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DEPARTMENT OF HEALTH

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Telephone 071 210 3000
From the Secretary of State for Health

13 SEP 1990

Dear Barry

file with AT,

CLINICAL RESEARCH CENTRE

Thank you for your letter of 31 July, requesting a copy of the interim report of the Steering Group, set up to consider the proposals to close the Clinical Research Centre (CRC) at Northwick Park. I enclose a copy of that report, as requested.

You referred in your letter to comments you had received about higher costs which might result from the closure of the CRC. As you know two factors were influencing the MRC's approach to the closure of the CRC -

a. advice from the Stoker and Nicholson Committees that the performance of the CRC was not providing the right value for money for a high recurrent investment. (There is a PAC interest here). The public knowledge of the scientific judgement on the CRC by these two Committees is also further adversely affecting recruitment and retention at the CRC.

b. concerns that effective clinical research needed to be more closely associated with basic science, and that without a further strengthening of basic science in an environment with a high level of specialty work the Royal Postgraduate Medical School at Hammersmith was likely to become less attractive to clinical researchers and could lose its prominent European position. The RPMS is the only postgraduate medical school within the UK. It focusses on advance training of specialists in clinical research and has global links.

When the Prime Minister met the Secretaries of State for Health and Education and Science on 28 November it was agreed that "the right policy was to disperse the greater part of the work of the CHC to other centres of excellence in regional centres" in order to "meet the joint objectives of focussing scarce research funds on key individuals and of limiting costs". However, before any decision could be taken to vacate Northwick Park's research facilities it was essential to identify the optimum means for redeploying the facilities and resources released at Northwick Park, taking account inter alia of the need to disperse a greater part of the work to regional centres of excellence. Subsequently a Steering Group was established, with the Prime Minister's agreement, to oversee the preparatory work by the MRC and the Regional and District Health Authorities and to seek to ensure that there would be satisfactory progress towards an orderly withdrawal, minimum disruption of NHS services, the effective continued use of the CRC buildings and ancillary facilities, and compatibility with national and local service and research strategies.

The first, interim, report of the Steering Group notes that the pattern of research at Northwick Park Hospital is changing (fewer than 50 of the 160 "national beds" originally designated for research purposes are now so used). It comments on the work being done by the MRC and by the District Health Authority with CRC managers to plan for future changes including dispersal of CRC divisions to centres around the country. The possible future occupation of the CRC building continues to be a key element and exploratory discussions are under way with a number of organisations who might be interested. (Incidentally, the Royal National Orthopaedic Hospital is now unlikely to be a candidate). More work needs to be done before a final report can be put forward and at a meeting on 22 August the Steering Group arranged for further reports on the cost implications for the DHA, and the alternative use of the CRC building, to be available at the beginning of October.

In parallel, the MRC had been asked by the Advisory Board of the Research Councils (ABRC) to rethink their proposals for securing better value for money in clinical research so as to reduce the initial capital costs of their initiative and secure the dispersal of a higher proportion of the CRC work to regional centres. This they have now done and the result is a scheme which is significantly less costly than their previous one which involved the establishment of a new national centre for clinical research at Hammersmith (£100m at 1988 prices). The MRC's revised proposals are more costly than the original tentative estimate available last November (£15m to £20m) but they are clearly focused on carrying forward necessary developments in particular areas of clinical science. The initiative now proposed would devolve the greater part of the work to eight provincial centres of excellence, with some 30 per cent of the work going to Hammersmith, the latter being complementary to and reinforcing the excellent research which has given Hammersmith its international reputation.

The ABRC gave these revised proposals top priority against other competing demands on the Science Budget, and asked the Secretary of State for Education and Science to make additional allocations to the MRC of £16m over the 1991-92 to 1993-94 PES from within existing PES provision for the Science Budget. This would cover about half of the £33m which the MRC estimated as the overall additional capital costs of implementing its plans to develop clinical research at dispersed centres of scientific excellence. The ABRC advised the Secretary of State to release this £16m from unallocated provision within the Science Budget baseline. This would leave the MRC to find any additional cost which it chose to incur above that level from its own baseline in the light of its judgement of its overall scientific priorities. The MRC has drawn up plans for implementing and phasing the initiative within this financial framework and will submit an investment appraisal. This, together with the final report of the Steering Group, will enable the Secretary of State for Education and Science to decide his response to the ABRC's advice that the Government should endorse the MRC's proposals which both bodies have clearly signalled as of such a high priority as to be met from within the funding levels which the Government has already decided for the Science Budget.

Neither the Steering Group (which meets again in October) nor the DES have yet reached firm conclusions though they are working through the financial, service and research implications of the developments at Northwick Park, including the continuing recruitment difficulties at the CRC and the related scientific future of the RPMS at Hammersmith. Further reports are due to be made to the Secretaries of State in the Autumn. These would be followed by a report to the Prime Minister.

I am sending a copy of my letter to Stephen Crowne at DES.

Yours,

Helen.

HELEN SHIRLEY-QUIRK
Private Secretary

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CLINICAL RESEARCH CENTRE STEERING GROUP - FIRST REPORT

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CONTENTS	Section

Appendices

July 1990

INTRODUCTION

1.1 The planned closure of the Clinical Research Centre (CRC) at Northwick Park Hospital (NPH) has wide-ranging implications for the provision of health services in Harrow health authority. In order to oversee the action being taken by the research and health authorities, a Steering Group was set up under the chairmanship of the Department of Health with representation from the MRC, North West Thames RHA, and Harrow HA. DES also attended meetings.

1.2 The steering group's terms of reference were:

> " Provided that satisfactory progress can be made on the issues to be addressed by the SG listed below, the aim is to move towards the closure of the CRC and dispersal of its work by December 1994.
>
> The SG will accordingly oversee the action being taken by the research and health authorities to achieve a withdrawal form the CRC facilities at Northwick Park Hospital. They will report periodically to Ministers and the Chief Executive on progress being made to secure :-
>
> - an orderly withdrawal;
> - minimum disruption of NHS service;
> - the effective continued use of the CRC buildings and ancillary facilities; and
> - compatibility with national and local service and research strategies.
>
> The SG would make its first report to Ministers and the Chief Executive by spring 1990, and aim to make a further report by autumn 1990."

1.3 This is the steering group's first report to Ministers. A further report will be made in the autumn.

CLINICAL RESEARCH CENTRE (CRC)

2. Background

2.1 In 1959 the Medical Research Council (MRC) reviewed the ways in which it was supporting clinical research. It concluded that it should bring together a concentration of relevant clinical research departments within a district general hospital. The hospital would provide a normal range of services to a community while the centre would make intense study of disease. Patients would be admitted to the

centre because they needed special investigations or complex treatment.

2.2 The centre, sited next to the new district general hospital at Northwick Park, was purpose-built and opened formally in 1970. The accommodation was divided into district hospital wards and service departments, purely for patient care; national wards, for patient care allied to laboratories concerned with clinical assessment (160 of the hospital's 860 beds); research laboratories and offices; ancillary accommodation in support of research (animal house) or patient care (residential accommodation for nurses) or for shared use (library, social club). A diagram and a map of the site are attached at Appendix 1.

3. Research Activities

3.1 Among the first divisions to be established were Anaesthesia, Cell Pathology, Communicable Diseases, Hospital Infection, Immunology, Metabolism, Haematology and Radiology. The latter two were primarily hospital service sections headed by NHS staff who also held some MRC sessions. MRC staff played some part in the provision of clinical service. Close links were planned with hospital departments. In some cases these have never developed as hoped, in others they have been retained, in others they have been gradually discontinued as the research organisations responded to different pressures placed upon them.

3.2 Over the last 10 years, there have been significant developments in the basic sciences related to medical research. The CRC has tried to strengthen its scientific base and been concerned to develop Molecular Biology, Cell Biology, Biochemistry and Immunology. In addition other areas of research have been established, most recently Molecular Medicine, Vascular Biology and Haemostasis.

4. Current Position

4.1 The CRC consists of some 30 research teams with approximately 400 staff of whom about 130 have scientific appointments. Some 40 of these scientific staff hold honorary clinical appointments with Harrow Health Authority. Half of the total staff are in the research support category; administration, secretarial and maintenance staff make up the balance. The revenue funds available to the CRC in 1989 from various sources (predominantly MRC) were £12.5M and an additional £1M for capital equipment.

5. Relationship between CRC and NPH

5.1 The NPH and the CRC have developed in parallel over time and the relationship between the two is complex. It has also changed since its inception, for example, **less than 50**

of the 160 national beds are now used for their original purpose. Beds for research in obstetrics and gynaecology (50), infectious diseases (10) and a special care baby unit (5) are no longer used for research purposes and measures introduced within NPH to contain revenue expenditure have meant that different service specialties now use the majority of the original national beds.

5.2 There has always been some clinical service spin-off from CRC research activities to Harrow HA. Of the 36 or so research teams in the CRC, about a third provide some clinical service to NPH. The level of service commitment varies considerably between specialties, from almost total consultant support in endocrinology (1.5 posts) to relatively minor components of other specialties. Overall there is participation in on-call and admission rotas, and specialist advice and support is given both to patients and NPH clinical staff.

5.3 Support services in a number of areas are provided to NPH by the CRC. Clinically these include a diagnostic service in immunopathology (wholly reimbursed), some support in nuclear medicine and minor support for maintenance of a blood gas analysis service (partially reimbursed) and in diagnostic electron microscopy. Non-clinical suppport includes shared use and funding of the John Squire library and the department of medical illustration and photography, specialist requirements in bioengineering and computing as they arise, and a stores service for laboratory items (see also para 8.2 and Appendix 5).

5.4 Under a cross-accounting arrangement with (NPH), the CRC pays £1.2M in respect of a range of services eg heating, lighting and the grounds. In turn, NPH pays £0.5M to the CRC for the shared use of the Library, Medical Illustration and reimbursement of some services.

REMOVAL OF CRC FROM NPH

6. Background

6.1 In 1984, a committee was set up under Sir Michael Stoker "to examine the remit of the CRC". This resulted from a growing feeling that it was not succeeding in fulfilling the role that had been hoped of it. The committee recommended a fuller report. The further committee, again chaired by Stoker, made a number of criticisms of the CRC. These included:-

a) the absence of major specialist units, such as those for kidney transplants, had restricted the development of scientific work at the CRC

b) the links between the senior staff of the CRC and those on the NHS side were not "as strong and

influential " as those between the academic staff of a medical school and its associated hospital

c) there was a lack of cohesion between the CRC and the hospital and indeed a growing divergence of the two populations of staff

d) despite the efforts of the director to link clinical with basic research, the committee felt that more was required, to create a "solid body of freestanding basic science".

6.2 The Stoker Committee concluded that the CRC had failed to establish itself as a major force in clinical research in Britain.

7. The Clinical Research Initiative (CRI)

7.1 The MRC accepted the recommendations of the Stoker report in 1986. A further committee, representing all the interests concerned and chaired by Sir Robin Nicholson, developed further the Stoker proposals for a new initiative. Subsequent discussions have retained the aims and objectives of the original proposals but have substantially modified the plans for their achievement to give rise to the present CRI. As a response it developed the CRI. The CRI aims at the convergence of multidisciplinary research in clinical and biological sciences with clinical practice and with teaching. Its aims are accepted by both DES and DH. The specific objectives are:

a) to apply the recent major advances in basic biology to clinical medicine;

b) to achieve this by bringing together outstanding basic and clinical scientists in teams large enough to enable them to collaborate and exchange ideas, information and discoveries, to avoid the problems of isolation, and to share sophisticated equipment and facilities;

c) to integrate research with teaching so that researchers can identify and attract the most talented recruits and train future researchers, practitioners and teachers to propagate the new techniques to other centres;

d) support this research in an appropriate clinical environment where:

* potential diagnostic and therapeutic advances can be clinically evaluated and introduced into practice;

* an appropriate balance can be maintained between the claims of service and research;

* high priority can be given to the clinical relevance of the research programmes in which all clinicians can be encouraged to take part.

7.2 The MRC believes these aims would best be met by developing basic and clinical research in a number of major centres - at the Royal Post-Graduate Medical School (RPMS) and at provincial sites - adopting a distributed approach and building on existing strengths, a view which has been endorsed by the ABRC. The greater part of the CRC resources would be redeployed to centres of excellence in the regions both by relocating existing teams and by investing freed resources in new ventures. The CRI also includes plans to strengthen basic biomedical sciences at the RPMS so as to provide a stronger infrastructure. **The intention is to release 60% of the CRC's posts by bringing to an end programmes that cannot usefully be relocated. The equivalent of 280 posts (of which 180 would be vacant) together with recurrent costs would be allocated to provincial sites, and approximately 120 posts (including 40 vacant posts) to the Hammersmith site.**

7.3 The MRC has established a number of working groups to take forward the scientific planning. These will aim to ensure the evolution of cohesive research programmes which build on the strengths of teams at the CRC and the complementary interests in the Universities.

7.4 The CRI will be firmly embedded in the university structure. In some instances (Cambridge, Edinburgh, Glasgow and Hammersmith) they are the product of joint discussions with institutions where there is already a large MRC presence; in others (Birmingham, Cardiff, Newcastle, Nottingham, Southampton) they need more exploration and concerting of ideas with the universities concerned and some plans will be realised sooner than others, depending on their scale, the resources required, and their state of development.

7.5 All are in line with the chosen priorities on which the MRC and its Research Boards have set their sights, and with their preferred means of attaining them, such as concentrating new or liberated resources where promising developments are already occurring or in prospect, or inseminating clinical departments with skills in basic science, or providing the means to set up new collaborations - linking basic and clinical sciences - either between centres or between departments within centres, or improving training and careers for clinical research workers. Appendix 2 gives a detailed summary of scientific plans in tabular form. A provisional timetable is at Appendix 3.

7.6 **The MRC's plans address the need for an orderly withdrawal from NPH - a key aspect of the steering group's terms of reference. Harrow Health Authority believes that the MRC**

timetable will enable them to adjust to the consequent changes in the pattern of service provision locally. The detailed implications are considered in the next section.

IMPLICATIONS FOR THE NHS

8. Services

8.1 Appendix 4 details the main clinical services to Northwick Park Hospital to which the CRC contributes. These services can be divided between:-

a) **Essential district or multi-district services** (with a limited research component) - notably anaesthetics. Alternative provision for these services would have to be made at NPH.

b) **Services provided at NPH by virtue of CRC research presence,** for example immunology, endocrinology and psychiatry. These services have mainly developed because of the research interests of CRc staff rather than the service needs of the HA. Over time, however, the hospital has come to depend on them.

c) **Services to other Regions, with a small Harrow HA component,** notably juvenile rheumatology and hypogammaglobulinanaemia.

8.2 The CRC also contributes support services for both clinical and general activities. Clinical support services to which a contribution is made include electron microscopy and radioisotopes. Non-clinical support includes bioengineering and medical illustration. Appendix 5 lists these services.

8.3 NPH is drawing up a business plan to guide its future development. Against a background of this plan, the opportunity presented by the CRC withdrawal gives Harrow HA a chance to review the current service interactions and options for future delivery. It is possible therefore that the future picture and pattern of service could be different from the present as it would be a lost opportunity merely to replicate the existing CRC input without thorough examination. For essential services - para. 8.1(a) - the HA is assessing current provision and exploring options for replacing the CRC input which could lead to a more efficient and effective service. CRC-inspired services - para. 8.1(b) - will also be reviewed to see whether they should continue to be provided at NPH or whether it would be better to secure them from another provider. Support services are being similarly assessed in the light of the hospital's business plan.

8.4 **The HA considers that in time the problems attendant on the CRC closure can be overcome. To ensure that the hospital's**

planning dovetails with the CRC closure proposals, a joint CRC/NPH group has been formed with strategic, operational, finance and personnel representation. The success of this group will be vital to minimising any disruption to services at NPH. The steering group will keep in close touch with this work but believes that the day to day progress is best left to NPH and the CRC.

9. Costs and Savings

9.1 The cost implications of the CRC withdrawal relate to:-

a) clinical services and support services - replacement costs;

b) site services support;

c) one-off costs; and

d) funding from the Department of Health (£7.8 million in 1990-91) in respect of the costs to the hospital of the clinical research conducted at the CRC.

A study by Deloitte, Haskins and Sells last year suggested net savings to Harrow, but further examination of their assumptions suggests that their findings must be reconsidered. The HA is currently undertaking a rigorous analysis of the full cost implications of the withdrawal of the CRC. The future of site services will be resolved first and discussions will lead to conclusions about clinical services. The HA believe that it will be simpler to resolve the position of support services once a view has been taken about their future configuration.

9.2 The future of the direct funding from the Department in respect of the knock-on service costs will depend on the timescale for allowing Northwick Park Hospital to adjust to the CRC closure and the nature of any research activities which continue at the hospital thereafter. The Department of Health will be discussing the question of direct funding with the HA. As a preliminary, the HA is identifying the nature of the costs involved. The Steering Group will be kept informed of progress.

ALTERNATIVE USES FOR CRC FACILITIES

10.1 The main CRC facilities are designed as highly flexible research accommodation. They are not of the optimum configuration for conversion to wards because two rows of structural columns in the main block dictate the width and positioning of a corridor down the middle. Potential occupants with a requirement for laboratory, office and special service space with whom possibilities are being discussed include:

* School of Hygiene and Tropical Medicine

* Imperial College (who are seeking lab space away from central London)

* pharmaceutical companies, following the lead of Glaxo who have already taken some space on site

* Polytechnic of Central London

* Regional and/or supra-Regional services (which are under discussion with North West Thames Regional Health Authority)

It would also be possible to use some of the facilities for private patient beds. Retention of any parts of the CRC which do not feature in the CRI would pose no accommodation problems.

10.2 **The steering group shares Harrow Health Authority's view that suitable future occupants can be found for the CRC facilities, but recognises that this will take time and that there could be gaps in occupation. One of the more difficult areas to occupy will be laboratory space within ward and theatre areas. These are an inescapable feature of the hospital design and are in some cases unoccupied and in others used for HA purposes. Any further expansion by the HA into these areas will result in higher running costs and higher capital charges for the departments concerned.**

10.3 Some exploratory discussions with potential users are being held. The Steering Group believes that a definite decision to close the CRC within a specified period would facilitate discussions with prospective users who would have a clearer notion of when the facilities would become free. Given the need for an orderly withdrawal and discussions on the disposal of research units, a resolution of the date for closure would also help morale at the CRC which has been badly affected by the continuing uncertainty over the centre's future.

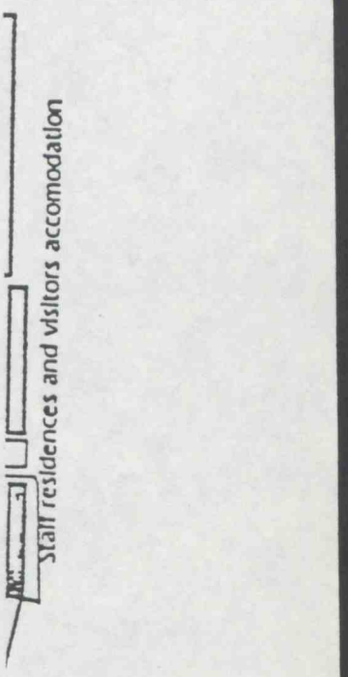
CONCLUSIONS AND FURTHER WORK

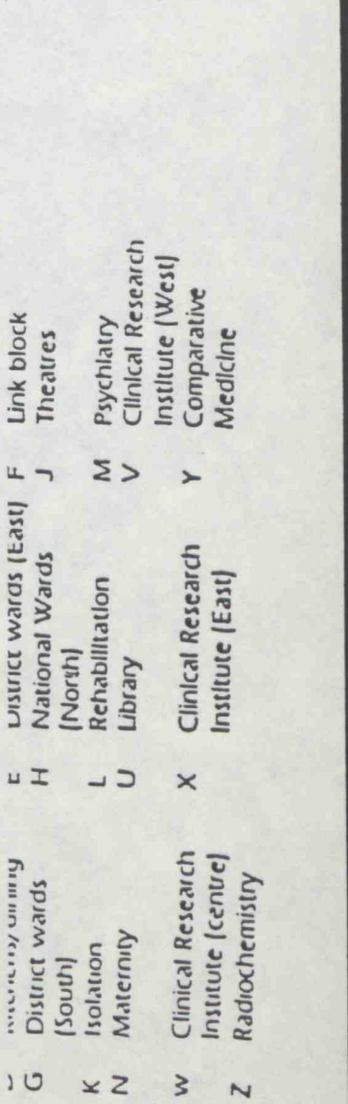
11.1 The steering group has concluded that:

a) Following the withdrawal of the CRC from the Northwick Park site, the vacated space can be reused, although there are likely to be gaps in occupation, particularly of ward laboratory areas. Harrow Health Authority, with the assistance of the Regional Health Authority, the MRC and the Department of Health, is taking forward discussions with parties who may be interested in using the vacated facilities.

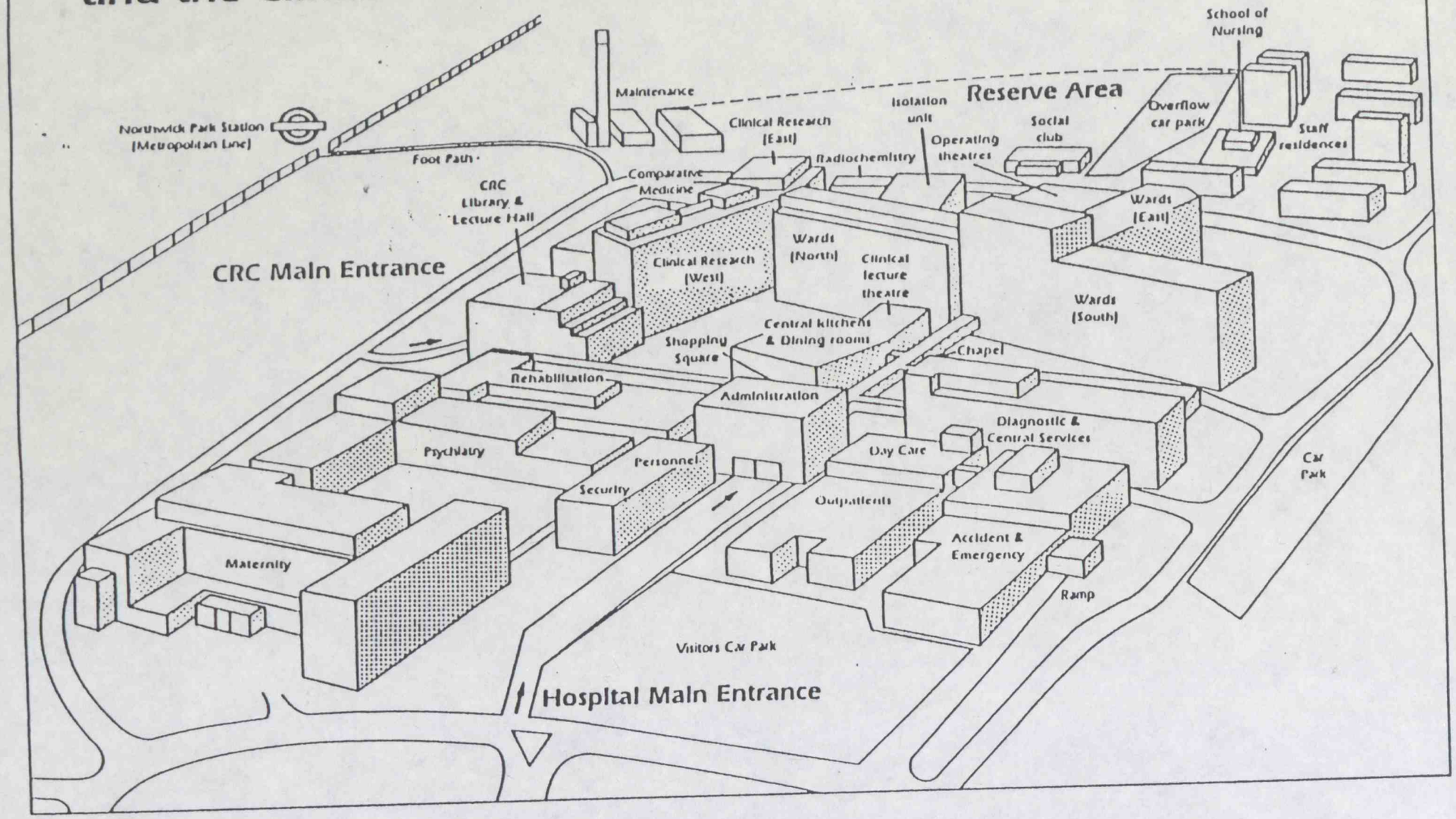
Appendix 1

b). Further work is being done on the financial implications of the CRC closure for Harrow Health Authority. The outcome is not yet clear. Once the work has been completed, the parties concerned will want to discuss how these changes should be managed. The Department of Health, for example, will want to discuss the future of the central funding with the Regional and District Health Authorities. The steering group should oversee these discussions to ensure that the net financial effect allows Harrow HA to adjust to the changes.





Northwick Park Hospital and the Clinical Research Centre



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Genetic approach to human health			**	***		****			
Clinical Neurosciences	***	**	***	**			**		
Infections and Immunity	***				***	****			*
Human Metabolism		***					***		*
Cardiovascular disease					***	****			
Environmental factors in disease					***				***
Imaging						****		***	

Key: **** = plans well advanced
*** = probability
** = strong possibility
* = possibility

May 1990	ABRC consideration of use of Flexibility Margin
July 1990	Recommendations on future locations of most CRC teams
July 1990	Ministerial decisions on CRI
July 1990-	Development of plans for future research programmes of teams moving to provincial sites
May 1991	Some movement of a handful of scientific teams, particularly those with no direct clinical implication; no reduction in support services
May 1992	Approvals of detailed plans for some teams
Summer 1992	Some moves out possible: review service provision
May 1993	Approvals of detailed plans for remaining teams
Summer 1993	Further moves out
Summer-Autumn 1994	Completion of relocation process.

Appendix 4

CLINICAL SERVICES PROVIDED BY CRC - SUMMARY

CRC DIVISION	TYPE OF SERVICE TO HARROW
Psychiatry	In and out patient work Support to A & E Department Teaching
Endocrinology	In and out patient work Diabetic service Participation in general medicine on-take Teaching
Anaesthetics	Highly integrated research/clinical service Operating lists, ITU and on-call rotas Teaching
Immunology	In and out patient work Participation in general medicine on-take Supra-regional hypogammaglobulinaemia service
Rheumatology	Paediatric rheumatology in and out patient service Diagnosis of inflammatory eye disease Support of general medicine on-take Bone disease service Support to general rheumatology service
Dermatology	Part of out-patient service
Therapeutics in Elderly	Parkinson's disease referral service - in and out patients
Haematology	Part of out-patient service
Molecular Medicine	Lipid out-patient service Participation in general medicine on-take
Clinical Genetics	Support to Regional service.

SUPPORT SERVICES PROVIDED BY CRC - SUMMARY

PART 1 - CLINICAL SUPPORT

CRC DIVISION	TYPE OF SERVICE TO HARROW
Anaesthetics	ITU equipment maintenance and blood gas analyses
Radioisotopes	Sample counting, nuclear medicine, bone densitometry
Electron Microscopy	Limited diagnostic service
Immunology	Immunopathology service

PART 2 - NON CLINICAL SUPPORT

CRC DIVISION	TYPE OF SERVICE TO HARROW
Medical Illustration	Clinical and medical photography and illustration Prints and slide work Medical art work
Medical Library	Full library and information service
Stores	Glassware and chemicals purchase
Bioengineering	Electronic and mechanical engineering Orthotic service Technical equipment advice Thermography scanning
Computing	Computer databases, backing up services


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