Below is the response from Senior Academic and Clinical Staff, Mental Health & Wellbeing, University of Glasgow.

The comments are organised into two sections:

(1) General comments

(2) Specific responses to the consultation questions

General Comments

- Given the major challenges that Scotland faces in terms of inequalities in health, we would encourage the CSO to be explicit in addressing this issue, in respect of both mental as well as physical health. Other disadvantaged populations (including those with intellectual disability) should also be prioritised.
- The emphasis on efficient R&D support for research is important. There is a general sense that most researchers have come to feel that whilst R&D do an excellent job of scrutinising research in advance of ethics so preventing greater delays at or post-ethics review, there would appear to be a great burden on R&D staff performing these important tasks and this has come to be something of a bottleneck in terms of getting projects approved. Are there sufficient staff to do these tasks? The complexity of the processes involved in project approval also put off clinicians from engaging in research within the NHS.
- The reason given for having a group of international experts to set the research agenda is that Scotland remains heavily reliant on international expertise. Yet no data is presented about the contribution that Scotland makes to published research in the field, and whether Scotland punches above or below its weight internationally.
- The importance of public engagement is highlighted but it is unclear how the proposed public involvement would help to influence or govern the research agenda.
- Narrowing the focus of funding opportunities by the CSO would risk undermining interest in health-related research amongst many University academics and clinicians alike.
- A range of new bodies has been recommended to co-ordinate and oversee research, presumably reducing the money available to actually carry out research. Is there any evidence to suggest that a more managed approach by the CSO will increase research activity and quality?
- It is an excellent idea to promote a research culture and more support for research in the NHS. Backfill for clinical time is essential to obtain service support for trials of complex interventions.
- As noted elsewhere, narrowing the focus of CSO response mode grants is potentially concerning. Perhaps if this is accompanied by a service that allows researchers an opportunity to put in a brief outline of a project to determine suitability and if not suitable to receive clear direction regarding where is more appropriate (i.e., if the only reason for narrowing the range is because other sources are specifically available it ought to be straightforward to provide the information on what source of

funding is more appropriate, and if not straightforward then narrowing the range would not seem to be helpful).

- It is absolutely clear that the culture of the NHS is such that research is not prioritised and most clinicians find it difficult to justify or defend time spent on research activities. This is preventing research from being done, making it more difficult for academics to form effective partnerships with clinicians. A research active clinical environment is more likely to lead to continually improving practice and so finding ways to continue to encourage this is vital and so more investment in clinical academics is important, but a strong focus on supporting a research active environment within clinical services is needed.
- It is important to continue to stimulate research activity in Scotland with moderate size grants up to 250k and expand funding for this given the high proportion of non-funded applications.
- The CSO should further consider fellowship funding for non-medical academic/clinicians. It would also be helpful to have more information/plans for auditing existing schemes.

Chapter 1 – Efficient R&D Support for Research

Question 1: 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 time, and if so what term would be appropriate?

RESPONSE: Yes, we believe that it would be helpful to specify eligibility criteria and that the term should be fixed (no more than 5 years) perhaps with the opportunity of an extension (subject to standard performance review processes).

Question 2: 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?

RESPONSE: We believe that the main functions and procedures of R&D offices should be consistent (to avoid researchers having to deal with different approaches between health boards), but there should be the provision for some local flexibility. There is a difficult balance to be struck. It would be important to have nationally agreed standards and workflow parameters but local flexibility could lead to some welcome fine-tuning with efficiency-savings. More university academic involvement would be helpful in this regard.

Question 3: 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?

RESPONSE: The operational role of the NRS-GMS and GM is clearly outlined, however, it is not clear the extent to which it would have a strategic role. In 1.11, it is noted that the NRS-GM will become a member of the NRS Strategy

Board. Will this simply be to reflect upon operational matters or would s/he contribute to the strategic direction of the Strategy Board?

We did not think other NRS functions should be transferred. However, we wondered whether one function of NRS-GMS might be to reduce confusion around how NHS support funds are calculated?

Question 4: To what extent should the joint planning of the deployment of infrastructure resources be formalised? Should there be a formal record of such discussions?

Response: Yes, such discussions should be open and transparent. In addition we think there should be regular national and local audits of the decision making/research support processes.

Question 5: 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?

RESPONSE: It is difficult to judge without knowing how effective the existing functions/systems are. For example, is their evidence that the detailed review of applications before they go to ethics is necessary and/or beneficial? It would be good to receive some reassurance that the proposed additional administrative resources are not going to further diminish the already scare resource for research funding. Having noted the resources issue, it might be worth examining the provision of more administrative support within nodal R&D centres, which, at times, seem to be overwhelmed by the volume of work.

Question 6: Are there any further changes that should be made to improve the efficient delivery of patients to studies through the NRS Networks and Speciality Groups?

RESPONSE: Although we understand the focus on stratified medicine and informatics, we are concerned that other areas and types of research may be forgotten. For example, is there any plan to invest in growing historically less active areas of research (e.g. mental health)? There is no reference to mental health in the document. It seems that investing more in supporting recruitment to studies in the "big" domains of Cardiovascular, Musculoskeletal and Reproductive Health and Childbirth runs the risk of limiting the growth potential of other areas that also have trouble recruiting for studies.

Question 7: 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?

RESPONSE: We welcome the establishment of the proposed NRS Integrated Support Services and the focus on supporting as well as approving

research. We believe that in recent years there has been considerable convergence in respect of the NHS versus university requirements. The delays are rarely on the University-side in respect of ethical approval and we hope that the new support services will reduce delays further.

A major issue that needs to be addressed, though, concerns the Research Passport system. As it is difficult to make much progress on obtaining this before a research assistant is in place, it can lead to up to six months delay in data collection (potentially jeopardising projects). We would urge closer cooperation between the NRS and the universities to address this bottleneck in the research process. A number of related issues are also worth highlighting which may be addressed by the new arrangements. There is still the tendency of the NHS R&D to adopt a "one size fits all" approach to approvals and governance processes. This can result in some delays and also inequitable treatment. For example, where a research council funded grant gets prioritised over doctoral student research for R&D processing. Although we can understand the need for prioritisation, teaching and training researchers is core university business and it is vital for training the next generation of health researchers. Perhaps there is an opportunity to agree processes between the NRS and universities so that they better match the different types of projects that are undertaken.

We also wonder whether the re-allocation of funding might be used to address the issue of funding staff through the AcoRD funding system, which arguably dissuades many researchers from pursuing treatment intervention research. Currently this system means that at relatively short notice a service may be asked to fund posts for eligible research projects from already stretched budgets. Whilst the amount of this funding is capped, it is still significant for any one service within a health board (e.g. 25K for GG&C services). This means that these costs can escalate quickly for individual boards where clinical and academic collaborations are successful. This may affect how NHS managers feel about research or academics feel about doing treatment research (particularly psychological interventions which are prioritised in the NHS Mental Health Strategy). There is a risk that Scottish Research will become a consumer not a leader in this research area.

Chapter 2 – Partnership with Scottish Patients and Public

Question 8: 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?

RESPONSE: Yes, this is a welcome development and we believe that it will be of benefit to patients seeking trials. We assume, however, that the pilot Trial Register will be evaluated? We also agree that it has the potential to be an effective way of partnering patients and researchers. It may also be worth working in partnership with major Scottish charities at local and national levels. Expectations of participants will need to be carefully managed. Potential participants needs to be made aware that there will be

study-specific inclusion and exclusion criteria and that the study may not be of benefit to the individual (however, this should be straightforward to manage with clear initial information and subsequent communication).

Question 9: Would using electronic NHS patient records to alert GPs to research studies for which their patients may be eligible 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?

RESPONSE: Universal agreement that this an extremely welcome development and the proposed method of access seems appropriate. A challenge, however, will be to ensure that eligible patients are routinely invited when the system goes live. However, we imagine this service would be evaluated in due course to examine its effectiveness/utility.

Chapter 3 – Targeted Deployment of Resources and Infrastructure

Question 10: 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?

RESPONSE: 23% of the UK population are affected by mental health problems at some point each year and the economic and social cost of mental health in the UK is £105 billion – yet only 5.5% of UK research is dedicated to the area. We would suggest that relative contributions to mental health research are considered against investment in other domains that are relatively better resourced.

Question 11: 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?

RESPONSE: Clarity of CSO response mode grants would be welcome but this should not necessarily mean that there is a narrower focus. The CSO scheme operates in the context of a wider research environment in the UK and greater clarity of co-ordination with other schemes would be helpful particularly the creation of pathways from feasibility and pilot studies to full scale definitive clinical trials. Funding ceilings need to reflect the work required to develop complex interventions guided by the MRC Complex Interventions Framework. An area of research funding that is not available in Scotland is the Research for Patient Benefit framework in England and this funding programme has been successful in cultivating innovations in research and collaborations between HEIs, NHS, patients and carers.

Question 12: 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?

RESPONSE: Insufficient information available to comment

Chapter 4 – Working in Collaboration
Question 13: Are there other key areas of partnership CSO should be seeking to build?

RESPONSE: Third Sector Organisations, Scottish Recovery Network and service user and carer organisations.

Question 14: 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?

RESPONSE: We are not yet convinced that the expense of this new Advisory Board would be justified. There are many researchers in Scotland with international reputations working on globally relevant issues. So it is quite possible to identify experts to advise CSO on international issues. The question seems to be more one of whether CSO should have an exclusive focus on issues that are relevant to Scotland or whether it wants to address issues that might not be apriority here but are elsewhere. One example might be treating malaria. Another might be assessing for dementia in people who are illiterate (not such a major issue here, but vital in all developing countries where literacy rates remain low). However, recruiting representatives from successful international research institutes, especially if those representatives are themselves successful in attracting funding for excellent research, is welcome – but the cost/benefits would need to be evaluated. Perhaps such a Board could be piloted and evaluated against very clear aims and objectives.

Question 15: Are there other areas were CSO funded research could better support the Health Directorates Quality agenda?

RESPONSE: The importance of developing opportunities for all health services staff to become involved in research and in particular the need to anticipate the needs of the research workforce of Scotland in terms of developing inclusive schemes for the development of clinical academics in nursing, applied psychology, PAMs and medicine.

Chapter 5 – Investing in the Future
Question 16: Is the Primary Care Research Career Award scheme suitably focused to attract suitable high quality applicants? If not, what would a revised focus be?

RESPONSE: not applicable.

Question 17: Do 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?

PROPOSED RESPONSE: A wider review would be welcome. The current Scottish Clinical Academic Training Fellowship Scheme is only open to medical disciplines.