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Date	20 October 2014
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Dear Professor Morris

CSO Draft Research Strategy

Please find enclosed a copy of the NHS Fife comments on the Draft Research Strategy. Please accept my apologies for the delay in forwarding these to you.

Thank you very much for the opportunity to make these comments which have been developed through formal consultation with senior clinicians, managers and leaders involved in R&D within NHS Fife.

Yours sincerely

Dr Brian Montgomery
Interim Chief Executive

Enc

NHS Fife response to CSO draft research strategy 2014

GENERAL COMMENTS

NHS Fife commends any steps taken to reduce bureaucracy, improve links between NHS & academia and increase investment in research to sustain the science base while improving the health of the Scottish population.

We support the strategy review and the 5 key areas identified for action.

NHS Fife has some concern about the increasing emphasis on supra-Board posts and functions. Organisations that are currently performing well such as NHS Fife should be supported to continue with their current approach. However, we acknowledge that central resources carrying out bureaucratic functions such as generic review and costings, which require to be undertaken with a consistent national approach, could benefit Scotland and in turn free up R&D offices to be more innovative in their approach to developing capacity, capability and collaborative relationships aimed at maximising research activity.

PREFACE

We support the principles outlined and the emphasis on data linkage research.

There should also be some explanation of how the research priorities have been identified. We would also wish to see a commitment to supporting other up and coming areas of clinical research. This in turn may lead to a decision to stop research into areas where NHS Scotland does not have an identifiable advantage.

CHAPTER 1

1.4-1.6 *"Nodal" R&D directors*

There has so far been relatively little input or support from the R&D directors beyond their own Boards so we are unsure whether this would be successful. Whilst the East of Scotland node has achieved some efficiencies this has been as a result of mutual input by all parties, rather than as a result of the specific direction of the Node Lead.

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 term, and if so what term would be appropriate?

Whilst NHS Fife accepts the potential usefulness of nodal R&D directors, there must be clear structures that allow existing/new R&D directors/leads, in all Boards, who are best placed to understand the needs of their own organisations and provide the most informed input into this process.

If the local leads are superseded by nodal Directors, the risks due to a nodal Director's actions would fall to the individual Boards without the Board having any control over the actions. The local and nodal leads should work collaboratively to achieve national aims and to operate as a pan-Scotland single site.

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?

Some standardisation would be advantageous and welcomed with the CSO setting out the functions that R&D offices must perform in order to make proper use of management funding provided to them.

It should be noted that each Board and R&D office has different structures and needs, and individual R&D offices have many functions out with those funded by CSO. Therefore, provided all CSO functions are carried out adequately, local flexibility must be retained within R&D, provided all CSO functions are carried out adequately, in order to support their local Board with its own unique portfolio of requirements in order to maximise local capacity, capability & collaborations.

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?

The main "generic" functions have already been identified: collecting activity information and managing funding. In addition, NRSPCC already co-ordinates generic aspects of R&D approval. Centralising these should help to increase the efficiency of research governance.

We remain unconvinced that the centralisation of Health Board functions is the preferred option in all cases. Current functions/activities of all partners should be mapped against the "ideal" map of functions/activities.

It should then be possible to identify the changes/efficiencies required and decide what additional functions might be taken on by NRS-GMS.

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?

Where one party is involved in planning that may affect the resources made available to another, this should certainly be formalised. If there is formal planning, then a formal record should be kept, for transparency.

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?

These steps will probably help address the issues identified in the question but are unlikely to solve them. This can only be done by further investment in R&D infrastructure posts such as research nurse and additional data management support. Such infrastructure along with Researcher Support funding would allow us to address the current shortfall in support/resources to facilitate time/backfill to allow clinicians the time away from normal clinical duties.

In NHS Fife we are currently undertaking organisation-wide awareness training, promoting to all staff the availability of NRS resources, and the support provided by the R&D Department and its staff.

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 Specialty Groups?

Measures must be put in place to ensure that the focus of the Networks and SGs goes beyond the 4 large Boards. The role and remit of the new topic specific and Nodal Delivery Managers should include specific provision for ensuring equitable support for all Boards.

In some Boards (such as NHS Fife) where we have employment responsibilities for 3 of the SG Leads the roles of the networks and SG is well embedded. Networks providing funding towards 50% of our R&D research nurses, enabling growth in activity. Although limited, any reduction in this support would severely compromise future effectiveness. Efficient delivery of patients to studies will be achieved by continuing to exploit local structures and relationships which must be preserved and developed to help deliver the strategy.

1.23 We will also seek to combine the Scottish Research Ethics Service and NRS R&D Offices into a single integrated service for researchers
The sentence should read "NHS R&D offices", not "NRS"

Given the considerable overlap in application forms etc., seems very sensible to integrate these reviews as far as possible, provided there is a very clear understanding about which aspects of the study MUST be reviewed and approved by R&D and which by the REC.

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?

Locally the main delays have occurred when working with Universities that continue to insist on using non-standard contracts or other documents. There can also be problems working with Universities that do not routinely carry out NHS research.

Where organisations work with NHS R&D regularly it is advantageous to have the various functions either integrated or carefully aligned to avoid duplication, contradiction and delay.

CHAPTER 2

New trial register

Increasing public awareness of, interest in and access to health research is very important. Although the discussion of the register only mentions clinical trials, the vast majority of research in the NHS consists of other types of studies of equal importance. Clarity is required around what the criteria will be for including studies in the register

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?

An online resource might not reach some older patients who are generally more likely to want to take part in research.

There are a number of issues that would need to be addressed in order to ensure that the register worked. These include the additional burden on GPs/consultants, the probability of unsuitable candidates putting themselves forward and the creation of unrealistic expectations

Question 9: 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?

We do not feel that this would be a suitable service to offer at the present time. The experience of sending electronic clinical alerts is that GPs do not make use of them. Providing suitably qualified staff to search the records would be difficult and expensive. This might be more suitable as an additional way to improve recruitment to locally approved studies. Before

implementing any scheme of this type it would be advisable to inform the people of Scotland that it is going to happen and perhaps allow them to opt out.

In addition, the proposal does not recognise the existence/role of community consultants and other community based clinicians.

CHAPTER 3

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?

The research community would have to be surveyed to answer the first question. It would certainly be sensible to avoid overlap with other available sources of funding, providing Scottish based researchers can be guaranteed equitable access to them

3.10 From 2016 CSO will revise the allocation of underpinning infrastructure funds to ensure a more equitable deployment of resource based on activity.

We strongly support this initiative. However, for it to be genuinely equitable infrastructure funding must be directed to and reach the organisations where activity is happening.

Early priorities for such review are …the £0.9m per annum investment in safe havens.
We strongly support the investment in safe havens

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?

We do not have sufficient information about the units to answer this. Clearly the work must be of a high quality. Units should be created and/or funded when there is a clearly identified need for a focus on a particular discipline and where it is clear that improvements can be achieved.

The default response should not be to create a new organisation.

Where a unit is carrying out work deemed valuable by the CSO, then it seems appropriate that the CSI should continue to fund it. This should not preclude the identification of and application for other sources of funding.

CHAPTER 4

Question 13: Are there other key areas of partnership CSO should be seeking to build?
Far greater links should be forged with Europe

Scotland's unique collection of patient data should make us a valuable partner to many research organisations, particularly for epidemiological work

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?

Although we would require further information re the membership/benefit of such a Board, if this provided a mechanism for raising Scotland's research profile and influence on deployment of funding then this would seem beneficial.

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

A greater emphasis on the actual uptake and implementation of innovation and improvement would be most beneficial

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?

It might be more valuable to offer awards to newly qualified medics wanting to go into GP practice, to provide them with additional training and support with course fees.

Question 17: 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?

We do not have enough information to answer this fully. In general, these schemes are biased towards medical staff.