

Dear Sir David Cooksey,

My comments on the Review of UK Health Research are below. Thank you for the opportunity to comment on this review.

I am a DoH National Clinician Scientist (2004-2009).

Yours sincerely,
Philip Preshaw.

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COMMENTS ON REVIEW:

1. Strengths and weaknesses of MRC and NHS R&D programmes.

Strengths: both promote excellence in biomedical research in the UK, which must continue to be a government priority given the beneficial effect such research has on the economy and the health of our people.

Weaknesses: by MRC and NHS R&D operating somewhat independently, despite their overall common aims, there is duplication of effort and confusion for researchers.

2. Challenges facing health research and underpinning training in the UK.

Main challenge is training researchers to a high enough level in research skills while at the same time these individuals also need to obtain clinical training and provide a service commitment to their employing hospital Trust. This is why programmes such as the National Clinician Scientist Fellowships (of which I am a recipient) are so important, by allowing relatively junior and more senior (in the case of senior fellowships) clinicians to develop their research skills by freeing them from the heavy burden of service that most Trusts are currently imposing.

3. Governments priorities for health research.

Speaking personally, one area that is definitely under-funded is that of research in dentistry. Since most oral diseases are very common and largely preventable and have major impact on quality of life, more research is needed.

4. Balancing research and healthcare, and balancing basic, translational and applied research.

These are difficult challenges.

Balancing research and healthcare funding is particularly difficult, but it should be remembered that research does translate into better healthcare. Therefore, funding only healthcare and not funding research would not overall lead to significant, lasting, population-level healthcare benefits. Therefore, I believe the proportion of funding for research must be increased.

Balancing basic, translational and applied research. These are a progression from one to the other. I think that historically, there has been far too much funding to support basic research (perhaps reflecting the make up of review panels) and not enough funding for translational and applied research. I believe there should be more funding for translational and applied research, and all review panels must include members who are not just basic scientists, for example, so that the relevance of the research can be determined more objectively.

5. How can uptake of advances in science and medicine be more effective?

By careful dissemination of the findings to relevant parties, particularly patient groups, charities and organisations that have a particular interest in the disease or condition under study. Every effort should be made to avoid sensationalism as typically results from interest in research by the non-scientific media.

6. Forging links across disciplines.

Good research nowadays is almost by definition multi-disciplinary. Researchers must apply for funding in teams, and explain in their applications what the various team-members roles will be.

7. How can government encourage translation, innovation, entrepreneurship?

By providing incentives. Most clinical researchers are incredibly pressured for time due to their other commitments, i.e. service and teaching. Therefore, funding must be in place to ensure that when clinical researchers undertake research, they are freed from service and teaching as much as possible. This therefore requires funding to increase the numbers of other staff who can take over these roles. Asking clinical academics to do research, teaching and service is nonsense. Their time needs to be prioritised to what they do best, whether it is research, teaching or service. The new consultant contract therefore needs to be refined for clinical academics, who cannot excel in research at present due to the very hefty service and teaching commitments that are required of them.

9. What lessons can be learned from other countries?

I worked in the USA for 3 years, and have experience in applying for NIH grants. My request to the UK is please, please reduce the bureaucracy, which was a major problem in the US system.

10. Merging of MRC and DoH / NHS R&D

It makes a lot of sense for MRC and DoH NHS/R&D to come together. However, there is a caveat to this. I am sorry to report that I find that NHS R&D departments are very inefficient, and poorly run. On the other hand, MRC is well run. I would worry very much that a wholesale merger would lead to great inefficiencies in grant schemes and handling of applications. I believe the efficiency of MRC is due to it being a centralised organisation, whereas NHS R&D is devolved.

11. Health research and the NHS IT system.

Using the NHS IT system (if it ever gets up and running properly) would be a very useful way to gather large amounts of data. I don't have a problem with that, providing confidentiality of data can be assured (major sticking point). I would not want to see a situation where research that didn't involve the NHS IT system was at a disadvantage, however.

12. NHS R&D is devolved and Research Councils are not.

Devolving the work of Research Councils would be a major mistake. The fact that Research Councils are not devolved means that they work efficiently. Therefore, I believe that a non-devolved NHS R&D body would need to be merged or work with Research Councils effectively.