COMMENTS ON CSO DRAFT RESEARCH STRATEGY

CHAPTER 1

Q1 Yes; the term should be 3 years with an opportunity to undertake two terms in office as consistent with other similar interface roles.

Q2 There should be more focus on single outcomes; agreements and partner agreed outcomes. As a result some standard activity could be agreed to reduce duplication, but also allow for local and flexible research.

Q3 No. The creation of the NRS general manager post would be considered an additional level of bureaucracy which is not required at a time when finance is very stretched. It is not clear that consideration has been given to the totality of the existing research resource available.

Q4 Yes, formal service level agreements with clear outcomes are required.

Q5 No, the challenges of clinical back-fill remain a significant barrier to research capacity.

Q6 No. There is a concern that the approval does not take a holistic or supportive role with patients, but sees them solely as a research commodity. This lack of personalised approach and medical/academic focussed culture requires to be overcome to increase participation levels.

Q7 It is desirable that a single standardised approach is put in place to achieve success.

CHAPTER 2

Q8 A trial register would be helpful if linked to an engagement strategy to ensure patients are kept informed of local work to manage their expectations.

Q9 It is suggested that this proposal requires discussion and engagement with GPs, local medical councils and national contracting groups prior to development.

CHAPTER 3

Q10 To meet the 20:20 vision research monies should now be focussed on early intervention and prevention. From 2014/15 all research monies should be community focussed and acute based work should reduce over time.

Q11 No, this is a narrow approach and SCO should now focus on H&SC partnership outcomes. The historical focus on Acute/Hospital services does not recognise the outcomes that Health Boards and other Community Care providers seek to achieve.

Q12 CSO unit role and future model should be designed to support national and local outcomes. All work requires to be time limited to ensure sustainability and relevance. It is suggested that a 3 year review is more appropriate.

CHAPTER 4

Q13 The focus on early prevention and intervention requires partnerships to be put in place with H&SCPs, third sector interfaces and independent sector.

Q14 There remains considerable challenges and gaps in Scotland and this should be the primary focus of work. However it is considered that international advice, carefully sought, could assist. The make-up could be split 50% international and 50% Scottish.

Q15 All research monies should be explicitly linked to the quality improvement agenda. This should remain focussed on community work as an early priority.

CHAPTER 5

Q16 The lack of interest reflects current pressures on primary care. The scheme needs to be refocused and further work would be required to identify what would appeal to primary care clinicians.

Q17 A wider review of the capacity building scheme would be helpful.