

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

RESPONSE TO COOKSEY REVIEW

JULY 2006

General Response

This Cooksey consultation is about "big picture" research and really does nothing to address the interests and concerns of local researchers in the NHS. It is obviously driven by the powerful academic lobby looking for the funding of basic scientific research and its translational counterpart.

This is NOT what the local NHS does. And it is a model that is incompatible with research into the delivery of care. This is the aspect of the NHS that most local researchers are interested in and that demands a robust local infrastructure to support research governance.

The development of the R&D backroom function in CHS following the initial Culyer funding has been a powerful support for researchers and the DoH has a duty to ensure that there is continuity of this infrastructure.

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 is doing good work in supporting the molecular and genetic science that is required for the future of medicine. However, it is failing to support the development of the practice of healthcare professionals including the evidence base of such practice in the NHS in general. Such initiatives are generally confined to the older university teaching hospitals and the other general hospitals where the majority of health care takes place have little or no opportunity to participate. The same can be said of the NHS research studentships that tend to go to university departments, and fail to create academic career opportunities within the general hospitals. More could be done to develop academic posts in all areas of health care within the general hospital settings. Service Delivery and Organisation is a good research programme, but the studies tend to be "given" to research departments outside of service, which by definition means less insight, and the findings do not have sufficient impact given the level of funding.

For years the MRC has stated in public that it wants more applications from non-medical staff for their research career awards. However, the criteria and

limitations of methods, for instance, have meant that the number of applicants from non-medical staff have remained very small. In the absence of a nursing research council, the new funding body might work with the social science research council to identify further academic career funding opportunities for non-medical staff.

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 funding of research needs to be less concentrated upon basic science and move over to funding research into the delivery of care. At present, the funding is too far slanted towards blue skies basic science, which is speculative and focusing upon genetic research. While this is important the delivery of care is of equal importance and this needs to be reflected in funding opportunities.

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?

Health research should focus on funding research into different, novel and effectiveness of delivery of care. Practitioners need to know how to work better and smarter and in the majority of situations, this empirical evidence is just not available. Rather than give such funding to external university departments, who only have a gloss of understanding such needs, grants should go to departments based inside the NHS and who really understand what the needs are of staff and patients in the NHS.

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?

Rather than the basic science lobby being the strongest and them getting the lion's share of the funding, the involvement of politicians, patient groups and patients, should be encouraged. As a result there will be a better split of funding, as well as having a clear line of justification that gets back to patients and to the population, by way of the politicians. Funding should be 60:40 in favour of research that improves the delivery of care. For the balance of basic, translational and applied, these should be funded in the ratio of 1:1:1.

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?

The research studies tend to be left as the findings and the report. Dissemination necessarily happens from the academics as a result of need to publish for the Research Assessment Exercise. However, little effort is put into a communication strategy to get the findings out to the people that need the information, and certainly nothing to ensure that these health professionals have engaged with that information. This needs to be built into the funding for the research study, and engage with clinical governance departments to ensure that this quality standard is being measured.

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?

Patients and Patient Groups are the key to bringing groups together. By focusing on the needs of patients, then the various scientists can bring their expertise to bear. Multi-professional research teams are only useful to a certain extent on their own, they become much more useful in applying their differing expertise to the patient problem. For instance, Community Development Social Scientists know how to get groups to help themselves, but Nutrition Scientists know the diets that communities should be getting. The combination is a powerful way to improve diets in deprived communities. The venue for such patient focus needs to be away from academe and in the environment where the patients and patient groups live, or go to hospital, for instance.

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

The NHS intellectual property framework is useful, and encourages some benefit going back to the originator of the idea. However, there are no funds that are obvious to NHS and University researchers to set up SMEs without risk to themselves, ie give them two years of funding on the same salary as their established post, but still allow them to return to that post if the SME is not successful. (The SME being about a service to the NHS that is not being provided as well as it could be, or as efficiently as it could be.)

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?

UK health research needs to work with the Department of Trade and Industry to identify matched funding for areas of innovation between the NHS and Commercial Companies. As a result, gaps in the market and gaps in terms of need for patients may well be filled. This approach will support innovation. With research being based upon patient groupings, drugs etc. that affect certain patient groups will necessarily lead to the need to commission studies on effectiveness and changes to lifestyle as a result of a new drug. Such studies would be commissioned jointly by NICE and the new funding body.

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?

Joint Chief Executive arrangements for Hospitals and University Schools/Faculties, etc. in the United States has led to a high level of creativity in both the use of research funds and in getting research from academe into practice. Despite the juxtaposition of medical schools, for instance and the large teaching hospitals, their use of joint academic/practice chairs, it has been surprising that this model has not been adopted as yet in the UK.

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 should be brought together into a single organisation. Areas of work should be identified, based upon patients and patient groups. This will by definition make the research patient-centred. This body should be accountable to parliament, rather than the Department of Health, so that politicians can be reassured that the funding is being used for patient benefit. This avoids contact with the Departments of Health, which are more likely to change funding policy on the basis of pressure from universities and the Royal Colleges.

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?

The research networks should be heavily reliant upon Connecting for Health, but the truth is that researchers and clinicians have no idea whether the systems will work, and are mistrustful as to whether they will have all of the necessary functions. As a result research networks have their own systems to make sure

that the processes work which are outside Connecting for Health, and will probably remain so until the CfH systems are proven to be reliable.

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 to Patients and Patient Groups as the unit of functioning. These grouping being held to account for the use of the funding and its impact upon the patients that they represent.

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