My response to some of the questions posed in the draft strategy are as follows:

Q1-7: the broad thrust of this is good - thinking about diversity vs uniformity. I am not sufficiently expert to answer the questions any more precisely, beyond making the general positive comment.

More negatively (sorry), despite the importance of this issue, I suppose I was a little surprised that R&D Support was the first area covered in a strategy document when Scotland and the rest of the UK is faced with such major challenges in terms of the health of its population and the 'austerity' faced by the NHS currently and going forward.

Q10: it is hard to recommend a fixed % for resources to be allocated to new initiatives. It might be better to indicate to the research community what these areas are and that more will be allocated to them depending on number and quality of applications received, and then work it 'at the margin' (i.e. disinvest in other areas accordingly). That way, each will find its level.

Areas for me would be;
- managing scarce resources in times of austerity. What are we doing research-wise to help the system do this? More of a management agenda, but then again we perhaps do too little to inform good system management as opposed to clinical research.
- community based interventions and initiatives for health improvement. The elephant in the room alongside all the wonderful clinical research we do is persistent and widening health inequalities. The same applies to public health research, whereby we seem to have reached the limit of individual risk-factor based interventions. The cutting edge would seem to be more complex communities in which people live their lives. But we are doing very little evaluation there.

Q11: likely the focus is indeed not specified clearly enough. However, my experience is that it needs to be broader not narrower and that the awarding panels do not really understand issues such as those above, and the research methods required to address them.

Q12: the units were a great initiative and have been remarkably resilient over time (reflecting what a great idea they were in the 1980s). However, it is an interesting question as to whether such funding should remain in perpetuity or in its current form and, of course, whether new ones should be created. In assessing the units, the usual questions apply: is there a major social need? Are the units performing well with respect to the usual badges of research income and outputs? Perhaps an extra level of requirement is to ask whether they possess world class researchers (which surely we would wish for our units)? I think we need major units in HSR, public health and health economics (not sure about hearing). But I am not convinced they address major issues of the day (see response to Q10, for example, as well as more suggested below) or why we need two public health units, two HSR units. Clinical research is best conducted in networks and I would recommend that that is what is now considered as a way forward for units - that national networks of researchers be created in the main areas of HSR, public health research and health economics. The units could still exist at their host universities, and likely lead the networks. That way,

they could likely also retain (most of) their funding. But certainly if more were to go into 'units' the extra could go to the network elements.

New areas for units? Well, we need some sort of move away from labs and clinical environments towards communities (again as indicated above). This is reflected in policy moves to health and social care integration and a greater role for the Third Sector, but the research agenda does not seem to be following or supporting.

Q14: international advisory board. The key issue here is purpose? Why would we wish to create such a Board? It may be good for a one-off overview of the CSO landscape, new directions etc, but would otherwise, I suspect, have a limited shelf life.

Q15: on supporting the quality (and safety) agendas. My view is that Scotland has to 'do its bit' here, but really this just leads to 'me-too' work which does not make Scotland as distinctive as it could be. I would also say the same about any stratified medicine agenda - which, although good to have a health economics agenda attached to it, the benefits to patients are not 'obvious' as stated in the draft.

Q16: primary care. I was somewhat dismayed to see this. We've been wrestling for decades about what to do about primary care research. I'd ask whether we've reached the limits here and wonder why it could not just be rolled into an HSR network as suggested above. As with many other clinical areas, what is required is to open up the research agenda to a wider range of people and disciplines than the clinicians themselves.

Q17: I'd need to see a list of personal awards made, but my impression is that it is too focused on the clinical agenda and does not cover areas of major social challenge as indicated above. To
repeat and add:
- managing scarce resources in times of austerity. What are we doing research-wise to help the system do this? More of a management agenda, but then again we perhaps do too little to inform good system management as opposed to clinical research.
- what are the values the community would wish to adopt in addressing the austerity agenda in health and social care? This is about empirical ethics and it's interface with areas like health economics.
- community based interventions and initiatives for health improvement. The elephant in the room alongside all the wonderful clinical research we do is persistent and widening health inequalities. The same applies to public health research, whereby we seem to have reached the limit of individual risk-factor based interventions. The cutting edge would seem to be more complex communities in which people live their lives. But we are doing very little evaluation there.
- how can be better engage and evidence the Third Sector?

I hope these comments are helpful and look forward to the next draft of the strategy.