NHS England

Q and A from the National Contract Value Review (NCVR): Process Update Webinar

Webinar held 24 June 2026

Who are the reviewers? Experience in research operations?	The reviewers are the current NHS staff colleagues who undertake NCVR reviews already. This is often a role within R&D with input expected to be provided by relevant areas of expertise as applicable to the study, including but not limited to CI, Delivery Team, Pharmacy, Imaging, Pathology and Labs.
Is that calendar or working days	Calendar Days
Can there be a primary care reviewer and secondary care reviewer for a study that will involve sites from both settings?	Yes, where the study spans different settings such as Primary and Secondary care providers there can be, and we would encourage there to be, a reviewer from each setting
With there be assurance that a mix of reviewers from different areas are utilised? I.e. will there be a secondary care and primary care reviewer? Our main escalation issues have been where our secondary care costs have not been considered by a lead primary care site and I'm sure this has occurred the other way around.	Yes, where the study spans different sectors such as Primary and Secondary providers a reviewer from each sector can act as reviewers. This should address resource issues experienced.
Is there funding for NCVR and the second reviewer this is a big cost pressure on trusts with many CIs ?	There is no additional funding attached to the NCVR process
Will secondary review sites receive additional fees for the work like the lead site? or does this come under R&D set up fees	There is no additional funding attached to the NCVR process
NCVR costs are covered in CI agreements for lead site - where will second reviewer costs be covered?	There is no additional funding attached to the NCVR process. Funds in the CI agreement are for CI resource, not R&D.
Will this also apply to ATIMP studies, as they are more complex and involve numerous departments and sometimes additional third party	Yes, all commercial contract studies are included

services (e.g. NHRBT) that may not be understood/needed by the lead reviewer.	
What will the turnaround be for reallocation to another reviewer due to leave etc. Thanks	National Resource Reviewers are expected to confirm within one day of allocation whether they can accept a review. If they cannot, that review will be reallocated within one day, with the same timeframe for acceptance placed on the new reviewer.
How do we select lead reviewer and second reviewers?	Applicants (sponsors and, as applicable, CROs) are expected to discuss NCVR National Resource Review with prospective sites during site selection and to provide contact details for named first (and where multi-site, second) reviewer(s) to the NIHR as early as possible and in any event, not later than at time of iCT submission (by populating the checklist available with the training in NIHR Learn). It would be usual for the CI's site (when this is an NHS site) to be the lead reviewer but this is not mandated. Applicants should consider costing expertise and capacity in selecting both (where applicable) reviewers. Careful consideration should be given to bringing additional expertise to the review through selection of the second reviewer, where a project crosses the primary/secondary care boundary, involves adult and paediatric services, or otherwise is to take place in materially different clinical settings or UK nations.
What happens if there is only 1 NHS site on the study? Where will the second reviewer come from?	On a single site study only one reviewer will be needed
There are a number of 'in flight' NCVR reviews that will not conclude before 1st July. Will they be managed under the current (soon to become old) process? Will escalations still apply to this group?	Yes, all 'in flight' studies will continue on the process they entered. Only new review applications from the 1st of July will be subject to the improved process.

Can the site significantly increase costs of assessments as compared to the NIHR tariff?	For investigations the answer is no, the costs are agreed values for diagnostics within the NHS. Any increase relating to local arrangements (3rd parties etc) is covered by MFF. For Procedures and General Procedures the values in the tariff and present in iCT are baseline assessment values of time that work for the majority of cases where that assessment is used. If the complexities of the protocol indicate that the timing values should be changed (either up or down) then this can be done by the company and reviewer with a comment to state why this had occurred. Please refer to the NCVR Standards and Checklist to ensure you are operating within them for your study.
I would like to understand archiving costs and what cost analysis is conducted to get a fair but realistic approach for locations. For example, a medium-sized clinical trial may generate: • **10–30 archive boxes** • **(ISF, pharmacy, source docs, consent forms, IMP accountability, etc.)** • **Estimated 25-Year Storage Cost** • **Boxes / Estimated Lifetime cost** • **10 boxes / ~£1,500** • **20 boxes / ~£3,000** • **30 boxes / ~£4,500** **This is before retrieval charges.** **For ATMP or paediatric trials retained for 30+ years, costs increase further.** **Some studies state £80 one off fee so cost has to be absorbed by R&D department but is not considered**	Archiving is not a component of costing in NCVR due to the variation of archiving companies and complexities in the fees, and exists in the main mCTA as a passthrough item i.e. the Sponsor has options here to either pass the whole incurred cost for archiving to the site or choose to archive itself at it's own cost. For commercial studies therefore all costs are always covered and the fee mentioned must be for a non-commercial study.
What happens if the timelines are not kept to - either by site or by CRO/Sponsor	NCVR timelines are expected to be met, and performance will be monitored nationally. Where timelines are missed, all parties should expect to be asked why: reasons will be reviewed and used to drive improvement, identify support needs and inform future

	performance management unavoidable study-specific issues will be noted a such The expectation remains that all parties work proactively to achieve the agreed timelines and escalate risks early.
Check NIHR Learn longevity…NHS Learn would be a better option?	NIHR learn has been utilised as this is a learning platform available to the whole UK research sector including Sponsors/CROs and all type of delivery organisations beyond NHS Organisations.
Will the industry hub support sites so lead NCVR site can have direct links to sponsor and also link with other sites taking part in the study?	Yes, and working with colleagues across the devolved nations
Understanding more about the NIHR Industry Hub and their role going forward would be extremely helpful - can we learn more about that?	Learn more about the industry hub: https://www.nihr.ac.uk/support-and-services/industry
How is this new NCVR model going to impact the CRDC network?	The CRDC UK Network have been involved in discussions regarding the streamlined NCVR process from the onset, and have ensured representation from CRDCs across both primary and secondary care and from across the four nations of the UK in the development of the NCVR guidance. The CRDC UK Network have shared all available information with the CRDCs to keep them informed about this new process, and will support the CRDCs in ensuring they are exemplars within the system for the streamlined process. When a study is CRDC-led and is therefore being supported by the CRDC UK Network throughout set-up, the network will be able to guide the sponsor in the identification of a suitable second review site, ensuring consideration of cross-setting and cross-nation insights.
Will the RDNs still have a role?	The RDN is part of the NIHR infrastructure, including the NIHR industry hub. The RDN continue to host and operate the UK interactive Costing Tool that underpins NCVR, on behalf of the UK system

Would this new process include revision of NIHR tariff ?	The NIHR's tariff document is reviewed periodically across the year with any changes to the data involved happening in April each year, this process will not change although some definitions have been tidied up to coincide with the 1st July. These definition changes do not affect any 'in flight' costings
Will there be a way to capture queries after 1st July so that reviewers can use that knowledge for future studies? If there is a recurring theme then this would be helpful to be acted on.	Yes, where the study review generates a learning or clarification for the process, learning package, standards document, UK iCT tariff or functionality these should be submitted here: https://www.nihr.ac.uk/guidance-using-interactive-costing-tool-ict#help-us-to-improve-the-ict.
What if in those 5 days the sponsor and lead site don't agree on any of the changes made?	The overall 30 day measure will apply in all cases, including where delays occur whilst the outcome of the review sits with the applicant (sponsor or its representative) and capturing instances where agreement between applicant and national resource reviewer is delayed. The streamlined processes will provide for rapid escalation within applicant companies, and to sponsor companies where the sponsor is not the applicant, where necessary. Detailed data will be captured for each review, which will be used not only to support escalation and resolution of individual cases, but also to understand causes of delay and to track and address related patterns.

What experience do the NIHR have of on the ground experience of the day to day costs and delivery of research within clinical delivery be that NHS, primary care. Community etc. We mustn't put speed in front of safety and there is real concern that rather that increase research delivery right across the healthcare community there is a remit to centralise delivery to the large Trust.	National Resource Reviewers are usually embedded within NHS organisations, including in NHS Trusts, Boards and in primary care settings, in R&D offices and in specialist support departments. Reviewers are experienced reviewers, usually previously responsible for local negotiations, prior to the creation of single-national negotiation with the launch of NCVR in 2022. There is no question of putting speed in front of safety. Currently, many reviews are concluded within 30 days and, with additional administrative support for timeline management and escalation, a reasonable target. Where this the timescales are not met lessons will be learnt. Work continues to support greater regional delivery, and related patient centred, approaches - and NCVR will continue to develop to support new ways of working.
Is there commitment from pharma to deliver all documents at setup stage, manuals, databases etc.	Pharma (all applicants) are required to provide sufficient information in order to conduct an accurate costing, this has always been the case in order to conduct NCVR so there is no change in this requirement. However, it should be noted that 'sufficient information' may not necessarily mean that manuals and brochures are required. There is often a sub-set of questions that can be asked or information provided that will provide the same information required to allow for an accurate costing. The NCVR Standards document helps illustrate what information is required. In instances where critical information is not available, reviews can often still begin and all other aspects of the budget agreed and finalised whilst making clear to the sponsor representative that to help us maintain timelines we do need the missing critical information to be provided.

Will these changes to this be included in "HRA Now" to ensure wider communication	The HRA will support the communications of delivery partners through usual channels. HRA Now is for communicating operational news and developments from within HRA and is therefore not an appropriate channel for this update. The HRA supports and partners in this development but it does not involve any operational changes to HRA or REC processes.
Does anyone know whether there are plans by HRA to add the Pharmacy manual, Lab manual, image manuals other imperative manuals as compulsory documents to the LIP or a process where sponsors have to provide these to ensure the NCVR review can be completed (without assumptions being made). In conjunction with this new NCVR process it would be reasonable to expect that this is considered.	The HRA has no plans to mandate the provision of pharmacy, imaging, laboratory or other manuals at IRAS submission or in documents provided to site for feasibility or set-up purposes. UK technical assurance processes for pharmacy and radiation are designed to ensure that relevant information is provided to sites, even where draft manuals are not yet available to applicants. Even so, in many cases draft manuals are available to support central technical review and we expect that where they are, they are provided. The HRA is actively improving its technical review process, via a dedicated improvement programme, to ensure the benefits are maximised and ultimately used for all studies and sponsors. In parallel the HRA is working with partners to ensure that these revised processes support NCVR National Resource Review. In the interim, additional NIHR Industry Hub support is available on request by applicants for pharmacy and radiation costing. National Resource Reviewers should always seek expert advice on areas such as pharmacy and radiation, where needed. In cases where a company is unable to specify information required to determine a cost, National Resource Reviewers must assume the highest cost. We will be relying on the community of practice to continue to share evidence on key missing information in such cases, so we can work with applicants to further standardise minimum data and document sets.

How will protocol amendments be handled - either a PA during initial set up (as a result of RA/EC queries in either UK or other countries) or after study set up	The changes to NCVR for projects with iCTs submitted on or after 1st July 2026 do not in any way affect how modifications to projects will be handled by the regulatory authorities, nor how updates to iCT should be made by applicants to account for such modifications.
Would this process be the same for protocol amendments affecting the budget and contract?	Contract valuation for modifications (and prior to the most recent amendment to the UK Clinical Trial Regulations - to amendments) are not within scope of the NCVR process. The changes to NCVR for projects with iCTs submitted on or after 1st July 2026 does not change this.
How would amendments, particularly those affecting activities or costs, be factored into these timelines?	National Resource Review should run in parallel to regulatory submission and review. Applicants should submit their iCT for National Resource Review at the same time they make their IRAS submission, with documents and information required by both submissions matching. As modifications are changes to approved documentation or information submitted for regulatory review, after regulatory approval, it is extremely unlikely that modifications will be made by an applicant during national resource review. Determining the impact on contract value of modifications remains out of scope of NCVR.
Do you have data on where the escalations come from? Is there any part of the system who's needs are less well met by NCVR?	Data from escalations are collected. This has been factored into the development of the NCVR Standards.
How do they commit to participation without knowing whether they are happy with the contract?	Under NCVR, sites are expected to assess participation based on whether they have the capacity, capability and patient population to deliver the study, rather than waiting for access to the iCT or seeing the budget. The study-wide budget is developed through a national costing review process designed to ensure all protocol-required costs are appropriately captured and appropriate buffers are built in. Sites should progress study set-up activities in parallel, enabling

	rapid study activation once the nationally agreed budget and approvals are in place.
Would be good if these questions are collated by organisers into a Q & A feedback	All questions have been collected and answered within this document
Could the training module be released prior to when the new process is due to start?	the training module was released on the 1st July. the training will support the implementation of the process, but it is not necessary for training to have been undertaken before implementation.
How does this square with NHS acute to community? Smaller community Trusts have very different costs to large acute Trusts. Our only options will be to potentially do a study at a loss, or to not take a study on.	The iCT is formulated to account for the different provider settings. If there is a nationwide issue with a tariff you can submit tariff feedback via the iCT feedback form (https://docs.google.com/forms/d/e/1FAIpQLSfss0n11zw-7UfWNi4WOPjPfaEQKPhsNEJWGXraBKSWMbyqFg/viewform) for review by the national Costing Reference Group
What about sponsors that do not have experience/not a lot of experience in the UK, newer biotechs etc. Are we expecting them to adhere to these timelines too?	Yes, all sponsors, CROs and Company Representatives will be included in the NCVR process. Support mechanisms are in place to assist all parties within the NCVR process.
Of the escalations submitted, what % / £ were applicable and accepted? Thus confirming they were appropriate escalations?	Escalation data only included those that were validated, therefore we do not hold data on unvalidated escalations.
I think the amount of comments & reactions shows how hard this is for everyone. Why try force this process to be even faster when there seems to be so many problems?	NCVR is an evolving process and system. The majority of processes are running smoothly – our focus is improving the efficiency of the system.
Just to check…. are the timelines applicable to all study types and phases? Advanced	Yes, the timeline is for all commercial contract studies.

Sponsors can submit to iCT before CWoW submission, so documentation including protocols can still be updated in the interim time. Would it not make more sense to have Day 0 on the day the sponsor submits the study to UK Regs?	Applicants are advised to submit their iCT for National Resource Review on the same day as they make their IRAS submission, with information and documentation required across both submissions matching where relevant. Future digital system will simplify and support this parallel processing. In the meantime, changing day 1 for National Resource Review to date of IRAS submission would risk incentivising earlier iCT submission, creating a greater risk of mis-matching information between the two submissions. All timelines will be captured as part of the test and learn approach including how iCT and IRAS submissions align and how NCVR fits into the wider 150 day roadmap.
Does the lead reviewer ensure that they check with all the support services e.g pharmacy department before they finalise the NCVR	Reviewers should engage with all relevant support services required to delivery the study.
Please could Lead Site Study Resource Reviewers connect with other site costing experts as part of the initial review and mutually review and agree on the costings?	All multi-site studies will have a lead and second review allocated. It is not expected that these reviewers will by default need to engage with other sites to conclude their reviews and NCVR is not an all-site negotiation process. It is a means of determining appropriate contract value for all sites. Where lead and second reviewer require additional expertise, be that from another costing expert, or from a professional in a specialist area such as pharmacy or radiation, this should be obtained as relevant to the individual project review.
Also, not all institutions have the same kind of units. Not everyone has dedicated research space. How are they going to accommodate for the discrepancy?	The iCT is formulated to account for the different provider settings however space is an indirect cost and should not impact the iCT costings. Where direct care is displaced for a prolonged period of time per patient, appropriate fees exist in the iCT that can be utilised. Please refer to the NCVR Standards for full information. NHS organisations are strongly encouraged to engage with the iCT through the established feedback mechanism.

Research team level - (1) How do direct negotiations with sponsors get covered by the metrics as this also takes place outside of the escalation process, where more negotiation and clarification is required than the middle man can offer without delaying the process further, and we've seen changes made to budgets as a result (2) Is there the potential for the review process to be reversed if there are persistent quality issues after the new QA process is implemented as we constantly find issues and on the other side, have been subject to escalations on our budgets. Time pressures in the metrics seem to result in even blatant errors (straightforward missing items versus schedule of activities) from our experience (2) will there be any recourse for budget errors e.g. "saved" for later for a future amendment when the budget is otherwise updated? (4) can we at a research team level feedback on issues with e.g. budget format as we've recently had examples which make subsequent invoicing really challenging, is the contract format of the output considered when drafting the budget?	1) There are no 'clock stops in the timelines and therefore the length of time taken for each and all stages will be visible through the timepoints. 2) Yes, the lead reviewer retains the ability to highlight quality concerns with company representatives, working with colleagues in the industry hub and devolved nations. Learnings from these situations will support process refinement. 3) A more standardised approach for amendments will be considered in future refinements that could include the formalisation of such recourse examples. However to be clear, there is no such thing as a contract variation to update the study-wide budget and this is not permitted. Costs can only be revised where driven by the protocol-mandated activities updating as part of a modification (not to add in missing/escalated fees). 4) Yes, where the study review generates a learning or clarification for the learning package, standards document, UK iCT tariff or functionality these should be submitted here: https://www.nihr.ac.uk/guidance-using-interactive-costing-tool-ict#help-us-to-improve-the-ict
Were NHS sites and support services consulted before these changes etc? If so can we have a list of which sites and specific departments please?	Yes, both NHS and Life Science partners were engaged in the discussion on improving the NCVR process. NHS and Life Sciences partners also co-designed the changes to the NCVR process from the 1st of July.
With regulatory approvals taking longer than 30 days, how are these two separate metrics working together? Final protocol's will be needed to 'sign off' the costs	Work is ongoing to better align two distinct submission and review processes (IRAS and NCVR) in future digital systems. For the time being, the two processes run in parallel. In the rare circumstance that regulatory review results in a change to research procedures that have an impact of study resource review,

	communication between regulators and resource reviewers will be essential.
Can we request that the updated document list includes these "core documents"?	Work on core information required to undertake a timely, quality and consistent review is part of the test and learn approach. Please refer to NCVR Standards for further details on information required.
What happens to escalations that are still going through the process on 1st July?	Studies that are 'in-flight' will continue to be processed, only new applications from the 1st of July will be included in the improved process.
Then if this is the case, shall we reject every Nuc Med MRT study because we don't have an imaging and dosimetry manual(s) available to review within the timeframe?	No. The absence of an imaging or dosimetry manual at the point of review does not mean a study should be rejected. Sites should review the information available, identify any missing information early, and work with the sponsor to obtain the necessary information. Where further information is genuinely required to finalise the costing, this should be communicated promptly and managed through the NCVR process rather than delaying engagement or automatically declining the study.
To add to this, what happens if there is a gap between lead site being selected and sponsor selecting further sites? For example, a recent project we only just opened, we were 2nd in the UK, however lead site opened in 2024.	These examples will be managed on a study-by-study basis to accommodate such scenarios.

It appears the UK PLC message and delivery of UK 1sts to open is the key outcome. But Trust / sites may not cover their costs which Trust CFOs will not allow. Trying to cover shortfalls from OHs is becoming more and more difficult. An unintended consequence would be for sites to say no we can't do the study? Not a message the UK wants to send? The chat shows that sites across UK are still experiencing significant and frequent issues and therefore the 8% stat highlighted and its a 'small issue' does not seem reflected across the UK?	NCVR is designed to ensure legitimate research costs are identified and recovered through a consistent national costing process and appropriate buffers are built in. Organisations are expected to adopt nationally agreed budgets and not undertake local review. NCVR operational data has been reviewed extensively to understand we are now in a position to remove escalations as the majority of sites and studies do not raise any. Financial reporting standards are being established across the system to increase visibility of research activity, income and funding. Wider services offered to UKPLC can ensure the full capabilities and capacity of the UK system is being utilised to optimise delivery of research.
I think the amount of comments & reactions shows how hard this is for everyone. Why try force this process to be even faster when there seems to be so many problems?	All engagement has confirmed the need for a streamlined process that removes variation and addresses the issues currently encountered. NCVR has always been a national sign off process with no local negotiation. We will take a test and learn approach refining and learning from implementation in the first few months.
I'd be interested to know what staff roles in different trusts undertake this resource review?	This data is not held centrally.
While the National Contract Value Review (NCVR) has been widely promoted as a means of reducing study set-up times and standardising commercial trial costing across the NHS, I'm interested to see a study examining whether participating sites actually recover their full costs under the model. And how many sites swallow losses to participate?	The iCT is formulated to cover all costs including appropriate buffers- NHS organisations are strongly encouraged to engage with the iCT through the established feedback mechanism.
How can you do that when you don't have all the info?	Unfortunately, we cannot answer this question without the context.
Will the spoke sites be forced to accept the lead sites costings from next month? What happens if the site	The reviewer approach is designed to reflect the delivery model of the study to maximise acceptability. Where site changes are

drops out of study to detriment on sponsor?	necessary, support will be available for Sponsors to minimise impact.
There is a well-known principle in business and project management that you can optimise for speed, cost, or quality, but rarely all three simultaneously. Faster delivery generally requires additional resources, while reducing costs often results in either slower delivery or reduced quality. The NCVR programme aims to reduce study set-up times, control costs and maintain high standards of research delivery. Has additional resource been considered to achieve this?	The NCVR process was designed to improve the consistency of commercial contract study set-up and reduce timelines for set-up. There is no funding available for conducting NCVRs as it's part of standard R&D business of an organisation
Would the site review clock pause if the sponsor has not provided a complete and stable document set, or if key documents are amended during the review? It would seem fair for timelines to begin only once the site has everything required to complete a meaningful review, so delays outside the site's control are not counted against it.	There are no clock stops/pauses within the NCVR process. Reviewers are expected to be pragmatic and complete what they can, flagging within the first 5 days any critical information required from sponsor in order to maintain the timelines. All issues and feedback will be collected during the test and learn phase so the information is not lost.