Joint Clinical Research Board

Wednesday 15th June 2022
MS Teams

Present:

Sven Bunn (SB)
Alistair Chesser (AC)
Coleen Colechin (CC)
Panagiotis Deloukas (PD)
Steve Ford (SF)
Deanna Gibbs (DG)
Nick Good (NG)
Ginette Hoare (GH)
Hemant Kocher (HK)
Gerry Leonard (GL)
Nick Lemoine (NL)
Jo Martin (JM)
Anthony Mathur (AM)
Jo Morgan (JMO)
Steven Newhouse (SN)
Neeta Patel (NP)
Rupert Pearse (RP) - Chair
Julie Sanders (JS)
Fiona Walter (FW)

Apologies:

William Ajala
Melissa Anderson
Mark Caulfield
Nikolaos Donos
Sharon Ellis
Richard Hooper

Agenda Item	Action
1. Minutes and Actions from the last meeting. Rupert Pearse (RP) welcomed everyone. The draft minutes of the last (JCRB) meeting were agreed. Actions from the last meeting were noted as follows: (i) NG & GL to provide an update on policies review. NG reported that the Joint Policies had been approved for Barts Health in March. They were still awaiting approval on the Queen Mary side with issues not so much about the policies themselves but around possible additional research-related, but not joint policies, that some people appeared to wish to append. At this stage of the meeting CC, who had been dealing with this side of the approval, was not present. RP said he was happy to take this up, and then JM offered her services in unblocking any block as it was agreed that the policies as they stand need to be agreed by Queen Mary as soon as possible so this review exercise can be concluded. **ACTION:** NG to inform CC of JM's offer to speak to someone in Queen Mary about the Joint Policies. (ii) GL to contact Chris Laing the new CEO of UCLP to discuss the BH-QM MOU. Then GL to work with him, QM and BH representatives and SHB to review the MOU. NG to put this item on the Agenda for the next JCRB meeting.	**NG/CC/JM**

GL reported that the meeting had not yet taken place but is being chased up. NL said that it is in the interests of all parties that this is actioned. RP said that if there are continued delays he is happy to escalate it within UCLP. (iii) RP and NG to discuss setting up a working group on research activity with membership as noted. RP reported that this has taken a different direction due to the Research Restart work and a new strategic focus on sites (ie, a change of change players). Work has begun on new appointments and timelines. One of the soon-to-be-appointed deputy CDs will be taking the working group forward. (iv) SE to meet with MC, MP, AC and RP to look at pulling together a joint research strategy meeting (or meetings). NG confirmed that SE had sent her apologies for this meeting. RP said that although this meeting has yet to happen, he was aware that the work on this had started, and he was sure this would return for discussion in due course.	
2. Data core update RP introduced SN to give an update on the development of the data core. SN thanked RP and introduced himself as Deputy CIO and this area of work. The Precision Medicine Programme has 4 stages of development: • Establishment of integrated data core and data access service to provide access to research-ready NHS data (Parts 1A/1B) • Integrating patient data with expertise in multi-omics, AI, and imaging to develop risk models and personalise screening (Part 2) • Innovative approaches to disease prediction and prevention (Part 3) £6.7million investment was awarded by Barts Charity in January 2020 to cover Parts 1A and 2. A team was recruited in the summer of 2021 but only now coming up to strength. The plan is to bring together and integrate information and research governance systems in a way that delivers patient and public confidence through a secure environment. Subject to additional funding the Precision Medicine Platform is due to be implemented in July 2023. RP thanked SN and asked if there were any questions. FW asked how primary care fits into this. SN said that primary care counted as “other data” outside of Barts Health hospital data (it not being Barts Health data). It could be brought into scope subject to agreement. SB said that in principle we’re very keen to integrate other services, such as primary care, but various data protection issues would need to be worked through, case by case. RP said that primary care is a key stakeholder in this work and he was grateful for to work that Charles Gutteridge and others have done on this. FW said that we are in danger of missing an opportunity as being able to access and use primary care data is very important. RP said that primary care is a topic continually at the top of the agenda in this area. SB said that he would not wish to seem negative on this and	

in the short to medium term help is being offered to particular projects. SN wished to stress that the challenges in this area are technical governance ones and that the team are working on them. RP asked if the data core has a proper name. SN said at present its working title is the Precision Medicine core. RP thanked SN for this excellent presentation. He recognised the ongoing work of his team, tackling various difficult data-related issues over the next 12-18 months.	
3. Barts Health – Queen Mary clinical research MOU Noting that this work is ongoing, from Actions, RP asked if GL had anything further to add. GL said that he had a related item for AOB but nothing further to add on this at present.	
4. NIHR portfolio research reset GH reported that, in a response to ongoing challenges the UK had experienced regarding research delivery, the Dept of Health had launched the Research Reset programme. The aim of this is to understand delays, establish more realistic delivery targets or close now unviable studies. Studies fit into three categories where sponsors need to act. In mid-May, we received a list of 64 QM- and BH-sponsored studies. More information has been requested and processed on each and a response sent back to the NIHR. Only two studies here are definitely being closed, others are either fine or under further review. This is becoming an ongoing process and four additional studies have already been flagged up. In response to this, it has been agreed that an ongoing review committee was needed, and this has been established. RP thanked GH and the team for their hard work on this. Apparently, 40% of NHS Trusts have yet to respond to this request so Barts' engagement is much appreciated. NL added his thanks and said that nationally there are 6.5k studies on the NIHR portfolio, two-thirds of which fit into one of the review categories. People think that these 'zombie studies' are not a real problem but, in reality, they are taking up resources that should be actively employed. He said that in the future R&D offices need to be more robust about sponsoring studies. RP agreed and said it is very important that our portfolio is up-to-date and accurate. The team has discovered that most of our issues appear to relate to incomplete data, rather than lack of activity but the small number of exceptions (real zombie studies) do take up a disproportionate amount of work. He stressed that all CIs need to respond swiftly to requests and work with the JRMO. NL raised a concern that studies were being re-reviewed by the JRMO which would make the current log jam worse. RP said he was not aware of any systematic study re-reviews or amendments ongoing. GH said there was no such review in hand. although the JRMO is involved in ongoing data updating and cleansing so that may be seen as a review of sorts by some. Finally, RP thanked GH for her wider paper on accrual, noting it was good to see that we are doing so well but there was still space for improvement and to grow activity over the next	

few years. He recommended that everyone study the paper that had been circulated in advance of the meeting.	
5. CRF bids update RP said he had given a fairly detailed update to the last meeting. The team had still not signed off on the specification for the new CRF as there were details around access to be resolved. Sign-off is imminent however with a target for set-up by September 2024, subject to funding. Barts Charity is being very supportive, running workshops with potential funders, and this should yield results. An advert for a full-time Clinical Director for the CRF will shortly be going out, open to internal or external applicants in any speciality. Commercial partnership discussions are at an advanced stage, making good progress. There is a lot to do but it is all broadly on track. There were no questions.	
6. A.O.B. (i) **Proposed CRN change.** GL reported that AC had received a letter announcing that the next round of CRN awards would be based on London having two CRN: North and South. This would mean change for us in terms of losing Essex and Herefordshire but combining with North West London (currently run by Imperial Healthcare). The outline application process for hosts will begin in the autumn, going operational in April 2024. NL commented that this change is part of an ongoing NIHR restructure to correlate networks with NHS regions and social care provision. This is probably good news for London. What the function and purpose of the news Networks will be is still to be agreed upon over the summer and made clear before applications are sought in October. The process will inevitably cause tensions with competition from Imperial, UCLH and others. RP thanked NL and said that Barts' participation is a discussion still to be had, although hosting the network had helped shine a light onto East London issues. AC said that the idea of a north-south London split made a lot of sense. Whether we bid again is a matter for review both internally and in collaboration with other local Trusts. To that end, it would probably be a good idea to get key players together in July. RP asked NG to get a date in diaries for late July. He and GL can suggest relevant players. **ACTION**: NG to work with RP and others to set up a meeting to discuss the Barts Health strategy for a new CRN bid. GL asked if this change in the area might have an impact on UCLP and the MOUY situation. NL felt that there was no direct causal link between UCLP and the CRN	**NG, RP**

so the works should still go ahead. RP agreed that we would need to know what UCLP thought about how any change could impact it.

(ii) **Clinical Director of R&D and related matters**

RP announced that he has been reappointed as Clinical Director but with a new remit. It is a real change as it aligns with other roles and structures. The new set-up will have clear interactions with infrastructure. Existing successes will be continued but the wish is to grow research and make delivery improvements. The CTU strategy is to be refreshed and a leadership team will be created, of Deputy Directors 3 x 0.2 FTE (although the actual number of people in post will depend on applications). Adverts for these posts are imminent. Posts will not be specific to clinical areas but general and task-based.

JMO asked how this related to the current clinical board leads. RP said that clinical boards are changing and so research leadership there may change, with some moves to site and facility research leads taking a more active leadership role with strategic direction. The proposed Deputy CDs would need to work with sites and specialism leads to develop more equal partnerships.

NL expressed concern that a move to site input risks losing clinical leadership expertise. RP said that it all depends on what happens around the clinical boards. He was about to write to all the board research leads to seek their views on possible changes.

AC said that the current thinking is that, except for Barts Hospital-based research activity, the clinical board structures are not working well. Whilst there is no wish to lose such cross-site strengths that exist, there is a need to better engage sites in research as a key driver to better clinical care for patients. It is possible that clinical boards could survive but become NE London clinical boards, wider than just Barts Health.

RP said that what comes out of these discussions should be a stronger research leadership structure; there is no desire to lose existing expertise. There were no further questions on that.

RP said that finally, given the importance of the JCRB going forward, he could announce that AC and Mark Caulfield (MC) had discussed the governance framework and agreed that in future they would jointly chair the JCRB and that it would be merged with the Trust Research Board (which would cease to exist forthwith). RP said that he would be operationally overseeing the work of the JCRB assisted by NG. There was agreement this would be a useful move to strengthen oversight and clarify responsibilities.

NG asked if, taking account of there being fewer board meetings overall, the JCRB should return to quarterly meetings. This was agreed.

ACTION: NG to adjust planned JCRB meeting times: Cancelling future BHRD meetings and reissuing JCRB appointments on the basis of quarterly, at times suitable for AC and/or MC.

7.	**Next JCRB meeting:** **T**BC September 2022	
8.	**Summary of forward Actions**	
(i)	NG to inform CC of JM's offer to speak to someone in Queen Mary about the Joint Policies.	**NG**
(ii)	NG to work with RP and others to set up a meeting to discuss the Barts Health strategy for a new CRN bid.	**NG & RP**
(iii)	NG to adjust planned JCRB meeting times: Cancelling future BHRD meetings and reissuing JCRB appointments on the basis of quarterly, at times suitable for AC and/or MC.	**NG**

NG
June 2022