



The Russell Group
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26 June 2006

Dear Sir David,

I write on behalf of the Russell Group of Universities to let you have our comments towards your Review of UK Health Research.

1. The Russell Group welcomes this opportunity to submit comments to your Review and should be pleased to meet with you to discuss in more detail the matters set out below.
2. We should commence by confirming that we very much welcome this Review, which we believe to be timely and of central importance to the future of health research in the UK and indeed to the UK economy more widely. This country has a number of major assets which will be central to its future success in biomedicine and in health research and delivery, not least of which are the strengths of its major research universities and the potential research environment offered by a National Health Service. This review offers a real opportunity to provide a framework for the future which will harness those strengths and deliver enhanced levels of globally competitive research and development.
3. We should like to commence with some observations about present arrangements and their effectiveness:-
 - (1) We believe that, more especially in recent years, the MRC has in general proved to be most effective. It has played a fundamental part in promoting research excellence and innovation from 'bench to bedside'. Any future arrangements must preserve and preferably enhance its role.
 - (2) The UK also benefits from the work of its major medical charities, which in some cases have a financial input equivalent to that of the MRC. Any future arrangements must recognise and respect the contribution and needs of those charities.
 - (3) Historically, funding for NHS R&D has been largely hidden within the general revenue budgets of the acute NHS Trusts. Only a minority element of the total funding made available is specifically earmarked and allocated for R&D. One primary objective of this review must be to ensure that on an agreed timescale monies intended for R&D are indeed spent on R&D. We return to this matter later.

- (4) 'Best Research for Best Health' has made real progress in starting to introduce into NHS R&D concepts of research strategy, of research selectivity, and of peer review. We welcome this development. However, the focus for their implementation continues to be NHS Trusts. This we believe to be a primary weakness which if perpetuated will confound the effectiveness of the reforms under consideration. For in practice, R&D in our major hospital trusts is very highly dependent on university staff for its planning and prosecution, whether such R&D be pure or applied, whether it be curiosity or service driven, or whether it be bench- based, safety-related or a clinical trial. Such university staff may have honorary contracts with their Trusts, but they draw their research competencies, their inspiration and rigour, from the academic culture and community in which they are based and employed. If we are to get more effectiveness from an enlarged and re-organised NHS R&D Fund, then the focus of attention must be more on the major research universities rather than their associated NHS Trusts and structures.
 - (5) If properly reorganised, this focus would then carry a consequent requirement for truly effective working relationships between Universities and NHS Trusts, and particularly for the greater involvement of universities in the governance and management of the country's key acute Trusts. We will return to this matter again below.
 - (6) Your invitation to submit comments invites observations about appropriate international exemplars and benchmarks. There is of course always a temptation to be drawn to the arrangements in the USA, and in particular the NIH. We believe that the context in which the NIH operates is so very different from that of the UK, and its real role is therefore so different from that which might be effective in the UK, that such comparisons are unhelpful. Rather, we would encourage a review of the arrangements in Canada, which has features which might usefully be considered for further study.
 - (7) Finally, in looking towards improved arrangements, we do recognise the importance of embracing all stakeholders to this endeavour, including the health service, universities, the research councils, the charities, industry and Government. With regard to the latter, the arrangements with the Devolved Administrations will require particular attention.
4. Turning now to future improvements and the primary purpose of your review, the best institutional arrangements for a new 'single fund' for health research funded primarily by the MRC and the NHS R&D Programme. We should like to make the following comments and suggestions:-
- (1) The central issue is that there should be a genuine synergy between any individual elements of funding, so that there is a seamless and co-ordinated strategy and policy, and optimal effectiveness of funding. Such synergy can only be ensured through properly integrated governance and management arrangements. Whether this is best delivered through a single fund or through multiple streams of funding will need careful debate, with identifiable strengths and weaknesses associated with each approach.

(2) What should constitute this 'Fund' or the various separate elements of it is also of central importance. At its core any arrangement must recognise:-

- The success of the MRC and its effectiveness in supporting project/programme-based research (including many clinical trials), as well as the academic career development of clinicians and allied specialists.
- The importance of any funding scheme encompassing the full breadth of biomedical research from basic molecular studies, through clinical research and into population studies;
- The growing impact of disciplines outside the conventional biomedical arena, such as engineering, physical sciences, social sciences etc and the need to maintain close interactions with the agencies funding these disciplines.
- The importance of operational research to effective service delivery in an organisation as large as the NHS.
- The capability offered by the *Connecting for Health* initiative in underpinning much of the research potential of the NHS.
- The importance of freeing any funding mechanism from interference by NHS service pressures.

These considerations emphasise the importance of supporting the closer integration of the management and planning of MRC funding (and perhaps also very directly relevant funds elsewhere within RCUK) with the full extent of NHS R&D funding. However, any arrangement which divides the present MRC funding portfolio, such as a split between the BBSRC and a new NHS service-orientated R&D fund, would be highly damaging.

(3) The style and ethos of the governance and management arrangement will be an essential pre-requisite for the success of any future arrangements. We have emphasised the successful operation of the MRC, alongside the gradual adoption within the NHS R&D Programme of approaches and systems based upon research council practices. We would urge that the governance and management arrangements for the new 'Fund' should be modelled on RCUK-type arrangements.

- (4) Governance arrangements will need to reflect the very wide range of stakeholders which would have a legitimate interest in the matters under consideration, so that there can be a framework to achieve the better integration of the various strands of biomedical and related research now being sought. These stakeholders must include government departments, the research councils, the universities, the NHS, the charities and industry. UKCRC provides an example of how such integrated governance might be effected. It would be essential that the Chairman of such a Governing Body or Council should be a senior figure independent of any Government Department or specific stakeholder interest. Such a Council would of course need to ensure the necessary synergy across the various elements of funding within its sphere, and no doubt in order to help it to do so it would want to establish appropriate scientific advisory body/bodies able to command the diversity of the funding elements within its remit. The Chief Executive Officer or Officers responsible for managing those funding elements would be expected to present the Council with co-ordinated policy and funding strategies, and would in turn be assisted in that process by the advisory bodies described above. Furthermore, we recognise that interim management arrangements might be necessary in the short term to bring these complicated root and branch changes into effect, and these would need to be led by a talented individual capable of understanding and empathy across the full range of research under consideration. Finally, accountability arrangements will need to be devised which reflect the detailed funding arrangements once finalised. It may be necessary and indeed may prove to be helpful to retain separate accountabilities for each of the principal elements of the 'Fund' to the respective Government Departments, but this in turn only emphasises the important integrative role to be provided by the Council and its attendant arrangements.

The precise arrangements for the Executive may require a period of transition from the current model of both a MRC and a NHS Director. There may prove to be merit in a model which allows the new structure to extend its remit, particularly in the area of clinical academic training and project/programme management, while the NHS retains its remit for operational research (including of course *Connecting for Health*). Such a model with (ultimately) a single CEO reporting to the Council has clarity and would enable the CEO to operate across the spectrum of funders more effectively than a bi-cameral model with its inherent frictions and potential ambiguities of responsibility. Although there may be recognisable risks to this approach which would need to be addressed, such as the possible disengagement of the NHS from research, nonetheless the strengthening of the lines of accountability which would result might recommend it over some of the shortcomings of the present situation.

- (5) As we have argued earlier, the effectiveness of future allocations in support of R&D within the NHS will only be ensured if at the same time there is a consequential change to the involvement of the major research universities in the governance and management of our major acute NHS trusts. The US model of major hospitals being part of and run by the major universities may be one approach, but there are of course a number of possible models which could achieve the objective and some of these should be explored as appropriate to local circumstances. However, a greater influence for the major research universities in the governance and management of their associated Trusts will be necessary whichever approaches are adopted.

- (6) We do also recognise that the proper reorganisation of the present arrangements for NHS R&D funding will create genuine financial challenges for Trusts in what are already difficult circumstances. Financial incapacity of our major health trusts cannot be in the interest of health R&D, and careful thought will need to be given to transitional arrangements and timescales and to the possibility of identifying compensatory funding from elsewhere within NHS budget arrangements.
 - (7) Whatever the decisions about the arrangements for NHS R&D funding, we would want to emphasise the continuing importance of the wider NHS to health R&D. The NHS offers a unique resource, the potential of which for research and development purposes has never been fully realised. Nowhere is this more evident than in the vital matter of clinical trials, a successful environment for which will be essential to the retention of international biomedical and pharmaceutical companies in the UK. Phase 3 clinical trials are an important goal but their continuation and growth will ultimately depend on cost effectiveness and access to patients. Expertise in these activities must be a core asset, because even if such trials may be carried out in other countries, it is essential that they remain co-ordinated in the UK if this country is to retain its vibrant pharmaceutical industry base. Phase 1 and Phase 2a and Phase 2b clinical trials remain a major strength of considerable importance and an essential component of clinical research in most of our major clinical centres. (Once again it is to be noted that by their nature such trials are largely steered by university clinical staff in the major research universities, whether the trials themselves are actually undertaken in directly associated trusts or in DGHs elsewhere). The country's competitive advantage in this area could be very considerably reinforced and enhanced if the potential within the NHS to deliver specified trial groups could be realised. The key to this development is 'Connecting for Health', but at present because of service pressures R&D needs are not being addressed in the development of this core initiative.
5. The work of your Review Group is of great importance to the future of health research in this country, to its contribution to the UK economy, to our ability to attract the best clinical talent to the UK, and indeed to the health of the nation. We do trust that you will find our comments to be constructive and helpful. We should be happy to provide any further detail or clarification as you might require, and of course we would be very happy to meet with you and your team if that would be of assistance.
 6. I should of course remind you that the Russell Group is composed of the Vice-Chancellors/Principals of the Universities of Birmingham, Bristol, Cambridge, Cardiff, Edinburgh, Glasgow, Imperial, King's College London, LSE, Leeds, Liverpool, Manchester, Newcastle, Nottingham, Oxford, Sheffield, Southampton, UCL and Warwick.

Yours sincerely,

Professor Christopher Edwards