The British Psychological Society
Promoting excellence in psychology

British Psychological Society response to the Chief Scientist Office

Scottish Government Health Research Strategy

About the Society
The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries
We are content for our response, as well as our name and address, to be made public. We are also content for the CSO to contact us in the future in relation to this inquiry. Please direct all queries to:-

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About this Response

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	• **Should CSO and the Health Boards set any eligibility criteria for nodal R&D Directors? Should appointment of a nodal R&D Director be for a specific term, and if so what term would be appropriate?**
1.	Comments: The Society believes that given the range of research undertaken in the NHS, it is potentially too problematic to set eligibility criteria around the type of research a nodal R&D director has undertaken. It would, however, be helpful if they had direct experience of undertaking research within an NHS context. Specific terms of appointment would be useful for review purposes with the understanding that appointments were renewable. An initial appointment term should be for no less than 5 years as a shorter term might deter quality applicants.
	• **CSO proposes to approve the functions of staff in R&D Offices; should CSO seek to standardise local R&D functions across Scotland, or is it preferable to allow local flexibility?**
2.	Comments: We would welcome local flexibility, as this will benefit the local research community and avoid unnecessary bureaucracy.
	• **Are there other NRS functions that might usefully be transferred from the Health Boards or CSO to the new NRS-GMS? Are there functions not currently being undertaken that the NRS-GMS might carry out?**
3.	Comments: The Society welcomes the proposal for NRS-GMS to facilitate the work of the NRS Strategic Board and to work independently of all Health Boards. It will be important, however, to communicate the role of the NRS-GMS to the research community to reassure them that the NRS-GMS do not add an extra layer of bureaucracy to an already complicated and paper-heavy system.
	• **To what extent should the joint planning of the deployment of infrastructure resources be formalised? Should there be a formal record of such discussions?**
4.	Comments: The Society welcomes plans to better advertise the availability of resources. A formal record of discussions may not be necessary and investment in increasing awareness

	may be a better use of funds.
	• **Taken together, will these steps to both free up and promote the availability of NRS resources address current concerns over lack of time and support? If not, are there other steps CSO should take?**
5.	Comments: We welcome steps to help ensure that research funding is allocated to support time. However, not all departments are able to back-fill clinicians' time; therefore blocks may still remain for some departments in terms of applying for funding and undertaking research.
	• **Are there any further changes that should be made to improve the efficient delivery of patients to studies through the NRS Networks and Specialty Groups?**
6.	Comments: The Society welcomes the plans to improve the impact of NRS Topic Networks and Specialty Groups both of which already do excellent work.
	• **To what extent do delays continue to occur as a consequence of differing NHS and university requirements? To what extent is closer integration of NRS and university functions possible and desirable?**
7.	Comments: The Society believes that it would be more efficient if NHS based studies could bypass the need for duplicate University based ethics processes. However, sponsorship of research projects by Universities could preclude this. We believe that including detailed expectations of University ethics committees (in terms of timeframes for consideration of applications etc) as part of the conditions of award for CSO funded work should be considered.
	• **Would a trial register be of benefit to patients seeking trials? Would it be an effective way to partner patients with researchers? Is there a danger that expectations of taking part could be unfairly raised?**
8.	Comments: Given the increasing use of SHARE, there is some confusion regarding the multiple websites that provide similar information. We believe that it would be beneficial to integrate a search function into the SHARE website that allows patients to search available research projects. The Society has concerns regarding the proposed trials register. A much wider range of research is undertaken in the NHS with much less support than is typically given to

	trials. We believe that it would be beneficial to include all research approved by NHS ethics in Scotland on such a register. The Society would welcome a comprehensive register but believes that it will require high quality management and oversight. It is important to ensure that patients are provided with information that enables them to make an informed choice about whether to volunteer for any particular study and what their participation will involve.
	• **Would using electronic NHS patient records to alert GPs to research studies for which their patients may be eligible be a service the NHS should offer? If so, would a process where NHS records are only accessed by identified NHS staff working in secure facilities, and only passing potential participant names to their GPs or hospital consultants for consideration, be a suitable way to proceed?**
9.	Comments: The Society welcomes the importance placed on improving recruitment into trials and acknowledges the important role primary care plays in this. However, we believe that before this strategy is implemented it is important to understand how GPs would use the information supplied to them. There is little evidence that GPs will act on the information to inform their patients and work to support them in their decision to participate. With GPs under immense time pressure, they could struggle to find the time to act on any information received.
	• **What proportion of CSO funding should be available for deployment in new research initiatives relevant to the NHS? In what areas should CSO seek to disinvest to free up resources?**
10.	Comments: Freeing up resources for new research initiatives is welcomed by the Society. However, more information on the criteria for withdrawing funding from existing areas of activity would be beneficial.
	• **Is the focus of the CSO response mode grant schemes adequately defined and understood by the research community? Should there be a narrower focus to complement and avoid overlap with other funding streams Scottish researchers have access to? What is a realistic upper level for CSO grants to allow worthwhile projects to progress?**
11.	Comments: The Society welcomes the current strategy to focus funding on the early development and feasibility stages and then to expect that funding for the later stages in trial development and implementation will be sought from UK sources. However, the £225K cap is low, especially as it has to accommodate 80%FEC. We recommend that

	increasing the cap to £500K is considered to allow their funding Boards, under guidance, to evaluate the merits of each application against the resources requested.
	• **What should determine the creation and continued funding of a CSO unit? Should any new unit have a plan for CSO funding to be time limited?**
12.	Comments: We believe that continued funding should be determined by the current quinquennial review process. New units could benefit from a review process that is not solely time determined. There is merit in also having a function/outcome focus. The timeframe for achievement of particular functions/outcomes would vary. For example, a unit established to increase research capacity in an area or discipline would require more time to achieve this outcome, as it requires the training of personnel and the career development and progression of such personnel.
	• **Are there other key areas of partnership CSO should be seeking to build?**
13.	Comments: The Society welcomes the diverse range of partners as this is seen as a strength. There is a general focus in the Strategy Review on the pharmaceutical industry and informatics. We acknowledge the importance of both sectors. However, the health priorities of Scotland will only be achieved through behaviour change on the part of patients, families and health professionals. Changes in behavior extend beyond the adoption of primary prevention behaviours such as the adoption of a healthy diet, smoking cessation, alcohol reduction and increased physical activity. All improvements in human health have required a change in the behaviour of patients and/or health professionals, for example, pharmaceuticals only improve health outcomes if patients adhere to their treatment; adherence is behaviour. The importance of behavioural science is absent from the current Strategy Review. Behavioural Science is the remit of psychology and the Society would welcome any opportunity to provide its expertise to the furtherance of the CSO's aim to improve the health and wellbeing of the people of Scotland.
	• **Would the creation of a CSO International Advisory Board be a positive step in raising Scotland's research profile and supporting our ambition? What should be the make-up of such a Board?**
14.	Comments: The Society would welcome such a Board. However, it would be important to ensure that the Board had a detailed understanding of the Scottish NHS context. This would be best achieved through an Advisory Board that included both national and international expertise.

	It will be important to include a wide variety of expertise such as academic researchers, clinicians (including allied health professionals) and representatives from the CSO's key partners.
	• **Are there other areas where CSO funded research could better support the Health Directorates Quality agenda?**
15.	Comments: We welcome the SISCC initiative. It is important that the work in the Quality Improvement field in Scotland is reflected by a Scottish presence in peer reviewed journals. It is important to ensure that Quality Improvement Science also addresses the integration of health and social care sectors. Care is increasingly delivered outside traditional NHS settings and there will be an accompanying need to ensure that patient safety is secured in this wider context.
	• **Is the Primary Care Research Career Award scheme suitably focused to attract suitable high quality applicants? If not, what would a revised focus be?**
16.	Comments: It would be beneficial to maintain this. However, we believe that the scope should be broadened to include all health professionals working within Primary Care.
	• **Are the current CSO personal award schemes targeted to meet our future needs? If not, should CSO conduct a wider review of its capacity building schemes?**
17.	Comments: The Society believes that it would be beneficial to review the current personal fellowship schemes with regard to the feasibility of applications from different health-related professions in Scotland. There are disparities between the current personal fellowship schemes for clinical (i.e. medical and dental) and other applicants. The clinical (medical and dental) scheme allows for a salary award at the clinician's own current scale, as well as research costs of £10k for each of the three years of the award. By contrast, the equivalent pre-doctoral scheme (HSPH) for non-medics/dentists sets a specific salary cap (£28k) and allows research costs of £10k for the entire award. The HSPH pre-doctoral scheme is the only scheme open to pre-doctoral non-clinical staff from a range of disciplines including psychology, social sciences, health economics, statistics etc, as well as all non-medical/dental clinical staff including nurses and allied health professionals. The salary costs allowed for this scheme are insufficient to cover anyone who is employed above the lower spine points of a university Grade 6 scale or the NHS Band 6 scale, i.e. all qualified clinical

	psychologists, allied health professionals at middle to senior level, and experienced university research assistants and research associates. The fellowship scheme allows for such applicants to apply for the maximum salary amount (£28k) for less than full-time hours in order that they can top up their salary with clinical sessions or other employment. This may not fit with the demands of the fellowship project (which must still be completed in three years) and creates additional complexity for those fellows. This situation could discourage able and suitable candidates from those professions from applying. The Society believes that it would be beneficial to harmonise the salary and research cost provisions of the medical/dental and HSPH fellowship schemes so that the best candidates feel able to apply on an equal footing from all health-related professions, therefore ensuring equitable investment in research training across the board.

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