

## **Cooksey review of UK Health Services Research**

### **A response from the CENTRE FOR INTEGRATED HEALTHCARE RESEARCH (CIHR)<sup>1</sup>**

#### **What are the strengths and weaknesses of the MRC and NHS R and 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?**

The strength of these two programmes is that they are able to deliver substantial funding to targeted areas of concern. One weakness is that the process whereby such areas are selected is not always clear and it sometimes appears as if the R and D priorities are developed by committee on the lowest common denominator basis. A second is that it is not clear how the results of such large scale investment feed into practice, particularly in the non-medical areas. More needs to be done looking at the medium term implications of the funding streams. There also needs to be more infrastructure funding particularly in developing new areas of research in the health and social care settings i.e., nursing, the allied health professions, and social care sectors.

#### **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?**

##### Challenge 1.

The shift of emphasis from the acute to the primary care and public health sectors represents a real problem and also an opportunity for the research community. It represents a likely shift in research methodology with the greater emphasis on health science giving way in part to an emphasis on social science or at least science that is better tailored to the needs of research relevant to the prevention of disease and the promotion of well being. The risk is that those with extensive "acute" research experience will continue to dominate the field by virtue of historical volume and strength thus dislocating current research from perceived need.

##### Challenge 2

There is a real need for practitioner researchers able to address the questions which need to be answered on the ground. This is not necessarily to detract from HEI priorities but the two do not necessarily overlap. While there is current mechanism for clinical research careers in medicine the same is not true in other professional groups, many of which have a clear sense of where the more applied end of research should be going. The current NHS provision on the ground militates against researchers becoming involved in research. Managers are focused on service provision and are poorly equipped to provide backfill etc. This issue must be addressed if the research is to come closer to the patient/service user. The NIHR aims to address this issue, and it will be important for similar developments in the other UK constituencies. It will be important to ensure that all areas of practice is supported to develop research and evidence based practice cultures, and that all professional groups are given the opportunity to develop research evidence which builds knowledge relevant to their roles.

##### Challenge 3

Identifying functional mechanisms for encouraging more health professionals to engage in research. This is not a new issue, but one that requires long term investment, particularly in PhDs and Post-Doctoral positions with salaries that are attractive to those with clinical experience.

##### Challenge 4

The increasing complexity of health and social care organisation. This represents methodological challenges in terms of studying the often unpredictable and invisible impact of

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<sup>1</sup> The Centre for Integrated Healthcare Research has been set up by the Scottish Executive to develop research capability and capacity in the Nursing, Midwifery and Allied Health Professions. It includes Queen Margaret University College, Napier University and the University of Edinburgh together with NHS Lothian, NHS Borders and NHS Lanarkshire.

interventions in complex systems. The gold standard of RCTs is poorly equipped to address this issue. Methodological development is needed, which also bridges the gap between research and practice.

**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 funding sources of support, what can it lower in order to release the necessary funds?**

This is always the million dollar question. The UK Health research analysis indicates that there may be the potential to redistribute away from underpinning or aetiological research towards more applied research. More resources should be spent on research that investigates the effectiveness of interventions that target individuals and more resources placed on interventions that focus on specific sections of society. There needs to be more emphasis on research that assesses interventions which address the social and cultural determinants of poor health, in particular the inequalities in health across socio-economic groups. This research should investigate how health care services can engage more effectively with those in areas of socioeconomic deprivation. It should also test the effectiveness of macro interventions such as taxation, housing, education, and interventions aimed at improving social relations, in closing the gaps between socio-economic groups.

**How should decisions be taken on the balance between the long term economic and social benefits of 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?**

Placing the service user at the heart of the health research agenda (see the structure of the National Institute of Health Research [www.nihr.ac.uk/about.aspx](http://www.nihr.ac.uk/about.aspx) ) is bound to result in a questioning of the status quo. A focus on service users' concerns, knowledge and expertise of health care, if addressed through relevant research methods, will lead to new priorities and questions for research emerging. The research must be framed in ways which allow user perspectives and expertise as full partners in care, to fully emerge. User focussed research may on the one hand empower the "consumer" while on the other hand patient demand may be seen to override the principles of evidence based practice.

Biomedical science has dominated the picture and will continue to do so until the relevant agencies make a decision to do otherwise. There should always be ring-fenced money for more theoretical or "blue skies" research and it makes sense for this to be provided within the MRC. A parallel concern is with the development of social science theory and methodologies which can address the current realities of NHS, i.e. complexity and constant change and thus underpin effective translational research. Rather than starting from here and asking the question of how do we shift the emphasis to translational and applied research there may well be a case for allocating the research monies evenly between the three categories and then arguing the other way.

In terms of it varying over time, it would probably be useful to see the balance in five year cycles with a review of delivery at the end of each cycle. There should always be contingency monies to deal with more short term emergencies.

**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?**

The UK Health research Analysis indicates that well over two thirds of the total spend on research in the UK is focussed on "underpinning" work or "aetiology", while only 16.6% is allocated to treatment development and evaluation. Given the high priority given to the

National Institute for Clinical Excellence and the UK CRC with their emphasis on interventions and a basic need for people to know what works and what does not, this imbalance seems surprising. It is proposed that the balance be shifted considerably to reflect our need to know more about intervention. This is likely to reflect the priority of the service users now placed at the centre of the research process. In a recent review of autistic services it was clear that this same imbalance prevails. Researchers like doing the basic research and work on diagnosis. Parents would prefer for them to spend more time on intervention research. The MRC then allocated 5m for this purpose. Is it that researchers "like" doing basic research or is this emphasis a function of where the research councils have sought to place their money and the researchers have simply followed the source of that money. A clear message to the effect that a significant proportion of the allocation was being transferred to intervention would make a substantial difference.

**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?**

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

The essence of translational and applied research is that they take place close to practice and arguably away from the large centralised research facilities. The most obvious way to prioritise this sort of work is to highlight their value and fund accordingly. There are currently relatively few mechanisms for doing this.

The most obvious way to do this would be to further expand the Knowledge Transfer Partnership model specifically aimed to bring academic and business and more recently health and social care elements together. This has a great deal of potential to make a real difference on the ground and brings a wide range of practitioner researchers into the frame and emphasising the need to examine the costing mechanism of specific healthcare activities. Paying overheads and FEC also makes this an attractive option from an HEI perspective.

The potential for links with physical scientists (engineers, physicists, chemists etc.) have been rather clearer than they have been for social scientists in the past. Given that some of the most important healthcare priorities in the 21<sup>st</sup> century concern the management of chronic disease and not the "curing of illness" this balance could usefully be addressed. In the future the margins between health and social care will be increasingly blurred and the research councils etc. need to pay due attention to this if they are not to overemphasise one at the expense of the other.

An additional line of funding could usefully come through the combined activity of the MRC and the ESRC and possibly linking with the large charity organisations that fund applied research.

**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?**

There is a clear need to sustain the research infrastructure in areas that demonstrate success and further potential for growth. A typical example is nursing and the allied health professions which received start up funding, and already demonstrate success in translational research. However this is not a short term fix and requires medium to long term investment to develop research activity at the intermediate or advanced level i.e., post doc and beyond.

Currently the research councils dominate the research picture as far as HEIs are concerned. In practice a great deal of research is funded by organisations that do not pay

overheads/FEC. This needs to be urgently addressed. These smaller organisations almost certainly have a disproportional role to play at the translational and applied end of the market. They are often closer to the ground and may have more potential to deliver results that are meaningful to the public. This type of activity is often regarded negatively by institutions because their costs are not absorbed.

NICE and NII could usefully be commissioning work arising out of the gaps identified in their determinations. There is currently a considerable disjunction between the results of systematic reviews in the Cochrane Collaboration, R&D Review and Dissemination (York), or Campbell Collaboration and what is subsequently commissioned by the HTA etc.

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

No specific recommendations here but it does seem that the NIH in the US more directly affects the research careers of a far wider range of health scientists than appears to be the case in the UK. There might also be the need to joint fund research that crosses international borders.

**In implementing the single fund for health research, to what extent should the MRC and DH/NHS R and 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 less a question of whether the MRC and the DH/NHS R and D should be merged than the precise delineation of their responsibilities that is key here. The new organisation should be sufficiently independent to decide its own priorities in the light of those in the health system at any one given time. It should report to an overarching body with an existing responsibility for the devolved countries of the UK. The most obvious place to house this would appear to be the UK treasury.

There is also the question of why just MRC and NHS R&D. There has been little mention of other Government or quasi-Government organisations which also fund research in health ie other funding councils, SDO, Department of Health and in Scotland Chief Scientists Office, Scottish Executive, and Health Scotland. Further, there is little mention of how the current plans will affect Scotland.

**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?**

Nothing to add on this point.

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

There is a good case for arguing that what might be termed "basic science" be retained within the MRC framework but that more applied and translational research be devolved because it is specifically designed to address relatively local needs. Although, of course, it could equally well be argued that good translational research by its nature should be generalisable.

There is a case for specifically encouraging comparison across the devolved countries as their health and social frameworks are separate and where costs and benefits can be usefully determined in what amount to natural experiments. For example, there would be a good case for making a direct comparison between the implications of different end of life care between England and Scotland. This inter-country comparison would need to be funded centrally. Similarly there would be benefits in comparing differences in research infrastructure development in the different countries and the impact that this may have on service users.

For example the Nursing Midwifery and Allied health Profession research initiative offers a distinct approach to improving research capability in professional groups which characteristically ask questions which are close to the needs of the patient. No such initiative exists elsewhere in the UK. What in the medium to long term are the implications of such an initiative?

**Professor James Law**  
**Director**  
**Centre for Integrated Healthcare Research**  
**Edinburgh**

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