This response is being provided on behalf of the UKCRC Registered CTUs Network. The Network consists of 50 academic non-commercial Clinical Trials Units across the UK. More information about the Network and a full list of Registered units can be found at www.ukcrc-ctu.org.uk.

We have summarised the responses below and have highlighted the following key points for consideration.

• Do you agree with the six design principles we have used to develop our proposals?

Yes, all respondents agreed that the six design proposals were reasonable and support a simple, consistent and transparent approach for awarding ETCs which will be fair and reduce variability.

Points for consideration:

- Some respondents were of the opinion that a national, centralised model of funding for managing ETCs regardless of whether the intervention was commissioned by CCGs or specialised commissioning would optimally meet the design principles and funding should be agreed and made once at a national level.
- To ensure consistency the LCRNs should work to a single process as establishing 15 different processes would barely reduce the current frustrations. The LCRNs need a forum for training and sharing best practice to make sure decisions are standardised across the country. There should also be a single standardised approach to costings and accountability for ensuring these are accurate.
- Cost neutrality should take into account the treatment savings which are generated by research. There should be a mechanism for accounting for these within the system and using them to offset ETC.
- The new system needs to be implemented efficiently with clear communication and available points of contact from the outset and not introduce a further level of bureaucracy.
- Transparency should also relate to the collection of accurate treatment cost and treatment saving data and not just to the decision making process.
- LCRNs need to commit to at least the same review times, if not faster review times, than specialised commissioning to ensure funding applications are not delayed.

• Do you agree that ETCs will be better coordinated by LCRNs at sub regional level with a single point of contact rather than managed by CCGs individually?

There were mixed responses to this question with most respondents agreeing that ETCs would be better coordinated by LCRNs than CCGs but some respondents were concerned that LCRNs lacked capacity and this could add an additional level of bureaucracy.

Points for consideration:

- A national centralised model may meet the main design principles better than LCRN management.
- There needs to be an assessment of LCRN capacity as well as capability to perform this role. Would the NHS Trusts bill the LCRNs annually and do the LCRNs have the capacity and expertise to perform this role?
- LCRNs would need to have a good understanding of local prioritisation within their regions to ensure local research needs are met.

- The oversight of the process needs to be clearly explained. Part of the frustration of the current ETC system is the opacity and perceived lack of accountability. It is not possible to speak with the "decision-makers". Would the LCRNs have the necessary authority for these new proposals?

• Do you agree that pooling risk across the 15 LCRNs to manage annual variation in ETCs would be an appropriate approach?

In the absence of a national process, which works well in Wales, most CTUs agreed that pooling risk across the LCRNs would be an appropriate approach as this would allow flexibility and ensure that the burden of ETCs are spread equitably across the NHS.

Points for consideration:

- A process to ensure the benefits of treatment cost savings are taken into account, and ideally spread equitably across the NHS, should be considered if feasible.
- Leveraging funding from CCGs is likely to be difficult especially in regions where ETCs are currently being refused. As the ETC budget will still come from CCGs it is important that all CCGs commit to the new process and a process of having to renegotiate this each year should be avoided.
- Different funders allow differing costs to be paid for within a research project and this may tend to make some research less attractive than others to Trusts when the scientific impact may be greater. This needs to be considered by those making decisions on what costs will have to be borne by Trusts.
- Will the DH subvention fund also be moved into this funding process?

• Will the proposals outlined work for both single site and multi-site studies?

Yes, the proposals should work for both single site and multi-site studies and improve set-up times in multi-site studies.

Points for consideration:

- It would be ideal if the lead LCRN takes responsibility for the coordination of ETCs within the CRN, such that ETCs are made available without restriction to all participating sites within England. It would also be helpful if they could support negotiations with the devolved nations.
- It would be positive to have timelines in place to make sure that the process for approval is timely.
- Single site projects sponsored and hosted by one organisation may have good local processes already in place and it would be a shame to introduce an additional layer of bureaucracy.
- A centralised process for calculation of ETC costings would be beneficial, currently this is done at local R&D offices and multiplied up for multi-centre studies. London costs are recognised as one of the most expensive in the UK and researchers with "expensive" ETCs should not be disadvantaged as their ETCs will be higher.
- There was a concern that a LCRN may preferentially support ETCs for a local single-centre study than a multi-centre study led from elsewhere if it would maximise recruitment within that LCRN.

• Do you agree with the proposal to strengthen the process for specialised services?

Yes, a clear process for all stakeholders would be essential but there is a lack of detail about this process within the consultation document. A single point of access, either via the LCRN or directly, would be welcomed and the commitment to a six-week turnaround is very positive.

Points for consideration:

- There needs to be an objective evaluation of high quality research and scientific value. NHSE will need to input to high cost projects from a commissioning perspective however how this process and the various bodies interact is vital. This decision making process should be monitored and decisions made in a transparent and consistent way.
- Ideally NHSE would review this at a national level and give a national approval by the relevant specialised commissioning group rather than devolving this to commissioning hubs. Specialised commissioning should have a dedicated ETC fund ring-fenced as per the proposal for CCG commissioned ETCs.

• Do you agree that applications that fall below the proposed minimum threshold would not be considered by NHS England?

There were mixed responses to this question with some CTUs agreeing that there should be a threshold but only if there is a clear process and Trusts are aware that they will be obliged to pay for those ETCs. If this is not enforced sites may choose not to participate in these studies and/or the protracted negotiations that currently occur will continue. Others suggested that there should be no threshold and all ETCs should be funded from a centralised "pot" of money as NHS Trusts cannot be forced to meet ETCs and, as above, could decline participation.

Points for consideration:

- Setting the minimum threshold will be challenging based on the limited data available. The minimum threshold for specialised commissioning isn't suggested within the proposal and it is important that this is higher than the CCG threshold as the costs are likely to be higher in studies where the intervention is funded directly by NHSE.
- Improved monitoring of treatment savings that benefit specialised commissioning is very important as they are likely to be getting the most benefit from commercial research.

• Are there any additional comments to add to the specialised services proposals?

- There remains a question of who assesses the value for money of a research funding application from an NHS Treatment Cost perspective, and at what point this assessment takes place. The detail of how decisions are managed between funder and NHSE is crucial to maintain a dynamic and internationally competitive research environment. The assessment of the balance between cost/value involves weighing scientific value with commissioning/budgetary considerations. As NHSE has no remit for research, it would seem inappropriate for funding decision to rest solely with this group, there may be conflicts, for example with studies about how treatments are used which may not be cost saving but which might significantly simplify patient care. Conversely if NHSE seek to commission and fund research there needs to be a process of governance to ensure such research is scientifically valid.

- Whilst the proposal indicates early engagement between the NIHR and specialised commissioners, there are clearly many other research funders in the UK which would need engaging with. Are the LCRNs expected to play this role for applications to non-NIHR (ie non-NHS) funding bodies?
- How will excess treatment costs be treated for research into areas for which there is no current treatment, where costs might be prohibitive; or for preventative treatments where costs or delivery are borne by local authorities?
- For specialised services, Trusts could be requested to fund the ETCs up to a limit, but this would need to be taken in the context of the total ETCs being requested from that organisation.

• Please rank the options outlined in Table 2 in order of preference with your preferred option first and your least preferred last.

The majority of CTUs ranked Option 2 as their most preferred option, with some support for Option 4 and one preferred Option 1. The second, third and least preferred options varied between CTUs so we are unable to provide a full ranking.

• Why do you think your preferred option is the best one?

Option 1 (one response) - Simple to understand and implement. The risk identified is acceptable since it's generally more research active Trusts that currently agree to participate in such studies in any case.

Option 2 (responses, summarised) – takes account of Trust income and therefore seems more equitable and realistic than options with fixed thresholds. This is the option that is most likely to assist sites with minimal resources. Improving the take-up of research at sites that have currently not been actively involved in research. This will increase generalisability of research performed as much more representative of the NHS as a whole.

Option 4 (responses, summarised) – This appears to be the fairest and isn't based on Trust income; research income may not be proportional to total income. There is a preference is for upfront knowledge of whether ETCs are likely to incur delays during site set-up however, this is countered by the possible disincentive for sites to agree participation if they were unable to sustain a high number of low cost studies.

• Are there any other ways to set thresholds that would work better than those presented?

- An ability to look at ETC at a national level; such that any cap does not de-incentivise specific types of sites or studies.
- There should not be a threshold and all ETCs should be funded from a centralised "pot" of money. Provider Trusts will not be able to absorb costs and Commissioners are struggling to fund standard care.
- A process for monitoring treatment savings on a Trust level with each trust absorbing ETCs up to the amount saved and costs beyond that applied for via the LCRN. There would need to be a period of data collection and then the system offset in arrears.

- Involve a statistician is modelling costs across a myriad of trial examples e.g. large and small sample size overall, large and small sample size per site, many sites overall in study, few sites overall in study, high ETC's per year per patient, low ETC's per year per patient, high ETC's overall per patient, low ETC's overall per patient, participants involved for short durations, participants involved for long durations then add an adjustment for the overall risk level of the trial (as this impacts the delivery at site – so ETC in a low risk trial will possibly cost less than ETC in a high risk trial due to additional standardisation or training required or more information needed by lead site about the intervention delivery in higher risk trials – not currently factored into the equation). From this, an equation could be developed and applied per project, and a threshold set for referral to NHS England or not based on that – CLRNs would 'plug in' data and a value would be generated but the actual equation would be background. This would avoid people trying to manipulate designs to push them above or below thresholds in ways that would not be ideal – design should come first irrespective of these thresholds and the system should accommodate those either way (ideally to the same timeline).

• Do you think there should be a nominal payment cap for primary care to discourage applications for ETCs where the cost of processing will significantly out-weigh the cost of the ETCs?

There were mixed responses to this question and a sense that this should be directed by primary care providers. If a nominal payment cap were to be set this would have to be at a very low level.