

Cooksey Report

Comments on behalf of Leeds Teaching Hospitals NHS Trust , University of Leeds and Bradford Hospitals Foundation Trust

A. Introduction and background

The Chancellor has asked Sir David Cooksey to advise on the best institutional arrangements to handle a single NHS research budget of £1.3 billion created by the merger of the Medical Research Council and the NHS R&D programme.

The process of implementation of 'Best Research for Best Health' (1), and the 'Science and Innovation Investment Framework' (2), is ongoing and will profoundly affect the issues raised in the Cooksey Report.

Responses to the specific questions are given below. There is concern that sudden changes of policy can lead to destabilisation and insufficient applications of quality when "particular areas of research" and "new ways of application" are introduced at short notice (even though they may have taken ages to come through the system) to the investigators. Any changes should be carefully phased in, perhaps with a pilot phase to identify issues that might arise, and the research community should be given plenty of notice and time to adapt to the changes.

B Addressing the specific queries:

1. What are the strengths and weaknesses of the MRC and NHS R&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 MRC has clear strengths in its portfolio of basic and laboratory-based research programmes. It also funds a number of high quality patient-orientated projects, including a wide ranging portfolio of clinical trials. The MRC has a high quality peer review system which places 'scientific quality' as a higher priority than 'medical/social impact'.

The NHS is a huge and unique resource, through which to pursue medical research. It is host to an impressive number of internationally competitive clinical academics and other AHPs undertaking research. Although there are DH-run schemes of high quality (e.g. HTA Programme), the method for allocating block funding to NHS Trusts, and the lack of rigorous peer review, has not provided incentives for undertaking high quality research in the NHS. The DH's new research strategy 'Best Research for Best Health' addresses these problems and will raise both the quality and profile of NHS-based research.

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?

Health research is being supported by a number of Government bodies, industry and charities. Historically there has been little coordination across this diverse range of sponsors and the UKCRC has been established to address this. There is much scope for better coordination across

Government Departments and the Research Councils and for the development of a 'joined up Government' strategy focused on health outcomes.

In particular, steps should be taken to promote partnerships between the NHS and University sectors, the strengthening of which is crucial to addressing research and training needs. For instance, there is a widely held belief that the RAE does not take sufficient account of the impact of research outputs and does not provide incentives for undertaking 'near patient research'. DoH programmes in applied research held by Trusts do not feature in RAE returns even though they represent important strategic partnerships between Universities and Trusts. If NHS/academic partnerships are to be encouraged to deliver real health benefits from research then both parties need to be rewarded – e.g. by including NHS activity in a new metrics-based RAE. This would require co-ordination between branches of Govt (HEFCE/DoH).

The funding mechanisms for undertaking near patient can be complex and need to be streamlined. For instance, the MRC provides the direct costs of the project, with a University overhead, the participating Trusts then have to recover excess treatment costs and service support costs from the DH through a separate finding scheme. There is a need for "joining up" at the research project application stage so that the necessary NHS elements of a research project can be applied for at the same time as the MRC components. This is particularly important given the huge changes in the mechanisms through which the DH is to distribute its research funding in the future.

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?

The Government's priorities should be focused, in general terms, on disease burden with the emphasis therefore on the common problems (cancer, cardiovascular disease, musculoskeletal disorders, and mental health problems). It is essential to maintain a balanced portfolio which ranges from 'blue skies' research to the organisation and delivery of health services and public health preventative strategies.

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?

Short-termism must be resisted in the funding for health research. Progress in improving health outcomes may come about as the result of investigator-led basic research studies (e.g. genetics and proteomics) which do not arise from a directed applied research programme and may take decades to have a health impact. On the other hand, it is equally important to direct funding to priority areas and the need to address specific healthcare and public health objectives.

The balance will of course change over time, and priorities can only be set through a coordinated approach involving all stakeholders and based on comprehensive information and analysis of current/future needs and activity to identify gaps and avoid duplication.

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 uptake of advances in science and medicine require, in the most part, the involvement of industry. Universities have substantial experience in collaborative research with industry and exploitation of IP. The NHS is now working more closely with industry through the regional IP hubs and this relationship should continue to be fostered. There is scope for a more coordinated approach between the university and NHS IP sectors.

There is a need for NICE to more explicitly acknowledge the research agenda of publicly funded clinical programmes. In particular, it is very challenging to develop a treatment strategy that combines agents or modalities if NICE rules against each of them individually on the basis of cost effectiveness.

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?

Strengthening University/Trust partnerships is essential to forge links between ‘basic’, translational and applied researchers and across disciplines. Incentives should be provided to stimulate local partnerships and HEFCE, the Research Councils and the DH need to work more closely together to support this.

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

Incentives need to be provided to improve the research-awareness of NHS staff. Links between publically-funded research in the NHS and University settings and industry, in particular access to new agents, will encourage translation, entrepreneurship and innovation in the health sector.

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?

The full economic costs of undertaking research in the NHS sector should be established (along the lines of the recently introduced system in the university sector). In the new funding model for patient care, Trusts will simply not be able to afford to undertake research or to maintain their research infrastructure unless they are provided with the full support necessary to do so. Schemes should provide incentives for Trusts and University’s to share access to pieces of high tech equipment with dedicated research sessions to protect these from being used for routine patient care.

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 UK has an enviable record of health research across the world. More should be made of the unique strengths of the NHS, in terms of access to patients and patient information. The profile of the UK's health research should be raised through the establishment of a national body responsible for this, along the lines of the NIHS in the US.

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.

The establishment of a single ring fenced fund for health research is supported and the focus on translational research is welcomed providing that this is not to the detriment of basic research. There are dangers if the fund was too closely linked to a single Government Department, e.g. DH, as this may skew its long term objectives. The MRC's current portfolio of basic research could conceivably be put under the remit of the BBSRC (there is overlap in the current remit of the two Research Councils) with the remainder moved to a 'National Institute of Health' jointly accountable to the DH and OST.

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?

A good national IT system is essential to exploiting the strengths of the NHS. This should allow the easy identification of patient bases for recruitment into clinical trials and to track long term health trends and outcomes to treatments/interventions.

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 single fund for health research should provide local incentives to both universities and NHS Trusts. Corporate identity and joint ownership should be encouraged by devolving elements of the budget to local health economies and through national coordination based on an expansion of the DH's research networks.

Dr Jonathan Gower
Senior Research Manager
Faculty of Medicine and Health at the University of Leeds
Leeds Teaching Hospitals NHS Trust

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