I should like to record some comments on this document. I think it is a very good broad brush approach in general, and my comments below are not critical but aim to help on some of the specifics.

My general comments are 1. the planned 'Targeted Deployment of Resources' that is a 'top slice' for initiatives is being proposed. Whilst I can see the distinct advantages in this approach, it is important that the cuts to infrastructure budget are not too great to prevent us providing the service to the PIs that we do. The infrastructure budget is very limited. And 2. The desire to be proscriptive and to standardise. This one size fits all approach will disadvantage us as a small Board. Performance metrics are a far better way of monitoring performance than making all R&D the same.

My specific comments are as follows.

Question 1. I do not believe criteria should be set down for the R&D Directorship as this could be too proscriptive, and as these Directors have come from very varied backgrounds and none appear to have failed as yet, this appears a bit heavy handed. Rather the CSO should be invited to sit on the appointment committees thus standardising the quality without being proscriptive. A variety in backgrounds can only be enriching.
I do not think a specific term should be defined as this post has a learning curve, and with three yearly MHRA Inspections a reasonable duration is actually good unless the Director is underperforming. Again a review period could be agreed. We in Tayside do this annually through the Board report. If performance is good then a change does not make sense. To be able to constructively contribute to strategy time is needed in post, a rapid turnover of personal would mean all strategy devolved to CSO, which does need input from those in the field, unless centralisation is the objective?

Question 2. Standardisation across all R&D Departments would be counterproductive as each node provides services unique to it based on the research environment in which it is located. Review of function and metric setting, should ensure that performance is of high standard. As each node has different requirements, with different research strategies it would be detrimental to force R&D into a 'one size fits all'.

Question 3. Worthwhile to explore this

Question 4. This is already happening. It should be remembered that not all research programmes fall within the Networks and that Node support is focussed on eligibly funded studies as stipulated by the CSO. We prefer a more local approach in the node, whereby the top SfS earners meet regularly with R&D as a 'Users Group'. These should probably be minuted in future, but could be rolled out to occur regionally. In this way the needs of the researchers, who are earning the support, are put first. If it is given to the Network and Speciality leads then regional/personal bias can creep in. The PIs who earn the support should have some input into strategy in their region, with, of course, input from the Network and Speciality leads.

Question 5. In Tayside we have nearly fully freed up the resource allocated to researchers, and for infrastructure over the past 3 years and should be at 100% by this time next year. In Tayside we are content that the steps have been sufficient. In other Boards this may not be the case, and allocating the funds directly through R&D might help these less fortunate Boards.

Question 6. Further steps to promote clinical trials. Access to electronic records should be rapid and streamlined, whilst maintaining data protection and patient confidentiality.

Question 7. In Tayside we have an Academic Health Science Partnership which builds on the very strong partnership already in place for the two institutions for research. The R&D Office in Tayside, its governance and management, is dually directed by NHST and UoD. All our process maps allow the PIs to progress through each stage of R&D without institutional block (see website for clinical trials road map). There are no delays in Tayside because of this, and the new Academic Health Partnership continues to work on institutional delays in other areas eg aligning contracts and IT.

Question 8. A trial register has many benefits, not least public engagement. To be successful it would have to be carefully managed so that PI time was not wasted by many inappropriate referrals and patient expectation falsely raised. In principal a very good idea, needs careful thought re implementation.

Question 9. Accessing GP records as escribed would be an excellent way forward as long as patient confidentiality were protected through the safe havens.