportion of services provided by the NHS. Many other services – including some which are clinically necessary – are covered by guidance which is not legally binding. These services can still be rationed and therefore, we feel further clarity is needed on how NHS England and the Department of Health will monitor access to other clinically necessary treatments and innovations which CCGs will commission.

We encourage Peers to ask the Government:

- How will NHS England respond to CCGs which fail to comply with NICE technology appraisals?
- How will NHS England monitor and prevent the rationing of clinically necessary services which are not covered by NICE technology appraisals?

Training and educating the future workforce

Training and educating the current and future workforce is essential to the adoption and diffusion of new techniques and technologies. Surgery differs from many other medical specialties in that the research and assessment of new innovations often requires the teaching of new manual skills.

Nationally commissioned training programmes, such as the National Training Programme for Laparoscopic Colorectal Surgery (LAPCO), have been effective in training and educating the surgical workforce in new techniques. The LAPCO programme was introduced by the national cancer action team and the Department of Health in 2007 to address the shortage of trained surgeons which hindered the implementation of the new NICE guidelines on laparoscopic bowel resection. It was promoted and delivered by the RCS through its new skills centres.

The RCS would like the Department of Health to ensure that the benefits of nationally commissioned training programmes are retained under the new funding system for training and education.

We encourage Peers to ask the Government:

- How can we ensure the benefits of nationally commissioned training programmes are preserved under the new funding system for training and education?

Time for training and research

Like the AMRC, the RCS is also concerned about the time available for staff to undertake research, as well as time for training and education to support the roll-out of new innovations.

We have highlighted the importance of ensuring time for Supporting Professional Activities (SPAs). SPAs are written into the consultant contract, as a defined category of programmed activities. During the time made available for SPAs, consultants are able to undertake training and education

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and research. The College is concerned that the time available for SPAs in job plans has been declining in many Trusts and that this will have a negative impact on clinical outcomes.

We encourage Peers to ask the Government:

- What will the Government do to help safeguard the time available for research in the NHS?

Decision-making on ethical issues

The College believes that clinical ethics committees (which differ from research ethics committees) in trusts can play an important role in facilitating the uptake of medical innovations within a hospital or other healthcare provider.

Such committees are not present in every trust and the support they provide varies. Nevertheless, they can help to support decision-making on ethical issues surrounding the provision of patient care, particularly around one-off innovations.

According to the UK Clinical Ethics Network there are around 85 clinical ethics committees in the UK. If all trusts had access to such a committee and their terms of reference were standardised to include decisions around relatively untried innovations, we could help to ensure that patients can benefit from new treatments while preventing irresponsible research.

We encourage Peers to ask the Government:

- What work is the Government doing to encourage the use of clinical ethics committees?

Incentivising providers to support research

The College believes that the Commissioning for Quality and Innovation (CQUIN) framework could be better utilised. CQUIN is a payment framework designed to enable commissioners to "reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals".[6]

The framework could be used to incentivise providers to support best practice guidelines or research. Commissioning contracts could mandate participation in established clinical audits so that providers only receive full payment for activity once data is submitted.

We encourage Peers to ask the Government:

- Will the Government consider whether the CQUIN framework could be better utilised to incentivise providers to support research?

[6] http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

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