



House of Commons
Innovation, Universities,
Science and Skills Committee

Office for Strategic Coordination of Health Research (OSCHR)

Oral and Written Evidence

8 June 2009

Professor Sir John Bell, *Chairman, OSCHR,*
Professor Sir Alex Markham, *Chair of OSCHR's*
Translational Medicines Board

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The Innovation, Universities, Science & Skills Committee

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Oral evidence

Taken before the Innovation, Universities, Science & Skills Committee on Monday 8 June 2009

Members present

Mr Phil Willis, in the Chair

Mr Tim Boswell
Dr Evan Harris

Dr Brian Iddon

Witnesses: **Professor Sir John Bell**, Chairman, OSCHR and **Professor Sir Alex Markham**, Chair of OSCHR's Translational Medicines Board, gave evidence.

Q1 Chairman: Could I very, very warmly welcome our two witnesses for this afternoon, which is rather strange as overnight the Department for Innovation, Universities & Skills has been disbanded, but we are carrying on manfully because we believe that visiting OSCHR is something which it is important to do. We very much welcome Professor Sir John Bell, the Chairman of OSCHR, and Professor Sir Alex Markham, the Chair of OSCHR's Translational Medicines Board. Welcome to you both. Our former committee, because we seem to get reorganised quite often, of which Dr Harris, Dr Iddon and myself were members, was very enthusiastic about the Cooksey report and we held a one-off inquiry into that. We did feel that there was a huge amount of merit in the way in which Cooksey was seen bringing together NHS research and the Medical Research Council. You said in your response to us that the "scope, depth and nature of translational research in the UK have all benefited dramatically" since OSCHR was formed. Do you have any evidence to support that very strong view that there has been a dramatic development?

Professor Sir John Bell: The only thing you can measure at the moment is activity and, of course, you would say, "You have had more money, there should be more activity".

Q2 Chairman: I would, yes.

Professor Sir John Bell: So I beat you to it! You have to remember where we started with all this and that was we had two funding agencies that were for the first time ever really attempting to do serious funding in the translational space. Their activities were not at all co-ordinated, they were overlapping with each other and in some spaces there were big gaps in what was available. The NHS was totally unprepared for one very large piece of translational medicine, there was virtually nothing going on, and the MRC, who had for many years said that they would never go into that area, had started rather helpfully to think about it but were only just getting going and starting to learn about what translational medicine might be.

Q3 Mr Boswell: Because there was a perceived need for it?

Professor Sir John Bell: Because there was a perceived need for it. I sat on the MRC Council in the 1990s when George Radda was the Chief Executive and we had the discussion—it will be in the minutes—and the decision was taken that the MRC would never go into that space, particularly the space of early clinical development. The world moves on and they recognised the need and were moving into that area rather slowly. I think the Cooksey review gave everybody an impetus to do it better, to cover the whole landscape to make sure we did not have these gaps in our capabilities. Do not forget, this is a pretty short timeframe because it is two and a bit years.

Q4 Chairman: We accept that.

Professor Sir John Bell: Alex's group at the Translational Medicines Board has done a terrific job, the funders have played the game and participated actively. There is a lot of activity going on. If you go into an NHS setting, and at any of the major teaching hospitals I think you will find this is the case, you will find there are lots of people there who feel like an important bit of their role is to participate in the research agenda to try and develop new agents, evaluate new therapies and so on in that context. Five years ago, forget it, there was not anybody in an NHS hospital who had those ambitions. Okay, it is fair to say that I am being a bit ebullient based on observation data, and that is a fair criticism, but we are now going to move into a phase to try and start measuring the output and that is one of the roles of OSCHR, to try and measure what has been achieved.

Q5 Chairman: With the MRC it was relatively straightforward to look at where the budget was and what it was spent on because it was basically grant-orientated and you could look at the research groups and how they were spending the money, but you could not do that with the NHS research. What you are describing is quite exciting, that you can go into any major teaching hospital and you see that research going on as a basic part of the job. Is that because of OSCHR or because they have simply changed the culture within the NHS and used that money for what it should have been used in the first place?

Professor Sir John Bell: There is absolutely no doubt that they have started to use the money in a more appropriate way and that probably would have happened with or without OSCHR. Where I think OSCHR has been powerful is in trying to align the various initiatives in the NIHR and the MRC to make sure we have a comprehensive programme that covers all aspects of translation. The important thing about translation is to remember if you have got a programme that helps you do this bit of translation and that bit of translation but then when you get to exploratory development, for example, there is no funding, you might as well not have any of it because stuff drops off the edge, it gets lost, it does not get properly looked after. Having a capability to do all the various steps in a translational pipeline I think is a really crucial bit to this discussion. They would not have got there as individual funding agencies.

Q6 Chairman: I can remember David Cooksey making the point, because I think we asked him as a Science and Technology Committee would he prefer to have one organisation, why have two because they are both involved in the same space, albeit on different continuums. Do you still feel that OSCHR was the right vehicle or should we have been bolder? Should the ministers have said, "Right, we will combine all this into one very large and effective organisation"?

Professor Sir John Bell: I think that the Cooksey decision and his judgment on this was probably correct and I will tell you why. The challenges of getting the NHS to operate as a functional platform for research are much greater than any of us would have perhaps anticipated. You really do have to have full cultural buy-in from the chief executive through the board down to the nurses and house staff on the wards. It has got to be a very comprehensive view. Getting that to happen if the agency responsible for it does not sit within the NHS would have been impossible, and that was Cooksey's judgment. The other model, which was to move the MRC and its activities into the NHS, had of course the history of the NHS regularly taking the chips off the table for R&D and spending it on something else. Most of the R&D money, as you know, was keeping the boilers going at the Hammersmith Hospital, amongst other things. There was no serious R&D money despite our 10 year commitment that there would be a substantial spend on R&D. It was really with the creation of the NIHR that the first really substantial commitment to R&D occurred. You can imagine the anxiety among the basic science community, which is one of our great assets in this country, if you started talking about moving it all into the Department of Health. The Cooksey judgment was the right one in my view.

Q7 Chairman: Looking at it now, because you were appointed very early on after that—

Professor Sir John Bell: Yes.

Q8 Chairman:—do you feel that OSCHR absolutely reflects what Cooksey wanted?

Professor Sir John Bell: Yes. David and I know each other pretty well and we talk about it pretty regularly and there is one aspect of Cooksey which we did not implement and I will explain why we did not implement it and get Alex to come in. His board was the Translational Medicines Funding Board, not the Translational Medicines Board. He also did not have boards for public health and electronic health, and those were creations that OSCHR made in its first few months because we felt they were two critically important areas for the nation that needed the attention that OSCHR and the funding agencies could provide. The reason that we did not take a large chunk of the money that subsequently came in under CSR and give it to a funding board that did not sit within the two agencies was that we really wanted to create a cultural change in the two agencies so that they worked together, and by saying, "You guys cannot do it, we will take the money away and we will give it to Alex", in my view that would have got us a much faster take-off, probably a more coherent set of programmes in the short-term but would never have created the cultural change to get the two agencies to work together. We did take the decision, I am afraid, to say, "Actually, we think there is probably a better way to do it that will be a little less efficient short-term but hopefully more efficient long-term".

Q9 Chairman: That slightly confused us. It does not take a lot to confuse us, but that slightly confused us because here was an organisation which was set up which was to try to simplify the plethora of organisations that were working in this space to bring them together and the first thing you did was to create another set of organisations. Is that a fair criticism?

Professor Sir John Bell: No, it is not actually and I will tell you why. The Translational Funding Board, which is now the Translational Medicines Board, is chaired by an independent chairman, who is sitting on my left, but is essentially owned by the two agencies. It is a board of the two agencies. They appointed and nominated all the membership and they have officers sitting in it. It is actually owned by the NIHR and the MRC with Alex in the chair reporting to the OSCHR Board, but it is a decision-making body which is driven by the views of the two agencies. We have not said, "You guys go sit down, we know how to do this better", what we have said is, "How do we do this together? You guys have got to nominate some people who know about translation, you nominate some people who know about translation, we are going to nominate Alex, who we know knows a lot about translation, and we are going to work together to make sure the whole piece is covered". It is not a brand new entity; it actually belongs to the crucial two agencies.

Q10 Chairman: In one word, in 10 years' time do you see these different organisations going and you having just one simple combined organisation which goes right across the continuum from NHS research through to basic research?

8 June 2009 Professor Sir John Bell and Professor Sir Alex Markham

Professor Sir John Bell: We are in the middle of a process and I think we have made a lot of progress.

Q11 Chairman: But will you disappear?

Professor Sir John Bell: I suspect it is very likely that OSCHR will disappear, yes.

Q12 Chairman: What about the UK Clinical Research Collaboration? That was in existence before and it was doing the job which ostensibly OSCHR is doing.

Professor Sir John Bell: It was not doing the job that OSCHR is doing actually, it was a different sort of a body and I know that because I was involved in its creation and sat on it for many years. It was a place for a whole range of different funders to share views as to how they might take medical research forward. It was not one that was focused on co-ordinating activity of individual agencies.

Q13 Mr Boswell: Just a little point, if I may, and I am not very familiar with the scene on this. If something is going wrong, ie that some work has not been done or maybe there is a disproportionate call on resources within the remits of your constituent boards, the ones that report to you, what is the vehicle for rectifying this? Does this go up to OSCHR or does it go to the two principal stakeholders, or both in parallel? How is it considered and put right? For example, it could be a difficulty with a personality or something like that.

Professor Sir John Bell: The answer is it goes up to the OSCHR Board and, as you know, the OSCHR Board has the two principal agencies on it but it has also got some rather powerful non-execs on it and the chairmen of the three boards, so it is a powerful board. We will have quite an open and frank discussion about it. It does end up solving issues if there are issues. Fortunately, there have not been a lot of big issues but there have been some issues that have not been dealt with. For example, it was very important that the MRC were responsible for the first bit of the translational pathway and the NIHR for the second bit. We wanted to make absolutely sure that if the MRC funded a programme all the way through the first bit and spent two or three million pounds of taxpayers' money getting a very exciting new programme at the end that there was going to be no risk that when they passed it on to the NIHR, the NIHR would say, "Well, that's very interesting to you but it isn't very interesting to us", which is something that happens in commercial settings often, so we left it to Alex to make sure that there was a plan and that took some time to put into place. It had to come and be discussed at the OSCHR Board on a number of occasions. Alex, do you want to comment?

Professor Sir Alex Markham: This goes back to the question of the Translational Medicines Funding Board versus a more co-ordinating function. We did have to change the culture of the two organisations. Perhaps not for minuting, the early stages were the two organisations competing as—

Q14 Chairman: Can I just say this is a public session and everything you say is being minuted and sent across the world.

Professor Sir Alex Markham: Quite.

Q15 Chairman: It is all right, nobody will listen!

Professor Sir Alex Markham: In the initial phases the two organisations would be quite competitive and slightly antagonistic and would say, "Chairman Markham, you must make a decision: are we going to be in charge of this or are they going to be in charge of this?" and I would say, "I am never going to make that decision until you decide between you how you are going to do it together. If you do not decide how you are going to do it together in a way that makes sense to me and the rest of my board then we will not do anything and you will have to answer to the people who have provided you with these large amounts of extra money why you are not making the best use of it". Very quickly the culture changed completely. Now I am quite confident that we have built enough mutual understanding and respect in the two organisations to be able to work together very effectively. I do think that issues of an obstructive personality or any other of the kinds of organisational problems that gum up the works can be dealt with by the board and by escalating things to John's board if need be. It goes back to your question of should we have done this differently or does OSCHR work. To our considerable satisfaction, I guess, the OSCHR process does seem to have worked very successfully so far.

Q16 Dr Iddon: The Chief Executive of GlaxoSmithKline is one of your non-exec board members.

Professor Sir John Bell: Was actually. He has stepped down because of commitments and we have just appointed another non-exec to replace him who is from industry.

Q17 Dr Iddon: From the pharma industry?

Professor Sir John Bell: From the pharma industry. The Appointments Committee have got it and they have got to make a decision so I cannot tell you who it is.

Q18 Dr Iddon: The concern I am going to express is the pharmaceutical industry is a pretty strong lobby in this place and elsewhere and, okay, one pharmaceutical non-exec board member is being replaced by another. You have just mentioned the Translational Medicines Board and obviously translating medicines from discovery into the clinic and beyond is a pretty regular stream of research in your line of business, but the former Science and Technology Select Committee were quite concerned about other areas of medical research, and I just quote, for example, medical engineering and technology, particularly preventative and public health, and we are very concerned that those areas should not be overlooked. I guess my question is how strong an influence is the pharmaceutical

industry on your work and will those other areas be of equal importance to the translation of medicines into the public arena?

Professor Sir John Bell: The answer is we have had a pharmaceutical representative on the board and we will continue to have a pharmaceutical representative on board. I think it is a crucial industry both in terms of delivery of benefits to healthcare but also in terms of UK plc, and we will probably get back to that discussion a bit later. You cannot get around the fact that we have a very powerful pharmaceutical industry in this country and we should be grateful for it. I agree entirely with the sentiment that there is more than drugs in the process of health delivery, much more, and if you look at the benefits we have had from devices they have been extremely substantial. In fact, in the cardiovascular space the development of devices, imaging, has had a huge impact. Of course, diagnostics is about to undergo a huge revolution on the back of the availability of our insights into genomic medicine and the like and that will be the subject of a report from the House of Lords over the course of the next month or so. That is a really exciting and important piece of what we are doing. We have been very interested in helping to develop those areas and, indeed, a number of the programmes that are in place, including the Developmental Pathway Funding Scheme from the MRC and there is a new NIHR programme to support diagnostic development, have been focused on trying to build those areas. Indeed, there are discussions at the moment about having a specific call around new molecular in the Health Service to try and help translate those. I also know that a substantial amount of the National Institute for Health Research Biomedical Research Centre money has been spent in institutions on translating diagnostic information so that it is of benefit to patients. This is one area where there are very tangible results right now. Chairman, you asked me whether there were some examples and I am glad to have been reminded. There is a whole set of tools and technologies that are now being applied to a range of diseases where there is some component of genetic involvement, susceptibility or whatever, sudden cardiac death, a variety of forms of mental retardation, autism, speech and language disorders, congenital heart disease, and those have been totally powered by the new technologies, new generation sequencing, array of methodology and the like. We are very upbeat about that because we think it has got short-term gains because it is a question of taking the information we have and rapidly applying it and showing that it is useful in a clinical setting and with diagnostics that can happen in a very short timeframe. We are very, very supportive of diagnostics and devices. You need to understand that the UK has a very fragmented devices industry as far as we can judge, it is not coherent in the way that it is in North America. The diagnostics arena is a bit better and we have some big players in imaging in the form of GE Healthcare in this country and Siemens has a fairly big place. It is not as easy to deal with as the commercial sector in pharma and biotech

where there are two or three big players and then a set of biotech companies, it is more fragmented, but it is still worth trying because there is a huge upside both for the economy but also for patients in that space.

Q19 Dr Iddon: It is good to hear that OSCHR is developing some breadth beyond pharmaceuticals. Another component of the question I just asked you was the prevention of ill-health. You have identified some Health Research Opportunities and I think that is one of them and Lord Ara Darzi is very keen to prevent ill-health in the first place. Have you managed to put some work on the ground in that direction because this Committee and the Health Committee particularly would be very interested to pursue that line?

Professor Sir John Bell: Let me talk to you a little bit about public health. When we were given our remit by David, in the first month or two we agreed, as an interim board, on my suggestion, I have to say, to build a capability in public health for exactly the reasons you describe, that is that it is very clear that if you are not talking about the economic growth of this country but you are talking about the health of people, which is very much part of our remit, then the translating and delivering public health capability is something that we have never done very well. We have a very weak public health arena, both professionally and academically, and it seemed to us to be a terribly important area to build capabilities in and to develop some focus in. The reason it has not been successful is it is a very complex field. There are lots of different bits of public health: there is infectious disease public health (the guys chasing the flu epidemic at the moment), there is chronic disease public health, there is health mental, there are all the public health issues associated with aging, there is childhood obesity. There is a whole set of different dimensions, and they tend to operate as their own little entities; so they do not work as a public health community, they say "I work in public health", meaning that they work in infectious disease public health, so it is a fragmented community, and there is a big difference, of course, in the sort of interventions that you can imagine applying, because those interventions range from giving everybody a stain tablet all the way through behavioural change to try and get people to ride their bikes and eat better diets, and so on. Of course the statin thing sounds easy because you get people to take tablets, but, of course, where we would all like to be is to get people to ride bikes, because then they are not taking statins, and the controls for making that happen do not sit within the NHS and, indeed, they do not sit within the bio-medical research community, they sit within the Department for Transport ("Can we have some cycle paths?"), the Department for Education ("What did you teach the students today about riding bicycles?"), the Department for the Environment ("Can we make some tax incentive to make that all help?"), and so, in fact, a lot of the controls for getting a really effective public health programme sit outside the normal domain in which we operate, and I think that has made it really

complicated, because in a sense OSCHR is a bit of an experiment in how you get two departments to work together, and if you are going to get public health to work, you have got to get five departments to work together, and I think this really challenges government. First of all, I think it is terribly important, and, secondly, I do not think you do it very well and it would be really helpful if it got a bit of a push.

Q20 Dr Harris: I accept that some of the best public health interventions may not be medical, but fact that you are not going to get the Home Office or some of these other departments interested in research at all arguably should not prevent you, if you can, doing what you can do with pills.

Professor Sir John Bell: Yes, I agree with that.

Q21 Dr Harris: The pharmaceutical industry is not going to run large trials that might show huge effectiveness on the use of medicines that are patent expired or new combinations of medicines arguably that are patent expired, like the Polypill. So why is not OSCHR saying: here is a big opportunity to do a trial on the Polypill which is strategic, it is long-term, it is translational, it is public health, it ticks a lot of boxes?

Professor Sir John Bell: Alex, do you want to start?

Professor Sir Alex Markham: OSCHR is doing exactly that; so the large-scale clinical trials work is growing really very quickly. Historically the sorts of studies that you describe between MRC and NIHR: we have done about 25 new ones a year almost since time immemorial. In 2007, the first year of OSCHR's work, that went up to 35, in 2008 we got 45 new trials going, and the aspiration in OSCHR is that we will be conducting 100 new trials per year, so about four times as many as historically, on exactly the sorts of studies that you describe, and we always have a model of the way the cancer community have done things, and they are, I guess, five years ahead of us in this. In 2002 the cancer community was funding about seven new trials a year: in 2008 it was 49. These are exactly the sorts of studies you described of new uses, of out of patent drugs to attack particular problems. So, although the Polypill may not be a study that has been approved (and we do not get involved in that vaster peer review, and there are some questions about the Polypill that are quite serious actually), that kind of study is very much on-going. Studies, for example, in the disease prevention space, again, large numbers of trials now on-going, for example studies to see what we should be doing about screening for prostate cancer. That is a huge trial funded by the OSCHR partners now; expected to report next year; very exciting. There are lots of things going on, and I think OSCHR can take some real satisfaction in the fact that we have changed that landscape, I think, very much for the better and in exactly the ways that I think you are encouraging us to think about.

Q22 Dr Iddon: One last question before we move on. We have talked about translational medicine; we have talked about public health research. The third

subject area that you appear to have chosen is e-health records. Is that a complete bag, or have you developed other subject areas that you are pursuing by this board treatment?

Professor Sir John Bell: Let me turn over to Alex on this one, because Alex also chairs the Research Capability Programme, which is in fact part of the OSCHR programme in the Department of Health to try and build research capability around electronic patient records. Alex, do you want to comment where we are on that?

Professor Sir Alex Markham: Yes. We had the three areas we do not have any more, so there is nothing going on that we have not told you about that I know of anyway. The e-health activity really cuts across both translational research and the public health aspirations we have. We are trying to make patient records more accessible for research purposes whilst, of course, maintaining absolute confidentiality. That work is going on under the auspices of the much maligned Connecting for Health programme. I am responsible for that. Our main business case is currently with the capital investment branch in the Department of Health and with Her Majesty's Treasury, and I would be very pleased to come back and tell you about their approval for it. We think we can do some very exciting things to support public health research, particularly to support health services research, i.e. how do we deliver the NHS more cost-effectively and efficiently, but also recruitment to clinical trials by that means will be a very important part of translation both of new pharmaceuticals, of the new diagnostic entities and particularly we are trying to develop ways to use electronic patient records for what is called pharmaco-vigilance where, if we can introduce new treatments at an earlier stage into routine care, we can monitor unexpected side effects through electronic records. So it is quite an exciting challenge, it has not been done before, but I am pretty optimistic that we can make that thing fly. So, hopefully, our electronic resources will be very beneficial to all the other things that we are doing.

Q23 Dr Iddon: I can see the interrelationship now between those three subject areas, but perhaps you could tell this committee how they were chosen in the first place and how you might choose other subject areas? Is this bottom-up for consultation or does it come from your board? Where do these ideas come from?

Professor Sir Alex Markham: The Translational Medicine Board came out of Cooksey, essentially, and we felt that we were put into place to help deliver Cooksey, and that seemed a reasonable thing to start with. If you are an aficionado of Cooksey, if you read it in detail, he also refers to the importance of public health, although did not recommend a board, and it seemed to the interim board that was set up in the first instance before we had a definitive board that it was a wholly appropriate arena to operate in and, also referred to in Cooksey, the electronic patient record was one of the unique selling points in the UK because of our potential capabilities of using the NHS, with its electronic record, to power a research

agenda and the dependence of both public health and translational medicine on that electronic health record, because you could not do either at the level that you should do them without it, we felt, required the attention of a separate board, and, in fact, I do not have any doubt that those decisions were correct. Whether there were other things that we could have done, I would not want to comment on actually. There may have been other things we could have done, but do not forget that the more you diffuse your attention, the less likely you are to achieve in a small number of areas.

Q24 Dr Iddon: So it is Cooksey driven?

Professor Sir John Bell: Cooksey driven.

Professor Sir Alex Markham: The electronic records also was a recommendation of UKCRC. They highlighted that back in 2006 as an important area for attention. So it came from that wider group also.

Chairman: We want to come back to electronic records in a second, but we will just move on.

Q25 Mr Boswell: Just some questions about what you might call the nuts and bolts of this. The national ambitions for translational research, when are they going to be finalised?

Professor Sir John Bell: We have been working with the OSCHR partners and had a process which bought them up where we solicited the views from the community, broadly defined, we then chose a variety of key opinion leaders, as it were.

Q26 Mr Boswell: For the record, these are independent. These are not driven by the principals?

Professor Sir John Bell: Exactly. We had a number of key opinion leaders nominated by the two major agencies to think about those and distil those into a more refined format. We started with many hundreds of suggestions, as you can imagine, and then a sub-group of the OSCHR board spent a great deal of time formatting those into a form that we felt was understandable, because they are intended to set out some ambitions for the research community over the next decade that we think are both achievable and important strategically, and those are now undergoing a sort of final draft, so they are very close to completion.

Q27 Mr Boswell: This year.

Professor Sir John Bell: Yes; absolutely. I would expect within the next month we might get more.

Q28 Mr Boswell: thank you; that is helpful. The second point is really almost picking up something you said about the devices, in which I happen to have personally taken some interest.. To what extent are these ambitions going to focus on drug development or on wider therapeutic approaches?

Professor Sir John Bell: No, wider therapeutic approaches, absolutely. In fact they depend on wider therapeutic approaches.

Q29 Mr Boswell: What you might call a systems approach to a particular condition.

Professor Sir John Bell: Yes, exactly. In fact, one would hope that we would get the sort of contributions that we have seen in many of the diseases where we have seen dramatic falls in age-adjusted mortality, and breast cancer is a very good one. Multiple different things have made a big difference to that: screening has made a big difference, imaging has made a big difference, early diagnosis by self-examination has made a big difference; the drugs have made a big difference; better diagnostics have made a big difference. You do not make an impact on a disease by a single methodology, you make it by taking a broad approach using things from a variety of different arenas and then using them cleverly and systematically to drive down mortality rates.

Q30 Mr Boswell: Turning to lead organisations, I gather in some cases you have even got the two agencies MRC and NIHR administering each other's budgets?

Professor Sir John Bell: Yes.

Q31 Mr Boswell: A kind of management consultant's nightmare. How does it work in practice?

Professor Sir John Bell: If I can take you back through the history, again we were confronted with an issue, and that is that from the beginnings of OSCHR, just after, I guess, January 2007, we had a virtual timeframe before the next CSR period and we needed to get ourselves sorted out. Of course, we did not have an office and it was essentially Liam O'Toole and myself, who was essentially OSCHR, talking to the two agencies, and it became very clear to us that we needed to have a kind of unified responsibility for everything across the patch, but if we started to say to the MRC, "Actually we are taking money out of your baseline and we are going to ask it to be passed to the Department of Health where they are going to spend it on something else", we would have had World War III, and that was not a good way to start a process that we hoped was going to eventually allow these agencies to work much more effectively together. So Liam O'Toole and I came up with this idea of the organisations where in fact, forget where the money came from, there would be a responsibility for this particular domain where a single agency would take that responsibility and money from both departments might go into funding that, depending on how we wanted to develop it, but there would be a single administrative route for managing the grants, organising the funding, the funding committees, and that both agencies would have some input into the decisions through the Translational Medicine Board. So that is where it came from. You are saying, has it caused lots of trouble? Surprisingly it has not. In the early days we did have some disputes about the territoriality issues that you might imagine, but in the end they were resolved and I think both agencies seemed very comfortable with the way that has happened.

Professor Sir Alex Markham: I think the best example we have seen so far is a funding committee we have called the Efficacy and Mechanism Evaluation Board, which is a board that funds early phase two clinical trials, where the idea is to prove that an agent is having the effect that you think it is having beyond the stage of phase one trials, which are all about: is it safe? There, historically, the money had been held by MRC, and that responsibility was handed in this lead organisation structure to NIHR, and there was such a pent up demand for this kind of work that that committee spent its whole budget almost immediately. All of the NIHR money and all of the MRC money that had been put into that went in the first round of funding last year, and, actually, MRC dug some money out of its own baseline to give to NIHR to address the unmet need there. So that joint working really actually has become part of the culture. I found the most reassuring thing in the last 12 months that the two organisations together fixed the problem; they did not play Tweedledum and Tweedledee about it.

Q32 Mr Boswell: Can I follow the next question which I think would trouble us on paper at least, which is only the moral hazard of this. MRC has an obligation to deliver high quality science, and there is the Haldane principle, which is broadly at arms' length from Government or from ministers; there is also perhaps a more prudential issue, which is that, in pushing for quick translation, you might neglect basic science. If we took Alex's comment about raiding their baseline literally, it could imply this was a risk. How have you managed to handle those pressures?

Professor Sir John Bell: Our starting point in all this was that the basic science budget needed to be retained, simply because when you have got such a strong platform as we have in the UK with basic science it would be crazy to raid that for translation, and, in fact, that was the argument that we put together in the joint funding bid to the Treasury.

Q33 Mr Boswell: You have to be very literal-minded about what Alex has just told us. The implication is that money was taken out of the MRC baseline precisely for translation.

Professor Sir John Bell: No, the money that was moved was money they were already spending on clinical trials; so it was not taken out of the basic science budget. We have been very careful to make sure that the basic science budget, as spent by the MRC, remains for basic science. You can say those words, but everybody knows that around the edges there is stuff where it is tough to tell whether it is basic or translational. The very early bits in translation are very often done by basic scientists. So you just let all that happen, but I think the sense from the basic science community is, having started with a great deal of scepticism about this whole process and scepticism about OSCHR, I have to say, I think there is now a wider enthusiasm that this has actually been a successful process and that it is probably for the greater good of UK bio-medicine.

Q34 Mr Boswell: Fast-tracking for new treatments or approaches: how can you do that without changing the system of drug approval? Is there a constraint there? Even if you are successful, can you actually deliver?

Professor Sir John Bell: Chapter eight of Cooksey was a very controversial chapter, because in there he discussed the clear limitations in the model for drug development that exist within the pharmaceutical sector. That is to some extent constrained by the regulators, the willingness of the healthcare system to reimburse early and, indeed, the cultural difficulties in the pharmaceutical industry, who are used to doing things in a certain way, and rather difficult to move into a different space. It was said repeatedly in our first year of functioning that we were never going to tackle that, so forget it, just do not go there, but we have persisted and have had a lot of facilitation, I have to say, from a variety of people. The ABPI, who represent the pharmaceutical industry, have been very good about thinking about progressive ways of moving this on. We have had the very helpful involvement of NICE and Mike Rawlins, who is very interested in seeing this work, we have had very helpful input from Alistair Breckenridge from the MHRA, and from the EMEA Thomas Lonngren, and there have been a series of meetings, which OSCHR has not co-ordinated but we have been involved in, which have actually moved this on to quite a substantial position where in fact it now looks like there are some things that can be done without changing any of the European legislation which everybody just thinks about and they lose the will to live. So I think the idea that you could do this within the existing framework is very attractive. I think that that is very likely to happen. Over the course of the next year we are likely to see some exemplars go out where, in fact, we think a little about earlier reimbursement terms, managing safety in a different way, trying to get the model for drug development to be faster and more efficient, and I am pleased about that, because I did not think we would get a chance to move that on, and, I think, in fairness to them, the APBI need a lot of credit for helping us to move that on.

Q35 Mr Boswell: One last question in this section on relationships. OLS and the UK Centre for Medical Research and Innovation, how much are you hands-on in relation to them, or are they very different?

Professor Sir John Bell: We watch with interest the UKCMRI. We have huge enthusiasm for a flagship project in London. It is not within our remit really. We let the MRC get on with that with CRUK and we are very enthusiastic to see it happen because I think it makes very important statements about the importance of biomedical research in this country and, as a result, we support it entirely. The Office for Life Sciences, of course, is very much more in our remit. We do not formally sit on the Office for Life Sciences' panels—that is done by the departments, so the Department of Health sits on that obviously—but we are quite engaged both with the minister responsible, Lord Drayson, who has been very active in keeping us briefed, and we have been

keeping him briefed on where we think this might go, and also our involvement in discussions with industry as to how they think it might be formulated to deliver a more powerful UK DIUS in this area. That is very much in our remit and we are actively engaged, although not sitting on any of the formal committees.

Q36 Dr Harris: You are charged with doing stuff that meets the priorities of the NHS in terms of translation. The MRC, and indeed it is a civilised country, has an interest in global health, dealing with diseases that are nothing to do with the NHS, or very little to do with the NHS. How can we be sure that your activities within your remit, quite rightly, do not distort funding priorities and organisation away from saving the lives of millions of people in other countries suffering from treatable diseases in favour of saving a bit of money for the NHS or coming up with a few new treatments for first-world diseases that are taxing the NHS?

Professor Sir John Bell: I think you can be reassured on that one. There are two bits of global health, and it is important to distinguish them. There are the diseases of the billion poorest people in the world, and, of course, the major causes of death in that group are the major infectious diseases—malaria, TB, HIV, diarrhoeal diseases—and that has been a focus both of the Wellcome Trust and MRC for a long time and it is an important focus and large foundations like the Gates Foundation have become increasingly involved and it is a major focus of UK academia and continues to be such. As you know, I am associated in my academic life with a number of those programmes and they are very successful. What I think has been largely missed is that the major cause of death in the low and middle-income countries are the same chronic diseases that are killing very large numbers of people within developed countries, and in fact the interesting thing is the inequalities of health for cancer, cardiovascular disease, diabetes and respiratory disease that exist in this country, where poor people die faster and in larger numbers, is exactly the phenomena we see in the developing world. In fact, in many ways one of the best places to work in the global health space in a way that is complimentary to diseases in this country is to think about chronic disease/global health, and that was an area where the WHO spent 1% of its total budget on chronic disease in the developing world up until last year, it was not the subject of a great deal of attention from anyone, but it has risen to prominence, in part, through activities that are related to the MRC who have said that they wanted to focus on this area, and we have supported that very heavily. Indeed, I was the senior author on the main paper on Grand Challenges in Chronic Diseases that was published in *Nature*, and of which Lez Borysiewicz was co-author last year, which has formed the framework for a new multinational initiative to bring funding agencies together from around the world, including those from India and China, to work in a co-ordinated way for those major diseases. So I do not think you need to worry about that.

Q37 Dr Harris: I do worry, and I will worry about the first group you mentioned, the infectious diseases that are not so much an issue for the NHS to do basic researches in those fields. Can they look to you for any help in translating their research discoveries into treatments, or do you say, “Look, you are going to have to look elsewhere, to Gates and other funders, because there is no role for the Translational Medical Board, which is focused on challenges for the NHS”?

Professor Sir John Bell: I do not think the Translational Medicine Board is focused on challenges for the NHS. I am not sure where that came from.

Q38 Dr Harris: Cooksey.

Professor Sir John Bell: I turn to Alex, but I think it is interested in translational medicine actually, not specifically that related to the NHS, and I do not think, although I do not know whether it has been the subject of discussion at their level, but at the OSCHR board we had extensive discussions about global health and who would have responsibility for global health, and, in fact, in the end we agreed that both agencies, the NIHR and the MRC, wanted to be involved in global health. So rather than people being squeezed out, I think everybody wants to play in this space because there are very substantial benefits to be had in terms of human health. Alex, do you want to comment?

Professor Sir Alex Markham: I would like to try and reassure you a little more. Let us take an example like malaria.

Q39 Dr Harris: Give me a brief example?

Professor Sir Alex Markham: Things like the MRC’s activity at laboratories in the Gambia will continue, but people who in the UK might be, for example, developing a new treatment for malaria or a new vaccine for malaria need support from the Translational Medicine Board in the UK to do all of the pre-clinical work that you would do for any other medicine. So if we have a group in Oxford developing a new vaccine, they will need to do all the toxicology, all of the manufacturing, all the formulation, all of the testing that you would do in animal models before you ever went into a patient, and what the new OSCHR system provides is resources for all of that. So anything you want to do in the developing world with a new treatment, for example, or a new vaccine, requires all of the same facilities and capabilities that you would require for a new treatment for coronary artery disease.

Q40 Dr Harris: You are not particularly focused on NHS use of the end product.

Professor Sir Alex Markham: No.

Q41 Dr Harris: That is fine. Looking at e-health and all that business, are you worried about political buy-in this close to a general election for the Connecting for Health programme? Is that something that troubles you or you think might be troubling the Treasury in deciding whether to send you down a path of investing a lot of money into something where funding might be withdrawn from

a wider project and at least slow you down? Clearly you could do e-health records without everything else.

Professor Sir John Bell: I think that is the answer to the question. It seems inconceivable we will be practising medicine without some form of electronic record of what is happening to patients. Whether that is Connecting for Health or not, I think, is a question that is well beyond us—that is not what we do—but Alex’s programme and the Research Capability Programme is essentially building the tools that will allow you to use that kind of electronic information in a powerful way to facilitate the research agenda, and, as you well know, there are a number of databases out there at the moment: the HES database is effective, there are a number of regional databases that work, the GPRD database works pretty well. There are a number of databases that are out there that could be used immediately for that purpose.

Professor Sir Alex Markham: I think it is terribly sad that nobody will ever stand up and defend Connecting for Health, because most of what it has done is excellent. Imaging now in the National Health Service is all done electronically, and it is superb. We have a national electronic programme in general practice that is complete. I think there are eight general practitioners in the UK who do not record all their consultations electronically. Two-thirds now of all out-patient clinics are booked by Choose and Book. So there are lots of good things in there. The one thing that is not satisfactory right now is the care record in secondary care, the hospital electronic record, and that needs more work.

Q42 Dr Harris: I want to ask you about that. You said, speaking to the House of Lords committee (and I am quoting but this may not be right, you may not subscribe to this) that there is nothing more unethical than preventing ethical medical research taking place, and that was in the context of people objecting to a default where care records, at least the standard care record, are, by default, uploaded onto the national system. Do you stand by that, that the most unethical thing is for people to object to their data being used?

Professor Sir Alex Markham: No, that is not quite what I said. I did take the trouble to read that. I made the comment that there is nothing more unethical than not conducting ethical research without direct reference to the fact that people should upload their records into the care record without having the right to refuse to do so. Frankly, if people do not want their records to be recorded electronically, I think they should have every right to refuse.

Q43 Dr Harris: But there is an impatience, is there not, in the medical community? I think the Academy of Medical Sciences, of which you are President, have argued, let us not get carried away by the consenting process for putting it on the database. Do you accept that there is a conflict between those who want to see rapid use of this amazing resource and those people who, for whatever motives, are arguing

against fast accessibility, or at least fast implementation, of an electronic care record system that might override the maximising of individual choice as to whether you are part of that because of fears founded, or otherwise, around data protection?

Professor Sir Alex Markham: I think that we do not need to rush our fences in this area. I think that the public should have, obviously, every right to decide on what is done with their records as individuals, and over the last year, as we have started to think very carefully about the use of electronic records for research purposes, it has become very clear (and we have discussed this absolutely actively at all times with the National Information Governance Board, a body that only came into existence in November) that there is an immense amount of research that can be done using entirely anonymised patient records, and I think the impatient sections of the research community (and historically I have often been one of those) can wait, because we can work initially with anonymised records, and those are already very extensively available from primary care and there is a huge amount to be done using those records linked anonymously to other databases like Hospital Episode Statistics, like the demographic databases, and I think there needs to be a very active public debate so that people are made more aware of what they could consent to do.

Q44 Chairman: Is that your job or is it the NHS’s job?

Professor Sir Alex Markham: I think it will be partially my job in developing the research capability programme, but, of course, lots of other people want to participate in that discussion too. I actually think that if we can develop systems that build public confidence, then the debate will be a lot easier to have.

Q45 Dr Harris: I want to talk a little bit about industry. You will be aware that Sir David Cooksey has expressed disappointment at the Government’s response in terms of initiatives to the Refresh and Review Report, and I can quote some of this briefly: “When you strip away the veneer of this report, you will find there is very little new in it. It is disappointing”, Sir David said. “We began discussing this issue”—this is about promoting faster development of drugs—“in 2003 and in the six years since there has been a lot of talking but in terms of change there has been relatively little.” We touched on this earlier in our discussions. If anything, there is this threat to R&D research funding, both in this country and globally, because of the market, the climate. Does OSCHR have a response to a changing situation: one of, first, impatience and, secondly, a reduction in the quantum of pharmaceutical R&D globally, Europe-wide and probably in this country?

Professor Sir John Bell: The answer is that I think that the UK still has to retain more than its expected share of pharmaceutical R&D. I am not sure you are right in suggesting that there will be less pharmaceutical R&D going forward. There are business models which actually put a lot more

money into the pharmaceutical R&D, and in fact you only have to look at the balance between R&D funding and marketing funding to realise that there is the capacity in the pharmaceutical industry to spend more on R&D should they choose to do it, and so I do not think one should assume there will be less money in the R&D pot. I also think that there is a very important message in the Refresh and Review BIGT Report, and that is that we had a very vibrant bio-technology sector in the 1990s and we are beginning to lose it, and I tell you for sure, you will not have a vibrant pharmaceutical sector without strong biotech. So, if you like biotech, go to the wall; then do not expect to have pharmaceuticals. If you do not have pharmaceuticals, you do not have the financial sector, then there are problems, I think.

Q46 Dr Harris: Do you have a role propping up or helping to prop up the seed corn of biotech?

Professor Sir John Bell: We have been involved in discussions but we, obviously, do not have any direct funding to support that activity, although some of the programmes that we have running through the agencies will ultimately support the biotech sector.

Q47 Dr Iddon: I am told that 40% of our drugs that are in clinical trials at the moment are biological drugs as distinct from simple chemical synthetic drugs?

Professor Sir John Bell: Correct.

Q48 Dr Iddon: Are the proportions of people on your different working parties, committees and boards reflecting that interest?

Professor Sir Alex Markham: I think so.

Chairman: Before you go on, can I say, rather than just think, do you have a deliberate policy to actually address what Dr Iddon has actually brought up, or not?

Q49 Dr Iddon: What I am getting at, Alex, is that the pharmaceutical industry are buying in a lot of it is innovation now from spin-off companies which come out, generally, of universities. Is that reflected in your work?

Professor Sir Alex Markham: The first example I will give you is from the cancer world, which involves collaboration between CRUK with the MRC and, of course, NIHR, because Cancer Research UK does not have any patients, so everything is done clinically is done within NIHR. They currently have four compounds in phase three which are biologicals, and CRUK has just spent £25 million building a new manufacturing facility for biologicals because we could not get the things made anywhere else in the UK, and they have a complete set of committees, which are populated by the appropriate experts, to give advice in that area, and I think that these things are coming through. The beauty of the work of OSCHR recently is that we have now got some MRC people chairing those committees. So the MRC is learning in that environment, which is a year or two ahead of them, and going back to the MRC with that learning, but let us not forget that

the MRC was right at the forefront of the development of biologicals for treatment, all of the monoclonal antibodies came out of the MRC and, indeed, have generated vast amounts of money in royalties that is now part of what is paying for the new St Pancras initiative; and we have a similar skill-set in the UK in the arthritis world where all of the anti TNF agents that we now use successfully to treat rheumatoid came out of British academic research and produced, again, a very nice royalty stream for Imperial College. So I think we do have the skill-sets. The MRC has got a lot of experience in there, their technology transfer people have got good experience here, and I think the people who are populating our committees are very competent to deal with the problem you raise.

Professor Sir John Bell: I think, by definition, the academic community are very powerfully positioned to contribute more to biologics development than they are to small molecule development. The truth is we do not do small molecule chemistry that is not chemistry in universities, but, boy, do we do a lot of biologics stuff. So I think it does work.

Q50 Dr Harris: Before I hand over to Tim Boswell for the last question, I just want to ask you about how fleet-footed you are and whether you have a role in seizing opportunities to bring people together. One good example is swine flu. If that starts hospitalising people in large numbers, there is clearly an opportunity, indeed, I would say an obligation, for research to be done to see if anything works to save lives. How is that going to be done, because the virus people are dealing with the virus and the vaccine, and the people dealing with the respiratory are dealing with the respiratory. Is there anyone there who is going to think about what we can trial, maybe one town versus another town, rather than the sophisticated randomisation between multi-centres? Does OSCHR have a role in sorting that out?

Professor Sir John Bell: OSCHR has been tracking that quite carefully and, rather helpfully, the Medical Research Council has a programme in place which is, in essence, prepared for an epidemic, which will allow them to start to do the kind of clinical investigation we need to do in the early stages of an epidemic to learn more about what the path of physiology of the disease might be, to understand better how the disease is being spread and, most importantly, to understand whether new novel interventions might be useful in the face of a full-blown epidemic, and they did that prospectively to say: what are the things that we could do that we might not do now but we would do in the presence of an epidemic? For example, they actually are following a cohort of people and monitoring their immune response to flu, and they have got the baseline data, so that if we hit a flu epidemic we will actually have all the data on when you get a cellular response, when you get a human response what is it to and who does well, to people with a little bit of background immunity. Is that enough to protect you or do they actually do worse? I think those are all things that are important.

Q51 Dr Harris: What about trials of treatment? Whose responsibility will that be?

Professor Sir John Bell: The trials of treatment, if it is large-scale trials, will be the responsibility of the HTA Programme at the NIHR. I think, though, you need to understand that in terms of novel therapies this has not been a ripe area for novel pharmaceutical development. As you know, there are two agents available, both of which are quite old and have issues associated with them. There is not an awful lot of activity in the drug discovery space for flu, and the reason is you cannot make money with anti-flu drugs unless you have a flu epidemic, and not many people want to bet on the fact that you are going to have a flu epidemic to make money. The reality is that it is one of those market failures, in my view, in that it is not very well incentivised. I think Glaxo lost a lot of money on Relenza.

Q52 Mr Boswell: Back, finally, to communications and stakeholders. It is notorious and very well known that there is a huge charitable involvement with the development of new medicines in the field of medical research. I know Mark Walport is involved with you, but do you feel you relate sufficiently to the charitable sector?

Professor Sir John Bell: Mark has been on our board since its inception. He is a fantastic contributor to our discussions, he very much brings in the Welcome Trust view, which in my view you have to have around the table when you are having these discussions because they do fund an awful lot of science in this space, and he brings a great deal of wisdom.

Q53 Mr Boswell: The smaller charities as well.

Professor Sir John Bell: Less so, and, in fact, I think, if you were going to criticise us to date, you could fairly say you have not engaged the smaller charities as effectively as you could. I think that is fair. We have had our plate pretty full but it is certainly something on the agenda to try and get the right group of people around the table to have those discussions. So I think that is a fair criticism.

Q54 Mr Boswell: The other point which I think, in a sense, comes out of that: in the progress report you said a lot of stakeholders are pretty uncertain as to

what the OSCHR process has been about, and I must say personally, I think your answers today have been very helpful and illuminating, but do you feel that there is more work to be done on what you might call your general remit?

Professor Sir John Bell: This emanates a little bit from where we started, and that was to allow the NIHR and the MRC to put their flags up for what they do, and that is really important because do not want their identities to be in any sense overshadowed by it. You do not know about OSCHR because we have intentionally kept out of the scene, but I think there is a really important message, and that is what does the whole UK public sector, biomedical research enterprise look like fully integrated? Do not talk about who is doing it. What is it? We have just finished a document which is essentially that vision document which describes in its whole what we are trying to achieve. Without saying, "We do this and this and they do that and that", saying, "This is what we do in total", and I hope that will have a big impact in informing the public at large but also other people interested in biomedical research of what we are trying to achieve, and I accept the fact, and I allude to it in my report, that ultimately do not think we have done that as well as we could, and I think everybody acknowledges that.

Chairman: One last question.

Q55 Dr Iddon: I think this is an important question and we should ask it before you go away. How will you relate to the proposed Office for Life Sciences?

Professor Sir John Bell: We have been involved in the Office for Life Sciences discussions but peripherally, not centrally. We have, I think, a good relationship with the people who are leading that from within Paul Drayson's team. We have talked to them about how certain projects that have emerged from that might end up the responsibility of the OSCHR board, and we would be enthusiastic about helping with that. We feel it would be a very important initiative.

Chairman: On that note, could I thank you very much indeed, Professor Sir John Bell and Professor Alex Markham. We hope that you have enjoyed your time with us. We have certainly enjoyed the frankness with which you have responded to our questions. Thank you very much.

Written evidence

Submission from the Office for Strategic Coordination of Health Research (OSCHR)

INTRODUCTION

1. This memorandum provides background on the establishment, operation and progress of the OSCHR. This memorandum was prepared by the OSCHR Office with input from the Department for Innovation, Universities and Skills (DIUS) and the Department of Health (DH).

2. The memorandum is designed to augment the OSCHR Chairman's First Progress Report, which was published in November 2008 and is attached at Annex 1.¹

BACKGROUND TO THE ESTABLISHMENT OF OSCHR

3. On 31 March 2006, the then Chancellor of the Exchequer, Gordon Brown, appointed Sir David Cooksey to lead a review to build agreement on the best institutional arrangements for a new single fund for health research announced in the budget. The Report of the review, "*A Review of UK Health Research Funding*", was published in December 2006.

4. The review concluded that, although good progress had been made in some areas, further work was needed to ensure that publicly funded health research was carried out in the most effective and efficient way, and to facilitate rapid translation of research findings into health and economic benefits. The Report recommended specific actions for the Government to take to achieve this. In his Pre-Budget Report on 6 December 2006, the Chancellor announced that he and the Secretaries of State for Health and for Trade and Industry (now Innovation, Universities and Skills) welcomed the report and would take forward its recommendations.

5. The Review recommended the establish a new Office for Strategic Coordination of Health Research (OSCHR) that would take an overview of budgetary division and research strategies of both the MRC and NIHR.

6. OSCHR was set up in January 2007 following the blueprint laid out in Sir David Cooksey's review, in order to develop a more coherent strategic approach to health research in England. During 2008, this role was extended to all three of the Devolved Administrations. This change reflects the collaborative, multi-disciplinary, multi-centre nature of much health research, and the need to maximise UK competitiveness in a global health research environment.

ROLES AND RELATIONSHIPS

The OSCHR Office

7. As recommended by the Cooksey Review, OSCHR was created as a jointly-staffed and funded office of the Department of Health and the Office of Science and Innovation (OSI) (now DIUS). OSCHR is headed by a non-executive Chair who is appointed by, and reports to, the Secretaries of State for Health and for Innovation, Universities and Skills. Professor Sir John Bell, Regius Professor of Medicine at Oxford University and President of the Academy of Medical Sciences (AMS), was appointed as the first Chair of OSCHR.

8. The work of OSCHR is overseen by the OSCHR Board, which first met in January 2007. Terms of Reference and membership are given at Annex 2. The Board has three non-executive members recruited through the Appointments Commission in accordance with the procedures set by the Office of the Commissioner for Public Appointments and appointed by Ministers. Initially there was representation on the Board from DIUS, DH England, MRC and NIHR, with a single representative for the Devolved Administrations. Following discussions with the Scottish Government, the Welsh Assembly Government, and the Northern Ireland Executive, Scotland, Wales and Northern Ireland agreed to become full Partners in OSCHR in 2008 and now have full representation on the OSCHR Board. The research funders, MRC, NIHR (for England), CSO (for Scotland) and WORD (for Wales), and the R&D Office of the HSSCSA (for Northern Ireland) are now referred to as "**The OSCHR Partners**".

The OSCHR Office

9. The Office is administered by DH England under an agreement between DH and DIUS, and is funded jointly by DH and DIUS.

10. The key messages emerging from the Cooksey Review were that there was the need to:

- ensure a more strategically coherent approach to publicly-funded health research;
- create a step-change improvement in the translation of basic research into health and economic benefits; and
- encourage a stronger partnership with the health industries and charities.

¹ Not printed, see www.nihr.ac.uk/files/pdfs/OSCHR_Progress_Report_18.11.08.pdf

The Roles of the OSCHR Partners

11. The OSCHR Partners are responding to these challenges by developing a shared Vision for UK Health Research. The Partners are working together to realise this Vision through the development of an integrated plan to deliver the Vision supported by five key areas of work: translational research, public health research, E-health records research, research methodology and human capital.

12. All the OSCHR Partners remain the direct funders of research with their own budgets and lines of accountability. Each has, and continues to develop, its own strategy. The major difference since the Cooksey Review is that, under the oversight of the OSCHR Board(s), the OSCHR Partners are now coordinating their strategies to deliver the shared Vision for UK Health Research.

The Role of the OSCHR Board and OSCHR Office

13. The role of the OSCHR Board and OSCHR Office is a) to forge agreement between the OSCHR Partners on the UK Health Research Vision and their integrated plan to deliver the Vision, and b) to monitor the coordination and implementation of the OSCHR Partners' delivery of the Vision.

14. Since the establishment of OSCHR in 2007, the OSCHR Partners have worked to coordinate their strategies in specific areas such as translational medicine, and have then brought these to the OSCHR Board for discussion and agreement.

15. OSCHR has the additional role of submitting a single funding bid to the Treasury covering the activities of the MRC (UK-wide) and the NIHR in England, and the allocation to the MRC and the NIHR rising to over £1.7 billion per annum by 2011 of Government funding needed to deliver the Vision.

16. The OSCHR Partners fund research that covers a very broad spectrum of activity. In order to help OSCHR fulfil its facilitation and monitoring roles three Boards—a Translational Medicine Board (TMB), an E-Health Records Research Board (EHRRB) and a Public Health Research Board (PHRB)—have been established to provide strategic oversight in these areas.

17. The roles of these Boards echo that of the main OSCHR Board in that they advise and monitor the coordination and implementation of the OSCHR Partners' delivery of the Vision according to their Terms of Reference. The Chairmen of the Boards attend OSCHR Board meetings and report on progress to OSCHR Board members. The three Boards were established at different times and are at different stages of development.

PROGRESS TO DATE

18. Full details of progress between January 2007—November 2008 are summarised in OSCHR's **first progress report** which was published on 18 November (Annex 1).

19. The purpose of the OSCHR progress report was to highlight the main elements of the combined approach that has been put in place by the National Institute for Health Research (NIHR) and the Medical Research Council (MRC) since the Cooksey review. This period has seen an unprecedented commitment to health research in terms of funding, infrastructure, research programmes and the volume of health research commissioned.

20. There is a much closer working relationship between the **OSCHR Partners**, the major public funders of health research. Together, as part of a coordinated approach, they are now investing much more into research aimed at translating basic science ideas into new products and approaches to the treatment of disease and illness.

21. During 2007–08 the MRC and NIHR have, under the oversight of the OSCHR Translational Medicine Board, chaired by Prof Sir Alex Markham, jointly developed an ambitious new approach to **translational medicine** research.

22. Coordinated strategies have been created that are designed to increase translational research activity and capacity.

- A system has been created which is designed to swiftly identify the latest advances in basic science, develop their potential into promising interventions, and evaluate effectiveness, value for money and broader impact for use in the NHS.
- By working closely together, a coherent approach to public funding of translational medicine research has been developed by the MRC and NIHR that that provide opportunities for those choosing to move basic medical research discoveries towards commercialisation and clinical use.
- For the first time, the “development gaps” where support was not consistently available have been addressed.

23. In the area of **electronic records research**, the OSCHR's E-Health Records Research Board, chaired by Prof Ian Diamond, has been working to facilitate coordination of funders' strategies in the area of E-health records research in order to maximise preparedness of the research community for exploitation of the CfH Research Capability Programme. A Strategic Framework for Health Informatics in Support of Research has been agreed to aid coordination of UK funders' strategies (including: maximising current

investment, funding of infrastructure & novel research, training of human capital etc.) and a Strategic Coordination Group bringing together the major funders from the Government and charity sectors has been established.

24. It is envisaged that the Research Capability Programme and equivalents in Scotland and Wales will enable faster and easier access to health-related data sets. This will lead to increased numbers of research applications linking health data with population based research data including biological (genomic), trials, epidemiological and social science data.

25. **Progress in methodology.** The MRC and NIHR share a vision that the UK should lead the world in the development of pioneering research methodologies. A programme of research now supports this aim. It is hoped that research in universities and the NHS will benefit from new and improved ways of designing and conducting clinical research, and translation into patient benefit will be supported by better tools to inform regulatory and adoption decisions, and to support industry R&D needs.

26. **Progress in public health research.** A Public Health research Board chaired by Professor Ray Fitzpatrick was established in December 2008.

27. One of the key recommendations from the 2006 Review of UK health research funding by Sir David Cooksey was to establish “. . . an agreed and understood set of health research priorities for the UK that target the biggest and most important health challenges for the UK over the coming decade.” During 2008, OSCHR coordinated a multi-stage project with the overall objective of identifying and prioritising “UK health research opportunities” over the next decade.

28. Extensive debate and discussion lead by the MRC identified that the key opportunities for maximum impact in health research over the coming years would be the application of a new and developing research approaches across a range of diseases and disorders. The Health Research Opportunities were published on the MRC website in February 2009.

FUTURE CHALLENGES IDENTIFIED IN THE CHAIRMAN’S PROGRESS REPORT

29. In his foreword to the 2008 Progress Report the Chairman of OSCHR, Professor Sir John Bell highlighted the progress that had been made in addressing the Cooksey agenda and identified future challenges:

- Communication.
- Commercial interactions.
- Public health research.
- Governance of E-health Records Research.
- Capacity building.
- Innovation in the NHS.

30. These challenges are well recognised by the OSCHR Partners and further progress has been made since the Progress Report was published. This is summarised below.

31. There is agreement of the need for better **communication** of the combined funding landscape particularly for industry. A co-ordinated Communication Strategy is being developed by the OSCHR Partners.

32. Developing **public health** research is an OSCHR priority for 2009. The new Public Health Research Board has met and is currently engaged in mapping the public health research landscape. It will monitor the coordination and implementation of the OSCHR Partners’ coordinated approach. Meanwhile, the MRC and NIHR have each taken a strategic coordination lead in two major areas of public health need with the MRC leading on Ageing and on Addiction & Mental Health, and the NIHR leading on Obesity and on Infection.

33. The OSCHR Partners have built further on their ongoing **interactions with industry**. Recent developments include the establishment of the MRC Industry Forum and the start of a collaboration between, industry, MRC, TSB and NIHR on stratified medicine announced in the recent Government response to Sir David Cooksey’s *Review and Refresh of Bioscience 2015* Report. The new (Government) Office for Life Sciences under the oversight of Lord Drayson is also concerned with this agenda. OSCHR and the OSCHR Partners are contributing fully to ongoing discussions.

34. **Capacity building** and training is an OSCHR priority for 2009. Work by the OSCHR Partners to develop a UK-wide Strategic Framework for Human Capital for Health Research is well advanced and will be discussed at the OSCHR Board in May.

35. Significant progress is being made in establishing the Health Research Support Service (HRSS) and equivalents in the Devolved Administrations and through the development of the Strategic Framework for Health Informatics in Support of Research. However, the OSCHR Progress Report highlighted the importance of agreeing appropriate **governance arrangements** that satisfy the public’s and professionals’ expectations and concerns with data security and patient confidentiality.

36. This issue is being tackled through a series of mechanisms that are designed to protect patient identifiable information, whilst enabling research to reach its potential in the UK. In England, a key development is the establishment of the Information Governance Services, to enable research using patient records within a risk based framework of controls. This work is being developed with the advice of the independent National Information Governance Board (NIGB).

37. The Progress Report highlighted the progress made through the NIHR but noted that the commitment to embrace research and innovation is still lacking in many NHS Trusts. Since then there have been a number of developments—the NHS Constitution was published in January 2009 after the publication of the Progress Report and makes clear that research is a core part of the NHS in that it enables the NHS to improve the current and future health of the people it serves. In addition the NHS Operating Framework 2009–10 states that providers of NHS care will need to increase their participation in research. The national ambition is to double the number of patients taking part in clinical trials and other well-designed research studies within five years.

May 2009

Annex 2

OSCHR BOARD MEMBERSHIP AND TERMS OF REFERENCE

OSCHR Board and key functions

OSCHR's mission is to facilitate more efficient translation of health research into health and economic benefits in the UK through better coordination of health research and more coherent funding arrangements to support translation.

The key functions of OSCHR are to:

- work with officials from DH, DIUS and the Devolved Administrations to set the Government's health research strategy, taking into account the advice, priorities and needs set out by NIHR and its equivalents in the Devolved Countries, MRC and the NHS;
- set the budget required to deliver this strategy and submit a single Spending Review bid to the Treasury;
- communicate the UK's health research opportunities to major stakeholder groups;
- monitor delivery of the strategy against objectives and report to Parliament on progress; and
- encourage a stronger partnership between Government, health industries and charities.

OSCHR's role is a) to forge agreement between the OSCHR Partners on the UK Health Research Vision and their integrated plan to deliver the Vision, and b) to monitor the coordination and implementation of the OSCHR Partners' delivery of the Vision.

Membership of the OSCHR Board

- Professor Sir John Bell—Chair, OSCHR
- Professor Sir Leszek Borysiewicz—CEO, MRC
- Professor Dame Sally Davies—Director General R&D, DH, England
- Dr Russell Hamilton—In lieu of CEO, NIHR
- Dr Tony Jewell—CMO, Welsh Assembly Government
- Sir Alan Langlands—CEO, HEFCE
- Professor Sir John Savill—Chief Scientist, Scottish Government
- Professor Adrian Smith—Director General of Science and Research, DIUS
- Sir Mark Walport—Director of The Wellcome Trust (Non-Executive member)
- 2 non-executive members currently being recruited

In attendance: Professor Sir Alex Markham (Chair TMB), Professor Ian Diamond (Chair EHRRB), Professor Ray Fitzpatrick (Chair PHRB), OSCHR Office lead officials.