

Cooksey Review of UK Health Research

Response from Hammersmith Hospitals NHS Trust

Introductory Statement

Hammersmith Hospitals NHS Trust welcomes the opportunity to comment on the Cooksey Review, since the outcome of this Review is likely to have a major impact on the entire spectrum of health research across the UK.

As a leading clinical research organisation the Trust works closely with our academic partner, Imperial College London, and is fortunate to benefit from funding from both MRC and NHS R&D. The Trust provides clinical support to the MRC Clinical Sciences Centre and to many researchers who hold programme and project grants from the MRC.

Response to Questions

<p>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?</p>
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The MRC has a reputation as an efficient and effective funding organisation, that has concentrated more on the basic end of the health research spectrum. It is seen to have a reasonable system for determining its funding priorities, with excellent peer review processes, and its decisions are widely respected. In addition to funding high quality biomedical and clinical research, the MRC also promotes development of the academic workforce through its successful fellowship schemes. However, it is recognised that there is a gap between basic research and clinical trials – in the areas of translational research and experimental medicine.

NHS R&D concentrates more on treatment evaluation and health service research. The Trust is in receipt of substantial portfolio funding from the NHS R&D programme and advocates this mode of funding. With programme or project grant funding alone it is not possible to meet the costs of the enabling capacity and infrastructure that allows international quality clinical research to be undertaken. Portfolio funding provides the flexibility to maintain equipment, staffing, service levels and patient flows in ways that foster research. Creating an environment which encourages clinical research and facilitates investigator led pilot projects, is important in starting up new areas of investigation and in developing larger scale projects.

It could be argued that, in some smaller provider units, NHS R&D funding is not always productively or cost effectively used. In the major research intensive centres, however, support funding is used to underpin and host what each organisation considers to be the research most appropriate to its aims and areas of expertise. There is inevitably some overlap with service provision, at the margins of providing cutting-edge treatment and investigating new approaches. The leading research organisations are therefore

vulnerable to narrow definitions of research and rigid boundaries between modes of research.

There are concerns that the peer review process for R&D funding could be strengthened, and here the expertise of the MRC could be harnessed. Funding of commissioned research for national priorities (although essential) needs to be balanced against potentially stronger requests for response mode funding.

The proposed merger of MRC and NHS funding streams offers the possibility of a shared strategy that should prove more effective than the existing separate strategies. A weakening of the NHS element though would undermine research capability overall.

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 is an increasing need to satisfy the demand for evidence based policy and healthcare, and research is the main vehicle to achieve this. Research also brings new and more effective treatments to patients. Research is, however, expensive and there are constant pressures from ever increasing service needs which can deflect clinicians from engagement in research. A greater overall level of health research funding, and a change in the perceived importance of clinical research, are badly needed.

Adequate funding is specifically required in a limited number of major centres to enable the UK to hold its place internationally in healthcare improvements through research. A significant proportion of such funding must be used for research capacity/infrastructure, and also for improving the IT support for research activity. We believe that concentrating most of the resources in a few centres is more likely to bring success, however defined, than spreading funding across the country and over a large number of types of research.

Together with increased funding for the major centres, we believe it is important to disseminate participation in clinical research across the country, for example via the UK Clinical Research Network. It is clear that incentives need to be provided for NHS organisations and individual clinicians to ensure their participation in such research.

It is also essential to maintain the critical mass of clinical researchers in the UK. This is being addressed, in part, by the integrated clinical academic training scheme of the UKCRC/MMC. Increased Fellowship funding from the MRC and the charities would also be welcomed.

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?

In terms of strategy there should be a blend of response mode funding, programmed activity and support for leading centres. There should be an emphasis on the major

disease burdens of our society, and on research which produces clinical impact. There is no pressing need for a major shift in the types of work that are funded, but there should perhaps be more emphasis on the applied end of the spectrum, which has been relatively lightly resourced. The balance of funding could be decided by an overarching committee (“or Health Research Board”) representing the current interests of both MRC and NHS R&D.

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?

This balance is best considered by an overarching committee (as mentioned above) which consists of experts spanning the whole range of clinical research. For longer-term benefit, there should perhaps be emphasis on more basic and translational research. This could be complementary to the formation of partnerships with industry in the development of later stage clinical trials. Clearly, the needs of society will change with time, and any consensus reached could be reviewed at appropriate intervals, e.g. 3-5 years.

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 leading, research intensive organisations have a vital role in the introduction of new treatment and diagnostic technologies. In these organisations, the cultural barriers between service and research are most effectively overcome, and individuals frequently have dual responsibilities. The research intensive organisations should also work through local and national networks to ensure rapid uptake of improvements generated through research.

There has been an active relationship between clinical academics and the pharmaceutical industry that has influenced drug development beneficially. There are many excellent examples of this, including the development of anti-TNF therapy for rheumatoid arthritis and other inflammatory disease. There has been less obvious influence of research on healthcare policy, because this area has been less well supported and promoted.

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?

These links are best provided by close working between NHS Trusts and academic institutions, particularly in the major research centres. The Universities are best placed to ensure the involvement of engineers and social scientists in health research, but their research agenda should be aligned with nationally agreed priorities. Universities may need to examine their reward systems to ensure that collaborative working across disciplines is recognised as valuable. Increased collaboration between the various Research Councils, with joint funding initiatives, is welcomed.

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

The most simple method of encouragement is to make funding available for such work, particularly in environments with a strong track record of innovation, e.g. the proposed BRCs. If this were to be coupled with some form of incentive for inventors, and a network of organisations able to ensure effective commercialisation of inventions, there should be no substantial barriers to increased entrepreneurship.

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?

We return to our underlying view that the funding of research capacity and infrastructure in a few leading organisations is an essential step. This should be accompanied by development of effective research networks. The linkages with industry and NICE will follow, particularly if this work is rewarded by appropriate funding.

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?

The NIH is often quoted as a model, but this has vastly greater resources and suffers perhaps from excessive political influence. The Canadian Institutes for Health Research is widely regarded as having been of benefit in integrating basic and applied clinical research. However, models from other countries may not be directly applicable to the UK, which has the potential benefit of the unique nature of the NHS. The challenge is to harness the resources of the NHS to the benefit of the research agenda.

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.

We believe that there should be a single overarching “Health Research Board” with two arms: one (like the MRC) dealing mostly with basic biomedical science and response mode funding; the other (like NHS R&D) covering applied clinical research, national priorities, and the infrastructure necessary to undertake research in the NHS. Each separate arm (or “Council”) would benefit from closer working relationships with the other, and overall direction from the “Board”. It is important that the more basic research side should be able to accommodate a long term perspective, and be relatively independent of government. Accountability of the “Board” should probably rest with the DH.

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?

It is our contention that the clinical research networks were primarily successful because the leading institutions were provided with the support funding necessary. It is true that data capture and data sharing are important, but just supplying a comprehensive IT system will not ensure success unless the issues of maintaining research capacity in the NHS are addressed. We hope that Connecting for Health will be of great benefit in the future, but more clinical input is required in its development.

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?

In practice, NHS R&D in England is currently concentrated in a few institutions, as are research council grants. We do not, therefore, envisage any problems with joint working, and a merged organisation would facilitate this. How the MRC, which is UK wide, should integrate with R&D in the Devolved Administrations remains a difficult problem which requires regional discussion.