Chief Scientist Officer Draft Research Strategy

RESPONSE FROM RCGP SCOTLAND

The Royal College of General Practitioners (RCGP) is the academic organisation in the UK for general practitioners. Its aim is to encourage and maintain the highest standards of general medical practice and act as the 'voice' of general practitioners on education, training and issues around standards of care for patients.

The College in Scotland came into existence in 1953 (one year after the UK College), when a Scottish Council was created to take forward the College's interests within the Scottish Health Service. We currently represent over 5000 GP members and Associates in Training throughout Scotland. In addition to a base in Edinburgh, the College in Scotland is represented through five regional faculty offices in Edinburgh, Aberdeen, Inverness, Dundee and Glasgow.

Comments

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?

It seems sensible to define the eligibility and responsibilities of the nodal R&D directors. We don't think there should be any set term of office.

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?

We believe that there should be a degree of standardisation concerning the nodal R&D offices across Scotland. However, there should also be some flexibility to take into account the various geographical and other variations in the regions. For example, what works well for the South East may not suit the North West. Island populations in particular may pose different challenges from those found in urban areas, and vice versa. Some elements of flexibility should therefore be built into any standardised functions to allow research opportunities and costs to be managed within each office.

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?

We agree that there should be some planned mechanism/team responsible for strategic oversight that allows the balance of standardisation and flexibility to be appropriately managed, and research to be coordinated.

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?

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?

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?

We would question the proposal to provide additional coordination only to high activity areas. Other areas where we feel additional support is merited include high risk or high cost areas such as dementia and osteoarthritis.

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?

We don't know enough about the current difficulties relating to coordinating research between universities and the NHS to respond to this question.

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?

We support the idea of a trial register. The risk that the expectation of taking part might be raised can a) be managed through good register design and b) does not outweigh the overall potential benefit.

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 have concerns about data sharing issues raised by such patient selection methods. We would refer this issue to the Information Commissioner for consideration.

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?

There is not enough information available about existing budgets for us to comment.

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?

It sounds appropriate that we should be able to measure how much research money has been sent on researcher time. However, there are other costs which are not discussed here, and which also have an impact.

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?

New units should have a review timescale built in, but not be totally time limited, only limited by end of useful purpose, to be assessed at predetermined intervals.

Question 13: Are there other key areas of partnership CSO should be seeking to build?

The list seems to include all the major stakeholders. We have no additional suggestions for inclusion.

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?

We believe that part of the strategic function of the CSO office should take into account the international perspective.

We have no suggestions regarding the make-up of an international advisory board.

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

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?

We believe the failure to run primary care research projects reflects the burn-out that is being experienced across primary care. We currently have an issue where many GPs are leaving the profession, new doctors are not wishing to join, and those remaining GP are struggling to work hard enough to prevent the whole system from imploding.

Recruitment of GPs to research could be part of a renaissance of a belief in the value and rewards possible in primary care. The revised focus would need to cover recruitment, to improve the profile of general practice, as well as covering locum costs, practice income, travel etcetera. In particular, research should be supported across the whole of General Practice, which presents some unique opportunities due to its access to a diverse population and geography.

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 believe that a review of the capacity building scheme is a good idea, as we are not sure if the current CSO Personal Award Scheme is suitable targeted.

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