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Dear Sir David

Thank you for providing the opportunity to comment on the Government's proposal for the future funding of health research in the UK. The University of Kent has a strong interest in this area, from the study of cancer biology, molecular cytogenetics, thrombosis and infectious disease, to research into health and social services and psychiatric disorders of old age.

I have been speaking to researchers from across the University about the proposals, and a number of common themes have emerged. These include:

- The need for transparency in distributing the new fund;
- The need for the new fund to have a broad appeal. It should not just be for consortia, but for individuals, with a particular focus on nurturing new talent;
- The need to ensure that total funding for 'health research' is not cut when the two funding streams combine. Additionally, any financial gain from administrative efficiencies resulting from this should be used to fund more research;
- The worth of the American model for health research and funding;
- The benefit of having a two-stage application process, so that time is not wasted in preparing proposals that have little chance of success;
- The potential benefit of breaking down the divide between academic and clinical research, and the encouragement of those whose work crosses disciplines, through schemes that fund networks etc.

As well as these generic issues, many of the researchers offered additional comments that arose from their experience of MRC or DoH funding, and from a knowledge of their specific subject area.

From those working on psychiatric disorders of old age

- The MRC currently has too great an emphasis on molecular research rather than public health. In addition it does, perhaps, have too narrow a view of Randomised Controlled Trial design;

- The Government's main priority should be excellence, with some prospect of NHS applicability;
- The impression is that the MRC has been a better 'talent spotter' than NHS R and D. Part of the problem might lie in the false separation of academic funding and funding given to NHS-based researchers (mentioned in the generic comments, above). The recent emphasis on university/NHS collaboration is to be welcomed;
- In terms of the most effective use of health research funding, Full Economic Costing (fEC) is probably less distorting than other means. The prospect of metric based core research funding allocation for universities may result in distortion of the research funding market by effectively subsidising and weakening fEC. Broadening the metrics to include standardised measures of research output (citation indices etc) would go a long way to redressing this possible imbalance;
- With reference to the Connecting for Health NHS IT system, there appears to be relatively little reliance at present on it, but the research networks have already had a big effect. The danger is that the networks will result in exclusion of those not in at the start – which risks jeopardising the fundamental aim of increasing recruitment to clinical trials across the country. The impact of IT networks will probably be delayed till the IT systems function and are fully bedded down, bug-free and above all trusted.

From those working in medical microbiology

- There is a need for more investment in a new generation of academic clinicians. If not we run into the difficulties of losing out on translational research;
- Funding priorities should be infections, cancer and stem cells;
- UK funders need to look to the American model, which is substantially ahead of that in Europe and Britain. The "physician scientist" (MD/PhD) is at the core of scientific innovation and translational research in most leading institutions;
- With this in mind, the new fund should also retain a capacity to fund non-clinical research rather than subsuming it into a generic fund for clinical research. There should be closer liaison with BBSRC to make sure that these aspects are not lost between the cracks and non-clinical research should not be simply bounced to BBSRC.

From those working in cancer biology

- One of the major factors affecting this area of research over the next decade is the increased level of paperwork and approvals required to use human tissue in biomedical research. This is principally evident at the level of ethical approval. To quote the President of the Pathology Society of Britain and Northern Ireland, '*..the impact on tissue based research has been really quite dreadful....There is no doubt that researchers in this country generally, and especially in pathology, feel ground down by the sheer bureaucratic burden of prosecuting research, and wonder if it is worth the candle.*'
Sir Nicholas Wright in "The Waxing and Waning of Academic pathology" 2006.

From those working in molecular cell biology

- There should be no diminution of the role of MRC in funding basic biomedical research. The proposed 'strengthened planning and coordination mechanisms' mentioned in one of the models must not be allowed to skew priorities against basic research. Blakemore himself is very insistent that basic biomedical research remains at the heart of MRC priorities - he quotes recent increases in funding for LMB as evidence of this - but the MRC's mission should continue to include high levels of funding for the best basic biomedical research.

From those working in health service research

- In principle the MRC and DoH programmes could and should be merged; however, this may create a considerable practical problem and it will be important that the best features of each programme are retained. The MRC programme is oriented to high scientific quality and therefore has strong links to scientific community especially in the universities with major medical schools. The Department of Health programme has a strong orientation towards the NHS and has a broader scientific base and a more applied orientation.
- Although the MRC supports high quality medical and health sciences research, it tends to focus on larger programmes of work, especially within biomedical sciences. This means that small, innovative and high risk research tends to get neglected as does research in some health sciences, especially the social sciences and interdisciplinary research. The Department of Health involves a wider range of academic disciplines, but the main emphasis is on clinical trials research to ensure the effectiveness of existing and new technologies. The development of the clinical networks has focussed research effort on a relatively small range of clinical conditions and tended to emphasise research within secondary care. This means that high quality studies using other designs have less chance of being funded.
- Social care tends to get rather neglected; it is difficult to obtain funding through either the MRC or Department of Health sources for social care research and only exceptionally do social care agencies see research as an integral part of their activities. The development of research careers has become increasingly problematic. While there are some MRC and DoH units that have a critical mass of funded research activity and can therefore offer research careers, but these only meet a limited amount of the demand, and it is becoming increasingly difficult to sustain posts which combine clinical and research components. Trusts and PCTs are not willing to fund activities that have a national or even international impact as they are being performance managed to achieve local targets. Traditionally, posts that combined clinical work and research made an important research contribution, especially through getting research findings rapidly accepted into practice. There are opportunities to develop and build on wider networks of support within the higher education system. There are a variety of research centres which could receive infrastructure funding plus awards to provide training and progression from Master levels, through doctoral training and beyond. It is unfortunate that the Department of Health has decided to limit membership of the new National Institute for Health Research to researchers who hold NHS contracts. This will prevent the NIHR from providing a network for a broader integration of health sciences researchers.
- While the strategy of investing in centres of excellence and building critical mass works well, small to medium size units are also often effective. It is therefore important that investment is made into academic units supporting health services research outside the major centres to ensure that there is a rapid and effective response to innovation, and also to stop investment in larger units if they are not capable of adjusting to changing needs and opportunities. Partnerships between higher education, the NHS and social care should also be encouraged, so that skills can be pooled and there can be easy movement of skills and expertise between sectors. Currently expertise and career structures are closely linked to clinical specialism and academic disciplines. The current structure of the RAE reinforces this divisive tendency. This prevents rapid and easy mobility and reduces the incentives for interdisciplinary and collaborative research.

- It is important that the Government continues to fund the range of research and takes into account research funding provided by commercial organisations and charitable foundations. While biomedical research in areas such as the human genome require high investment and tend to generate long term benefit, applied research such as organisational and social science requires less resources and can generate immediate benefits in terms of improved outcomes. It is important that government effectively evaluates the outcomes and benefits of research and uses this information to shape its investment strategies. Currently most research is priorities led. The experiment which SDO and others have conducted in providing opportunities for investigator-led research indicates that such research is effective at identifying new and important areas of research. It is important to recognise that developing research proposals is both time consuming and risky and that more investment should be given to funding pilot studies that can then be used as the basis for more substantial projects.
- While the development of clinical guidelines is having an important impact on getting evidence into practice, there is currently little understanding of the ways in which clinical practice is shaped and develops and the ways in which professional communities process and respond to information. This is clearly an area that merits much more attention.
- Currently research funding is focussed either on project/programme funding or on individual capacity development. Scientific/clinical networks do develop either around the process of developing bids or through traditional conferencing. The ESRC initiatives to fund seminar series and networks provide a model which could be considerably expanded at modest costing.
- As to infrastructure funding, if the new fund adopts Full Economic Costing, it would go some way towards this. This may need to be supplemented with specific infrastructure funding.
- The IT system: IT in the NHS continues to lag behind that in the HE sector. Given that the focus of the NHS IT system is on booking systems and transferring patient records it is likely that it will continue to lag for scientific use.
- The current changes in the NHS are providing far more central direction over funding, e.g. shift from priorities and needs funding to programme funding probably indicates a convergence. There is a danger in this transition that it will disrupt current research activity in the NHS. The current research governance structure in the NHS is a serious impediment to research and needs to be rethought.

Yours faithfully

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