Response by UK CRC registered Clinical Trials Unit network to the Health Research Authority (HRA) consultation on the UK Health Policy Framework

We welcome this draft HRA policy framework and the devolved administration's efforts to provide one set of principles of good practice in the management and conduct of health and social care research that will apply to the whole of the UK. We understand that the aim is to describe the principles at a 'high-level' and, whilst we are concerned that it lacks some of the useful detail contained in the current Research Governance Framework for Health and Social Care: Second Edition, we appreciate that more detailed instruction will be provided in supporting guidelines. On that basis, we agree that the policy is fit for purpose. However, we would welcome the opportunity to comment on any supporting guidelines that are subsequently produced, particularly those concerning risk proportionality and how priorities are set based on the real risks of research, which are not covered in this high level policy.

We would like to make the following comments on the policy:

1. Throughout the document there is a focus on the value of research being only to evaluate new treatments and interventions, without mention of the need for research to evaluate many existing interventions where reliable evidence on their effects does not exist.

For example, in the introduction on page 1-2, the draft document states that the HRA and the UK Health Departments are committed to an environment where (second bullet point):

- *"new treatments, care and other services are developed through ethical and scientifically sound research for the benefit of patients, service users and the public"*

This could be changed to:

- *Both for new treatments, care and other services, and for existing ones where reliable evidence about their effects is not available, there should be a rigorous process of evaluation by ethical and scientifically sound research for the benefit of patients, service users and the public*

Reference might also be made to the updated NHS Constitution[1], which emphasises the importance of research in providing the highest quality care. For example, the third of seven guiding principles of the NHS ("*The NHS aspires to the highest standards of excellence and professionalism*") states that:

[*The NHS] aspires to provide high quality care that is safe, effective and focused on patient experience. This is achieved by the support, education, training and development they receive of the people it employs, in the leadership and management of its organisations and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population (our emphasis) […]*."

The policy should be revised throughout to avoid implying that research is only about new treatments, care and other services.

2. It is inappropriate to reference ICH-GCP as one of the "relevant sources" that underpins the "principles, requirements and standards" for research

Page 4 – under the section on the scope of the new policy, paragraph 3.4, the footnote refers to several pieces of legislation and other publications about good research practice. One of these is the International Council on Harmonisation (ICH) guideline on Good Clinical Practice (GCP). We and others have drawn attention to fundamental problems with ICH-GCP, and although the ICH has acknowledged that its guidance requires revision[2], it has failed to address the major issues in its recent update. The ICH-GCP guideline increases bureaucracy and hence needlessly increases both the complexity and cost of trials, without improving quality. Therefore, reference to it should be removed.

3. Balance of benefits and risks

9.2.a states that chief investigators should develop research proposals and protocols that are scientifically sound, safe, ethical, legal and feasible, ensuring that they remain so for the duration of the research. Research projects involving new medicines or technologies may be conducted to test the safety of that new medicine or technology. We believe it would be better to state that the' benefits are considered to outweigh the risks' rather than state 'safe'.

4. Provision of information to potential participants

Page 12 – responsibilities of the research team, paragraph 9.8 correctly sets out the principle that "*proportionality should be applied to the provision of information to potential research participants*" and goes on to say that the more the research deviates from standard practice "*the greater the amount of information that needs to be provided to potential participants*."

[1] 1https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#principles-that-guide-the-nhs

While we welcome the addition of the principle that the information provided should depend on the likely risks of the study, we are concerned that without further clarification this requirement will just accelerate the trend in recent years of overly long participant information sheets (PISs), which now commonly extend to 25-30 pages for an unlicensed new drug, and 10 or more pages for a pragmatic trial. Feedback from research participants indicates that PISs of this length will not be fully read, and it should be entirely feasible for trials (even those of new drugs) to summarise the key information in 4-6 pages (with supplementary information available upon request, maybe via the trial website). Therefore, this paragraph should be revised to include the above points and to make it clear that the ultimate objective of the participant information is not the volume of information provided, but rather the potential participant's understanding of what taking part would involve.

5. Ensuring site staff have appropriate training and experience

9.2.d states that it's the Chief Investigators responsibility to satisfying themselves that everyone involved in the conduct of the research is qualified by education, training and experience, or otherwise competent, to discharge their roles in the project. We think that this is an unrealistic expectation, particularly in terms of multiple site research. In a clinical trial setting, it would be the Principal Investigator at each research site who is responsible for ensuring that the local research team are adequately trained. A progressive approach would be to expect the employing institution to accept responsibility for ensuring that their staff are adequately qualified and trained to perform their duties and to be legally bound to this by signing the research agreement. This could help reduce the bureaucracy and administrative burden associated with evidence collection by sponsors (multiple collections) of CVs, GCP training certificates of PIs and other staff at a trial site.

6. Role of academic Clinical Trials Units

9.13 states that "*A contract research organisation (CRO) is a person or an organisation (commercial, academic or other) contracted by the sponsor to perform one or more of the sponsor's activities*". We are concerned about the implications of this statement. CRO involvement in research is usually as service provision, whereas academic involvement is usually as an academic collaboration. Clinical Trials Units managing trials on behalf of an external sponsor provide intellectual input into the design and analysis of the trials and expect research recognition as the main output; they are not service providers and as such it is not appropriate to identify or define academic Clinical Trials Units as CROs; we would welcome a separate definition of academic Clinical Trials Units within the document.

Annex

The answers/comments to be added to the online response survey at https://www.surveymonkey.co.uk/r/BCBJFKB

1. **Is the level of detail in the policy framework sufficient for it to be implemented? If not, how could this be improved?**
   Yes, however there are some areas which require clarification - as detailed in the comments/responses to certain questions below.

2. **Does the policy framework place sufficient emphasis on a proportionate approach to the conduct and management of research?**
   Yes

3. **Does the policy framework address all the key issues (e.g. obstacles to good practice in the conduct and management of research)? If not, what are they and how could they be addressed?**
   No – time delays in the award of funding or the implementation of contracts is not considered. This can cause issues with staff contract timelines, fitting in with certain schedules/necessary to conduct research at a certain time of year. Delays may occur at the start but then, due to the grant duration, it may not be possible to extend the study at the end.

4. **Do you think the principles that apply to all health and social care research are right?**
   Yes - **however Comment re 8.17 c:** details as to how information will be shared across Trusts when medical records (paper and electronic) are not shared. How will this be achieved? Will there be increased pressure on the HSCIC to be a point of contact/liaison?

5. **Do you think the principles that apply to interventional health and social care research are right? ('Interventional research' here means research where a change in treatment, care or other services is made for the purpose of the research; it does not refer to research involving other methodological 'interventions' such as issuing a postal survey.)**
   Yes

6. **Do you think the policy framework adequately addresses the needs of social care research? If not, what needs to be covered? In particular, are the responsibilities of local authorities clear and is the terminology in relation to social care research correct?**
   Yes

7. **Do you agree with the responsibilities stated for chief investigators?**
   No. See comments above. In addition:

   Comment re 9.2a – in early phase/novel research, it may not be possible to categorically establish that the research is scientifically safe and feasible, that is part of the process. However,

the CI would be certain that the research was in the best interest of the patient, and the disease area as a whole. Making this section very narrow reduces the novel options so often used in areas such as HIV and cancer.

Comment re 9.2 d – for a Chief Investigator for a multicentre study to satisfy this criteria would be a very onerous task and merely serve to complicate matters, increasing timelines and the administrative burden. Surely this is an area that falls to the local Principal Investigator – and also the local authorisation process in assuring the competence of the local research team.

Comment re 9.5 – clarify that changes can only be implemented after approvals have been sought (unless urgent safety measures)

Comment re 9.10 – whilst the sponsor may be the employer of the Chief Investigator, as stated here; for multi-site clinical trials run through an academic Clinical Trials Unit (CTU), where the CTU is effectively managing the trial on behalf of the Chief Investigator, it may also be appropriate for the host institution of the CTU to accept the role of sponsor. We would welcome a caveat to clarify this.

8. **Do you agree with the responsibilities stated for research teams**? -
   Yes. However, including "summaries of systematic reviews of relevant research and evidence showing why the research is justified" could be clarified that the summary should be brief and understandable. Providing information that is not written in a way understandable to the general public may raise more concerns, issues or anxieties than it allays.

9. **Do you agree with the responsibilities stated for funders?**
   Yes, however 9.9.a states that funders should use patients, the public and service users in arriving at funding decisions. Whilst we fully support the involvement of patients, the public and service users in academic research, we do not believe this is realistic or appropriate in terms of commercial funders and suggest a caveat is added to clarify this.

   Also 9.9d states 'making funding conditional on … and on relevant approvals being in place before the research begins". Taken to its logical conclusion, this would suggest that the funder would not release ANY funding until all of the approvals are in place. But applying for and securing these approvals takes time and trained personnel, and so requires some funding to be available.

10. **Do you agree with the responsibilities stated for sponsors?**
    Yes, however 9.12 states that "*Universities and Colleges should accept the role of sponsor for all educational research conducted by their own students, unless the student is employed by a health or social care provider that prefers to do this*". This could be interpreted either as relating to student projects undertaken as part of their course, or as educational research. Hence it should be clearly stated what is being referred to.

11. **Do you agree with the responsibilities stated for contract research organisations?**
    Yes, however see comments above

12. **Do you agree with the responsibilities stated for research sites?**
    Yes however – **Comment re: 9.16f** from Efficient Trial Conduct Group - it is unclear whether this section refers to a "research site" which is already participating in that particular trial or that the site is just "research active". It would be unfeasible to transfer a patient to a research site not participating in that trial and expect them to continue participation if it relied upon staff and services during their stay.

    Additional comment re: 9.16f from NPEU CTU, University of oxford: We feel point 9.16 f within the policy document is required as it addresses the need and recognition for continuing care sites/shared care sites sharing responsibly. This is a particular issue within our Neonatal trials as approximately 50% of our recruited participants are transferred to different hospitals sites. Historically it has been difficult to engage or get approvals from these continuing care/shared care sites.

13. **Do you agree with the responsibilities stated for professional bodies?**
    Yes

14. **Do you agree with the responsibilities stated for regulators?**
    Yes

15. **Do you agree with the responsibilities stated for employers?**
    Yes

16. **Do you agree with the responsibilities stated for health and social care providers?**
    Yes

17. **Do you think the policy framework will help make the UK a better place to do research?**
    Yes
    If not, is there anything more it could say in order to achieve this? N/A

18. **Is there anything the policy framework should leave out?**
    No

19. **Do you have any suggestions about how to measure the policy framework's contribution to achievement of the ambitions set out in the "Purpose" section?**
    No

20. **We would appreciate your views about the scope of the policy framework set out in paragraph 3.1. In particular, what are the positive or negative consequences for health and social care**

research that is not currently covered (e.g. relevant sports research or nutrition research in universities, phase I clinical trials in private units)?

It is suggested that the framework covers all research with a health implication/connection. Anecdotally it is noted that research which is only covered by University Ethics Approval (or similar) within a non-NHS setting but which concerns health may not be conducted to the same standards/requirements – in terms of approvals, but also the training/governance of staff. It is imperative that any research relating to health is governed by the same quality assured processes, to ensure the safety of participants, valid and reliable data and due processes. For example, the same standards/due process for conducting research involving NHS outpatients should apply to research, including public health research, where recruitment may be outside the NHS, for example studies involving school children or students, or recruiting in workplaces, through community registers or direct to the public. Similarly, mandatory training for researchers should be the same in NHS and non-NHS settings. Currently there is disparity between that required by the NHS and that required by Universities. ALL staff should be required to undertake training, as appropriate, on information governance, safeguarding vulnerable adults and children, capacity to consent – in addition to consent training and GCP.

21. **Do you have any other comments**?
    9.19 states that employers are the organisations employing the Chief Investigator and members of the research team, including research teams at individual sites. It also states that employers may also be research sites. We don't understand how that differs from the previous sentence.