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GERIATRIC MEDICINE
Division of Health Sciences
SCHOOL *of* CLINICAL SCIENCES
The University of Edinburgh
Room S1642
Royal Infirmary of Edinburgh
51 Little France Crescent
Edinburgh EH16 4SA

Secretaries: Ms M Harding
Mrs S Moncrieff

Telephone 0044 (0)131 242 6481
Fax 0044 (0)131 242 6370

www.geriatric.med.ed.ac.uk

Professor Andrew Morris and Mr Mike Stephens
Chief Scientist Office
Scottish Government Health Directorates
St Andrew's House
Regent Road
Edinburgh
EH1 3DG

Dear Professor Morris and Mr Stephens

NIHR Ageing Scotland's response to draft CSO research strategy

Thanks you for circulating the new Scottish Government Health Research Strategy. I have consulted with colleagues in the NIHR CRN Ageing Scotland Group, and I am delighted to submit a response on the Group's behalf.

The Group welcomes the CSO vision of supporting and increasing the level of high quality research that is performed so that Scotland is recognised globally as a "come to place" for health science. The Group supports the six guiding principles listed in the strategy and the focus on the five key areas of Efficient R&D Support for Research, Partnership with Scottish Patients and the Public, Targeted Deployment of Resources, Working in Collaboration and Investing in the Future.

The Group notes that there is no focus on supporting research specifically in ageing. In 2010, the Scottish Government published a paper on Demographic change in Scotland (http://www.scotland.gov.uk/Publications/2010/11/24111237/0), in which the increased proportion of older people in the population was identified as a big issue for Scotland. We note that the Scottish Governments National Performance framework (http://www.scotland.gov.uk/About/Performance/scotPerforms) includes the important strategic objectives: 'We lead longer healthier Lives', and 'Our people are able to maintain their independence as they get older and are able to access appropriate support when they need it'.

We welcome the increased longevity that the people of Scotland enjoy, but we are also aware that demographic change brings challenges. A key goal of much of our current research is to ensure that older people remain healthy and able to maintain their independence. Clinicians and researchers need to continue to work collaboratively to find novel ways to prevent and treat age-related conditions such as dementia, stroke, osteoporosis and sarcopenia. We also need to find better ways to provide care for frail older people-many of whom do not fit into 'single organ' specialties but who have multiple co-morbidities and often present non-specifically with falls, confusion and incontinence. We wonder whether the focus on informatics, big data and stratified medicine might reinforce the single disease paradigm and discourage much-needed research into the management of frail, disabled older people with multiple comorbidities? We would welcome a statement in the strategy about demographic change and the need for researchers to focus not just on single organ diseases but on frail older patients with multiple comorbidities.

We welcome the opportunities that NRS fellowships bring for consultants who are at an early stage in their consultant career. Our Group has noted that it is very difficult for established NHS geriatricians to contribute to research due to increasing clinical workload and pressure on job plans. Many NHS geriatricians in Scotland have had research training and experience as well as having extensive clinical experience caring for older people. We hope that the CSO's proposals for R&D support will enable these more experienced geriatricians to actively contribute to research.

We note that the CSO intends to work more closely with NETSCC and we welcome this. However, a major concern is that some NIHR funding streams e.g. program grant applications are not open to researchers based in Scotland. Members of our Group have had some recent successes in obtaining major NIHR funding from Health Technology Assesment, but being unable to apply to all the NETSCC streams puts us at a major disadvantage compared with our English counterparts. Could the CSO explore with NETSCC the possibility of opening up all NETSCC funding streams to Scottish researchers?

The £225K limit is probably appropriate for most study types if early-phase / pilot work is to remain the chief aim of CSO grants. However, we would, however, support an increase to £300K limit for pilot randomised controlled trials (RCTs). RCTs typically cost more to run, and the provision of good pilot data (especially if we can do pilot trials across 2-3 sites) will make Scotland more competitive for getting big NIHR grants. Doing this sort of pilot RCT at the £225K limit (especially if drugs are involved) is currently very challenging. Furthermore, researchers need to consider the costs of long-term archiving of data, to allow for future data linkage, for example. This can be costly, particularly if considering imaging data, but this should be seen as an integral part of the funding the original studies.

We welcome the plans to streamline the ethics and R&D processes, and acknowledge that the existing research governance processes have not always been quick or easy to navigate. This also applies to the processes of obtaining research passports-which can be complicated if the researcher needs access to more than one research site. We would ask that the new proposals facilitate the recruitment of adults who cannot consent for themselves. It is crucial that Adults with Incapacity are offered the same opportunities as people with capacity to take part in research which might potentially be of benefit to them, and also to ensure that our research can be generalised to a 'typical population' of frail older people-many of whom have cognitive impairment. As a group, we also support the need to remove any arbitrary upper age cut-offs in any sort of research, to ensure that all clinical research is applicable to older, as well as younger people.

We hope these comments are informative and can be taken into account.

Kind regards

Professor Gillian Mead
Professor of Stroke and Elderly Care Medicine and Ageing specialty lead for Scotland
On behalf of the NIHR CRN Ageing group