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On behalf of MRC Institute and Unit Directors

Dear Sir David,

We, Directors of MRC's Institutes and Units, are writing in response to your consultation on the best institutional arrangements for the proposed single funding stream for health research. We are responsible to MRC Council for the strategy and direction of the intramural research programme. This comprises about half of MRC spend. Many of us hold joint MRC and University positions and therefore appreciate the different strengths of both the intramural and extramural support adopted so successfully by the MRC. The breadth of research carried out by the MRC intramural programme covers the spectrum of biomedical and health research in the UK, from basic cell and molecular biology through to social and statistical sciences of whole populations, and from basic research through to applied research including clinical and community trials.

The opportunities offered by a single funding stream, with appropriate governance, have the potential to enhance UK health research significantly. With enough effort, any system can be operated effectively. However, for UK health research as a whole to prosper, governance should be optimized for effective and efficient operation by everyone in it. Some reforms of NHS R and D governance are already underway - "Best Research for Best Health" - and these should be allowed to continue since the single funding stream will take some time to implement. Any changes following your report should be introduced carefully and according to a well-considered timetable, to enable researchers to continue their work in parallel with its implementation.

It is not our intention to present a detailed model for how we believe the single funding stream should operate, but rather to outline what we believe are the key principles that must be adhered to, and risks that must be avoided, if the UK is to retain and build on current strengths. Critically, in any reorganization it is imperative that efforts to rectify shortcomings elsewhere do not undermine the strengths within the MRC, which is arguably the most successful and cost-effective research organization in the world. A culture that breeds scientific excellence is easily destroyed, and once gone is very difficult to revive.

Size of the fund. There is disquiet in the research community at the £1B funding stream announced in the budget. This is less than the £1.3B currently allocated to the MRC and NHS R and D budgets. Even with recent Government funding increases, there is a significant amount of truly internationally-quality research in the UK which cannot be supported due to lack of money. While we accept that £1B may have been an approximation, it is critical that, besides making optimal use of current funds, any changes in governance must not decrease (and ideally should increase) the total funding available across the spectrum of health research.

Arm's length Governance. The MRC has a long and distinguished history in health research, both basic and patient-oriented, which is respected internationally. The MRC is seen as authoritative and scientifically rigorous (for example, this is why it has recently been charged with reviewing and conducting research on contentious issues such as Gulf War syndrome, water fluoridation, chronic fatigue syndrome etc). This, in our opinion, is a strong endorsement of research governance at 'arms length' according to Haldane principles. These principles must be retained, and in the future applied equally across the entire funding stream including relevant parts of the NHS R and D budget, if UK health research is to prosper.

Clarity of funding goals. It is the experience of those of us whose units are embedded in NHS hospitals that a proportion of NHS R and D money is currently used to underpin clinical service rather than research. We welcome the intention to identify clearly which funds are targeted towards research and which are targeted towards patient care. If delivered, this will release money which can only benefit UK health research.

In ring-fencing research funds it will be necessary to ensure that any 'hole' this generates in NHS service is plugged – there is no purpose in strengthening research in a major hospital which cannot then deliver effective medical care.

The concept of the 'well-found clinic'. We are all familiar with the concept of a well-found laboratory, so essential to the conduct of internationally-competitive research. This is generally provided by the MRC for its units and institutes, or through full economic costing from research funders and HEFCE/SHEFCE funding to the Universities. Critical for patient-based research and experimental medicine is the 'well-found clinic' – provision of services over and above basic clinical care to facilitate research, such as additional biochemical assays or MRI scans, additional nursing staff or radiographers. This is currently intended to be provided by NHS R and D budget awarded to NHS chief executives.

The concept of a well found clinic for research must be maintained in the NHS at all levels of primary, secondary and tertiary care as well as in social care. Furthermore, a culture of pride in research should be restored and fostered in all NHS Trusts; acute, primary care and mental health. It must, however, be recognized that research requires critical mass and expertise and, realistically, world class research in experimental medicine and translational research can only be carried out in a limited number of centres (hospitals) in the UK. These are generally those closely linked to research-intensive medical schools and which, not coincidentally, host a significant proportion of MRC units and institutes.

Currently, this 'dual support system' for clinical research is not fully effective. There should be a careful study of the best model for funding clinical infrastructure, and whether this is best funneled through the NHS hospital trusts or through the Universities (Medical Schools). A proportion of the NHS R and D funding intended to underpin research ends up supporting NHS service delivery because of the overwhelming pressure from the Government on NHS Chief Executives to deliver NHS service targets. These conflicting pressures could be avoided if funding intended to support clinical infrastructure is managed and distributed by an organization whose primary mission is to support research, rather than patient care (i.e. the NHS). We note that universities manage this well for laboratory infrastructure. Academic-led NHS Trusts, as has been proposed for some key UK centres, could also achieve this. Similar issues need to be addressed to ensure that primary care and mental health trusts also provide world class infrastructure for clinical research and the UK clinical research network is fundamental to this.

The clinical infrastructure requirements of the medical research charities, and their contributions to UK research, must not be forgotten. However, as with HEFCE, it is not difficult to put in place mechanisms that ensure charity research funding is recognized and underpinned. It will also be easier for charities to develop partnerships with the body overseeing a single funding stream (indeed, they could even be represented on this body), instead of the current need to negotiate three-way partnerships involving both the MRC and NHS.

It is also apparent that clinical infrastructure is not always effectively aligned with the best or most relevant research. This is for a variety of complex reasons but, principally because the MRC and research charities on one side, and NHS R and D on the other, have very different missions and governance. A single funding stream placing both project and infrastructure funding under common governance, and with a mission solely focused on research, is the simplest way to facilitate alignment. Achieving better alignment should be one of the key outcome measures of any change.

Peer Review. To ensure research excellence the peer review standards set by the UK research councils have been adopted throughout the world and such a mechanism must continue and be extended to new areas at all costs. In addition, because research is a long-horizon occupation, transparency and consistency in strategic direction can only be achieved if peer review panels of independent experts (such as existing MRC Boards) are served by a professional and scientifically-qualified administration which is not subject to day-to-day political pressures.

Industry. Partnerships with industry are critical in translating research advances to healthcare benefit. The MRC and other Research Councils have been successful in developing such partnerships – the NHS much less so. Thus, MRC-Technology is, arguably, the most successful technology transfer organization in the UK, based on research from MRC institutes and units. The therapeutic advances based on humanized monoclonal antibodies arising from research at MRC units in Cambridge are extraordinary. The majority of MRC units and institutes have been instrumental in leading the formation of both small and large partnerships with industry.

It is critical to ensure that industry can benefit from the unique advantages potentially provided by the NHS in delivering its healthcare research agenda in the UK. There is a view, supported by experience, that being part of a Government department constrains innovation and industrial partnerships by NHS R and D. This constraint would be removed if infrastructure funding were at arms length from the DH, and able to benefit from the lead currently shown by MRC and MRCT (and other Research Councils).

Links between molecular, cellular, population and clinical sciences. Health research should always be conducted for patient and population health benefit. However, this requires that underpinning research, which might have long term potential but no immediate applications for patient benefit, must be nurtured. This applies to basic laboratory science, basic social science, and key basic disciplines such as statistics and epidemiology.

It is a given that many skills are required to translate basic research through to healthcare benefit. It is critical that, in any reorganization, strengths in basic, clinical and public health research are all maintained and strengthened. Partnerships between individuals working in these areas must be enhanced. One of the strengths of the current MRC intramural programme is that it facilitates links between laboratory scientists, clinicians, social scientists, epidemiologists, and health policy makers in the UK and abroad (the fields of genetics and HIV/AIDS are good examples of fields which have benefited from these multidisciplinary partnerships). Any changes which might disrupt such links must be avoided.

A single funding stream also provides an opportunity to equalize demoralizing and destructive pay differentials frequently experienced by equally valuable individuals with different skills who work in partnership towards a common goal and alongside each other.

Other Research Councils. Health research is increasingly dependent on the physical sciences, engineering and the social sciences, as well as the biological sciences. Partnerships with other Research Councils are going to be critical to the future of current MRC and DoH research. Strong links to BBSRC, EPSRC and ESRC, in particular, through RC-UK and the OSI must not be broken in any reorganization. Any new governance arrangements should also ensure strong links between what is currently the NHS R and D funding stream and all Research Councils, not just the MRC.

Research is international. The MRC has an international strategy and a truly excellent international research programme (including, for example, units in The Gambia and Uganda), while the DH (and its equivalents in the devolved administrations) restricts R and D funding to the UK. Health is an international issue and any reorganization that restricts funding to UK issues will seriously damage the impact and effectiveness of UK biomedical research. International research also benefits UK research directly. Global health issues are of very great importance and the UK has a leading international position in this area. An international approach must be protected in any future reorganization of health research funding.

We do not wish to suggest a solution to the issues [that](#) arise when considering the devolved administrations. [However](#), it is critical that these [solutions](#) do not restrict the funding of research in any part of the UK, wherever the skills and ideas exist.

The MRC as a brand. This is not a trivial point. The name MRC is recognized around the world and is synonymous with research excellence. The excellence associated with the MRC brand ensures the UK is currently well-placed to attract and foster young talent from around the world, a critical component for future UK success. It would be very detrimental if this were lost in any funding reorganization.

DH Research. There are, undoubtedly, some activities currently funded by NHS R and D that should remain within the DH (Government Department) rather than being incorporated into the proposed single funding stream. These may include, for example, some directed (contract) research required to meet NHS needs. Nevertheless, the UK will only achieve effective coordination and rigour if a major part of current NHS R and D resource, including public health, applied research and infrastructure, is part of the same, arms-length funding stream, and subject to the same rigorous review mechanisms as the more project based biomedical and health research currently funded by the research councils.

The DH not only funds research through the NHS R and D programme but through the policy research programme which, *inter alia*, supports 13 research units (Including for example, the childhood cancer research group, Jenner Institute for vaccine research, and the Centre for Health Economics). It would seem illogical not to consider the DH research units and policy research programme within a single health research fund.

Overarching Governance. To ensure the single funding stream delivers both [DH](#) and [DTI](#) priorities any Council [which](#) oversees the funding stream will need to answer to both Departments. We note that the light-touch, priority setting currently adopted by the DTI for the Research Councils is a proven mechanism to foster excellence yet ensure direction.

As research directors we are well aware that two general scenarios for the single funding stream are being discussed. Some of us are in favour of one and some in favour of the other. Rather than giving the Cooksey team a mixed message, we feel it is better simply to point out potentially mission-critical risks which must be avoided whichever model is adopted.

(a) A single budget, with a single Chief Executive and Council. This 'big bang' model would, in essence, create a large Research Council with the benefit of bringing all health research under common governance and the potential to facilitate co-ordination across the entire spectrum of activity. If got right, this would be an extremely powerful international organization, responsive to both DH and DTI priorities. Unlike the current MRC Council, the new overarching Council would ideally include observers from the research charities to ensure coordination (particularly with respect to clinical infrastructure).

We see three principal risks with this model which must be avoided. **First**, introducing such a substantial change could, if got wrong, be seriously disruptive. Change must be implemented thoughtfully and carefully to ensure that the current UK research strengths are not disrupted or diluted. **Second**, it is important in bringing two organizations together that compromises are not introduced which reduce all to the lowest common denominator. Instead, current strengths and good practice must be exploited to develop similar strengths where they are currently lacking. **Third**, such a very large and diverse organization would be challenging for any Chief Executive and Council, and so a transparent internal organization would be important.

(b) Two separate budgets, with two Chief Executives but linked under an overarching Council. Such a model, in outline, might leave the current MRC governance relatively untouched but strengthen the Governance of current NHS R and D funding to ensure it is more responsive, transparent and accountable. This model is much closer to *status quo* and will be simpler to implement with less potential for major disruption. It is possible that this second scenario might be implemented as a stepping stone towards the first, but if so there must be a clearly defined timetable to avoid confusion.

The three key risks associated with this model, and which must be avoided, are around clarity of governance. **First**, it will be less easy (but not impossible) to ensure effective co-ordination across the spectrum of health research and infrastructure with two independent Chief Executives. It will not necessarily be easy to decide what goes into each budget or to avoid counterproductive internal competition between the two chief executives for budgets and on other issues. **Second**, there is a significant risk of confused (and duplicated) accountability and responsibility. If the Chief Executives responsible for each of the two budgets are responsible to an overarching Council which is anything other than light-touch this will lead to real confusion and significantly downgrade the CEO roles, making them less attractive positions for truly excellent individuals. **Third**, it is critical to avoid such an overarching Council duplicating the responsibilities of RC-UK and simply becoming an additional and unnecessary layer of management whose responsibilities are not clearly differentiated from those of RC-UK.

Conclusions. The arguments above lead us to believe that UK health research could be significantly enhanced if a significant proportion of the NHS R and D budget is merged with the MRC budget into a coordinated funding stream accountable to both DTI and DH, with similar governance principles to that of the current Research Councils. With appropriate safeguards in place to ensure funding of the entire spectrum of research from basic molecular biology to public health, and provision of the necessary clinical infrastructure, this fund could reinvigorate UK research, partnerships with industry, and the continued excellence in basic research and its translation to substantial healthcare benefit.

Yours sincerely,

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