The Health and Social Care Professoriate

Institute of Health and Community Studies, Bournemouth University

Response to the Cooksey Report

July 2006

General Comments

Thank you for the opportunity to comment on the Cooksey Review of UK Health Research. The following comments represent the views of the professoriate at the Institute of Health and Community Studies (IHCS), Bournemouth University.

The Professoriate greatly appreciates the opportunity to contribute to the consultation on this important matter and we therefore hope that our insight and responses will help in the discourse concerning the future development of a single fund for health research. We welcome the timing of this review because of the global trends and emerging scenarios around healthcare which require there to be a major review of research activity and focus.

We believe there is a need to build on the UK's existing assets to develop and enable new and different approaches to research by ensuring that new partnerships are formed in order to stimulate research activity. To be effective, such partnerships must extend across the newly emerging health community and the new universities, as well as more traditional institutions, because they are developing the knowledge base that the emerging healthcare delivery system now needs. I will return to this later in the paper, but we believe it is time to focus upon health research and not just medical research.

In general, the professoriate at IHCS supports the following points from the commentary:

a) Continuing development of research into biomedical considerations;

b) Research featuring a systematic peer review system;

C) Outputs utilising indicators of quality as defined by the RAE or its successor.

We would also support a stronger link to health policy. In particular, we feel that this should become much more explicit both with regard to the implementation of UK health policy and, increasingly, European health policy.

To return to the point we raised earlier we strongly support the view that future research opportunities should extend beyond the biomedical into the field of health and well-being so as to understand the effectiveness of current services in the promotion of good health and well-being throughout the population. Crucially, we believe that because the health and well-being agenda represents a shift in the paradigm of healthcare, such a shift should also occur in the research that underpins healthcare. We believe that funding opportunities should be accessible to all health and social care disciplines, which would mirror the requirements of current and future health policy. Linked with this accessibility is the need to support and help establish different methodological approaches to health and social care research far beyond the role of the randomised controlled trial, which we acknowledge has its place within the family of health and research methodologies but not to the exclusion of other methods. Health is not simply a biomedical phenomenon; it is also a social, economic and demographic one. Therefore, understanding the trends and the impact of these trends on healthcare requires appropriate research methodologies, design and activity. Without this, the needs of health and well-being will not be met. A similar approach should also be taken in terms of public health research.

Specific responses to the individual questions posed by Sir David:

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

A measured strength of the MRC is its focus on international excellence. Nevertheless, as the title suggests, it is mainly supportive of medical research rather than health research and this contravenes our view, as already stated in our general response to the report. The field of research sponsored by the MRC is somewhat narrow and does not provide an opportunity for others, with either a different methodological viewpoint or research area, to fully explore the world of health and social care.

To ensure that research supports the health and social care community, industry and academia, career pathways for the clinical researcher need to be established. Research training at post-doctorate level must be provided, and so capacity building in the form of clinical/practice researchers is a prerequisite to maximise the effectiveness and efficiency of research investment. Knowledge transfer activity should also be acknowledged and funded, particularly regarding evidence-based practice, evidence-based commissioning and evidence-based learning.

It must be noted that English healthcare reforms are fast adopting a more market-orientated system than those of the Celtic countries. The impact, therefore, of such a market structure within the English health and social care

system needs to be considered when the funding and the creation of the infrastructure for research are decided.

It is perhaps worth considering that, since devolution, the four nations of the UK are developing different suites of policies with regard to health and social care provision. It is perhaps also important to acknowledge the need to build capacity in new disciplines emerging within this changing healthcare situation. For example, in other European countries alternative and complementary therapies are more mainstream than in the UK. Therefore one would expect that the merged funding stream would support studentships and research activity in emerging and non-traditional fields. The provision of a broader notion of studentship needs to be considered.

Although there is good support from the pharmaceutical and medical equipment industries for research, we believe that neither the MRC nor the NHS R&D programmes is yet doing enough to meet the needs of different aspects of those industries that service the provision of health within the UK. This needs to be addressed.

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?

There are a number of challenges underpinning the answer to this question. One challenge relates to the ability to spread available money across health and social care, particularly in response to the epidemiological and

demographic implications for our health and social care systems. Living with chronic health problems, understanding the nature of health, keeping people well by preventing them from getting sick, promoting self care or family care, all move us away from the focus of treating sickness. There are also ecological differences that have to be considered between the regions and the nations of the UK when funding appropriate research activity which is addressing these emerging implications.

Another challenge concerns the role of the public. To be involved with cutting edge research activity and how the public is engaged and informed is particularly problematic with regard to the ethical perspectives and moral dilemmas facing 21st century research. Debates regarding genetics and nanotechnology, ageing and lifestyle choices have implications for everyone. These issues need to be researched in a way that has not been possible in the traditional paradigm using the current funding structure.

Other challenges are how we engage younger people in understanding science and taking science as a subject. How do we attract people into the health and social care professions to allow them to research and implement the findings of their research? How are health and social care workforces supported and enabled to understand the impact of health information in terms of management and technology? Perhaps the newly merged funding will allow universities to provide more multi-professional research training and develop technology in the context of best evidence of research, both clinical and educational. This is all about cultural change. Developing a research agenda that supports this cultural change, as part of a paradigm shift, is a challenge.

To further a culture of innovation and experimentation within a risk assessment framework, the Government may wish to consider how other countries, particularly Scandinavia with its strong philosophy of humanitarian welfare, is meeting these challenges. There is a tendency to look to the United States for answers. We are not sure that professional solutions will be found by simply importing American ideas. The culture is so different.

In many respects, the new paradigm of healthcare that is slowly emerging for the future will be based and dependent on lifestyle choices for individuals, which presents a particular challenge. By patenting a drug or device it is possible to get an economic return through the research investment; but how can economic returns be achieved and measured in terms of lifestyle change? Although there are difficulties around such change, they can and must be overcome. The research agenda is part of finding the solutions to this changing agenda.

For predicting and understanding lifestyle issues, good research activity is needed. For example, regarding the issue of obesity, the current Government is having to change previous policy on such things as sports field provision and catering services in schools because the original policy impacts were never fully evaluated.

Our argument is for an end to the dominance of the traditional paradigm of research and a move towards a different approach to understanding research and research activity.

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?

The shift away from clinical treatment to health and well-being research is essential. We have a distorted model that is perhaps not fit for the purpose of policy implementation in the 21st century for reasons already alluded to.

Research activity needs to be awarded to those institutions that can help build capacity and be holistic in nature. Currently only medical schools are attached to traditional research universities – the majority of healthcare students are not at these kinds of institutions. The need now is for a research strategy and funding that can build bridges between these health and medical faculties and that of service.

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 science, translational science and applied science? Is this something that should vary over time? What mechanisms should be used to make judgements about this balance?

The provision of public services in this country is still dependent on Government funding through taxation. Government funding should therefore reflect research into the public well-being. All streams of Government activity have a health component and this needs to be better understood and a matrix drawn to show how the linkages and the networks build a cohesive understanding of lifestyle

and living within the UK. Therefore, Government funding in terms of environment, social policy or education issues needs to highlight where health gain and improvement fit because of environmental, social and educational policy change. For example, consider transport policy and how it has evolved over the last 20 years. The health implications in terms of accident reduction, pollution, congestion and so forth, need to be understood. Florence Nightingale's reforms of the 19th century were not just about the development of the nursing profession but also about housing, ventilation, lighting, the use of clean air, sanitation, etc. All of these Victorian public works were for the betterment of the population as a whole. The development of the medical model, and the scientific medical model since the Second World War, has skewed our view of health and so the research programme needs to rectify this.

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?

Greater support for knowledge transfer in terms of practice development activity is something the Cooksey report should be advocating. There needs to be some sort of vehicle whereby the consequences of any NICE recommendations are applied to practice. The creation of RDSUs was theoretically how the NHS R&D programme was to come alive, but it could be argued that these have become too detached and do not focus on applying research findings into practice. What also needs to be better understood in the creation of clinical career research pathways is how a university health faculty and clinical network need to be designed, created and fostered as this could influence the uptake of

research findings into practice improvement for health gain, particularly if lead clinical academics have accountability and responsibility for it.

Current practice is still not influenced by research findings: there is still the possibility of individual practitioners doing what they have always done because nobody is there to police them or encourage them to think or work differently. It is increasingly important to shift things within organisations so that the use of evidence-based factors and research findings becomes part of the culture. Therefore, chief executives and their teams need to be much more engaged in research promotion. There should be greater accountability to ensure research is implemented in any clinical situation. Clinical governance systems do not seem to impact on the work of lone practitioners who are mavericks. Who is going to take responsibility for this?

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 disciplines, e.g. with engineers, physicists, and social scientists?

   There is a need to build brokerage systems to perhaps include media specialists, health educators, built environment specialists, etc. A wide range of individuals who work across the health and social care arena is required and we need new brokerage models for the public to explain the purpose and aim of the research and to clarify how the public can inform what sort of research spending and decisions have to be made.

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

There is a need for the research councils in the UK to recognise policy change and to promote far more effective knowledge transfer strategies. Currently, once the money is allocated the research councils have no further involvement – research is taken on trust and the investigators are expected to deliver what they said they would deliver. There is little evidence of research councils co-ordinating or sharing good practice in relation to their activities. It is partly due to a lack of clarity of what knowledge transfer is among the research councils which often leads to confusion among users about the knowledge transfer role. The impact of good knowledge transfer is not widely known, disseminated or understood, and that which does happen, particularly with regard to research activity, is often of a quantitative, short-term output indicator type that fails to bring about long-term change or gain. We therefore need a more proactive role in promoting and facilitating the transfer of knowledge, and the RAE or its successor should perhaps be more focused on ascertaining how the research has brought about change in terms of patient care or welfare. This, in itself, would be the source of new knowledge generation and application.

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 most effectively used to support the work of NICE, facilitate innovation and collaboration with industry, and address market failures in the application of healthcare?

Current views and the status quo should be challenged. The way forward involves looking at health behaviours and processes rather than just outcomes

and a strategic decision to fund infrastructure is required. This will include training, funding and the provision of peer reviewers to ensure quality.

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

   There is a need to look to Europe as well as America. The European social model provides many perspectives in which to understand lifestyle issues, while the American capitalist model is perhaps not appropriate to health and social care in the UK. However, the Canadian model is perhaps worth considering e.g. the Canadian Institute of Health Research (CIHR) features geographical as well as disciplinary and methodological diversity. There is also a need to promote European collaboration.

10. In implementing the 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.

    There is the potential for the old paradigm to remain dominant and this must not be allowed to happen. If the merging of funding between the MRC and the NHS R&D framework is likely to perpetuate the old paradigm then we as a professoriate would not encourage a funding merger. We advocate the new paradigm; one that is accountable to the public and that features independent review.

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

    There needs to be strengthened links between clinical research networks and faculties of health. Joint appointments between the networks and faculties should feature strongly. They should be funded by the research infrastructure allocation from the merged new body. Also one should note that currently the clinical research networks are located in England and are mostly medical and Randomised Control Trial (RCT) focused. This is not fit for purpose and will not acknowledge regional and national diversity. Nor will it support connection for health.

    We would suggest consideration be given to connection for health and its relevance for potential research and educational development for the health and social care professionals and for planning service redesign. Such activities require research. .

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 maximise the health and economic benefits to the UK?

    Devolution is what is called for with regard to funding between the regions and nations of the UK. The NHS R&D model is our preferred means for building the new paradigm of health and social care, based on the laws of health and well-being, so as to take the agenda forward.