National Research Ethics Advisors' Panel

A meeting of the National Research Ethics Advisors' Panel held on:

Date: **27 November 2014**
Time: **14:00 – 17:00**

Venue: HRA 1
Skipton House
Health Research Authority
Skipton House,
80 London Road,
London SE1 6LH

MINUTES

Present:
Andrew George (AG) (Chair)
Malcolm Boyce (MB)
Søren Holm (SH)
Ros Levenson (RL)
Mark Sheehan (MS)
Simon Woods (SW)

In attendance:

Clive Collett (HRA Ethics Guidance & Strategy Manager)

1. Apologies: Peter Heasman; John Keen
2. Declarations of Interest:
   AOB 'Mental Capacity Act and Research tissue Banks prospectively gathering identifiable data': Søren Holm is a member of the UK Biobank Ethics & Governance Council
3. Minutes of meeting held on 02 July 2014
   The minutes of the previous meeting were agreed as a true record.

4. MATTER ARISING

4.1. **Payments & Incentives**

Received for Discussion:

- Email response from Dr Thomas Kabir

At the last meeting the panel reviewed the recent NIHR guidance:

- “Recruitment of participants to research studies who are in receipt of state benefits: rules regarding payment for participation”
- “Taking part in research? Here are some helpful benefit tips”

The panel noted that the advice contained in the NIHR guidance had been obtained from Julie Scott who had advised that:

> "Some years ago when service user involvement was introduced, a number of NHS Trusts sought formal legal advice from different legal firms on the status of people who they were planning to pay for service user involvement. The advice was that where the organisation had no duty to offer further paid involvement above a one-off event and that the person had no duty to accept further involvement people would be deemed to be casual workers who have some employment rights. These rights are mostly not applicable to involvement circumstances. The MHRN Model Payment Policy has a chart setting out a number of possible employment status variables and the implications. ACAS has been consulted on these employment status variables. HMRC have been consulted on payments to service users and PAYE

The panel considered that the advice received was primarily related to "involvement" rather than "participation" in research and the matter of whether participation was deemed as "employment" was still an open issue.

MB recalled that the HMRC had issued guidance regarding clinical trial volunteers. [Following the meeting MB sent a link to the HMRC statement: http://www.hmrc.gov.uk/manuals/cirdmanual/cird84400.htm which states that *"Clinical trial volunteers are not employees of the companies and so the expenditure cannot be on staffing costs"* however this does not address whether participation in research should be considered "employment"]

The panel felt that it would be useful to issue a statement on this issue following further research.

Action: CC

4.2. **Proposed HRA/Nuffield Council on Bioethics Sham Surgery Workshop**

Received for Discussion:

- Roundtable on the use of sham surgery
- Draft Agenda

Proposed aims of the workshop:

- Identify the problem of whether and when sham surgery is appropriate;
- Understand the concerns of those carrying out the procedures;
- Understand the regulatory framework in which it is currently carried out; and
- Consider whether further clarification, guidance or procedural advice is needed.

The workshop should involve researchers from different specialities, as well as regulatory/REC and patient/public perspectives.

The panel noted that the Nuffield Council were in agreement that the speakers at this workshop should include patients. The panel agreed that the draft agenda, once updated to include patient representatives, would result in a worthwhile workshop.

RL suggested that the seeking of a representative from Healthwatch England would provide an additional perspective to this workshop.

5. NREA Activity Log

Panel members were invited to provide updates to CC by email regarding NREA activity since the last meeting.

6. Action Register

Noted:

- NREAP Action Register

7. Feedback: Consistency in REC Review

Received for Discussion:

- Updated Collated Feedback regarding NREAP Statement 'Consistency in REC Review'

The panel noted the feedback regarding consistency and in particular agreed that the examples given in the statement were somewhat biased towards clinical research and that future statements/guidance should strive to include examples from other areas such as social care research.

The panel asked CC to ask Operations for an update on how the recommendations made in the consistency statement were being taken forward.

Action: CC

8. Feedback: Payments and Incentives in Research

Received for Discussion:

- Updated Collated Feedback regarding NREAP Statement 'Payments and Incentives in Research'

The panel noted the feedback.

The panel discussed what form such guidance produced by the panel should take. AG noted that the view had been expressed to him that short, sharp advice was the most useful. He asked who the audience was for NREAP guidance and suggested that these stakeholders should be asked what form of advice they preferred. It was agreed that the question should be asked at the next round of NREAP/Chairs network meetings.

9. Payments and Incentives in Research: Travel Expenses

Discussed:

The following Operational Management Email Alert was issued to REC Managers on 24th October highlighting the issue of payment of travel expenses.

OMEA #67 (Issued 24/10/2014)

Travel Expenses

Joan Kirkbride (Director of Operations) recently attended a meeting with representatives of Cancer Clinical Trials Units. The representatives advised that they had experienced inconsistencies with RECs in relation to the payment of travel expenses for patients. Whilst their wish would always to be able to pay travel expenses, this was not always possible and they provided examples of where studies were delayed whilst trying to resolve matters. The NREAP has recently issued guidance on payments and incentives in research which includes the following statement:

"Where the risk and burdens of the research are considered by a REC to be justified by the potential benefits then it will normally be acceptable for competent adults to participate in the research study without being paid **(including reimbursement of expenses**)."

The NREAP will consider developing a short guidance paper on travel expenses for participants.

The panel discussed whether a "short guidance paper on travel expenses" or other further statement/guidance should be issued and decided that there was no need to issue specific advice but emphasised the point made in the guidance on payments and incentives in research that competent adults should be allowed to take part in research without receiving reimbursement of their travel expenses provided that this is clearly and fully explained to them prior to their decision to participate.

RECs may wish to explore with the researchers and the sponsor whether reasonable travel expenses can be paid to participants but non-payment of travel expenses should not normally constitute grounds (either partially or fully) for an unfavourable opinion.

10. Seeking Informed Consent for Simple and Efficient Trials in the NHS - Draft guidance: For Comment

Received for Discussion:

- Seeking Informed Consent for Simple and Efficient Trials in the NHS - Draft guidance: For Comment
- Response Form

RL asked that the word "strong" should be deleted from the sentence "Patient has not expressed a strong preference for any particular treatment" included in the "Suggested specific principles regarding seeking consent in simple and efficient trials"

SH noted that the guidance should be clear that simple and efficient trials should not be used as an easy way to collect biological samples for inclusion in a research tissue bank for future research use.

SW asked whether the guidance was intended to include research involving adults lacking capacity. CC responded that inclusion of such research was not originally envisaged but the call for comment asked whether respondents felt that simplified

consent procedure should be extended to include adults lacking capacity and children. SW felt that whilst research involving adults lacking capacity, which would involve approaching consultees, should be excluded from this guidance due to the additional complexity, the issue of simplifying procedures for seeking consent from consultees for research under the Mental Capacity Act should be reviewed with a view to issuing separate guidance.

MS emphasised that there was a danger of reinforcing the bias against research involving children and adults with mental health if simple and efficient trials cannot be undertaken in these groups.

11. Shared Ethical Debate 15

Received for Discussion:

- ShED15 Report

Whilst it was noted that there appeared to be a superficial inconsistency with regards the category of opinions given in this ShED SH wondered whether this actually reflected a deeper inconsistency or whether the underlying ethical assessments were not so different. He suggested that RECs might be asked to specify how significant they thought the problems they had identified were on a scale of 0-10.

RL noted that the report appeared to show that those committees who considered the item earlier in their agenda tended to discuss more themes than those who left the ShED application until the end of their agenda. AG agreed and suggested it might be worthwhile to examine real REC opinions and correlate them to their agenda position. The panel agreed that such an "order effect" study would be very useful to undertake and that the academic members of the panel might be able to make suitable students available to undertake such a project.

The Panel reiterated the recommendation made in their recent 'consistency' paper regarding 'appropriate opinion type' i.e. that the decision regarding the appropriate opinion type (favourable, provisional, unfavourable etc.), consistent with the reasons and requirements underlying that opinion, is a matter of procedure amenable to SOPs and thus should be formally taken in consultation with the REC Manager and/or other HRA staff.

The panel asked CC to approach operations to recommend that an order effect project is considered and to offer the assistance of the NREAs in the design and conduct of the study. If Operations are in agreement then a paper should be prepared for the next NREAP meeting for further discussion.

Action: CC

12. Challenges to REC Opinions by Third Parties

Received for Discussion:

NREAP were asked to consider proposals for consideration of third party complaints (other than appeals by CI/Sponsors) that seek to challenge an existing REC opinion.

The NRES SOPs do not currently provide for a further challenge where the original concerns have been investigated and the study is permitted to continue under a favourable ethical opinion.

RL considered that NREAP might have a role as a "tribunal" and that this should include the ability to bring in appropriate external expertise in order to provide truly independent and informed view.

SH stated that we should bear in mind that this was a real and current practical problem i.e. the HRA were currently engaging with two challenges to existing REC opinions. He felt it was important to address two questions: 'what is the overall process presented broadly correct?' and 'is there a role for the panel in this procedure?'. He felt that the procedure presented was broadly suitable but considered that, for pragmatic reasons, advice should always be sought from the whole panel and not individual NREAs.

AG agreed with RL that NREAP would need to be able to draw upon appropriate internal/external expertise as necessary in providing advice on such challenges. AG proposed that the proposed revisions to the standard operating procedures should be supported subject to minor modifications but that the panel should address the basis and ethical issues related to appeals procedures and examine the various models used by other institutions. The panel agreed.

The panel asked CC to provide a scoping document on appeals for the next meeting.

Action: CC

13. Similar Research Trials Conducted to Satisfy FDA Requirements

Received for Discussion:

- Newcastle and North Tyneside 2. REC Applications and relevant Minutes:
    - AMAGINE-2 (REC Ref: 12/NE/0201)
    - AMAGINE-3 (REC Ref. 12/NE/0202)
- Nottingham REC 2. REC applications and relevant Minutes
    - 13/EM/0426. Short Title: COMPOSE I
    - 14/EM/0090. Short Title: COMPOSE II
- FDA “Guidance for Industry Providing Clinical Evidence of Effectiveness for Human Drugs and Biological Products” (1998)

HRA Operations asked for the panels’ view on the following issue regarding submission of similar studies in order to satisfy FDA requirements:

> The HRA are aware of three instances where RECs have been asked to review and approve two identical studies. There may be more as this only comes to light when the submissions are made to the same REC.
> The reason behind the identical submissions is that the FDA requires 2 efficacy studies to be undertaken (see extract from FDA guidance below), the expectation being it would be assumed that they are undertaken consecutively with the outcomes and findings of the first study feeding into the design of the second study. However, with these submissions, identical studies have been submitted to run concurrently.

The RECs view has been that each study on its own was suitably powered to meet the objectives and therefore to run two identical studies concurrently would be unethical as it exposes twice the number of participants to the risk of harm with no real benefit. It would also not be ethical to halve the numbers in each study and combine the data as then neither study would be powered to answer the research question. It was therefore deemed unethical to undertake two identical studies concurrently.

Do NREAP consider that it would be reasonable for a REC to give an unfavourable opinion for both studies and advise that they should resubmit just one application?

Background Information:

Relevant extract from FDA "Guidance for Industry Providing Clinical Evidence of Effectiveness for Human Drugs and Biological Products" (1998):

"With regard to quantity, it has been FDA's position that Congress generally intended to require at least two adequate and well-controlled studies, each convincing on its own, to establish effectiveness. (See e.g., Final Decision on Benylin, 44 FR 51512, 518 (August 31, 1979); *Warner-Lambert Co. V. Heckler,* 787 F. 2d 147 (3d Cir. 1986)).

FDA's position is based on the language in the statute[1] and the legislative history of the 1962 amendments.Language in a Senate report suggested that the phrase "adequate and well-controlled investigations" was designed not only to describe the quality of the required data but the "quantum" of required evidence. (S. Rep. No. 1744, Part 2, 87th Cong. 2d Sess. 6 (1962)). Nevertheless, FDA has been flexible within the limits imposed by the congressional scheme, broadly interpreting the statutory requirements to the extent possible where the data on a particular drug were convincing. In some cases, FDA has relied on pertinent information from other adequate and well-controlled studies of a drug, such as studies of other doses and regimens, of other dosage forms, in other stages of disease, in other populations, and of different endpoints, to support a single adequate and well-controlled study demonstrating effectiveness of a new use. In these cases, although there is only one study of the exact new use, there are, in fact, multiple studies supporting the new use, and expert judgment could conclude that the studies together represent substantial evidence of effectiveness. In other cases, FDA has relied on only a single adequate and well-controlled efficacy study to support approval — generally only in cases in which a single multicenter study of excellent design provided highly reliable and statistically strong evidence of an important clinical benefit, such as an effect on survival, and a confirmatory study would have been difficult to conduct on ethical grounds.

[1] Section 505(d) of the Act uses the plural form in defining "substantial evidence" as "adequate and well-controlled investigations, including clinical investigations." See also use of "investigations" in section 505(b) of the Act, which lists the contents of a new drug application."

Modernization Act (1997):

Section 115(a) of the 1997 Modernization Act amended section 505(d) of the Act states that the FDA may consider **"data from one adequate and well-controlled clinical investigation and confirmatory evidence"** to constitute substantial evidence if FDA determines that such data and evidence are sufficient to establish effectiveness.

SH pointed out that the answer to the question posed ("*Do NREAP consider that it would be reasonable for a REC to give an unfavourable opinion for both studies and advise that they should resubmit just one application?*") would depend upon whether one seeks to obtain scientific knowledge or simply wishes fulfil regulatory requirements in order to get a drug to market. Often these two aims coincide but it was important to acknowledge that given the importance of getting drugs to market then there may be circumstances when two identical studies might need to be approved to facilitate this and this would be ethically acceptable.

MB explained that the FDA will accept one large study provided this was overwhelmingly positive (see 'Modernization Act' above). The studies under consideration by the panel are large phase 3 studies and as such are likely to have sufficient prior evidence to support efficacy but MB pointed out that all regulatory authorities want evidence of *safety* as well but are often vague regarding the numbers required to provide satisfactory evidence of this. He noted that, because of "study centre effects", pharmaceutical companies will often conduct three trials in the hope that two of these will provide positive results. MB further explained that there will often a number of reasons why two similar studies might need to be conducted, these included the number of participants required, variability of the disease requiring different populations to be studied, need to satisfy key opinion leaders (all of whom may be vying to be part of the study) etc. However, it was not clear in the cases presented why the two studies were being conducted in the same country.

AG summarised the discussion as indicating that the issue was more nuanced than the simple question of 'is it reasonable for a REC to give an unfavourable opinion'. It is important that trials are replicated but this would normally mean that they are conducted in a slightly different manner as is pointed out in the FDA guidance:

"The need for independent substantiation has often been referred to as the need for replication of the finding. Replication may not be the best term, however, as it may imply that precise repetition of the same experiment in other patients by other investigators is the only means to substantiate a conclusion. Precise replication of a trial is only one of a number of possible means of obtaining independent substantiation of a clinical finding and, at times, can be less than optimal as it could leave the conclusions vulnerable to any systematic biases inherent to the particular study design. Results that are obtained from studies that are of different design and independent in execution, perhaps evaluating different populations, endpoints, or dosage forms, may provide support for a conclusion of effectiveness that is as convincing as, or more convincing than, a repetition of the same study."

It is important to recognise that there are justifiable reasons for conducting two similar or identical studies and if the researchers provide such justification then RECs must take this into account.

Fulfilling regulatory requirements can be an ethically acceptable reason for conducting two similar studies. However, RECs should always engage with the arguments presented to assure themselves that regulatory requirements do indeed necessitate two similar studies rather than a single 'adequate and well-controlled clinical investigation and confirmatory evidence' as provided for under the Modernization Act (1997).

14. Prize Draws

Discussed:

A query was received from a REC Chair regarding the use of "prize draws" in research.

> "The researchers whose proposal was under consideration proposed to enter participants into a prize draw. When we expressed surprise at this approach we were informed that this suggestion had come from the REC to which they had taken their previous study. One of our members, a retired lawyer, had concerns that this might cause problems with the lotteries act. He wishes us to say clearly that 'this is the view of a committee member (albeit a former lawyer) and not commissioned legal advice'. Nevertheless we think you will find it useful to be aware of his opinion and to consider whether there needs to be any guidance to RECs or researchers on this matter:
>
> The issues about a prize draw (as this offer is) is that lotteries are closely regulated and if what is offered amounts to a lottery not conforming to the regulation the lottery is unlawful. The essential characteristics of a lottery are that the participant pays to enter and the distribution of prizes is based on chance. A prize draw shares that second characteristic (chance allocation of the prize or prizes) but, in order not to be classed as a lottery, must have no element of payment to enter whether direct or indirect. If there is no payment the draw is not a lottery and is lawful. Because of the payment requirement, competitions in magazines or promoting products or services are set up so that the prizes are awarded not on chance but on the exercise of skill, knowledge or judgment. They are, accordingly, not lotteries because there is no basis of chance even though the purchase of the magazine or the product is regarded as payment to enter the competition. It is the broad definition of payment to enter which causes the concern over prize draws and it is possible to conceive of certain clinical trials in which there could be an element of payment. However, in the sort of study which we were considering I think it safe to say that the prize draw would be lawful and not of any legal or ethical concern. So, I suppose our comment when faced with a study in which a prize draw is offered should be (assuming that the sums involved or other conditions do not themselves raise any ethical issues) that the applicant should check that the prize draw is legal and not an unlawful lottery."
>
> The panel noted that the query presented a comprehensive analysis of the issue and considered that it was not the role of RECs to have a detailed knowledge of the Lotteries Act nor comment on compliance with it.

15. Research Ethics Committee (REC) Chair's And Member's Feedback Form: Phase I Cancer Trials

The panel were asked to consider the following feedback submitted to the HRA QA department from a REC Chair.

> "Phase one cancer trials pose unique ethical dilemmas. Because the drugs have such severe side effects, the trials cannot take place in healthy volunteers, and are performed on cancer patients who are running out of treatment options. These patients are in poor health in association with a limited life expectancy.

We know that some phase one cancer trials are not followed up for “procedural” reasons, and that most recently approved cancer drugs have at best a marginal improvement on cancer survival. The composition of RECs is such that we do not have the competence to judge whether there is any likelihood of a new drug being other than a copycat of an existing drug, and we do not see an analysis of the research behind the drug development which might make that judgement realistic.

Phase one trials in cancer patients are unusual in that there is no equipoise and that there is a significant burden on patients who are ill with a short life expectancy.

There should be a separate mechanism for assessing the ethics of phase one cancer trials which would include:

Steps taken to ameliorate the burden which the participants face:

- Assessment of the likelihood that the researchers will continue to develop the drug if the research is promising.

- Consideration of the ethics by a group which has been given good information on the likelihood of the drug being superior to existing treatments.

References:

‘Unintended consequences of expensive cancer therapeutics’
JAMA Otolaryngology-Head and Neck Surgery. Published Online July 28 2014

ABSTRACT: Cancer is expected to continue as a major health and economic problem worldwide. Several factors are contributing to the increasing economic burden imposed by cancer, with the cost of cancer drugs an undeniably important variable. The use of expensive therapies with marginal benefits for their approved indications and for unproven indications is contributing to the rising cost of cancer care. We believe that expensive therapies are stifling progress by (1) encouraging enormous expenditures of time, money, and resources on marginal therapeutic indications and (2) promoting a me-too mentality that is stifling innovation and creativity. The modest gains of Food and Drug Administration–approved therapies and the limited progress against major cancers is evidence of a lowering of the efficacy bar that, together with high drug prices, has inadvertently incentivized the pursuit of marginal outcomes and a me-too mentality evidenced by the duplication of effort and redundant pharmaceutical pipelines. We discuss the economic realities that are driving this process and provide suggestions for radical changes to reengineer our collective cancer ecosystem to achieve better outcomes for society.

‘Discontinued drugs in 2011: oncology drugs’
Robert Williams.
Expert Opinion Investig. Drugs (2013) 22 (1): 9-34

ABSTRACT: This year's analysis of discontinued drugs in oncology reveals that the trend of increasing numbers of candidate drug development terminations seen in recent years has continued into 2011. Thirty-seven drugs were dropped from the global oncology development pipeline in 2011, significantly more than the 28 discontinuations reported in 2010. Of note were the number of terminations reported for strategic reasons and the striking number of drugs (23) discontinued in or at the end of Phase I development. This article provides a summary of those drugs discontinued in 2011 and discusses the observations in the context of the rapid changes occurring in the way new anticancer drugs are developed.

MB stated that he recently heard Sally Burtles (Director of Research Services and Business Development and previously Cancer Research UK Director of Centres) speak on this issue and she made the point that many patients feel they are "doing their bit" by taking part in phase 1 cancer trials.

SW noted that such trials present the REC with difficult decisions to make. One major concern will always be the likelihood of therapeutic misconception which is always high in such studies i.e. that the participants misunderstand the purpose of the research and the likelihood of therapeutic benefit, which is normally low or absent in such trials. If patients participate in phase 1 trials they may not be offered palliative care, which is very effective at controlling cancer pain in the end stages of the disease. He acknowledged that cancer patients who took part in these studies were often "grasping at straws" but that did not mean that they should not be allowed to take part nor that RECS should not approve such studies.

RL stated that she was unsure what the panel's response should be to the questions posed by the correspondence. She felt the best that could be done was to engage with cancer charities and patient groups over these issues.

AG noted that the correspondent felt that RECs should consider whether the trial drug was likely to make it to the marketplace but that this was not within the RECs control.

MS was of the opinion that there were issues involved in this research and whether such trials should be approved and the question was how NREAP, and the HRA, could engage with these issues. It was not clear how to facilitate the discussion of these issues which were an "outward" problem (requiring external engagement) rather than a "downward" problem (i.e. an internal discussion between NREAP the HRA and RECs) for the panel.

One obvious issue raised was that regarding the requirement for equipoise. Should equipoise be a requirement for phase I research or indeed for research more generally? The rationale for conducting any research could either be "scientific", "clinical", or related to the "market" and thus equipoise may not always be directly relevant to these.

AG asked that these arguments be summarised and presented to Sally Burtles for her opinion on them and how they might be taken forward.

Action: CC

[Post meeting note: Sally Burtles has left CRUK and so the issues identified should be raised with her successor]

16. NREAP/Chairs Network Meeting Minutes

Received for Information:

- South Central – 19th November 2014

MS noted that one of the issues raised in the minutes was related to the attendance of researchers at REC meetings. He explained that he was currently working on an academic paper that addressed this issue and the arguments for and against the attendance of

researchers at ethics committee meetings and the biases introduced by this practice. He offered to bring a paper on this issue to the next meeting.

The panel accepted his offer and would discuss this issue further at the next meeting.

Action: MS

17. Guidance on Genetic Findings In Research

Discussed:

At the last London/S.E. Chairs meeting the issue of feedback of genetic findings in research was raised by a REC Chair. It was suggested that NREAP guidance on this issue might be of benefit to RECs.

The panel were invited to consider whether guidance on this issue should be developed by NREAP.

For Information:

The following paper suggests that *"The lack of relevant studies emphasizes the urgent need for empirical investigations into the disclosure or non-disclosure of genetic incidental findings, and the provision of guidelines to assist healthcare professionals and researchers"*

- **Incidental Findings in Genetic Research and Clinical Diagnostic Tests: A Systematic Review**
  Jackson L, Goldsmith L, O'Connor A, Skirton H. 2012.
  Am J Med Genet Part A 9999:1–9.

SW explained that this was an emerging issue but felt it would be problematic to issue guidance at this stage, unless it was extremely general, as there isn't a consensus on how to manage such findings. What he felt was emerging was an understanding that broad consent, involving fewer ties on researchers obligations, may be desirable.

MS explained that research participants initially say "yes" to genetic feedback but that once it is explained to them exactly what this entails they often change their mind and decline such feedback. MS agreed with SW, stating that it was too early to point towards any specific guidance or produce guidance as a lot of work was currently going on in this area.

SW stated that there needed to be a way to distinguish between 'primary', 'pertinent' and 'secondary' findings etc. and that researchers need to have a decision tool in place as part of the protocol for the study for dealing with these. SH agreed stating that in some cases the findings are "predictable" rather than "incidental". What is important is to have a justified process in place for dealing with these findings.

18. Any Other Business

18.1 Mental Capacity Act (MCA) and Research Tissue Banks prospectively gathering identifiable data

Will Bowen (WB) joined the panel to present the issues related to the prospective collection of identifiable data (e.g. through Hospital Episode Statistics (HES)) to link to tissue held in a

research tissue bank, in circumstances where the involvement of a large number of participants will mean that some of the participants will inevitably lose capacity.

WB asked the panel to consider the following questions:

1. Does this type of activity fall under the provisions of the MCA?

2. If so should the research provisions of the MCA apply?

3. If the research provisions do not apply how do these projects adhere to the MCA and who should ensure this?

SW stated that there may be a need for a legal opinion on this issue noting that the MCA does add some complexity to how data should be managed in these circumstances. It is not clear whether such data collection constitutes research but SW felt it was disingenuous to say that research tissue banks were not a form of "research". His personal view was that such data collection is research and the MCA is engaged.

SH pointed out that a database could be established by consent or under the provisions of the MCA but that the legality of continued extraction of patient data into the database once the individual loses capacity, even if originally consented to, hinges on whether this is a research project not. Furthermore, the MCA only allows consent for specified purposes, any proposed broad purposes would need to be compliant with these specified purposes.

SW noted that the MCA allows for further use of anonymised data but where there is a commitment to the feedback of results then clearly the data are not anonymised. There is no onus on a researcher to continually check the capacity of the participants but where there is constant, active engagement then the researcher would have a duty to monitor capacity. If the researcher becomes aware that a participant is incompetent, and the activity is "research", then the research provisions of the MCA will apply. Part of the problem with such complex research involving prospective data collection and linking these with the tissue bank is that the various strands of clinical and research activity are merged. SH noted that the activities within such a "biobank" were a grey area. Predictions will be made and papers will be published so it would not be correct to say such activities were "audit" or some other activity, it would be difficult to say that such activities were not "research".

RL felt that any attempt to get round the research provisions of the MCA by pragmatically declaring an activity not to be research was uncomfortable. The MCA was put in place to protect vulnerable people.

MS stated that there was a need for provisions within the project to deal with the following circumstances:

- The transition from childhood to adult where the individual lacks capacity
- where the researchers become aware that an adult participant has lost capacity

19. Date of Next Meetings

CC asked the panel whether they felt the current for meetings a year were adequate.
The panel felt that it would be preferable to move to 5 meetings a year with a break in the summer. In addition, an "awayday" style meeting should be arranged early in the year (in addition to these 5 meetings).

[Post Meeting Note: the following dates have now been set:

- Monday, 02 March 2015
- Monday, 18 May 2015
- Thursday, 30 July 2015
- Tuesday, 13 October 2015
- Thursday, 26 November 2015]