

Clinical Research Network

Primary Care Strategy

March 2021



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1. What is the purpose of this strategy document and who is it for?

This strategy document describes the direction for expanding research activity in Primary Care settings and how this is to be achieved through both concerted work within the NIHR Clinical Research Network and through its links with the wider NIHR and key organisations influencing the Primary Care landscape.

Since the strategy is focussed on Primary Care as a key setting for

research activity going forward it concerns all directorates and LCRNs in the NIHR Clinical Research Network, their work with internal systems, processes and approaches, and external partnerships.

In this respect it recognises a whole system in which there are important internal and external interdependencies, not all of them in the sole control of the Clinical Research Network.



2. Blueprint vision statement

The Clinical Research Network, working with our NIHR and wider strategic stakeholders, will develop, promote, and facilitate high quality research in the Primary Care setting that is integral to delivering health and care, for the population's benefit.

The strategy therefore prescribes the foundation for building a coherent research theme embedded in Primary Care. It will develop research activity enablers within the sector through focused partnership work.

Above all, it will provide a proactive approach, aiming to achieve an equitable opportunity for patients and public across the country to be engaged in and benefit from NIHR research.

It focuses on four main areas:



responsiveness to the health and care needs of the population



aligning information systems and processes with the setting



strategic engagement



workforce

3. Background

It was recognised that the CRN had reached a crisis point with a number of factors conspiring to significantly inhibit current Primary Care research activity. This was evidenced by the falling levels of engagement in research activity set against the Higher Level Objective 6c (used in the CRN), a reduction in patient recruitment numbers in studies managed by Primary Care and a significant drop in the number of participating practices. Key factors include a lack of academic opportunities for GPs and other healthcare professionals in the setting, a rapidly changing landscape of Primary care provision, increasing workload, transfer of work from secondary care, inadequate research funding, and the need for a cultural shift in CRN leadership towards acceptance of this setting as fundamental to wider research delivery and best patient care.

This is further discussed in Appendices 1 and 2 (pages 27 and 29).

The move to a ‘top-down’ network delivering commercial and non-

commercial research on its portfolio, as is the current CRN model, has of necessity meant that ‘bottom-up’ engagement with general practices and communities has been reduced. This is in stark contrast to the international move towards more Practice Based Research Network (PBRN) models that facilitate engagement with GPs, their practices and other Primary Care staff.

These issues are further discussed in Appendices 1 and 2 (pages 27 and 29).

During the COVID-19 response, the relatively successful adoption of the PRINCIPLE study in Primary Care demonstrated what was possible with a study of clear and present relevance to this setting. However, much more is possible with a wider baseline of engagement of Primary Care practices in meeting the wider health and care research needs of these services and people who use them. The burden of ill health lies in the community with only the most severe needing hospital care, this being a small minority in relation to this wider whole.

For this strategy we have considered Primary Care as a:

- research setting which is accessible to almost all the population, and
- a CRN ‘specialty’ for research driven from the specific requirements of this setting for increasing knowledge to support the unique and diverse health and care needs of people presenting to these services.

This clearly involves a two way process of research going into this setting for support and research coming out of the setting for support in the wider system.

The strategy addresses the wider context of the health and care needs of the population in the 21st Century, not just where Primary Care fits into the existing research ‘system’. Furthermore, multimorbidity research, genomics, big data and AI offer greater potential for a needs-based understanding going forward. Primary Care is also a good place for the wider population to benefit from changes in practice resulting from implementation of

relevant health and care research evidence.

It is recognised that the CRN has responsibilities to all people who use Primary Care services, with respect to improved integration of research and care. This is, for the vast majority of the population, the first point of contact. As such, the Primary Care strategy builds on the work already undertaken by the CRN in both Primary and Secondary sectors to achieve integration of research into routine care. By providing a firm foundation for a responsive and proactive research culture within Primary Care settings, this strategy aims to promote research that addresses those conditions, including multimorbidities, that have the greatest impact for people along their health and care journey.

It is also recognised that building firmer foundations and resilience for research in Primary Care drives the ambition and value of research and research evidence use in the wider population in the UK as a whole.

Key drivers:

- Providing access to, and benefits from, health and care research in the wider population and the diverse communities within it.
- Increasing integration of research and care at a Primary Care level.
- Providing greater diversity in the CRN research portfolio relevant to the experienced complex health and care needs of individuals and groups within the population.
- Contributing to an overall increase in research activity across the health and care sector.

Aligned with:

- NHS Long Term Plan
- Life Sciences Sector Deal 2
- NIHR Outcomes Framework
- NIHR Operating Principles
- NIHR Digital Strategy

4. Strategy scope and focus

The CRN Primary Care Strategy is focused on the opportunities and challenges of delivering research in the complex, developing and locally varied environment of Primary Care services. Primary Care services have a variety of important links with wider community services. There is local variation in the way these services are configured,

contractually supported and funded. The strategy therefore needs to support both local and national innovation to bring research and research benefits to the wider population, including underserved communities. It is important that the scope of the strategy includes this wider interaction whilst maintaining its core focus on Primary Care.

‘Primary’ and ‘Community’ Care

The strategy covers all research activity in Primary Care settings and therefore includes wider Community Care settings where part or all of the research process is supported or initiated in Primary care.

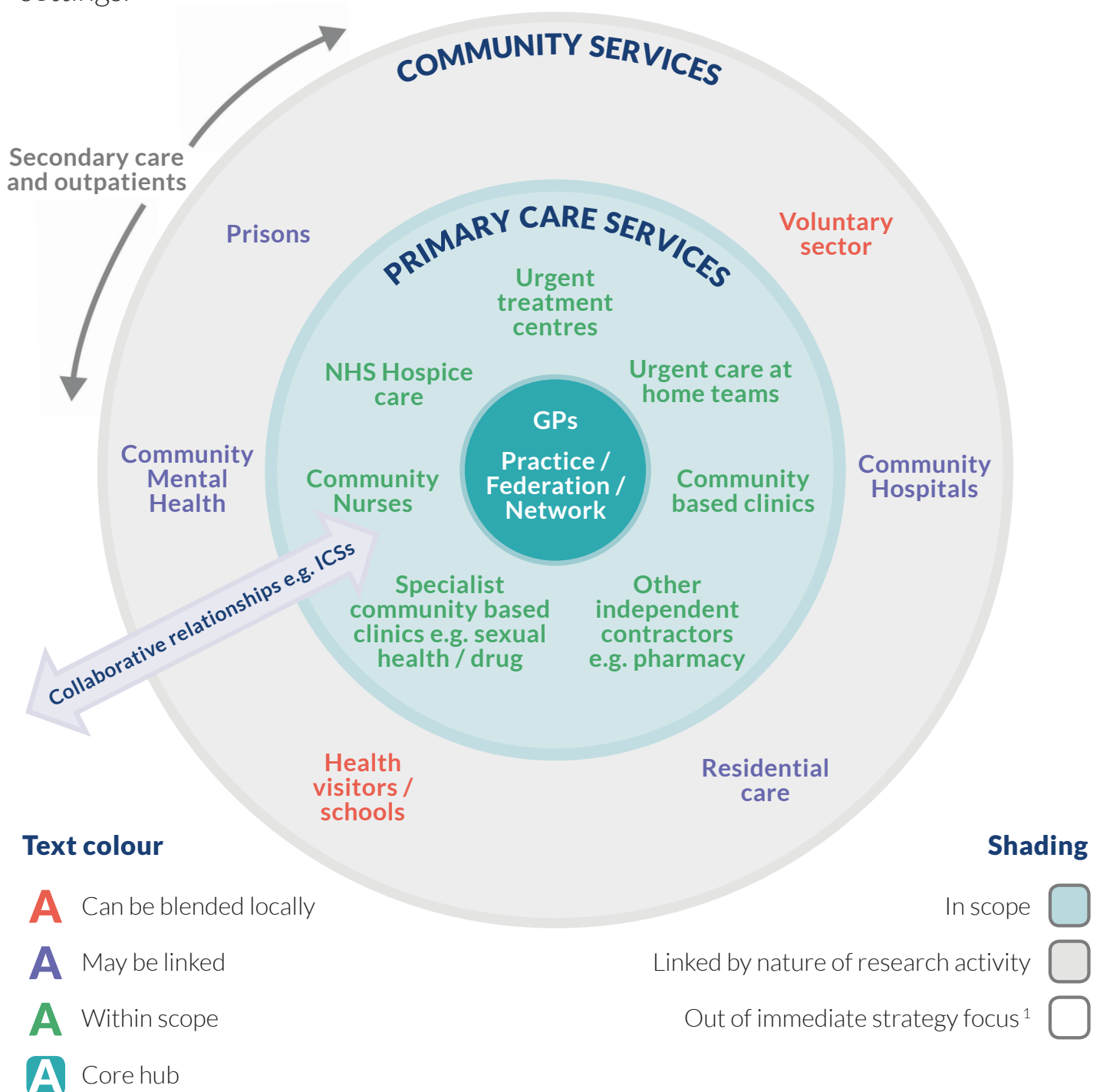
In order to define this with more clarity, we propose only to include in the operational scope research activity in Community Care that is at some stage of the research process actively supported in a traditional Primary Care setting.

We have therefore defined this as **at least** one of the following taking place in Primary Care:

1. Feasibility
2. Invitation to participate (or self-referral)
3. Consent
4. Delivery of intervention
5. Delivery of follow-up



The following diagram illustrates typical settings that are or could be in the focus of this strategy but it is not intended to be a complete list of Primary Care and related settings.



¹ Can be considered operationally in scope where they encompass patient referral activity involving Primary Care in the blue area of the diagram.

Note: Patient and public referrals can take place to and from any part of the health and care system in the diagram and are in scope where they include activity in Primary Care.

The focus of the strategy around Primary Care settings and the way they can interact with the wider community services acknowledges important interdependencies that reflect the diverse individual health and care pathways of people using these services.

It is envisaged that other research strategies in public health and social care may have an influence on these wider community settings more comprehensively as they develop. Further it is essential that Primary Care is seen in the context of the emerging Integrated Care Services (ICSs), and whilst the strategy scope necessarily focuses on the particulars of the Primary Care setting, it values collaborative relationships with Secondary Care where the unique challenges and opportunities in these very different settings are fully recognised.

There remain different interpretations as to what 'Primary Care' itself covers or could cover. However, defining the scope of the strategy itself is very important to its deliverability given available resources over a period of time. The scope is therefore expected to be covered in a phased approach over the life of the strategy. This is outlined in more detail in the operational planning section of this document (**Section 9, page 19**).



5. General approach

The strategy is designed to be agile and responsive to changing healthcare and research environments within a strong governance structure. As such it aims to balance ambition and vision with capacity and anticipated patient needs at any given time.

Therefore it will:



Utilise CRN's annual planning cycle and connect wider strategic development in the health and care field through regular reviews.



Encourage the development and knowledge sharing of innovative practice within the CRN.



Balance activity to optimise flow in the research pipeline and opportunity in the patient pathway.



Incorporate a strong review and oversight function through a CRN Primary Care Programme Board.



Develop a strong and focused external partnership culture for driving change.

6. Strategy themes

The strategy covers 4 core themes:

Theme A

Research is available and responsive to the health and care needs of our population

Theme B

Adaptive connection of research systems and processes to Primary Care systems

Theme C

Strategic engagement and incentivisation in Primary Care

Theme D

Strategic development of the Primary Care Research Workforce

Commentary and benefits of each strategy theme:

A

Commentary: Research is made available and proactively offered to our population and adaptive to their needs in a Primary Care setting, using Primary Care systems.

Benefits: Increased breadth of research evidence better matching the range of patient and public health needs from the first point of contact with care providers.

B

Commentary: The CRN flexibly adapts systems to enable research in Primary care, and to utilise Primary Care information systems relationships to support research activity.

Benefits: Increased research relevance, capacity, efficiency and effectiveness in this setting.

C

Commentary: Research becomes seen as a mainstream activity as widely as possible across Primary Care, and is incentivised and promoted accordingly.

Benefits: Increased relevant health and care research evidence in care services used by most of the population.

D

Commentary: The CRN attracts, develops and maintains a highly skilled diverse Primary Care Research Workforce to enable the achievement of our ambitions.

Benefits: Increased research capacity, skills and leadership in Primary Care settings.

7. Cross-cutting principles to be applied to all areas of strategy delivery activity and oversight

In a fast-changing Research and Primary Care environment, it is important that the following principles are applied across the board to ensure a fully agile and responsive approach to embedding research in Primary Care settings relevant to the needs of the wider population:

7.1

Continuous improvement and innovation across all initiatives/themes

7.2

Patient and Public Involvement and Engagement for population benefit.

7.3

Research activity at **the right place for the right people**, including underserved communities.

7.4

Commitment to partnership working with key stakeholders and understanding their needs and concerns.

7.5

Actively supporting **equality, diversity and inclusion**.

These principles are consistent with those in NIHR Operating Principles and NIHR Outcomes Framework.

8. Strategic aims

Theme A

Research is available and responsive to the health and care needs of our population

- A1** Working internally and through facilitation with key partners, e.g. SPCR, ARCs etc., to develop methods to better understand and demonstrate the current, changing and sometimes highly complex health and care needs of our population and the diverse communities within it. This is in order to identify the research required to support best care in Primary care settings.
- A2** The CRN catalyses and supports work with key partners and stakeholders to drive patient, public and practitioner involvement identification of new patient-focused research, the gaps in research evidence, and the incorporation of existing evidence into practice.
- A3** The CRN works proactively with key partners and stakeholders to routinely review opportunities to incorporate research activity into Primary care, including the introduction of a study by any person or service configuration.
- A4** The CRN supports work with partners and stakeholders to help ensure that the benefits of our research are available to the population through Primary Care providers.

**Theme
B****Adaptive connection of research systems and processes to healthcare systems**

- B1** The CRN develops a good understanding of information sharing and information systems in the primary and community health care landscape at a national and local level at any given time, and assesses their potential application in supporting research activity relevant to the population.
- B2** The CRN evolves research information systems and processes that can be flexible enough to allow adaptation and integration with primary and community healthcare systems and data/IT infrastructure, including those enabling effective study and participant identification/self identification.
- B3** The CRN works with partners to develop information systems that give Primary care practitioners awareness of the Primary care study pipeline and the research opportunities that can be offered to a population through their Primary care services, the GP record, and the unique opportunities presented by health and care professional-patient relationships.

Theme
C**Strategic engagement and incentivisation
in Primary Care**

- C1** The CRN will work with NHSE and other key partners to scope, enable and develop coherent systems of incentivisation that recognise the benefits, challenges and options for healthcare research as part of Primary care, taking into account the variations in funding of Primary care and the independent contractor status of many providers.
- C2** The CRN will work with key partners and stakeholders across the sector to monitor and develop broad ongoing knowledge of the fast changing sector and the implications in incentivisation for Primary care e.g. the national imperative to support the life sciences industry.
- C3** The CRN garners the support and policy engagement of all relevant national and regional bodies to actively promote and support Primary care research, including funders and academic partnerships as well as others including NHSE/I, RCGP, NIHR SPCR, BMA, APBI, CPRD and regional bodies such as ICSs / STPs / CCGs / ARCs / AHSNs for example.
- C4** The CRN works with key partners to develop and implement relevant approaches to performance measurement of Primary care research activity that reflect its value in the wider system.

**Theme
D****Strategic development of the Primary care Research Workforce**

- D1** Both the Primary Care Research Workforce, and the CRN approach to the workforce, is adaptable, flexible and responsive - being available to meet service needs, often at short notice, or in extraordinary circumstances, or settings e.g. future pandemics. Taking into account the wide variation in research involvement from signposting, opportunistic recruitment through to actually leading research (as PI or CI).
- D2** The CRN establishes and maintains strategic collaborations with professional bodies, Higher Education Institutions, NIHR Academy and employers, in developing and supporting a range of career and/or learning pathways for both the current and future Primary Care Research Workforce.
- D3** There is an active programme to develop the knowledge and continuous learning of all CRN staff and researchers about the full range of Primary care settings, their systems, care pathways, funding and the needs of the population using them.

9. Operational planning

Importantly the delivery of the strategy will be phased to ensure all areas within scope can be addressed over the period, but prioritised in a way that is manageable within resources available.

Year on year objectives will, for example, focus on activity that very broadly follows a succession of overlapping phases over the period:

Phase 1

Taking into account contemporary COVID-19 response impacts on the delivery of Primary Care services (e.g. current workload pressures), undertake activity of immediate benefit in strengthening and expanding areas of Primary Care research already being developed and laying foundations for wider work likely to have longer term benefit to the population. It is likely this will build upon current engagement with general practices, PCNs etc.

Phase 2

Developing/innovating in areas of Primary Care only partially engaged with research where there are significant developmental and infrastructure needs e.g. pharmacy.

Phase 3

Developing research coordination across wider Primary Care services, and the interface with community services, enabling innovative health and care studies that address complex health care needs across the whole population e.g. community mental health.

Ongoing operational planning will be the responsibility of a CRN Primary Care Programme Board as part of the wider CRN governance. Led within the CRN's Medical Directorate, it should incorporate CRN CC, LCRN, patient/public and clinical and local delivery lead perspectives.

In order to underpin agile, continuous improvement across the domain of the strategy, all planning should be

informed by a review schedule taking into account the impacts of operational delivery activities already undertaken in relation to the intended short and long term outcomes.

Planning should also have the benefit of close consideration of the unique circumstances, challenges and opportunities in the Research and Primary Care landscape at that time.



Development of specific annual objectives for the delivery of the strategy aims will be informed by these factors and then methodically prioritised for the year going forward.

Model for effective prioritisation:

Identify innovations and actions likely to have positive impacts on achieving aims at this time.

Check against current challenges and opportunities in the Primary Care landscape.

Shortlist against level of urgency, importance and time range and define resources.

Cross reference with other identified actions for overlap, clashes or opportunities.

Prioritise and develop SMART annual objectives.

A model for an objectives planning and prioritisation tool to support this activity is illustrated in Appendix 3 (page 33).

Identified objectives for the upcoming financial year will form the Primary Care Operational Plan that will feed into the CRNCC and LCRN annual planning process. Agreed activities will then be the responsibility of identified

CRN teams/functions to include in their annual plans as SMART objectives on which they will lead and report. These objectives will be easily identifiable as those supporting the Primary care Strategy through kitemarking or similar.

10. Strategy benefit reviews and governance

A strategy review process will be the responsibility of the CRN Primary Care Programme Board. Regular (possibly annual) strategy benefit reviews will be undertaken to ensure the strategy remains entirely relevant and responsive to the actual or developing landscape of Primary Care and the wider research ambition at that time.

Each benefit review will begin retrospectively and then consider carefully the current and emerging

landscape both in terms of opportunities and challenges. If the aims of the strategy are considered to remain pertinent then this is to be reported to the CRN CC Executive along with a summary of the actual benefits observed as a result of the strategy to date.

If, however, changes to any aim or group of aims, however small, are identified as needed this will require formal Executive approval based on written recommendations made.



11. Remit of the CRN Primary Care Programme Board

The CRN Primary Care Programme Board should incorporate senior CRN CC, LCRN, patient/public and clinical and local delivery lead perspectives. Led by the CRN's Medical Directorate, it will have

a clear link with the CRNCC Executive. It should also incorporate other internal and external stakeholder perspectives on an advisory basis as needed. The Board's responsibilities should include:



Maintaining the governance structure ensuring appropriate reporting through it.



Ensuring a continuous improvement approach is applied across the domain of the strategy.



Ensuring there is responsiveness to and national sharing of effective innovative practice.



Ensuring there is a good level of patient and public involvement in key aspects of strategy delivery.



Ensuring the research pipeline in respect of Primary Care is suitably visible, rationalised, measured and balanced in terms of stakeholder drivers, needs and capacity going forward.



Ensuring activity is balanced to optimise opportunity in the patient pathway.



Ensuring other cross-cutting principles from the strategy are being followed in delivery.



Maintaining a top-level stakeholder mapping and management process.



Checking measures of research activity that the CRN uses for Primary Care reflect the value the strategy aims to create in this setting and escalating if not.



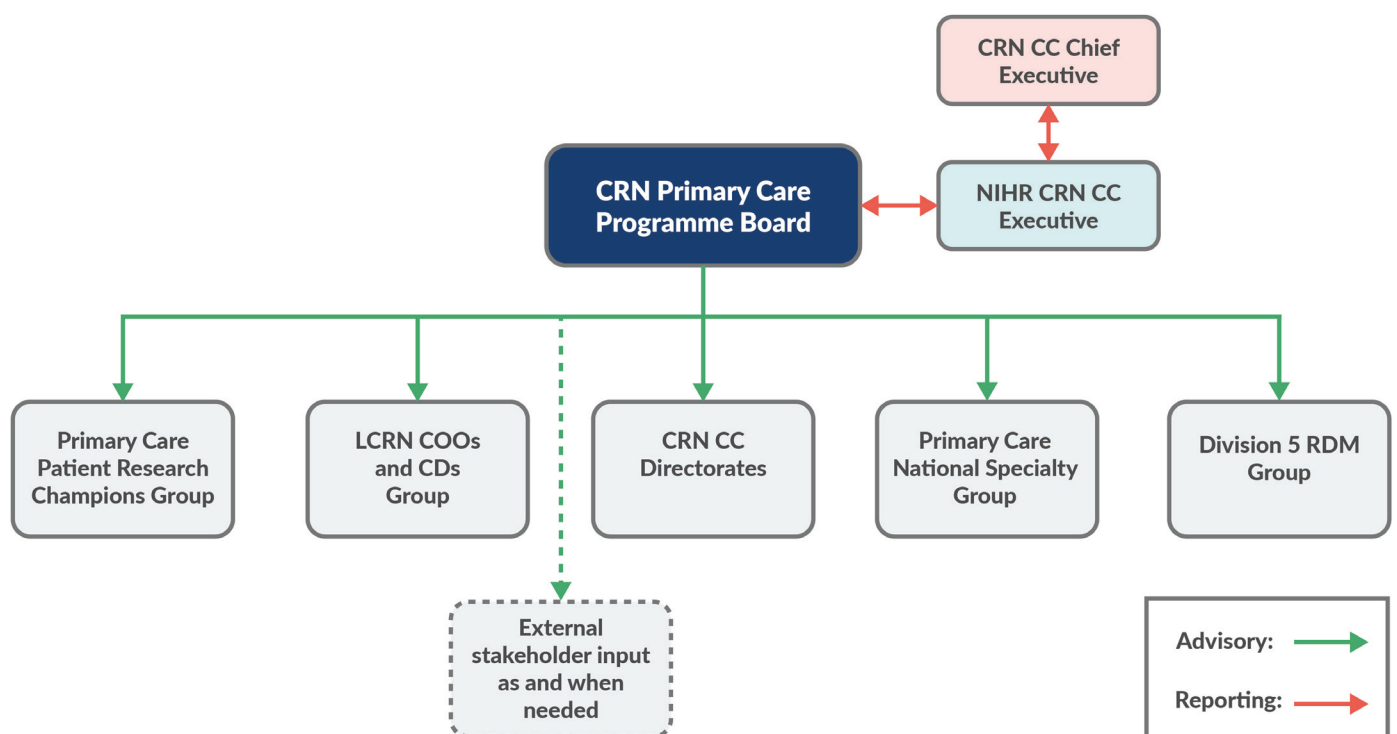
Undertaking impact and benefit reviews.



Developing annual operational plans for the strategy that feed into the CRN CC Annual Planning and LCRN Performance and Operating Framework processes.

A full draft of the CRN Primary Care Programme Board terms of reference and a draft terms of reference for the Strategy Oversight Group can be found in Appendix 4 (page 34).

Board Governance is illustrated below:



12. Summary

The strategy provides a high level context for what is needed to increase research range and capacity in Primary Care whilst pointing the way to how this can be operationalised. It aims to create a more coherent approach in the CRN, whilst at the same time being outward looking. Key to success is the need to strengthen and focus external partnerships to achieve a better Primary Care environment for research because it is not in the control of one organisation alone.

There are already excellent examples of useful partnership work locally and whilst recognising local differences in the way Primary Care is provided, more needs to be done to replicate good

practice across the country. The national policy environment needs to be better at supporting it and the CRN can be a catalyst for partnership because it is within its interests to deliver (in normal times) an increasing breadth of patient and public focussed health research.

It is conceivable that there will eventually need to be a higher level Primary Care strategy that encompasses the key structures in the wider policy environment and this may supersede the CRN strategy. However, in the meantime, we have this one which recognises the unique challenges and opportunities of research delivery in the Primary Care setting and it is possible to build from there.



Appendices



Appendix 1:

Brief history of Primary Care networks

“

With Primary Care Research we are faced with the Law of Inverse Opportunity in that the largest part of the medical profession has the least research opportunities.

”

Denis Pereira Gray in **BMJ Clinical Research**

302(6789):1380-2 · July 1991

Historically, the last three decades have seen a large increase in both the number and reach of Primary Care research networks.

From the humble beginnings of the Birmingham Research unit of the RCGP 50 years ago, a number of local and regional networks have built on the pioneering work of our GP predecessors, such as Julian Tudor Hart, which enabled the establishment of a number of regional GP research

networks. These were traditionally ‘bottom-up’ research networks facilitating research within their constituent general practices with small amounts of funding and encouraging larger collaborative research bids.

These networks included WReN, SaNDNet and YReN, and were funded by the Department of Health and became members of the fledgling UK Federation of Research Practice Networks (1998).

This development was accompanied by the formation of a small number of RCGP accredited research general practices and a larger number in the South-West research general practice scheme funded by the Department of Health.

Subsequently, once the NIHR was established in 2006, these networks were absorbed within the NIHR Primary Care Research Network (PCRN) structure of eight PCRN covering England along with the other Topic-specific networks and the Local Comprehensive Research Networks. During 2014-2015 these networks






transitioned to the current CRN structure with Primary Care as one of 31 clinical specialties within the overarching CRN structure.

The move to a 'top-down' network delivering commercial and non-commercial research on its portfolio, as is the current CRN model, has of necessity meant that 'bottom-up' engagement with general practices and communities has been reduced. This is in stark contrast to the international move towards more Practice Based Research Network (PBRN) models that facilitate engagement with GPs, their practices and other Primary Care staff.



Appendix 2:

Brief summary of the situation prior to the development of the strategy, September 2020

-  General Practice, Primary and Community Care exist in a rapidly-changing NHS geography with considerable overlap and the potential for confusion around boundaries, and nomenclature.
-  GP practices are autonomous legal entities functioning as small/medium sized enterprises (SMEs) with a corresponding turnover. GP Practices contract to the NHS to provide medical services and employ their own staff to achieve this.
-  GPs are therefore at the same time active front-line clinicians, employers and directors of a SME. Many GPs still value both their independent contractor status and the partnership model.
-  With respect to research, there are good links in some areas between the local Clinical Commissioning Groups (CCG) and their constituent practices, whereas in others this is almost non-existent. Some R&D Trust Offices cover GP Practices, most, however, do not, and there is a lack of a clear organisational structure with respect to research governance in Primary Care research.
-  There is a differential level of investment into secondary and tertiary care research delivery when compared with Primary Care. It is therefore likely that a substantial increase in investment would be needed both to generate new research studies for the pipeline, but also to deliver at scale as indicated in this strategy.

Challenges

1. **Falling engagement with General Practices** with a **gradual downward trend** in the HLO6c figure of GP Practice engagement with CRN, which was down to 36% of all GP practices being research active in the UK (2019/20) and below the CRN target (45%).
2. The **RCGP Research Ready®** accreditation programme has suffered from considerable lack of interest with many General Practices questioning its fitness for purpose and hence not subscribing and is being re-launched.
3. **Recruitment fall:** There has also been a gradual reduction in the number of participants recruited into Primary Care Managed Studies over the last few years, a drop of 9.5% between 2015/16 and 2019/20.
4. **Patient Identification Centre** (PIC) activity is not reflected in the NIHR CRN HLO6c figure which reflects actual recruitment at General Practice sites. GPs have consistently reported that they feel devalued by the current PIC process.
5. **Workload increase:** There is **increasing time pressure** on GP services, which is coupled with the shift of workload from Secondary to Primary Care and the increasing challenge of recruiting and retaining GPs to provide clinical care.
6. **Salaried GPs** now comprise 33% of qualified GPs and ensuring that this large group within the GP profession are directly incentivised to undertake research is a key challenge.
7. **Independent contractors:** Primary Care services are run by independent contractors, hence there is no set salary or minimum income, nor programmed / funded time within the contract for research activities, unlike Secondary Care.

8. **Primary Care teams:** Most research in general practice therefore has to involve additional staff and the key role of Primary healthcare workers is to identify and invite patients they know well to join research studies.
9. **Multimorbidity:** The increase in people living with multimorbidity and multiple long-term conditions has further increased the Primary Care workload.
10. **Attitudinal and cultural Primary Care issues:** Traditionally clinical research has been perceived by colleagues in Primary Care as the domain of Secondary Care, or even Tertiary Care. There is also a feeling that research is “done to” rather than being “done with” Primary Care and is cited as a reason for not engaging.

Opportunities

1. **Primary Care Networks (PCNs):** in April 2019 PCNs were introduced into the NHS in England. They are developing a population perspective and it is likely that PCNs could be the unit of engagement with CRN Research moving forward. There is also the potential for commissioners in Primary Care to commission research that is relevant to their population at a CCG, PCN or ICS level.
2. **Indemnity:** The introduction in April 2019 of state-sponsored indemnity for research (at the request of the CRN) should be reassuring for GPs and encourage uptake of research studies without concerns about indemnity.
3. The **Primary Care IT Solutions** work has developed over the last two years making it easier to access patients for CRN Research. CRN funding has recently been secured for the second phase of the IT solutions development work - the creation of a coordinating hub.

4. The launch of the NIHR's **Be Part of Research** in 2019 should not only make it easier for patients to find research for themselves but also be a useful tool for Primary Care to link with research activity. Similarly, the **Join Dementia Research** team have introduced the use of kiosks to give patients the opportunity to sign up to the register whilst visiting for an appointment.
5. The NIHR has also made efforts to reach out to **Pharmacy** Practice in the last few years to make research options more available to both patients and staff.
6. **NHS England** has been considering a financial incentivisation scheme for Primary Care which would typically be facilitated through the GP contract. This would be an important facilitator for greater research engagement and activity at a PCN level.
7. The **NIHR Policy Research Programme** has recently funded a study on the Associations between Research Activity and Patient Health Outcomes as it applies to General Practice. This ARAPAHQ study will, over the next two years, give a unique insight into the structure, processes and outcomes of research taking place in research-active practices.
8. This current **COVID-19 crisis** demonstrates a positive experience of identifying GP Practices previously inactive in research to help deliver the numbers needed for recruitment into the COVID-19 priority PRINCIPLE study. The situation makes visible the importance of Primary care in the delivery of healthcare research where there is the highest patient contact.

Appendix 3:

Operational planning and prioritisation tool illustration

	Description and rating				
	High = G Medium = A Low = R	High = R Medium = A Low = G	High = R Medium = A Low = G	High = G Medium = A Low = R	Strong = G Medium = A Partial = R
Proposed year objective	Opportunities	Challenges	Likely resourcing needed	Likely impacts	Number of strategic aims supported
Objective 1					
Objective 2					
etc					

Appendix 4:

Draft terms of reference for the CRN Primary Care Programme Board

The CRN Primary Care Programme Board exists to ensure that the CRN Primary Care Strategy is delivered according to the principles, themes and aims encompassed within it.













A key role is to enable an agile continuous improvement approach at all levels of its delivery and to review the fitness for purpose of the strategy in the light of a fast changing Primary Care setting environment.

The CRN Primary Care Programme Board should routinely incorporate representation from senior and experienced CRN CC, LCRN, patient/public, clinical and local delivery lead perspectives and have a clear routine reporting link with the CRNCC Executive.

It should also incorporate external stakeholder perspectives in an advisory capacity on an ad hoc basis.



Minimum membership

-  CC Executive sponsor
-  *National Specialty Lead for Primary Care,
-  *Lead LCRN COO representative linked to national COO and CD meetings
-  LCRN Clinical Director representative linked to national COO and CD meetings
-  *Senior Division 5 RDM representative linked to RDM group
-  *Patient/public representative
-  Senior Research Nurse (Primary Care)
-  CC Research Delivery lead
-  BDM lead
-  WLOD lead
-  NHS Engagement lead
-  BI lead
-  PPIE lead

Quorate

Six people are required for a decision to be quorate including those above marked with a *

Responsibilities



Maintain the governance structure ensuring appropriate reporting through it.



Work with the CRN Executive and SMT to fully position Primary Care as a high value cross cutting research setting in the work of the organisation.



Ensure a continuous improvement approach is applied across the domain of the strategy.



Ensure there is responsiveness to and national sharing of effective innovative practice.



Ensure there is a good level of patient and public involvement in key aspects of strategy delivery.



Ensure the research pipeline in respect of Primary Care is suitably visible, rationalised, measured and balanced in terms of stakeholder drivers, needs and capacity going forward.



Ensure different activities contributing to the delivery of the strategy are logically balanced in relation to each other to optimise increased research capacity and opportunity in the patient and service user pathway.



Ensure other cross-cutting principles from the strategy are being followed in delivery.



Maintain a top level stakeholder mapping and management process.



Ensure the Operational Plan is kept up to date.



Check measures of research activity that the CRN uses for Primary Care reflect the value the strategy aims to create in this setting and escalate if not.

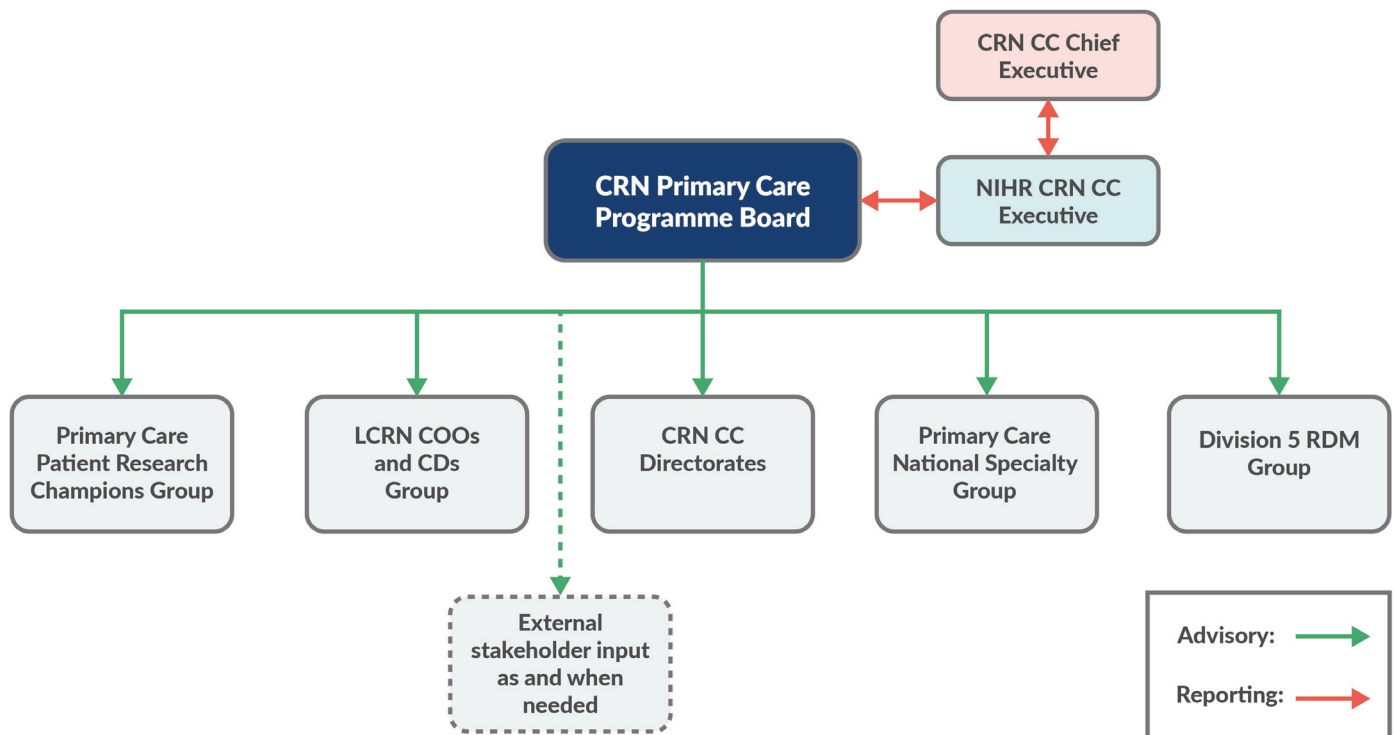


Undertake impact and benefit reviews of the strategy.



Develop annual operational plans for the strategy that feed into the CRN CC Annual Planning and LCRN Performance and Operating Framework processes.

Governance



Reporting

The CRN Primary Care Programme Board will report to the CRNCC Executive at regular intervals and ensure that it is likewise cognisant with any wider strategic work being undertaken in or reported through the Executive.

Primary Care has important cross linking with wider community, social care and public health research, and where there is strategic research capacity development in these wider sectors there needs to be a good understanding of mutual impacts.

Scope

The scope of the CRN Primary Care Programme Board will be the same as that of the strategy itself, focused on core Primary Care services research activity with a recognition of interdependencies with wider community services.

Appendix 5:

Explanation of technical terms used

Acronyms

AI	Artificial Intelligence
AHSNs	Academic Health Science Networks
APBI	Association of the British Pharmaceutical Industry
ARCs	Applied Research Collaborations
BMA	British Medical Association
CCG	Clinical Commissioning Group
CRN	Clinical Research Network
CRNCC	Clinical Research Network Coordinating Centre
CRPD	Clinical Research Practice Data Link
DHSC	Department of Health and Social Care
HL06c	Higher Level Objective 6c (used as performance indicator in CRN contract with DHSC)
HEI	Higher Education Institution
ICS	Integrated Care Systems
LCRN	Local Clinical Research Network
NHSE/I	NHS England/Improvement

RCGP	Royal College of General Practitioners
PBRN	Practice Based Research Network
PCN	Primary Care Network
PPIE	Patient and Public Involvement and Engagement
SME	Small and Medium sized Enterprise
STPs	Sustainability and Transformation Partnerships (NHS)
SPCR	School of Primary Care Research

Words

Multimorbidity	Where a range of health related issues are present in one person at the same time
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Appendix 6:

Key documents and links

Proposal to Form a CRN Strategy for Primary Care in the CRN | September 2020

<https://drive.google.com/file/d/1tv5y24Ds6tZXXAY4Pi9qZDpeRc8R1cq5>

GP funding and contracts explained - Kings Fund | June 2020

<https://www.kingsfund.org.uk/publications/gp-funding-and-contracts-explained>

Primary care networks explained - Kings Fund | November 2020

<https://www.kingsfund.org.uk/publications/primary-care-networks-explained>

Life Sciences Sector Deal 2 | 2018

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/768570/life-sciences-sector-deal-2-web-ready-update.pdf

NIHR Outcomes Framework | (not yet published)

NIHR Operating Principles

<https://www.nihr.ac.uk/about-us/our-mission/our-operating-principles.htm>

NIHR Digital Strategy | 2021

<https://sites.google.com/nihr.ac.uk/nihr-digital-strategy/digital-strategy>

Appendix 7:

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