CSO RESEARCH STRATEGY 2014

Question 1.

Good R&D directors come from a variety of backgrounds, and great care would need to be taken to ensure that strong candidates are not precluded. I would favour keeping eligibility rather broad.

R&D directors should be appointed for a fixed term, with possibility of one further term at the helm.

Question 2.

Given the spectrum of size, resource and budget, I think that retaining local flexibility is wise.

Question 3.

No opinion

Question 4.

I am surprised that there is no formal record of such important discussion.

Question 5.

Achieving transparency in this, finally, would be most welcome.

Freeing up resource, and a universal understanding of how much this is, where it is, and what the criteria are for receiving it will be very helpful.

Question 6.

I accept that SGs should support all eligible studies in their clinical area.

However I am unclear about Specialty Groups “no longer being able to adopt” studies. This will disadvantage cross-cutting groups, which currently make major contributions to recruitment across the entire portfolio. For example, ageing co-adopting a musculoskeletal study to assist with recruitment in a trial in which most participants are elderly. Stopping co-adoption will adversely impact on recruitment in most SG, and in the cross-cutting SGs.

Having flexible access to additional research nurse time on an intermittent basis is critical to delivering studies to time and target.

Question 7.

Obtaining approvals in Scotland is still a tedious and frustrating process, including submitting identical information to 2 separate departments, which are apparently unable to speak to each other, or share the information. Current systems are a major disincentive to junior researchers who become overwhelmed by its complexity and bureaucracy. And little of the current system is about the patient. There is a real risk that researchers are completing paperwork for organisations which need paperwork, but that no-one is thinking about the research participants in this long process. Closer integration is highly desirable.

Question 8.

Patient and public engagement. It would be great to see NHS Scotland/CSO leading the way on this.

Many researchers already consult Lay Advisory Boards in the preparation of grant applications, and during the conduct of their studies. If CSO is to increase lay involvement on its committees, then appropriate training, available on a consistent rolling basis will need to be provided.

CSO has the opportunity to lead the UK in establishing meaningful partnership and in demonstrating that Scotland's research is equitable:

a. Require researchers to record age (or age range 40-49; 50-59; 60-69; 70-79 etc) of participants as a mandatory field on the new CPMS portfolio. This will enable researchers (and CSO) to assess how representative of the clinical population their study population is. It will also allow Scotland's research community to demonstrate equity in access to research. "Rare conditions" could be excluded from this, as is likely in England.
b. Require researchers to share the findings of their research with the participants. This can be done by letter, by email, at a feedback session. This is a simple courtesy that would pay dividends in public knowledge and motivation to participate in research. One Specialty Group is already doing this across the UK.

SHARE is a great initiative, and there is potential to detract from that and/or causing confusion by having a parallel system. I know that SHARE has already raised expectations and that signatories are disappointed not to have been approached.

Question 11.

Raising the grant funding limit would be welcome and is overdue, having not kept pace with the associated costs of running clinical studies which have ballooned e.g. CTU costs.