

RESPONSE FROM THE SCOTTISH EXECUTIVE HEALTH DEPARTMENT

I write on behalf of the Chief Scientist Office of the Scottish Executive Health Department to express support for the underlying ambitions of your Review while sharing with you our concerns about some aspects of implementation. This response also incorporates the views of the other main research funding Divisions of the Scottish Executive.

Background

The Chief Scientist Office (CSO) is the research funding office of the Scottish Executive Health Department. Created in 1973 by the then Scottish Home and Health Department it funds research that aims to secure lasting improvements to the health of our population and improve the quality and cost-effectiveness of health services and health care in Scotland. It has many responsibilities that parallel the Research Directorate of DH England.

CSO's funding has always come exclusively from within the Scottish financial allocation. The long-standing investment by CSO now supports a significant life sciences skills base. The CSO supported scientists contribute to the 12.5% of UK life scientists based here in Scotland. They therefore make a disproportionate contribution to UK success (as demonstrated by attracting > 13% of research funds allocated by UKCRC organisations in its recent analysis). It will be crucial that any changes arising from the Review support rather than undermine this success.

Working relationships with DH and MRC

Communication

CSO has long-standing working relationships with both funding bodies directly affected by this review. The MRC currently provides a valuable unifying force across the UK that is able to respond to and reward scientific excellence irrespective of geography. It is well respected internationally for its quality and standards and its significant role in fostering and sustaining the healthcare science base in the UK should be recognised.

For many years all 4 Health Departments and the Medical Research Council have operated under a concordat with the aim of co-ordinating our research activities; central to this arrangement was a structured annual diet of meetings that helped good communication. Such regular interaction with DH and MRC was considered valuable by the devolved administrations; while no substitute for the regular informal communication possible for the London based organisations, they did nonetheless ensure that DH and the MRC were better informed about the agenda of the other countries.

We regret that the concordat meetings have lapsed but recently instigated regular informal meetings of the Devolved administrations with MRC have greatly improved communication and understanding. Meetings between DH and the other UK R&D Directorates of the devolved administrations are fairly frequent but there remains

scope for greater understanding of the impact of DH policy decisions on the other countries.

Funding

As mentioned above, the devolved countries have all felt the need to create budgets which address their own needs and priorities, structures and policies. This will also apply in England. The MRC, of course, has a UK-wide remit. There are some very good examples of collaborative funding across the Health Departments and the MRC in areas of common need or interest, although more could be done to engage with the devolved administrations as full partners in some of these enterprises. The UKCRC is the latest and largest such collaboration to date, involving a wider range of funders than those mentioned above. However much of the UKCRC effort is closely linked to the research strategy for England; and while it is entirely appropriate for the UKCRC to act in support of its member organisations, care must be taken to ensure that it does not become a vehicle for pursuing one member's policy to the detriment, however unconsciously, of others. The proposed closer integration of DH and the MRC has the capacity to exacerbate this problem, and we would be pleased to work with you to consider how this might be prevented.

Health Departments also meet the costs of research infrastructure in the NHS although allocation systems differ across the UK. In Scotland, a significant part of this budget is allocated on a formulaic basis determined by volume and activity in the preceding year. A portion (Programme Funding) is also provided to reflect local needs and priorities; these programmes are currently under review and some changes to encourage further quality improvement and accountability seem likely. The allocation systems were developed with the NHS in 2000 and are now well established and accepted. As England addresses concerns with its allocation mechanism it will be important to ensure that the ability to conduct pan-UK research studies is not complicated or undermined. Each country will probably need to have a system that reflects local NHS structures and accountabilities since the funding provided meets the costs of marginal amounts of time from many NHS employees. We believe that it would be inefficient and unhelpful to draw NHS infrastructure monies into the Single Fund.

Before the other countries were devolved, England also funded research across the UK in areas where it was best placed to take the lead - on those subjects applicable across the entire UK and those health policy areas that are now reserved. The HTA programme is the only residue of former DH England practice and is a good exemplar. In recent years it has not always been clear that DH England continues to fund research that covers these UK-wide issues; the practice should be re-established and extended to cover other areas that are relevant across the UK. There would appear to be efficiencies in these funds being managed within the Single Fund.

Existing priorities of both DH England and the MRC largely focus on therapies or research to design novel approaches to prevention or reduction of disease. We are very supportive of such priorities and welcome a broad spectrum of research that also includes e.g. work on health maintenance through life style change and research to understand the relationship between environment and health. However,

there is relatively little good research on health service management, service re-design or how to implement change effectively. While these subjects come within the embrace of the Service Delivery and Organisation Programme we would argue that this programme is currently under-resourced although the recent English R&D strategy indicates some increase. Currently the opportunity is being lost to pursue the natural experiment arising from the 4 member countries' different policies and approaches. MRC should also do more to study effective implementation of change, a subject that features little in its existing portfolio.

IT Systems

We note your particular concerns about English IT projects. UKCRC is seeking to engage with the Connecting for Health Programme in England looking to improve efficient and effective use of NHS data. Scotland is also implementing new systems which address many of the aspects covered by Connecting for Health in England. There is close dialogue between our Information Division in the Health Service and the Executive to explore and develop research and commercial research potential. Our Clinical Research Networks already draw on this source but are working to develop more automated IT linkages that respect the conflicting needs of access and confidentiality. The greatest utility to the wider UK endeavour in clinical research will obviously result from all of these systems and structures being able to communicate and share data between systems.

Improving economic benefit

We support the thrust of this review that greater returns to society and the economy should be sought from our excellent science-base. The main role for Government in this area would seem to be to address aspects of market failure. In doing this it needs to avoid creating perverse incentives for industry to hang back from bearing those costs and activities that more appropriately fall to them. Comparison with the closely related agri-chemical industry would tend to suggest that the pharmaceutical industry currently benefits more from public sector funded support.

Following the unpublished Barnes Review of agriculture research in the mid-1980s, Government withdrew from funding so called "near-market" research. The speed of withdrawal was damaging as other funders and the research community had little time to adjust to a dramatic change in circumstances. To draw the parallel with health care indicates which mistakes not to make but would suggest that both pharma and the NHS as the large user communities should be looking to contract and pay for the work they need. In some respects the current working of the HTA programme gives an opportunity for NHS bodies to indicate their priorities for research while also providing a convenient centralised function that avoids different parts of the NHS paying more than once for similar research to be conducted. The new single fund should perform a similar role to address NHS needs.

Achieving greater economic returns is not a new issue and various bodies have sought to address the gulf, more usually from the supply side. We believe this now needs to be balanced by a stronger emphasis on the demand side of the equation. Most public sector research funders, including the University Funding Councils, have attempted to encourage their grant holders both to publicise and commercialise their

findings. Our experience (and research evidence supports this view) is that such supply side “push” alone is inefficient and ineffective. Equally it is evident that the NHS is a key part of the demand side of the equation and is not a research-hungry user willing or able routinely to take an enquiring approach to practice or improvement. Change is difficult and slow. Innovative new products are often adopted slowly even when offering evidence-based advantages over the status quo.

The means through which basic research findings make their way through to practical application has tended to be serendipitous. To some extent researchers will settle at a point along the basic to applied research spectrum but we believe that in the right climate more translational activity can be encouraged. The UK Clinical Research Collaboration, of which we are a member, has made several significant investments recently in that belief.

It is also our experience that not all innovation comes from researchers. We established a company (Scottish Health Innovations Limited) some 3½ years ago to gauge the commercial potential of innovations from staff of NHSScotland. At least half the 300+ technologies they have examined came from non-research staff. Only a small proportion are judged worthy of commercial exploitation; these ideas are then protected and championed to the market place. The rest are usually shared within the NHS with a view to ensuring that good ideas are communicated and awareness-raised to potential improvements and cost savings. The literature similarly records that successful uptake of innovation has usually been championed in some way. Although a relatively new company we are impressed by the progress and potential demonstrated by Scottish Health Innovations’ work since its incorporation.

There is a deeply entrenched view in parts of academia that applied research is of a lesser intellectual calibre than basic studies. This must be addressed if translational research is to thrive. The view has been played out to varying degrees during successive iterations of the Research Assessment Exercise. While this exercise has made increasing efforts to recognise and reward more applied work, its perceived lower worth has already ensured that good applied researchers in the University sector have either left academia or become less involved in research. The situation may be slow to reverse and this review will need to send a strong message that skills in translating research are valuable and will be valued. With the mechanics of the RAE itself under review, it will be essential that this aspect helps to inform and shape future assessments. There is also possibly a gap in understanding between researchers and research-users that might necessitate the increased use of translators: individuals, not necessarily active researchers, who are able to understand and articulate research needs to researchers and research findings to users.

Government potentially has a key role in increasing demand-side “pull”. This now needs to be catalysed but is made more complex in healthcare as a large part of the demand side is itself public sector ie the NHS and its various NDPBs responsible for providing it with advice. These have been established with other objectives in mind and it would be for much wider consideration whether these organisations are or should be tasked to act in a manner conducive to creating demand side pull.

Equally existing research funding “levers” could probably be used more imaginatively within the NHS. The sizeable funding going to support NHS research infrastructure might reasonably carry with it more strongly the obligation to demonstrate how research they have helped to support has addressed their needs or been adopted by their NHS economy. We are currently considering how to introduce this in Scotland after our review of Programme Funding and would be pleased to work in collaboration with other parts of the UK.

More could be done to encourage continuous improvement within the NHS and an expectation that such improvements be evidence-based. The focus for much of this will lie outside the research domain but if all public sector research funders in the healthcare sector placed a more overt emphasis on societal benefit, it would be a promising start. For example more might be done to ensure that research syntheses would be utilised as efficiently as possible at UK level. It is not always clear that systematic reviews are being conducted once and used for several purposes nor that their practical findings are having a swift impact on practice. This should be an automatic expectation in return for the significant public funding involved.

Bodies such as NICE (and its Scottish counterpart) draw on the healthcare science base for their guidance and might play a key part in this. Equally thought might be given to whether NICE might have a role in prioritising and then seeking solutions to existing healthcare problems in addition to responding to industry innovation when they seek access to the NHS market. We believe that a new relationship needs to be forged with industry to maximise the overall efficiency of the interaction.

The Single Fund for Health Research

It will always be a subjective judgement to determine the proportions of funding allocated to different types of research but the determining factors should be to nurture our strengths well, to fill strategic gaps effectively and provide an environment that expects and catalyzes proactive use of research. There is a risk that this review provokes a sudden swing to support more applied studies which we would discourage for two reasons. The first is that it is likely to operate initially to the detriment of basic research and the second is that until we understand better how to ensure the application of research findings, such a transfer of resource seems likely to be a waste of public money. In the medium to longer term more funding for good applied research may be justified. However the Review team might consider exploring the work of the Netherlands organisation, ZonMW that offers a number of parallels with the purpose of the single fund.

The Chancellor’s budget announcement creates some material concerns not least because the solution would appear to have been announced ahead of the analysis of the underlying issues that prompted it. We would strongly support the objectives underlying this review and much of our response addresses the issues raised. However we cannot be confident in the light of past experience that the policy, needs and structures of Scotland or the other devolved nations will be properly understood by the merged body proposed. It is a particular concern that its lines of accountability are planned to be jointly to the English Secretaries of State for Health and for Trade and Industry.

It will be essential that the Government Department to which the new body is accountable has a good current focus and respectable track record on UK wide matters to which this additional responsibility can be added. Reporting lines to a Whitehall department dominated by English policy considerations could be disastrous and undermine the new body from its inception. Thought should also be given to how this new body should discharge its UK-wide responsibilities in relation to the Governments of the 3 devolved countries.

Certain key principle underpin how we would wish to see the proposed new fund operate and interface with devolved administrations:

- Scottish research must not be disadvantaged by the new body or bodies. This means equitable access to research resources for all 4 parts of the UK on a basis that reflects research quality. If there is to be a part exclusive to England, then that needs to be clearly ring-fenced from existing DH funds and from the wider UK funding arrangement.
- The funds allocated to programmes such as HTA and SDO should be absorbed into the single fund. Funding to meet research needs for further work relevant to the NHS across the UK and to address reserved issues should also be transferred to the single fund. NHS infrastructure monies should not be included in the single fund.
- Funding arrangements must continue to fit all Departmental support systems. A system which fits DH aspirations but creates problems for the devolved administrations must be avoided at all costs. We understand the medical research charities have similar concerns.
- Any re-distribution of the proportion of funds available for basic or applied research should be without detriment to funds being allocated on a competitive basis and solely on scientific merit.

Finally, we would urge that your review be strongly guided by increasing efficiency and effectiveness and improving societal and economic benefits from research rather than being unduly bound by creating a particular structure.