

ADDENBROOKE'S NHS TRUST VISIT SUMMARY

Held at Addenbrooke's Hospital, Cambridge on Thursday 6th November 2003

In the Chair: The Baroness David

Member, The Foundation for Science and Technology

Speakers:

Dr Mary Archer

Chairman, Addenbrooke's NHS Trust Hospital

Sir Keith Peters FRS PMedSci

Regius Professor of Physic, Cambridge University

Professor Krishna Catterjee FMedSci

Professor of Endocrinology and Director of Wellcome Trust Clinical Research Facility

Professor Alastair Compston

Professor of Neurology

Professor Bruce Ponder

Professor of Oncology

Professor John Pickard FMedSci

Professor of Neurosurgery and Chairman and Clinical Director of Wolfson Brain Imaging Centre

Dr Robert Winter

Medical Director, Addenbrooke's NHS Trust

Dr Richard Henderson FRS FMedSci

Director MRC Laboratory of Molecular Biology

DR. MARY ARCHER, welcoming the Foundation, said this discussion and visit were a follow up to an earlier discussion at the FST on building partnerships in Medical Sciences¹. She outlined briefly the status, regional stretch and specialisms of the hospital; its close links with the Cambridge School of Clinical Medicine and its outstanding research work, which was closely aligned with NHS priorities. Its aim was to create, in partnership with the University, the R&D Consortium, Cambridge Enterprise and other bodies, an academic and clinical centre of international stature for world class treatment, teaching and research. Its 2020 Vision enshrined major developments of research centres which, together with the MRC (Medical Research Council), would create an outstanding biomedical research site.

PROFESSOR SIR KEITH PETERS stressed the importance of the partnership between the University, the NHS and the MRC. He viewed the work of clinical academics as an integral part of NHS delivery. But inevitably there were tensions between research and teaching agendas and NHS priorities. The report of the Academy of Medical Sciences "Strengthening Clinical Research"² addressed these issues, and its recommendations, if accepted, would greatly help.

PROFESSOR CHATTERJEE outlined the great benefits that the establishment of the Wellcome Trust Clinical Research Facility had brought. Whereas in 1990 the pressure on NHS facilities had been such that research was severely impeded (some patients had to be housed in B&Bs), an integrated programme of research from clinical researchers, non clinical scientists, and health care professionals could now be implemented. Obesity research and brain imaging work (which enabled more reliable predictions to be made of the outcome of coma) were current projects. But funding for NHS R&D; finding and training staff with the necessary skills, and the effect of the European Clinical Trials directive were all problems.

PROFESSOR COMPSTON outlined the work in the Neurology Unit, which was seeking to help patients with common problems such as stroke and MS. He described the use of Campath in treating MS; the biological and clinical lessons learnt from its use, and the initial failure to reduce the impact of the disease. But clinical research, which necessarily involved using NHS patients, was leading to more successful treatment.

PROFESSOR PONDER described the ability of researchers to use the NHS "laboratory" as unique. It must not be wasted. It should provide an excellent clinical service, a strong platform for research and a firm environment for clinical research. Research, which led to better care for cancer patients,

¹ Report available on www.foundation.org.uk

² Report available on www.acmedsci.ac.uk/p_scr.pdf

depended on clinical doctors asking the right questions, an organization collecting data, and scientists working on it. The West Anglia Cancer Network was providing a database and enabling improved standards of care to be rolled out. Close vicinity of research and clinical work, as at Addenbrooke's was vital; joint appointments were made. He described research, which would lessen the toxicity of treatment on individuals, and predict circumstances when cancer might develop. The problems were, still, the danger that clinical research would be squeezed between NHS priorities and pure science, and the lack of trained staff.

PROFESSOR PICKARD described the importance of the Brain Imaging centre for examining the scale of brain damage, studying who can benefit from treatment and assessing the likelihood of recovery. But effective work on the brain should be holistic-starting from preventing damage (seat belts), learning how to avoid secondary shocks, and assessing long term effects (do head injuries in children tend to make them more likely to lead to criminality?). He stressed, therefore, the need in this work for interdisciplinary scientists, (e.g. physicists, psychologists,). This meant resources and recognition by "pure" scientists that clinical research was as important for their careers as other research. But crucial was the ability to analyze a large mass of cases, and to recognize the importance of chance discoveries – serendipity – from within the mass. The alternative was futile Stalinist planning, which assumed you knew what to look for and how to deal with it.

DR. HENDERSON, Director MRC Laboratory of Molecular Biology, outlined some of the major achievements of the Laboratory, not necessarily all medical. He said there were strong links between biologists and clinical school researchers, and between those researchers and clinicians. But the link between biologists and clinicians was weak and should be strengthened.

A major topic in the ensuing discussion was how to identify and preserve ring fenced funding for clinical research; why was it that earlier attempts have its importance recognized and ensure provision for it had failed? Reference was made to Cancer Care, 30 years ago, where a report had led to effective action because the writer had instigated action. But there had been many years of underinvestment. Cancer was now doing well because indicators revealing the benefit of clinical research had become available and networks developed. But other areas were still not being adequately funded, and the value of networks, e.g. for stroke – on the cancer analogy – was not recognized. There was strong support for the "Strengthening Clinical Research" recommendation that a National Network for Clinical Research (NNCR), with allocated funds, should be established: in the context of the NHS budget, the cost would be small.

But the case needed to be made in stronger terms – "stellar" individuals had headed the cancer effort; similar personal commitment was needed now. Ministers would ask, where should the money come from within the NHS budget? Would the savings which came from the research be real? Brain Imaging might mean that more patients spent longer on life support in hospital; no doubt Campath treatment would save money but when would it be widely used in MS case, given the conservatism of many clinicians and delay in getting regulatory approval? 3 or 5 or 10 years? Also, was it right to create a new body outside the MRC and within the existing NHS structure, when that structure was still undergoing change (e.g. Foundation Hospitals (from which Addenbrooke's, as a three star hospital might well benefit). Perhaps more radical thought needed to be given to the existing structures. It was noted that the valuable presentations had inevitably focussed on research; the viewpoint of those committed to meeting NHS priorities was important.

With or without such an NNCR, Cambridge was showing the way in integrating research and clinical work. At the heart of their success was the belief that research was not seen as a luxury; it was considered an essential element within the medical culture and, as such, embedded in the mission statement. Collaboration with industrial and commercial partners was also seen as key. Planning permission for a major extension of the Addenbrooke's site was likely because local politicians realized that it would be of great economic, social and academic value to have research, clinical treatment, and entrepreneurial activity generated in the vicinity.

But perhaps the most important argument for re-establishing clinical research as a well funded and prestigious academic and medical function lay in the need to encourage able scientists and practitioners to develop their skills in areas where they were not only needed but wanted to work. Many of the speakers had outlined their concern about trained staff; and had identified anxiety that if researchers left those well-worn paths in their specific academic disciplines, even if their personal interests lay in clinical research, their careers would suffer. A new body and stable funding would encourage scientists to continue in science in the assurance that they could develop their personal interests as well as helping meet the needs of clinical research. Another argument was economic. Medical research was a vital export; unless the UK continued to produce the scientists and researchers who specialized in it, we would suffer competitively.

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