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Dear Sir

Please find the response from the Leeds Primary Care Trusts to the Cooksey Review of UK Health Research.

**Leeds Primary Care Trusts
Response to the Cooksey Review of UK Health Research**

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 strength of the MRC lies in its large collection of high quality bench research projects and clinical trials, however the rigour of the peer review system seems to place higher priority on 'scientific quality' rather than 'social impact'. This has therefore historically supported more research coming out of academia and larger acute trusts rather than primary care. And whilst it does have a portfolio of projects in its public health section, historically, the MRC appears to have made little emphasis on subsequent and effective knowledge transfer, therefore the primary care sector as a whole have been unable to benefit.

Historically the block allocation of funding by the DH has resulted in the R&D funding being hidden within the general revenue budgets of the acute trusts and whilst Best Research for Best health addresses this issue through creation of a strategy and transparent funding streams, there does not appear to be an emphasis on research capacity building or research incentives to enable primary care to embrace R&D within the new change to provider and commissioner arms. This may create silos of excellent primary care research but provides no incentive for other primary care trusts to develop a research culture and therefore enable them to support the networks that have been developed.

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?

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One of the key challenges is the lack of “joined up thinking” across the government departments when facing health research, the classic example being the RAE and its perceived focus on academic outputs rather than health service impacts. This has a direct impact on priority given to establishing knowledge transfer pathways from academia back into NHS services to implement evidence based practice, particularly in primary care.

One of the governments priorities for health research should be to ensure that any white papers that are produced do not merely pay lip service to the importance of R&D but actually complement the direction that the DH R&D department is travelling in – as such buy in from primary care trust executives will be a given and not a chore.

In order to change NHS and primary care (in particular) culture into and R&D driven one, many more primary care clinicians need research exposure than happens at present

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 order to support the NHS as an illness prevention service, there is a need to focus on public health and disease prevention research, in particular around the cost effectiveness of public health initiatives and in common disease areas (e.g. cancer, coronary heart disease) with an emphasis on looking at the effectiveness of interventions in deprived/minority populations. This must however be balanced with the need to support firstly ‘blue sky’ research in order to further develop medical science and secondly, organisational development in order to provide a cost effective NHS.

Knowledge transfer in order for the NHS to benefit from research is a key priority as would be the development of a DH knowledge transfer (KT) function to help guide the NHS and academics in this developing discipline – it is not enough to say that KT must be done.

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?

Investigator led research projects have traditionally supplied the NHS with its greatest improvements/leaps in service or medicine development.

Due to the long term nature of research, the balance for funding of the different sciences must vary with time. The balance of funding can only be decided by a co-ordinated approach involving all the stakeholders, which is based on comprehensive information about existing research, resulting gaps and good quality information about what NHS priorities and questions can actually be answered by research. Essentially, the ‘consumers’ of health research need to be engaged from the outset and more involved throughout the research lifecycle. This could then lead to a long term, planned approach

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to funding of research in different topic areas and in turn a long term, planned approach to care development.

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?

In our experience the uptake of publicly funded research on healthcare practice has been dependent on service level commitment to supporting research and the number of research active staff within a service.

Uptake of research is dependent on research awareness of NHS staff (front line and management) and in turn this implies that staff gain more research exposure in their undergraduate and postgraduate training.

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 not only University/Trust relationships but also inter-trust relationships within a health economy, is vital to developing the links to take bench research into practice. This may be achieved by development of local health economy research strategies to ensure that 'buy-in' has been achieved from all the stakeholders.

Links across the disciplines has historically relied on the input of industry however there is a need for the universities to develop further their own multidisciplinary research activities and then this can be translated through development of the links with the local trusts.

Further links could also be developed by making any DH R&D funding jointly accountable to the OST.

The RAE or its successor can incentivise cross discipline outputs and activities

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 encourage research awareness and participation amongst NHS staff.

In addition incentives need to be provided for academics to disseminate their work through routes other than journals, therefore there is a focus for them to develop the translational opportunities for their own research.

Translation can be improved by getting stakeholder buy in to research before it is started and ensuring that funding covers a period of time for translation activities.

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

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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?

In order to use funding most effectively, a market for the research has to be identified prior to it being undertaken. Any project then becomes a research partnership which is collaborative rather than commissioned without a full understanding of each stakeholder's agenda (industry and the individual trust) by those involved in the project and hence has a much higher chance of application.

Funding should also be allocated dependent on the progress that PIs have shown in exploiting translational opportunities from previously funded research.

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 Canadian Health Services Research Foundation (CHSRF) provides a portal for all Canadian health services research from funding and translational opportunities to support in actually developing protocols and relationships with industry. They also have a role in supporting stakeholders in developing national and local policies for research. The profile and effectiveness of UK health research could be raised by developing a national and overarching body such as this which is independent and not for profit (NB the CHSRF was established with endowed funds from the federal government and its agencies)

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 fund could support the development of a comprehensive research portfolio which would avoid duplication and allow for long term research planning and more effective translation of research into practice.

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 new IT system will provide a vehicle for identification of patient populations for the relevant trials, however this may not enable the patients to be recruited into trials for several reasons including lack of support at site so its value may be limited until the smaller site issues are resolved.

More importantly, the new IT systems could provide the basis for recording and follow up of outcomes where evidence is not yet strong enough to favour any one care pathway, eg childhood obesity

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?

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In order to work together it is vital that the NHS R&D and the MRC have a joint strategy and joint ownership of any funding, such that although devolved NHS R&D can continue to benefit at a local health economy level and perhaps through relatively short term planning, there are long term goals which can be achieved at a national level through research council funding. There must then be a pathway for disseminating any resulting outcomes to inform the devolved R&D funding.

This response has been made on behalf of the Leeds PCTs by the Directors of Public Health from West Leeds PCT (Jon Fear), Leeds North West PCT (Ian Cameron), Leeds North East PCT (Ray Duffel) and East Leeds PCT (Mike Robinson – Director of the Leeds PCTs Research and Development Consortium)

If there are any queries about any of the responses please do not hesitate to contact me.

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