

Attached comments

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Review of UK Health Research

Response to review questions

Number 1

Strengths

National programs provide opportunity for local investigators to participate/contribute in worthwhile credible research and to justify their undertaking of appropriate training.

Weakness

Programs can be uncoordinated in that several similar programs can be ongoing at same time and topics are not always dealing with the priorities as seen by clinicians who are at the “coal face” so can seem less attractive to participate/contribute towards

Suggestion

Enable “coal face” clinicians to participate by reducing bureaucracy – leave paperwork to data managers and R&D depts.

Number 2

Organisational - Main challenge is need to undertake a raft of conditions – training such as GCP for clinical trials – appreciate this is a must do.

R&D Resources are often focused on ensuring Research Governance is being met for projects that are actually service evaluations or service developments rather than research and might be managed more appropriately via another mechanism that ensures ethical and data protection issues are addressed locally.

Scientific – all research within NHS requires an ethical approval, management approval will not be granted until this has been achieved – ethics applications should include a copy of the peer review as compulsory – this would speed up the ethical approval and management approval times and provide scientific rigour. Applications without peer review leaves all parties with extra work and the potential for less than scientifically robust projects to be submitted.

Objectives should be to ensure research resources for health are directed towards the current health of the nation. At a recent presentation from academia to encourage NHS participation/collaboration no topics were offered that were priorities for the current health of the nation – no obesity, diabetes, CHD, stroke, mental health etc. Support for research into the current health issues (priorities) would give maximum benefit to most that would ultimately free up resources for other areas. In addition the support out with Health Services – academic involvement and public support would

be more likely and meaningful with the research designed to target the big health issues.

Number 3

Priorities should be limited to a certain number of areas per year – based on the greatest national health need – numbers affected and cost to govt. This ensures that the expectations of both the public and govt are addressed. UK Govt is spending a considerable amount of health research resource on non-research and research into non-priority areas.

Number 4

The answer to this depends upon the aforementioned priorities and what is identified - e.g. if the healthcare issue identified as a priority is related to obesity then funding could be targeted towards projects designed to help improve current services as well as addressing the long term issues – however the balance would need to be altered in light of the outcomes and as new priorities are identified. Balance should always be in favour of priorities for health of nation.

Number 5

In light of the recent publicity about post code lottery for treatments – if govt highlight health priorities for research, publish outcomes including the acceptance or not of these outcomes, and the rationale for the subsequent action or non action this would help justify the next round of govt priority funding. Also, if research findings are conclusive and costs can be met then findings should be recommended for uptake. e.g. Treatment X for condition Y is being researched – outcome is not conclusive or negative effect then treatment is not recommended. If findings show benefit then Govt needs to be prepared to justify why not recommended for uptake. Support what the medical profession is asked to i.e. “evidence based practice”

Number 6

Answer to this is in the identification of the priorities and asking for collaborative bids for funding so that a program is inclusive of all relevant disciplines and agencies rather than a subset of a priority health problem that might never be linked and therefore less likely to be resolved.

Number 7

All parties are “fighting and guarding” their own corners and budgets – agreements should be at the highest level possible e.g. HEI and NHS rather than each HEI and each NHS especially when funding is from Govt!

Number 8

Apportion funding by per head of population – to health care service providers who then are charged with forming collaborations and bidding for allocation to research the priority. If a local Trust/Board did not bid for their allocation it should lead to reallocation of the funding to those with successful bids – also if bidding was presented as a regular opportunity those who have good ideas and possible solutions to test could prepare for a future round – do not put all resources into a one off opportunity to fund. This would allow for inclusion of those investigators and their relevant population of patients - often the announcement of funding opportunities is

geared towards the larger institutions who have the expertise to prepare the bid timeously.

Number 9

No comment

Number 10

If agreements are made at national rather than local levels then it should not matter who is accountable for Govt funds.

Number 11

Simple already available IT systems are tried and tested to aid communication – access for researchers to e.g. records held virtually and for which pharmaceutical companies require hard copies of evidence (to satisfy approvals) will be impracticable. New IT and relevant confidentiality/data protection needs to address this. Foresee problems when research is across primary and secondary care.

Number12

Best to work via national agreements.