Q1: Should CSO and the Health Boards set any eligibility criteria for nodal R&D Directors? Should appointment of a nodal R&D Director be for a specific time, and if so what term would be appropriate?
Eligibility criteria should be set and this role should not be limited to those of a medical background. A recognised standing within the field of research is crucial. If a specific term is set this needs to be of sufficient length to be able to influence the research culture. It is suggested that the term would need to be a minimum of 3 years.
Q2. CSO proposes to approve the functions of staff in R&D Offices; should CSO seek to standardise local R&D functions across Scotland, or is it preferable to allow flexibility?
Flexibility would be a more appropriate approach to local R&D Function. This allows areas to develop to match local strengths and clinical service delivery differences. This knowledge/expertise can be shared intra- and inter-node for the benefit of the R&D community.
Q3. Are there other NRS functions that might usually be transferred from the Health Boards or CSO to the new NRS-GMS? Are there functions not currently being undertaken that the NRS-GMS might carry out?
The NRS-GMS needs to look at IT systems that R&D/ethics currently use and identify what systems will be used for future data management. At the moment there is duplication in some basic administrative activities such as uploading documents, repeat entry of recruitment figures. Review of the existing systems that are currently available UK-wide and national agreement would provide efficiencies and accurate potential ‘real-time’ reporting capabilities that would be attractive to our commercial partners.
Q4. To what extent should the joint planning of the deployment of infrastructure resources be formalised? Should there be a formal record of such discussions?
It is essential that infrastructure funding deployment is transparent and this would be facilitated if such discussions were formally recorded.
Q5. Taken together, will these steps to both free up and promote the availability of NRS resources address current concerns over lack of time and support? If not, are there other steps CSO should take?
Unfortunately these activities will not address all the problems. Lack of time and support is not always resolved by the provision of funds as barriers to the development of research activity includes clinical services being unable to appoint to clinical posts. Long-term vacancies in clinical services can be an added difficulty for some staff involvement in research. Having a vibrant research culture within an

organisation may help to attract staff but is only one component of recruitment issues.
Q6. Are there any further changes that should be made to improve the efficient delivery of patients to studies through the NRS Networks and Speciality Groups?
Better discussion and data mining between trial centre/companies and the network and speciality groups in the identification of patient groups would be helpful. This is where a more robust feasibility process in the identification of patient groups involving other resources such as the Safe Haven initiative, ISD and patient registers would ensure better delivery of project targets.
Q7. To what extent do delays continue to occur as a consequence of differing NHS and university requirements? To what extent is closer integration of NRS and university functions possible and desirable?
Unfortunately some delays do still occur but these tend to relate to a misunderstanding on the HEI staff understanding of the order of the processes rather than a conflict in the processes in HEIs and NHS R&D. Implementation of future changes should factor in joint training/information distribution to try and minimise this occurring.
Q8. Would a trial register be of benefit to patients seeking trials? Would it be an effective way to partner patients with researchers? Is there a danger that expectations of taking part could be unfairly raised?
The principle of a trial register is positive. However there are governance issues that need to be rigorously addressed at the establishment stage. There is a risk that expectations will be raised in patients that cannot be delivered when patients do not meet inclusion criteria. It is difficult to see how this will be managed at a national level. The added costs (not financial)/benefits of establishing a Scottish Clinical Trial Register need to be established to ensure that this does not 'turn-off' patients entering studies due to poor experiences underpinned by a lack of robust clinical governance.
Q9. Would using electronic NHS patient records to alert GPs to research studies for which their patients may be eligible a service the NHS should offer? Is so, would a process where NHS records are only accessed by identified NHS staff?
This system runs the same risk as the trial register and would need to be carefully managed to ensure it is a positive experience for both the patients and clinicians. Is there a risk that if such systems are in place that trials would become more centralised which would lead to a greater inequity in service as not all potential participants could access central delivery even if they met the entry criteria.

Q10. What proportion of CSO funding should be available for deployment in new research initiatives relevant to the NHS? In what areas should CSO see to disinvest to free up resources?
There needs to be an open, robust and transparent governance process for the identification of new initiatives. This should include the cost/benefit analysis (not only financial) and this would inform the decision making about the proportion of CSO funding.
Q11. Is the focus of the CSO response mode grant schemes adequately defined and understood by the research community? Should there be a narrower focus to complement and avoid overlap with other funding streams Scottish researchers have access to? What is a realistic upper level for CSO grants to allow worthwhile projects to progress?
It would be helpful if the focus was more defined so that researchers could submit more appropriate applications. The upper limit will depend on the discussion about the focus. If the focus remains the same, a limit of £300k may be more appropriate given the nature and complexity of the proposals.
Q12. What should determine the creation and continued funding of a CSO unit? Should any new unit have a plan for CSO funding to be time limited?
The projected service pressures should inform in part the establishment of new Units. If funding is to be time limited then the duration of funding will need to be agreed. The CSO needs to consider if time limited funding may act as a necessary distraction to the establishment of a rich research portfolio with the appropriate staffing.
Q13. Are there other key areas of partnership CSO should be seeking to build?
It would be helpful for there to be greater clarity about the partnership with the innovation agenda.
Q14. Would the creation of a CSO International Advisory Board be a positive step in raising Scotland's research profile and supporting our ambition? What should be the make-up of such a Board?
Although the concept of the establishment of an International Advisory Board is exciting, it is unclear whether this would be successful in reality. Much of the strategy is focussed on strengthening the partnerships with commercial bodies, the potential risk of a conflict of interest between key global leaders and existing or future commercial collaborations needs to be considered.

Q15. Are there any other areas where CSO funded research could be better support to the Health Directorates Quality agenda?
At this stage it would be more appropriate to ensure that the existing areas are successful as evidenced by robust performance measures before further funding is allocated to such initiatives.
Q16. Is the Primary Care Research Career Award scheme suitably focused to attract suitable high quality applicants? If not, what would a revised focus be?
It is unclear why there needs to be two separate funding schemes. Could there be a single Fellowship scheme?
Q17. Do current CSO personal award schemes targeted to meet our future needs? If not, should CSO conduct a wider review of its capacity building schemes?
The same comment applies and a wider review of capacity building scheme should be undertaken to reflect the changing workforce composition.