

Response to the Cooksey review

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The potential to form a unified fund for health research, analogous to the NIH in the US, is a major opportunity for the UK, but one which also carries potential risks that must be managed. My responses to your questions below:

1. I am going to concentrate on strengths and weaknesses rather than the 'anatomy' of the current system.

Strengths: The MRC has a world-renowned reputation for funding good science, and for making the most of its budget in impact terms. MRC funding is highly competitive, perhaps too much so, in view of the potential opportunity costs. In an ideal world, NHS R&D funding enables research groups to conduct pilot work leading to MRC applications, and funds both programmes of applied research and essential clinical research infrastructure.

Weaknesses: The MRC is too competitive, and has too little funding for the research base of the UK, too much time and talent is wasted in fruitless applications, and there is a danger that the boards become too cautious. Research is a 'risky business' and not every project will succeed. The NHS allocates its funds by obtuse and anti-competitive principles, most funding does not go to research but to prop up patient care and NHS R&D, like the service, is subject to short term political imperatives.

2. The key challenges are:

- Utilising IT to link the genome and the community. ¹
- Utilising IT and networks to achieve greater economy, hence greater output in clinical research.
- Balancing the roles of public and private interests. ²
- Ensuring that the MRC maintains its independence.
- Ensuring that NHS funds for research are used for research without destabilising the service in the transition.

3. The priorities for health research should be quite simply to ensure that the following principles are met:

- Breadth from 'blue sky' basic research to applied clinical research and translational research. Basic research is needed, but without applied and translational research it is fruitless.
- Prioritising areas that are of public interest but neglected by industry, e.g. non-pharmacological interventions, new uses for off-patent medicines, filling in the gaps left by industry trials. For example, in the Cochrane review of oesophagitis treatment there are no RCTs of 'maintenance' doses of PPIs for 'healing'.³ This is a common clinical practice, and one that would have cost-savings for the NHS, but which has not been studied by industry.

4. The MRC should set and be accountable for priority setting.

5. I will give you an example of a subject I know well. In 2005 Barry Marshall received the Nobel Prize in medicine for his 1982 identification of *Helicobacter pylori* as the major cause of peptic ulcer disease. In the years 1994-2001, the NHS R&D programme and then the MRC funded a series of pragmatic primary care-based RCTs seeking to identify how best to translate the growing body of evidence on *H.pylori* into evidence-based strategies for primary care. These are now best summarised by a Cochrane review,⁴ and have now found their way into NICE, European and US guidelines. The UK- funded studies have had a major impact on practice worldwide. Of note, the Cochrane Upper GI and Pancreatic Disease Review Group is also funded by NHS R&D.

6. The 'Best Research for Best Health' strategy of NHS R&D encourages the development of both centres of excellence and disease-focussed networks. However, it is important that Primary Care and Public health research is not neglected in these networks. Strong academic links with universities are the best way of linking with scientists.

7. No comments

8, 9 and 10. I have brought these together as I think the UK should look closely at the National Institutes of Health as a model for funding. The NIH with its 26 institutes responsible for both disease-focussed programmes and cross-cutting programmes such as the National Center for Research Resources (NCRR) has some similarities with a merged NHS R&D – MRC model that would go some way to addressing the failures of the current UK system, particularly the failure to ensure centrally that MRC-funded research is adequately supported via support for science funds. The central institute director and his support are responsible for ensuring balance across the fund. I would recommend bringing NHS R&D funds within the remit of a broader MRC and setting up a separate 'Research Infrastructure Board' with a dedicated budget to ensure that NHS R&D funds were appropriately used. Some funds would go into specific programmes of investigator-led research in the priority disease areas and to be supported by the infrastructure networks.

As an NIH 'Roadmap' grant holder, I attended a recent meeting in Washington, 'Inventory and Evaluation of Clinical Research Networks' (IECRN), to show a demonstration of 'proof of concept' for our (University of Birmingham/University of Minnesota) NIH Roadmap-funded e-Trials system for Primary Care (ePCRN). This project was funded via the NCRR. The IECRN meeting materials and presentation webcasts are available online:

<http://www.clinicalresearchnetworks.org/forum.asp>

11. In the future strong links between CfH and research are essential. Work has already started on a form to support the Secondary Uses Service under the leadership of Sir Muir Gray, and this work should be highlighted as a potential 'win' for CfH. In addition, the input of Computer Science and Engineering departments of universities, via their involvement in collaborative projects such as ePCRN would do much to balance the commercial interests in CfH. The MRC and NIH funded e-Science and Roadmap/NECTAR projects are working together at several levels, especially in the

clinical trials and cancer arena. There is much potential for international collaboration in this area, that will in time deliver considerable economies of scale and efficient links between electronic health records, practitioners and researchers.

See:

<https://cabig.nci.nih.gov/>

https://vishnu.cceb.upenn.edu/portal/page?_pageid=36,63082,36_63137&_dad=portal&_schema=PORTAL

<http://www.epcrn.org/index.php>

<http://www.cancergrid.org/>

<http://labserv.nesc.gla.ac.uk/projects/votes/index.html>

<http://www.psygrid.org/>

12. NHS R&D should not be devolved. There is a confusion of aims between the necessary local implementation of Research Management and Governance, which carries statutory responsibilities for the Chief Execs of NHS bodies, and the conduct of research in the NHS. Only the former needs to remain locally accountable, but efficiently managed. Local research infrastructure is also essential, but should be performance managed and funded from the centre via the Research Infrastructure Board. There really is no other reason why any NHS body should have a call on research funds 'as of right', and the BRFBH implementation plan echoes this in the long term.

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1. Peterson K, Practice-based primary care research--translating research into practice through advanced technology. *Fam Pract.* 2006 Apr;23(2):149-50
 2. Delaney BC, Commentary: Is society losing control of the medical research agenda? *BMJ* 2006;332:1061-4.
 3. Mason JM, Delaney B, Moayyedi P, Thomas M, Walt R; North of England Dyspepsia Guideline Development Group. Managing dyspepsia without alarm signs in primary care: new national guidance for England and Wales. *Aliment Pharmacol Ther.* 2005 May 1;21(9):1135-43.
 4. Delaney B, Ford AC, Forman D, Moayyedi P, Qume M. Initial management strategies for dyspepsia. *Cochrane Database Syst Rev.* 2005 Oct 19;(4):CD001961.