

## **Review of UK Health Research**

### **Response of the Academic and Research Board of The Royal College of Surgeons of England to Consultation Document**

#### **Proposal for single research fund**

One of the main concerns of the Royal College of Surgeons of England (RCS) in recent years has been the demise of Clinical Academic Departments throughout the UK and particularly in the craft specialties. This has occurred due to a variety of factors which have been well documented in the Report from the Academy of Medical Sciences (2002). One significant factor which has had a particular effect on the surgical disciplines has been the bias in the Research Assessment Exercise towards basic science as opposed to applied clinical research. This seems to have been reflected in the apportionment of funds by the Research Councils. Consequently, the RCS views any mechanism which might improve this imbalance as beneficial. The setting up of a single fund for health research might be a means of achieving this aim provided adequate sums are available. We wish to register our concern that since the idea of a single fund and related consultation document emanates from the Treasury, this might be construed as a cost-cutting exercise designed to reduce overall spending on health research, which of course this College would oppose totally.

The RCS can see some merit in a single fund. However, despite our previous comments with regard to the apparent imbalance in funding between basic science and applied clinical research, we recognise the important contribution of the former to the latter. We would therefore not support a system which resulted in the pendulum swinging so far the other way that basic science research was irrevocably damaged. It would be important, therefore, that within the single fund, appropriate budgets were set at the outset for the different types of research.

We note also that the single fund is to be jointly held by the Secretaries for Health and Trade and Industry. We do not support such a proposal. Ideally, we believe that such a single fund should be controlled by an independent body free of political influence, and perhaps The Academy of Medical Science should have a role here.

One problem in the past with Research Council grant-giving boards is that their composition has failed to have adequate clinical representation and consequently decisions have been biased. We would therefore encourage that such decision-making committees within the single body are composed of individuals who are fully conversant with the topics they are asked to assess. Thus, within the new single fund there should be a fixed budget for basic science that is allocated by boards dominated by basic scientists but which have clinicians who advise on the potential healthcare benefits of the basic science. Clinical boards should also have fixed budgets which should be dominated by clinicians with a few basic scientists to advise on translational research.

#### **Research Assessment Exercise**

As mentioned above, the RAE has been a major reason for the demise of certain clinical academic specialties. For too long the RAE has appeared to be biased against applied clinical research. Good quality clinical studies often only appear in specialty journals with relatively low impact factors and consequently these have been devalued in the assessment process when in effect they have had a major impact on healthcare. Whilst we support the concept of the assessment of research, we are critical of the methods used in the RAE which up to now have tended to demean the applied clinical variety. If better evidence-based medicine is to be practised, it is essential that good clinically applied studies are acknowledged in assessment and

should score highly irrespective of the impact factor of the journal they are published in, provided that journal has stature within the specialty.

### **Career Structure for Clinical Scientists**

We welcome the recent Walport initiative with regard to the Academic Clinical Fellowship and Lecturer Scheme and would hope to see more surgical awards in the next round, which is targeted to threatened specialties.

However, despite this initiative, more needs to be done. Academic surgery still appears a relatively unattractive route for most trainees. There are the competing needs of the NHS and University pulling the individual in opposite directions as she/he attempts to fulfil the obligations of clinical care on the one hand and teaching and research on the other. This is particularly seen in the surgical disciplines which require more time in gaining operative skills. Although there is an argument for taking medical research away from universities and siting it within the NHS, a more attractive option might be if University Hospitals were jointly funded as autonomous bodies controlled by an executive board with equal representation of University and NHS members. No matter what governance structure is finally decided upon, there is an urgent need to attract the brightest and best into research and a clinical academic career should be at least as attractive as a purely clinical career. There has been concern of late as the Merit Award System has been replaced by the Clinical Excellence Award Scheme in which academic achievements are a relatively small component in the assessment system. Either this system needs to change with the academic component being given greater weight or a separate system needs to be developed for academics.

### **Priorities for health research and speed of decision making**

There needs to be more debate on priorities and a speedier mechanism for decision making. A recent analysis of health research in the UK showed that cancer receives the largest share of funding despite having a lower overall burden of illness than some other diseases, including cardiovascular disease (UK research collaboration 2006). Allied to this finding is that substantial funding at present goes into disorders which are likely to be lethal and this seems to be to the detriment of disorders which are chronic and result in a severe impact on quality of life. Since it is easier to raise charitable funds for the former, it might be more logical to provide a greater proportion of public funds for the latter.

It should be recognised that prioritising research and subsequent commissioning as has been done by NHS R&D has, in the main not been successful. The process has been too slow, with major initiatives being funded after the important research had already been done. Research funding needs to be rapidly responsive which has been a major failing with MRC and NHS R&D which are seen to be excessively overburdened by bureaucracy. We strongly support more response mode funding with an emphasis on clinical and translational research, and an appropriate amount of Health Services and Social Science research.

### **Co-location of Multidisciplinary research groups**

There has been a recent vogue to physically separate basic medical scientists from clinicians. There appear to have been two reasons for this. First the belief that there is more synergy if basic medical scientists from different disciplines are co-located and second is the cost of embedded space within the clinical environment. Whilst there are no doubt some economic and indeed scientific arguments for such a policy, there are dangers in scientists pursuing research agendas which have no clinical end point. We therefore believe that wherever possible basic medical scientists in relevant disciplines should be co-located with academic clinicians to ensure that relevant clinical questions are addressed. Such research groupings should also regularly interact with other relevant scientists in non-medical disciplines. This could be aided by regular

conferences on specific problems where it is envisaged that interaction would be beneficial. The Internet could also be used more imaginatively for such interaction

### **Need to instil research ethos into NHS personnel**

Despite best efforts, a large percentage of the NHS professional workforce does not feel inclined to participate in any form of research, and surgeons are no different in this respect. Many more interesting and important questions could be answered if such individuals were engaged particularly in the recruitment of large numbers of patients into clinical trials. The recent initiative to redistribute NHS R&D funds to targeted programmes and projects (Best Research for Best Health, 2006) may redress the balance to some extent although we remain to be convinced. Another ploy might be to encourage individual clinicians through the Clinical Excellence Award system. We would also support the introduction of a research based curricula for non-academic SpRs which would help to cultivate a continuing research ethos when such individuals are appointed to consultant posts.

### **Influence of publicly-funded health research in the development of new treatments on policy and healthcare practices**

Considerable sums of money are invested in research that frequently do not translate into clinical gain. It is our view that there should be a more robust and publicly accountable method of measuring value for money.

Because of the plethora of scientific discoveries, it is not always easy for the average practitioner to be aware of discoveries particularly outside his/her specialty. Nevertheless, we are constantly dismayed how long it takes for new discoveries/developments to be taken up by the healthcare community. We recognise that NICE and other agencies have made some contribution in improving awareness but this aspect of healthcare policy needs greater encouragement. Perhaps this can best be done through the appraisal system and revalidation.

### **Academic Clinical Centres**

The RCS, like many organisations, supported the concept of Academic Clinical Centres as outlined in Best Research for Best Health. However, it was envisaged that these would be established across the country (after suitable pilot studies) in most of the major medical schools and University Hospitals using the proven integrated management techniques which have so benefited Toronto General Hospital and its associated Medical School. We are therefore dismayed to see that a shortlist for such centres has selected only Trusts (with the exception of Manchester) in the Golden Triangle. Secondly, all but two of these specialist centres short-listed are in London. The adverse consequences for university hospitals across the country not awarded Centre status are likely to be profound.

### **References**

UK health Research Analysis at [www.ukcrc.org.uk](http://www.ukcrc.org.uk).

Clinical academic medicine in jeopardy: recommendations for change. Academy of Medical Sciences June 2002

Best Research for Best Health Department of Health, 2006

25 July 2006