Universities UK

UUK response to Cooksey Review of UK Health Research

Introduction

1. Universities UK is keen to contribute to the Cooksey Review of UK Health Research, which we believe to be of central importance to the future of health research in the UK and to the UK economy as a whole. This response has been developed following wide consultation and focuses on issues that are of key relevance and concern to universities.

Breadth of universities' contributions to health R&D from all subject disciplines

2. Universities undertake most UK health research in partnership with the NHS in England, Wales, Scotland and Northern Ireland. This underpins evidence-based practice and supports patient care. University interests in health research are not confined to medicine - they stretch across the range of disciplines that contribute to a modern health service whose biggest challenges are supporting an ageing population and managing chronic conditions. The health service needs to draw on research capacity from a range of disciplines - from biomedicine to lab based research; from engineers to health economists; from computer scientists and business managers to sociologists and medical statisticians. It is not possible to list all the expertise universities can offer but they are uniquely placed to support health research on a multi-disciplinary basis. Our response is informed by this breadth of potential contribution, which funding mechanisms in future will need to recognise.

Governance arrangements for the new merged fund and the principles for its implementation

3. The proposal to merge the MRC and NHS (England) R&D budgets into a single fund for health research offers an opportunity to further improve and develop health research in the UK. That potential will only be realised if the opportunity it taken to roll out the MRC's standards of excellence across the range of health research and so drive up standards in applied areas.

4. The proposal offers the opportunity to be more strategic and plan research for the longer term. If the outcome is that Trusts and NHS consultants will be able to obtain the full economic costs for their research, as University researchers can now do, this may act as an incentive for researchers to plan programmes in the longer term. It is important that the fund is established in a way which capitalises on this opportunity.

5. It is also important that a single fund is used to erode the artificial distinction that exists between research carried out in NHS Trusts and within universities, enabling genuine partnerships to develop which can be led by the most appropriate individuals. Universities, where research expertise resides, must be allowed to play their full part in research supported by the new funds and not excluded on the grounds that some of it should be reserved for NHS employees.

6. It is essential that the current financial instability in the NHS should not be allowed to jeopardise health R&D, which is vital to the UK economy as a whole and requires long-term planning. Careful thought therefore needs to be given to transitional arrangements and

timescales for implementation of the merged fund. We are assuming that the proposal to implement a single fund for health research will depend upon the success of the 'Best Research for Best Health' ambition to make available for direct funding of research the notional funds hitherto included in the current block grants to NHS Trusts. Whilst this may offer opportunities to incentivise research within the NHS, it would also require about £550m to be taken out of the NHS at a time when it is over £500m in deficit. This would be financially unsustainable and would strain the university/health service research partnership even further, at a time when the financial impact of other reforms (for example, full economic costing, the review of SIFT funding and the introduction of payment by results), will start to become apparent. There is a risk that this combination of changes will fundamentally damage the underpinning infrastructure for health R&D. The transitional arrangements need to be managed so that this does not happen.

7. It is also important that maximum use should be made of the UK's high quality research base, wherever that is found. If there is a successful re-allocation of NHS resources, based on the proposals in 'Best Research for Best Health', it is likely that there will be a concentration of funds for R&D infrastructure in relatively few centres. This will mean that some regions may not be able to contribute to clinical research, so affecting the UK's ability to deliver large scale clinical studies. There is also a danger that too much concentration will deny access to the best of the research base, which may lie outside those centres, and outside traditional medical research. It is critical that the full breadth of disciplines that underpin health research are accessed if innovative, high quality health care is to be widely available across the country.

Governance arrangements for the merged fund

8. Universities UK believes that the style and ethos of the governance and management arrangement needs careful planning. The fact that the single fund will be an amalgamation of a UK function and a NHS England function will pose a significant challenge in terms of governance and operation. Governance arrangements will need to reflect the very wide range of stakeholders involved in health R&D, so that the governing framework better integrates the various strands of health research in progress across the UK. These reach beyond biomedical and related research and encompass translational and operational research in relation to service delivery, management and organisation. Key stakeholders such as government departments, the research councils, universities, the NHS, patient groups, charities and industry would need to be included, but it is essential that the merged fund is managed in a way which is visibly independent of any government department. Three models have been identified:

    a) The UKCRC model has integrated a wide range of organisations, and might provide a useful guide to a new organisational model. This would be an alliance of funding bodies, each with its own governance arrangements, but with a commitment to joint formulation of strategy. However, this does not meet the test of visible independence from government.

    b) A reconstituted MRC to include stakeholder representation from the range of health professions outside the sphere of medicine. This offers the benefit of building on existing

expertise and a reputation for high quality, peer reviewed research, funded on the Haldane principle. As well as funding basic biomedical research, a re-constituted MRC could continue to fund clinical trials and extend its fellowship schemes to train clinical academics from a wider range of health professions. This is essential in order to develop interdisciplinary collaboration between health researchers and also draw on expertise from other disciplines such as engineers, physicists, and social scientists. The MRC's existing responsibilities for global health could also be retained within this sort of structure. The retention of links with the DTI and RCUK would also facilitate the continuation and development of inter-research council initiatives, which would be essential to develop interdisciplinary collaboration between health researchers and other disciplines such as engineers, physicists, and social scientists.

c) A variant of a) would be to maintain separate funding structures in DH and MRC, but with an overarching Governing Body or Council established, to oversee the management and governance of the single merged fund, on an arms'-length basis. The Chairman would be a senior figure independent of any Government Department or specific stakeholder interest. The establishment of appropriate scientific advisory body/bodies would be able to command the diversity of the funding elements within the Council's remit. The Chief Executive Officer/s responsible for managing those funding elements would be expected to present the Governing Council with co-ordinated policy and funding strategies, and would in turn be assisted in that process by these advisory bodies. Accountability arrangements would need to be devised which reflect the detailed funding arrangements once finalised. It may 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 Governing Council and its attendant arrangements.

9. Although views of UUK members differ as to emphasis, in broad terms either b) or c) would be acceptable. All of the above models would enable the Department of Health to acquire the latest and most reliable evidence to deliver up to date health care. They would also enable continuation of existing high-quality national programmes, such as the Health Technology Assessment (HTA) programme.

10. Universities UK has also noted the Canadian model which may present an alternative for consideration by the Review Team. The Canadian Institutes of Health Research (CIHR) were created under an Act of Parliament that came into force in June 2000. Its attractions lie in the following:
    a) It operates as an arms length agency of government, being accountable to Parliament through the Minister of Health.
    b) Its Governing Council is comprised of a number of Canadians, with a wide range of backgrounds and disciplines, including the Deputy Minister for Health as an *ex officio* and non-voting member.
    c) The Institutes bring together researchers, health professionals and policy-makers from voluntary health organisations, provincial government agencies, international research

organisations and industry and patient groups from across the country with a shared interest in improving the health of Canadians.

d) The peer review process is a vital part of CIHR. This allows flexibility for both responsive-mode funding as well as approximately 30% allocated to strategic managed calls.

e) The CIHR funding relationship with universities (partly through the response mode and partly through the virtual Institutes) is based on the assumption that the university model supports multidisciplinary research and maximises scientific and financial flexibility. It should be noted, however, that the Canadian system is distinct from the UK, as the CIHR and its predecessor the Canadian MRC have never directly funded universities. So it would be necessary to consider how this model would take account of the funding councils and medical charities that fund so much of the UK's health, biomedical and translational research.

11. Clearly, further work needs to be done to identify which governance model(s) would be most appropriate for administering the new merged fund and Universities UK would be happy to provide further evidence to the Review Team to support this exercise. In considering these models, it is essential that any new governance arrangements for the joint fund should be administered according to the Haldane principle, as specified in the *10 year science and innovation investment framework: next steps* consultation document. Whichever governance approaches are adopted will undoubtedly require universities and NHS Trusts to seek to improve and build upon existing relationships.

Priorities for the type of research funded under the new arrangements, including capacity building

12. Universities would welcome an increased emphasis on removing the obstacles to research, for example in supporting a reduction in bureaucracy. There is a particular need to incentivise the NHS to utilise research, which should be recognised as essential to the provision of high quality patient care. Reforms in the NHS should be evidence-based and informed by high quality research outputs.

13. There is an urgent need to build research capacity in nursing and allied health professions and in the social sciences that underpin vital health research. More dedicated funding should also be made available to develop capacity in applied, clinical and translational health research. Consideration should be given to the ringfencing of research funding into three broad areas: a) basic (primarily lab based) research; b) clinical research; and c) applied research. Each of these should encourage a broad range of professional and disciplinary inputs. Care should be taken to ensure that such funding is not limited to clinical medicine and traditional biomedical sciences but spans the whole range of growing disciplines, including the humanities, as referred to in paragraph 2 above. The contribution of all the UK research councils is an important aspect of this - BBSRC, ESRC and ERPSRC (via its Life Sciences Board) all undertake research that is relevant to healthcare delivery and practice. Research Councils UK , (RCUK) is the strategic partnership which brings together the various strands of work that

the eight Research Councils support, and may be the most suitable mechanism for enabling the health service to draw on wider range of programmes than has previously happened.

14. A key priority should be to ensure that funding is distributed according to UK strategic imperatives. Prioritising the major killer diseases is understandable; however, the social and economic impact of conditions that may not kill but cause long term morbidity must be recognised and funding for research in these areas should be enhanced. Universities would welcome further provision for research into neurodegenerative disorders and public health problems, such as obesity, where the effects of the associated morbidity will have an increasing impact on the economy. The implications of these trends for primary care are particularly significant – the current bias towards hospital based research needs to be adjusted to ensure that the expanding primary care sector is able to sustain and utilise relevant high quality research.

15. Given that by 2020 the world population of elderly people is expected to have trebled, universities would also expect to see an increasing priority given to research in health provision for an ageing population.

16. In general, priorities should follow the requirements of the National Service Frameworks in England and Wales, and their equivalents in Scotland, and should be patient led. However, a rolling programme of priorities should be established and regularly reviewed. This would facilitate alignment with the policies of the four UK health departments but also allow for some important local flexibility. Increased effectiveness of expenditure could be ensured by the monitoring of the efficacy of the outputs which should then become a core feed into rolling review process, and thus determine future priorities. However, whilst universities recognise that the setting of priorities for research under the new merged fund would be necessary and indeed desirable, it would also be important to ensure that there was sufficient funding to support research into other health problems which researchers identify outside these.

17. We would support the inclusion of international health research in the remit of a new merged fund, focusing particularly on public health and communicable diseases in low and middle-income countries. This would involve working closely with the Department for International Development (DfID) to identify priorities for funding in this area.

18. UK's Universities are key players in the delivery of strategic objectives and priorities for health research. Investment in University-based, or associated, research centres, programmes, fellowships and studentships give the best value for money. Research activities are often more efficient and cutting edge, as universities are able to exploit the research expertise and skills of academic researchers and clinicians.

Eligibility for funding from the merged budget

19. Eligibility for funding from the merged budget is an area of concern. Universities are concerned about the potential impact that the merged funding may have on the eligibility of Institutions without medical schools where excellence in nursing and allied health professions,

for instance, is often located. These disciplines are at an earlier stage in their research capacity than medicine but must form part of any future strategy for health research since their contribution to improving patient care is essential.

20. It is also unclear what the position would be of some post-1992 universities that are currently investing substantially in building research infrastructure, and developing a sound research base, but are not as yet recognised by the Research Councils as centres of excellence. If all the funding were to be focused on HEIs that are already in receipt of Research Council Funding, newer institutions may be unable to break through these barriers, thus reducing the opportunity for capacity building. Since one of the key benefits of a university education for health and medical students is the opportunity to develop skills of using evidence to underpin their practice, there could be a potentially serious impact upon the teaching in universities that have restricted access to research funding. In addition, a concentration of funding could result in a greater concentration of research into narrow areas, which could limit the inventiveness of our researchers in the long term.

The impact of the changes upon the devolved administrations

21. The concerns outlined below, based on responses to Universities UK from its members in Scotland and Wales, focus mainly on the risks that such a merged fund would become exclusively oriented to NHS priorities in England, and could be used to prioritise health =-related research in English HEIs.

Scotland

22. The following comments are based on responses from Scottish HEIs to Universities UK. Universities Scotland is also responding separately to this consultation.

23. Scottish HEIs felt that it would be essential to know whether or not there would be a top-sliced amount from the MRC budget to match the Scottish Source of NHS funding.

24. Scottish HEIs considered that the new merged fund could potentially lead to some very divisive and damaging effects for UK biomedicine. They believe the proposals should be treated with immense caution; there were twin dangers that such a merged fund would be used to assist the English NHS, or would prioritise research in English HEIs, especially if, as seems likely, research funds at the disposal of the Scottish Executive Health Department are kept separate.

25. There are four ambitious Medical Schools in Scotland with Glasgow and Edinburgh scoring very high success rates in MRC funding: current award levels are proportionately higher than expected for their size. At the same time the Scottish equivalent of the DH/NHS R & D funding, the Chief Scientist Office (CSO) budget, is very small and seen to be incompatible with its English counterpart. The only way to maintain the excellent input to UK health research by Scottish higher education institutions will be to align the CSO's budget with DoH's with the resulting ring-fenced fund dedicated to clinical research. In its response, Universities Scotland has stressed the comparative benefits of the CSO's grant-giving powers for

Scotland, which should be protected. The MRC's processes should be implemented to award these funds in open competition. Scottish HEIs consider the alternative solution of a devolved Scottish MRC to be inconceivable and feel that its impact would be bad for Scotland and UK alike.

Wales

26. Welsh HEIs emphasised that clinical research in Wales had already been disadvantaged by the disconnection in NHS R&D strategy between Wales and England. This reflects to a large extent the inequalities of funding (NHS R&D funding in Wales represents 0.47% of the NHS Wales Budget. Pro rata the figure for England is 0.9%) and the performance gap will widen as *Best Research for Best Health* is implemented in England, without robust, well-considered and well-funded R&D developments in Wales. Welsh HEIs stressed that developments in the health research strategy should not take place without close engagement with the Welsh Assembly Government and the Wales Office of Research and Development. It is clearly for Welsh Assembly Government to address the lack of sufficient R&D funding in Wales and to develop the appropriate strategy to prevent further disadvantage, but robust links with those developing NHS R&D strategy in England must now be established. However, it would be appropriate for a UK review of health research to note the inadequacy of NHS R&D funding in Wales as a spur to giving the issue a higher profile.

27. It is already the case that MRC and other health related peer reviewed funding to Wales is well below the per capita amount for England. Wales receives only 1.4% of the MRC budget and 1.6% of health related peer reviewed funding from major grant giving bodies compared with per capita expectations of 6% (for example, Cardiff University currently receives > 89% of Wales' MRC funding and 90% of the total peer-reviewed health related spend). It is essential that the introduction of a single fund in the UK does not result in yet further disadvantage for Wales. It seems inconceivable that Wales will become ineligible for funding from the merged fund, but it seems possible that the low level of R&D funding could act to further reduce access to the new merged fund, since it seems likely that there may be some initiatives under the joint fund which would draw on both DH and MRC/DTI streams. The modalities of these funding overlaps will have to be considered carefully to avoid any unintentional bias against researchers working in HEIs in Wales.

28. HEIs and health researchers in Wales have been arguing for a review of the levels of NHS R&D funding in Wales for some time and the prospect of a joint fund makes this pressing. Higher Education Wales has argued that NHS R&D remain a devolved function, and that it should not transformed into a UK-wide function in law as a result of the Cooksey review. Were NHS R&D to become a non-devolved function, the Welsh Assemby Government would lose the Barnett formula consequentials in this area which may lead to a significant reduction in funding for the Wales Office of Research and Development.