

Cooksey Report – Comments on behalf of Royal Liverpool and Broadgreen University Hospital Trust

1. (a) MRC

Strengths: (i) High quality research.
(ii) Good support for innovation

Weaknesses: (i) Uneven correlation between subject areas funded and their impact on health and wealth. This is partly due to the historical structure of MRC panels with some subject areas well served by subject-specific panels and others not.

(ii) Inadequate funding which results in an arbitrary and often subjective cut-off between the very good applications that are funded and the many very good applications that are not funded.

(b) NHS R and D

Strengths: (i) Can be very useful for pump priming for new clinical researchers.
(ii) Facilitates clinical trials.

Weaknesses: Difficult to identify where funding has been spent with a resulting suspicion that much has been spent on supporting clinical service.

Overall: (1) More should be done to identify funds that can be targeted for clinical and/or translational research.

(2) It should be recognised that the current problem lies much more with lack of effective use of NHS R and D funding than with any lack of efficient use of MRC funding.

(3) The increased funding for clinical and/or translational research should therefore be identified from within the current NHS R and D budget.

(4) It is very important that any merging of MRC and NHS R and D funds should be used to increase funding for clinical research but without reducing funding for the basic biomedical science which has been so successfully done in the UK.

(2) It needs to be firmly accepted that research should be a component of medical training for all trainees. The apparent shift towards a second tier of “teaching only” medical schools should be reversed by ensuring that the new medical schools have an adequate budget for research.

The principal objective should be (a) to increase the % of GDP spent on medical research to place the UK in the top quartile of European countries and (b) to increase the proportion of this spend on clinical research.

(3) and (4) Quality of research should take priority over choice of subject area. Medical progress is international and each country should fund primarily according to its research strengths.

(5) Many important innovations have started in the UK:

Monoclonal antibodies, many antibiotics, acid-suppressing drugs, beta blockers, CT and MRI scanners. Others such as DNA structure, contribution to the human genome project and understanding of cell cycling have been fundamental and underpin many other advances. The UK has generally been slow to exploit these discoveries. Initiatives to give a higher priority to commercial exploitation in personal promotion will help. The Health Service should work closely with the universities on this.

(6) The Faculty structure of many universities is unhelpful. Faculties of Science and Medicine that encompass all relevant disciplines including physics and engineering, although large, would be helpful.

(7) (8) and (9) No comment.

(10) It would be appropriate to have a single fund for translational research and clinical trials. Health Services research should be left with NHS R and D. It is very important that we avoid a “turf war” between NHS and MRC or between NHS and the Universities. A National Institute for Health Research should include all three as equal partners.

(11) There is only a minor role for the new IT system in “proper” research although it should prove invaluable for clinical audit and service development. A greater emphasis on funding passing to hospitals proportionate to the number of subjects recruited into clinical studies would be very helpful.

(12) see response to (10) above