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| **Meeting title:** | Nutrition and Cancer NIHR infrastructure collaboration Steering Committee |
| **Date:**  | 26th February 2015  | **Time:** |  11am-1pm |
| **Location:**  | WCRF, Bedford Square, London |
| **Present:**  | Prof Alan Jackson (AAJ) – ChairKate Allen (KA), Leanne Black (LB), Carrie Bolt (CB), Karen Brown (KB), Ramsey Cutress (RC), Matthew Hallsworth (MH), Arabella Hayter (AH), Elio Riboli (ER), Lesley Turner (LT), Martin Wiseman (MJW) |
| **Apologies:**  | Lucy Allen (LA), Helen Campbell (HC), Anne Helme (AH), Richard Martin (RM), Steve Wootton (SAW), Yi Lu (YL) |
|  | **Welcome and apologies**AAJ opened the meeting and thanked everyone for coming. Leanne Black (LB) attended in place of Rowena Sharpe (Royal Marsden BRC).  | **Action** |
| **1.** | **Previous minutes and matters arising**The minutes from the last meeting (September 24th 2014) were agreed with no amendments. * 1. Timeline and update of progress

AKMH presented the Gantt chart and highlighted notable dates; the first complete draft of the final report is due on March 31st and a finalised version on 30th April. AAJ thanked AKMH and YL for keeping to the project timelines and deadlines. * 1. Proposed board membership (att. 3)

AAJ went through the TORs of the management structure of the collaboration in detail. *The Board*LT asked who would conduct the formal review of the Board. AAJ said they report to NIHR. MJW said the invitations to the Board should come from NOCRI/NIHR. NOCRI will send formal invitations for the Board. NOCRI will not nominate a specific person; this will be up to each organisation to decide. *Steering Committee*AAJ said that the SC should be as inclusive as possible because the collaboration has a large remit. KB asked that the TORs be changed so that she represents the ECMC network rather than the secretariat. This change will be made to the TORs. KA asked if her role be changed to WCRF UK; KA is head of WCRF International but she will represent WCRF UK on the Steering Committee as this is a UK-focused project. AAJ linked this point to a discussion of how to involve the devolved administrations. Initially, the remit was limited to England to get the work started quickly; once the initiative is better established, Wales, Scotland and Northern Ireland should be more heavily involved. MH said this involvement should be driven by the science rather than influenced by the way that funding works. CB asked if there is an equivalent of NIHR for the devolved administrations. MH said there is but they are structured differently (e.g. there are research networks and early research centres in all areas of the UK).*Task & Finish Group* AAJ explained the remit of T&F group and highlighted that the group would become a secretariat once the ambition of the collaboration is better defined. AAJ suggested the Board reviews the TORs of all three groups at its first meeting.  | **LC/LA**AKMHAKMH |
| **2.** | **Mapping – preliminary results** MJW and AKMH presented a summary of the results of the mapping activity. MJW emphasised that the results are preliminary and will need to be revisited at a later stage. This is a first go at filling a clearly identified need to get a picture of research in the UK. We will compare the results of the mapping against people’s perceptions of gaps (informed from the patient and clinicians surveys). MJW noted that the final number of awards included (158) is very small, given nutrition and cancer is such an important area. AAJ stressed that the mapping exercise was not designed to be too detailed but to get an overall sense of the picture. MJW explained that the most common type of awards are about infrastructure and delivery of services, rather than understanding the biology of the nutrition and cancer as a basis for therapy. There is also a substantial amount of work going into aetiology and prevention. MJW presented an overview of awards according to nutrition sub-themes. He noted that body composition is very far down the list (although anthropometry, which appears separately, may address similar issues), while dietary exposures seem to dominate where funding is going.MJW highlighted three key findings: 1. There is a relatively small amount of money dedicated to nutrition and cancer
2. A large proportion of funding goes to infrastructure rather than to understanding the biology of disease.
3. It is not clear if these awards are trying to answer the most pressing questions or, those that present the biggest burden, or those where answers might more easily be obtained.

KB asked if dietary compounds and components were excluded from the mapping. RIC said that if the dose was relevant to a dietary dose it was included. She also asked if specific components of food and cancer risk are included; MJW confirmed they are not excluded so long as the dose and means of exposure were relevant to cancer in free-living humans. LT noticed that since presenting at NCRI, the inclusion criteria have been changed and now include studies with cancer as a secondary objective. This decision was made because there was a risk of excluding relevant studies if only looking at studies with cancer as a primary objective. LT agreed that this was a sensible approach. KB asked if the NCRI database includes awards from international funders. AKMH said that it is only UK-based funding but that it may fund awards which involve international research.LT asked what ‘non-specific lifestyle factors’ are. AKMH said that the final report will include detailed definitions of nutrition sub-themes. AAJ said that a fundamental problem that this work highlights is that there is currently no common and structured language to communicate nutrition themes within cancer research. MH asked if the included awards could be mapped against funders to see if data was being steered by funders’ agendas. YL and AKMH will see if this is possible. LT would like to know who is funding what to see how much one could expect to get out of each funder? Unfortunately it is difficult to apportion funding to specific research questions because of the nature of the NCRI data.  AAJ and MJW invited members of the SC to suggest ideas for additional analysis and send to AKMH. AAJ reminded the SC that the big challenge at the start of this work was to understand what level of granularity could be expected. Given the time available, it may not be possible to include all suggestions in the current analysis but they may be useful for future work and will be included in the final report. **Plans for the final report** The final report will be circulated before the next meeting of the SC. MJW said he expected the report to become the work plan for next phase of the collaboration. The report will primarily be factual and will include the results of the mapping and two surveys. The Board should meet after the next SC meeting to review the report and discuss the next phase and direction of travel. MH suggested that it should be an internal report at this stage. He suggested three key questions: What are the key messages from the results? What should people do with the information presented? What is the call to action?MJW said the report should be put in the public domain after it has gone through the review with the Board. LT stressed that it is important that it be made public eventually.ER suggested the report be written for three audiences: the public, funders and researchers. There should be a simplified version of the report for the public which includes recommendations and shows clearly why the work has been done. AAJ recognised the complex nature of the landscape; it is difficult to consider nutritional exposures, cancer sites, stage of cancer journey and levels of complexity of investigation (e.g. cell, tissue, whole body, society) at the same time. | **YL & AKMH****ALL** |
| **3.** | **NCRI** * 1. 2014 report

AKMH presented a summary of the 2014 NCRI report. LT asked for clarification of the toolkit that is being developed. AAJ and RIC explained this was a part of some work by Southampton BRC because there is a need to measure nutritional parameters routinely in cancer care in a standardised way. * 1. 2015 plans

Unfortunately, a negative response was recently received to host a symposium at the NCRI 2015 (application submitted in December 2014). LT offered to contact her consumer contacts on the NCRI panel to highlight the importance of this session and see if they would change their mind; consumers at the NCRI say there is too much biological science and they want more consumer-focused work The symposium would help fill this need. LT suggested giving a presentation to the Supportive and Palliative Care group who would be very interested to hear about this work. It is small group (25 people) but many of them may be able to help raise awareness of the initiative. The next meeting is on 25th March. LT to ask the head of CSG about talking at the March meeting or the following one. KB stressed that we need to educate people about why this work is important and to raise awareness of the initiative. KB suggested applying to the BACR (British Association for Cancer Research) for funding to host a meeting. ER is organising a day long meeting at Imperial College London about cancer epidemiology (potentially September or October 2015) and suggested including a session to raise awareness of the initiative; the meeting follows on from a similar meeting in Oxford which was attended by 60-70 epidemiologists. AKMH will follow up with ER to pursue this option.  | **LT****ER & AKMH** |
| **4.** | **Stakeholder engagement** * 1. Industry

AAJ asked for suggestions on how to engage with industry; industry is a central part of NOCRI’s work. LC suggested the collaboration need not pursue this yet until there is a clearer vision of the way forward. MH said the collaboration should consider two things: 1) what is the offer to industry? 2) what can the collaboration ‘sell’ to industry? * 1. Dissemination of results

The report needs to be directed towards a range of audiences; each will require a different language and way of presenting the results (e.g. scientific journals for academic audiences). MH asked how the report will address which are the most important gaps and which ones should become priorities for research. We should attempt to define what the priorities are for patients, researchers and funders. The difficulty is to understand whose priorities are most important and dedicate the appropriate resources to each area. ER suggested encouraging researchers and funders to fill in the gaps but reminded the group that there is a risk that researchers will only apply for funds for work that has been done before because it has a higher probability of being funded. Using the gap analysis, we can identify priority areas for clinicians, patients and researchers and aim to come up with maximum of 5 priority areas to focus on.MJW reminded the group that the aim is to help develop an infrastructure for research and to bring coherence to the work that is currently being done so important areas get the recognition they deserve. It is also important to encourage inter-disciplinary work. Although the application for NCRI 2015 was rejected, a number of other routes of communication were discussed, eg give a presentation to CSGs (eg the Palliative and Supportive Care CSG; AH will liaise with LT to explore options with this CSG). It was agreed that a plan for disseminating and networking should be created for the next year of the initiative.  | AH/LT |
| **5.**  | **Priorities and next steps**The priorities and actions for the next phase are as follows: 1. Produce draft report for the next meeting of the Steering Committee (May). Include an action plan for next steps within the report
2. Send ideas for dissemination of report to AKMH
3. NOCRI to send invitations for Board
 | T&FALLLC/LA |
| **6.**  | **AOB**There was no other business.  |  |
| **7.** | **Date and host of next meeting:** The next meeting will be hosted by Imperial BRC on Tuesday 12th May, (Praed Street Room, Imperial College London, St. Mary’s campus, Norfolk Place, London W2 1PG) |