

Review of UK Health Research:
Response from the NIHR Central Commissioning Facility

This response has been prepared by Emily Gardner, Ph. D. of LGC Ltd, in her capacity of Director, National Institute for Health Research (NIHR) Central Commissioning Facility and Senior Manager for the Department of Health National Programmes for Genetics Research and New and Emerging Applications of Technology (NEAT).

Background: Since August 2001, LGC Ltd has been contracted by the Department of Health to provide research programme management. The External Programme Management Group (EPMG) at LGC has won contracts through OJEC to manage the NEAT programme (June 2001), the Genetics Research programme (December 2003) and the Central Commissioning Facility (CCF) for the NIHR.

R&D funding in the Department of Health is undergoing major change. The old system of research support via “Support for Science” and “Priorities and Needs” funds will be phased out, and new funding streams are opening. Clinical research networks have been created to provide support for clinical research and to facilitate the conduct of randomised prospective trials and other studies, with a major role in developing world class infrastructure to support clinical research in the UK. The Department of Health is also a key sponsor of the UK Clinical Research Collaboration (UKCRC). All of these initiatives are in their infancy. The first clinical research network (UK Cancer Research Network) was created in 2001, whilst the UKCRC was established as recently as 2004. The new strategy for DH R&D in England “Best Research for Best Health” is itself little more than six months old.

The new research strategy is a bold step towards addressing many of the perceived issues regarding R&D funding allocation for clinical researchers, by making it competitive and transparent. In the creation of the NIHR and its faculty, the Department of Health will recognise and reward the achievements of the country’s finest clinical researchers, in establishing the Biomedical Research and Safety Centres, the Department will provide stability and continuity of funding for centres of clinical research excellence. The CCF that will underpin the work of the NIHR has been created to provide a single entry point for applicants for the majority of DH funding, with a remit to provide efficient, streamlined, non-bureaucratic application and management processes. Central to this function, is the development and construction of a bespoke website and database, similar to one that is currently in operation for the DTI funded Technology Programme.

The implementation of the research strategy, including the establishment of the CCF has an extremely ambitious timetable. Despite this, the work remains on track and on time. Selection of the Biomedical Research Centres is underway, as is the first call for Programme Grants for Applied Research, whilst the Research for Patient Benefit Programme launches at the end of July. However, none of these programmes will have commissioned any research in the timescale of this consultation. The success of DH R&D funding schemes must therefore be drawn from the existing national programmes. Prior to January 2006, the major funding streams for DH R&D comprised the Health Technology Assessment Programme (HTA), the Service Delivery and Organisation Programme (SDO) and the NEAT programme (qv).

Together, these programmes represent c. £22 million funding (not accounting for increases specified in the Strategy), a figure which is a fraction of the total budget of DH R&D. Notwithstanding this, the programmes have each made a significant contribution to UK applied clinical research. The aims of the SDO programme are at the heart of the health service, in the distinctly unglamorous area of providing an evidence base for improving the organisation and delivery of health services and thus the programme contributes to the quality of patient care and improved public health. The HTA programme is designed to answer the key questions of commissioners of healthcare, providers and users of services, assessing the efficacy and cost-effectiveness of treatments. The programme is internationally renowned for its contribution to the evidence base for decisions on treatment provision. The NEAT programme was created to fill a perceived funding gap for translational research which was no longer considered fundamental (and therefore out of scope for Research Councils), but was nonetheless too early to attract commercial interest. The programme was recommended for increased funding in the Healthcare Industries Taskforce report 'Better healthcare through partnership: A programme for action', published in November 2004.

Previously, the three National Programmes described above may have been viewed as a disparate set, being managed by different contractors. The NEAT programme was underfunded with an insufficient probability of funding for applicants. Now, under the auspices of the NIHR, they are more obviously part of a DH funding continuum, which will support applied research at almost any stage. This is particularly true for the NEAT programme, which will form part of a new programme "Invention for Innovation", with a budget of c. £10 million, and will incorporate collaborative funding with industry to promote technology transfer.

"Best research for best health" is a bold and courageous strategy. It addresses many of the issues that have previously existed in DH R&D funding. The research funding streams of the NIHR are being managed by organisations with many years experience of research management. The EPMG at LGC, which is setting up the CCF has been running Government research programmes since 1991. The EPMG management team has an absolute commitment to continuous improvement and excellence in customer service, whilst providing excellent value for money. The team developed close links with the NHS over the past five years and has a good understanding of the NHS and its research needs. We have successfully commissioned over 60 projects in such diverse areas as implants, diagnostics, imaging and bioinformatics across a wide range of diseases. Throughout we have used stringent selection criteria, engaging expert peer review, encompassing a range of stakeholders (typically academic experts, clinical experts, service users and providers) with final recommendation from an expert panel. We recognise the need for technology pull into the health service, with the involvement of service users and providers being paramount at all stages of research commissioning, and this is reflected in the selection of our peer reviewers and commissioning panel members. We do not believe that the management of DH R&D funding should be changed, as the existing providers have all been selected by a rigorous, competitive process, ensuring appropriate expertise and cost effectiveness. Therefore, for all the reasons given in the preceding paragraphs, we believe the single fund for health research should be managed by both DH and the MRC and the point at which they have appropriate expertise, as is currently divided.

Clinical research funding faces many challenges. There is the obvious balance between investment in R&D and sustaining patient care and other services. In any decision, it is vital that a long term view is taken, given that investment in research is unlikely to provide short term benefits. It is important to ensure that precious funding resources are not squandered by funding research projects of a similar nature. Equally it is important that there is a clear path for funding an idea from initial concept through to implementation. It is helpful to have distinct pots of 'money' available for work at different stages of development however I am not able to assign a monetary value to these. I do believe that there should be some flexibility in funding, with contingency available for urgent priorities, such as emerging infections and other public health emergencies. The balance of funding would need to be decided with consideration of many things and may be facilitated by information such as the recent review of UK health research funding carried out by UKCRC.

From my current involvement in DH programme management, it is obvious that excellent links already exist in many instances between academic, clinical and commercial researchers. It is possible that there stronger links could be made with allied health professionals and commissioning managers to ensure that developments have the greatest chance of uptake in the NHS. Interdisciplinary links are also evident, particularly in the NEAT programme, where technology from other sectors maybe applied for the first time in clinical research. Joint funding programmes, such as the DTI Technology Programme and the Health Technology Devices programme will facilitate this. We have always included representatives from stakeholder Research Councils on our Programme Advisory Committees, where they bring valuable insight into fundamental research and some opportunities for joint funding of research (although these have been limited).

The Government actively encourages translation, entrepreneurship and innovation in health research through its research funding activities, in particular via DTI and DH funding schemes. It is important that this creative drive is not suppressed by over regulation and bureaucratic processes, and that routes to gaining regulatory approval are clearly stated and that support is given at each stage. It is also important that a career in research is an attractive proposition for young scientists, and that reward and recognition are competitive with other sectors. Current schemes, such as the Research Capacity Development Programme, the MRC Clinical Training Fellowships and the work on infrastructure and training through the UKCRC are integral parts of this.

In summary, this is an exciting and challenging time for all those involved in clinical research, and we are grateful to be consulted on the future of the single research fund.