Best research for best health: a new national health research strategy

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Clin Med 2006;6:435–7

On 25 January 2006, Health Minister Jane Kennedy announced a new health research strategy aiming to give patients better access to new medicines and treatments, and to support those carrying out health and social care research throughout England.[1] Identified within the document as drivers for this strategy are:

- the need to support the Government's ambitions to improve the nation's health and increase national wealth
- the requirement to place people at the centre of a research system characterised by quality, transparency and value for money
- the need to respond to changes in society, the environment and challenges to the current system used to support applied health research.

In summary, the aim is to create a health research system in which the NHS supports outstanding individuals working in world-class facilities, conducting leading-edge research focussed on the needs of patients and the public.

What specific goals are outlined within the document? The first is to establish the NHS as an internationally recognised centre of research excellence. Consequently, a National Institute for Health Research (NIHR) will be developed in England designed to provide the NHS with relevant support. The idea seems to be that the NIHR will coordinate the efforts of networks, NHS trusts and universities with those of its own activities which will include support for, and (inevitably) monitoring of, NIHR faculty; NIHR programmes (research projects, research programmes, research units, research centres); NIHR systems (governance network, information systems, advice service, research ethics); and NIHR infrastructure (research networks, experimental medicine facilities, technology platforms, national schools for research). There will be interaction with medical charities, industry partners and other relevant organisations including the National Institute for Health and Clinical Excellence (NICE) and the NHS Institute for Innovation and Improvement.

The second goal is to attract, develop and retain the finest research professionals. Identifying the NIHR Faculty membership will be a key objective, as will enabling the Institute to develop the skills of researchers and strengthen career pathways. It is hoped that the Faculty will include excellent clinical researchers who hold substantive or honorary contracts with the NHS irrespective of their source of funding. A national advice service for researchers is also proposed, but it is not yet clear what form this will take.

The third goal relates to commissioning research concentrating on improving health and social care. This will be achieved by strengthening and focusing the funding mechanisms through which the NHS commissions research, and through expanding and strengthening its existing programmes. These are many and diverse, and include the health technology assessment programme, the NHS service delivery and organisation programme, the new and emerging applications of technology programme, the health technology devices programme, and a number of other smaller programmes amalgamated into a 'challenge fund for innovation'. New programmes designed to maximise effective public involvement and to empower patients are also envisaged. Possibly most importantly, programme grants for applied research will also be introduced, replacing those currently supported by the priorities and needs component of NHS support funding. Research units and possibly 10 biomedical research centres (covering general and specific areas of innovation, and translational research in biomedicine) will also be funded. In addition there will be two NHS service, quality and safety research centres. Centres will work in a five-year cycle and the amount of funds allocated will be related to the quality, scale and nature of research activity made in open competition and judged by peer review.

The fourth goal concerns strategic knowledge management, and involves working with Connecting for Health to ensure that the planned electronic patient record and its supporting infrastructure meet the needs of the research community. A single IT system for researchers and NHS research management is envisaged. Key goals will be getting research into practice, ensuring dissemination of knowledge and securing the support of NICE and other relevant organisations including the National Electronic

Library for Health, the World Health Organisation (WHO), the Cochrane Collaboration, and the Centre for Reviews and Dissemination, University of York.

The final goal accommodates governance and patient/public involvement (PPI). PPI will oversee all stages of the research process, ranging through priority setting, defining research outcomes, selecting research methodology, encouraging patient recruitment, interpreting findings and disseminating results.

How realistic are these goals? Some are likely to be achievable in the short term; others are reliant upon extracting funds for research from an already cash-strapped NHS. The report identifies a series of 16 implementation plans divided into six categories relating to the NIHR and its Faculty, funding transition, 'bureaucracy busting' (governance advice and ethics; research information systems, etc), a clinical research network for England (including the clinical research facilities for experimental medicine, technology platforms and the NIHR school for primary care research) and an overview of NIHR research projects, programmes, units and centres. Each document has a common structure comprising aims, purpose, organisation, governance and relationships, funding, architecture and establishment. Moreover, they all contain specific objectives and date lines by which they will be achieved. These provide a robust series of standards against which progress on process can be assessed.

What is the likely value of the initiative to the research community? As always, some detail is missing and there will be winners and losers. The attempt to identify a clear research and development (R&D) budget that will support research within the NHS in a transparent manner is to be welcomed. The initiative seems to represent a genuine attempt to reduce the bureaucracy associated with clinical research and to reorganise and 'sweep up' the many different grants and funding streams currently financed by the Department of Health (DH), but it will be important to monitor progress as there is an urgent need to reduce the bureaucratic burden faced by clinical investigators. Many organisations will undoubtedly aspire to become biomedical research centres (BMRs, general or specialised) and it will be important to ensure that this centralisation of resources does not disenfranchise wider participation in research across the NHS. Depending upon the speed of reallocation of funding after the initial assessment, centres currently heavily dependent upon their DH subvention who do not become BMRs may not initially be destabilised by such a withdrawal, especially if their research-active NHS consultant staff attract individual support. The means by which applications for centre status will be reviewed is, however, clearly of fundamental importance, as will the means by which specialist research areas are identified.

Are the goals an appropriate response to the crisis in academic medicine? The idea of *establishing* the NHS as an internationally recognised centre of research excellence is interesting. Most would assert that 'UKplc' already holds such status, at least in certain areas. Why the NHS in particular should be targeted is unclear, especially given the emphasis on partnership. The extent to which UK universities, research funding bodies and other relevant organisations (eg patient and public pressure groups) can be seen to work together towards this aim will clearly be important, and the announcement that the NHS R&D budget and the Medical Research Council's budget will be ring-fenced provides an opportunity to foster the partnerships between universities and NHS that are so essential for success. Secondly, the idea of attracting, retaining and developing the best research professionals to conduct people-based research should be recognised and developed. Thirdly, commissioning research focused on improving health and care is a laudable aim but may be perceived as excluding translational and basic research. The key issue will be who selects research priorities, which criteria are employed in this process and how this relates to the proposals for the unified budget. Any loss of basic biomedical research would pose a great threat to the future of a research-based healthcare system. Strengthening and streamlining systems for research management and governance is also a praiseworthy objective and it will be important to determine whether this has an effect on the movement of clinical trials commissioned by pharmaceutical companies away from the UK. Finally, researchers acting as sound custodians of public money for public good should be a given, but the definition of 'public good' and its application (eg neglect of basic in favour of clinical research) will be crucial in determining the direction and possibly therefore the success of the strategy.

What are the strongest and weakest points of the presented strategy? First, more money for research is to be welcomed, especially if it is allocated where it is needed. Moreover, recognition of the value of NHS-based research and the contribution it has made to academic medicine in the past represents a significant advance, although the publication of some kind of baseline audit would enhance this perception further. Second, reduced red tape and more appropriate governance systems will be widely welcomed and as a key objective this must be monitored carefully, as will the practical steps aimed at encouraging research activity amongst NHS staff. Given the emerging changes in junior medical staff teaching, however, it is difficult to know precisely how many consultants will be trained in the future to initiate/take part in research. Third, using the patient population to develop research protocols, if it can be achieved in the current climate of increasing suspicion and litigation, is also to be welcomed, as is the development of a national school for primary care research. Finally, managing knowledge resources is potentially the biggest benefit if the single IT system and the planned national electronic patient record system (Connecting for Health) actually work as envisaged.

By contrast, the report has an isolationist feel, although integration with other systems and providers (universities, research funding bodies, etc) is clearly planned. Thus, in May 2006 the Government produced a consultation document[2] which expressed aims, among others, of improving the effectiveness of the research councils and of supporting excellence in university research in both the biological and physical sciences. How these processes will complement and enhance those outlined in Best Research for Best Health is not immediately apparent. More specifically, maintaining the Haldane Principle, whereby decisions about what to spend research funds on should be made by

the research councils rather than politicians, is of crucial importance. In that the selection of relevant research projects and topics has not been a traditional strength of UK academia, much will rest upon the shoulders of those entrusted with this process and the transparency of their deliberations. Concentration on research likely to be politically (but not scientifically or clinically) attractive could be potentially disastrous. Second, some existing research centres will lose money. Whether the potential shift of funding from the 'winners' every 5–7 years is sustainable remains to be seen. Third, the NIHR could merely represent another body (albeit virtual) to which researchers will be responsible (in addition to the NHS, universities and funding bodies), thereby unintentionally increasing red tape. Finally, the implicit assumption that the pharmaceutical industry will respond to the 'single gateway' proposal seems unlikely. The high costs of conducting research in the UK will be largely unaffected by this document.

The overall direction of the strategy is right and should be welcomed. The NHS already makes a significant contribution to research in the NHS, but has been conspicuous in not effectively publicising. Those hospitals with significant international reputations have almost all gained these through the dissemination of research as well as clinical excellence. While some initiatives outlined here, for example cutting red tape, are welcome and within the power of the Government to change, the Government largely imposed them in the first place. Others, for example selecting topics and strategy, and reallocation of resources, are not likely to do so, particularly if any changes are not coordinated with other relevant bodies, especially the universities.

Acknowledgement

The author gratefully acknowledges the assistance of the Academy of Medical Sciences in reviewing this paper before submission.

References

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