As HDR replaced Farr,[1] what replaces HDR? – a path for UKRI/WT

As if UKRI asked for more paper clips,[2] HDR HQ has sprawled and taken for itself resources that could have gone to researchers. The delivery of HDR UK's predecessor did not satisfy funders;[3] has 'Farr v2' done any better than Farr v1? And what might Farr *v3* look like?

HDR's big projects (COCONNECT, DECODE, ICODA, ODAP, PRUK, DARE,[4] the digital hubs, *et al*) make for an impressive series of announcements – but, read consecutively,[5] announcement after announcement raises the question: **what has HDR actually delivered?**

Was there even a continuation plan for any of those "infrastructure" projects that did not rely on HDR's continued existence and current culture? As it was with the Farr TREs,[6] the only projects likely to survive without an 'HDR lifeline' are those co-led by a national public body.

Just as JISC has had many incarnations as the technology and infrastructure centre has needed to evolve, so should the institute, learning from experiences and outcomes. Given where we are now, how should Farr *3* be structured to learn the lessons of both predecessors?

At time of writing, HDR has renamed its TRE plans to *appear* in line with the Goldacre Review, without any meaningful changes to support it; the latest HDR presentation[7] suggests DARE will provide little, if anything, for UKRI researchers using NHS / ONS data (who run their own TREs).

Researchers are funded by HDR, who are funded by MRC, who are funded by UKRI, who are funded by HMG – and everyone at every stage tells their funder what they think they want to hear.[8] This process has resulted in HDR UK having a culture akin to that of the Russian state; those at the top making decisions having been told that much is being achieved, and that things are going swimmingly, while the ground reality is very much different.

There is no obviously correct answer as to the hierarchy, though ideas may arise from a parallel, similar question, i.e. what should SAGE look like for longer-term challenges? COVID-19 deaths are (currently) ~1200 per week; smoking deaths are roughly 1500 per week (permanently) – COVID is exceptional only in that it is new, and that it affects everyone through the choices of others.

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[1] See parts 1 and 2: https://medconfidential.org/wp-content/uploads/2021/08/Farr.pdf and https://medconfidential.org/wp-content/uploads/2021/08/PRUK_DARE.pdf

[2] https://hackernoon.com/the-parable-of-the-paperclip-maximizer-3ed4cccc669a

[3] https://medconfidential.org/wp-content/uploads/2021/08/Farr.pdf

[4] DARE is still in 'pilot' mode with 4.5 FTE long term staff with contracts that seem to run beyond the one-year funding provided by UKRI, and with more people working on DARE at HDR HQ than on most projects. The goal of several large DARE projects seems to be to show that you can run a TRE on AWS, which is not a novel finding to the national bodies who have been doing it, and similar, for years.

[5] This is not hyperbole; we encourage you to read every announcement HDR UK has on its website, one after another.

[6] https://medconfidential.org/wp-content/uploads/2021/08/Farr.pdf

[7] https://dareuk.org.uk/your-views-on-core-federation-services-for-a-more-joined-up-national-data-research-infrastructure/

[8] Eg. DARE will spend a vast amount of UKRI data infrastructure money, and is likely to deliver almost nothing *usable* out of that, in a way which will say "we want more money and more time and don't fund anything else in the interim". HDR will point at UKRI review for independence and balance, but the review panel will do only what they are tasked with doing – they will review (well) proposals against the objectives and priorities they are given, without the ability to say whether they are sensible in of themselves. When HDR offer their preferred infrastructure suppliers, what don't *they* offer? **It is hard for HDR to understand the Goldacre Review when their funding and culture depend on *not* understanding it.**

What do MRC and Wellcome want the institute for health informatics to do in the world?

Noting the oblique critique of HDR in DHSC's recent Goldacre Review, HDR and the Review team should be asked to each provide an assessment of how HDR currently implements the recommendations of the Review, and where it falls short.[9] We note that HDR's published responses to Goldacre Review (and our) questions do not entirely answer the questions.[10]

As we enter post-COVID times, discussions that should happen more widely than just health science can still be led by health science. Farr3's national discussion entity should be what Wellcome, MRC, etc. currently think the best post-pandemic model can be. It may need to be an umbrella body to discover that approach, or to discover that different approaches are needed for different topics.

One initial outline model for Farr3

We will leave the "functions" of Farr3 to others, but it is sometimes necessary to understand the structures that can be used to kneecap those functions.[11]

Operating Structure: Maintain the functions of the "research hubs" as disease-focussed networks of expertise; replace the HDR HQ overhead with a light umbrella akin to the continual evolution of ESRC's CLOSER. (HDR is currently doing a review of CLOSER's datasets; CLOSER should do a reciprocal review of HDR's approach.)

Levelling Up: The successor to HDR's Hubs may become something akin to existing MRC centres. Funders can address the geographic imbalance in existing research hubs with the money saved from cutting HDR HQ overheads, DARE, and the other money-pits into which HDR pours good money after bad.

Reporting: Require attribution of contributions[12] to all outputs[13] across the entire (UKRI[14]) portfolio.

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[9] https://www.gov.uk/government/publications/better-broader-safer-using-health-data-for-research-and-analysis
[10] https://www.hdruk.ac.uk/news/response-to-the-goldacre-review-trusted-research-environments-and-data-management/
[11] Q17 https://committees.parliament.uk/oralevidence/9979/html/
[12] In a manner becoming the norm in some fields: https://authors.bmj.com/policies/bmj-policy-on-authorship/
[13] Page 3, https://medconfidential.org/wp-content/uploads/2021/08/Farr.pdf
[14] It must be noted that HDR as a dysfunctional quango could only emerge with the tacit approval of UKRI.