NIHR CLINICAL RESEARCH NETWORK

PROPOSALS FOR THE DESIGNATION OF CLINICAL THEMES

A CONSULTATION DOCUMENT

FOR A RESPONSE BY 10 FEBRUARY 2013

JANUARY 2013
WHAT CHANGES ARE TAKING PLACE TO THE CLINICAL LEADERSHIP OF THE NIHR CLINICAL RESEARCH NETWORK AND WHY?

The NIHR Clinical Research Network (CRN) has developed since the establishment of the National Cancer Research Network in 2001 with the subsequent establishment of 5 other Topic Specific Networks (Mental Health, Diabetes, Medicines for Children, Dementias and Neurodegenerative Diseases, and Stroke), followed by the Primary Care Research Network and Comprehensive Clinical Research Networks in 2007. The Comprehensive Clinical Research Network provides support for all areas of clinical need not covered by the Topic and Primary Care Networks and its portfolio has been organised into 23 “specialties” each led by a National Specialty Group.

The current configuration of the Network provides support for research into all areas of clinical need. However, the way the Network has developed has resulted in a number of inconsistencies in the way clinical leadership is engaged and support is delivered for different clinical areas at both national and local levels. Changes to the organisational structure of the CRN are being made to bring the different parts of the CRN together to form a more integrated and flexible organisation.

The focus on clinical themes will be retained (since this has been such an important part of our success to date), however, in future, these themes will be delivered through a simplified national structure comprising 15 geographically-based Local Clinical Research Networks, in place of the current structure of more than 100 local Networks with different boundaries.

Integral to the plan to reconfigure the NIHR CRN is the development of a consistent framework to further enhance the engagement and leadership of the clinical research community and ensure that support is provided in a consistent and equitable manner across all areas of clinical need and across all parts of England.

Clinical “Topics” and “Specialties” are being reorganised into “Clinical Themes” and we are aiming to group cognate disease/therapy areas into 10-12 Clinical Themes. The themes will generally be broader than the current topics/specialties, and will allow us to combine the expertise that we have in both topics and specialties in productive and more streamlined ways. This will be an evolutionary process and is likely to continue to evolve to reflect national and emerging priorities.

The nine existing Coordinating Centres (6 Topics, Primary Care, Comprehensive and CRN) will be integrated into one NIHR Clinical Research Network Coordinating function which will provide executive/operational leadership and management for all areas of the NIHR CRN and support for the national clinical leadership of the Clinical Themes.
WHAT ADVANTAGES WILL THE THEMATIC APPROACH BRING?

An explanation of the changes which are being made to the configuration of the CRN, and the benefits which these will bring, can be found at Appendices 1 and 2.

The Clinical Themes will provide the managerial framework through which support will be provided in the future and will,

At a national level:

- Provide a consistent model of clinical leadership across all areas of clinical need;
- Provide full national coverage for research into all key therapy areas;
- Enable collective decision-making to ensure a balanced portfolio across different clinical specialties, with the needs of research areas considered “as a piece”;
- Promote engagement with key stakeholders;
- Enable a consistent approach to performance management across the whole of the CRN’s Portfolio;
- Provide a consistent level of service to all study teams and researchers across all clinical areas and geographies.

At a local level:

- Provide a single model of workforce coordination, responsive to local need;
- Promote a flexible approach to staffing with specialist staff working within one theme and a generic workforce deployed across themes according to local needs;
- Promote a critical mass of research activity through having local networks having larger geographies and broader “Clinical Themes”;
- A consistent way of agreeing, and allocating, support for all therapy areas;
- A consistent way in which local clinical leadership is integrated into the management and governance structure of the local Clinical Research Network.

WHAT WILL BE THE FUNCTIONS OF NATIONAL THEMATIC LEADERSHIP?

A national Leader will be appointed for each Clinical Theme who will be supported by staff as part of the integrated NIHR CRN Coordinating function. A Theme Clinical Lead will be appointed at each Local CRN and these Local Clinical Leads will form a National Clinical Theme Group.

Suggested elements of the national thematic leadership role include:

- Performance management oversight of the Theme’s national portfolio;
- Championing and promoting clinical research in their respective theme to their research communities and relevant stakeholders (including industry);
- Engaging with the funders of studies on the Theme’s portfolio;
- Linking with national patient groups to ensure patient involvement in the successful delivery and promotion of the Theme’s research activity;
- Thematic business intelligence in relation to the research pipeline;
- Thematic national feasibility;
- Achieving a balanced portfolio of studies nationally, taking into account the need to achieve the NIHR CRN’s High Level Objectives, and the need to balance different study types;
- Providing a national focus and source of advice for the clinical theme;
- Working at a national level to identify and address barriers to the successful delivery of research which are specific to that theme;
- Taking an oversight of the national theme’s portfolio and working at a national level to match opportunities with capacity/capability within the Local CRNs (e.g., finding additional recruitment sites for multicentre studies).

WHAT WILL BE THE FUNCTIONS OF LOCAL THEMATIC LEADERSHIP?

Each Local CRN will provide local leadership and management for each of the Clinical Themes which will consist of a Theme Clinical Lead, a Theme Manager and a Theme Management Team (theme support staff). There will be flexibility in the way support for the Clinical Themes is arranged locally to reflect local circumstances (e.g., nature of the local portfolio, geography and specialist Trusts). It is likely that several Themes will be managed by a single Theme Manager with a workforce deployed across several themes as appropriate to local circumstances and need.

The Theme Clinical Leads will sit on the CRN’s Clinical Advisory Group which will be Chaired by the CRN’s Clinical Lead. This clinically focused strategic leadership team will provide advice to the Local CRN Executive team on a range of issues including the clinical implications of national policy at a local level, the allocation of funding across the patch in accordance with clinical need, and on appropriate reallocation of funding in the event of performance issues.

Suggested elements of the local thematic leadership role include:

- Thematic performance management of the local portfolio;
- Provision of clinical advice and leadership in relation to local CRN delivery;
- Promoting engagement with their local clinical communities and helping to embed research into the clinical delivery pathways of the theme;
- Provide a strategic overview of the local infrastructure required to support the clinical theme with an emphasis on identifying and addressing local blocks to successful delivery, referring issues to the national Clinical Theme Group as appropriate;
- Provide local intelligence to the National Clinical Theme leadership on pressures/issues relating to delivery of the portfolio in their locality and emerging clinical needs and unrepresented patient populations;
- Engage with relevant local strategic clinical networks for their theme and commissioning groups;
- Involving patients in the successful delivery and promotion of local research activity within their theme;
- Help to develop local research capacity for the theme through actively seeking new opportunities for contributing to national multicentre studies and identifying local opportunities to expand expertise/experience across the CRN’s geography thereby supporting and enabling additional Trusts to become involved;
- Undertake local feasibility assessments for commercial studies, including identifying potential sites/investigators that could conduct the study, assessing the available
research resources including skills, facilities and equipment and provide robust recruitment goals;
- Agreeing thematic targets for the constituent organisations of the local CRN;
- Ensuring the appropriate deployment, development and support of CRN-supported staff who are employed by Trusts to deliver in their thematic area;
- Managing the day to day business of thematic portfolio delivery across the local CRN.

WHAT PRINCIPLES HAVE BEEN USED TO DEVELOP THIS DRAFT SET OF PROPOSALS FOR CLINICAL THEMES?

The following principles, in order of priority, have been used in developing this draft set of proposed clinical themes:

1) Grouping of cognate disease/therapy areas together (eg MCRN and Non-Medicines paediatrics; gastroenterology and hepatology);

2) Grouping topics/specialties together which share similar support requirements/environments/specialist skills, ie where a workforce, eg of research nurses, could work across several areas in a flexible way. Examples include: Dermatology and Musculoskeletal Disease; Stroke and Cardiovascular Disease;

3) Ensuring that each Theme covers a significant part of the portfolio (each has at least 200 open studies) so that there is likely to be a critical mass of research being undertaken in each Theme in each of the 15 CRNs.

An analysis of the current overlap (co-supported studies) between the portfolios of the Specialty Groups and Topic/Primary Care Networks (Appendix 6) has also been useful in developing the proposed themes.

Although these proposals set out Clinical Themes which are constituted of the “whole” portfolios of current Topic/Primary Care Research Networks and Specialty Groups, this is not a requirement and the way the current portfolio is organised should not be a restriction on agreeing the new Themes, ie. Themes can be made up of partial elements of the portfolios of the Topic, Primary Care and Specialty Group portfolios. Once the Themes have been agreed, all studies on the Portfolio will be individually allocated to the most appropriate Theme.

WHAT CONSULTATION HAS PRECEDED THIS CONSULTATION PAPER?

Discussions have taken place at a meeting with the Clinical Directors and Assistant Directors of the Topic, Primary Care and Comprehensive Clinical Research Networks and at a meeting of the Chairs of the CCRN’s Specialty Groups in November 2012. These proposals have been discussed and endorsed as the basis for further consultation by the NIHR CRN Transition Programme Board.
WHAT ARE THE PROPOSED THEMES?

The distribution of open studies, totalling 3488 (UK-wide as at 17 December 2012), between the current 6 Topic Clinical Research Networks, the Primary Care Research Network and the 23 CCRN Specialty Groups is at Appendix 3.

11 Clinical Themes are proposed (Appendix 4) with portfolios ranging from around 220 studies to around 580 studies. The size and composition (in terms of the proportions of single centre and multicentre studies and commercial and non-commercial studies) of the proposed Themes are shown in Appendix 5. Two Themes map directly onto Topic Networks (Cancer and Mental Health), 5 Themes bring together Topic Networks and Specialty Groups and 4 Themes comprise of specialties currently supported by the CCRN.

Engagement with key stakeholders will be an important part of the remit of national thematic leadership and a list of Royal Colleges (and Faculties) associated with each Theme has been included in Appendix 4; engagement with funders of research will also be key.

HOW WILL THE SPECIALTIES WHICH MAKE UP A THEME BE MANAGED?

It is recognised that the current structures which involve Clinical Studies Groups (Topic Networks) and Specialty Groups (Comprehensive Clinical Research Network) provide the vehicle through which to harness the expertise, enthusiasm and engagement of researchers working in their specific disciplines. The Clinical Themes will provide the conduit through which each of the distinct specialties which make up a Theme will contribute to the local and national leadership, governance and management of the CRN. The new arrangements will ensure that the specialties which make up a Theme continue to be recognised at both national and local levels, eg in terms of support requirements, performance management and engagement with stakeholders. Once the Themes have been agreed, detailed consideration will be given as to how these “sub-themes” will be led and managed at both the local and national levels.

WHAT ARE THE NEXT STEPS?

Comments on these proposals would be very welcome by 10 February. The findings of this consultation exercise will be taken into account and a finalised set of proposals will be presented for sign off by the Transition Programme Board prior to being submitted to the DH which will make the final decision on Clinical Themes.

Once the new thematic structures have been agreed, work will then commence on implementing these arrangements which will include consideration of the detailed leadership and management arrangements at both national and local levels. Everyone involved with the CRN will be kept informed of progress and there will be further opportunities to input into this process.

WHO SHOULD I SEND MY COMMENTS TO?

Please send your comments to Dr Jonathan Gower, Assistant Director, NIHR CCRN (jonathan.gower@nihr.ac.uk) by close of play 10 February 2013.
APPENDICES

APPENDIX 1 - Transition Plan, Key Messages

APPENDIX 2 - Transition Plan Q&A

APPENDIX 3 - Current distribution of “open” studies (UK wide) across Topic/Primary Care Research Networks and CCRN Specialties

APPENDIX 4 - Proposed Clinical Themes

APPENDIX 5 - Size and composition of the 11 proposed Clinical Themes

APPENDIX 6 - Analysis of the overlap between the portfolios of the current Topic/Primary Care Research Networks and CCRN Specialty Groups
APPENDIX 1 - Transition Plan, Key Messages
1. The transition plan has had the green-light from the Department of Health, and we are now concentrating on implementation. This work will be led by the Transition Board, which includes all the Network Clinical Directors, plus Jonathan Sheffield and members of the CRN CC Executive Team. Individual streams of work are being led by the Network Assistant Directors.

2. By April 2014 the NIHR Clinical Research Network will comprise 15 Local Clinical Research Networks, each with a single host organisation. The area host will hold the contractual responsibility for achieving the performance standards set by an integrated CRN Coordinating Centre, and for disseminating funding for research delivery across the area.

3. Hosts will be decided through an NHS competition. We plan to complete this by autumn 2013, so we can put a shadow structure in place before “go-live” in April 2014.

4. The boundaries for each Local Clinical Research Network will align with the boundaries for Academic Health Science Networks. We expect Local Clinical Research Networks to forge close ties with AHSNs, but we will remain separate and distinct from them due to our different remits. (The Clinical Research Network has a national responsibility for research delivery; the AHSN has a local responsibility for the dissemination and implementation of innovation). We do not expect that any AHSN will host a Local Clinical Research Network.

5. Local Clinical Research Networks will have a five year contract, with one year operational planning.

6. As part of the Transition Plan, we are assessing how best to organise clinical “themes”, to see where there are natural alignments between the current Topics and Specialty Groups (eg bringing together paediatric medicines and non-medicines). This will see the current Topic CCs and Primary Care CC take on a broader portfolio. Network Clinical Directors, Assistant Directors and Specialty Groups will be involved in formulating a proposal for Department of Health approval.

7. We expect the Transition Plan to have minimum impact on the ground. The key differences are that: research nurses and data managers may be involved in delivering studies across a broader portfolio - but one relevant to their skills and experience; LRN Managers will migrate to Theme Manager roles. (Note: dependent on the size of a clinical theme, there may be a number of Theme Managers in each Local Clinical Research Network).

8. It is "business as usual" while the planning work goes on. Our key collective priorities are: delivering studies to time and target (with a particular emphasis on life-sciences industry studies); achieving the Prime Minister's research priority for patients with dementia.

9. The benefits of our new, integrated structure include: a clear set of delivery priorities at local level - determined by an integrated CRN coordinating function; national coverage for key clinical themes; simplified administrative arrangements for Trusts; a more flexible workforce to “future-proof” the Network, and enable us to respond to changing healthcare delivery structures and priorities.

10. Ways to keep in touch with developments (these are just a few, but there will be more): online interview with Jonathan Sheffield available next Monday; web conference on 19 December at 3.30pm; Transition section on The Message where you can post questions (answers within five working days); Network Managers meeting (in March not January) will be devoted to Transition.
APPENDIX 2 - Transition Plan Q&A
Q & A

**Q** What changes are taking place?

**A** We are evolving our organisational structure in three main ways:

- We are bringing the different parts of the Clinical Research Network together to form a more integrated and flexible organisation.

- We are retaining the focus on different clinical themes (since this has been such an important part of our success to date). However, in future, these themes will be delivered through a simplified national structure comprising 15 Local Clinical Research Networks, in place of the current structure of more than 100 local Networks with different boundaries.

- We are uniting the leadership across the Networks to create a more inclusive and collective coordinating function, to set performance standards for the 15 Local Clinical Research Networks, bring a national oversight to delivery of the CRN portfolio, and ensure that funding to deliver local priorities is allocated appropriately.

**Q** Why are we evolving the structure of the Network?

**A** There are several reasons why we need to evolve.

- To increase transparency and efficiency in governance and administration
  The government is keen to see maximum transparency and efficiency in all publicly-funded organisations, and we need to ensure that our structure meets this agenda. NHS Trusts have told us that our current administrative model is complex, bureaucratic and hard to understand, but by simplifying our area boundaries and hosting arrangements we can improve this dramatically.

- To improve our ability to respond to the changing healthcare environment
  The Health and Social Care Act is changing the landscape for healthcare services. If the Network is to be “future-proof”, we need a more flexible structure, which allows us to respond to these changes, and to new government research priorities that may emerge in the future. A more integrated Network model will help us to be more agile and responsive.

- To simplify the setting of performance standards, and increase consistency in allocating funding
  To date, the Topic Networks have had “flat” funding, and have applied to the Comprehensive Clinical Research Network for additional resources to meet local needs. However differences in boundaries have made this a complex and burdensome process. By uniting the Network coordinating function and simplifying our organisational structure, we can set delivery priorities at national level, give clear performance standards to Local Clinical Research Networks, and ensure that funding is allocated accordingly. This should reduce the admin burden, so we can concentrate on research delivery.
Q Does the fact that we're changing mean that people don't believe the Networks are successful?
A No. The Networks are a success story, with notable achievements in the number of patients now recruited into research studies, and the level of NHS engagement across England. However, to stay successful in the future, we need to evolve further.

Q How will the new host sites be selected?
A Each of the 15 Local Clinical Research Networks will have a single host. The Department of Health has advised that the hosts will be selected through an NHS competition. The details of this are still being determined, but we hope to begin soon, with a view to completing the competition in autumn 2013.

Q Are we merging with the Academic Health Science Networks (AHSNs)?
A No. We will share geographic boundaries and build strong partnerships with AHSNs, but we will have separate leadership, management and governance arrangements and we will retain our separate remit.

Q Are we losing topic and speciality groups?
A No, although they will evolve.

The fact we will be working more closely together does NOT mean that we are losing our focus on particular therapy areas. If anything, the opposite is true. However, as we move towards our new structure, we will stop using the terms "topics" and "specialties" and will start to work in "themes".

The themes will be broader than the current topics, and will allow us to combine the expertise that we have in both topics and specialities in a productive and more streamlined ways.

The details of what sits within each theme are under discussion by the Network leadership, and will need to be agreed with the Department of Health before any changes are made.

Q Given the range of specialist skills required to carry out research delivery, will staff be expected to work outside their skills set or therapy area?
A Specialist skills are very important to the success of the Network now and in the future, but we need to make sure we balance specialism with flexibility of resource. That is why we are looking at how to organise our workforce in clinical themes. Although the details of what sits within clinical themes are yet to be decided, the discussions are centring around aligning topics and specialities that have a natural synergy. For example, it may be that we bring all paediatric research into one theme (medicines and non-medicines), so staff working in this area would be able to use their expertise in an extended but closely allied area.

We expect that thematic working will allow staff to extend their expertise into a related therapy area, but we do not anticipate that anyone will be expected to acquire a radically different skill-set. Training and support will be given to staff who wish to extend their expertise both within their current specialty, and when moving into extended thematic areas.
Q With so much change already in the NHS would we be better waiting until NHS structures are in place before changing ours?
A No. The NHS is changing, and as an integral part of the NHS, it is important that we evolve alongside it. We need to engage with that change now.

Q How will roles change in relation to band, location and employment contract? Will staff be slotted into appropriate roles or will there be a selection process?
A These are things that will become clear as the implementation plan progresses. Established HR policies and practices will be followed at all times, and we will keep staff informed at all stages.

Q What will happen to non-clinical frontline staff?
A Clinical research is a team effort and non-clinical staff will continue to have an important role to play in the future success of the CRN. We anticipate that there will be minimal changes on the ground, although there may be some realignment of roles to take account of the new structure.

Q How will we maintain our commitment to patient and public involvement in the evolved structure?
A The new structure offers us an opportunity to strengthen the structure for patient and public involvement across the Network. We envisage that the PPI roles at a thematic level will continue, linking with a local presence in each Local Clinical Research Network.

Q What career development opportunities will there be in the new structure?
A The local delivery model will present opportunities for cross-training and for research delivery staff to move between aligned specialities. This will extend experience and support continued professional development. There will be opportunities for clinical staff to be involved in an integrated research culture in frontline health and social care.

Q What is the relationship between the local partnership group and the clinical advisory group?
A Both groups form part of the local governance model. They will have separate accountabilities and responsibilities but links will be essential for the Local Clinical Research Networks to operate effectively. The details the interaction between these groups is still being defined, and will emerge as we start to model the new structure.
APPENDIX 3

CURRENT DISTRIBUTION OF “OPEN” STUDIES (UK WIDE) ACROSS TOPIC/PRIMARY CARE RESEARCH NETWORKS AND CCRN SPECIALTIES

Number of Open Studies in all Topics and Specialty Groups

Numbers indicate the number of “open” studies led by each Topic/Specialty as at 17 December 2012 (this includes studies led by all four UK nations). Topics are shown in dark blue and Specialties in light blue.
## Proposed Clinical Themes

### Appendix 4

<table>
<thead>
<tr>
<th>Theme</th>
<th>Current Topics/Specialty Groups</th>
<th>Size of Constituent Portfolios</th>
<th>Size of Theme Portfolio</th>
<th>Associated Royal Colleges</th>
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<td>MHRN</td>
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<td>277</td>
<td>Royal College of Psychiatrists</td>
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<tr>
<td>Mental Health</td>
<td>Nervous Systems Disorders SG</td>
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<td>Royal College of Physicians</td>
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<tr>
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<td>125, 122</td>
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<tr>
<td>Dementia and Neurological Diseases</td>
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<td>125, 122</td>
<td>247</td>
<td>Royal College of Physicians</td>
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<td>Reproductive and Child Health and Genetics</td>
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<td>Reproductive and Child Health and Genetics</td>
<td>Reproductive Health &amp; Childbirth SG, Paediatrics (Non Medicines) SG, Genetics SG</td>
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<td>476</td>
<td>Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health</td>
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<td>Primary Care, Oral &amp; Dental, Public Health and Health Services Research</td>
<td>PCRN, Health Services Research SG, Oral &amp; Dental SG, Public Health*</td>
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</table>
*Although there are not Specialty Groups for Public Health and Urology, there are a small number of studies on the portfolio which are badged against these specialties.

**KEY:**

NCRN – NIHR Cancer Research Network

MHRN – Mental Health Research Network

SG – Specialty Group

DeNDRoN – Dementias and Neurodegenerative Diseases Research Network

MCRN – Medicines for Children Research Network

PCRN – Primary Care Research Network

SRN – Stroke Research Network

DRN – Diabetes Research Network
SIZE AND COMPOSITION OF THE 11 PROPOSED CLINICAL THEMES

APPENDIX 5

<table>
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<th>Clinical Theme</th>
<th>Non-Commercial Studies</th>
<th>Commercial Studies</th>
<th>Multi Centre Studies</th>
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<td>Cancer</td>
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<td>Primary Care, Oral &amp; Dental</td>
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<tr>
<td>Public Health and Health Services Research</td>
<td>204</td>
<td>44</td>
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## ANALYSIS OF THE OVERLAP BETWEEN THE PORTFOLIOS OF THE CURRENT TOPIC/PRIMARY CARE RESEARCH NETWORKS AND CCRN SPECIALTY GROUPS

| % of studies with support from subject area that are cosupported by other subject areas (limited to only showing >5% overlap) | Age and Ageing | Anaesthesia, Peri-Operative Medicine and Pain | Cardiac Care | Diabetes Research Network | DENDRON | Diabetes and Endocrinology (not diabetes) | Injury and Emergencies | Metabolic and Endocrine Disorders | Mental Health Research Network | Musculoskeletal Disorders | Nonsmoke Research Network | Non-Malignant Haematology | Paediatrics (non medicines) | Primary Care Research Network | Public Health Research | Renal | Respiratory | Stroke Research Network | Surgery | Urology and Urogynaecology | \n|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age and Ageing | 8 | 6 | 10 | 6 | 22 | 6 | 47 | 90 | Anaesthesia, Peri-Operative Medicine and Pain | 10 | 7 | 2 | 2 | 7 | 8 | 6 | 51 | 61 | Cardiac Care | 5 | 9 | 375 | 433 | Critical Care | 8 | 9 | 7 | 70 | 87 | DENDRON | 8 | 10 | 246 | 262 | Dermatology | 11 | 12 | 104 | 133 | Diabetes Research Network | 22 | 23 | 397 | 461 | Ear, Nose and Throat | 9 | 20 | 55 | 65 | Gastroenterology | 8 | 6 | 136 | 166 | Genetics | 7 | 8 | 5 | 7 | 23 | 6 | 83 | 150 | Health Services Research | 6 | 15 | 164 | 185 | Hepatology | 11 | 12 | 5 | 7 | 138 | 180 | Immunology and Inflammation | 6 | 8 | 229 | 282 | Infectious Diseases and Microbiology | 6 | 9 | 71 | 86 | Injuries and Emergencies | 6 | 9 | 272 | 304 | Metabolic and Endocrine (not diabetes) | 12 | 11 | 106 | 147 | Mental Health Research Network | 13 | 14 | 650 | 689 | Musculoskeletal Disorders | 5 | 11 | 370 | 428 | NIHR Cancer Research Network | 8 | 11 | 801 | 858 | Nervous System Disorders | 8 | 11 | 223 | 262 | Non-Malignant Haematology | 5 | 8 | 13 | 7 | 12 | 44 | 60 | Ophthalmology | 6 | 11 | 155 | 174 | Oral and Dental | 7 | 15 | 30 | 46 | Other | 11 | 6 | 18 | 18 | Paediatrics (non medicines) | 9 | 6 | 6 | 190 | 386 | Primary Care Research Network | 14 | 11 | 6 | 6 | 386 | 806 | Public Health Research | 8 | 5 | 33 | 5 | 28 | 39 | Renal | 5 | 166 | 187 | Reproductive Health and Childbirth | 9 | 210 | 247 | Respiratory | 7 | 15 | 289 | 339 | Stroke Research Network | 10 | 171 | 187 | Surgery | 5 | 14 | 10 | 6 | 15 | 5 | 6 | 46 | 98 | Urology and Urogynaecology | 10 | 29 | 10 | 48 | 10 | 7 | 21 |

Notes: All open, closed, in set and suspended studies (commercial and non-commercial) with a portfolio qualification date from 1/1/2008 have been included in this analysis. The number of studies where 2, or more, Topics/Specialty Groups were providing co-support were counted and expressed as a percentage – in the number of studies group 2 (in columns) is cosupporting with group 1 (in rows) as a percentage of the number of studies supported (led-cosupport) by Group 1. Only overlaps of 5% or greater are shown (and columns removed if empty) and the degree of overlap put into colour-coded bands (5-10%, 10-20%, 20-30%, 30-40%, 40-50%)