

Funding and Provision of Support

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Allocation of Funding

the principles (1)

- Support is directed to where it is needed
- A dynamic system which reflects changes and growth
- Necessary and sufficient funding to support the studies on the Portfolio
- Infrastructure support through the NIHR Networks
 - Direct research costs should continue to be supported by research funders
 - Excess treatment costs the responsibility of the commissioning bodies
 - More clarity being provided (ARCO)

Allocation of Funding

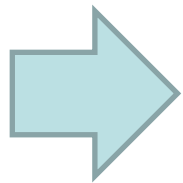
the principles (2)

- There to provide a standing infrastructure to support Portfolio work
 - Need pragmatic solutions
- NIHR infrastructure support comes from a variety of sources:
 - CLRN
 - TCRNs/PCRNs
 - Experimental Medicine Facilities
 - Flexibility and Sustainability Funding

Budget allocations to CLRNs

- The development of the 2009/10 funding arrangements has been, and continues to be an iterative process which presents **an interim solution for one year.**
- 2009/10 funding allocations incorporate :
 - core team
 - fixed per capita allocations, includes key service support
 - historic adjustment (2009/10 only)
 - **plus an activity driven element**
- **Activity driven element** – patient accrual used as surrogate for activity. Retrospective data used to inform overall allocation. Locally this data can inform 9/10 funding but should NOT be used as the primary driver for 9/10 CLRN budget planning

- Model builds on 2008/09 arrangements but includes 2 key refinements :
 - considers complexity
 - utilises actual activity data held on the national database.



- **Genuinely activity driven and informed by real study costs**
- **Positive development – all CLRNS have received more than 2008/9 allocation**

- Complexity bands:

- **Interventional**

- **Observational**

- **Large scale high accruing**

- Large (per patient allocation)

- Very large* (n~12) dealt with individually via national contingency

*current indicative allocation does not cover funding for this activity

- **Outliers / Complex**

- National contingency available to cover additional costs

- **Activity data**
 - April – October 2008 Accrual
 - Active drive working closely with CLRNs to collect outstanding accrual successful – substantial increase
 - All activity information received at 6 Jan 09 incorporated in allocations (even if input manually)
- Limitations of data are recognised but measures have been put in place to address these

Adjustments applied to address limitations

- Actual activity data uplifted to represent full year effect
- 20% uplift to account for pipeline studies
- Additional provision for CLRN contingency
- Adjustment based on historic activity - addresses issues, such as follow-up, for historic activity which may not be reflected in the current activity data.
- Plan to re-run model using current data throughout 2009/10
- National contingency

Allocation of support by CLRNs (1)

- CLRNs differ in their compositions and have different models for allocating resources
 - Devolved to Trusts (but actively managed)
 - Centrally-managed pools of research nurses and other research professionals
- Takes into account where Portfolio activity is taking place
- Apply local considerations about what is actually required
 - Complexity of studies
 - Level of support from other sources
 - Discussions with TCRNs/PCRNs where CLRN resources are being directed to these areas
 - Follow-up
 - What's current, what's in the pipeline, turnover

Allocation of support by CLRNs (2)

- Clinical sessions and research nurses
- Other Service Support
- Key Service Support
 - Pharmacy, imaging, radiology, pathology
- Priority areas and non priority areas
- Local contingency (up to 20%)
- Use of Resources agreed by the CLRN Board
- Annual planning cycle
 - Outline Use of Resources and Business Plan (March)
 - Annual Report and Year End Financial Return (June)
 - Mid-Year financial review (Oct)

Accessing support through the NIHR CRNs

- Only for Portfolio studies
- Registration through CSP allows for sign-off by CLRNs and planning (mandatory from 1 April)
- Early discussions with CLRN senior management team are recommended
 - Local Specialty Group Leads
 - Individual Trusts
 - Local TCRNs/PCRNs
- Access to infrastructure support (not a per patient fee)

Multicentre Studies

- Approval through CSP has huge advantages
- Developing concept of a “lead CLRN”
 - “One stop shop”
 - What elements can be supported by the Networks
 - Costings (template)
 - Manage process across the other CLRNs
- Specialty Groups
 - Early feasibility checks
 - Identification of PIs and new sites
 - Oversight of recruitment

Summary

- A huge change
- Made a good start, ongoing development
- Funding is ear-marked for research and needs to be accounted for
- A dynamic system with incentives
- Visibility of funding requires clarity and communication
 - Researchers, Funders, Networks and Trusts need a clear understanding of what support can be provided by Funders and by the Networks
- Balance between national consistency and local ownership
- Pragmatic solutions to support a sustainable research infrastructure in the NHS
- Will take time to achieve