CT:IQ
Clinical Trials:
Thinking Smarter

Australian Research Data Commons

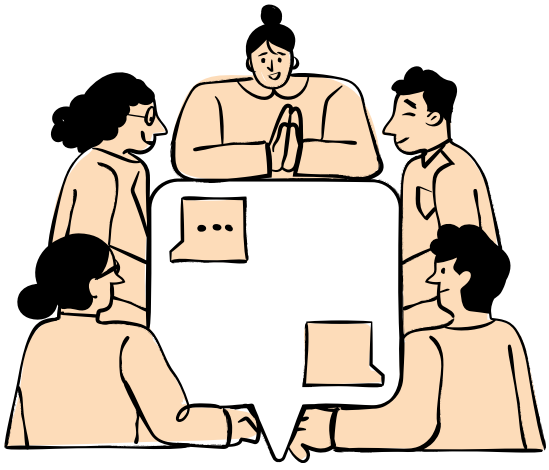
Clinical Research Data Sharing Frameworks
Ethics Review Body Benchmarking Activity

REPORT ON FINDINGS

Vanessa Warren
Senior Research Associate, CT:IQ

Rebekah McWhirter
Senior Lecturer, Australian National University

Lisa Eckstein
Ethics Specialist and CT:IQ Programme Director
24 July 2025



Published by: CT:IQ

Contents

This Report can be cited as V. Warren, R. McWhirter and L. Eckstein, 'Clinical Research Data Sharing Frameworks: Ethics Review Body Benchmarking Activity' (Report, CT:IQ, July 2025).

Acknowledgement of Country

CT:IQ acknowledges Aboriginal and Torres Strait Islander peoples as the traditional custodians of the land on which we meet, work and learn. We pay our respects to Elders past and present.

1. Background

The Clinical Research Data Sharing Frameworks project was established by Clinical Trials: Impact and Quality (CT:IQ) and the Australian Research Data Commons (ARDC) under the HeSANDA program, as part of the People Research Data Commons.

The Clinical Research Data Sharing Frameworks project outputs will provide informational resources to HeSANDA's clinical trial partners to support secondary sharing of clinical research data. It aims to develop practical principles and guidance for researchers, ethics review bodies (ERBs), data custodians, research institutions and consumers to support trustworthy sharing of clinical research data in Australia. The project seeks to improve efficiency and quality in the application of requirements for the secondary sharing of research data by Australian researchers, ethics review bodies and governance offices.

The project includes four work packages:

Work package 1: Principles and rules for sharing secondary research data (Governance Framework)
Work package 2: Consultation report on current challenges and practices regarding ethics and governance approval for data sharing
Work package 3: Benchmarking report of Ethics Review Body data sharing review outcomes
Work package 4: Governance resources

This document outlines findings of the Work Package 3 benchmarking activity

2. Approach

This study is based on the Shared Ethical Debate (ShED) protocol,[1] an established ethical review quality and consistency process facilitated by the Health Research Authority in England. As a novel application of this approach in an Australian-first benchmarking exercise, some adaptations have been made to ensure it is appropriate for the local context and for the specific aims of the project.

This report outlines findings for the Ethics Review Benchmarking Activity, in which participating ERBs were asked to complete a review of a mock ethics application (in accordance with their standard processes), and to return de-identified minutes and feedback resulting from their deliberation to the research team for analysis. Participating ERBs were also asked to complete a brief post-review survey. Participating ERBs received a $100 gift card honorarium in recognition of their contribution.

The activity was approved by the expedited review panel of the Central Adelaide Local Health Network (CALHN) Human Research Ethics Committee (HREC) (Ref 20447).

2.1 Recruitment

All HRECs registered with the National Health and Medical Research Council (NHMRC) and with accessible contact information were invited to participate (N=188). An invitation email was sent on 16 January 2025 to the Chair or Executive Officer of each registered HREC, or to a generic mailing address depending on the contact information available. This email (see Appendix #1) invited Chairs or Executive Officers of HRECs or other ERBs to take part in a de-identified survey, and/or to express interest in the benchmarking exercise, directing them to the project website for more information, and access to the Participant Information Sheet (PIS). The recruitment information was also shared with ERBs through the NHMRC fortnightly newsletter Tracker, in the CT:IQ and ARDC newsletters and LinkedIn accounts, and via personal networks including the HREC Community of Practice mailing list and an independent list of ERB Chairs managed by team member Gordon McGurk.

[1] Trace, Samantha, and Simon Erik Kolstoe. "Measuring inconsistency in research ethics committee review." BMC Medical Ethics 18 (2017): 1-10.

Chairs or Executive Officers, on behalf of their ERB, could self-select to participate in the benchmarking review by email or as part of completion of the de-identified survey. All ERBs were provided with a PIS and a Chair or Ethics Officer confirmed their consent before commencing. Participation was not blinded, however all returned deliberation material was anonymised prior to analysis.

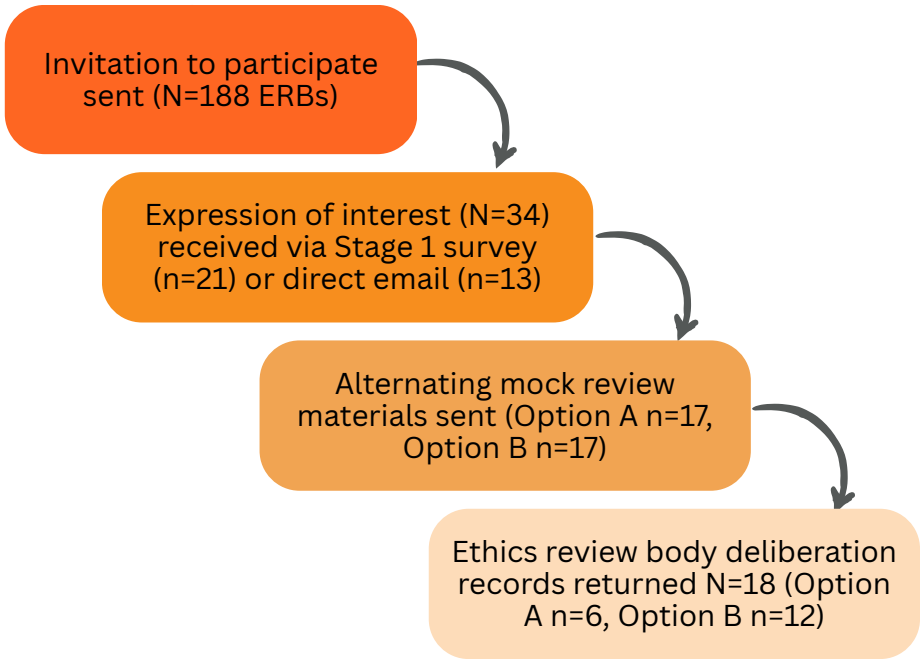
Participating ERBs were alternately assigned one of two variations of a mock application:

- Option A, which included broad consent for future research in the original project Participant Information and Consent Form (PICF).
- Option B, which was silent on consent for future research in the original project PICF and the current investigators sought a waiver of consent.

The mock review application materials were identical in all other ways.

Recruitment was scheduled to close on 11 April 2025. Seven (7) ERBs were granted an extension to 14 May due to workload and/or staffing complications. Nine (9) ERBs who had expressed interest in participating subsequently withdrew from the study, again citing high workloads and staffing problems as barriers to participation. A further seven (7) ERBs who had expressed an interest in participation did not return any review documents or respond to follow-up communication. In sum, 16 of the initial 34 recruited ERBs withdrew from participation. Coincidentally, the majority of withdrawn participants had been allocated to a Group A (broad consent for future use) cohort, meaning that Group B (silent on future use) is over-represented in our final sample of 18 reviews, limiting the potential for comparison between cohorts. Other characteristics of participating ERBs can be found below in Table 1 under Results.

Figure 1. Diagram of recruitment process



2.2 Mock review material

All participants received application material for a mock research scenario involving a request for data to undertake a hypothetical meta-analysis to establish quality of life (QOL) of parents of very preterm infants in Australia. The mock application sought participant-level data from a hypothetical 2018 trial comparing oxygen levels to support very preterm infants, including a parental QOL survey at 6 and 12 months. QOL data was listed to include health outcomes, social and familial wellbeing, financial status and psychological wellbeing. As outlined above, two versions of this application were developed; one in which the original study included broad consent for future use, and one in which the original study was silent as to future use.

Participants received corresponding versions of either Group A or Group B application materials, which included:

- Letter from the investigator outlining the request for data access (authored by Jonathan Williams and Kylie Hunter, NHMRC CTC)
- A protocol for the meta-study for which secondary access to data is sought (authored by Jonathan Williams and Kylie Hunter, NHMRC CTC)
- One of two versions of the PICF of the original study from which the data originates (authored by Vanessa Warren, CT:IQ)

These materials were not designed to represent a straightforward or 'ideal' application, but to reflect known areas of complexity to encourage considered discussion among participating HRECs. The research team did not attempt to complete institution-specific requirements such as cover sheets and standardised application forms.

See Appendix 2 for full mock review documentation.

2.3 Coding and analysis

De-identified ERB records of deliberation including minutes, transcripts, and feedback summaries were assigned a numerical identifier and coded in Microsoft Excel, using a combination of deductive and inductive qualitative codes. Deductive codes were identified through the Trace and Kolstoe (2017) example, and relevant provisions of the NHMRC National Statement on Ethical Conduct in Human Research (National Statement). Inductive codes were identified, added and reviewed throughout coding.

Each set of deliberation records was iteratively reviewed and every reference coded to a domain category (theme), and sub-category (sub-theme) as appropriate. If themes demonstrated too much overlap or duplication they were reviewed and collapsed. If themes became too broad or divergent they were reviewed and split into new themes/sub-themes. Once coding was completed all minutes were reviewed by Investigator 1 (VW) to make sure all references had been coded. All coding was then reviewed by Investigator 2 (RM) and Investigator 3 (LE) before undergoing quantitative and qualitative content analysis.

3. Results

3.1 Participation

Of the 188 ERBs contacted by the research team, 34 (18%) agreed to participate in at least one facet of the benchmarking exercise (17 ERBs in each group). Of these, 18 returned records of their deliberation for our analysis (6 in Group A and 12 in Group B). This sample met our target of 15-50 participating HRECs.

Table 1. Characteristics of participating ERBs

ERB characteristics		N (%) ERBs
Location		
	NSW	6 (33%)
	VIC	3 (17%)
	QLD	2 (11%)
	WA	2 (11)
	SA	3 (17%)
	ACT/NT/TAS	2 (11%)
	Total	18 (100%)
Institution type		
	Higher Education	5 (28%)
	Health	9 (50%)
	Government	2 (11%)
	Private/NGO	2 (11%)
	Total	18 (100%)
Does your institution participate in the National Mutual Acceptance (NMA) Scheme?		
	Yes	6 (33%)
	No	7 (39%)
	Not sure	1 (6%)
	Information not available*	4 (22%)
	Total	18 (100%)

**Some ERBs participating in the benchmarking review did not complete the post-review survey from which this table draws.*

ERBs returned their de-identified record of deliberation in a range of formats, including:

- full transcript of their deliberation meeting (synchronous deliberation)
- minutes of the deliberation meeting (synchronous deliberation)
- summary of the deliberation (synchronous and asynchronous deliberation)
- written responses to the proposal from different committee members (asynchronous deliberation)
- feedback to the investigators
- notification of outcome
- combination of the above

Returned documents varied in length from several pages to one paragraph.

3.2 Consistency in shared ethical debate

3.2.1 Consistency in outcome of shared ethical debate

Noting the small sample size, ERBs allocated to Group A (broad consent for future use) demonstrated notably divergent outcomes of deliberation, with equal numbers selecting to approve (2), reject (2), or require revisions/more information (2). ERBs allocated to Group B (silent on consent for future use) had a more consistent assessment outcome, with the majority (10) requiring more information or revisions before reconsidering the proposal and the remainder rejecting (2).

Table 2. Outcome of deliberation on mock study by participating ERB

Option	Approved	Required revisions	Rejected	Total
A (broad consent for future use)	2	2	2	6
B (silent on consent for future use)	0	10	2	12
Total	2	12	4	18

Content analysis identified 47 unique themes across the participating sample. Substantial diversity was identified both across and within the themes.

Table 3. Themes and subthemes appearing in participating ERB minutes and feedback

Theme	Sub-theme	# of ERBs	% of ERBs
Social or scientific value; scientific design and conduct of the study			
	Research design (proposed study)	15	83%
	Alignment of scope and intent between proposed and original study	8	44%
	Merit and integrity (proposed study)	13	72%
	Research design (original study)	4	22%
	Merit and integrity (original study)	4	22%
Recruitment arrangements and access to health information and fair participant selection			
	Recruitment in original study	5	28%
	Inclusion/exclusion of data for those who have withdrawn consent from the original study	7	39%
Care and protection of research participants; respect for potential and enrolled research participants' welfare and dignity		10	55%
Informed consent processes and the adequacy and completeness of research participant information		7	39%
Suitability of the applicant and supporting staff		5	28%
Waiver of Consent justification			
	Waiver of consent - unspecified criteria	12	67%
	Level of risk to participants	11	61%

	Risk-benefit calculus	8	44%
	Impracticability of obtaining consent	7	39%
	Likelihood of participants having consented if they had been asked	5	28%
	Protection of participant privacy	12	67%
	Protection of confidentiality of data	10	55%
	Plan for making information arising from the research available	3	17%
	Possibility of commercial exploitation of derivatives of the data or tissue, and how this related to any financial benefits the participants may be entitled to	2	11%
	State, federal, or international privacy laws	5	28%
Evidence of ethics approval			
	Evidence of ethics approval of original study	2	11%
	Evidence of ethics approval of proposed study	7	39%
Scope of consent in the original study		13	72%
Community expectations and/or consultation		4	22%
Nature of the data			
	De-identification and re-identification potential	12	67%
	Use of retrospective data	4	22%
	Raw data vs processed data	2	11%
	Data from Aboriginal and/or Torres Strait Islander people	4	22%

Data cleaning and harmonisation		6	33%
Variables to be shared		11	62%
Data management and handling			
	Data governance and oversight	4	22%
	Data transfer, sharing agreements, custodianship	8	44%
	Data management plan	6	33%
	Data storage, access and security	8	44%
	Data retention and destruction	9	50%
	Cross-border transfer of data	2	11%
	Multiple sites	1	6%
	Data re-use and availability	4	22%
	Data withdrawal	1	6%
Project governance and funding		3	17%
Standardised application form required		2	11%
Institutional requirements or expectations		3	17%
Overall quality of the application		3	17%
Completeness of the application		6	33%
Suggestions for application structure, language, copy editing		6	33%
Limitations of the National Statement		1	6%
Self-reflection, commentary, role of the ERB		7	39%

3.2.3 Top themes identified in ERB deliberations

Top themes were defined as any theme or sub-theme appearing in the analysed documentation of half or more participating ERBs. Eleven (11) top themes were identified (23% of the total 47 themes and sub-themes).

Table 4. Top themes (themes appearing in ≥50% of ERB deliberations) in descending order

Top Theme	% of ERBs
Research design (proposed study)	83%
Merit and integrity (proposed study)	72%
Scope of consent in the original study	72%
Waiver of consent (unspecified criteria)	67%
Waiver of consent (protection of participant privacy)	67%
Nature of the data (de-identification and re-identification potential)	67%
Variables to be shared	62%
Waiver of consent (level of risk to participants)	61%
Waiver of consent (protection of confidentiality of data)	55%
Care and protection of research participants; respect for potential and enrolled research participants' welfare and dignity	55%
Data management (data retention and destruction)	50%

The remaining 36 themes and sub-themes (77% of the total identified themes) appeared in less than half of the documented ERB deliberations. This indicates a diverse range of considerations, questions and concerns held by participating ERBs. The infrequency with which many of these themes occurred across the sample, however, suggests that they were not considered widely relevant by other ERBs in their decision-making.

This finding may also indicate that some ERBs did not address important themes that could have been raised more frequently. For example, despite two thirds of ERBs (Group B) being explicitly asked to consider a waiver of the requirement for consent, only three of the nine waiver criteria set out in National Statement para

2.3.10 appear as top themes (see Section 4. for further discussion of waiver of the requirement for consent criteria). That said, it should also be recognised that the fact an ERB didn't raise a theme in its analysed materials cannot be equated with a failure to consider or deliberate upon that theme, with the coded themes reflecting only the content that was recorded and returned for analysis. Further, it is reasonable to expect that there may be differences in the frequency with which a theme was raised depending on how straightforward or self-evident it is, compared to themes that are more contentious, for which there is limited guidance, or which require more discussion to reach consensus. It should also be noted that there are some themes that apply more directly to Group A or Group B that may affect whether an ERB raised them.

3.2.4 Consistency in themes across the ERB deliberations

Consistency scores were calculated as a ratio of top *themes:all themes* identified in each ERBs deliberation records. This ratio has been expressed as a decimal. An ERB that only identified top themes would show a consistency score of 1.0; an ERB that did not identify any top themes would show a score of 0.0.

While there is a large range between the highest and lowest consistency scores in the sample, most ERBs fell broadly in the middle.

Table 5. Summary descriptive statistics for calculated ratios

	Option A (n=6)	Option B (n=12)	Whole sample (N=18)
Minimum	0.17	0.33	0.17
Maximum	0.62	0.86	0.86
Range	0.45	0.53	0.69
Mean	0.42	0.47	0.45
Median	0.46	0.43	0.44

All ERBs expressed some degree of confidence in their decision being consistent with other ERBs. Approving ERBs tended to feel more confident about their decision being consistent with others, while rejecting ERBs were less certain. Notably, the ERB with the weakest consistency score (0.17) expressed a high degree of confidence that their decision would be consistent with other ERBs.

3.2.5 Consistency of sentiment within top themes

Consistency in the frequency of top themes appearing in deliberations doesn't necessarily indicate consistency in the ways in which ERBs addressed and interpreted these themes. There appears to be significant divergence across ERB approaches to, and application of, identified themes.

As well as thematic coding and the quantitative content analysis described above, the ERB deliberations were also coded to reflect the sentiment of their commentary. This coding described ERB comments within each theme area as indicating either: their satisfaction or dissatisfaction with the application in that theme area; requests for more information or suggestions for inclusions; and neutral or unclear statements (i.e., comments that were descriptive, but did not indicate the ERBs' satisfaction, dissatisfaction or other feedback such as 'The Committee discussed data security (i.e., its transfer, storage, etc.) and its importance when considering sharing research data.' (#28)).

The mean percentages for each sentiment category appearing across the top themes fell within a range of 19% (neutral/unclear comments) to 34% (requests for more information).

Table 6. Sentiment of ERB comments for top themes

	Sentiment of ERB comments (as % of total comments for each theme across the sample)			
Top Theme	**Satisfied with application /supportive comments**	**Not satisfied with application /critical comments**	**Request or suggestion for more information**	**Neutral/ unclear**
Research design (proposed study)	16%	22%	32%	30%
Merit and integrity (proposed study)	32%	28%	16%	24%
Scope of consent in the original study	12%	32%	12%	44%
Waiver of consent (unspecified criteria)	26%	42%	26%	5%
Waiver of consent (protection of participant privacy)	16%	44%	34%	6%
Nature of the data (de-identification and re-identification potential)	35%	35%	15%	15%
Variables to be shared	6%	0%	72%	22%

Waiver of consent (level of risk to participants)	69%	25%	6%	0%
Waiver of consent (protection of confidentiality of data)	8%	23%	54%	15%
Care and protection of research participants; respect for potential and enrolled research participants' welfare and dignity	17%	33%	17%	33%
Data management (data retention and destruction)	0%	0%	88%	12%
Mean	***21%***	***29%***	***34%***	***19%***

Given that the majority of ERBs requested revisions to the mock application for reconsideration, rather than an outright rejection or approval, it is not surprising that requests for more information were also the sentiment appearing most frequently among the coded comments in the top themes. That said, the relatively diverse spread of sentiment across the top themes indicates significant divergence in approach and interpretation among participating ERBs. ERBs demonstrated an equal split, for example, between satisfaction and dissatisfaction with the mock applications' claims around the *Nature of the data (de-identification and re-identification potential)*, with 35% of ERB comments accepting the mock investigators' claims that data was de-identified and 35% of comments disputing this claim. Similarly, ERB commentary demonstrated a near-equal split between satisfaction (32%) and dissatisfaction (28%) with the *Merit and integrity of the proposed study*. Instances of clear consistency in sentiment largely centred on requests for more information, for example in commentary under *Data management (retention and destruction)* and *Variables to be shared*. This suggests that these are areas in which the participating ERBs require significant detail to be satisfied.

4. Divergence within deliberations

Some key areas of divergence for further examination and support development indicated by the findings include:

4.1 Differences in ethics review body approach to, and understanding of, their role

Some ERBs adopted a collaborative approach in the feedback provided on the mock application. This included express statements of alignment between the mock research and requirements of the National Statement ('The Committee found the potential benefits were outlined and clearly articulated' (#3); 'The public health interest in this study is very strong' (#1)) and requests for additional information worded in ways that were specific, actionable, and clearly linked to the ERB's remit ('Please justify why all data collected in the original research are relevant to the current study under review. Please explain if it is possible to share only data points that are relevant to the current study.' (#34)).

Other responses took a more adversarial approach. Some ERBs raised concerns that were outside the remit of the National Statement requirements, including proposed authorship of original study researchers, and processes by which other research groups were authorising waivers to contribute their data.

These differences highlighted fundamental tensions in ERB conceptions of their role: as gatekeepers or enforcers to ensure a suite of protections, or as collaborators or partners in research processes. As one ERB described this tension: 'What is [our] role – protector of human participants or commentator on scientific design?' (#15). A related question that emerged from ERBs was the scope of their role, and how it fits with others in the research ecosystem ('My question is, is our job as an HREC to approve that project, or simply to approve the release of our data to that project which belongs to somebody else?' #5); 'Where lies the responsibility of a HREC? Where does peer review start and HREC roles end?', #15).

4.2 Varied views on the overarching ethics of data sharing activities

One ERB explicitly noted the ethical benefits of secondary data sharing activities: 'The use of existing data reduces the need for new studies and burden to a population at a very stressful time in their life (having a very preterm infant). Therefore, the research has been designed to minimise the risks of harm or discomfort to participants (NS 1.7)' (#18). In contrast, another ERB expressed a broad aversion to data sharing, stating: 'We don't approve groups looking at data outside of department – data to people unrelated to original treatment' (#10).

4.3 Concerns around the ethics of the original study

Some ERBs took on a role of re-reviewing the ethical acceptability of the original study from which data was being sought. This included a concern that the PICF for that study included 'insufficient information on available support services for participants who may feel upset or distressed' (#26). Another ERB, which rejected the hypothetical application, noted: ''We've got no idea how much informed consent there was, as MEMBER B said. That's a stressful time.' (#5). Several ERBs raised concerns that the data from the original study had not been destroyed, despite more than five years having elapsed since it was collected. No commitment was made to destruction after five years in the hypothetical study protocol and PICF; this concern appears to have emerged through the ERBs' own assumptions about data retention and destruction, outside the protocols outlined in the application documents.

4.4 Divergence on whether the data 'de-identified,' and what the implications may be

There was significant divergence in whether ERBs considered the requested data to be identifiable. Some accepted the removal of direct identifiers to be sufficient to render the data de-identified ('Only non-identifiable data will be sent to the collaborative research group, therefore the study may be considered Low Risk' #1; 'they will use de-identified data' #15; 'The Privacy Act does not apply as the data is de-identified.' #23). Other ERBs took the view that the removal of direct identifiers was insufficient, in and of itself, to de-identify the data ('Would it be possible to re-identify participants based on other data points collected? These seem quite substantial – disability or illness, hospital admission, parent demographics,

geographical. The larger the number of data points collected, the greater the chance for identification. How is this possibility handled?' (#5); 'How will the data be de-identified? Only removing direct identifiers (names, addresses and contact information) may be insufficient to render the data non-identifiable' (#4) 'The collected data is so detailed as to personal information, demographics, birth details and medical information about hospital stay and other information about wellbeing of the family after the birth, financial status etc as to present a clear risk that the participant and their baby might be personally identifiable from the relatively small population of very preterm births in Australia' (#32).

Although the hypothetical application included a description of the data items being requested for the secondary research, a complete list of data variables had not been included with the application. Some ERBs sought this more granular information to feed into their assessment of identifiability and—more specifically—to understand whether Indigenous status was being shared and, therefore, whether Indigenous data governance practices should be observed ('Given that data from Aboriginal or Torres Strait Islander people are likely to be used, how will the project meet the AIATSIS code of Ethics for Aboriginal and Torres Strait Islander Research...?' #32).

4.5 Role of waiver of consent and criteria for authorising

While some ERBs engaged deeply with the criteria for authorising a waiver of the requirement for consent, others addressed only some of the waiver criteria. Notably, few ERBs explicitly commented on the likelihood of participants having consented if they had been asked or the practicability of reconsent. Divergent assessments of whether these criteria had been satisfactorily met occurred even within the small group of ERBs that did address them ('there's no way in my mind that researchers could go back to the original participants and ask them if they can reuse data' (#5); compared to '…it is feasible to contact all participants. I don't consider it impracticable to obtain their consent' (#32)). Several ERBs questioned whether the availability of identifying data and relatively up-to-date contact information was adequate to constitute practicality of reconsent; yet another provided almost a diametrically different approach in accepting the justification for a waiver, stating that 'while it may be possible for researchers to try and contact participants, response rates would likely be low given the time that has elapsed' (#28).

One ERB in Group B did not explicitly address any of the waiver of consent criteria outside a general statement indicating that the criteria had not been satisfied: there was no further indication of which criteria were in question, or how the ERB's concerns could be addressed.

There were indications that the role of waivers may be generating confusion for some ERBs, most notably a comment that: '[The] original PICF form has clear statement that once contacted after x point you will have no further input in this study therefore a waiver of consent could be seen as contradictory to the original PICF' (#10). Another ERB, which approved the application, expressed the view that a waiver was not applicable as 'The Privacy Act does not apply as the data is de-identified' (#23).

4.6 Scope of broad consent

Due to the small sample size in Group A, it is challenging to draw conclusions about the breadth with which ERBs are interpreting the scope of original consent for data to be shared for 'related' research. However, the information available suggests an ERB willingness to interpret the requirement relatively broadly. As one ERB stated: 'Although the aim of the original research was to investigate the treatment and outcomes for very low birth weight babies, quality of life for caregivers was one of the outcome variables assessed. Therefore, the current study for which data will be used is sufficiently close in intent that it could be considered a "related study".' (#5). Others noted 'The proposed secondary use of data falls within the scope of the original study' (#23) and 'the aim of the new research aligns with the original clinical trial' (#4). No ERB in Group A expressed reservations about whether data from a clinical trial focused on the treatment of neonates was sufficiently related to secondary research on carer QOL to fall within the hypothetical extended consent.

5. Conclusions and recommendations

Findings from the Ethics Review Body Benchmarking Activity suggests that there are significant differences in the way that ERBs interpret and apply the National Statement and privacy requirements, as well as how different ERBs view the role and scope of their decision making.

Key findings include that:

- ERBs approached the exercise with very different approaches to the ethics of secondary data sharing activities. While some expressly commented on the ethical benefits, others took a more sceptical angle and instead focused more actively on protecting the participants in the original research project.
- There were considerable variations between ERBs in outcomes of their review, the criteria of the National Statement on which they focused, and how they applied the benchmarking project to the National Statement criteria. Each of these domains of variability raises challenges for researchers seeking authorisations from multiple reviewing ERBs.
- ERBs had divergent approaches to assessing the waiver of the requirement for consent criteria. This included assessments of whether the research should be considered low risk, the practicability of reconsent, and views on protection of privacy and confidentiality. This resulted in a complete spectrum of responses all the way from one ERB that stated that the waiver criteria were clearly justified, and another that considered there to be no justification for a waiver.
- ERBs differed markedly in their views on whether participant-level data from which direct identifiers had been stripped was ‘de-identified’. While some accepted the researchers’ assertion of deidentification, a greater number sought more detailed assurance about the privacy challenges inherently associated with unit-level data.
- When faced with a benchmarking task, some ERBs appeared to approach the activity as a test of their abilities to find problems. This may reflect ERBs’ self-consciousness of their participation in a benchmarking review presenting as critical hypervigilance.
- Participating ERBs expressed enthusiasm about participation and an interest in being informed of the findings of this activity. Informal feedback further indicates that many ERBs found participation in the benchmarking review activity to be a challenging and valuable exercise in their learning and reflective practice.

There is a need for resources that support both researchers (to design compliant studies and write applications that communicate the relevant information efficiently) and ERBs (to review the applications in line with legal and ethical obligations). These resources will promote consistency and quality in applications and review and contribute to promoting a more collaborative research culture.

Targeted resources and activities for both researchers and ERBs is required to facilitate thorough and informed review processes grounded in the principles in the National Statement.

For researchers:

- Guidance on the information required to inform a review of an application for secondary research involving clinical trial data, including a complete list of the data items being requested
- Indicative examples of the expectations required to satisfy criteria for waivers of the requirement for consent under the National Statement, including aspects for which there is known divergence among ERBs.
- Education and resources on whether and how participant-level data can be de-identified for the purposes of the National Statement and the Privacy Act.

For ERBs:

- Education on the ethics of secondary data sharing research, including the trade-offs between respect for the privacy and autonomy of original study participants and the benefits to scientific knowledge.
- Resources articulating the role and remit of the ERB when considering requests to access clinical trial datasets for secondary research, including relationships with other reviewing ERBs and how to deal with concerns about the ethics of the original trial.
- Resources on the privacy risks associated with participant-level data, including the circumstances in which such data can/cannot be considered de-identified. This may be through written materials or additional access to technical expertise.
- Guidance on the provision of responses to applicants, including tone, link to National Statement criteria, and degree of specificity in requests for additional information.
- Opportunities for consensus-building on key criteria of the National Statement, including waiver of the requirement for consent criteria.

6. Appendices

Appendix 1: Email to ERBs inviting them to participate in benchmarking activity

To: Ethics review body Executive Officers
Subject: Invitation to Participate in National Benchmarking Project

Dear Executive Officer,

The CT:IQ/Australia Research Data Commons Clinical Research Data Sharing project team invites you and your ethics review body to take part in a nationwide ethical decision-making benchmarking and needs assessment process.

In recognition of the demands placed on ethics review bodies as they assess ethically and technically complex research proposals, this project aims to identify and understand how ethics review bodies apply criteria for the sharing of secondary research data. It will also explore the barriers, enablers, and support needs experienced by ethics review bodies as they undertake this important work.

This investigation will be used to inform the development of appropriate supports for ethics review bodies, researchers, institutions, and other stakeholders, to help foster best-practice approaches to data sharing across Australia. This investigation will not be used to assess or rank the performance of individual ethics review bodies, nor to standardise review outcomes.

Participation in this project will involve:

- Ethics review bodies' Executive Officers and/or Chairs completing a brief survey about their committee's prior experiences in assessing research applications involving secondary data sharing;
- Ethics review bodies reviewing a hypothetical research application that involves the use of secondary data, and sharing the de-identified minutes of the review discussion with the Clinical Research Data Sharing project team for analysis;
- Ethics review bodies' Executive Officers and/or Chairs completing a brief post-review survey about the specific challenges and information/support needs experienced when reviewing the hypothetical research application.
- Ethics review bodies' Chairs/Executive Officers may also opt-in to complete a brief interview about their ethics review bodies' particular expectations and priorities when reviewing applications involving secondary data sharing.

Participating ethics review bodies will receive an $100 gift card honorarium in appreciation for their time.

To ensure the outcomes of the investigation are responsive to the needs of the diverse range of ethics review bodies across Australia we welcome and encourage participation from all those that are experienced in reviewing research involving the use of secondary data, to those who have never done so before. We would welcome your participation in this national project.

You can view the project description, Participant Information Sheet, and NHMRC letter of endorsement here: https://ctiq.com.au/current-projects/clinical-research-data-sharing-frameworks/. You can also access the survey link at the same page to begin participating and, if you choose, to register your interest in participating in the review exercise.

Warm regards,

Lisa Eckstein (principal investigator, CT:IQ)

https://ctiq.com.au/current-projects/clinical-research-data-sharing-frameworks/
Research approved by Central Adelaide Local Health Network HREC, reference number 20447

Appendix 2: Mock application documents

a. Mock protocol

Quality of Life of Parents of Very Preterm Infants in Australia (PVPIA): A Systematic Review and Individual Participant Data Meta-Analysis Protocol

Short Title
QOL of parents of very preterm infants in Australia: a study protocol for an IPD meta-analysis

Keywords
Quality of Life, Very Preterm Infants, Systematic Review, Individual Participant Data Meta-Analysis, Neonatal Studies, Australia, PVPIA Collaboration, prognostic factor study, prediction model

Authors and affiliations
[This section has purposefully been left blank for the exercise]

Abstract
Background
Very preterm infants, born before 32 weeks' gestational age, face numerous health challenges requiring intensive medical care. The stress and anxiety associated with caring for these infants can significantly impact the quality of life (QOL) of their parents. Despite the critical role parents play, their needs and well-being are often underappreciated and inadequately addressed in both clinical practice and research.

Aims
This study aims to establish QOL of parents of very preterm infants in Australia. It will assess if there have been changes over time in QOL of carers. Additionally, this study aims to determine if there are predictive factors to poor parent QOL and suggest variables to consider for a core outcomes set.

Methods
A systematic review and prognostic factor meta-analysis will be conducted with individual participant data (IPD). Eligible studies include those that recruited parents of very preterm infants and collected QOL and infant outcome data at follow-up 1 year. A systematic search will be performed in medical databases and trial registries. Data will be harmonized into a common format and stored securely. QOL of parents at one-year follow-up will be established, and prognostic factors that predict poor parent QOL determined.

Discussion
This study will provide the first comprehensive analysis of factors negatively influencing the QOL of parents of very preterm infants. The findings will be used to evaluate current support systems in Australia and track improvements over time, particularly in relation to the 'Guideline for Growth, Health and Developmental Follow-up for Children Born Very Preterm 2024'. By identifying predictive factors and setting a standard for measuring the impact of these guidelines, this study aims to inform better support and interventions for parents.

Background
Very preterm infants, defined as those born before 32 weeks' gestational age (GA), face numerous health challenges due to their early arrival. These infants often require intensive medical care immediately after birth and throughout their early development. In Australia, approximately 3,500 babies, or 1.1% of all births, are born very preterm each year. Of those that survive, about 60% will experience significant difficulties, including developmental delays, chronic health issues, and disabilities. The risks associated with very preterm birth are substantial, with these infants being more susceptible to complications such as respiratory distress syndrome, intraventricular haemorrhage, and necrotizing enterocolitis. As a result, very preterm infants are more likely to have challenging lives and may require ongoing medical and developmental support.

Caring for very preterm infants is a demanding and often overlooked aspect of neonatal care. Parents of these infants face a more difficult task compared to those with full-term babies. The emotional and physical toll on parents can be immense, as they navigate the complexities of their infant's medical needs, frequent hospital visits, and the uncertainty of their child's long-term health outcomes. The stress and anxiety associated with caring for a very preterm infant can significantly impact the quality of life (QOL) of parents and carers. Despite the critical role that parents play in the care and development of their very preterm infants, their needs and well-being are often underappreciated and inadequately addressed in both clinical practice and research.

In response to the challenges faced by very preterm infants and their families, new guidelines have been established to improve the long-term care of these infants in Australia (1). Developed by the Murdoch Children's Research Institute (MCRI) in collaboration with a multidisciplinary team of experts, these guidelines are the first of their kind in the country. They focus on the follow-up care of babies born before 32 weeks' GA, from the time they leave the hospital until they reach six years of age. The guidelines recommend structured and specific post-discharge care to address the increased risk of growth, health, and developmental problems in very preterm infants. While these guidelines represent a significant advancement in the care of very preterm infants, there remains a lack of focus on ensuring that parents receive the necessary support to manage their caregiving responsibilities effectively. Addressing the needs of parents is crucial for improving the overall outcomes for very preterm infants and their families.

Individual participant data (IPD) refers to the raw, row-by-row data collected from each participant in a study, as opposed to aggregate data which summarizes results at the group level, such as that in a publication (2). Using IPD over aggregate data offers several significant advantages, particularly in the context of quality of life (QOL) research. IPD allows for a more detailed and nuanced analysis, enabling researchers to explore individual-level data and identify patterns that may not be apparent in aggregate data. This is especially important given the variation in the collection of QOL data across different studies. QOL surveys can differ in terms of the instruments used, the timing of assessments, and the specific aspects of QOL measured. Access to IPD allows researchers to standardize these variables and perform more accurate and comprehensive analyses. Moreover, IPD for QOL can facilitate the identification of important factors that may negatively impact the lives of those surveyed. Aggregate data, on the other hand, often lacks the granularity needed to uncover these critical insights, potentially leading to incomplete or biased conclusions. By leveraging IPD, this study aims to provide a more robust and detailed understanding of the QOL of parents/carers of very preterm infants, ultimately informing better support and interventions.

Aims

1. To establish the quality of life for parents of very preterm infants in Australia, allowing the impact of the 'Guideline for Growth, Health and Developmental Follow-up for Children Born Very Preterm 2024' to be measured.
2. To assess if the quality of life in parents of very preterm infants has changed over the years in Australia.
3. To model if there are any prognostic factors associated with reduced parent quality of life in Australia.
4. Provide suggestions for a core outcome set for the collection and reporting of quality of life for parents.

Methods

We will conduct a systematic review and individual participant data meta-analysis. This protocol is presented in accordance with the PRISMA-P statement (3).

Eligibility Criteria

Eligibility of studies for the research question is based on PICOST (Population, Intervention, Control, Outcomes, Study design and Timeframe).

Studies

All clinical studies will be included (randomised controlled trials (RCTs), non-RCTs, and quasi-RCTs), with no exclusions based on the number or type of intervention investigated. Studies must have at least one site in Australia, collect the Parental QOL, and be able to share their IPD with the PVPIA Collaboration. There will be no exclusion by year and studies will be included if there is an English abstract available.

Participants

Studies must include predominantly (>85%) infants born <32 weeks gestational age.

Outcomes and prognostic factors

Studies must have collected any version of QOL survey data for the parent(s) at ≥ one year (+/- 3 months) of age and have data on the health outcomes of the infant available. Only data from Australian sites will be eligible.

Search Strategy and information sources
A systematic search will be conducted in medical databases including Medline, Embase, Cochrane Central Register of Controlled Trials (CENTRAL), and CINAHL, in accordance with the Cochrane Handbook of Systematic Reviews (4). Additionally, trial registries including ClinicalTrials.gov and the WHO International Clinical Trials Registry Platform (ICTRP) will be searched to identify unpublished results and ongoing studies (5). The Health Data Australia (6) national catalogue for health data will also be searched for eligible datasets that may not be published. Reference lists of relevant systematic reviews and consultations with clinical experts will help identify additional eligible studies. Studies will be screened in Covidence Online Software by two independent reviewers, and discrepancies resolved by discussion or a third reviewer when a consensus cannot be reached.

Governance and Project Management
To conduct this study, the PVPIA Collaboration will be formed. The collaboration will consist of the 'Project Team', 'Advisors' (including advisors with lived experience) and 'Study Investigators'. The project will be led by a 'Steering Committee', who will be independent from individual studies, and consist of lead investigators, lead statistician, project manager, senior advisors and advisors with lived experience. The steering committee will meet monthly, reporting back to the PVPIA Collaboration periodically and holding at least one annual meeting for all collaborators.
The principal investigator (or main contact) of eligible studies will be contacted and invited to join the collaboration as a study investigator. Study Investigators will be expected to provide IPD for their study and answer any queries about their data. They will be invited to attend meetings and to co-author main publications (in line with ICMJE authorship criteria). In the case where study leadership is shared, a maximum of two study investigators for each study, may be negotiated. Advisors invited to join the collaboration will be key figures with topic expertise or unique skills to cover all aspects of the project, including clinicians, methodologists, statisticians, and those with lived experience. Advisors will be expected to attend 50% of the 6 advisory meetings each year and provide input from their area of expertise.

Ethical Considerations
Ethics approval for this project has been obtained from PVPIA collaboration's primary researchers' host institution (2024/XXXX) and has been deemed low risk. The project protocol has been prospectively registered on PROSPERO (CRDXXXXXXXXXX).

Only clinical studies that have been approved by a human research ethics committee (HREC) or another authorised ethics review body will be eligible to contribute data. Ethics approval to share study data will be the responsibility of the 'Study Investigators' in consultation with the original HREC. The PVIPA Collaboration will only receive de-identified IPD, where a minimum of all participants; names, addresses (besides centre) and contact information has been removed or pseudonymised.

Data Sharing, Collection and Management
Data transfer agreements
Study investigators' host institution will be responsible for the template of data transfer agreements. If a template is unavailable, the PVPIA collaboration can provide one upon request. Any terms that differ to the intentions of the current protocol must be dictated in an agreement.

Data Receipt
Study investigators will be asked to share their de-identified IPD and associated study documents via secure data transfer (AARNet FileSender with encryption). Efforts will be made to obtain all IPD, including data for those that have been excluded from the original study for any reason. Confirmation of data receipt will be provided in email, upon successful access to data files.

Data Processing
Upon receipt, data will be harmonised into a common format and checked with respect to range, internal consistency, consistency with published reports and missing items. Any queries will be resolved with the original Study Investigator(s). Once finalised, data from each of the trials will be combined into a single database. Data will be cleaned, checked against published results, assessed for integrity and checked for logical values.

Data Storage and access
Data will be stored in line with the project's host institutional data management policy. Data will be stored on approved institutional servers with restricted access by approved personnel only; no local copies of data will be made. Personnel with access must be named on the ethics application and will consist predominantly of the 'Project Team'. Access will be via a VPN (or on the local University network), using University credential login (with OKTA verification).

Risk of bias and certainty of evidence
Bias of individual studies will be assessed using the Quality in Prognosis Studies (QUIPS) appraisal tool (7). Two reviewers will independently rank five domains: study participation, study attrition, prognostic factor measurement, outcome measurement and study confounding, as high, medium or low risk of bias. Studies with multiple domains rater high risk of bias will be removed and included in sensitivity analyses only.
For assessing certainty of prognostic factors for poor parent QOL, we will use the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) approach for prognostic factors (8). Certainty can be rated as high, moderate, low, or very low. The GRADE approach is typically applied at the outcome level.

Outcomes and prognostic factors
QOL for parents of very preterm infants
A mean value for QOL of parents of very preterm infants will be calculated at 1 year follow-up (to birth). This will be used to establish the current baseline value to reference in future studies. A harmonisation process of QOL data will need to occur, due to difference in collection and existence of multiple subscales. QOL will be reported accordingly and subject to the availability of harmonizable data.

Change in QOL for parents of very preterm infants
QOL of parents of very preterm infants will be assessed as change over time (years), to determine if there is a current trend.

Prognostic factors
All prognostic factors, subject to data availability, will be explored. At a minimum, we forecast to be able to use the following categories:
- Disability or illness: Impact of individual disabilities or illnesses and combined any disability or illness, severity of disability or illness.
- Hospital admission: Influence of level of care, duration of hospital stay, and duration in NICU.
- Parent demographics: Socioeconomic factors, age, relationships, culture and ethnicity.
- Geographical: Urban vs regional and rural, hospital.

Estimated sample size
From initial scoping search results it is estimated that >50 clinical studies will be eligible, totalling approximately 10,000 participants. Due to the age of some studies and previous work, we estimate a data collection rate of no higher than 75%, or 7,500 participants.

Data harmonisation and core outcomes
Reporting and publication
Findings of this study will be reported in accordance with the PRISMA-IPD statement (9). Results will be made publicly available in peer-reviewed, open access journals. The study protocol, statistical analysis plan, and final manuscript will be circulated to all collaborators with adequate time for feedback and approval before publication. Authorship will be offered to all Collaborators; however they must meet ICMJE authorship criteria.

Data Analysis
A comprehensive statistical analysis plan will be formulated and reviewed by all collaborators at a later date, before being date and time stamped when uploaded to Open Science Framework. This will ensure that analyses take into consideration data availability and harmonisation efforts, but analysis approaches are pre-defined and not post-hoc. A two-stage approach will most likely be used for data analysis, as it allows for incorporation of covariates and interactions. A one-stage analysis may be used if the two-stage is deemed inappropriate (according to the IPD MA Handbook (2)). In this case a sensitivity analysis will be performed to compare the results. Sensitivity analyses will be predefined and subgroup analyses will not be performed, rather analysed as prognostic factors.

Discussion
Currently, there is a significant gap in the guidance available for improving the quality of life (QOL) of parents of very preterm infants. While there are numerous studies focusing on the medical and developmental outcomes of these infants, the specific needs and challenges faced by their parents remain underexplored. This lack of targeted guidance leaves a critical aspect of neonatal care unaddressed, potentially impacting the overall well-being of both the parents and their infants.
This study represents a comprehensive and pioneering effort to fill this gap by providing detailed information about the factors that negatively influence the QOL of parents of very preterm infants. By compiling and harmonizing individual participant data (IPD) from various studies, we aim to conduct

a thorough analysis that will predict poor parental QOL, so they can be better supported. This information will be invaluable in evaluating the current support systems in place in Australia and identifying areas that require improvement.

Moreover, this study will serve as a benchmark to track changes over time, particularly in relation to the implementation of the 'Guideline for Growth, Health and Developmental Follow-up for Children Born Very Preterm 2024' (1). By establishing a baseline of parent QOL, we can measure the impact of these new guidelines and determine whether they lead to meaningful improvements in the support provided to parents. Additionally, the study will seek to identify predictive factors that influence parent QOL, offering insights that can inform future interventions and support mechanisms.

In summary, this study will not only provide a detailed understanding of the challenges faced by parents of very preterm infants but also set a standard for evaluating and improving the support systems available to them. The findings will be crucial for shaping future policies and ensuring that the needs of these parents are adequately addressed.

Acknowledgment
[This section has purposefully been left blank for the exercise]

Conflict of Interest Statement
The authors have no conflicts of interest to declare.

Funding Sources
Funding for the project has been obtained through XXXXXXXXXXX, grant number XXXXX.

Author Contributions
[This section has purposefully been left blank for the exercise]

Data Availability Statement
Individual participant data will be requested from the relevant trialists for the purpose of the described meta-analysis and future updates only. Individual trialists will remain the custodians of their data. Pooled individual participant data will not be made available by the study team.

References

1. Preterm Follow-up Guideline Development Group. Guideline for Growth, Health and Developmental Follow-Up for Children Born Very Preterm. Melbourne: Centre of Research Excellence in Newborn Medicine; 2024.
2. Riley RD, Tierney JF, Stewart LA, editors. Individual Participant Data Meta-Analysis: A Handbook for Healthcare Research: John Wiley & Sons Ltd; 2021.
3. Moher D, Shamseer L, Clarke M, Ghersi D, Liberati A, Petticrew M, et al. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. Systematic reviews. 2015;4:1-9.
4. Higgins J, Chandler J, Cumpston M, Li T, Page M, Welch V, editors. Cochrane Handbook for Systematic Reviews of Interventions version 6.2 http://www.cochrane-handbook.orgupdated 2021.
5. Hunter KE, Webster AC, Page MJ, Willson M, McDonald S, Berber S, et al. Searching clinical trials registers: guide for systematic reviewers. Bmj. 2022;377.
6. Australian Research Data Commons (ARDC). Health Data Australia 2022 [Available from: https://researchdata.edu.au/health/].
7. Hayden JA, van der Windt DA, Cartwright JL, Côté P, Bombardier C. Assessing bias in studies of prognostic factors. Annals of internal medicine. 2013;158(4):280-6.
8. Foroutan F, Guyatt G, Zuk V, Vandvik PO, Alba AC, Mustafa R, et al. GRADE Guidelines 28: Use of GRADE for the assessment of evidence about prognostic factors: rating certainty in identification of groups of patients with different absolute risks. Journal of clinical epidemiology. 2020;121:62-70.
9. Stewart LA, Clarke M, Rovers M, Riley RD, Simmonds M, Stewart G, et al. Preferred reporting items for a systematic review and meta-analysis of individual participant data: the PRISMA-IPD statement. Jama. 2015;313(16):1657-65.

Part 2. Option A.
Mock application letter – broad consent

Dear Ethics Review Committee,
RE: Approval XXX/2018 - 'Resuscitation of very preterm infants with room air or 40% oxygen: A randomised Clinical Trial'

I am writing to you regarding a clinical trial that was conducted in 2018 with HREC approval. I was the principal investigator for this trial, and although it was completed some time ago, an opportunity has arisen to re-use that data, and hence I wish to apply for an approval to share data from the trial. This new opportunity is to be involved in an individual participant data (IPD) meta-analysis, which will address health concerns that have been deemed a national priority. A comprehensive draft protocol has been provided to support this letter. To participate, the study needs to be able to provide de-identified individual participant data to the coordinating research group.

Written consent from participants was obtained prior to intervention in this study. As you will see, this includes the use of data for "research that is related to this topic". The new project will pool data from research projects that have measured the quality of life of carers for very preterm infants. In my view, this falls within the scope of research related to the original clinical trial, which sought to investigate the treatment and outcomes for very low birth weight babies.

In the event that the proposed sharing is not considered to fall within the scope of the original consent, I wish to request a waiver of consent to share the information. I provide these extensive reasons to support my request:

- The new project is a low-risk study and has obtained ethics approval. It uses de-identified IPD. Re-identification of individuals will not be possible with this dataset, hence there is no risk to participants.
- It is impractical to try and re-consent for the 203 participants who provided their consent for data to be used for future related studies, and will require a significant amount of staff time. Funding for this study completed in 2008 and this task would make participation in the meta-analysis impossible.
- The intended new use of the data uses questions from the original study in the same way they were intended, and therefore there is nothing to suggest that study participants would not have originally also consented to future use.
- Participants support for sharing clinical study data is high, even if initial consent to share was not obtained (Hutchings et al., 2021, Hutchings et al., 2020, Moon, 2017).
- The ICJME has declared in a statement that there is an ethical obligation to share clinical trial data (Taichman et al.).
- A waiver of consent will allow that no participant contact information is required. Over five years have passed since the completion of the study and this information may also be outdated.
- Contacting participants may have more of a negative impact. For participants that were impacted by disadvantage, disability or mortality (after study follow-up), this may negatively impact the mental health of those participants.
- This study aims to maximise the use of existing datasets to inform evidence around a national priority area. Participation will mean the opportunity for additional publications for principal investigators and the institution.
- Appropriate data security measures are being taken for transfer, use and storage and have been detailed in the protocol.
- Results will be made publicly available (through peer reviewed publication and national guideline reporting) and there are no commercial/financial benefits expected for investigators or their institution from this study.
- There is no law that prohibits this request for data sharing

References

HUTCHINGS, E., LOOMES, M., BUTOW, P. & BOYLE, F. M. 2020. A systematic literature review of health consumer attitudes towards secondary use and sharing of health administrative and clinical trial data: a focus on privacy, trust, and transparency. Systematic Reviews, 9, 235.
HUTCHINGS, E., LOOMES, M., BUTOW, P. & BOYLE, F. M. 2021. A systematic literature review of attitudes towards secondary use and sharing of health administrative and clinical trial data: a focus on consent. Systematic Reviews, 10, 1-44.
MOON, L. A. 2017. Factors influencing health data sharing preferences of consumers: A critical review. Health policy and technology, 6, 169-187.
TAICHMAN, D., BACKUS, J., BAETHGE, C., BAUCHNER, H., DE LEEUW, P. & DRAZEN, J. & James, A.(2016). Sharing clinical trial data: A proposal from the International Committee of Medical Journal Editors. Annals of internal medicine, 164, 505-506.

I hope that I have provided sufficient information for you to assess my request, and you equally agree that a waiver is appropriate under these circumstances. Should you have any further questions, I would be happy to provide the details.

Thank you for your consideration and I look forward to receiving your response.
Kind regards,

Dr Nom Al Nom

Part 2. Option A.
Mock PICF for original study – broad consent

Project Information Sheet and Consent Form

Project Title: Resuscitation of very preterm infants with room air or 40% oxygen: A randomised clinical trial.

Research team

Principal investigator
Dr. Nom al Nom, Director of Research, Clinical Research Unit, HealthR Inc
nomalnom@healthr.com.au, (03) 4321 1234

Research team:
Dr Onamae Namaedesu, Private Hospital
Dr. Name McNameson, HealthR Inc
Ms. Nome di Cognome, Private Hospital

Dear [participant name],

You are invited to part in an upcoming research project "Resuscitation of very preterm infants with room air or 40% oxygen: A randomised clinical trial," which is investigating the treatment and outcomes for very low birth weight babies. You have been invited to take part in this study because:
·Your baby is due during the study period 30 November 2017 – 30 November 2018
·You plan to give birth at Private Hospital, where this study takes place
·Your doctor has identified that you may be at higher risk of preterm labour.

You and your baby's participation may help us to identify and improve resuscitation and respiratory support for very preterm babies at birth, leading to better birth outcomes and long-term health for these babies and their families.

Please read this Information Sheet carefully to find out what your participation in this project will involve. You can contact Dr Nom al Nom (HealthR Inc Clinical Research Unit) at nomalnom@healthr.com.au if you have any questions about the project or your participation.

After reading the Information Sheet, if you are willing to participate in this study please sign and date the attached consent form (the last page of this Information Sheet). You can return the signed form to your midwife or doctor at the Private Hospital.

Thank you, and with best wishes for your pregnancy and beyond,

Dr. Nom al Nom
Director of Research, Clinical Research Unit, HealthR Inc

Project Description

Infants who are born very early (preterm) are at greater risk of experiencing a range of complications and ongoing health problems. Because their lungs are underdeveloped at birth, very preterm infants may suffer from respiratory distress syndrome, which can be fatal if untreated. To prevent this, all very preterm babies are treated with resuscitation and respiratory support immediately after birth, and during their care in their hospital's Neonatal Intensive Care Unit (NICU). These treatments increase preterm infants' survival rates and can help to prevent a range of other complications and disabilities.

However, we do not currently know the best concentration of oxygen to give very preterm infants during resuscitation. This means that the concentration of oxygen given to these infants can range from around 21% oxygen (room air level) through to 40% oxygen depending on the preferences or procedures of different doctors or hospitals.

This study will compare room air (21%) and 40% oxygen during the respiratory support of very preterm infants. We will investigate the relationship between these different levels of oxygen and:

- health outcomes at birth for preterm infants
- developmental outcomes post-birth
- maternal quality of life

We hope that through this investigation we can identify the best concentration of oxygen to administer to very preterm infants to increase survival and ongoing health for these babies. 250 babies and their families will participate in this trial at Private Hospital to help us achieve this aim.

What does participation involve?

If you agree for you and your baby to take part in this study, the following steps will happen:

Stage One – Treatment at birth
If your baby is born very preterm (earlier than 32 weeks gestation) during the study period (30 November 2017– 30 November 2018) they will be randomly assigned to the following treatment pathways:

Positive pressure ventilation resuscitation (using mask ventilator or oral/nasal intubation) administering ***either:***
a.Higher levels of oxygen (40% oxygen)
or
b.Lower levels of oxygen (room air level, or ~21% oxygen)

Both of these oxygen levels are within the current accepted levels administered to very preterm infants. This trial will not deviate from established resuscitation practices that are currently used to resuscitate very preterm infants. We want to find out the best possible approach within the established guidelines to ensure the best outcomes for preterm infants and their families. Your baby will not be exposed to untried or unusual treatments during their resuscitation and respiratory support. Your doctor or midwife at Private Hospital can discuss these treatments with you in detail at your next appointment.

Following resuscitation using either higher or lower concentrations of oxygen, your baby will be monitored and assessed for different developmental and health indicators as part of their standard care in the Private Hospital neonatal intensive care unit (NICU) facility. We will collect some of the medical information about your baby during their stay in NICU to assess the effectiveness of their resuscitation treatment. No additional medical tests or procedures will be performed as part of this study.

If your baby is not born very preterm you will not take part in this study and any information you have provided to us up to that point will be destroyed.

Stage Two – Infant Development and Maternal Quality of Life

When your baby reaches 6 and 12 months of age, you will receive a follow-up phone call from a member of the research team. The phone calls will be planned and scheduled at a time convenient for you. They will take approximately 30 minutes each. In these phone calls we will:

- Ask you about your baby's health and development, including questions about your baby's breathing, coughing, physical and social development, and any medical diagnoses or treatments they may have undergone since discharge from NICU.

And:

- Ask you to complete a brief verbal survey about your quality of life. The survey is based on the Maternal Postpartum Quality of Life Questionnaire developed by Hill et al (2006)[1]. It may include questions about your experiences and satisfaction with your health, family life, social and romantic relationships, financial status, and psychological wellbeing, among other items.

This will be the end of your participation in this study.

What are the alternatives?

If you choose not to participate in this study your baby will still receive resuscitation treatment at birth if medically required. The oxygen level will be decided by your baby's treating team based on their clinical judgment.

What information will be collected in this study?

If you consent, we will collect a range of information about you and your baby over the course of this study, including:
- Maternal personal information (name, address, phone number)
- Maternal demographic information (age, gender, ethnicity, education, employment)
- Maternal medical information (eg, risk factors, health conditions, complications during birth)
- Date and location of birth of your baby
- Birth outcomes for your baby, including resuscitation treatment and outcomes, complications during birth
- Medical information from your baby's stay in NICU, including results of measurements, tests, medical complications, treatments
- Date and location of treatments for your baby for 12 months after birth
- Self-reported information about your baby's wellbeing and development at 6 and 12 months
- Self-reported information about your own quality of life, including health outcomes, social and familial wellbeing, financial status and psychological wellbeing.

Your information, and your baby's information, will be combined with and compared to other participants in this study. No identifying information will be used in any publications or reports.

How we will use your information

Some of the information we will collect is personal information, that is, information that relates to an identifiable (or reasonably identifiable) individual. To prevent the risk of your privacy being breached through unauthorised access to this information we will ensure that:

- All information will be collected according to Private Hospital guidelines, the National Statement on Ethical Conduct in Human Research (2007), and any relevant legislation such as the *Privacy Act 1988*.
- We will only collect information that has already been approved for use in this study by a Human Research Ethics Committee.
- Any identifying information will be stored separately to other information.
- Any identifying information will only be accessible to members of the research team.
- All data will be stored on secure, password-restricted servers.

We will also ask whether you are willing for your de-identified information from this study to be used for research in the future that is related to this study.

Benefits of participating in this study

Your participation may help researchers to better understand the optimal oxygen levels and treatment procedures for very preterm babies, which will benefit children and their families into the future.

There is no guarantee that your baby will receive other direct benefits as a result of participating in this study. It is possible that as a result of observation and follow-up after receiving treatment in this study other health conditions may be identified that might otherwise have gone unnoticed, but this is not guaranteed, nor the purpose of the study.

No financial compensation will be paid as a result of your participation in this study but we will reimburse any necessary travel costs you incur.

Risks of participating in this study

Preterm babies are at higher risk for a range of medical complications. The treatments used in this study are known to be associated with reducing some of these risks and are currently within accepted medical practice for the treatment of preterm babies. This study does not introduce additional risk beyond those already associated with the current treatment practices.

There is a potential risk to your privacy, for example if your personal information, or your baby's personal information, is accessed by unauthorised parties. We will strive to prevent this occurring by adhering to ethical and secure data management practices as outlined above. No identifying information will be shared by the research team or used in publications.

There are no costs associated with participating in this study. In the event of an adverse medical event during the study period your baby will receive medical care. Medicare covers some or all costs of NICU depending on the required treatments and care; please contact Medicare and/or Public Hospital for more information.

Your Consent to Participate

Your participation in this study is voluntary. You can choose to withdraw you and your baby from this study without explanation. If you wish to withdraw from the study after you have given consent to participate, please contact the Principal Investigator Dr Nom al Nom (Clinical Research Unit, HealthR Inc). No further information about you or your baby will be collected, however we will retain the information we have collected. This will ensure we can measure the results properly. Only participate in this study if you are happy with this approach.

Even if you do not choose to allow your baby to participate in this study, your baby will still receive standard resuscitation treatment according to current medical guidelines, and ongoing treatment through NICU.

You and your baby may be withdrawn from the study without explanation if you or your baby no longer meet the criteria for inclusion when your baby is born (for example, if your baby is born after 32 weeks gestation, if your baby is transferred to a different hospital). In this case, any information that you have already provided to the research team will be destroyed.

By signing your consent for you and your baby to participate in this study you do not waive any of your other legal rights or responsibilities.

Questions

We understand that you may have some questions about this study. Please do not hesitate to get in touch with the project team with any questions or concerns, or to discuss any detail of your participation. Your doctor at Public Hospital can also discuss the procedures outlined in this Information Sheet with you.

Participant Consent to Participate

Project: Resuscitation of very preterm infants with room air or 40% oxygen: A randomised clinical trial.

Please Tick or Cross:

I have read (or been read to) and understood the information provided in this Information Sheet	
I have had the opportunity to ask questions about this study	
I consent to participate in this study	
I consent for my infant to participate in this study	

I would like my information collected for this research study to be:

Only used for this specific study; OR	
Used for future related studies	

_____
Participant Name

_____
Participant Signature

____/____/____
Date

Researcher

_____
Researcher Name

_____
Researcher Signature

____/____/____
Date

Part 2. Option B.
Mock letter – waiver of consent

Dear Ethics Review Body,
RE: Approval XXX/2018 - 'Resuscitation of very preterm infants with room air or 40% oxygen: A randomised Clinical Trial'

I am writing to you regarding a clinical trial that was conducted in 2018 with HREC approval. I was the principal investigator for this trial, and although it was completed some time ago, an opportunity has arisen to re-use that data, and hence I wish to apply for an approval to share data from the trial. This new opportunity is to be involved in an individual participant data (IPD) meta-analysis, which will address health concerns that have been deemed a national priority. A comprehensive draft protocol has been provided to support this letter. To participate, the study needs to be able to provide de-identified individual participant data to the coordinating research group.

Written consent from participants was obtained prior to intervention in this study, however upon review, the PICF did not stipulate that data may be used for future studies. I am contacting you now to seek a waiver of consent to use the data for an additional purpose. For your consideration, I provide these extensive reasons to support my request:

- The new project is a low-risk study and has obtained ethics approval. It uses de-identified IPD. Re-identification of individuals will not be possible with this dataset, hence there is no risk to participants.
- It is impractical to try and re-consent approximately 250 participants and will require a significant amount of staff time. Funding for this study completed in 2018 and this task would make participation in the meta-analysis impossible.
- The intended new use of the data uses questions from the original study in the same way they were intended, and therefore there is nothing to suggest that study participants would not have originally also consented to future use.
- Participants support for sharing clinical study data is high, even if initial consent to share was not obtained (Hutchings et al., 2021, Hutchings et al., 2020, Moon, 2017).
- The ICJME has declared in a statement that there is an ethical obligation to share clinical trial data (Taichman et al.).
- A waiver of consent will allow that no participant contact information is required. Over five years have passed since the completion of the study and this information may also be outdated.
- Contacting participants may have more of a negative impact. For participants that were impacted by disadvantage, disability or mortality (after study follow-up), this may negatively impact the mental health of those participants.
- This study aims to maximise the use of existing datasets to inform evidence around a national priority area. Participation will mean the opportunity for additional publications for principal investigators and the institution.
- Appropriate data security measures are being taken for transfer, use and storage and have been detailed in the protocol.
- Results will be made publicly available (through peer reviewed publication and national guideline reporting) and there are no commercial/financial benefits expected for investigators or their institution from this study.
- There is no law that prohibits this request for data sharing

References

HUTCHINGS, E., LOOMES, M., BUTOW, P. & BOYLE, F. M. 2020. A systematic literature review of health consumer attitudes towards secondary use and sharing of health administrative and clinical trial data: a focus on privacy, trust, and transparency. Systematic Reviews, 9, 235.
HUTCHINGS, E., LOOMES, M., BUTOW, P. & BOYLE, F. M. 2021. A systematic literature review of attitudes towards secondary use and sharing of health administrative and clinical trial data: a focus on consent. Systematic Reviews, 10, 1-44.
MOON, L. A. 2017. Factors influencing health data sharing preferences of consumers: A critical review. Health policy and technology, 6, 169-187.
TAICHMAN, D., BACKUS, J., BAETHGE, C., BAUCHNER, H., DE LEEUW, P. & DRAZEN, J. & James, A.(2016). Sharing clinical trial data: A proposal from the International Committee of Medical Journal Editors. Annals of internal medicine, 164, 505-506.

I hope that I have provided sufficient information for you to assess my request, and you equally agree that a waiver is appropriate under these circumstances. Should you have any further questions, I would be happy to provide the details.

Thank you for your consideration and I look forward to receiving your response.
Kind regards,

Dr Nom Al Nom

Part 2. Option B.
Mock PICF for original study – waiver of consent

Project Information Sheet and Consent Form

Project Title: Resuscitation of very preterm infants with room air or 40% oxygen: A randomised clinical trial.

Research team

Principal investigator
Dr. Nom al Nom, Director of Research, Clinical Research Unit, HealthR Inc
nomalnom@healthr.com.au, (03) 4321 1234

Research team:
Dr Onamae Namaedesu, Private Hospital
Dr. Name McNameson, HealthR Inc
Ms. Nome di Cognome, Private Hospital

Dear [participant name],

You are invited to part in an upcoming research project "Resuscitation of very preterm infants with room air or 40% oxygen: A randomised clinical trial," which is investigating the treatment and outcomes for very low birth weight babies. You have been invited to take part in this study because:

- Your baby is due during the study period 30 November 2017 – 30 November 2018
- You plan to give birth at Private Hospital, where this study takes place
- Your doctor has identified that you may be at higher risk of preterm labour.

You and your baby's participation may help us to identify and improve resuscitation and respiratory support for very preterm babies at birth, leading to better birth outcomes and long-term health for these babies and their families.

Please read this Information Sheet carefully to find out what your participation in this project will involve. You can contact Dr Nom al Nom (HealthR Inc Clinical Research Unit) at *nomalnom@healthr.com.au* if you have any questions about the project or your participation.

After reading the Information Sheet, if you are willing to participate in this study please sign and date the attached consent form (the last page of this Information Sheet). You can return the signed form to your midwife or doctor at the Private Hospital.

Thank you, and with best wishes for your pregnancy and beyond,

Dr. Nom al Nom
Director of Research, Clinical Research Unit, HealthR Inc

Project Description

Infants who are born very early (preterm) are at greater risk of experiencing a range of complications and ongoing health problems. Because their lungs are underdeveloped at birth, very preterm infants may suffer from respiratory distress syndrome, which can be fatal if untreated. To prevent this, all very preterm babies are treated with resuscitation and respiratory support immediately after birth, and during their care in their hospital's Neonatal Intensive Care Unit (NICU). These treatments increase preterm infants' survival rates and can help to prevent a range of other complications and disabilities.

However, we do not currently know the best concentration of oxygen to give very preterm infants during resuscitation. This means that the concentration of oxygen given to these infants can range from around 21% oxygen (room air level) through to 40% oxygen depending on the preferences or procedures of different doctors or hospitals.

This study will compare room air (21%) and 40% oxygen during the respiratory support of very preterm infants. We will investigate the relationship between these different levels of oxygen and:

- health outcomes at birth for preterm infants
- developmental outcomes post-birth
- maternal quality of life

We hope that through this investigation we can identify the best concentration of oxygen to administer to very preterm infants to increase survival and ongoing health for these babies. 250 babies and their families will participate in this trial at Private Hospital to help us achieve this aim.

What does participation involve?

If you agree for you and your baby to take part in this study, the following steps will happen:

Stage One – Treatment at birth
If your baby is born very preterm (earlier than 32 weeks gestation) during the study period (30 November 2017– 30 November 2018) they will be randomly assigned to the following treatment pathways:

Positive pressure ventilation resuscitation (using mask ventilator or oral/nasal intubation) administering either:

a. Higher levels of oxygen (40% oxygen)

or

b. Lower levels of oxygen (room air level, or ~21% oxygen)

Both of these oxygen levels are within the current accepted levels administered to very preterm infants. This trial will not deviate from established resuscitation practices that are currently used to resuscitate very preterm infants. We want to find out the best possible approach within the established guidelines to ensure the best outcomes for preterm infants and their families. Your baby will not be exposed to untried or unusual treatments during their resuscitation and respiratory support. Your doctor or midwife at Private Hospital can discuss these treatments with you in detail at your next appointment.

Following resuscitation using either higher or lower concentrations of oxygen, your baby will be monitored and assessed for different developmental and health indicators as part of their standard care in the Private Hospital neonatal intensive care unit (NICU) facility. We will collect some of the medical information about your baby during their stay in NICU to assess the effectiveness of their resuscitation treatment. No additional medical tests or procedures will be performed as part of this study.

If your baby is not born very preterm you will not take part in this study and any information you have provided to us up to that point will be destroyed.

Stage Two – Infant Development and Maternal Quality of Life

When your baby reaches 6 and 12 months of age, you will receive a follow-up phone call from a member of the research team. The phone calls will be planned and scheduled at a time convenient for you. They will take approximately 30 minutes each. In these phone calls we will:

- Ask you about your baby's health and development, including questions about your baby's breathing, coughing, physical and social development, and any medical diagnoses or treatments they may have undergone since discharge from NICU.

And:

- Ask you to complete a brief verbal survey about your quality of life. The survey is based on the Maternal Postpartum Quality of Life Questionnaire developed by Hill et al (2006)[1]. It may include questions about your experiences and satisfaction with your health, family life, social and romantic relationships, financial status, and psychological wellbeing, among other items.

This will be the end of your participation in this study.

What are the alternatives?

If you choose not to participate in this study your baby will still receive resuscitation treatment at birth if medically required. The oxygen level will be decided by your baby's treating team based on their clinical judgment.

What information will be collected in this study?

If you consent, we will collect a range of information about you and your baby over the course of this study, including:

- Maternal personal information (name, address, phone number)
- Maternal demographic information (age, gender, ethnicity, education, employment)
- Maternal medical information (eg, risk factors, health conditions, complications during birth)
- Date and location of birth of your baby
- Birth outcomes for your baby, including resuscitation treatment and outcomes, complications during birth

- Medical information from your baby's stay in NICU, including results of measurements, tests, medical complications, treatments
- Date and location of treatments for your baby for 12 months after birth
- Self-reported information about your baby's wellbeing and development at 6 and 12 months
- Self-reported information about your own quality of life, including health outcomes, social and familial wellbeing, financial status and psychological wellbeing.

Your information, and your baby's information, will be combined with and compared to other participants in this study. No identifying information will be used in any publications or reports.

How we will use your information

Some of the information we will collect is personal information, that is, information that relates to an identifiable (or reasonably identifiable) individual. To prevent the risk of your privacy being breached through unauthorised access to this information we will ensure that:

- All information will be collected according to Private Hospital guidelines, the National Statement on Ethical Conduct in Human Research (2007), and any relevant legislation such as the *Privacy Act 1988*.
- We will only collect information that has already been approved for use in this study by a Human Research Ethics Committee.
- Any identifying information will be stored separately to other information.
- Any identifying information will only be accessible to members of the research team.
- All data will be stored on secure, password-restricted servers.

Benefits of participating in this study

Your participation may help researchers to better understand the optimal oxygen levels and treatment procedures for very preterm babies, which will benefit children and their families into the future.

There is no guarantee that your baby will receive other direct benefits as a result of participating in this study. It is possible that as a result of observation and follow-up after receiving treatment in this study other health conditions may be identified that might otherwise have gone unnoticed, but this is not guaranteed, nor the purpose of the study.

No financial compensation will be paid as a result of your participation in this study but we will reimburse any necessary travel costs you incur.

Risks of participating in this study

Preterm babies are at higher risk for a range of medical complications. The treatments used in this study are known to be associated with reducing some of these risks and are currently within accepted medical practice for the treatment of preterm babies. This study does not introduce additional risk beyond those already associated with the current treatment practices.

There is a potential risk to your privacy, for example if your personal information, or your baby's personal information, is accessed by unauthorised parties. We will strive to prevent this occurring by adhering to ethical and secure data management practices as outlined above. No identifying information will be shared by the research team or used in publications.

There are no costs associated with participating in this study. In the event of an adverse medical event during the study period your baby will receive medical care. Medicare covers some or all costs of NICU depending on the required treatments and care; please contact Medicare and/or Private Hospital for more information.

Your Consent to Participate

Your participation in this study is voluntary. You can choose to withdraw you and your baby from this study without explanation. If you wish to withdraw from the study after you have given consent to participate, please contact the Principal Investigator Dr Nom al Nom (Clinical Research Unit, HealthR Inc). No further information about you or your baby will be collected, however we will retain the information we have collected. This will ensure we can measure the results properly. Only participate in this study if you are happy with this approach.

Even if you do not choose to allow your baby to participate in this study, your baby will still receive standard resuscitation treatment according to current medical guidelines, and ongoing treatment through NICU.

You and your baby may be withdrawn from the study without explanation if you or your baby no longer meet the criteria for inclusion when your baby is born (for example, if your baby is born after 32 weeks gestation, if your baby is transferred to a different hospital). In this case, any information that you have already provided to the research team will be destroyed.

By signing your consent for you and your baby to participate in this study you do not waive any of your other legal rights or responsibilities.

Questions

We understand that you may have some questions about this study. Please do not hesitate to get in touch with the project team with any questions or concerns, or to discuss any detail of your participation. Your doctor at Private Hospital can also discuss the procedures outlined in this Information Sheet with you.

Paricipant Consent to Participate

Project: Resuscitation of very preterm infants with room air or 40% oxygen: A randomised clinical trial.

Please Tick or Cross:

I have read (or been read to) and understood the information provided in this Information Sheet	
I have had the opportunity to ask questions about this study	
I consent to participate in this study	
I consent for my infant to participate in this study	

_____
Participant Name

_____
Participant Signature

____/____/____
Date

Researcher

_____
Researcher Name

_____
Researcher Signature

____/____/____
Date