

## **Response to Cooksey Review**

*Prepared by Professor David Foxcroft on behalf of the School of Health and Social Care, Oxford Brookes University, July 2006.*

We welcome the proposal in the Cooksey Review to combine health research funding into a single stream. This will enable a more coherent strategic plan and should also achieve some economies of scale. Importantly, the proposal also provides an opportunity to consider how to “fix” particular problems that are apparent in the existing health research funding mechanisms. The points below follow the questions posed in the invitation to submit comments.

1. The MRC has historically focused on biomedical and medical research, to the exclusion of other relevant professions and disciplines. It has a strong international reputation for high quality research. The NHS R&D Programme is more inclusive but also has a more patchy reputation, apart from clear successes like the HTA Programme. Most of the NHS R&D budget has remained in NHS Trusts, and the use of this part of the budget has not been clear or successful. The best research is led by Universities, including the post-1992 sector, and it is Universities that should be the focus for the better strategic use of the NHS R&D budget once incorporated into a combined fund. This essentially moves the NHS R&D “spend” toward the MRC model, so the challenge for the new strategy is to broaden the scope of the MRC whilst not weakening its reputation. We suggest that the MRC should be reconstituted to include stakeholder representation from the range of health professions outside the sphere of medicine. This offers the benefit of building on existing expertise and a reputation for high quality, peer reviewed research. As well as funding basic biomedical research, a re-constituted MRC should continue to fund clinical trials, applied and public health research and extend its fellowship schemes to train clinical academics from a wider range of health professions, operating on a quota system. This is essential in order to develop interdisciplinary collaboration between health researchers and also draw on expertise from other disciplines such as engineers, physicists, nursing and social scientists.

2. Eligibility for funding from the merged budget is an area of concern. Specifically, what will be the impact that the merged funding may have on the eligibility of Institutions without medical schools where excellence in nursing and allied health professions, for instance, is often located? There is an urgent need to build research capacity in nursing and allied health professions and in the social sciences that underpin vital health research. These disciplines are at an earlier stage in their research capacity than medicine but must form part of any future strategy for health research since their contribution to improving patient care is essential.

Further, It is also unclear what the position will be of some post-1992 universities that are currently investing substantially in building research infrastructure, and developing a sound research base, but are not as yet recognised by the Research Councils as centres of excellence. If all the funding were to be focused on HEIs that are already in receipt of Research Council Funding, newer institutions may be unable to break through these barriers, thus reducing the opportunity for capacity building. Since one of the key benefits of a university education for health and medical students is the opportunity to develop skills of using evidence to underpin their practice, there could be a potentially serious impact upon the teaching in universities that have restricted access to research funding. In addition, less widespread funding could result in a greater concentration of research into narrow areas, which could limit the inventiveness of our researchers in the long term. This is one of the major limitations of the “Best

Research for Best Health” proposal to concentrate funding in a small number of centres on the basis of selectivity. But selectivity already operates through the peer review system and it is this peer review system that should be improved to ensure complete objectivity and inclusivity in research selectivity, rather than the favouring of certain institutions which just compounds the existing MRC “old boy network” tendency.

3. A key priority should be to ensure that funding is distributed according to national strategic imperatives. Prioritising the major killer diseases is understandable; however, the social and economic impact of conditions that may not kill but cause long term morbidity must be recognised and funding for research in these areas should be enhanced. Hence, research that goes beyond traditional biomedical boundaries to consider health, social and economic characteristics and consequences of such conditions and behaviours is important. We would welcome further provision for research into alcohol problems, estimated to cost £20 billion per annum in a recent Government report. Accordingly, the National Prevention Research Initiative (NPRI) should continue to be supported and ideally strengthened under the new merged budget. The NPRI is currently co-ordinated by the MRC but receives funding from a number of different agencies; in a developed model the NPRI should enlist the support of the alcohol industry and the Alcohol Education and Research Council (AERC).

4. Funding for basic science, translational and applied research should all be supported in the new merged budget, with the funding from the NHS R&D “spend” used primarily to support projects and programmes in the applied and to a lesser extent translational research areas. Many possibly ineffective health care technologies (interventions) are extant, and this includes many care and therapy interventions where the effectiveness of nursing and therapist care is unknown. Future research funding should be balanced between extant, costly interventions and basic and translational research that produces the interventions of the future. Cost effectiveness modelling should be used to clarify the potential returns on translational and applied research and therefore inform decision making. Similarly, the merits of qualitative research should be fully appreciated in the new mechanism.

5. One major influence on evidence adoption has been NICE through its technology appraisals procedures. More recently NICE has broadened its remit to include public health guidance through the incorporation of the HDA. However, the evidence standards that are applied to the NICE public health guidance do not meet the high standard set by the NICE technology appraisals process. The issued public health guidance is therefore somewhat less robust and credible, and this problem should be addressed. A second major influence is the Cochrane Collaboration, who provide high quality systematic reviews for health care decision makers. These reviews are increasingly influential and core and project grant support for UK Cochrane entities, and for reviewers attached to overseas Cochrane entities, should be provided through the new infrastructure, including resources for updating Cochrane reviews.

6. This is currently a shortage of funding for programmes of research to take an idea from pre-clinical through Systematic Review, Phase I, II, III and IV activities. This is how pharmaceutical companies fund the development and testing of particular compounds so it is somewhat remiss of the MRC not to have a clear funding pathway for programmes of research. Importantly, this programmatic funding should not only be available for biomedical projects but also for care and therapy interventions where the development, translational and applied phases of research are equally applicable.

The new structure should also stimulate multi-disciplinary collaboration through the peer review process, and not especially through so-called “multidisciplinary” funding schemes as have been the case in the past. Multi-disciplinary peer review will stimulate such collaborations because all funding applications will be examined from a range of perspectives. It is suggested that this revised peer review process should include perspectives from nurses, allied health professionals, medics, medical statisticians and health economists as a minimum. Engineers, computer scientists and other specialist can also be called on to provide peer review as appropriate.

7. A major obstacle to entrepreneurship and innovation is bureaucracy. Both Government and Institutional managers are risk averse, especially in the current economic climate within public services, and the hoops that researchers and knowledge transfer workers have to jump through before an idea is taken forward can be prohibitive. The solution is to encourage institutions to be less risk averse so that ideas can get off the ground, but once they are up and running to routinely monitor progress and, if necessary, to “pull the plug” on those projects that are not delivering as expected. The RAE also has a detrimental effect on translation and entrepreneurship because our researchers are focused on getting out peer reviewed papers in top journals and winning research council grants, rather than taking forward knowledge transfer activities that might fail. Institutions compound this because they are very concerned about RAE success.

Government should encourage Universities to become more involved in their local and regional community, working alongside Regional Development Agencies. In the United States medium- to long-term funding is provided for “University Extensions” that take a lead on knowledge transfer activities within local and regional communities, importantly for both technological and social developments. For example, Iowa State University receive funding for a University Extension to support and develop effective parenting. This is an interesting model which provides a clear link between the intellectual capital available in Universities and technological and social progress outside Universities.

8. The single merged fund provides a clear strategic advantage when planning infrastructure for basic, translational and applied research. It allows for coherence, which the previous system did (does) not. This infrastructure should include significant investment for education and training of researchers from different disciplines in a range of methodologies so that they understand the requirements of the different research phases.

The work of the HTA programme should continue to be supported and the methods and standards used in the NICE technology appraisal process should be applied similarly in the new public health function that NICE is charged with taking forward. Investment in research infrastructure and the development of expertise in all Universities is central to the question of collaboration with industry: industry will seek out and seek to use the best researchers with the highest credibility to support their activities. UK plc will only develop this expertise through appropriate investment. To this end, Government should take the “bigger picture” perspective on the contribution that Universities make to the UK economy through their research and innovation activities. Further, Universities are well placed to lead on social and technological developments if knowledge transfer activities are supported. Recognising and supporting the potential that Universities have to utilise their intellectual capital for the general improvement of social and business activity would be an important step.

9. The development of a ring-fenced budget for nursing R&D in the US NIH, in the form of the National Institute for Nursing Research (NINR), is a compelling model that should allow the development of capability and capacity amongst nurse researchers. In the U.K. any such development should be time limited, perhaps at twenty years, to give sufficient encouragement and protection to this developing research field. Recent developments in health research funding in Canada should also be reviewed to see if there are any general lessons that can be adopted for the UK. The Canadian Institutes of Health Research (CIHR) are spread geographically across the country, illustrating the value that the Canadian government places on geographic diversity as well as disciplinary and methodological diversity. This model could be used in the UK NIHR with institutes having bases in the four countries of the UK.

10. The MRC should be restructured to incorporate the NHS R&D budget, perhaps with a new title to recognise this major development. The most important challenge is to ensure that any transition to the new structure should not destabilise NHS Trusts that rely on NHS R&D funding to prop up clinical services. If replacement funding is not available to cover this clinical activity in the short-term then a phased transition over three years would be appropriate, with joint Directors of the new budget for the first and second years. The single, ring-fenced fund should be dually accountable during this transition period to the Secretaries of State for Health and for Trade and Industry. This should be reviewed after two years after which time a single accountability should be established, if possible.

11. The new NHS IT system provides a great opportunity to improve researcher's access to patient information. This will certainly help Clinical Research Networks to function effectively by boosting recruitment into clinical trials, but it will also provide a welcome resource for non-trials based research, for example work undertaken by epidemiologists and patient outcomes researchers. Therefore the new health research structure should work closely with the NHS IT system strategic development to ensure that opportunities for research are maximised and realised. A further possibility, though suggested more tentatively, is the potential to use the NHS IT system to provide diagnosis-relevant information on latest research evidence and clinical guidance. This would require a coherence between the NHS IT system and other structures, for example NICE and the National Knowledge Service.

12. During the transitional phase there should be two streams of funding within the new merged budget. One would provide core funding to regions and devolved administrations, to primarily support translational and applied research and knowledge transfer activity. The second should be UK wide (i.e. not devolved) and should provide infrastructure and grant funding as per the Research Councils current remit and activity. This would provide the least disruptive process in the establishment of a merged fund but it should be reviewed after three years with a view to establishing which model would be preferable in the prevailing political climate.