NHS
Research and Development Forum

RESPONSE TO HRA CONSULTATION: SPONSOR SELF DECLARATION
February 28th 2014

INTRODUCTION & METHOD

- The Forum working groups have discussed the HRA proposals at three working group meetings and agree there is variation in Sponsorship, which can be a problem for research in the NHS. The Forum therefore welcomes the HRA's aim to improve the quality of Sponsorship for NHS-based research.

- This response is a collation of views and has been drafted by the Forum manager on behalf of the Forum, but has not yet been ratified by any particular Forum working group. This should be taken into consideration by the HRA when reviewing the response. Any ongoing comments from the Forum working groups shall be fed back to the HRA to support ongoing work.

- Forum members regularly experience Sponsors that do not understand their Sponsor responsibilities or perhaps how these responsibilities translate into practice. This often will result in a work burden for NHS research offices in their attempt (and in their obligation) to resolve study-specific issues, which then in turn may become a perceived "R&D block". This circular problem is one that it would be extremely beneficial to avoid/resolve (perhaps with a distinction drawn between R&D support or 'services' verses the performance of quality checks)

- As stated in the consultation, responsibilities are already specified in the Regulations, GCP guidelines, Research Governance Framework, Sponsor declaration in IRAS and other literature and it is therefore agreed that Sponsors may not fully understand what these responsibilities actually mean in practice or how they could be risk-adapted for different study types. This is particularly true of Universities and NHS organisations if they lack capacity or experience, (where Universities are experienced Sponsors of CTIMPS or have dedicated offices to support their role as Sponsor the quality is usually improved.)

- It is also acknowledged that organisations are not always able to discharge their responsibilities fully due to a lack of capacity and experience, and so articulating the work involved in Sponsorship of research may help organisations to better recover the costs, and ultimately build up their expertise.

- The problem for R&D offices can be two-fold. The first is that organisations have systems in place but the end result is still poor (for example, the Sponsor has a *system* of peer review in place but the protocol is still only 2 sides of A4 and of poor quality). The second is that the study is seemingly OK but the Sponsor doesn't have the actual systems in place or capacity to set-up or oversee the study on an ongoing basis, placing an emphasis on host organisations to have quality systems of their own (for example if there is no expectation to have a site file for a study the Sponsors will not provide a study-specific template).

- It is therefore extremely important that significant emphasis is placed on study conduct and oversight responsibilities as historically so much focus has been placed upon approvals.

- The Forum response is summarised below in an Executive Summary and detailed comments in relation to the specific HRA objectives of (a) Setting out HRA Expectations and (b) the Sponsor Self Declaration

EXECUTIVE SUMMARY

- Setting out HRA expectations of Sponsors is welcomed and possibly more significant with regards to changing practice than the Sponsor self declaration.

- The Forum suggests that the HRA risk-adapt their expectations to study type, in line with MHRA and adding to existing CSP checks

- It is considered that more detail would be needed in order for the expectations to make a real change in practice.

- A link between all the current resources available might be made to provide clarity (RSS). The Forum would like to support and add value to this work with the development and hosting of a Sponsor "how to" toolkit.

- There would need to be more guidance around the declaration and how this might be used in assessing a Sponsor as this might be difficult to manage and, if adopted, should be linked to the RDOCS for NHS organisations

- Significant emphasis should be placed on study conduct

- Specific more detailed comment on each objective of the consultation are as follows:

SETTING OUT HRA EXPECTATIONS

- It is welcomed that the HRA is to set out its expectations however the groups were generally doubtful that in its current form, this would bring about the desired change in the quality required and that the documents may not yet provide enough information about how these responsibilities are to be met to make a significant difference.

- It is suggested that the HRA might consider taking each Sponsor responsibility as already defined (perhaps using the new Research Governance Framework to redefine them) and set out the HRA's risk-adapted expectation for what might be acceptable under each study type. As shown in the consultation paper, this is already an approach taken for GCP training of Chief Investigators, and could be expanded in a similar way to MRC/MHRA/DH paper for risk adapted approaches for the management of clinical trials of IMP (www.**mhra**.gov.uk/home/groups/l-ctu/documents/.../con111784.pdf)

- There might also be much more detail about the systems required. *Some* of this is also provided in the CSP "study-wide" checks, which are also adapted by study type. These checks are currently only used by NHS staff and help to articulate what is expected of a study to be "NHS-ready" such that all Sponsors should have an awareness and understanding of what they are.

- Without this detail in place there is a danger that inexperienced or underfunded Sponsors will self declare they have the systems in place, but without a benchmark against which to judge or assess themselves (or be assessed!) it may become a meaningless or "tick box" exercise. Although it is acknowledged that peer-to-peer bench marking would be enabled by this approach, without a more detailed reference guide making things more explicit, "*they won't know what they don't know*". This was always the problem with the regulations for CTIMPs, which have been made much clearer through the MHRA "grey guide" publication (Good Clinical Practice Guide, 2012) that has helped enormously to better articulate how the legislation can be translated into practice.

- It is considered that protocol templates can provide a lot of the solution as this will force Sponsors to have systems in place in order to populate specific sections (safety monitoring for example), and researchers will be forced to have more meaningful conversations with their Sponsor representatives from the outset.

- It is considered sensible to link capability to types of IRAS study category and making the differences of each study type clearer with regards to risk-adapted expectations would be helpful to organisations.

- It should be taken into account that an organisation's capability to Sponsor might depend on whether the study has involvement from other organisations who are undertaking some of the roles on their behalf. For example a multi-centre CTIMP with involvement from a Clinical Trials Unit might mean that the Sponsor is able to meet regulatory compliance, without having some specific quality management systems in place itself. Therefore a Sponsor organisation might have limited research management SOPS and tools, but might have robust systems in place for ensuring the quality of its contractors and also its oversight and assurance of their quality systems, as well policies for the management of serious breach and safety, for example.

- The document could make more of ensuring and managing data quality, as this is relevant to all types of study and central to research quality. It is also not limited to systems of peer review. Archiving and end of study procedures should also be included, as well as systems for ensuring the management and monitoring of safety, where appropriate (this is a difficult area and may not be well understood by some sponsors, especially if not CTIMPs).

- It is acknowledged that the RSS SOP dependency framework provides some clarity of systems required but is perhaps not widely understood by Universities as they are for NHS Research Support Services. It is suggested that the HRA might provide some clarity with regards to how the RSS framework fits and could be linked up. This might look like a "standard" and then a risk-adapted HRA expectation by study type for **what** is required, possible SOP templates for support services provided through RSS for the responsibilities and provisions of these services to meet the standards expected.

- The Forum should very much like to help with this work and in addition is developing a Forum "Sponsor toolkit" to provide further resource driven by the Research Management Working group. This toolkit aims to enable the competent Sponsor by articulating requirements and providing best practice resources for Sponsors on **how** to achieve the expectations and standards required of them which could link to all the work described above.

SPONSOR SELF DECLARATION

- The self declaration is considered to be a good idea in principle to make signing up to be a Sponsor more meaningful, but it is currently unclear what the HRA or R&D study-wide review might be able to do with this information, or whether this in itself will bring up the quality of Sponsor Organisations. It is acknowledged that the declaration would provide the ability for organisations to assess the capability of a Sponsor and provide some due diligence for those undertaking the study-wide review and it should be considered how this would be managed as part of the review process.

- Guidance should be given on how to manage the assessment as part of the "check" to confirm a Sponsor was in place. For example, where the Sponsor declaration was unconvincing due to a lack of written procedures in place, the Sponsor might need to provide additional evidence to assure that the study was of high quality or going to be well managed, or that those procedures would be put in place in a timely manner (for example archiving), otherwise the whole system might grind to a halt and have a reverse effect. It would however enable research offices to demonstrate some due diligence in assessing the competence of the Sponsor and would also be available for funders to use in their decision making process. This declaration should take into account the ability of Sponsors to subcontract with partners to provide sponsorship support, as outlined above. This may mean that the Sponsors themselves do not have the quality management systems in place for some things.

- The self declaration is considered to be similar to the RDOCS currently in use by NHS Trusts, and it is therefore urged that if adopted it is brought into the RDOCS system for *NHS* organisations, and not held as a separate document to avoid duplication. It should be noted that many Trusts simply provide links to their Policies and SOPs online in the current RDOCS to ensure they are up-to-date and would not want to write-up all of their procedures separately and the HRA would need to decide if this was acceptable.

ADDITIONAL COMMENTS ON GCP

- The documents stated that GCP training of Chief Investigators *should* not be a requirement and although understood this was raised as possibly too strong. Whereas it is acknowledged that a pragmatic and proportionate position should be taken by Sponsors and NHS Organisations, it is felt that they should still be able to take the decision to require training, following careful consideration of the risks and experience of and support for the investigator. Many Trusts feel that this training, although CTIMP specific, provides a good general grounding in good practice for clinical research (especially for interventional clinical trials) and in the absence of specific training for consent, delegation of responsibilities, managing essential documents etc, may choose to stipulate general GCP training is required. This might therefore not be a requirement for the "check" but may be an organisational policy for all Chief and Principle Investigators, particularly of clinical research depending on other provisions within their organisations.

- However, it might be useful to describe in detail risk-adapted GCP HRA requirements by study type as this would aid organisations to make the decision on what level of training should be required; i.e. is an investigator site file required for each study type (and also for sites vs. PICS); what level of recorded delegation or consent procedures are required and in the notes;

what levels of safety monitoring and data management etc **NB:** For some requirements/risks e.g. safety reporting, study types might be grouped into (a) CTIMPS, Interventional Studies, and Studies with Procedures of Additional Safety Risk (that is a risk over and above that considered aligned to normal care) (b) other "low risk" studies such as observational (with no high risk procedures), questionnaire, qualitative, tissue and data only studies