Commentary on the CSO Draft Research Strategy

Thank you for the opportunity to comment on the SCO Draft Research Strategy. Our comments are as follows:

Q1	It seems reasonable to have a standard job description, title and person specification for a nodal R&D Director, but this would be enhanced by describing in better detail the linkages between the Nodal Directors and the R&D Directors of other Health Boards. This may help to overcome the current situation in which different approaches to issues, eg. research passport, PIC sites, etc. could be harmonised. We would suggest that continuity of role is important and that the role should not be for a specified term.
Q2.	If the goal is to work towards a pan-Scotland or Scotland plc approach then R&D functions should be standardised. The local flexibility which is evident at the moment leads to piecemeal decision making, inconsistency of approach, multiple duplication of effort, delays in getting through the research pathway and a degree of disillusionment among researchers.
Q3.	The NRS-GMS is a new role which might be expected to grow organically. At this stage we would favour the GMS establishing an overview and developing a clear operational pathway for research personnel.
Q4.	It makes sense to have the process formalised, transparent and the results published. Formal records of discussions should be included in this process.
Q5.	This is a controversial area which requires careful thought. At the moment potential researchers are put off by being told that their time is "paid for already" and that consequently no resources can be freed up to allow them to undertake research. This may well be true in theory but a potential researcher has no recourse to any action if the research time allegedly "paid for" is not included in their contract. The argument presented is that research monies can be readily identified, stripped out of existing budgets, and allocated to those engaged in research. However, this may be counterproductive to expanding the range of clinical research currently available to patients in Scotland. Clinicians with designated time in their contract can clearly demonstrate that this time is being used and thus secure funds. Thus research monies might become more and more centralised in a few clinical areas with no clear mechanism to engage new researchers in fields where current research activity is low but which might be nationally recognised priorities. In addition, while it might be possible for a clinician to volunteer to pursue a more research active career there are issues of back-fill of that clinician's time, which require the agreement of their colleagues. How such back-fill is provided in the current economic and human resources climate needs considerable thought. As a first step, however, clearly identifying how current research monies are disbursed amongst NHS Services would be very useful.
Q6.	Paragraphs 1.17 – 1.19 refer to active studies. However, the Networks and Specialty Groups have a clear role in assessing the feasibility of potential studies, including technical aspects and potential capacity to take on studies within the timescale

	proposed by investigators. The Network and Specialty Group Leads should become the focal points for the examination of these feasibility requests since they have a national overview of research activity in their topic area. The current system of these protocol and feasibility requests being widely distributed across Health Boards and then possibly coming under the aegis of a Network or Specialty Group is inefficient.
Q.7	As with Q 2 above, if the goal is to have a pan-Scotland approach to clinical research then there should be a common response from NHS and University Departments. Duplication needs to be minimised. The issue of perceived inequity of research funding in relation to indirect costs also needs to be addressed. The fact that two bids to conduct the same research attract completely different funds under the current system is confusing and makes no sense to patients or the public, who are increasingly engaged as partners in research.
Q8.	There are several examples of Trial Registers which are available to the public, eg. The Alzheimer's Association in the USA. To work well they should be married to a data source such as a well phenotyped research interest register or at least one in which there is some credence given to the typical and relatively extensive inclusion and exclusion criteria now increasingly common in clinical studies. In the field of dementia SHARE does not appear to be sufficient. There would be advantages in concentrating efforts in a slightly more detailed registration process, which could be extended to cover other neurodegenerative diseases. Issues of patient capacity also need to be addressed. It is important that those who may not be able to consent directly are not excluded from clinical research, particularly in areas such as dementia and neurodegenerative diseases.
Q9.	More thought needs to be given to this. A system which would alert GPs to every research study in every clinical area would be a significant burden on primary care and asking GPs to pass on names might be considered as an enhanced service which would attract payment. The alternative of having dedicated NHS staff acting as the triage point requires further exploration.
Q10.	It is not clear what proportion of CSO funding is currently available for new research initiatives or in which area the CSO is investing in a time limited way. Thus it is difficult to comment on issues such as disinvestment. The NHS has a responsibility to ensure that the best treatment is provided to all its population and as such should ensure that there is equity of research being done across each clinical field. This might mean that CSO requires to retain some funding to pump prime research in clinical fields which are currently under researched, particularly if they are national priorities.
Q11.	We believe that it would be worthwhile setting a ceiling for funding for feasibility and/or pilot studies if this would allow the ceiling for more substantive studies, including RCTs, to be raised, perhaps to £300,000 per grant. The question of how indirect costs and FEC are dealt with needs to be made more understandable if these limits are to be achieved equitably.
Q12.	These lie outwith our Network experience but should reflect Governmental priorities for research.

Q13.	No comment
Q14.	This may be essential following the Referendum!
Q15.	More needs to be done on how research findings are translated into improvement in clinical practice and better outcomes for patients in general. There would be advantages in exploring the CLARHC model in England.
Q.16	No comment
Q17.	While it is essential to be able to recruit and retain high quality early career clinical academics and maintain support for those developing at a more senior level there is a pressing need for wider engagement of NHS clinicians in the research field which might require a more ambassadorial and negotiating role to be undertaken across Scotland. This would require a sufficient level of seniority and experience if the role was to be successful. An acknowledgment such as a title of “Special Academic Fellow” might help to make such a post attractive.