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NHS Lothian response to Department of Health R&D Changes and the Cooksey review

The remit of the Cooksey Review is to advise on best arrangements for public funding of health research, taking account of health objectives, science objectives and economic objectives.

NHS Lothian welcomes the opportunity to respond to the consultation offered by this timely Review. The Board appreciated the opportunity in conjunction with the University of Edinburgh to present the Scottish perspective to Paul Devenish of HM Treasury, courtesy of SEHD Chief Scientist Office on 20th June 2006.

The Board's position can be summarised in the following principles:

- there is a need for research funds to be properly 'ring-fenced' wherever it is disbursed from and demonstrably spent only on research .
- infrastructure support remains essential and should be separated from activity based grant funding. While infrastructure cannot be linked to specific projects it can change culture, modify working practices and provide facilities which themselves generate new programmes of research activity (see Q1 below)
- there is a crucial need to retain and build on links between basic, clinical and translational research within multidisciplinary groups and with encouragement for discipline hopping
- there is a need for local academic and clinical researchers to work together, to understand their different perspectives and to deliver good research outcomes through collaborative working. So too with the MRC and NHS R&D.
- to maintain the UK science base, the breadth of the basic research portfolio must be retained and not become swamped by fashionable areas such as translational medicine, randomised clinical trials.
- Linking the MRC and Department of Health R&D funding has significant implications for the Devolved Administrations which need to be fully addressed (see Q10 &12)

Specific responses to several of questions posed:

Question 1 The Culyer report in 1994 offered the opportunity to support high quality research within the NHS but was not implemented fairly or fully. The positives associated with the current infrastructure support for R&D, at least in Scotland, include

an evolving change in culture over the last decade and inclusion of all professional groups in the research process. Operating at its best NHS R&D support can already ensure that 'health research is rooted in, and a key priority for, the NHS'. Scotland does not require the large scale redistribution out of London for infrastructure support which is seen as essential for the NHS in England. There are a good number of high quality collaborative research ventures which would have floundered without such support e.g. the Wellcome Trust Millennium competition to create and run 5 clinical research facilities nationwide. Edinburgh was successful in this bid, mainly due to intensive and effective collaboration between the University of Edinburgh and three associated NHS Trusts. Close collaboration continues leading to highly successful and expanded facilities with the model being utilised elsewhere. This is probably the single most successful aspect of dedicated, ring-fenced R&D infrastructure support to the NHS in Lothian. Other positives include greater accountability and consistency in reporting on outcomes.

On the negative side, these funds have remained largely 'embedded' in clinical costs, are not seen as 'real money' and the process is over-bureaucratic compared with other aspects of health care. There have been few real incentives for undertaking high quality research within the NHS and indeed, highly productive NHS based staff remain disadvantaged in seeking grant funding through Research Councils compared with their academic colleagues. Commissioned research programmes are of variable quality and poorer quality work has been supported both as intrinsic research and activity associated with postgraduate degrees and training programmes.

The MRC is envied by many countries and has supported many research projects and programmes of the highest quality while promoting links between basic science and clinical research. Its processes of peer review and academic rigour usually ensure funds go to centres of excellence. Major aims of the MRC are to foster innovative fundamental medical research and to strengthen areas of applied clinical research. The need for close working between the academic base from which most researchers come and their associated NHS organisations is mirrored by the need for closer links between the MRC and experts in the NHS and Departments of Health. Nevertheless, the MRC must be allowed to retain its 'arms length' approach.

Question 2. The biggest challenge facing health research is the need for effective co-operation across agencies, particularly the NHS and Universities. Changes would be required to the RAE to ensure maximum return from clinically based research, which may not be published in such high impact journals but have more significant outcomes from a health perspective. The establishment of research networks has provided an impetus for such co-operation in certain areas but needs to expand, include more disease areas, link more effectively to managed clinical networks and bring in external agencies, such as social and community care. The balance between healthy competition and effective co-ordination is difficult but essential. The introduction of full economic costing has made the gulf in cost recovery between NHS and Universities greater. The funding mechanisms for undertaking patient associated research are complex, even to research managers let alone researchers and need to be streamlined.

Question 3. Priorities for health research must allow for the complete spectrum of activity from blue skies research to applied health services research. Research career structures could be improved and should reflect the greater number of professional groups who are graduate based and whose tertiary education exposes them to research initiatives. More could be done to ensure parity of opportunity and reward for good researchers in academia to link to the clinical environment and good clinical researchers to benefit from academic kudos. Examples include the poor remuneration for highly skilled nurses who wish to pursue academic research and the highly trained post doctoral scientists who opt to come into NHS service and who have few opportunities to turn their research training into clinical developments. More non-medical funding opportunities within career settings would promote higher quality research in certain areas.

Question 7. The greatest encouragement which could be given to translation and innovation in health research would be a guarantee that funding was ring-fenced for research and freed from interference by NHS service pressures. The challenge within this would be to keep the associated bureaucracy to a minimum, allowing freedom of use within a research portfolio in return for specified milestones and outcomes over a reasonable length of time such as 5 years.

Question 8. Infrastructure funding should be directed towards the provision of core facilities and staff to an agreed level commensurate with the scale of research activity within a particular region, leaving project funding for support of specific activities. Adequate resource should be allowed for governance and monitoring of research quality. Forward planning and defined deliverables should be agreed at the outset.

Question 10. As covered in sections above, links between MRC and Departments of Health should be strengthened but it would be detrimental both to the overall standard of basic research and delivery of relevant applied research if the two were merged. There is considerable concern from Scotland that any such merger would seriously disadvantage the centres of excellence here.

Question 11. Clinical research networks provide new ways of expanding clinical research. Successes are already emerging, but it is important not to see the networks simply as vehicles for delivering higher recruitment to clinical trials. Rather they should be seen as opportunities for innovation and integration across the full spectrum of basic to translational research. To realise their full potential, robust IT systems which exploit the strengths of the NHS in relation to patient data are essential. For example, it should be possible to flag all aspects of research activity within electronic patient records. However dialogue between the needs of service delivery and clinical research is often lacking. Connectivity with University platforms where expertise in informatics, bioinformatics and e-health abounds could offer exciting opportunities for sharing of research data, extend potential research directions and allow new links to be forged across disciplines.

Question 12. See Q10 above. It is difficult to see how the functions of NHS R&D and MRC can be merged if we are to maximise health and economic benefits to the UK as a

whole. Nevertheless greater linkage would be helpful with a simple model of infrastructure support to the NHS from NHS R&D and project/programme funding from MRC in collaboration with local University partners being preferred.