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Dear Sir

Please find attached some comments on the CSO Health Research Strategy. I write with a perspective of a clinical academic critical care researcher, the CSO lead for critical care, anaesthesia, ED, and surgery network, and the UK chair of the NIHR critical care research network for the past 6 years. I have a particular interest in growing research training in Scotland in relation to health services research, especially for doctors and NMHAPs.

Responses:

***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?***

I believe some flexibility should be used. However, as a specialty lead, and also reflecting on experience through UK-wide NIHR role, a major frustrations for clinical researchers has been different approaches within different regions in terms of access to R&D resource, patterns of distributing NHS support costs to individual organisations, access to research time in job plans etc. This is especially relevant to delivery of large scale multicentre research, such as clinical trials. Lead researchers/Cis need to know that there will be an equal playing field across the organisations. If we get this right in Scotland it will put us at an advantage in delivering both investigator led and commercial research.

It would be particularly attractive and advantageous if large project NHS support costs could be negotiated nationally, for example for an HTA or EME funded trial in which we might want almost all eligible Scottish hospitals/organisations taking part. This approach would also be a strength during funding application in terms of demonstrating minimisation in set-

up delays. Great progress has been made but there are still frustrations from the researcher's perspective.

***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?***

Helping CIs/researchers negotiate excess/additional treatment costs that are not funded by the grant-funder at the Board hospital level would be hugely helpful. This can be a major problem.

***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?***

Transparency and equity is vital for the research community. As indicated above, for large scale projects it would be hugely beneficial to plan set up through a national system that decreased reproduction of frustrations and inequity within each board/hospital. Even if not driven nationally, a central "appeal" or help resource for researchers who get "stuck" would be helpful. Often the problem is inequity in actually getting the NHS support costs agreed within each centre. This is especially frustrating for complex studies and/or those requiring significant screening/consent effort. Examples are emergency research (eg. trauma; emergency dept; critical care) where 24/7 models of research support make a huge difference to performance. A formal record that supports researchers overcome blocks and frustrations would help. I have seen this work in England and in many ways NIHR in England has solved this better than NRS (in my view) until now.

***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?***

These steps are very welcome. The full disentanglement of funds is overdue and I know has been phased. It MUST be linked to activity through job planning and clinical directorate research performance. This MUST be done consistently and transparently across Boards and within boards. I would suggest the data are publically available for scrutiny by researchers and CSO.

The current model of ABF with a fixed remuneration is, in my view, too "half-way-house". There is enormous difference in complexity between studies. If ABF is to continue it MUST reflect complexity of screening/recruitment AND research delivery (ie the NHS support element). Otherwise the tendency will be to disincentivise complex work in favour of simpler, likely lower impact studies. It will also potentially disadvantage more challenging

areas of research. Even with the English tariffs, which do grade and recognise complexity, we have evidence that LCRNs are starting to prioritise simple high volume studies.

The NIHR funded clinical academic training schemes for both medics and NMHAPs in England offer a major opportunity to train and add research resource for clinical research simultaneously. We have NO ACF schemes in Scotland to my knowledge, and CLs are very hard to come by and often focus on basic science post-PhD fellows. If we are to train clinical researchers we desperately need more of these schemes. They add the double value of training while also providing resource to "do" research within the NHS if they are clinically focussed. This area is a major concern to me as I believe it will disadvantage Scotland and reduced our ability to attract high quality trainees (already a problem in some key specialties such as anaesthesia, emergency medicine, etc). A modest investment could dramatically increase this opportunity if done in partnership with PG deans and regional training leads.

***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 need a way of supporting research leadership/champions with the R&D boards or hospitals to support the SG leads. As someone close to this in my area I have already submitted a paper to the R&D directors (attached). Without these plans I do not see real progress with these networks being made in the current climate of job-planning etc. We also need modest funds to support meetings of research champions 2-3 times per year to plan research delivery/strategy etc. This has been one of the most effective ways the SGs have progressed in England where this was well supported and meetings were mandated 3-4 times per year!

**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?**

I agree this is an excellent proposal. I also wonder whether a system whereby specific cohorts of hospitalised patients might be approached while in hospital and flagged as agreeing to long-term use of their data related to a specific condition, or for long term follow up, for example for HRQoL or to track outcomes that are not routinely available. The ability to approach patients for HRQoL questionnaires would be hugely efficient in relation to prjects that might want to link routine data sets with HRQoL/utilities in order to model cost-effectiveness etc.

***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?***

***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?***

I think a key issue here is not so much the total budget (obviously relevant) but the funding available for each project/programme. The current £225K is insufficient to carry out any large scale research, especially once FEC is added by a HEI. This is smaller than the RfPB in England which is for pump-priming/smaller scale NHS-based projects. Accepting that the aim is to put investigators in a position to bid for HTA, EME etc we need a larger potential ceiling per grant, say £400K. Similarly, we miss out substantially on the NIHR programme grant scheme. Is it possible to invest to buy in to this scheme? My impression would be that Scotland would be a net beneficiary if this scheme were open to Scottish leads.

***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?***

I agree that the units are clearly important. However, one practical issue which may merit consideration is how collaborative projects between the units and HEIs that are not the host institution are set up. For example, a project initiated by an academic in Glasgow, but wishing to work through the HRSU in Aberdeen. Who carries the HEI "credit" and FEC for these projects, Glasgow or Aberdeen? This creates a tension that dis-incentivises collaboration between academics and these units. A discussion about this issue might increase the collaborative use of the units across Scotland.

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

As above, buying in to the NIHR programme grant scheme would be of great benefit. This is a gap in Scottish funding, especially for clinical programmes of research.

**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?**

Excellent idea, although the challenge will be to feel that sufficient representation is on the board across disciplines and types of research. A link between this board and the various

clinical network/specialty group leads would be useful so that proposals/opportunities can be fed in. If this board could access and/or have a high level international profile with life sciences/industry this would be an effective way of connecting researchers with opportunity in this area.

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

I support this proposal, but would highlight that there needs to be a way to link improvement science to R&D support. At present, there is no way of undertaking many QI projects that acknowledges them as research. Without this the incentive to undertake them is lessened (they don't "count" as R&D activity, or attract R&D support.

**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?**

In my view this is a key issue. In medicine we have major gaps in supporting academic time during medical training (see my comments above in relation to ACF and Clinical lecturer). In addition SCRED lectureships provide less research time (about 30%) compared to England (50%). I believe a competitive process for these schemes at national level would attract and support the brightest and best into academia in Scotland and place them well for senior awards from WT/MRC etc. For example the WT-funded ECAT scheme in Edinburgh has an excellent record of success, but is focussed on basic science research. We need schemes to train health service researchers, trialists, epidemiologists, translational researchers, engaging them around ST2/3 level through ACF schemes. This approach would also maximise the use of bioinformatics strengths in Scotland, which require clinicians with high quality training in statistics, epidemiology, etc but from a range of clinical disciplines. Doing this well would truly make Scotland the place to train in these areas, especially for current "orphan" research specialties. Such training would likely bring future investment through senior fellowships and NIHR/MRC/WT grants.

Yours sincerely

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