Joint Clinical Research Board

Monday 10th December 2018
Room 2.36, Garrod Building, Whitechapel

Members present:

Amrita Ahluwalia (AA) – by telephone
Coleen Colechin (CC)
Sandra Eldridge (SE)
Sharon Ellis (SE)
Deanna Gibbs (DG)
Hemant Kocher (HK) – by telephone
Nick Lemoine (NL) – by telephone
Gerry Leonard (GL)
Jo Martin (JM)
Rupert Pearse (RP), Chair
Steffen Petersen (SP) – by telephone
John Prowle (JP)

In attendance:

William Ajala (WA)
Nick Good (NG)
Mays Jawad (MJ)
Jo Morgan (JMO)
Neeta Patel (NP)
Felicity Sartain (FS)

Apologies:

Mark Caulfield
Jack Cuzick
Stephen Kelly
Kieran McCafferty
Anju Sahdev
Anthony Warrens
Tim Warner

Agenda Item	Action
1. Minutes and Actions from the last meeting RP opened the meeting. The minutes of the last meeting were agreed. Actions from that meeting: (i) NG to ensure that the Trust Risk Register is updated to represent the 2 continuing facets of the Pharmacy risk situation: staff and accommodation. Action completed and it was noted these risks remain active, with ongoing oversight, into 2019. (ii) JMO and AS to work together to have a meeting with key players, including RP and Alistair Chesser re the Pharmacy issue. Action completed. (iii) RP to follow up with Trust Estates on the new Pharmacy accommodation matter. Action completed, although RP noted that until Pharmacy is in its new RLH site accommodation this remains a live concern. (iv) SE to send NG a list of the kind of information NIHR routinely requests. Completed (today) NG agreed to forward this list to CC as she is working with Lucy Morrisey (LM) on a similar data set that could be available to the Trust Board. (v) Others, particularly MJ, CC and GL, to review the Key Metrics list and propose any changes that would be easier to deliver. NG will then co-ordinate. Review is ongoing. As noted above CC and LM are working together.	

	ACTION: Key Metrics to return as a substantive item for discussion at the next JCRB with a JRMO paper from GL and CC proposing metrics it can maintain and deliver.	**GL, CC and others**
(vi)	NG to invite Paula Aubrey (PA) to attend the next, and future, JCRB meetings. This was done then undone as it was subsequently decided that PA should attend the Barts Health Research Board in future; that body will have ongoing insight of the Network's performance.	
(vii)	NG to include an update on key network changes in the next Research News Bulletin. NG confirmed that this appeared in the September News Bulletin. It was noted that further changes on the Network should appear in future editions.	
(viii)	NG to push ahead and get the Research Misconduct policy and procedure implemented ASAP. NG confirmed that this had been completed – the Policy and related SOP are now live.	
(ix)	GL to draw together a list of this year's RCF awards, specifying amounts, relevant CB and Site.	

1. Life Sciences

FS had circulated a slide set and talked through the main points. The vision for Life Sciences (LS) at RLH site is about uniting Trust and University strengths and fitting with the wider NHS industrial strategy.

SE asked what the LS governance structure is. FS said that key leaders are in place but the next tier down is being appointed. It is to be a joint BH-QM project with a joint governance structure, working to an agreed joint strategy that works within the umbrella of both QM and NH's agreed research strategies. FS said that the main purpose is to join the dots between existing pools of work, not necessarily create whole new workstreams.

SE thought that there would need to be some over-arching decisions made. RP agreed and said that the governance structure needs to be both high-level and practicable. FS agreed and said that it seemed to have gone from high-level, long-term planning to imminent quite quickly. That was why posts were being recruited to now to ensure that practical accountability can remain 'joint'. The aim is to hold the first LS Board meeting in January.

AA asked if all the Board members had been appointed. FS said 2 had – Rakesh Uppal, Sven Bunn, 3 remain open.

ACTION: FS to send a list of LS Board members to NG, for onward circulation to JCRB members, as soon as it is available.

Looking at the proposed LS work programmes, SE commented that the wording does not seem to mean much or at best be ambiguous, particularly in the education and training areas that she is familiar with. FS said that her areas are business and innovation so she could not speak to the detail on education and training but would feed-back these thoughts.

FS said that a Trust intranet page for LS now existing and further comms would be coming –

once the new LS Board had agreed a comms strategy. She stressed that this and earlier slide sets were created pre-Board, so much may change fairly soon around comms. There was a discussion around prioritising space and resources, for example for a larger Clinical Research Facility. FS said that whilst the LS focus will be on clinical research and education this will not be static and the ongoing aim is to challenge and co-operate. NL asked what QM's aims were re LS. FS said that her involvement was primarily on pushing and developing the Trust's agenda in this regard so could not accurately comment on that. She could however say that it will not be possible to capture everyone's wishes and the focus will be on developing strengths, particularly common strengths. SE said that what we chose to do needs to be useful and achievable. FS agreed and said that if anyone has any idea around this she is happy to discuss and push things through to Sven and Rakesh. On the CAP –AI project FS said that 6 clinical fellows are being appointed, the project plan is being finalised and this launches in 2019. RP thanked FS and asked that she, Sven or others should return to update JCRB, or seek its input as necessary, at future meetings. This is an open invitation.	
2. Barts Health research strategy RP reported that the new BH Research Strategy had now been agreed. It is currently being polished and readied for publication. There is no great departure from the previous drafts shared and the more recent draft that the Trust Research Leads will have seen. It is now more granular, with some specific impact criteria, and is designed to work with the existing clinical strategies. It is also couched within the terms of the NIHR's strategy. On specific points RP commented that continuing to grow turnover will be challenging. This is dependent on fixing the various infrastructure issues already identified: Imaging, pharmacy, finance and data storage. One of the issues around the disconnect from research at Newham and Whipps can be addressed by getting greater QM involvement there. In response to a question from NL about research PAs, RP said that the Trust strategy is to grow the number of consultant PAs dedicated to research rather than recruiting new consultants; it is also important to ensure that consultants theoretically engaged in research deliver to their agreed PAs. There was a discussion around this. RP said that there needs to be greater clarity around CB finances and PAs. He said that the Trust does want to grow the number of research-active consultants but not necessarily the number of PAs per consultant. He commented that the use of commercial research income to support consultant research PAs should be considered by the Research Finance working group that Bill Boa and Gerry Leonard are working on. He asked how progress on that going. GL reported that this group, arranged by BB, had met once but subsequent meetings had not been established. RP asked GL to liaise with BB to arrange the next meeting. **ACTION**: GL to contact BB to request further finance working group meetings take place and to include a review of the use of PAs.	**GL and Bill Boa.**

3. Pharmacy progress NG noted that apologies had been received from Anju Sahdev. JMO reported that a new deputy chief pharmacist had been appointed – that person may be taking over from Tase with pharmacy escalation. Also a lead research pharmacist had been recruited, Stuart Chandler, to start possibly February next year (awaiting confirmation). From Sept 2017 to October 2018 the 'green light' period has reduced from 150 days to 53 days. Anju and the team are looking at what resource is required moving forward to reduce to 35 days. Five research pharmacists were now in post, a research co-ordinator and there are 15 other members of staff to conduct work on research. RP reported that a meeting, which Alistair Chesser had chaired, had addressed many of the recent frustrations with service provision. Many concerns were based on misunderstandings. These meetings need to continue to ensure that we can move forward in partnership, and avoid future misunderstandings. He said that Tim Stephens has been working with research pharmacy to support their development work, but a lot remains to be done. Having and working to agreed processes and responsibilities is the key. NL hoped this was so. RP asked for any concerns and, equally, good news stories of progress to be fed back to him.	
4. Excess treatment cost changes GL reported that there is a national NIHR initiative, being lead locally by our CRN, to ensure that excess treatment costs (ETCs) get proportioned out fairly across Trusts using a somewhat complex system. He reported that so far we have benefitted from this scheme as traditionally we did little to recoup ETCs. There are however a number of issues to resolve including old projects (are these included?) and live projects (should we reclaim costs "live" or wait for studies to conclude?). The mechanism the NIHR has created seems over-geared considering that often ETCs are trivial amounts involved. The Network is currently channelling requests bit in due course it will run the entire scheme for our area, so we have little say in proportionality of work versus the amount of the claim. GL said that we need to ensure that researchers and costings teams put in suitably worked-up costing s that take account of potential ETC outgoings in due course. This is yet another reason why all applications for funding need to go through the JRMO and that applications for costings need to be made in a timely way. SE said that this had been a concern at NIHR Senior Investigator meetings. If any thoughts could be sent to her she is happy to take them forward at future NIHR Senior Investigator meetings. RP commented that if the problem is national then the solution could well be national. **ACTION**: Any updates on implementation of Excess Treatment costs and related concerns to be sent to SE for onward communication to Senior Investigator meetings.	**All**
5. Research Capability Funding (RCF) GL reported that, whilst it is too early for detail, the general picture is a significant cut and a general winding down of this funding stream. That winding down may come very soon, rather than over several years. The total amount next year looks to be significantly less and links to BRC funding will be reduced. Existing Senior Investigator support will roll-over but new Senior Investigators will be supported in a different way.	

RP said that with amounts significantly reduced putting this to specific clinical areas will probably not work; the overall decision on allocation would therefore sit with the Barts Health Research Board, according to agreed strategic needs to encourage or support.	
6. Research data sharing MJ reported that The International Committee of Medical Journal Editors (ICMJE) has revised its rules on what information needs to be published in relation to clinical trials that feature in its members' journals. This is a clear move towards making data sharing mandatory rather than just the bet practice. Investigators should be aware that editors may take into consideration data-sharing statements when making editorial decisions. Some ICMJE member journals already maintain or may choose to adopt, more stringent requirements for data-sharing. Sharing clinical trial data is one step in a process articulated by the World Health Organization (WHO) and other professional organisations as the best practice for clinical trials. RP said that this needs to be read in conjunction with GDPR and other information governance regulations which can impose restriction on data sharing even with consent. The message to researchers is that significant changes are in process and in the future assumptions will be on greater openness both to other researchers and to patients. JP asked if the fact that the outcome of research will be subject to greater disclosure needs to be factored into patient information sheets and when consent is taken. MJ said yes, but we are still transitioning and so not in a position to provide final advice. MHRA guidance on best practice in the UK is expected soon; the JRMO will then circulate that. MJ said that an issue to note is that the publication standard applies to all research, not just clinical research, so there are layers to a technical solution.	
7. Research Misconduct update NG reported that the Research Misconduct policy has been approved, along with the related Procedure by Queen Mary Senate. Both the joint policy and joint procedure were n published by the JRMO and made available on the JRMO website. This launch had been flagged up in the November Research News Bulletin. The policy had been agreed by Barts Health, without the need of a related Procedure in 2017. RP thanked NG for his help in pushing this through.	
8. Matters arising from the information reports MJ talked through some key points of the Activity Report she had circulated. She highlighted the NIHR performance targets: we are doing well in meeting the delivery target, but consistently badly on the initiation target. The latter covers the gap between site selection and first patient recruited, measures outside the control of the JRMO, reliant on the Network, in the first instance, and researchers in the second. RP said that engagement within clinical areas was needed to push home the message that we should not take on work that we cannot expedite.	
9. AOB • New Network Joint Clinical Directors – JM reported that this had happened and suggested it be covered in the next Research New Bulletin:	

ACTION: NG to cover the appointment of joint clinical directors in the next Research News Bulletin. In the light of network oversight moving the BHRB (see Action vi above) there was then a discussion about network representation at the JCRB. It was agreed that one of the Network's 2 joint Clinical Directors could usefully attend the JCRB to discuss network research related matters re Barts Health and Queen Mary. **ACTION**: JM to pass this invitation to the new Network CDs and NG to extend invitation to these meetings so that one of them can attend in the future. • RP asked SE what her early impression were of research development. She replied that she was focussing on three areas: work around roles and clarity, both in relation to joint Trust-QM working and internally within Queen Mary; strategic overview and interconnections; and she would be focussing on special projects such as Life Sciences.	**NG** **JM & NG**
10. Next meeting 18th March, Charterhouse Square.	
11. Summary of forward Actions	
(i) Key Metrics to return as a substantive item for discussion at the next JCRB with a JRMO paper proposing metrics it can maintain and deliver.	**GL & CC**
(ii) FS to send a list of Life Science Board members to NG, for onward circulation to JCRB members, as soon as it is available.	**FS/ NG**
(iii) GL to contact BB to request further finance working group meetings take place and to include a review of the use of PAs.	**GL/ BB**
(iv) Any updates on implementation of Excess Treatment costs and related concerns to be sent to SE for onward communication to Senior Investigator meetings.	**All**
(v) NG to cover the appointment of joint clinical directors in the next Research News Bulletin.	**NG**
(vi) JM to pass this invitation to the new Network CDs and NG to extend invitation to these meetings so that one of them can attend in the future.	**JM/NG**

NG
19th December 2018