Video transcript of a presentation from the NIHR Research Design Service North West Developing proposals for the renewed NIHR Research for Patient Benefit programme seminar. Held on 11 February 2016.

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Presentation title: An overview of the RfPB programme.

The video can be viewed here.

Good morning everyone; my name is David Armstrong and I'm the Programme Director for RfPB and thank you for inviting me to Liverpool in the Liner Hotel we'll all decide whether it was the Titanic at the end of the meeting or not.

What I want to do today is just give you a brief overview of RfPB and especially looking at some recent changes and also I want to involve you a little bit in sort of feeding back some of the issues.

So basically RfPB I'm sure most of you in the room know about it; it's a response mode funding programme unlike some of the commissioned programmes across NIHR, we're just taking the ideas of investigators and investigators come with their ideas; we are not saying what we think would be a good idea or not; we are just inviting people in with their ideas; so a response mode investigator lead funding programme.

The grants are up to £350,000 plus, of course, on top of that you can get your support costs from the networks and treatment costs and so on so it can add up way beyond 350 for the overall research project.

We have three funding competitions a year about roughly every 4 months and we have regional panels, which Mark has explained; you have a regional panel up in the North West which will see mainly applications from the North West but often when there are conflicts of interest around members of the panel, we actually put those applications elsewhere at different parts of the country and equally sometimes we get applications, say from London will come up to the North West to be looked at because there are conflicts on the London panel.

It's about addressing issues importance to the NHS. I'll come back to that later on and its essentially a small grants programme; people who are not acquainted with medical research often sort of think £350,000; small grants but it is compared with all the other programmes, you know, the HTA programme, HS&DR, Public Health Research and so on. We tend to be small grants; they tend to be above 350K and so RfPB it's a sort or conduit into some of those other grants, especially feasibility studies we will fund which might then go on to HTA or the Public Health Research programme.

So we're the small grants programme and if you have a small idea, require small amount of money then we are the place to come to.

Now my job as a Director is to oversee the programme; there are a lot of programme managers who are at this central commissioning facility; the way NIHR runs its thing it's a very small central team in the Department of Health in Whitehall. Can only be about a dozen people there and what they've done is they've outsourced a lot of the different functions to other agencies.

So there's a thing called the Central Commissioning Facility which is based in Twickenham where there are a lot of Programme Managers who look after the different programmes that are based there and RfPB is based there and I have a number of Programme Managers who do the operational bit of the RfPB. My job is to sort of swan around and think strategically I guess about RfPB and what we need to do.

What I have constantly got to think about and I guess my job is about thinking what's wrong with RfPB and on my travels I hear various people tell me what's wrong very forthrightly but I thought you might as good North Westerners tell me what's wrong with RfPB.

Now because of etiquette in this situation you probably can't tell me that the Director should be sacked; you could tell me that privately afterwards. But what is wrong with RfPB; what do you yourself thinks wrong with RfPB or you've heard the problem with RfPB is:-

Anyone like to volunteer? Thoughts about what's the problem with RfPB.

They won't fund my research; surely you've cursed; you've had a rejection letter and you thought what the hell are they playing at not funding this brilliant study.

Any other thoughts about what's wrong with RFPB? Yes please.

It takes too long yeh. It's a long time between putting in the application and actually hearing the results six months later. It's a long period rather bureaucratic perhaps yeh.

Feedback is vague; those bullet points you get back sometimes they seem relevant and sometimes they're all over the place yep.

Yeh it's because we're slightly stuck with going through the Trust and therefore you've got to negotiate not only you've got to do the research bit you've got to negotiate with the Trust. You've got to try and get your costings right tricky.

Are they oh right; yes thank you for that. Sometimes the website is not up to date with the recent calls and requirements yep.

Any others yes:

Yeh there isn't a comeback position; there isn't an appeals mechanism; that you can't really come back and discuss it further.

You've got to go the RDS for that. They don't know because they weren't there necessarily.

Any others? Yes please sorry;

Very serious; worthwhile criticism. I think we very rarely get it but I'm not sure if it's fair; perhaps it fairs badly when we do get it; I don't know.

Any other?

Well as in Blue Peter I have prepared my own list of things which we can pick up some of your points that I haven't covered here.

It's a bit bureaucratic;

takes time;

all those different panels;

it's very complex;

it's quite a difficult organisation and as you said takes 6 months;

it's not kind to new investigators. I've heard that; it always goes to the same old lags, you know, these old aged professors who've got loads of money anyway and they keep coming back and getting more. What about new people; how do they get a foot in the doorway.

It's a lot of work for just 350K.

Why go to RfPB to get 350K when you can go to HTA with exactly the same application form and add a couple of zeros to the end and go to HTA and get your millions. So it's a lot of work for the form you've got to complete.

It can seem capricious in its judgements and feedback. You get these bullet points; You get these rejections and you think why did they do it; it's not very clear because judgement they're making, some days it seems you go through and other days you don't go through. It's not very routine, regular in its feedback.

Has PPI lost its way*;* I'll come on to a specific example of that in a moment but when I travel round and I look at the committees, the panels in operation I wonder sometimes if the PPI has lost its way but no doubt we'll hear more of that later on this morning.

It gets a lot of me-too applications. In the drug industry if you want to make a new drug what you do it you take an existing molecule and you tweak a couple of atoms on the end and you put it out as a new anti-depressant. It's almost identical to the old one; probably got a few worse side effects but you can charge a lot of money for it. So the drug industry does a lot of that me-too things.

There's real innovation at getting a really new drug is relatively rare in big pharma. I am afraid that happens also in research to get an original application is actually quite rare. We do tend to get a lot of me-too applications and again I'll come on to explain that.

Finally it doesn't really engage with the NHS*.* That goes not only for RfPB but right across NIHR. I think there's a big issue here. We're meant to be the research arm of the NHS. If you ask the NHS is NIHR the research arm they'll say, no it isn't; can we have their money please. We need their money for services. So the

billion pounds that goes into NIHR why spend it on research; why not put it in to services within the NHS.

So in my view we're not really delivering that engagement with the NHS where we're supporting, helping, facilitating the NHS in its task. I think if any of the programmes should be doing that its RfPB. It is meant to be closer to the NHS so we should be doing more for the NHS and I think it's a valid criticism that perhaps we're not.

So let me take each of these in turn and explain what I am trying to do and my colleagues are trying to do about trying to address some of these issues.

It's a bit bureaucratic: yes we have 10 panels; we used to call them committees and we are now calling them panels because we're one NIHR and that's what they call their groupings across the other programmes so we too are going to have panels.

We are merging two of the smaller regions; it doesn't affect you guys but there are two regions particularly South East Coast and North East which were relatively small, which weren't getting many applications and we think it's just administratively too expensive to actually sustain this. So we have merged two of them.

Secondly we're pushing the pace of the processes; there is a drive across NIHR to speed up the decision making as far as we can, though there are actual physical limits of how fast we can do that.

Also we are doing this idea of one NIHR so there's a seamlessness about the different programmes. So if you come into one programme and it looks as if that application will be better in another programme, we'll move it across for you.

We will try and make the systems and the processes as similar as possible so if you want to go to RfPB and then next year you want to go to HTA it will seem very familiar to you. So the whole idea as NIHR should be one NIHR and we are a committed to that strategy, across the board strategy.

Are we kind to new investigators: Well we have on the website but I think some people haven't read it properly that it's ok for the new investigator to be the PI. If you want you've never ever held a research grant before you can apply to RfPB. We are relaxed about that so long as the rest of the team has got the experience to deliver that research.

So if you like the panels are answering two questions; the first is do we like the research we've got in front of us; is this a reasonable proposal? Yeh this is really good; we would like to see the outcome of this research.

The second question is can this team deliver it? The emphasis is on the team can deliver it. So if you've got a team for example to do a trial and you don't have a statistician, the panel's going to say you really need a statistician for a trial. Yeh you've got to have a statistician in your team. Now that statistician could be the PI if they've never held a research grant before. Now the statistician, they could be the PI so long as the rest of the team has got trials experience.

So we are very welcoming to new investigators and we try and work closely with the training coordinating centre in Leeds to try and get new trainees who've come through their Fellowships and so on into the RfPB. So we try and get a seamlessness across those organisations.

A lot of work for the money; We are stuck with this because of this one NIHR; all the programmes have signed up to the same standard application form. So if you apply to one programme you should be familiar with the form because it's almost the same. We are allowed a little bit of discretion but fundamentally the form is the same right across the board.

Now what we try to do to recognise that a lot of people put a lot of work into this form; they fill out this form and it's a long form and it just keeps growing and it isn't under my control unfortunately and there's different groups who say, let's look at IP in the form; let's look at the finance page; let's look at the summary page; let's look at this and they extend it, they increase it. Whenever anybody looks at the form it grows and what I would like to see is somebody looking at the form and condensing it because forms should be as short as possible.

So what we've done with RfPB in the last competition and this will roll on now; I think it's been successful is to do a two stage application process. Now this isn't like the other programmes where we invite an outline or an expression of interest, which will be different from the application you will actually put in. We are asking you to just complete half the form; so you get the form its familiar but a lot of its greyed out and you've only

got to do certain bits of the form and if you're successful those bits of the form will then be transferred seamlessly across into the final form because you've completed them.

So it's a two stage process and first of all what we want at Stage One is to complete half the form with the aim, the questions, the background and the methods. We want to look at the science. Are we interested in this question and can this question be answered using these methods. That's what we're trying to make a judgement on.

So I hope it saves all the applicants going through all those finances, talking to your Trust, talking to all these people, doing the IP section and so on and so forth, doing all the sections that you tear your hair out over you don't have to do them. You've just got to do this and it is roughly half the form.

An opinion will be made on that half of the form and at that Stage One there will be triage; sometimes the panel will say we're not interested in that question; it's not important enough for the NHS; it's the background it's not right; the question has already been answered elsewhere; the methods won't answer the question and so on. So there's a triage out and we get rid of some applications.

But the other ones which we really like we are going to do a formative assessment; that is we're trying to do feedback to the applicants to say we really like this idea and if you do X Y and Z you'll have a better chance of success when you submit your full application at Stage Two.

So if you're invited at Stage One you will get this feedback which says how you can improve it. You then paste across; we'll do it for you at the CCF, paste across your Stage One data will go across into the full application and then you've got to fit out all the other bits.

We hope that at that Stage Two success rates will be about 50%; so hopefully a lot of people are not spending a lot of time doing work, which will then be simply declined.

In fact we've started this system working and in January we had our panel meetings which just looked at Stage One; we are just introducing gradually over the next two panel meetings. So in January Stage One we had about 200 applications and part of this was to encourage people to apply because applications to RfPB were going down and this was a huge number.

I don't know whether it's going to be sustained but this was a huge number 200 applications were assessed across the 8 regions; 140 were triaged out and 60 were invited, about 60 I haven't got the exact numbers, were invited to Stage Two and offered some sort of formative assessment; some sort of advice on how it can be improved.

So at our May meeting coming up we will have some more Stage Ones; the new Stage Ones will be coming in and they'll consider those perhaps in the morning and then the afternoon they will assess the 50 or 60 completed applications which have come in through Stage One and will fund about 50%.

Because of the tight timelines we are saying to people who've completed Stage One who are invited to Stage Two you've got about 4-5-6 weeks to actually do that. If you miss that deadline because you can't get the finances or something, well you can defer to the next panel meeting. We are offering this sort of quick service if you like right the way through.

Now because people at Stage One are triaged out that makes it a very short period. I think it's just over a month to get feedback on your Stage One because we are not going out to external reviews we're trying to make it as short as possible so people will get very quick feedback on whether they're through to Stage Two or they have been triaged out.

I would hope that because there are still a large number of people are not being funded but they would have only done half the work that perhaps they would have needed to do under the old system.

So that's the new system just coming in; we're still discussing and got a meeting in March with all the chairs of the panels to discuss how we can make it better because we've got to tweak it, we won't have it perfect the first couple of rounds but we are trying to get this better. Also I have got a meeting with RDS Directors too to get their views about how we can improve this system.

Stage One as I said is this triage and formative assessment and also I am going to discuss with RDS because in a way this formative assessment is part of RDS function and are we sort of encroaching on RDS territory here and I need to talk to the RDS Directors about how we can make sure that we work in tandem on this particular stage of the process.

Do the panels make capricious judgements? They're all over the place. Yes they do; occasionally I go and listen to a panel and I think oh I wouldn't have funded that or oh I think that we brilliant; why did you reject it.

So I do have different opinions but I can't go in there and say I'm going to reverse the panel's judgment. If I did that I might as well take over the whole programme. I've got to respect the panels and what they say.

So first of all the panels; who are these panels? They are a mixture of experienced and relatively new assessors. If we are the nursery slopes for investigators coming in to try and get their first grant, which I think we are, we are also the nursery slopes for people being panel members and starting to get on that side of the table in terms of evaluating research grants. So we do have some relatively junior people; they should have all published; they should have all held grants themselves but some of them are relatively young, relatively inexperienced and this is their first time doing this sort of thing but its counter balanced by experienced members.

When I go round the different panels around the country and I listen to them first of all I don't seem to see any systematically tough or easy. Sometimes people tell me oh London is very tough and another region oh that's easier to get your research funded in that region. Well I don't see that personally and I look for these systematic biases in the region and I don't see it. As I said occasionally I see an application where my personal view is that they got it wrong but it's the panel whose got to make that decision.

What I try and do the bottom the scoring range there the panels score the application; if it's a 6 – 10 they fund that project and I have agreed with the panels that I will not intervene even if I disagree with that judgement they've got to take some responsibility for doing that otherwise they would all go home.

If they score between 5 to 5.9 on the borderline I've said look I will exercise discretion there and I do that because if say the North West the panel is harder and tougher and they give a 5.2 to an application and in Yorkshire they give it a 5.9, the same similar application, well I'm there to sort of moderate to make sure that at that boundary the best ones go through. So I exercise some discretion there and try to equalise, moderate if you like the judgements of the different panels. Then there's a group that are non

fundable which I can't rescue but the panels have just said that these we don't want to fund.

The third bullet point there I forgot is to try to maintain a balance of methodological expertise across the panels. So mainly when I look at panel members which I approve they emerge from the chair's recommendation, from the programme manager recommendation and they cross my desk and I approve them if they sort of fit the methodological slot.

So I want every panel to have a couple of statisticians, health economics, qualitative research, trialist experience and so on. I want all this experience on the panels. Then after that it would be great to have subject experience; it would be great to have gender, ethic mix, geographic mix and so on, on the panels. So we try and get a balanced panel but the main criteria for appointed to a panel is methodological expertise.

We are always recruiting to panels and occasionally, of course, you can say I would like to be on that panel and you might not be selected, not because you're no good, but because we've already got that particular methodological expertise on the panel and we are waiting for that slot to become vacant.

In terms of clinical topic expertise, which obviously we can't get on the panel; we can't have a dentist or a gynaecologist on every panel and therefore what we try and do there is use our external referees to get the clinical topical expertise; this is an interesting question or nobody would respond to the answer to this particular trial so why do it. We get that sort of view from the external experts but we rely on methodological expertise within the panel itself.

So that's as far as I can go with these judgements and as I said I do think occasionally we get these odd judgements but overall I think we're probably getting it about right and those odd judgements are also my capricious judgements that they're not getting it right. I think in the main the panels do get it right.

Has PPI lost its way? When I watch the panels in action I will see, I remember a project recently came up about some drug x improving cardiac ejection fraction and the lay members looked through the applications and said have you got anything to contribute this. They said the travel costs for public members of the team are below the involved recommended rates. What they've done they have become ghettoised in my view that

lay members, because there's a PPI section in the form they focus on. Every panel I should say every panel has got 2 or 3 lay members; very important we have those as part of the evaluation team looking at the applications.

To my mind the PPI has began to focus increasingly on this PPI section to see if it's sufficiently detailed and all the i's are dotted and t's are crossed. To my mind lay members should be broader than that should be doing other things and I think we've began to pin them down a little bit with this Stage One application where there is no PPI section; deliberately there's no PPI section so they can't get focused on their little ghetto of oh this is the PPI section I'm going to look at. What I want them to do is say, would in answer to this question be important to patients. How important do you think this is to the NHS, to patients out there. Sometimes the researchers don't really understand that they're particular interest isn't of wide applicability to the NHS.

Are the outcomes relevant for patients? Who's interested in their cardiac ejection fraction? I'm not interested in my cardiac ejection fraction. It's only if it's going to affect me in some way; it's going to affect my mobility; it's going to affect my life expectancy; it's going to affect my energy levels. That's the things that I'm interested in so surely we've got to have the outcome measures which are relevant to patients and who better than public members of the panel.

Thirdly very often I see the burden for patients taking part in the research is incredible. You won't believe that some of the applications come in and the patients got to fill out ten questionnaires and I think that's going to take them two hours to fill out all those questionnaires. Do they really need all those questionnaires in this study?

Again that's where I think the public members should be coming in and saying, hey I don't think I'd join this trial because look at the burden that it would require in terms of my commitment, my travel, my attendance, my questionnaires. I think this is too much for a patient.

So this is the sort of area I would like them to focus on overall as well as that PPI section. So we'll see whether I've got it right in time to come but I hope they will broaden it out from this ghettoisation which I have witnessed in recent years.

The me-too application – I have created, I should have patented the research one arm bandit. Now my computing skills are not up to it but these should rotate, each of these

red blocks should rotate and this is for designing a study. If you can't think of a study to do you just use my research one arm bandit and this will give you a study to do.

What you do it you first of all pick any intervention and the common ones I see out there are CBT, some variant of CBT or exercise and you roll that and you get one of those and then you say; this is your trial or your feasibility study towards your trial; is it effective in treating and you take one of those diseases and there's lot of other diseases out there and then you take a population and there's lots of different populations out there and this is your question. So we get is CBT effective in treating adherence with diabetes in Manchester ethnic minorities and then somebody else will come along.

Is CBT effective in treating the adherence to diabetes in older people?

Well I think haven't we seen that one before; no we haven't because nobody has ever looked at it in older people. They have looked at it in ethnic minorities Manchester but nobody has ever looked at it in older people.

So we get this me-too thing and I put a little bit of guidance on the website to say look you've got to its almost a Bayesian idea; we've got an idea that CBT does work and it seems to work for a lot of different conditions and seems to work for a lot of populations. But we don't have to trial it in every single disease and ever single population.

The same with exercise; we know these's hundreds of exercise interventions out there – most of them don't work – but there's hundreds of exercise interventions out there but I keep seeing somebody came up there was before surgery for some, I can't remember what the condition was; before surgery what would an exercise intervention a pre-habilitation improve the outcomes of surgery for this particular condition whatever it was.

There's lots of other studies which have looked at this pre-habilitation for other surgical operations to see whether exercise, giving patients exercise before improves surgical outcomes. Can't we apply some of that logic to these others?

When I look through the list of new applications I see these me-toos and my heart sinks; sometimes they get funded and I think well is that the useful use of public money but there is a sort of me-too.

So if RDS and researchers out there can come up with something a little bit original, a little bit different from these it would make my heart sing. This is the problem I think we

often face; we've got these me-toos where we sort of know the answer before we've actually started the research from previous studies.

We have also got the other sort of me-too application we get is these high risk inductive proposals where it's not very clear what the programme is buying. The programme is about buying knowledge which is going to benefit patients; so we would like to know if somebody says I'm going to do a trial of drug x to see whether it increases life expectancy. Well I can think well is it worth funding this? Is it likely to do it? But at least I know what I'm buying.

At least we say we've put 350K into this and we will have an answer whether drug x works or not, if they conduct the research appropriately. At least we will have an answer but these inductive proposals are very difficult to evaluate because they take the form of and this is caricaturing it; somebody says we want a new intervention to tackle obesity; it's a theme call so here you are; get your pens at the ready. A new intervention to tackle obesity.

What we will do we will conduct qualitative interviews with obese patients to identify the barriers to losing weight and then we will construct an intervention, wowee, and then we will use consensus methods to agree the final intervention. Once we've got this we will then apply for a feasibility study and a trial with HTA and no doubt the Nobel Prize is in their sights.

Well the chances of this coming through, well you might disagree, but I think they're just negligible that the fact that we've sort of over the years we've missed an intervention into manage obesity. If only we had thought about this; if only we'd talked to these patients and found out what the intervention is.

So these opened ended inductive proposals where we're not sure what will come out of them. In this one, for example, I don't think anything will come out of it; that's my judgement. Maybe the panel would be more generous than I am but we've got to make a judgement about what we're buying and what's likely to come out. So something which has got a very specific question is easier to fund than something that's open ended and you're not sure what will emerge from it.

So development of interventions where it's not very clear whether you will actually produce anything at the end. I think they do badly and quite appropriately they do badly.

However, high risk proposals we should be considering it because sometimes high risk produces good pay off and I absolutely recognise that and so how do we accommodate that within the programme because we must encourage innovation. We might not want that sort of study but we want other innovative ideas; some of them which are a big high risk.

So what we've done over the last year or so is to make the cost commensurate with the risk; so we have these funding tiers. So we have the first tier which is the absolute limit; we can't fund more than 350 because that's the agreement with the DH that the programmes got a maximum funding limit of 350 and this is research which has a clear and close trajectory to patient benefit; so trials for example. A trial which will produce an outcome which could then be rolled out into the NHS well that is a 350 limit.

We have also got a ceiling of about 250 for feasibility studies. Feasibility studies are essentially about de-risking future big trials. So rather than send a trial to HTA costs 2.5 million. HTA said do we want to commit 2.5 million to this; is it feasible? So what they often do they'll send the applicants to RfPB to do a feasibility study to see if it can recruit, particularly the major problem is recruitment. Can it recruit to patients to this study?

So we do a lot of those feasibility studies; I think they're very worthwhile because even when they say no, at least we've saved all those millions further downstream at HTA and if they say yes then obviously they've got a lot of the systems in place ready for the main trial.

The new tier we've introduced recently; this is the novel one is this higher risk which is less than 150k or that amount. Obviously these limits are slightly wobbly if you want to make a jolly good case why it should be more, well by all means do it. But this is to recognise that some of the research that needs doing is a little bit further from patient benefit. It's not the trial level; its development of other things and to recognise we need this and there isn't a funding mechanism out there to fund these slightly more high risk studies which are on that trajectory but are fairly upstream.

So what we need to say is look they've got to be under £150 because they've got to go all the way downstream and the chance of them going all the way downstream aren't that great. So therefore we've got to have a financial limit on them.

The sorts of studies we have in mind here are observational studies, you know, before you do a trial of a new surgical intervention why don't you look in the clinic to see, well and it can be confounded the clinical observation but you might just want to look and compare different groups in the population to see how well they fare with these two types of intervention.

An observational study might give you a clue as to whether there's going to be an effect there.

Developing and refining interventions worthwhile. Developing new scales or outcome measures. Exploratory studies that might provide insight into an intractable problem. Additional follow-up of patients on a completed clinical trial. Most clinical trials finish after 3 perhaps maximum 5 years but why can't they be followed up? Because sometimes the outcomes we're interested in are the longer term outcomes. We don't just want to stick to the short ones.

Post marketing surveillance for unknown side-effects for a drug; these phase four studies. They are very rarely done but very important. Let's follow through we've got big databases now, clinical databases in the NHS which you can look to see whether this new drug actually had harmful side effects which weren't picked up in the original trial because you need large numbers to pick this up.

Systematic reviews where the number of relevance studies is likely to be limited.

There's no doubt other areas but we would like to encourage these cheaper studies which are clearly upstream; when you've got the results of these studies that isn't going to change patient care tomorrow, it's going to be other studies between the end of the 150K study before you get to patient benefit.

Engagement with the NHS which is my final and the big dilemma is how do we get better engagement with the NHS? Well what RfPB should be doing is engaging with – I think the ideal, what I would really like to do is engage with coal face clinicians, clinicians who are out there in the clinic seeing their patients who have an idea. They are the ones who are going to get the ideas because they see the patients and say, oh I wonder if this would work? I wonder if this is a side effect that we should be looking at? They have these thoughts; I am sure they have all these thoughts all the time. But wouldn't it be great to get these thoughts crystallised and turn their clinical problem into a researchable

question and then come to RfPB. So that's the ideal. I don't think it works because as I said earlier, it's the old lags; it's the old established professors who get the money and we don't quite reach to those people.

Now I hope the two stage application makes it more accessible because I have talked to clinicians before and they say, I filled out all our form, took me ages and then they rejected me; I am never ever going to go back to RfPB. Sort of understandable; you put all this energy into it and it's just swatted away.

So I hope the two stage application makes it more accessible and also I hope RDS is going to help in this task as indeed it has in the past.

How can RDS help? Help me; help RfPB; it can highlight the changes to the programme when advising applicants or at any workshops as today. Particularly focus on the research question and the methods when advising in Stage One and then contributing to Stage Two if the applicant is invited. Potentially be ready to provide advice to you in Stage Two submissions, provide feedback to the RfPB team of how it's going and I think we do have mechanisms for that to happen which we do value.

How can RfPB help the RDS? Programme Managers – they gave me this so I'm just reading it out. Programme Managers always happy to take the scope queries directly from RDS or provide further detail on application processes. So sometimes you know you think would this social care project be viable through RfPB and the Programme Managers can advise.

I suppose very occasionally Programme Managers might not get it quite right but I'm happy to take things that come through which are contentious and offer my happeth as well.

Application guidance plus a Word version of both Stage One and Stage Two forms are on the RfPB website. It's great to have a Word document so you can actually do it in draft before you start filling out the form online. The Regional Programme Managers are happy to attend many days and workshops if required and that's their address but I think you are going to have these slides later available.