CSO RESEARCH STRATEGY 2014

NORTH NODE RESPONSE TO QUESTIONS

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: We suggest that the eligibility criteria should include the following: strong managerial skills (including financial awareness), excellent communication skills; good negotiating and interpersonal skills, research experience especially involving clinical trials (commercial and non-commercial) and a good grasp of complex governance issues. We are aware that CSO is represented on node R & D Directors interview panels, and agree that the CSO and Health Boards should work together to set eligibility criteria

The initial appointment should be for 3 years, with the option of extending to another term if appropriate.

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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: The North node response is that local flexibility is both desirable and essential. It allows us to respond effectively and efficiently to changing circumstances. We agree that CSO should define the functions but we wish be able to have flexibility as to how these are delivered. It should also be noted that there are a number of staff within our R & D departments who are not funded by the CSO but yet who work to meet CSO targets- for instance our commercial managers. There may also be other staff who perform work that the CSO may not have a detailed knowledge of.

The North node aims to work together to develop an integrated approach to promote our strengths, diversity and our unique remote and rural geography. Such an approach would allow us to use our resources strategically across the North Node.

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 Generic review process is a function that could be transferred but this would need to be addressed by a consultation process and/or a short term working group in order to explore the potential benefits and risks. However, there is a concern that losing control of local functions will result in R & D departments becoming more administrative and less pro-active in stimulating and facilitating research.

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: Currently, all issues relating to infrastructure resources are planned, fully recorded and documented within the local site. These decisions could be fed back to the NRS through a Scottish operational board, whose membership should include the senior R & D nodal managers.

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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: We do have departments in which research time and activity is clearly labelled and appropriate time allocated. We would aim to support research active consultants to have time allocated in their job plan whenever this is feasible, in particular we would aim to fully support our NRS fellows to continue research once they have completed their fellowships.
While we fully support the proposal to fully dis-embed researcher support, in the North Node due to a relatively small number of staff and thus reduced flexibility in some departments, the issue of backfill is a major problem. Many of the consultants who are research active in small departments appreciate and indeed are completely reliant on the nursing and administration resources that are provided. Freeing up consultant time without this support would not be effective.
Research nurses would wish more national recognition of the central role that they play in achieving study participation and patient recruitment. This should be supported by easier access to permanent contracts and a CSO pan-Scotland nurse training and career development programme.

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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: The Networks and Speciality groups have been restructured. . There is a clear obligation for network managers to oversee recruitment. We are aware of the plan to appoint performance managers who will also facilitate this process. The North Node would wish there to be a formal process through which the networks are obliged to flag up any local issues to R & D so that we can help provide solutions and support our researchers. We believe that the impact of the recent changes should be evaluated at a suitable time point before any further changes are introduced.

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: In the North Node the NRS and University functions are well aligned with an appropriate MoU, shared sponsorship, offices and excellent channels of communication. However, there are many non-standardised practices in existence in Universities which can be problematic when dealing with a large number of universities.

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: Local experience with a research register has highlighted the dangers of raising expectations of trial participation. However, we believe the current SHARE system serves as a registry of patients who are potentially willing to take part in research. This system does not raise patients' expectations to take part in individual studies and has appropriate governance.

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: A system where research interested GPs are notified that they have a potentially eligible patient, with a quick and easy system of communicating that information on, and/or, the practice being able to generate automated recruitment and consent materials would be of value. Certainly, a secure system within NHS systems of generating an electronic list of

potential recruits to research studies for quick screening would be welcomed by the cohort of GPs who are interested in research. We would welcome such a system and would hope that it would not be prevented by undue concerns relating to data protection. Clearly any potential patient concerns regarding confidentiality would need to be addressed.

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: We believe that the majority of CSO funding should be addressing the Cooksey second gap. Other grant awarding bodies have grant streams directly aligned to the first gap.

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: We believe that the focus should be more clearly defined. While there may be some overlap with the NIHR funding streams, the grants should complement NIHR areas which may not be available to Scottish based researchers. The devolved health care may mean that some multicentre studies cannot easily be performed within the UK and consideration should be given to increasing the funding for selected multi-centre trials. However, in general we would not wish to reduce the number of projects which are funded.

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: The North Node has excellent relations with the CSO units.
We believe that all CSO units should be reviewed at 5 yearly intervals and their performance assessed against pre-defined objectives which include collaboration, income, publications. and strategic fit to current national health priority areas.

Chapter 4 – Working in Collaboration

Question 13: Are there other key areas of partnership CSO should be seeking to build?
Response: The forging of international partnerships and collaborations would be of value and facilitated by both an International Advisory Board and European Clinical Trials Network.

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: This would of value and should include the CSO funded Unit Directors, university representatives and R & D directors.

Question 15: Are there other areas were CSO funded research could better support the Health Directorates Quality agenda?
Response: Clinical and- academic collaboration is essential to ensure that research and evidence underpin and drive improvements in quality. This is achieved by close collaboration between the NHS and Universities which is promoted within CSO funded research projects. The North Node would wish that research involving remote and rural aspects of health care should be considered within the health and wellbeing quality agenda.

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: There is a sense that potential academic GPs have more opportunities in England than Scotland. For example the current CSO fellowship scheme precludes applications from people who are more than 5 years post primary qualification. This makes it very hard for GPs to qualify unless they have wanted to pursue a research career from the onset.
If the aspiration is to produce research interested GPs the PCRCA fulfils this but a five year scheme with a 20% 80% split – more in keeping with the major clinical fellowships (MRC, CRUK etc) is probably more what is required. Specific primary care NRS fellowship would also be welcomed.

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?

Response: We do not believe that the personal awards schemes are particularly targeted to future needs and agree that the CSO should conduct a wider review of its capacity building schemes.