HOUSE OF COMMONS

Petitions Committee

Oral evidence: Funding for research into brain tumours

https://www.parliament.uk/business/committees/committees-a-z/commons-select/petitions-committee/inquiries/parliament-2017/funding-brain-tumours-inquiry-17-19/

HC 1792

Tuesday 15 January 2019

Ordered by the House of Commons to be published on 15 January 2019

Watch the meeting.

Members present: Helen Jones (Chair); Catherine McKinnell; Liz Twist; Mike Hill; Steve Double; Paul Scully; Martyn Day; Daniel Zeichner.

Questions 1-48

Witnesses: **Rt Hon Matt Hancock**, Secretary of State, Department of Health and Social Care; **Helen Campbell**, Portfolio Manager for DHSC Research Network, Clinical Research Facilities, and Cancer Research, Department for Health and Social Care; and **Mike Batley**, Deputy Director of Research Programmes, Department of Health and Social Care gave evidence.

Chair: Good afternoon, everyone. I welcome our witnesses, the right. hon Matt Hancock, Secretary of State for Health, and Helen Campbell and Mike Batley from the Department of Health. The aim of the session this afternoon is to follow up on the Committee's report on brain tumours and the subsequent announcements of funding by the Government and to see where that money is being spent. We will also want to explore with you how the Tessa Jowell Brain Cancer Mission fits in with and can continue the work of the Task and Finish Working Group.

I am going to hand over to Catherine McKinnell to ask the first few questions.

Q1 Catherine McKinnell: The Committee undertook its inquiry because it felt that brain tumour research just had not had the level of attention that it needed. There has been powerful campaigning by families such as the Realf family, by charities and by the late Baroness Jowell, and the subject has therefore attracted the political attention that it needs and there have been some very welcome announcements. How would you consider your role in keeping that momentum up and responding to that?

Matthew Hancock: Thank you very much for having us. The most important thing that we can do is to make clear the strong commitment of the Department, and the whole of Government, to driving this agenda. I know that the petition came in before I was Secretary of State, but I fully endorse the amount of drive and determination there has been in this space, which of course started with your petition and with Tessa Jowell's incredible advocacy and has led to the increase in the amount of funding for brain tumours.

Although this was an area where there was an awful lot of work under way when I arrived, it is something that I wholly endorse and support, and I am enthusiastic for the continued drive in this area. I pay tribute to the work that you have done in making that happen. There have been, as you say, significant developments. I am not sure whether the £40 million of brain tumour research funding would have happened were it not for the work of this Committee and then of the Tessa Jowell mission. Obviously, I fully support that.

Making sure that that is spent in the best possible way is the job that we have to do now, and maybe that is something that Mr Batley can talk to in more detail. We fully expect significant increases in research activity, and I think that this political attention, which we welcome, has been a significant catalyst in that.

Chair: We will come back to finance later.

Q2 Catherine McKinnell: Yes. Obviously the personal testimonies and stories of some of the campaigners have really been the powerful driving force behind raising awareness of this issue. There is some concern that perhaps now that it finally has the political attention that it needs, they are not guaranteed to be involved in that process going forward. I think that there is a quite strong feeling that there is still a huge amount to contribute to taking forward this work, and the work of the Task and Finish Working Group in particular. What assurances can you give that families who have lost loved ones to brain tumours will be involved and included as much as possible in taking this work forward?

Matthew Hancock: I can give you a full assurance that the work they are doing will be involved. There are various different organisations that are enthusiastic advocates in this space, and we want to work with all of them equally. The Tessa Jowell Brain Cancer Mission has very successfully managed to galvanise those efforts together and provide a focus point of leadership in this space, which is excellent.

Of course, when research projects are assessed, it is very important that that is done on the objective and rigorous basis that is standard, well honed and well organised for medical research. I think that everybody involved would support that approach, and it is very important that it happens properly, both to get the best value for money and to promote the best research on an objective and clinical basis. I do not have a view on which particular bit of research we should be backing. I want to make sure that they are all looked at properly, and that an objective decision is reached.

Q3 Catherine McKinnell: There does need to be some continuity between the considerable progress that was made by the Task and Finish Working Group and, as you mention, the work of the Tessa Jowell Brain Cancer Mission. What do you see as the difference in emphasis between the two groups? Is there a difference in emphasis, and to what extent are the Government involved with how the mission is focused?

Matthew Hancock: The mission is, of course, independent, and rightly so. Quite reasonably, it will make its decisions about what it wants to advocate. It is entirely up to the mission or any of the other organisations to bring forward areas of research that they think need to be looked into, and then it is the decision of the clinically-based objective process how that money is spent. The money is spent by Government. It is taxpayers' money, and it is spent according to the way in which we get best value.

As with all the different research bodies, and research spending right across the board, there is a well-honed process for how the expenditure occurs. I can commit to you that we will continue to engage with everybody in this space to make sure that all the thoughts, all the expertise and all the understanding of the realities and consequences of brain tumours are brought to bear on those decisions. Mike, I do not know whether you want to say more about the process.

Q4 Chair: Before you do, one of the things that concerned me was that although any emphasis on working to solve the brain tumour problem is very welcome, it seemed to me that in many of the working groups that the Brain Cancer Mission had set up it was replicating some of the work already done by the Task and Finish Working Group. As is frequently pointed out, people who get a brain tumour live for about five years, on average. There is not time to replicate work that has already been done. I am asking: what is being done to avoid that pitfall? In particular, why is the Government's chief scientific adviser, who chaired the Task and Finish Working Group, not involved in the Tessa Jowell Brain Cancer Mission?

Matthew Hancock: Because the chief scientific adviser has a huge remit right across the board, and we have a whole team that works on these areas. Therefore, it has been delegated, and hence I have brought Helen and Mike with me today. Chris Whitty is a brilliant man, and I think he did an excellent job on the Task and Finish Working Group—from what I have read, obviously, because that was all started before I was in post. Now we have an excellent team that is taking it forward.

Q5 Chair: How is the membership decided?

Matthew Hancock: Helen, do you want to take up this point?

Helen Campbell: Yes. I see a great continuity between the Task and Finish Working Group and the mission, especially the funders. For the Task and Finish Working Group, we needed to get the cancer research funders all together and it was the first time we had brought them together to think about this problem. It is very complicated. There are a lot of barriers, as you will know and as you have found, which means that there is no quick fix here. We have to take each barrier and analyse it. The way you do that is to get all the stakeholders together.

The funders have very much moved seamlessly from the Task and Finish Working Group to the mission. Also, we have with us Peter Realf, whose daughter, Maria, set up the petition. Peter is very closely involved with the mission, as is Tessa Jowell's daughter, Jess Mills, who is very helpful in guiding us in the mission. I am very closely involved with all the dealings of the mission, and I definitely see a continuity between the two.

Q6 Chair: Can I just ask you to clarify? My understanding was that Mr Realf had asked to be involved with the work of the mission, but has not so far received an answer to that request.

Helen Campbell: It is my understanding that that continuity will continue. I understand that there are actions under way for that to happen.

Q7 Chair: I think that he has been waiting for an answer since November, so he would probably appreciate one.

The other problem is that the chief executive of the Brain Tumour Charity, in a recent session at the New Philanthropy Capital conference, said, "We don't collaborate, and I can't. It is wasting time and resources that we ought to be spending on meeting that need". She later went on to say, "I am done with collaboration." That sounds to me like a rather strange thing for a CEO of a charity to say when, after all, everybody is working towards the same end. Can you reassure the Committee that enough steps are being taken to make sure that everyone involved in this area, including charities that fundraise and work to raise the profile of this dreadful disease, is ready to co-operate? I think this Committee would take it very badly if we thought that was not happening.

Helen Campbell: There is absolute commitment from the charities involved with the mission that the Tessa Jowell Brain Cancer Mission is the way forward. That is an incredibly useful tool for each of the individual stakeholders to contribute in a way that reflects where their strengths come from, which will be different because they come from different places. Through the mission, the whole will be more than the sum of the parts, and things will move more quickly than otherwise they would.

Q8 Catherine McKinnell: Just to go back to where we started, it is absolutely right that those in the sector—the charities and the mission—drive and take this forward, but there is often a worry that the Government have a tendency to take quite a hands-off approach to health policy at the moment. I just wanted clarity from you, Secretary of State, about what you consider your personal role to be in driving this forward. Where does the ministerial responsibility currently lie, given that Lord O'Shaughnessy has stood down as Minister? Where does the ministerial responsibility now lie?

Matthew Hancock: He has been replaced by Nicola Blackwood, who has been a Health Minister before. She is an absolutely brilliant parliamentarian and will do this job superbly. Of course we drive this forward in the Department. It is the first time I have been accused of being hands-off in anything—normally I am accused of trying to drive things too hard—so I do not recognise that at all. We have significant engagement on driving forward this whole area, as with the entirety of early intervention, prevention and treatment of cancer across the board, which featured heavily in the long-term plan that was published last week. It is a very important area that we will engage with throughout.

Q9 Paul Scully: The Government's response to our original report in 2016 said that the diagnosis of brain tumours in A&E had fallen to 53% in 2013 from a figure of 64% in 2006. What further progress has there been in reducing the proportion of brain tumours diagnosed as emergencies in A&E?

Matthew Hancock: I do not have an update on those figures, but clearly this is an important area. As part of the long-term plan, the goals of more and better diagnosis are at the heart of what we need to do to be able to spot and then treat these diseases. I do not know if there is anything extra you want to add, Helen.

Helen Campbell: No; that is exactly what I would say.

Q10 Paul Scully: Presumably, you would agree with me that more than half is still far too high?

Matthew Hancock: Absolutely. I would agree with that across the board. You have picked out A&E, but identifying brain tumours in all settings, in primary care as well, is incredibly important.

Q11 Paul Scully: Yes, that was what I was going to ask in the next question. Can you describe the steps that the Government are taking now to help GPs to identify symptoms so that diagnosis is not delayed?

Matthew Hancock: There is a programme of work on early diagnosis that goes right across the board. First, the need for better access to diagnostics when there is a potential diagnosis is important, and that is recognised in the plan. There is also the potential for data and technology to be used better in the future, and we are rolling out

a broader programme of the use of genomic diagnostics, too. That is not going to apply to everybody, because—at a cost of almost £1,000 per person—genomic diagnosis only increases the chance of spotting a risk factor, as opposed to a tumour. There is a whole range of improvements that we need to see that are set out across the board in the plan and need to be drilled through the diagnosis of brain cancer as well, as every other cancer. After all, for children, it is the most common type of cancer. It is incredibly important and the attention is very important.

Q12 Paul Scully: Are there any plans for the Brain Cancer Mission specifically in this area?

Helen Campbell: Awareness and early diagnosis is a very active workstream. There is a dedicated workstream for awareness and early diagnosis. There are a number of things that I could go through, but we are aware of the HeadSmart guidelines for children with cancer, which are now well known and have been promoted heavily through Public Health England. Research is under way to provide evidence that would build on similar guidance for adults as well, which absolutely will include awareness for GPs.

Q13 Paul Scully: People who have a brain tumour may present with a breadth of symptoms. We found that a lot of GPs were unfamiliar with brain tumour symptoms, and that is one of the reasons for poor diagnosis. Do you see a role for rapid diagnostic and assessment centres outside the GP system?

Matthew Hancock: There is absolutely the potential for that, as we have with other types of cancer. It is something that we should consider. It has to be driven by the data. When a condition or a disease is hard to diagnose, the data on the link between symptoms and diagnosis is ever more important. Improving that data is vital, but so too is access to diagnostics, which we are rolling out across a whole series of different cancers and which we should make sure that we consider here.

Chair: Mike Hill wants to follow that up, I think.

Q14 Mike Hill: Yes. On that point, given the decreasing cost of brain tumour scanning, should GPs now be referring far more patients for early scans to rule in brain cancer rather than to rule it out further down the line?

Matthew Hancock: I am very happy to look at that. That is not something that I have personally considered. In a screening programme like that where there is a risk to an individual of a particular condition, it is very important to get the balance right—to get the screening right. You do not want type II errors, which give false positives, as well as not wanting false negatives. You have to make sure that you do not over-screen, and this is especially difficult for rare diseases.

In the case of a rare disease, if you over-screen, you will end up with far more false positives. A false positive, individually, is not as problematic as a false negative because it is essentially the precautionary principle. But where the numbers of the

condition are very small, a very large screening programme will lead to a large number of false positive diagnoses. That is because all of this is a risk-based assessment in diagnosis until you get a lot further down the track. With that caveat, the answer is: yes, it is possible to go too far in screening. It is possible to lead to worse outcomes by going too far, but you have to go quite a long way to get to that point, and I do not think we are nearly there yet.

This brings me back to the point about genomic predispositions and the importance of data, because that can, of course, narrow down and improve the likelihood of the test results.

Q15 Mike Hill: Information is vital. My questions are based on the fact that there has been an identified problem of late diagnosis. Professor Cruickshank from the University of Birmingham pointed out in his opinion that three weeks was far too long for a patient to receive a diagnosis, which is why I asked about GPs referring people through more quickly. Do you agree that we should be aiming for no longer than two weeks, given Professor Cruickshank's assertion that three weeks is far too long? Do you or the mission intend to set any targets at the end of this?

Matthew Hancock: Obviously, the faster the better; that is, without doubt, the best situation for everybody. Nevertheless, even within that, it is vital to be able to bring forward the most urgent cases as fast as possible, so there has to be the potential for clinically-based discernment about who should go faster. I would love all these diagnostics to be available as fast as possible. We are working to speed that up by putting in more resources—not into the research, but into the diagnostics—and training to try to get earlier diagnosis, as well as the information and the logistical systems. It is not just a clinical information issue; it is also about the logistical systems for making sure that somebody can get a diagnosis as quickly as possible. There is a programme of work, right across the board, in trying to improve that. It has to be clinically led, but it is something that is incredibly important. After all, the UK is pretty good at post-diagnosis treatment. Where we fall behind is that diagnosis is often too late.

Q16 Mike Hill: I was not on the original inquiry, because I was not a member of the Petitions Committee until 2017, but a close friend of mine—a neighbour—sadly died from a brain tumour. I have to say that from his experience, the NHS was pretty joined up all those years ago, but it could have been better at the early referral stage. I think that that would possibly have had some impact on longevity. However, do you intend to issue guidance to NHS trusts and clinical commissioning groups to enable that kind of early access to diagnosis and scanning for diagnostic purposes?

Matthew Hancock: We are working on that across the board, and it is important to make sure that brain cancer takes its place in that programme. I do not know if Helen wants to give any more detail.

Helen Campbell: No; I would just absolutely reinforce that point.

Q17 Chair: Can we talk about the money and how it might be spent? The Government made two announcements on the funding for brain tumour research: £45 million over five years following the Task and Finish Working Group, and then later in that year £65 million to honour Baroness Jowell's campaign. I am right, am I not, that that £65 million announcement includes the £45 million that was originally announced? Is that correct?

Mike Batley: There was the original commitment to £20 million from the Department of Health and also £25 million from Cancer Research UK. The future announcement of £40 million for NIHR spend, yes, includes the original—

Q18 Chair: It is an extra £20 million, effectively?

Mike Batley: Yes.

Q19 Chair: Is that Government money all new funding, or is it coming from elsewhere in the budget for cancer research?

Matthew Hancock: The £25 million is from Cancer Research UK.

Chair: Yes, I know that. I am coming to that in a moment.

Matthew Hancock: Okay, but the Government money comes from the NIHR budget. The NIHR budget is £1 billion in total, so it is a very significant research budget. It is, of course, Government money. It can only be spent once. It is, in fact, taxpayers' money, as all Government money is. That money is in place for NIHR to spend and it has allocated the £40 million to brain cancer research.

Q20 Chair: The cancer research money is going to be spent at two specific centres in London and Cambridge, as I understand it. That leaves £40 million over five years for other projects. However, one of the things that the Committee and the Task and Finish Working Group were concerned about was that we needed to develop the infrastructure in order to promote research in different areas of the country and to grow the workforce that we need for that. Can you enlighten us on how that funding will be used for that task, to provide us with a better infrastructure for research and developing research projects? Mike might be able to answer that, I hope.

Mike Batley: The NIHR essentially relies on high-quality proposals coming into it for it to spend that money, and it does this through things like the highlight notice that was published in April last year. That, again, sends a very strong signal out to the broader research community, "We want to spend money on this issue; this is clearly an area of need, and the money is there." That is one way of attracting interest and attracting academics into a particular area.

The NIHR funding broadly falls into a number of types. There is funding for very specific projects, when people come in with a specific project that they would like to be funded, and that is funded through NIHR programmes. There is also providing a lot of the infrastructure that allows clinical trials and research to happen, whether it is clinical research facilities or research networks that help with the setup and running of trials, recruiting patients and so on. They provide the platform that helps people like Cancer Research UK and others run their own trials and find their own investments. NIHR will spend that money through a mixture of modes.

In terms of building the profession, a number of barriers to that were flagged up in the Task and Finish Working Group report. I wonder if Helen would like to pick up on that from the point of view of the Brain Cancer Mission.

Helen Campbell: Yes. A big part of the mission is training, specialisation within the NHS and subspecialisation in neuro-oncology for patients with brain tumours. That is a very active work programme that is being taken forward, and I think that steps have already been taken, working closely with the Royal Colleges, who are best placed to lead on this. Early discussions have been very fruitful, and we do have the promise of the fellowship programmes coming on board.

Q21 Chair: We received a lot of evidence that researchers were either moving out of this area altogether or moving abroad because they could not get funding for their research projects in this country. Can you tell us exactly how much of this funding will be used to address that particular problem—if you like, to grow the research workforce?

Matthew Hancock: In a way, all of it. The research funding is spent according to the quality of the bids in. The better the bids in, the easier it will be to spend the money, and all the money goes on projects that are submitted by researchers. Of course, you can try to split out the training element, but all of this will go towards having a more richly funded research environment, which is one of the things that attracts people here.

Q22 Chair: Yes, but a lot of the evidence that we received suggested that in order to get to the stage of vying for research funding and being peer reviewed, you need to do preliminary work in gathering evidence and running small-scale projects and trials and so on, and very often the funding is not available for that. People perhaps will get the funding from the charities if they are lucky. How will that be addressed in the programme you are developing?

Mike Batley: The NIHR has a number of programmes. One of them is part of NIHR Academy, and in the highlight notice they have asked people to send in proposals for personal awards. This supports everyone from pre-PhD right the way through to professorships, so that should directly help to build that workforce.

The NIHR has a number of other programmes. The Research for Patient Benefit Programme is specifically there to attract clinicians who may not have worked in research before to undertake smaller projects that can help to lead to a longer-term

career. Again, there is support across the NIHR for that sort of work. For example, the Research Design Service is another NIHR function that works with researchers—particularly people who are new to research—to pull together those proposals, to put in those proposals to NIHR and to support them to develop where those projects are going to go.

Q23 Chair: I see. How much will be invested in the eight adult oncology centres that we already have in order to support more clinical trials?

Mike Batley: Again, this all depends on the proposals that are coming in. We fund the high-quality proposals that come in rather than try to say beforehand, "We want to put this much here or there." We put the money where the best research is going to happen, and where we think the best proposals are coming in.

Q24 Chair: I understand that, but this is a chicken-and-egg problem, isn't it? Unless you grow the research workforce first, you cannot get the number of high-level clinical trials that you need in this area.

Matthew Hancock: It is slightly different. Because applications for funding can also be at the development stage not only of an idea, but of an individual, and because the research money can flow to high-quality applications even at pre-PhD level, as well as during PhDs, post-docs and full-blown professorial research, it means that attention is paid to the pipeline—I think that is what you are getting at, if I understand correctly—as well as just the cutting-edge research. That is why I have tried to let Mike answer these questions, because it is rightly done by NIHR at arm's length from Ministers so that we can get the best clinically-led decisions in those applications, rather than me making them with my inferior oncological understanding. I cannot even pronounce it, let alone make clinical judgments based on it.

Q25 Chair: That is quite interesting, because we have had evidence from some of the experts that gave evidence to the Committee originally that researchers are still unclear about the remit attached to these funds and how they might be accessed. What is being done to make that clear to those who are at the coalface?

Mike Batley: The NIHR highlight notice is up there, writ large. It is very clear, saying, "We would like you to bid into our programmes." It has links through to the programmes in NIHR that people can apply to, both for specific projects and for personal awards. The support is out there. The Research Design Service is there to help people navigate NIHR and find their way to this funding. It is partly the messaging to say, "We are here, bring us ideas," and the support is there through things like—

Q26 Chair: From what we are hearing, that message is not getting through. It needs to get through more clearly.

Matthew Hancock: I think that we all have a role to play in that and we will take that on board. You have done some great work on this, as did Dame Tessa Jowell and the Tessa Jowell Brain Cancer Mission.

Just to put that into context, though, in this financial year we have had a record number of applications in this area and the financial year is not even over yet. There is undoubtedly increased focus in this area compared to the past. Although it is reasonable for us to take on board the critiques that have been expressed to you and learn from them, this is moving in the right direction.

Q27 Chair: You anticipate my next question, Secretary of State, which is: how many research funding applications have come in since last April, and of those, how many have received funding?

Matthew Hancock: There have been 20 since last April. Two have so far been successful and eight are still under consideration or have been withdrawn.

Q28 Chair: How does that compare to the previous year?

Matthew Hancock: There were 10 the previous year, so twice as—

Q29 Chair: How many of those got funding?

Matthew Hancock: None that year. The year before there were 18 applications and five were successful.

Q30 Chair: We are two up so far.

Matthew Hancock: We are two up on two years ago and 10 up on last year, yes. The previous year there were six applications. Twenty is the best year yet since the start of my figures in 2003-04.

Q31 Chair: Although that is very welcome, and the extra funding is very welcome, I think everyone in this room would accept that it is still nowhere near enough funding to tackle brain tumour. What is the long-term plan in respect of growing our research capability and funding it? We believed very clearly after our inquiry that Britain had the capacity to be a world leader in this kind of research, but that is not happening at the moment.

Matthew Hancock: There is a big opportunity; I agree with you on that. We are open to considering increased funding in this area. We have to make sure that the quality of bids means that you get good research in return for the money. Forensic progress in this area should also be quite demanding in terms of the quality of the research, at the same time as making sure that it gets all the way down the supply chain so that we are drawing through researchers.

Having arrived in the job six months ago, I have no doubt that the amount of attention in this area has increased radically in what is, in the research world, quite a recent period. We politicians might regard a year as a long time—we might regard a week, or indeed 12 hours, as a long time sometimes—but in the research world that is relatively short. I have read out the figures for the number of applications in the last three years. A decade ago there were four applications, and the year before that five, and before that one and one and one. We are making progress in the right direction.

As well as being open to the potential for more money to go in, we need to make sure that this is relentless. I think that the cross-party political support for it is incredibly valuable, because it is very clear to those who are not operating at the political level that this is an important area and that we want to see parity of attention for brain cancer and all others.

Q32 Chair: If we are to encourage the best and the brightest of our students to go into this area, they have to see a prospect of long-term funding, do they not?

Matthew Hancock: Absolutely.

Chair: Otherwise, why try to make a career there? You think that is crucial. Catherine, did you want to come back in?

Q33 Catherine McKinnell: I wanted to just add something; it is a slightly different dimension, but it very much continues what you have been saying. I am sorry if it brings the tone down, but I just wanted to ask what you have considered in terms of the impact of Brexit on research. I ask because it is a key concern that was raised with me by cancer researchers in Newcastle, who are great on this. Among the concerns that have been raised are the ability to retain EU researchers as part of those research groupings, the ability to attract EU researchers—I know a number of EU researchers have gone back—and also the ability to collaborate with EU partners. Obviously, much of the best scientific research that we, as Britain, undertake is very much in collaboration with our European partners. What consideration has been given?

Matthew Hancock: Obviously, this is an important consideration. We have a whole separate briefing section on that. This has Brexit written at the top.

Catherine McKinnell: You have come prepared.

Matthew Hancock: Exactly. This is something that we work on a lot. It is very important. We have more than recompensated in terms of cash—Government cash,

taxpayers' cash—going into this area. Even if all of the EU cash were to be withdrawn, for instance, in a no-deal scenario—that is not what I want to see—on the money side, the money is there.

The challenge is more the links. Academic links throughout history have tended not to recognise borders and to be engaged right across the world, and long may that be so. Mere political considerations like the nature of our relationship between the UK and the EU tend to be low on the priorities of a researcher who is looking to collaborate. Indeed, we collaborate right across the world. I want our future collaboration with our European partners to be strong, but I also want our future collaboration with the best brains around the world to continue to be strong. That is true right across the research piece. It is true in brain tumour research, as it is in all medical research and indeed the whole research approach. I hope that the strong political consensus that we should be open, outward-looking, progressive and engaged around the world when it comes to research continues and withstands the debate on the exact nature of our departure from the EU.

Q34 Catherine McKinnell: I do not think anyone could argue with anything that you just said, but the concern is still out there. What concrete steps have been taken? I know you said you have a whole programme there. What concrete steps have been taken to make sure that current clinical trials that we may be part of can continue and also that the EU researchers and worldwide researchers that use Britain as their base to collaborate with the EU will not be affected in the coming few years?

Matthew Hancock: The first and most important thing is that we offer all EU citizens here settled status. They are welcome, and I very much hope that they will stay. We are open to the brightest and the best around the world and, in fact, just six months ago we took off the cap for the number of doctors who can come here, which is a very welcome step. The future immigration policy White Paper sets out that that will continue, so that is good.

More specifically with the Withdrawal Agreement, the future relationship political declaration sets out that we want to continue collaboration. The exact nature of that will depend on the nature of that negotiated relationship. The very best thing we can do to recognise the result of the referendum and deliver continuity in this space will be to vote for the deal this evening.

Q35 Liz Twist: I want to return to the training position. The Task and Finish Working Group looked at the training of specialist doctors and consultants in neuro-oncology. As I understand it, there is only one medical oncologist with a brain cancer specialism in the UK. What steps are you taking to address that problem and to develop skills in that area?

Helen Campbell: As I said, for the Tessa Jowell Brain Cancer Mission, training is one of the four strategic programmes. It is led by Dr Sarah Jefferies from Cambridge. I know they have been having very active discussions with the Royal Colleges and are working on a Tessa Jowell fellowship scheme to try to make it very attractive to

young doctors to go into, to encourage them see a career in the NHS in neuro-oncology for brain tumour patients, and to put the infrastructure in place to support those people and fund them throughout that fellowship, such that we can get many more subspecialists.

Q36 Liz Twist: You would agree, then, that there is an urgent need to look at this area and perhaps to develop a specialism in neuro-oncology?

Helen Campbell: Exactly. I think the Tessa Jowell Brain Cancer Mission identified that very early on. We identified it in the Task and Finish Working Group report, and that has been carried through. We are at an exciting stage now, because there is prospect of getting some real traction on that issue.

Matthew Hancock: I would say that if you are a specialist in this area then you should be looking to the UK, where the funding is growing. The appetite is strong. We are warmly welcoming to those who want to specialise in this area.

Q37 Liz Twist: It is positive that that fellowship is being developed and progress is taking place, but it seems to be taking some time. Is there anything that can be done to speed up progress in this area?

Matthew Hancock: It is the sort of question I ask my officials a lot.

Helen Campbell: I am a research specialist, so it is not my specific area, but my impression is that the look for the future is very optimistic, from the very low start that you have just described—one subspecialist in the whole country—to creating a career pathway that is attractive for new entrants to enter and to be supported through. It seems to me to be moving quite fast, but research is my specialty.

Q38 Liz Twist: Of course, we are looking at the experience of patients with brain tumours, so I am sure everyone would want to see that developed as quickly as possible.

I will move on to a different subject, the Accelerated Access Collaborative review, which is looking at repurposing drugs for the treatment of brain tumours. Will it be the responsibility of the Dame Tessa Jowell Brain Cancer Research Mission to lead work on that repurposing, and what has happened so far?

Matthew Hancock: The Accelerated Access Collaborative is an organisation within the NHS led by Lord Ara Darzi, one of our best doctors, to spot brilliant new areas and drive their uptake across the NHS. That is about driving them through the various different and necessary parts and organisations within the NHS—for instance, should they need licensing and should they need NICE guidelines around them—to literally accelerate the access across the NHS to some of the most innovative ideas. Thus far, they have supported the uptake of seven high-potential technologies. None of those is related to brain tumours, but they are heavily engaged with NIHR in seeing whether there are potential technologies that can be driven through in this way.

Q39 Liz Twist: Of those new technologies, are we looking at repurposing existing licensed drugs for a different use?

Matthew Hancock: We are completely agnostic about that—whatever works and whatever has the biggest potential.

Q40 Liz Twist: Do you know whether they are looking at that repurposing toward brain tumour research and effectiveness?

Matthew Hancock: I do not know. If that is what it takes, then that is fine by me. What matters is how high the potential is. That is a clinical judgment led by Dr Darzi.

Q41 Liz Twist: Clearly this is one of the things that has arisen from the Committee's report. I am just wondering whether you might be able to write to the Committee and let us know whether there is any work looking at repurposing drugs and technologies for brain tumour.

Matthew Hancock: I am very happy to, unless you have the answer, Mike.

Mike Batley: We can. The other side of this is getting the trials quickly enough to support their uptake. Something that Baroness Jowell herself raised was the importance of adaptive clinical trials in this space. Certainly, as that is something that the UK is world-leading on, there has been a lot of work with MHRA, HRA and others to support these trials getting set up quickly. That is there now. Consolidating our position on novel and innovative trials, such as adaptive clinical trials, was a key part of sector deal 2. Again, NIHR will be playing a large part in that, with experimental cancer medicine centres flagging their expertise in this. Clinical research networks are going to be delivering e-learning courses. There is a range of activity to support these new, faster trials that will help support the repurposing of drugs. In the brain cancer mission—do you want to talk about the BRAIN-MATRIX trial, Helen?

Helen Campbell: Yes. One of the four strategic programmes from the brain cancer mission is treatment and trials, and we are moving forward with the so-called BRAIN-MATRIX trial. It is a platform for recruiting people with brain tumours and having a look at the characteristics to see what arms of the trial they might be eligible for, so we can get the right patient into the right trial.

That is all under way at the moment. It is led by Professor Colin Watts from Birmingham. We are going to be working very closely with the MHRA to get it approved as quickly as possible and to get it set up. We are very actively supporting that through the NIHR, through our experimental cancer medicine centres and through the clinical research network, to recruit patients and get the research delivered as quickly as possible.

Q42 Liz Twist: That is looking specifically at new kinds of treatment or innovation. Is it looking at repurposing as well?

Helen Campbell: The platform could be used for drugs, surgery, technologies or repurposing.

Q43 Liz Twist: If you could let us have that information, it would be useful to see whether or not there is work going on in this specific area of brain tumour research, by way of repurposing.

Matthew Hancock: Yes, very happy to do that.

Liz Twist: That would be very helpful.

Q44 Chair: Can I ask you about one other thing? It is not a drug, but something that I always have difficulty pronouncing: 5-Aminolevulinic acid, 5-ALA, which is the dye used in surgical operations to identify brain tumours. NICE has produced new guidelines on this, but we have again received evidence from some of our specialists that that has not yet reached specialised commissioning teams who make the decisions about these on a regional basis. If they are not implementing the guidance properly or are unaware of it, a lot of variation can occur. At the moment we are told this is only used in about half of brain cancer operations. Can you enlighten us as to what can be done to spread that guidance more widely and ensure that it is used where it is needed?

Matthew Hancock: Yes. The NICE clinical guidelines of course need to be taken into account alongside the individual patient's circumstances by the clinicians treating them. Nevertheless, having said that, we are committed to ensuring that there is universal availability right across the country. By "the country" I mean England, which we are responsible for. We have plans to roll out and fund the dye to improve the precision surgery that it assists with.

Q45 Chair: Thank you very much. Just one last question before we let you go. Although more money is clearly needed for research into brain tumours, we still have this money that needs to be spent over five years. Are you confident that research applications of sufficient quality will now come in—things like better trials, better training and so on—so that this money will be spent where it is needed?

Matthew Hancock: I am confident that that will happen. We cannot guarantee it because it has to be for Mike and his experts to make those judgments, but we are confident that it can happen and we are working to ensure that the pipeline is available over that period to keep seeing this research grow.

Q46 Chair: As was said to me earlier, although peer review on applications is very good, no one would have given Frank Whittle the money to develop the jet engine on that basis.

Matthew Hancock: How do you deal with that, Mike?

Chair: There are some people who manage to think outside the box.

Mike Batley: Research is always a tricky endeavour. You put in your money and you will not know until a few years down the line if you have been successful or not. Having high competition and setting those very high quality standards, which at the moment include peer review, are part of what we do to maximise that.

Matthew Hancock: I think that is a bit unfair on the approach to innovation in research funding. First, our research funding budgets are very big as a proportion of national income, and that helps. That would have helped Frank Whittle get his money. The attitude is not to look for dead certs; it is to look for good prospects.

Q47 Chair: I hope so. What we would say to you, Secretary of State, is whatever we have been doing over the past 20 to 30 years is not working, because we have not made as much progress in tackling brain tumours as we have with many other cancers.

Matthew Hancock: Absolutely right. Let me just give you one example of where the Whittle test is being passed by the NHS and the research community with flying colours now, and that is genomics. As set out in the NHS long-term plan last week, we are going to have genomic testing for every child with cancer. That unlocks a whole host of research information as well as data that can help with the clinical treatment of those individual children. There is early evidence—not yet published, so I put the appropriate caveat around it—that in one test at scale, with several hundred participants, three-quarters of treatment pathways are changed because of this genomic information.

We are building a whole hospital in Cambridge—a new children's hospital that we announced just before Christmas. It is a £100 million project. That will tie in with the globally-leading genomics that happens in Cambridge, which is the best city in the world for genomics; it will tie in with what is now the Million Genomes Project—up from the 100,000 Genomes Project, which we successfully concluded in December—and, crucially, it will tie in not just with the research side, but with changing and saving children's lives now.

Genomics is an area that is in its infancy, in terms of what it could provide. It could be the jet engine of cancer treatment over the next two decades. I very much hope it will be, but it is impossible to know. It is an area where we have been able to make this sort of judgment and very significant investments based on the early evidence—seeing the evidence that is there and getting going—at the same time as continually assessing how it is progressing.

I have said all the stuff about how it has to be Mike's decision. There are some times when the whole system spots something and we are going to back it. We very much hope that it will work, but there are no guarantees in science; there is only the scientific method of continuous progress.

Q48 Chair: Sometimes you have to take a calculated risk. On behalf of the Committee, can I thank all of you for coming here this afternoon? You have given us some food for thought. This was the Committee's first inquiry shortly after we were set up and we will want to follow progress on this, particularly in ensuring that the work of the Task and Finish Working Group is taken forward. We look forward to perhaps having more sessions on that in the future, and we thank you very much for your attendance this afternoon.

Matthew Hancock: Could I just add, on the parliamentary point, that I think that having this Committee helps us to respond to the public better than we previously have done? Responding to petitions—not just with a debate in Westminster Hall, which is very important, but with ongoing following of a subject—is really important. We have dived, in this discussion, into one particular condition, but it is a very important condition. You have made a difference to the amount of attention it has in Government. That is this process working in a collaborative way for the benefit of our citizens.

Chair: Thank you very much. That is something we try to tell our colleagues frequently.