



4th ANZMUSC Annual Scientific Meeting Report 21-22 March 2018 (Melbourne, Victoria)

ANZMUSC Executive Committee

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Professor Jane Latimer
Professor Christopher Maher
Professor Sally Green
Associate Professor Will Taylor
Dr Bethan Richards
Dr Sam Whittle
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Overview

The Fourth ANZMUSC Annual Scientific Meeting was held in Melbourne on March 21st and 22nd 2018. Day 1 of the meeting (March 21st) was held in the AMREP (Alfred Medical Research & Education Precinct) Lecture Theatre at the Alfred Hospital. Day 2 (March 22nd) was held in the Cabrini Institute affiliated to the Cabrini Hospital. The 2018 meeting was attended by 75 participants from across Australia and New Zealand representing 18 Universities and research institutes, 14 consumer and health insurer organisations and professional associations, and 6 hospitals.

Day 1 Presentations (March 21st 2018)

The Australian Clinical Trials Alliance (ACTA) Plans and Update

Prof John Zalcberg OAM, Chair, ACTA provided an update on ACTA which was launched in March 2014 as a national body to support Clinical Trial Networks (CTN) that conduct investigator-initiated clinical trials in Australia, clinical quality registries (CQR) and coordinating centres that support CTNs and CQRs. Currently, there are around 50 clinical trial networks within ACTA. The aim of ACTA is to provide a

voice for CTNs, build capacity within these networks, provide expert advice on investigator-initiated clinical trials and foster partnerships between researchers, policymakers, healthcare providers and consumers. Following identification of network gaps through an initial sector gap analysis, there was an expansion of CTNs. Although the Medical Research Future Fund (MRFF) has pledged support for clinical fellowships and clinical trials, ACTA faced early challenges in soliciting funding which was justified using the rationale of conducting more research and establishing CTNs in areas with no existing networks. The current way in which real world clinical trials generate data has created a system where the effectiveness and cost-effectiveness of the existing clinical practices have not been established. ACTA achievements include economic evaluations of investigator-initiated clinical trials, submissions to the MRFF legislation and development of the MRFF strategy and priorities as well as a ten-year report (2004-14) on the activities of CTNs in Australia. Future plans include infrastructure changes allowing registry randomised trials, data linkage and simulation models for clinical trials and embedding clinical trials into the Australian health system. Clinical trial networks and registries are good examples of successful integration between research and healthcare delivery but a critical gap is that there is insufficient utilisation and coordination of these organisations to improve health care. Evidence is needed to measure the impact of CTN trials on practice and the impact of consumer engagement in clinical trials.

The Australian and New Zealand Alliance for Cardiovascular Trials (ANZACT) Network initiatives for cardiovascular trials

Prof Chris Reid, John Curtin Distinguished Professor, Curtin University presented on the network initiatives for cardiovascular trials. Although Australia has a strong history in cardiovascular disease trials (Australian National Blood Pressure studies, Long-Term Intervention with Pravastatin in Ischaemic Disease (LIPID) International Studies of Infarct Survival (ISIS)) current evidence shows that recruitment in these trials in Australia and New Zealand is falling below previous standards due to the lack of coordinated efforts. There are several centres conducting cardiovascular clinical trials but the lack of an organised CTN for cardiovascular trials led to the establishment of ANZACT. The first meeting was held in Feb 2017 and convened by the NHMRC CRE in CVD Outcomes improvement. There was wide representation from the government, NGOs and consumers from both Australia and New Zealand. Craft groups included Interventional, Surgical, Clinical, Primary care, and Allied Health groups. The role of ANZACT is to bring various CVD research groups together and facilitate the conduct of research. A steering committee was established with a focus on geographic and speciality representation. ANZACT Membership is inclusive and broad-ranging with fee-based organisational membership which includes committee representation and free individual membership. The ANZACT vision is “to lead and participate in the development and conduct of cardiovascular trials of the highest domestic and global relevance, and to achieve this utilising

established clinical trial facilities and state & national cardiovascular registries”. ANZACT acknowledges the guidance gained from ANZMUSC in the development of its governance and terms of references. The terms of reference detail the role of ANZACT in a) supporting the development of high-priority research questions as well as the design and conduct of investigator-initiated trials; b) facilitating collaborations to deliver high quality trials in Australia and New Zealand c) coordinating the engagement of clinical sites in trials across Australia and New Zealand d) facilitating the involvement of Australia and New Zealand in key investigator-initiated trials led from elsewhere and the exchange of ideas and information on relevant trials being conducted globally. Future plans of ANZACT include: a membership drive; finalising committee members and endorsement processes; and the development and implementation of a strategic plan.

The ANZMUSC Research Question Priority Setting Project

Associate Professor William Taylor, University of Otago, Wellington, New Zealand discussed the challenges and steps involved in determining the importance of research questions in musculoskeletal research. One of the ANZMUSC objectives is to identify important research questions that focus on improving the musculoskeletal health of populations. There are several approaches to research prioritisation. However, several problems such as an inflexible process (difficulty in incorporating new questions) and ‘black box’ (information goes in and top ten research questions come out, no clear rationale why those ten were prioritised and lack of transparency). The ANZMUSC Prioritisation project consists of a literature review, Delphi surveys, a research question ranking exercise, a determinants meeting workshop, and a weighting workshop. The final result would be a list of research questions ranked by importance. The initial Delphi survey was completed by 66 ANZMUSC members identifying 347 determinants of research question importance which were then organised into 43 non-duplicate items for subsequent rating. A final list of 32 items with a minimum median rating of 7 were grouped under 5 areas; 1) nature of the condition 2) nature of the intervention 3) potential for impact 4) broad appeal 5) project is able to deliver. The research question ranking exercise resulted in 30 questions being ranked in their order of importance. Some of the highly ranked questions were based on high patient burden of disease and prevalence, identification of patients most likely to benefit from an intervention, and widely used interventions with a poor evidence base. The lowly ranked questions included animal model studies, testing interventions that are already known to be ineffective or effective, little prospect of scalability or uptake and diagnostic research not linked to patient outcomes or benefit. Six key dimensions of research question importance were identified – 1) the extent to which the question is important to patients and other health decision makers 2) addresses an area of high patient burden 3) addresses an area of high social burden 4) potential reduction in patient and/or social burden due to the intervention 5) potential scalability and uptake of the intervention 6) extent to which the question addresses health equity.

The next steps include reliability testing of the framework, whether each of the six dimensions should be equally valued or not and determination of the research question importance threshold for ANZMUSC endorsement.

Embedding Clinical Trials into Routine Practice

Prof Ian Harris AM, Orthopaedic surgeon, University of New South Wales discussed the implications of embedding research into clinical practice. There is an urgent need for integration of research into health services (McKeon review - The Conversation 2012). Since 2012 several organisations aim to achieve this integration including the Academic Health Science Centres, Academic Health Research Technology Centres, Academic Health Research translation centres and the NHMRC Advanced Health Research and Translation Centres (AHRTCs). The AHRTCs work on the principles of ‘Collaboration’ (between practitioners, academics, consumers, policy makers) ‘Innovation’ and ‘Translation’, where the knowledge generated on the ground is to be used on the ground to improve health care. In general, randomised clinical trials (RCTs) provide low bias estimates of comparative effectiveness, control for confounding and generate evidence needed to improve health care. However most clinical trials are challenged with high running costs, implementation difficulties and conducted as small scale studies often not reflective of real life situations. To overcome these issues, ‘embedding’ involves the use of existing patients and clinicians as study participants and researchers respectively, as well as the use of existing systems for recruitment, intervention delivery and follow-up, thus making it part of routine practice. Use of registries can increase the size of clinical trials at a low cost and ensure long-term follow-ups, however carry the risk of confounding which can be overcome by RCTs. The economic evaluation of clinical trial networks has shown a return of \$5.80 for every \$1 invested; and a return of \$51 for every \$1 invested in NHMRC trials. Registry-nested trials which aim to leverage current data systems provide the necessary infrastructure for trials, expand trial expertise and enhance believability, resulting in practice change. The barriers to implementing nested trials include inertia in current health systems, lack of motivation in providers and lack of awareness in patients. Platform trials have emerged as an effective strategy to evaluate multiple treatments and extend beyond the clinic to track people in the community.

The STARS back pain app – using real time data to capture outcomes and drive change

Dr Bethan Richards, Head of Rheumatology, Royal Prince Alfred Hospital presented on the STARS (SLHD Targeted Activity & Reporting System) back pain app. Evidence shows that it takes an average of 17 years for new knowledge generated by RCTs to be incorporated into practice (IOM,2001). A quarter of patients receive either unnecessary or harmful treatments and only 55% receive care consistent with evidence based practice (Med Care 2001, NEJM 2003). Currently, evidence

translation into the real world is impaired by health care delivery in silos, disengagement of clinicians and lack of access to real world data. The Sydney Local Health District (SLHD) with a population of 670,000 has 169,264 hospital admissions and 160,235 Emergency Department (ED) presentations each year. Clinicians are faced with huge sets of routinely collected data resulting in their disengagement and these datasets are not effecting practice change. There is an urgent need to harness current technology to drive best practice through linking datasets, facilitating analysis and delivering meaningful data in real time. The STARS back Pain app is a data linkage and analytics tool with an interactive user defined interface capable of working on a PC, Mac or iPad (Qlik). Collaborations between clinicians, managers and the hospital executive have led to the successful uptake of this app in the system. Each year there are 50,000 presentations of back pain to the NSW Emergency departments with 34% of patients undergoing scanning, 61% being prescribed opioids and 17% being admitted. The STARS app is used to implement an evidence-based model of care to improve care to ED back pain presentations. Some of the key features of the app include, embedding low cost research into routine clinical practice, engaging clinicians, optimising patient outcomes and reducing the time taken to translate evidence into clinical practice. The measurable outcomes are proportion of patients receiving opioids, imaging, laboratory investigations, hospital admissions and re-presentation to the ED in less than 48 hours. The STARS app is being rolled out into the entire NSW health system with the promise that patients would be expected to have the best quality of care and best possible outcomes in the near future.

Use of placebos in surgical trials

A/Prof Manuela Ferreira, MRFF/NHMRC/Sydney Medical Foundation Fellow, Institute of Bone and Joint Research, The Kolling Institute, The University of Sydney, presented on the use of placebos in surgical trials. Until recently most surgical studies were retrospective case series. Data from 2009 to 2011 shows that out of the 83 RCTs involving more than 9000 orthopaedic procedures conducted, only 2 were placebo-controlled trials. Wartolowska et al, found in a systematic review of placebo controlled surgical trials, that 51% of trials did not support current practice (BMJ 2014). Open label surgical trials (82%) are faced with several challenges including lack of patient's equipoise, difference in perceived benefit/harm and preference, which lead to slow recruitment, risk of selection bias and ethical issues. Breach of randomisation can also occur, for example the SPORT trial had 43% crossover to the spinal stenosis decompression arm wherein patients can have a perception of higher benefits in the surgical arm, compromising the internal and external validity of the trial. Lack of blinding also compromises the rigour of the trial with larger treatment effects in the intervention arm, risk of performance bias, lack of equipoise and high crossover rates. While blinding decreases cross over rates, studies have shown that large placebo effects have been associated with lack of blinding (0.63 greater effect size). Adding a third 'no treatment' arm enables the estimation of the treatment effect size, especially with treatment cross-over. It is important to note the difference

between a sham and placebo procedure – in a sham trial, the entire surgery is a sham procedure whereas in a placebo intervention, the crucial/critical surgical element is omitted and the remainder of the procedure is identical to the actual surgery. Although placebo interventions are more complex to implement, it is easier for blinding to be maintained in them, and to justify for consent than with a sham trial. SUCCESS is an example of a placebo-controlled surgical trial where surgical decompression or placebo surgery was used for the management of spinal stenosis. Consumers were engaged in the trial design which also factored in the ethical framework for the use of placebo procedures in clinical trials (Hornig and Miller 2002). Primary outcomes include walking ability and function. SUCCESS has just been granted ethics approval and will soon commence recruitment.

Partnering with consumers in research: current evidence and examples

Ms Anneliese Synnot, Research Fellow & Editor, Cochrane Consumers and Communication Review Group, La Trobe University discussed consumer partnering/engagement in research. Consumer engagement is a bi-directional relationship between stakeholders and researchers resulting in informed decision-making about the selection, conduct, and use of research (Concannon 2012). Consumers essentially shape the research by being involved in all stages of the study including planning, implementing and dissemination of findings. Partnering in research involves consumers sharing power and responsibility in the research where a collaboration is established between consumers and researchers. The advantages of consumer partnering include increased relevance of the research where the research question is a consumer priority, development of participant-friendly research materials and improved uptake of results via consumer networks. Consumer partnering can be time and resource-intensive and also be challenged by difficulties in recruitment, group dynamics and conflict resolution. Consumer engagement can be implemented using formal methods such as focus groups, interviews, Delphi surveys and consensus workshops, or informal methods including meetings, advisory groups and public consultations. This bi-directional relationship has benefits for both consumers and researchers. Consumers feel empowered, gain knowledge of their condition and have the opportunity to develop life skills. Researchers are able to develop consumer networks and incorporate consumer perspective in the design of the study. Key indicators of a successful partnership entails adequate funding, appropriate consumer training, coordinated planning by both parties, professionalism in consumer involvement (keeping consumer updated on all project activities and value their ‘lived experience’).

Patients as Research Partners: Lessons Learned from OMERACT

Prof Lyn March AM, Professor of Rheumatology and Musculoskeletal Epidemiology, Sydney Medical School, The University of Sydney presented on the challenges and opportunities of involving patients as research partners in clinical trials. **Outcome**

MEasures in Rheumatoid Arthritis Clinical Trials (OMERACT) include pain, painful and swollen joint counts, disability and acute phase protein. While the OMERACT filter (2.0) has been used to gauge the validity, reliability and feasibility of data instruments, the need for measurement of a clinically important change was discussed in OMERACT 5. Following which 11 patients were invited to OMERACT 6 to help meet this need. Patient involvement in OMERACT grew from 2002 when a patient panel was established in 2012 with patient participation in working groups and discussions. Over the years their role has grown from offering support to a more integrated and defined role. A responsive evaluation of the OMERACT conferences demonstrated a significant impact of patient involvement as research partners on outcomes research (Maarten de Wit et al BMJ Open 2013). Patient involvement led to the identification of topics (wellbeing, fatigue, sleep disturbance, work etc.) for inclusion in conference research agendas. For example, measurement of fatigue led to the update of the existing core set for Rheumatoid Arthritis, and its inclusion as an end point in clinical trials. Several factors facilitate the inclusion of patients as research partners including a meticulous selection process (strong leadership skills), conference design (facilitative moderation style) and offering individualised support (pre-conference information pack, buddy system, OMERACT glossary). Barriers to successful patient engagement include lack of time and resources, intensity of the program (language, travel, physically challenging), scepticism and composition of the patient group (representativeness, patient-doctor relationship). To address these and other challenges, OMERACT developed a set of recommendations for involving patients as research partners. These recommendations highlighted various aspects of the role of patient research partners in OMERACT including specifications of their relationship with researchers.

DAY 2 PRESENTATIONS (22nd March 2018)

ANZMUSC CRE Launch 22 March 2018, Cabrini Institute, Melbourne

Hon. Minister Greg Hunt's speech

For most Australians back pain is more than just low back pain it is emotionally debilitating and impairs the capacity of the sufferers to function fully, one quarter of Australian have some form of chronic back pain. The impacts of back pain are enormous 300,000 work years and 5.5 billion dollars in lost productivity are lost per annum. This is a significant issue which has been under-represented and today the Lancet has given global recognition to the importance of low back pain. Now that we have identified the challenge, the response to this challenge is what the CRE will be addressing. Through the NHMRC we have given particular focus to arthritis and low back pain, over a period of 10 years \$240 million has been allocated for primary research in diagnosis and treatment, this figure includes \$25 million specifically for arthritis. The Lancet response is timely, the opioid crisis has been identified by the research team and was addressed by Minister Hunt in the recent past. There are issues

around the right care and treatment which is currently being reviewed by the MBS review taskforce under the leadership of Prof Bruce Robinson from the University of Sydney to form recommendations for high value care and treatment.

“With the CRE your task is simple in mission but difficult in execution”, the minister added. The simplicity of the CRE mission is to assist with the diagnosis and better treatment so more people have less back pain and have more mobility. However the big picture is, several ANZMUSC members are involved in research across a variety of conditions and with the NHMRC complemented by the biomedical translation fund which is providing \$500 million dollars to go directly into commercialisation of drugs, data, devices and treatment within Australia, there is potential for improved research funding. The CRE is the first step to providing a roadmap on MSK health conditions and management and working alongside the National Arthritis Action plan there is scope for significant funding in the near future to address low quality health care in the treatment of chronic back pain and arthritis.

The big player is the Medical Research Future Fund (MRFF) and this 20 billion dollar fund spans from \$60,000 to \$640,000 over a 5 year period. This fund is split across 4 main themes- 1) Patients - rare diseases (19 clinical trials are funded so far), the unmet needs component has huge potential for funding within this theme. 2) Researchers - \$78 million available for clinical fellowships and new frontier science medical CRC type programs, researchers are encouraged to put forward proposals. 3) Translation – various translation research centres who are natural partners with CRE carry the potential of advancing the work. 4) National missions - focussing on various areas (eg: Australian brain cancer mission) including personalised diagnosis and treatment following work on precision medicine and genomics, presents itself as a once in a lifetime medical opportunity. The minister briefly described the impact of chronic back pain in his family members and was delighted to acknowledge the work done by the Lancet back pain series group. He declared the ANZMUSC CRE open and pledged his support for the work carried out by ANZMUSC in the next 5 years.

Minister Hunt Press interview – 23 March 2018

<http://www.greghunt.com.au/Health/tabid/175/ID/4566/Doorstop--Melbourne.aspx>

Research with Indigenous Australians for better Musculoskeletal Health

Mr Mick Gooda, Former Aboriginal and Torres Strait Islander Social Justice Commissioner discussed the various ways in which research could contribute to the achievement of positive musculoskeletal health outcomes in Aboriginal and Torres Strait Islander people. He began by highlighting the areas of improvement for research among the indigenous people of both Australia and New Zealand. Firstly, indigenous people have been treated as objects of research and not as equal partners. More research is needed where indigenous people set the research agenda, lead the research and advocate for its implementation. During his role as CEO of the

Cooperative Research Centre (CRC) on Aboriginal Health in Darwin, he became aware of the presence of several well-qualified indigenous people in the community who have the potential of becoming world class researchers for the indigenous community as well as the power of evidence in informing policy and practice. This led to the establishment of the 'Facilitated Development Approach' a community-driven research agenda which identified that traditional research methods (expressions of interest, blinded peer review, funding decisions made by independent groups) did not work for the indigenous community. The Facilitated Development Approach comprised three essential criteria - best practice research methodology, capacity building, translation of evidence into policy and program including a strategic plan development for implementing the program. Consultations with health practitioners and health service users within the indigenous community led to the identification of research projects capable of addressing issues important to the community. The Chronic Disease program is one such example where Aboriginal health workers cited the need for indigenous people to take preventative health measures before undergoing amputations for chronic diseases. This led to the inclusion of self-management, health promotion and men's health components within the chronic disease program. Consultation with the community is key to conducting research within the indigenous community.

In 2009, the CRC found that in the past 20 years, 80% of the research undertaken in indigenous people focussed on describing the problem, 8% were on methodologies with only 12% dedicated to solutions. The Australian National University were in possession of 6000 tissue samples collected from indigenous people from approximately 50 years ago and had to make decisions around the use of these samples. The first step involved obtaining consent from the indigenous community regarding the access and use of these samples. The consultative process with the community included presenting various options to manage the samples including access to donor lists, use for research purposes, and destruction of samples. This led to the formation of a committee which was responsible for informing the indigenous donors on their participation in research projects.

To sum up, it takes time and patience to build relationships with the indigenous community which is key to their effective involvement in research. Ensuring the equity of outcomes in research, which requires the application of substantive equality, a human rights concept where the approach and actions need to be tailored for different groups of people, is important. Involving indigenous people as research partners (interpreters, recruiters, community champions) as opposed to research subjects or participants will ensure the success of research projects conducted among the indigenous community.

Preventing falls in older Aboriginal people: the IRONBARK trial

Prof Rebecca Ivers, Director, Injury Division, Professor of Public Health, Faculty of Medicine, The University of New South Wales presented on the development and

piloting of the Ironbark program. Current evidence shows that the highest rates of falls among Aboriginal people occurred among those aged more than 60 years. An increasing ageing Aboriginal population coupled with the lack of falls prevention programs available for this group, has led to the development of the Ironbark program. Ironbark incorporates key elements of success learned from other Aboriginal programs such as being locally owned, community-based, under Aboriginal leadership and capable of building capacity. This trial aims to establish the effectiveness of a community based fall prevention program (the *Ironbark Program*) on the rate of falls in community-dwelling Aboriginal people 45 years and older, compared to controls who receive a healthy ageing program. Recruitment into the trial is through dissemination of information to Aboriginal Medical Services by Aboriginal peak bodies, local advertising in community newspapers, and engagement with local Aboriginal community/health services or Local Aboriginal Land Councils. The Ironbark program is delivered in weekly 1.5 hour sessions for 12 months and consists of a 45-minute exercise session comprising strength and balance training followed by a 45-minute education component, held within yarning circles. A trained program leader (e.g. exercise physiologist/physiotherapist, Aboriginal Health Worker, nurse) facilitates each session. The program was trialled at 6 pilot sites for a 3 or 6 month period. The study outcomes (standing balance, timed sit to stand, 4 m walk, gait speed, short physical performance battery score and BMI) were measured at baseline, 3 and 6 months by Aboriginal Research Assistants. The primary outcome is the rate of falls after 12 months of program delivery. Secondary outcomes include health-related quality of life, physical activity and functional mobility. The direct involvement of the Aboriginal community in the study (development of research processes, data collection, analysis and sharing findings back to the Aboriginal community) and the longstanding collaborations between the research team and the community contribute to the success of this program.

Communicating your message to the media

Ms Julia Medew, Walkley Award-winning journalist, PhD student, Bond University discussed the various methods and implications of communicating research findings to the media. The potential of mainstream media is massive and much bigger than conferences or journal articles. Research covered by media has more citations and can be instrumental in people's health decision making. The top news website is www.news.com.au which has approximately 1 million readers reading the top stories. The last decade has seen tumultuous shifts in media globally. Change in media has revealed what people want to read about – personal stories, surprising and shocking information (eg: The Lancet back pain series). Journalists have a responsibility of disseminating high quality evidence to the public. However, as majority of them do not understand research studies, they can tend to favour weaker studies, overlook negative findings and conflicts of interest and use relative risk rather than absolute risk. 'Fake news' movement is important for health and medicine, for instance articles on Facebook tend to be inaccurate or outdated.

There are several ways for researchers to get the information across to the media. Media units at universities often function as the channel through which evidence from research projects can reach the public. Another method is by being part of a larger group such as the Australian Science Media Centre which has a database of most science experts in the country. When a paper is released, they reach out to appropriate experts ('expert reaction' email) and get a short response as feedback on the paper. Journalists are often under time pressure and use the researcher's words exactly as they receive them as they have no time to write about the findings in their own words. High quality press releases are more likely to attract higher quality associated papers. Opinion pieces are another important way of communicating research findings through the media, there is a lot of focus on opinion pieces in all news organisations and they are well received. Journalists view information on 'The Conversation' as credible material and look for experts there.

Currently, journalists lack a clear understanding of the work that scientists do and there is a need to bridge that gap. One way of overcoming this challenge would be for scientists to send a headshot, stick to a word limit and give the journalist/news organisation their mobile number. It is recommended to always follow up the submission with a phone call. When researchers are faced with an interview request from the media, it is wise to get equipped with as much information as they can (including the statistics) on the topic before they engage with the journalist. It is also useful to do some quick research about the journalist and what/how they've reported before. Preparation of 3 to 5 key messages that have been well-rehearsed would help when in front of the camera. It is advisable to deliver these key messages without jargon and where possible delivered as an opening to the interview so the audience receives them even if the journalist forgets to ask questions related to these key messages. It is good to begin an interview with the following lines 'before we begin I want to say this.....' which would help the interviewee get on the front foot at the beginning. Often people get unnerved if they don't know an answer, this is usually because journalists don't understand the issue. One way of overcoming this challenge is by calmly stating that you do not have the information to answer that question. Another approach commonly used by politicians is to use 'bridging phrases' where the question is acknowledged and then the speaker moves onto delivering a key message to the public. With regards to talking 'off the record' it is important for interviewees to be cautious and understand exactly what the implications are, the most common reason for this is people want to communicate the information to the public but do not want to be attributed to them. Having an understanding of what journalists want will help researchers pitch their story from angles that will catch people's attention.

ANZMUSC CRE PLANS, QUESTIONS AND ANSWERS

- Special Interest Groups (SIGs) query - SIGs give a sense of belonging to those with specific expertise in certain areas. Future ANZMUSC meetings - the

entire meeting will be multidisciplinary as it is now but can include break-out sessions for SIGs or a SIG breakfast session.

- CRE and ANZMUSC – are they separate or do they work together?
RESPONSE - they are not separate entities but working together, CRE Chief Investigators are on the ANZMUSC executive committee. Seed funding for research from CRE is open to all of ANZMUSC members. QUERY - Are there going to be opportunities for people to get involved in different initiatives in the CRE and how? At the moment ANZMUSC is working on putting together a structure for central support and trial specific support.
- Endorsement of trial proposals – QUERY - is there a vision of how many trials are being endorsed, or how often that happens, whether they meet a certain threshold, is there a limit? RESPONSE - One of the aims is to expand and ANZMUSC is keen to endorse as many trials as possible. However, at the same time it's not unusual to be refused endorsement eg: if trials were targeting an area that wasn't going to help many people and if feasibility is a problem. The whole idea of endorsement is to make research better, help people, have a two way conversation, and the process of SAC reviews is to enable trials to get through the next grant.
- Endorsement of funded trials – QUERY – If trials are already funded can they still be endorsed? Is there a clear plan what funded trials could get from ANZMUSC – eg: recruitment, project management? RESPONSE - Proposals can get ANZMUSC endorsement after being funded. The CRE will offer support in areas of need as required. Study investigator team can contact ANZMUSC with specific areas in which they can get support.
- Prioritisation tool – QUERY - What will be done with the prioritisation areas – are they for the ANZMUSC scientific committee to apply or to give people ideas of what we prioritise? RESPONSE – Prioritisation is a tool that can be applied to research proposals, not a tool they must fit into.
- Positive Feedback from consumers on the inclusiveness of ANZMUSC in including a proposal on cataract and falls prevention.
- Need more PhD students and New Zealanders to attend the ANZMUSC meetings.