

Response to HM Treasury, ‘Cooksey’ Review of arrangements for a new single fund for health research.

Introduction

The Care Services Improvement Partnership (www.csip.or.uk) is an England-wide organisation responsible for supporting service improvement across programmes for mental health, services for older people and people with disabilities, services for young people and families, learning disabilities, and health and criminal justice partnerships. As such, CSIP has an interest in R&D (reflected in its R&D Advisory Group) across a wide range of health and social care arenas and is endeavouring to make stronger links between research, policy and practice – in all directions.

CSIP is pleased to be invited to contribute to this review. The format of this response is to reply to the specific questions listed in the invitation.

We are pleased to enter into correspondence about this topic if the review team would like to. Please send correspondence to Prof. Clair Chilvers, Research Director of CSIP (Clair.Chilvers@dh.gsi.gov.uk).

NB CSIP is commissioned by the Department of Health, but this response is completely separate from the formal Department of Health’s response to this review.

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 provides support for academically strong research. Its procedures for peer review of applications and reports quality assure the research it commissions. The MRC is not always able to satisfy:

- all of the alpha-rated applications it receives due to insufficient funds;
- a quick response to policy priorities for research as it operates in response mode to investigator led research;
- a match between grants it gives and clinical priorities.

The recent reviews of research spending from the UK Mental Health Research Funders Group¹ and the UKCRC², supplemented by additional analysis³, have shown that mental

¹ UK Mental Health Research Funders Group (2005) Strategic Analysis of UK Mental Health Research Funding. Available on line at www.csip.org.uk/index.cfm?fuseaction=main.viewItem&intItemID=80140

² UKCRC (2006) UK Health Research Analysis. Available on line at <http://www.ukcrc.org/activities/coordinatingresearchfunding/ukhealthresearchanalysis.aspx>

³ **Kingdon D, Letter - Health research funding: Mental health research continues to be underfunded...** *BMJ*, Jun 2006; 332: 1510 ; doi:10.1136/bmj.332.7556.1510

health does not receive an appropriate proportion of research funding for its clinical priority and total burden to society and the economy. The picture for the other areas of concern to CSIP, such as learning disabilities has not been so clearly mapped. On the basis of the two previously mentioned reports, there is good reason to believe that the other CSIP clinical areas are not well served by the current research funding arrangements in terms of certain types of research required, notably health promotion and prevention and service delivery research. In particular, the current arrangements do not adequately serve an important area of service delivery of relevance to CSIP, namely areas of overlap between health and social care. The area of health and criminal justice partnerships is a new effort to better coordinate policy and practice which has the potential to make a big impact on society, but it has a weak research base. Research funding systems which only reward track record do not help to develop research in new areas such as these.

The NHS R&D funding programmes have improved greatly over the last 5 years in terms of quality of research, and in their responsiveness to clinical and policy priorities. The national programmes provide good coverage of broad areas of research, but we would like to see a clearer way of matching work commissioned within them to national clinical and policy priorities.

The programme of research in NHS Trusts has improved in quality and in terms of ability to identify what research is being undertaken at any time (e.g. www.nrr.nhs.uk). The greatest strength of the work in Trusts is that it gives many more Trusts a stake in R&D and, related, an interest in keeping abreast of research findings. A further benefit of this is a larger patient base for research. We need to ensure the continuation of the NHS as a site or ‘laboratory’ for research – which means providing incentives to as many Trusts as possible to engage in research. It remains to be seen what the impact of implementation of *Best Research* will have on NHS R&D, but we would recommend a thorough stock-take in 2/3 years to better inform the new single fund.

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 key challenges are:

- Ensuring that NHS Trusts and clinicians feel they have an interest in R&D and are keen to implement the latest research findings;
- Developing the research workforce for the future, across all care and research disciplines;
- Better matching research funds to national clinical and policy priorities;
- Supporting research and innovation in important, new areas of work which would not compete well in a system which only recognises research track record.
- Addressing research needs in important areas of service which do not match well to traditional understandings of health research topics, such as interfaces of care between health and social care;
- Ensuring that the UK remains an attractive place to undertake research and develop a research career, in all areas and careers of care.
- Supporting stronger strategic international links for undertaking research and for organising health research systems, notably across the UK and the EU.

- Ensuring a balance between centrally driven research and investigator-led research, and links between them;
- The involvement of patients/consumers, users and carers in determining research priorities, and in all subsequent stages of research, is vital and of particular concern to CSIP.
- Translating and implementing research findings into practice. This should mean a greater emphasis on “consumption” as opposed to “production” of research through a comprehensive programme of knowledge management. Consideration of this should be built into research funding streams, research programmes and individual projects at a very early stage.

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?

Research priorities should more clearly match national policy and clinical priorities. This is likely to mean more focus on developing the right relationships between research funders and policy makers, clinicians and users of health services.

Research capacity across the disciplines requires mapping in order to determine a future multi-disciplinary research training strategy

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 benefits of a high quality biomedical research base and the needs for research to improve health care and public services are not mutually exclusive. There is significant overlap between them. We do recognise, though they can be competing demands on scarce funds. We might argue that the balance has been too much in favour of the biomedical research base, which has led to the neglect of some health care priorities. Stronger bases for making such judgements should be developed, assessing the diverse ways in which they can have an impact on individuals and society. Buxton and colleagues have undertaken work of relevance which could be built upon⁴.

⁴ See for example:

Buxton M, Hanney S, Packwood T, Roberts S & Youll P (2000) Assessing benefits from Department of Health and National Health Service Research and Development. *Public Money & Management*. 20 (4), 29-34

Hanney SR, Gonzalez-Block MA, Buxton MJ, Kogan M (2002). *The utilisation of health research in policy-making: concepts, examples and methods of assessment*. A report to the World Health Organization, Health Economics Research Group: Brunel University, Uxbridge.

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?

There is no simple model of the interactions between research and policy and practice. There are good examples of research informing policy and improving practice. There are also examples where policy and practice have raised questions that research has been able to help answer. Equally, there are examples of poor interaction across research, policy and practice; of research not being implemented, and of questions not being researched.

One example of the interaction between policy and practice is the Mental Health National Service Framework. The evidence base was analysed in preparation for the National Service Framework and gaps identified which were filled by research commissioned following its implementation. Funders contributing included the MRC as well as DH funding sources.

The research-policy-practice links should be seen as more of a continual dialogue between the three arenas. Sometimes one arena will be ahead of the other, but a dialogue should highlight this. Means of supporting the dialogues and of enabling other arenas to catch up are key mechanisms to identify and develop. In CSIP, we have maintained a strong dialogue for mental health, as can be illustrated by the reports of research-policy-practice seminars we have held so far⁵. Ensuring that the NHS, policy makers and researchers have a stake in each other's worlds is important to achieve this. The interlinked development of Early Intervention in Psychosis and Assertive Outreach policy, practice and research are good examples of this approach⁴.

The place of a diversity of research methodologies in improving health and health services should also be noted and supported in any new developments. Good quality research to improve health and care should be the priority, rather than an undue emphasis on particular methodologies.

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?

Links are most readily forged by having researchers across the whole field of health research co-located in large research institutions, such as the Addenbrooks site in Cambridge. The challenge then becomes making links between such centres and the rest of the NHS for recruitment of participants in research and generalised implementation of developments. Links between different disciplines can be facilitated by organisations, such as CSIP, research

⁵ See:

www.csip.org.uk/index.cfm?fuseaction=main.viewItem&intItemID=80174

www.csip.org.uk/index.cfm?fuseaction=main.viewItem&intItemID=85762

www.csip.org.uk/index.cfm?fuseaction=main.viewItem&intItemID=85252

networks and individuals and is most likely to be successful when bringing together researchers to work on areas of common interest. This may be incubated by targeted funding initiatives.

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

A danger with funding research on the basis of ‘track records’ in research is developing a conservative approach to R&D and innovation. The initiatives in the *Best Research* strategy to support investigator research (*Research for Patient Benefit*) and innovation in research are welcome, if small scale, efforts to address this. At the same time, some centralising tendencies in the strategy, such as removing existing research budgets to Trusts which allow some freedom to innovate in research, may overall undermine innovation in the system.

Stewardship of the health research system is important, but this can be a shared activity. Investigators, care professionals and, increasingly, service users and carers, are well placed to quickly identify important clinical questions and pilot innovations and research to address them. Ensuring they feel they have a stake in, and authority from, the health research system to do this is important. Centralising tendencies need to be minimised for fear of undermining this.

Lessons from the Research Assessment Exercise and the emphasis on journal publications and their impact rating should be drawn to highlight dangers of developing conservatism in research, and excluding or appearing to downgrade a range of research and research disciplines which are necessary to improving care, such as health service and translational research.

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?

Research recommendations from NICE need to be more effectively taken up by the HTA Research Programme. A range of infrastructure funding is needed, including cohort studies.

Means of integrating a range of research evidence appropriately to inform future research and development of guidance need to be better developed if we are to make full use of the previous investment in relevant research. Realist synthesis is one such approach⁶. The randomised control trial is the best methodology for a many research questions, but it has its limitations. Many of the issues CSIP is concerned with, such as service improvement and delivering systems change, are not best answered in this way. Multidisciplinary and multi-methodology research which triangulates a range of approaches and evidence should be encouraged more to answer complex questions.

⁶ Pawson R et al. (2004): Realist Synthesis: An introduction. ESRC Research Methods Programme (<http://www.ccsr.ac.uk/methods/publications/documents/RMPmethods2.pdf>)

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 the USA the separation of research funding from SAMHSA's budget and its allocation to NIMH (US) has had a negative impact on health service research. Canada has been recognised for work on national coordination and support of health research, particularly health services type research.

The Health Research System (HRS) model developed through the WHO provides the beginnings of a helpful conceptual framework to guide our work on improving the organisation of research⁷, as does the work of Buxton and colleagues referenced earlier. These need to be developed and integrated with the evidence base about the research system, such as the funding reports referenced in our reply to question 1. Using the HRS model to consider the strategic direction for mental health in England led to a healthy discussion about the nature of the system, the limits of central direction, workforce issues and other challenges⁸.

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.

It is perhaps less important how the funds are brought together, or not, than how it is allocated. Changes should not destabilise existing strengths in the funding and research systems, but this new fund is an opportunity to examine afresh how in the medium term we can move to a funding allocation system which better reflects clinical priorities, develop a more innovative research culture, and supports quick responses to priorities identified by the public. Knowing more clearly where we want to be will help to map the path we need to follow to get there.

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 new Connecting for Health NHS IT system, and to what extent should it do so?

⁷ See: Pang T, Sadana R, Hanney S, Bhutta Z A, Hyder A A & Simon J (2003) Knowledge for better health: a conceptual framework and foundation for health research systems. *Bulletin of the World Health Organisation*. 81(11): 815-20; Sadana R & Pang T (2004) Current approaches to national health research systems analysis: a brief overview of the WHO health research system analysis initiative. *Ciência & Saúde Coletiva*. 9(2), 351-62; Clark M & Chilvers C (2005) Mental health research system in England: yesterday, today and tomorrow. *Psychiatric Bulletin*. Dec; 29: 441 - 445.

⁸ Clark M & Chilvers C (2005) Mental health research system in England: yesterday, today and tomorrow. *Psychiatric Bulletin*. Dec; 29: 441 – 445; Lelliot P (2005) Beware the problems of centralisation. Commentary on. . . Mental health research system in England. *Psychiatric Bulletin*. Dec; 29: 446-7; Szmukler G (2005) The ground is in great shape, but can we field a kitted-out team? Commentary on. . . Mental health research system in England. *Psychiatric Bulletin*. Dec; 29: 447-8

The successes of the networks to date have not relied on Connecting for Health. When implemented, Connecting for Health will provide a valuable resource for research data and potentially a sampling frame for identifying potential participants in large scale projects. This may help the research networks and researchers initially to identify potential recruits, but the process of recruiting and of then managing participation in the project will still need to be undertaken and this is where the networks have a strong role to play.

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?

The issue of centralisation versus devolution of R&D has bedevilled much of response to this consultation, and the history of NHS R&D. Stronger centralisation has achieved a better understanding of what quality R&D is about and how to organise for it., but this may have now reached its limits and risks alienating the NHS and researchers from R&D and stifling innovation. Stronger guidance to the NHS on what is expected of their organisation of R&D and means of achieving could now be issued on the basis of lessons learnt to date. Better conceptual models, such as those referenced above, and means of monitoring the health research system could then be developed to scrutinise the system.

The devolution of funds to the NHS through ‘Priorities and Needs Funding’ was partially successful. It allowed local decision making about research priorities and encouraged Trusts to have a stake in R&D, but was bedevilled by the impact of the initial method of identifying research budgets from overall funding of NHS Trusts.

The new response mode scheme being developed by the National Institute of Health Research (Research for Patient Benefit) is a welcome return to the devolved approach to planning research. The old Regional Office Schemes for investigator led research fostered new talent, by supporting small scale projects, and pump-primed new research teams and topics.

Centralisation of other research funds to ensure separation from patient care is welcome, as long as the funds are safeguarded. There is an issue about whether the £1 billion is actually less than the combined NHS R&D and MRC budgets.