

Response to the Cooksey Review

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1.

What are the strengths and weaknesses of the MRC and NHS R&D programmes at present?

The strengths of the MRC and NHS R&D programmes lie in their complementary nature, resulting in a relatively well-balanced portfolio of health research with basic scientific research being supported by the MRC and the DH supporting more applied translational health research.

How do each of these support the research and training needs of the NHS, social care, industry and academia?

Both programmes in the last few years have supported R&D capacity and capability development especially in primary care, nursing and allied health professionals. This should now be extended to the areas of public health and social care.

Does more need to be done?

Support for the development of methods and skills in implementing research into clinical practice should be emphasised.

Research capacity development in primary care and public health is at risk from the current reforms in the NHS 'Commissioning a Patient-Led NHS'. The main focus and priorities for PCTs will be delivery of stringent governmental targets and research will take a back seat.

2.

What do you believe are the key scientific and organisational challenges facing health research, and underpinning training, in the UK over the next decade?

One of the main challenges is the appallingly low proportion of spending on public health and preventative research. The UKCRN's UK Health Research Analysis (1) states that 2.5% of funds is dedicated to research focused on the primary prevention of disease, or conditions or promotion of well-being and encompasses behavioural, environmental interventions, vaccine development,

nutrition and chemo-prevention. Sir Derek Wanless (2) and the Prime Minister's Strategy Unit have pointed at the lack of available evidence base for key health policy aspects. Moreover, there is a moral case for following the existing knowledge about the aetiology of chronic diseases with further research on methods for preventing known risk factors. In addition, new public health challenges posed by environmental and societal changes require evidence-based responses (e.g. global warming, communicable diseases).

Research into the area of service delivery and organisation should be strengthened and research to establish the most effective models of commissioning by PCTs and practices is particularly required.

In the context of clinical trials in primary care, primary care trusts should be able to understand and plan for treatment and excess treatment costs.

Finally, getting the balance right between Industry and public bodies rights and responsibilities is an urgent priority. Unless addressed well, there is a danger for further neglecting important, but low profit, public health research.

How might the UK Government best help address those challenges?

In relation to the last comment, set out a clear/enforceable framework.

What do you believe should be the Government's objectives for health research, and why?

- Blue sky research
- Needs based research
- Translational research
- Capacity and capability building

3.

What should be the Government's priorities for health research?

While the aims and objectives set out in the DH publication 'Best Research for Best Health' are supported, priority should also be given to research into those chronic conditions largely treated in primary care and the promotion and maintenance of good health. This is particularly important given the DH's policy of moving treatment of many conditions from secondary to primary care

Is there anything it should stop doing or funding?

What is it not doing or funding that it should do, and, in the absence of further sources of support, what can it lower in order to release the necessary funds?

The UK Health Research Analysis Report (1) provides support for an increase in funding is for research focused on the primary prevention of disease and health promotion (currently only 2.5%). This should be increased along with robust health economic evaluation of policy decisions and the effectiveness of public health interventions.

About 75% of research funding is related to specific disease areas, and the

above analysis suggests that the research funding in areas of respiratory, oral and gastro-intestinal disease is low relative to the disease burden. This could be achieved by re-distribution of funding among disease areas.

The distribution of research funding in England shows a big imbalance with the major proportion of DH R&D Support Funding in London and the SE, including Oxford and Cambridge), and this is reflected in MRC funding (3). This is in direct contrast to the geography of health inequalities which shows the poorer health statistics, including lower life expectancy, in the North. It is hoped that the introduction of Clinical Research Networks will help at least partly to redress the imbalance in research funding

4.

How should decisions be taken on the balance between the long-term economic and social benefits of a high quality biomedical research base; and the needs for research to improve healthcare and other public services?

Decisions should be taken openly and explicitly, with separate allocation of budgets between the two: upstream and downstream agendas

What is the appropriate balance between public funding for investigator-led and priorities led research?

30% investigator-led research :70% priorities-led research

How do we balance funding for basic science, translational science and applied science?

With difficulty, but if we agree the above two, then should it not become easier

Is this something that should vary over time?

Yes, but over longer term, perhaps review after 5 years

What mechanisms should be used to make judgements about this balance?

As above - openly and explicitly

5.

In your experience, how have the results of publicly-funded health research in the UK been used, both in the development of new treatments and to influence / change wider policy and healthcare practices?

It is difficult to see how publicly funded health research pays-off because the NHS traditionally has not exploited its intellectual capital and it is most likely that the rewards have been reaped by the industry. More recently, there has been a tension between research findings and governmental policy, with the latter perhaps dominating the former.

What lessons can usefully be learned to improve the uptake of advances in science and medicine?

Building on the NICE model and ensuring that initiatives like NICE link up with mainstream policy/planning and delivery mechanisms.

6.

How might better links be forged between ‘basic’, translational and applied researchers, working across the whole field of health research, from the laboratory bench to the front line of the NHS?

Links should be forged at locality levels, around subject areas and between institutions.

How might better links be forged across disciplines, e.g. with engineers, physicists, and social scientists?

These are most likely to be topic based.

7.

How can the Government encourage translation, entrepreneurship and innovation in health research to improve public services in the UK?

By ear-marking funds, eg for SDO programmes, and ensuring that research outputs are used non-commercially, for the benefit of the public.

8.

How can UK health research funding be most effectively used to provide the appropriate infrastructure for basic, translational and applied research, whether funded by the UK public sector or other sectors?

A research culture needs to be embedded in all aspects of NHS organisations including board level and including those less research-active.

How can UK health research funding be most effectively used to support the work of NICE, facilitate innovation and collaboration with industry, and address market failures in the application of healthcare?

9.

What lessons should the UK learn from other countries in making the proposed changes to the institutional arrangements for the funding of health research?

10.

In implementing the single fund for health research, to what extent should the MRC and DH / NHS R&D be merged or brought together?

The two funding systems, MRC and DH/NHS R&D Programme currently provide a balanced portfolio of research (see answer to question 1 above). If it is difficult to put them together, then there should be much closer collaboration between the two streams.

If organisations were to be merged in the future, this would have to be funded which should not be at the expense of reducing research funding

And to whom should the single, ring-fenced fund be accountable?

An independent Monitor

Please provide reasons and any supporting evidence for your response.

Based on the Foundation Trust model.

11.

To what extent does the success of recent innovations in health research (e.g. Clinical Research Networks) and the proposed structures rely on the new Connecting for Health NHS IT system, and to what extent should it do so?

It is not clear how well the Clinical Research Networks are doing at present.

Clearly proposed structures for health research should rely on Connecting for Health. We are already working with a local acute trust to develop a combined clinical information system /research tool.

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Given that NHS R&D is currently devolved, but that the work of Research Councils is not, how can these functions work best together to maximise the health and economic benefits to the UK?

References

(1) UK Research Health Analysis, May 2006, UK Clinical Research Collaboration

(2) Wanless Report - Securing Good Health for the Whole Population, 2004, HM Treasury

(3) Hacking J. Medical Research. Fools' gold. Health Service Journal, 2004 Apr 1; 114(5899):32-3.

