30.9.14

Dear Professor Morris and Mr Stephens,

RE: Response to CSO Research Strategy 2014

Thank you for circulating the CSO Research Strategy 2014 and seeking comments. I am pleased to submit this response on behalf of the Scottish Heads of Departments of General Practice Group (SHoDs) – see list of members in appendix 1.

SHoDs welcomes the ambition of the strategy to increase the level of high quality research conducted in Scotland. It supports the guiding principles and agrees that the five areas identified are critical to success. It would particularly emphasize that investing in the future is crucial.

I attach the responses of SHoDs to the Consultation Questions in appendix 2 but the Group would like to make the following important points:

1. CSO's existing key partnerships are single disease focused and this approach risks neglecting more generalist approaches. Multi-morbidity and the frail elderly have been recognised as key challenges for the NHS in Scotland. CSO could address these challenges by developing research partnerships with relevant charities such as Age UK and Dementia UK or better still by establishing a CSO funded unit specifically to research multi-morbidity.
2. General Practitioners are the largest group of doctors working in Scotland and yet they are very poorly represented in research and academia with fewer than 1% of GPs employed in academic or research positions. The current group of senior GP academics in Scotland will all retire within the next 15 years and it is important that they are replaced by GPs trained in research so that the evidence base in Primary Care can be refreshed. It is, therefore, vital that CSO research training schemes are open to, and can foster, researchers from general practice.
3. The Scottish Primary Care Research Network via the Scottish School of Primary Care has been highly successful in engaging large numbers of GP practices in research and this has enabled important research to be carried out in Primary Care. It is crucial that the CSO Research Strategy includes a commitment to nurture and sustain this network.

We hope these comments are helpful and we look forward to working with CSO in achieving its strategy.

With regards,

Professor David Weller (chairman)/ Professor Jill Morrison(secretary)

Scottish Heads of Department of General Practice Group

Appendix 1

Members of Scottish Heads of Department Group

University of Aberdeen

Professor Christine Bond

Dr Chris Burton

Professor Lewis Ritchie

University of Dundee

Professor Jon Dowell

Professor Bruce Guthrie

University of Edinburgh

Professor David Weller (chairman)

University of Glasgow

Professor Frances Mair

Professor Jill Morrison (secretary)

St Andrews

Professor Cathy Jackson

Appendix 2
Responses to individual 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?

The person specification for nodal R+D Directors should include extensive previous experience of research.

The appointment should be for specified period of time e.g. four year term with a possibility of renewal if doing a good job.

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?

The key issue is consistency of delivery of service to the research community so that a researcher in one area knows what to expect when dealing with an R+D office in another area. For example, support from research nurses is available in some areas but not others.

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?

No comments.

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?

See response to question 2 – the key issue is consistency across different areas i.e. they should all be operating in the same way.

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?

This resource is not used to support general practitioners. This acts as a barrier to GPs being involved in research. Funding needs to be distributed equitably and needs to be realistic e.g. it should include GP locum cover.

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?

Additional funding from CSO to roll out the RSI scheme currently being piloted in NHS Tayside and greater access to CRF outreach research nurses who could deliver studies in primary care would allow more efficient delivery of patients to studies.

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?

Our experience is that delays are mainly caused by needing R+D approvals and occasionally by delays in ethics approval not because of differing NHS and university requirements.

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?

A trial register seems to be a good idea. It is not clear how CSO could guarantee that it would be "secure". It is unknown if this would be an effective way of partnering patients with researchers. Perhaps it could be piloted.

SHARE is successfully consenting patients for contact, but needs investment to link it to routine data to develop and optimise recruitment methods. In the medium term, that link is likely to be to primary care data via SPIRE, but linkage to other data now and recruitment to studies using it would be very helpful to inform the way that the future SHARE-SPIRE link and a Clinical Trial Register will work. Rather than patients not "eligible for their preferred study will be given the opportunity to register for SHARE", it would be better if all patients contacting the clinical trial register were given an opportunity to register for SHARE (the two should be tightly linked, not alternatives). Alternatively, there should only be one "register of people interested in participating in research" – something very like SHARE.

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?
We need more detail about what is proposed. Does this mean that identified staff working in secure facilities will screen GP/hospital records to identify patients who may be suitable for entry into a study, they will then write to Consultants and GPs and suggest that they could be entered into a study? What happens next – does the GP/Consultant send the patient information about the study? Who would explain the study to the patient? Who would consent the patient? It is unlikely to be effective without support for clinicians to do something with the information. A lot will depend on the specificity with which patients are identified, and whether the expectation is that clinicians just send information on to the patient, or do some initial screening (at a minimum, clinicians will probably be expected to screen out patients likely to be unsuitable, but better judgement of eligibility would likely require manual record review for hard to code elements). Perhaps piloting should be conducted. SPCRN do this already for GP records so help to recruit more practices into SPCRN and more resources for SPCRN to search GP records might be more effective.

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?
A proportion of CSO funding should be available for health services research addressing important topics. A good example is the Applied Research Programme Grants which included three grants to researchers in general practice/primary care and were large enough to allow rigorous research over long periods and are believed to be very successful.

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 focus is reasonably well understood by the academic research community in our view. The focus should not be narrowed as the breadth of possible research projects funded is a key strength of this grant funding. The upper limit could be raised to about £300k (however some very worthwhile projects have been delivered within the current funding limit and the danger is that fewer projects that are more expensive will be 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?
Current and recent performance, outputs, value to the Health of the people of Scotland should determine the creation and continued funding. Funding should be time limited but over a reasonable period (minimum 5 years, possibly 7 – 8 years) to balance sustained funding to develop capacity, with the potential for disinvestment if priorities change. We would call for a unit focused on multi-morbidities and people with complex needs or frailty, which otherwise fall between diseases and is a core challenge for the NHS

Chapter 4 – Working in Collaboration
Question 13: Are there other key areas of partnership CSO should be seeking to build?

CSO should develop research partnerships with relevant charities like Age UK and dementia charities. CSO might also wish to consider partnerships with some of the other major charities such as British Heart Foundation and Cancer Research UK. We also suggest that CSO should encourage research and collaboration between Health and Social Care.

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 the quality of research in Scotland and the UK speaks for itself and are not sure that creation of an international advisory board would necessarily raise Scotland's research profile.

Question 15: Are there other areas where CSO funded research could better support the Health Directorates Quality agenda?
We suggest the following areas: Multi-morbidity, care coordination, frail elderly, organisation of primary care, managing the primary-secondary care interface, managing the health and social care interface.

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?
The PCRCA was designed to allow doctors with a PhD or MD working as NHS GPs to have dedicated research time. The problem is that few NHS GPs have a higher degree, because GP clinical speciality training is only 3 years long and there was no mechanism historically for GPs to do a PhD or MD during it. The PCRCA scheme was, therefore, very successful at allowing eligible GPs to do more research, and for many to make the transition to highly successful formal academic careers (eg. Prof Brian McInstry, Prof Stewart Mercer, Prof Phil Wilson, Dr Chris Burton and Prof. Pat Hoddinott)). However, over the next few years, applications dropped due to every one of the small number of eligible GPs being recruited. There has been investment in early stage GP academic careers in the last 5 years, with the establishment of GP SCREDS scheme (4 posts at any one time) and NES funding for post-CCT one year academic fellowships (currently 3.5wte posts annually). This partly redresses the longstanding difficulties for GPs in gaining academic experience during a very short and hospital/service dominated speciality training and has led to growing success in obtaining nationally competitive PhD fellowship funding (although it is worth noting that there are still only 4 GP SCREDS lecturers at any one time despite GPs being almost half of the medical workforce). However, to our knowledge GPs are not eligible for NRS Fellowships which specify medical applicants must be NHS employees and consultants – we are not sure if this is intended to exclude GPs but we believe that this is how all Regions have interpreted it. There is, therefore, a cohort of qualified GP early career academics about to emerge from this pipeline, with a risk of some or much of the prior investment being wasted without access to postdoctoral fellowship support for the best candidates. This will require a review of the PCRCA scheme's eligibility (to potentially include those who have previously obtained CSO PhD Fellowships).

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?
Funding Health Services and Population Health Research fellowships is very important, since there is less access to charity and industry funded training than there are for single disease focused academics.