

## Response to the Cooksey Review of UK Health Research by AUKUH

The Association of UK University Hospitals welcomes this initiative as one of profound potential importance to the economy and as an opportunity to develop a framework for service delivery and research across the spectrum of activity found amongst member Trusts. Central to all AUKUH members, is the tri-partite mission of clinical service, clinical education and bio-medical research. Members work closely with their University partners and with other local stakeholders: University Trusts and their associated Medical Schools have overlapping and interdependent, but non-identical goals.

The 33 member Trusts in England represent only 18.6% of the 177 acute Trusts – however they undertake 28% of the patient workload and account for 27% by value of the total specialized workload. Despite handling the most complex cases, there is evidence that there is a relatively lower risk of mortality in teaching Trusts compared to the national average (Dr Foster, 2006). There are no teaching Trusts in the upper end of the distribution, confirming the association between teaching trust status and mortality rates. University Hospitals in England employ one third of all doctors in training grades and provide a wide range of training resources.

In a world of changing service delivery, AUKUH members are central to large numbers of managed clinical networks and to the development of integrated services. They also carry out significant research activity, attracting over £500M in external funding annually. In 2005 there were 14,619 externally funded research projects in progress in university hospitals, an average of 418 projects per Trust. Charities fund 36% of the research projects in university hospitals, with the universities (through HEFCE) as the next largest source of funding at 25%. NHS R & D support funding totalled £375M for university hospitals in 2004/5 and nearly 20,000 peer-reviewed publications resulted from research projects in university hospitals in that period.

In responding to this consultation, AUKUH believes it essential that the first priority should not be to decide on how the fund should be managed, but should be to devise a strategy for health research for the future. This should include optimal use of resources and seek to put in place transformational leadership which brings about personal and organisational achievement leading to gains both for patients and the economy.

Development of such a strategy must be based on a realistic assessment of what is actually achievable and should involve joint working between Trusts, Universities and all relevant stakeholders and partners. It is vital that discussion does not simply centre on the creation of internationally competitive “centres of excellence” but that regional research strengths and priorities are also considered. Research active provincial centres will be of major importance in the creation of research networks. Regional Development Agencies must be engaged in strategy development.

Priorities should be informed by patients’ views of what is acceptable and must focus on tractable areas of research. A formal risk strategy should be included to ensure investment in a wide spectrum of

possibilities, from the speculative to the secure, with mechanisms to encourage inter-disciplinary research. An appropriate balance must also be struck between fundamental science and applied clinical, health services and public health research. Whilst key stakeholders must be involved in the creation of the strategy, there must be no Government involvement in individual funding decisions.

The link between basic research and patient care is absolutely fundamental and cannot be stressed too strongly. Research provides better health, better means of delivering health and stimulates innovation in diagnostics and devices which in turn contributes to the international competitiveness of the UK as well as to local social and economic development. It is essential that this interdependency is recognised when creating any new funding schema.

It must also be borne in mind that institutional arrangements for a single health fund will not, in themselves address the question of how the policy environment can better support university hospitals in providing the institutional setting for the greater part of NHS-based research. This is a central issue and must be addressed lest university hospitals be weakened by the cumulative effects of policy initiatives that consider service, research and education in isolation.

## **Response to questions posed by the Cooksey Review Team**

*1. What are the strengths and weaknesses of the MRC and NHS R&D programmes at present? How do each of these support the research and training needs of the NHS, social care, industry and academia? Does more need to be done?*

The MRC demonstrably funds excellent research based upon rigorous peer-review and application of the Haldane principle. Its reputation for funding basic biomedical research is not in question. The MRC is the largest public funder of clinical trials and has steadily increased its investment in RCTs. In the past 2-3 years the MRC has strengthened its commitment to clinical research by establishing a board with specific responsibility for clinical research (Physiological Systems and Clinical Sciences Board) and by more than doubling the budget of the Health Services and Public Health Research Board. However, it would seem logical that certain areas which have clearly been neglected in the past, such as, health services research should move to the orbit of NHS R & D.

The MRC has for many years run fellowship schemes to train university employed clinical staff from which many senior UK clinical scientists have benefited – training is central and must continue.

The NHS too has made some significant contributions, for example in the development of systematic reviews. Programmes such as HTA (Health Technology Assessment) and SDO (Service Delivery Organisation) are both world class and ground-breaking. The new national Joint Registry is also an important step forward. The creation of similar large-scale registries for all new medical procedures would prove valuable in monitoring use and efficacy. AUKUH supports the proposals for change outlined in *Best Research for Best Health* and believes the new strategy provides a superb mechanism for focusing clearly on research priorities and providing value for money in clinical, health service and wider health-related research.

*2. What do you believe are the key scientific and organisational challenges facing health research, and underpinning training, in the UK over the next decade? How might the UK Government best help address those challenges? What do you believe should be the Government's objectives for health research and why?*

The service target culture with which the NHS is now imbued is a major challenge: the

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research culture needs to be re-invigorated and prioritised in all Trusts across the UK. Central to this is creating a culture throughout the health service which seeks to extend the evidence base and to question the foundation on which decisions are taken and care provided. Trust and independent sector managers must be committed to this heightened focus on research and will need to be incentivised to become involved. Patients and the public must be actively engaged, must understand the importance of their personal data being used and of the need for animal research and testing.

Any strategy must satisfy the need to support internationally competitive centres of excellence but balance this effectively against the need to distribute funding transparently to support regional strengths. For this reason it is vital to engage the Regional Development Agencies in the planning process. Mechanisms should be put in place to ensure that local research priorities are recognised and provision is made for the support of research-active provincial centres. Regional centres should not be disenfranchised from the national agenda and incentives should be put in place to recruit Trusts to research networks.

Challenges to be overcome at the interface between service and research include: developing a strong focus on clinical research; optimising the use of resources; developing minimally bureaucratic regulatory and governance arrangements in order efficiently to initiate and undertake clinical trials and ensuring that excellence flourishes in all Trusts rather than simply current research centres of excellence.

With proposals to shift the balance of healthcare provision from acute trusts and into the community comes a further challenge, as services are increasingly concentrated in the PCTs. It will be vital to engage the PCTs in research or risk the loss of university employed staff from the acute trusts, with their corresponding concentration of research resources and expertise, to organisations with little research focus, leading to the loss of vital critical mass in many specialties.

As the NHS moves steadily towards a decentralised, devolved, healthcare provider system, the responsibilities and accountabilities of NHS organisations as employers, as well as providers of service, needs to be recognised. It will be very important to set any new system in the context of changes already occurring in the NHS, to avoid destabilisation and to ensure that the system for R&D fits with the overall strategy for the NHS.

Reform of the VAT rules to re-define education and collaborative research as front line activities, central to the delivery of service, rather than add-on business activities, could have a dramatic impact – at zero cost to the Public purse. If HMRC accepted that the supply of education and research was a service and included them in the list of Contracted Out Services on which VAT could be reclaimed, then a number of VAT-related issues, hampering collaborative research would be resolved.

*3. What should be the Government's priorities for health research? Is there anything it should stop doing or funding? What is it not doing or funding that it should do, and, in the absence of further sources of support, what can it lower in order to release the necessary funds?*

Government needs to link research priorities to wider economic planning. But behind this, a key priority for health research must be ensuring that the type of environment where research flourishes is valued and promoted within the NHS and maintained within the universities. The current focus on service targets has damaged the previously active research culture of the NHS and this trend should be reversed. Time should be made available, and protected, within job plans to pursue research activities.

Priorities should be set following informed debate between all interested parties: patients,

service providers, pharma, development agencies and the universities. Such discussions should consider the existing knowledge base and assess those areas where investment is likely to produce an outcome which will be acceptable to patients.

The Government must recognise its limitations. It will be vital that ministers take advice and guidance from the healthcare sector when setting any priorities for health research. Biometricians, statisticians, social scientists and representatives from both basic and applied clinical research must be included in any decision making process.

*4. How should decisions be taken on the balance between the long-term economic and social benefits of a high-quality biomedical research base; and the needs for research to improve healthcare and other public services? What is the appropriate balance between public funding for investigator-led and priorities-led research? How do we balance funding for basic, translational science and applied science? Is this something that should vary over time? What mechanisms should be used to make judgments about this balance?*

There should be a central strategy which could guide the flow of funds.

It needs to be understood that the timeframe necessary to resolve different problems will vary and will be dependent both upon the current knowledge base and on the availability of talented people with creative ideas, working in an environment that fosters innovation. The academic sector, drawing on its specialist skills, must be engaged in identifying and validating proposed targets for research funding. As we have explained in answer to Q2, the creation of the strategy needs to link to both central and regional economic planning in order to optimize the benefits that will accrue from strong clinical academic partnerships delivering excellent service for the benefit of patients.

*5. In your experience, how have the results of publicly-funded health research in the UK been used, both in the development of new treatments and to influence/ change wider policy and healthcare practices? What lessons can usefully be learned to improve the uptake of advances in science and medicine?*

Dissemination of information and acceptance of the need to change practice is indeed a challenge. There are examples of national audits which have resulted in change in practice - see for example [www.entuk.org](http://www.entuk.org) - and widespread, high quality audit could prove an effective mechanism to move to evidence based practice. The emerging range of networks will aid dissemination and the new institution should take a lead in embedding evaluation principles and ensuring research outputs are translated into healthcare benefits across the country.

Trusts must be incentivised to engage in research. Research activities and collaboration should be rewarded, and should contribute to the overall performance ratings of a Trust. The issue of additional R&D metrics to be used by the Healthcare Commission is controversial however, and not unanimously accepted by AUKUH members. Any system to encourage participation in NHS R&D will need to recognise that any such participation will not be uniform and thus could not be incorporated in a universal assessment process.

Grants should be available to Trusts to support the translation of basic research to applied clinical care, at both an institutional and individual level. These grants should be viewed as prestigious with a Trust in receipt of such an award receiving appropriate recognition through performance ratings or otherwise.

*6. How might better links be forged between 'basic', translational and applied researchers, working across the whole field of health research, from the laboratory bench to the front line of the NHS? How might better links be forged across the whole field of health research, from the*

*laboratory bench to the front line of the NHS? How might better links be forged across disciplines e.g. with engineers, physicists and social scientists?*

Health Service Research and Clinical research need to be recognised as valuable contributions to the sector. The RAE acts as a disincentive for NHS funded university employees to pursue research for patient benefit. A study comparing two types of cement used in hip replacements, for example, may not be recognised by the RAE. As the RAE is reformed, it will be important to give weight to the significance of outcomes, in terms of the quality of patient care, alongside the output of researchers.

It must be remembered that health systems and organisations are themselves health technologies, having an impact on patients and as such deserve study. This complements the proposals in Best Research for Best Health for research on Patient Safety and the Quality of Service.

Links across the translational spectrum from bench to population will be facilitated by research training for some that develops a portfolio of skills. It is likely that future health research will draw more heavily on the physical sciences and social sciences and clinicians skilled in these domains will become more important. The new system should have mechanisms for incentivising and evaluating interdisciplinary initiatives that are required to secure translation.

*7. How can the Government encourage translation, entrepreneurship and innovation in health research to improve public services in the UK?*

University Trusts own only 164 patents - generating an income of £790,000 in 2004/5. £585,000 of this was reported from two organisations, illustrating that IP rights currently make up a very small proportion of the income of teaching hospitals. This must be rectified. The existing 'Regional NHS Innovation Hubs' could form the basis of encouraging and strengthening the promotion of IP and its associated value, to NHS member organisations. Innovation hubs within the NHS should be open to ideas from outwith the health service and could play a major role in strengthening the all-important partnerships between NHS organisations and universities. Links must be established for collaborative research. The new Institution should develop a strategy to include funding for blue-skies' projects. There is a history of success in following this route as demonstrated by the Henry Wellcome Anniversary Awards. Initiatives to reduce bureaucracy must continue. Mechanisms to provide support for worldwide patent applications and renewals from SMEs should be developed.

Trusts and Universities must work together to ensure that the principles laid down in the Follett Report are realised in everyday practice.

*8. How can UK health research funding be most effectively used to provide the appropriate infrastructure for basic, translational and applied research, whether funded by the UK public sector or other sectors? How can UK health research funding be more effectively used to support the work of NICE, facilitate innovation and collaboration with industry and address market failures in the application of healthcare?*

Strategic planning must recognize the benefit of strong partnerships between universities and university hospitals and the need to nurture and encourage a research culture.

The new NIHR provides an excellent opportunity for service to appreciate the benefits which can accrue from involvement in research and to become engaged in it. The combination of faculty centres and programmes is an appropriate model and makes use of some of the best elements of current MRC and NHS R & D infrastructure.

9. *What lessons should the UK learn from other countries in making the proposed changes to the institutional arrangements for the funding of health research?*

In many other countries governments have recognized the interdependency of service, research and education and have regard to the institutional challenges facing university hospitals when developing policy. There are lessons to be learnt from Denmark, for example, where the role of academic medical centres has been linked to wider economic planning. It is disappointing that in the UK the Department of Health has persistently refused to acknowledge that the management of the tripartite mission at the institutional level presents particular challenges.

. It would be worth considering commissioning a consultancy such as RAND to advise the strategy development group.

10. *In implementing a single fund for health research, to what extent should the MRC and DH/ NHS R&D be merged or brought together? And to whom should the single, ring-fenced, fund be accountable? Please provide reasons and any supporting evidence for your response.*

Time should be taken to merge the two organisations and for the moment the most acceptable model for the sector would probably be an over-arching Board (with an internationally respected independent Chair) with joint accountability to DTI, via OSI and to DH. The joint fund MUST be administered according to the Haldane principle with independence from political pressures. The retention of links with DTI and membership of RCUK will also facilitate inter-research council initiatives. It will be vital to retain the appropriate balance between funding for basic and more applied studies and so some ring-fencing will be necessary and possibly some movement between funds at the margins.

11. *To what extent does the success of recent innovations in health research (e.g. Clinical Research Networks) and the proposed structures rely on the Connecting for Health NHS IT system, and to what extent should it do so?*

Whilst research networks have indeed proved successful in cancer, there is a danger in assuming that they offer the only route forward. Researchers need to be fully engaged in assessing the most appropriate mechanism to tackle different issues.

An effective IT infrastructure is imperative but the lack of interface between NHS and university systems must be resolved as a priority. Connecting for Health could in future provide a superb platform.

12. *Given that NHS R&D is currently devolved, but that the work of Research Councils is not, how can these functions work best together to maximize the health and economic benefits to the UK?*

In England the DH must ensure that funding is provided to cover the costs of conducting research in a clinical environment. The devolved nations will clearly take their own decisions but might be encouraged to see the value of this approach and the desirability of NHS funding for R & D at the equivalent level per capita, to England. The new institution should develop relationships with the devolved administrations that allow it to have an overview of national research capacity, even if some funds are regionally restricted. It would be very unsatisfactory if research funding were entirely devolved.

