Joint Clinical Research Board

Monday 19th March 2018
Room 2.48 Garrod Building, Whitechapel

Members present:

Coleen Colechin (CC)
Deanna Gibbs (DG)
Hemant Kocher (HK), by telephone
Nick Lemoine (NL)
Gerry Leonard (GL)
Jo Martin (JM)
Kieran McCafferty (KMC)
Rupert Pearse (RP), Chair
Mauro Perretti (MP), by telephone
Steffen Petersen (SP)
John Prowle (JP)
Tim Warne (TW)

In attendance:

William Ajala (WA)
Paul Astin (PA)
Nick Croft (NC)
Nick Good (NG)
Carol Greening (CG)
Mays Jawad (MJ)
Jo Morgan (JMO)
Neeta Patel (NP)
Felicity Sartain (FS)

Apologies:

Sharon Barrett
Mark Caulfield
Sandra Eldridge
Pier Lambiase
Shakila Thangaratinam
Anthony Warrens

Agenda Item	Action
1. Minutes and Actions from the last meeting RP opened the meeting. The minutes of the December meeting were agreed with a slight change to the reporting of the Pharmacy update item. The following actions from the December meeting were addressed: (i) Minutes from research review boards or committees in Clinical Boards and Institutes: NG reported that these were now coming through regularly and he had circulated the most recent batch two weeks previously. (ii) The risk register for pharmacy was at 20. The JCRB reviewed this and agreed it should be at 20. NG confirmed this remains the case. (iii) Research Integrity training had gone live last autumn but no-one seems to know about it. JM reported that this remained an action for MP and they will discuss offline. (iv) FS was to identify how the JCRB could assist her with the LSI and the AI fellowships. This work was ongoing. ***ACTION***: FS to update the JCRB on Life Sciences at its next meeting in June.	**FS**

Pharmacy-related actions (v – vii): (v) JM to take pharmacy problems, including the lack of helpfulness shown by some staff, forward and ensure a full update report is made to the next JCRB. This covered in 3 below. (vi) CC to move forward with the work to have the JRMO post-award team undertake invoicing for Pharmacy work. Work is in hand but it has not happened yet due to Pharmacy focussing on simplifying its systems before handing over. ***ACTION*:** JCRB to review progress on Pharmacy invoicing and the JRMO take-over of that work at its next meeting. (vii) PA to give CC the names of companies keen for the invoicing to be done centrally. Completed. (viii) Researchers and their teams need to better understand the EDGE and OPD reporting platforms. MJ said that guidance on EDGE and other systems exists but it needs to be better known. She is working with the Network on this and, additionally, systems are being reviewed by the JRMO as part of an internal move to reduce the number of systems being used by both researchers and JRMO. ***CRF-related actions (ix and x):*** (ix) JM to discuss the overheads and profits it appears that Skanska will make from CRF development at RLH with both Skanska and Barts Charity. JM reported that this had proved inconclusive. She had been told that any tender need not go to Skanska. GL said that this was known but that even so Skanska would still take an overhead for preparing plans, offsetting risks etc. GL reported that revised estimates were due to be delivered next week. (x) PA to brief KMC regarding the current situation with the CRC challenges. RP having asked KMC to assist with the CRC strategy and challenges. This had happened and KMC has attended CRF steering group meetings. (xi) Imaging receives RCF to fund an MRI assistant band 6 and a microbiology research assistant 0.5WTE band 7. AS was to tell MJ exactly which individuals are paid for from this RCF funding. This is outstanding – see ACTION in 5 below. (xii) JRMO finance reporting: patient numbers to be added to this report. CC confirmed that these had been done.	**JRMO/ CG/ JCRB**
2. Order of business NG presented a revised draft Membership List for the JCRB. It was thought necessary to formalise various changes including the move from CAGs to Clinical Boards. RP thanked NG for this. He noted that the list added Anju Sahdev (AS) as the Research Lead for CSS, but CSS is not in fact a Clinical Board, so a Research Lead appointment did not automatically follow. The Board agreed unanimously that it would be very helpful if AS would act as Research Lead for CSS. The revised list was accepted without change.	

ACTION: NG to publish the new JCRB membership list. ***ACTION***: NG to contact AS and ask her, on behalf of JCRB, to take up the position of Research Lead for CSS.	**NG** **NG**
3. Pharmacy update ***(a) Pharmacy service provision*** CG had circulated a paper setting out a strategy to get back up to speed with the pharmacy side of research study set-up. The near-collapse of the service that was experienced in late 2017 has been halted and the backlog is now being dealt with. CSS has supported the immediate recruitment of agency staff and now 20, out of a possible 32 trials, have been opened in period. By June the backlog should be cleared in full and from July onwards it should be business as usual. CG said there was now a much greater understanding of the income flow and the invoicing process was also being reviewed to iron-out anomalies that she felt had crept in. She felt that a hand-over of this work to the JRMO would be most appropriate once the processes were clarified. CG confirmed that CSS had set aside £440k to 'rescue' the research pharmacy service and suggested that further investment from the Trust could be sought on the basis of service improvement. RP said that it was incorrect to view this as either a rescue or a service improvement. These problems had come about as a result of long-term under-investment in the pharmacy service by CSS. The issue is one of service maintenance and restoration, not improvement. Having a fully funded research pharmacy is integral to the idea that Bart Health supports research. CSS receives more than adequate income, through the JRMO, to pay for this service so it must be provided. NL agreed and said that none of this work was new it was ongoing 'business as usual' and CSS needs to ensure that it is fully resourced, in accordance with the income it already receives. RP said that the JCRB accepts that CG intends to make the improvements set out in the report but continues to have concerns about the adequacy of CSS investment plans for research pharmacy. He will make the case for full and adequate resourcing by CSS of this work when he and Alistair Chesser present at a Trust Board seminar later that week. CG said that Pharmacy still needs help prioritising studies. JMO said that work has, in large part, been completed but that input is required from the Network, not just JRMO. ***ACTION***: JMO to work with CG and CRN to complete prioritisation of studies ASAP. ***ACTION***: Progress on pharmacy matters is to be reported to the June JCRB meeting by CG. ***(b) Research pharmacy premises*** This remains unresolved although discussions have now moved onto exactly what services need to be provided on site.	**JMO and CG** **CG**

ACTION: RP and CG to meet and go through the proposed plans and outstanding points. JM commented that this has been going on far too long. The Trust seems not to prioritise CSS and CSS seems not to prioritise research.	**RP and CG**
4. R&D budget GL reported that he had anticipated further cuts from the Trust. However, so far in the negotiations, it would appear that a cut has been avoided. The Trust's deficit reduction target, to which RD contributes, does of course remain.	
5. Research Capability Funding (RCF) review At RP's request GL's 2017 RCF paper had been recirculated. Discussion around RCF and what it supported had continued, it was therefore appropriate to review last year's decision. Primary Care support (technical outside of Barts Health) remains a live issue. GL said he was happy to pull that out as a figure separate from the general 'Medicine' figure and would discuss further with KMC offline. There remained strong support from the JCRB for using RCF funds to support maternity leave for research staff. There were questions over the amount of money that had been so allocated to this in the financial year. GL confirmed that the amount of money set aside for maternity cover was all used up; indeed it had been used within 4 months and was only ever a contribution towards this ongoing issue. There was discussion around whether the top-slice for CSS had resulted in improved service provision and it was felt that there was a lack of clarity around this. Before agreeing to renew the CSS top-slice RP asked that Anju Sahdev (AS) report back to the JCRB on how this money has been spent, its impact and plans should the JCRB continue to award it this next financial year. ***ACTION***: AS to report to JCRB in *June* on CSS use of the RCF top-slice. ***ACTION***: GL to report to the JCRB in *September* on use of RCF funding for maternity cover. ***ACTION***: GL to circulate Dept of Health working on clinical theme RCF allocations as and when that is made available. **DECISION**: The JCRB agreed to continue with RCF allocation 'Option 5' this year, that is, quoting from GL's 2017 paper: **Option 5: Top-slice for Maternity Leave, CSS and a 50% Primary Care Allocation.** This [option] will enable the Trust to create a reserve that can be applied to contingent requests to cover maternity leave costs, allocated as needs arise, but limited to the total value top-sliced. This will have the effect of reducing annual CAG RCF allocations by approximately 8%.	**AS** **GL** **GL**

In addition to the creation of a maternity leave fund, this option also top-slices an additional £80k per annum to provide additional infrastructure resources for CS... This additional resource can be conditional on improvements in trial approval processes and set-up. This will reduce other CAG RCF allocations by approximately 15%. It is worth considering that CAGs will still have a call on the maternity leave fund and that the CSS allocation will improve our time to target metrics, so there is a cross-CAG benefit associated with the use to which these top-sliced funds will be put. This option would [also] calculate a Primary Care allocation using the same model currently used for CAGs, again as outlined in 2 above. Essentially 50% of the allocation is made up of the attribution methodology used by the DoH to determine BH RCF… and the other 50% would be based on any NIHR activity badged to BH that PC researchers are involved in. As there appears to be no direct association with BH NIHR Network activity or other Trust activity aligned to the NIHR for PC, the activity related attribution for the group would be zero.	
6. Performance in Delivery (PID) concerns MJ had circulated a short paper highlighting an ongoing problem with NIHR Time to Target reporting. Researchers are required to upload to EDGE when they recruit their first patient. NHS Trusts must recruit the first participant to a clinical trial within 70 days of receiving the nationally defined 'local document set' from the study team. She reported that BH consistently fails to meet its target for this. MJ said that Pharmacy issues (see above) had not helped but that is just one factor in the problem. In addition to failing to recruit the first patient in time we are also consistently under-performing in recruiting all the patients we say we can to trials. ***ACTION***: RP asked that all Research Leads take these concerns back to their colleagues and Boards. They need to review the adequacy of their local feasibility assessments and ensure a realistic, rather than optimistic, view is taken of potential research involvements. CC questioned the role of the Network is generating over-optimistic targets that we then fail to achieve. KMC said that in general challenging targets are thought to be a good thing but in this case we need to push back and be more realistic. MJ said she is working on better training for researchers and research leads but the more ways this message gets disseminated the better. It was agreed this would be helpful and MJ was urged to bring any other issues like this back to JCRB.	**All Research Leads**
7. Matters arising from Information Reports RP flagged up paper 7 – Research Governance Activity – and said this demonstrated some very good work in progress.	
8. AOB JM flagged up the WHO collaboration centre work with Women's Health as a success story.	

9. Next meeting 18th June, Whitechapel.		
10. Summary of forward Actions		
(i)	FS to update the JCRB on Life Sciences at its next meeting in June.	**FS**
(ii)	JCRB to review progress on Pharmacy invoicing and the JRMO take-over of that work at its next meeting (link to Action vi and vii).	**CG and JRMO**
(iii)	NG to publish the new JCRB membership list.	**NG**
(iv)	NG to contact AS and ask her, on behalf of JCRB, to take up the position of Research Lead for CSS.	**NG**
(v)	JMO to work with CG and CRN to complete prioritisation of studies ASAP.	**JMO**
(vi)	Progress on pharmacy matters is to be reported to the June JCRB meeting by CG (link to Action ii and vii).	**CG**
(vii)	RP and CG to meet and go through the proposed plans and outstanding points (link to Actions ii and vi).	**RP & CG**
(viii)	AS to report to JCRB in *June* on CSS use of the RCF top-slice.	**AS**
(ix)	GL to report to the JCRB in *September* on use of RCF funding for maternity cover.	**GL**
(x)	GL to circulate Dept of Health working on RCF clinical theme allocations as and when that is made available.	**GL**
(xi)	RP asked that all Research Leads take these concerns back to their colleagues and Boards. They need to review the adequacy of their local feasibility assessments and ensure a realistic, rather than optimistic, view is taken of potential research involvements.	**All Research Leads**

NG
26th March 2018