Question 1: 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 term, and if so what term would be appropriate?

Without having a better understanding of the role I cannot offer any eligibility criteria. But to attract someone of calibre you will need to assign a 5 year term, minimum.

Question 2: 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 local flexibility?

In general, devolving this will be preferable as the local teams will have a much better appreciation of the needs. However, this runs the risk of losing control. One solution would be to set a flexible framework for functions, with R&D offices having to justify variance from these. This will give a balance of subsidiarity vs control.

Question 4: To what extent should the joint planning of the deployment of infrastructure resources be formalised? Should there be a formal record of such discussions?

Given that you wish to change behaviours, this request will help. It could also be part of the process that you abandon once the process is underway effectively.

Question 6: Are there any further changes that should be made to improve the efficient delivery of patients to studies through the NRS Networks and Specialty Groups?

Does Scotland have patient registries for the major disease categories, including dementia? Having these available can help patient recruitment, An average centre recruits about 0.5 people/month to an AD trial, which is very low.

Question 8: 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?

This is an excellent idea but you may need to broaden the range of media you use to publicize it. ARUK have a phone line where people who call with an interest can be readily directed to the appropriate information sources. Of course, there is a danger of raising expectations but without having ready access to patients the numbers of trials conducted in Scotland will not be high.

Question 9: Would using electronic NHS patient records to alert GPs to research studies for which their patients may be eligible be a service the NHS should offer?

This could be a very efficient way of increasing patient awareness.

Question 11: 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 is very difficult to cherry-pick the types of research that might be productive. The use of researchfish, which is commonly used, does not measure well if the research funded has the potential to, or has, provided patient benefit, as opposed to researcher benefit. I would advocate increasing the maximum funding allowed to £400,000. ARUK's top limit is currently £2million, for comparison.

Question 14: 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?

Very much so. At ARUK, we have recently formed an IAB and it enables us to get a better global perspective and moreover the IAB's networks have been useful in facilitating increased global interactions.