

THE UNIVERSITY OF NOTTINGHAM
Faculty of Medicine and Health Sciences

RESPONSE TO THE COOKSEY REVIEW OF UK HEALTH RESEARCH

Introduction

- We welcome the invitation to submit comments.
- We also welcome the fact that health research in the UK is seen as sufficiently high priority for the Chancellor of the Exchequer to have taken a particular interest in safeguarding the future of the full spectrum of health research.
- We also recognise that Professor Sally Davies, Director of NHS R&D, has achieved a great deal in highlighting the need to protect and enhance NHS R&D. The Government's strategy for NHS R&D, "Best Research for Best Health" recognises the need for peer review, ring-fencing of R&D funding within the NHS, which we particularly welcome, and tighter research management.
- Furthermore, we acknowledge that the Government will wish to safeguard not only fundamental scientific research but also near patient research which can lead in the near future to real benefits for patients within the NHS. This is in keeping with the Association of Medical Research Charities' concern that exercises such as successive RAEs have emphasised outputs rather than outcomes and perhaps have diverted both researchers and funding away from more difficult clinical research, with all its attendant logistical and ethical problems, towards research with more guaranteed outputs.
- We have clear views on how the £1 billion per annum to be jointly held by the Secretaries of State for Health and Trade and Industry should be managed to best achieve these goals.
- We do not believe these goals will be best served by parallel structures or separation of basic or clinical research. We are concerned that "Best Research for Best Health" hints at moves in these directions.

History

- The Medical Research Council has a very strong record (OSI report on Research Councils, key performance indicators assessing MRC performance) of:
 1. successful science underpinning health research (the discovery of penicillin, DNA, the mapping of the human genome, DNA fingerprinting are examples);
 2. successful applied science with direct clinical impact (the link between smoking and cancer, the sequential trials of chemotherapy for leukaemia which have dramatically improved childhood survival, magnetic resonance imaging);
 3. spending the majority of its budget on research and researchers rather than administration;
 4. an excellent track record of peer review and research governance.
- There have been concerns that the percentage of funding devoted to intramural funding has perhaps been excessive and that these intramural staff do not compete in the same way as other researchers for external funding.
- There has also been concern that the Medical Research Council's peer review process itself favours hard laboratory science with guaranteed time

lines and easily measured outputs, in comparison to clinical research which is much more likely to be unpredictable in terms of recruitment, has ethical and logistical difficulties, has to be conducted in partnership with other stakeholders, and often relies on proxy outcome measures. In the last decade, many of these concerns have been addressed: the MRC now has Boards for Clinical Trials and for Public Health and Epidemiology in addition to the Physiological Sciences and Clinical Studies Board and, more recently, an Experimental Medicine initiative. Furthermore, the move of the Mill Hill facility to a site adjacent to a university with both basic sciences and university and NHS clinical research facilities is also to be welcomed.

- The Medical Research Council has also, more latterly, returned to an emphasis on response funding with funding of specific research projects and programmes, including robust estimates of both direct and indirect costings. The outputs from the funding of MRC projects and programme grants are tangible and can easily be linked to the funding which led to the discoveries.
- In contrast, the funding for NHS R&D has been embedded, structural, historical, with a relative lack of peer review, and a lack of demonstrable outputs or outcomes. The indirect costs are often uncertain and much of NHS R&D funding, despite the attempts of Culyer onwards, has been difficult to identify and has often been diverted into subsidising clinical service.
- Sadly, much of NHS R&D funding has been squandered on small, underpowered studies conducted by enthusiastic individuals working in isolation and without adequate infrastructure or scientific backing to lead to real breakthroughs for patients.
- There are exceptions. The Health Technology Assessment initiative is a good example of an NHS R&D programme that has had strong leadership, adequate scoping, a competitive bidding process and has generally funded studies which are well designed, well supported and have a realistic chance of answering important questions.
- Furthermore, where NHS R&D has been successful, this has mostly been in conjunction with leadership from university academics, although again there are exceptions (the Charnley hip and assisted reproduction are frequently cited examples).

The Future

We believe that the Chancellor's initiative can increase the quality and quantity of research for the benefit of patients but only if the following are adhered to:

- The £700 million of NHS R&D funding really does need to be pulled out of the recurrent funding of NHS Trusts. It must be available for competitive, peer reviewed bidding and not protected for only NHS employed or NHS funded principal investigators. We are concerned about how this can be achieved without destabilising major Trusts who have benefited from embedded funding in the past.
- We are also concerned about how much of this £700 million is already committed by new initiatives such as the UK CRC. Whilst we support the creation of the UK CRC and research networks in priority areas such as stroke, diabetes, Alzheimer's and medicines for children, a raft of further initiatives such as this would perpetuate more embedded structural funding and very little of the £700 million may be available for a competitive peer review process. Highlighting priority areas also results in lack of funding for other, often equally important, areas (for example there is no current funding stream from DH for respiratory or gastro-intestinal research despite major importance to NHS).

- We need to preserve the successes and principles of MRC peer review and research governance which have served us well.
- Concerns that a single organisation would divert money away from clinical research to basic science or vice versa could be addressed by ring-fencing a fixed percentage of the total £1 billion for basic research, for translational research and for clinical research, subject to periodic review.
- The Haldane Principle is important. Nevertheless, we recognise that whilst there should not be ministerial interference in day-to-day decision making or in the peer review process, decisions regarding the funding of science and health research have always reflected the political priorities of benefiting the public, both in this country and elsewhere, in terms of economic wealth, health and the environment.

Mechanisms of Administering the £1 Billion Per Annum

- There should be no split between basic science and clinical research, ie there should not be a move to have parallel structures in place. We would prefer a single organisation which encompassed the full spectrum of health research.
- We would strongly advise against the single new organisation being wholly based within the Department of Health. The Department of Health has a major role in running the NHS, one of the largest health systems in the world, and in planning and training the workforce required to deliver the NHS targets long term. It should not be burdened with a new body given it has very little track record in overseeing the whole spectrum of health research, compared with the research councils for example.
- The mechanism for administering the research budget must have the support and confidence of the clinical academic community. There must be robust peer review in place (rather than the use of debatable metrics such as those used to short list for the specialist medical centres recently). The current methods in use by the MRC and other RCUK/AMRC funders have the support and confidence of the research community and should be the model for the allocation of a unified research budget.
- Whilst we agree that research funding should support excellence and funding should be targeted to the best institutions and the strongest research groups, we are concerned at plans flowing from "Best Research for Best Health" for a small number of academic medical centres. This has the potential to drive the majority of universities with Faculties of Medicine and Health Sciences towards a teaching-only role. This is particularly likely because of the insistence that each bid to be an academic medical centre must be from an NHS Trust and must be from only a single NHS Trust and not from a consortium of Trusts and universities. For example, the East Midlands M1/M69 corridor has a population the same as that of Scotland but it is spread across at least six acute Trusts, three mental health Trusts and over 20 Primary Care Trusts. No one of these Trusts can make a bid which reflects the areas of very excellent research within some of the NHS Trusts and universities along the East Midlands M1/M69 corridor. A further concern is that many Universities and NHS Trusts which will not be supported through the academic medical centre initiative have very strong groups working in specific areas: any move to reduce the ability of these groups to receive support in open competition will have a major detrimental impact upon the UK research output.
- The review's remit covers health research funded by BBSRC, EPSRC and ESRC, as well as MRC. EPSRC and BBSRC spend large amounts of money on basic and applied science of direct relevance to health. Is there an expectation that this will be brought under the umbrella of a single body? If so, the £1 billion is woefully inadequate but, more importantly, the

breadth of work this single body will need to cover will be very substantial and potentially unmanageable.

Conclusion

This new initiative can increase the quality and quantity of research for the benefit of patients provided:

- Funding is ring-fenced
- Funding is administered by a single organisation
- There is no split between basic science and clinical research
- The track record of research councils is the model for the new single organisation

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