



Committee of Public Accounts

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The Countess of Mar
House of Lords
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1 February 2017

Dear Lady Mar,

CONCERNS ABOUT PUBLIC FUNDING FOR THE PACE TRIAL

Thank you once again for your email of 31 October, and attachments, in which you set out in detail your long standing concerns about the PACE trial. You asked the Committee of Public Accounts to enquire into the public funds spent on the trial itself, the cost of defending requests to release the trial data, and the broader costs associated with flawed diagnosis and treatment of people suffering myalgic encephalomyelitis (ME). In that context, you raise serious concerns about the conclusions reached by the PACE trial, and the robustness with which the Medical Research Council (MRC) oversaw the project.

I let you know in my previous response that I had asked the National Audit Office for their initial advice. In making a judgement about whether, or when, it would be appropriate for the Committee of Public Accounts to investigate further, I have been led by two broad principles: whether parliament and the public can be confident that there is effective oversight of publicly-funded scientific research; and whether the NHS is offering treatment that is evidence-based and cost-effective.

Oversight of publicly-funded research

MRC's funding for the PACE trial and other research relevant to ME and CFS

The summary document you attached argues that behavioural interventions were already known to be ineffective for ME/CFS and that conducting the trial was therefore "professional misconduct and/or fraud". It points to World Health Organisation classification of CFS as a neurological rather than a mental condition, and argues that Professor White obtained ethical approval for the study "under false pretences" because PACE was designed to look at the effectiveness of psychological interventions.¹

I note that MRC, in its response to correspondence from Professor Hooper, argued that "the peer reviewers and the MRC Board were satisfied that the PACE trial was

¹ Key points for M.doc, paragraphs 4, 9

adequately justified based on the extant literature when the funding decision was taken".²

The decision whether or not to fund any specific clinical trial is essentially a clinical judgement on which the Committee of Public Accounts is not well placed to comment. Because ME/CFS is still not fully understood, and was even less well understood at the start of the trial, there is limited value in second-guessing, with hindsight, a scientific judgement that was made over a decade ago.

I am aware that one of the criticisms of the PACE trial is that it may have been vulnerable to selection bias (that participants may have been included who met criteria for fatigue, but not other symptoms specific to ME).³ This means that some patients participating in the trial may well have had debilitating illnesses, but that these were not necessarily ME or CFS as defined by other criteria. The PACE trial included some people with depressive symptoms, for example, for whom psychological therapies may well have had some benefit. The concern raised is that results for the cohort of patients receiving cognitive behavioural therapy may have been inflated because of effective treatment of depression, not treatment of ME/CFS itself.

You also highlight serious concerns that have been raised within the ME community about the effectiveness of psychological therapies, and question whether further research funding directed at psychological interventions is good value for money. I too would share that immediate concern if psychological trials were the only research to be funded, and that other research into ME/CFS were to be neglected as a result.

It does appear to me a fair question, therefore, to ask whether MRC, or other funding bodies, have unduly prioritised research into psychological or psychosocial therapies at the expense of research into neurological or pathological causes of ME and/or CFS. In that context, the papers you enclosed highlight three further trials:

- 'FINE', for the most seriously affected patients, that was inconclusive;
- 'GETSET' (graded exercise therapy guided self help), that has yet to report; and
- 'MAGENTA' a trial of graded exercise therapy in children and teenagers, that has also yet to report.

In addition, I note that the National Institute for Health Research (NIHR) Health Technology Assessment programme funded, in May 2016, the FITNET-NHS trial targeting children with ME/CFS who do not have access to local specialised services. I understand that the trial will investigate the effectiveness of online cognitive behavioural therapy.⁴

The MRC has said it is also currently providing £1.65 million funding to other projects that include pathological and biological research.⁵ I do not see at as the role of the Committee of Public Accounts to question the scientific basis of funding decisions that have been subject to peer scrutiny. However, it is important that the public can be confident that those decisions are objective, fair, and that they take account of all relevant evidence. In light of the concerns about the PACE trial raised following

² Letter from Medical Research Council to Professor Hooper, February 2011

³ Stats.org, *PACE: The research that sparked a patient rebellion and challenged medicine*, 21 March 2016

⁴ University of Bristol Centre for Child and Adolescent Health, *FITNET – NHS Study*

⁵ Medical Research Council, *MRC-funded research projects*, MR/J002895/1, Professor Anne McArdle

release of the trial data, I will ask the National Audit Office to keep in view the balance of future funding awards and, if appropriate, provide further advice in due course.

Access to data generated by publicly-funded research

You raise specific concerns that Queen Mary University of London resisted requests to release anonymised clinical trial data. Aside from the public costs involved, this meant that data from the PACE trial was not subject to the extent of critical peer scrutiny that would otherwise have been possible.

The previous Committee of Public Accounts voiced very similar concerns about the transparency of data generated by publicly-funded clinical trials. Reporting on *Access to clinical trial information and the stockpiling of Tamiflu*, the then Committee was critical of the fact that information was routinely – and legally – withheld. The Committee noted that this undermined the ability of clinicians, researchers and patients to make informed decisions, and potentially restricted the evidence available to the National Institute for Clinical Excellence (NICE).⁶

I note that the MRC's own policy and guidance recognises the benefits of data sharing, including independently verifying established research findings, and "using to best effect the gift of data made by study participants", concluding that "data sharing therefore represents an efficient use of public money and supports more timely scientific discovery".⁷ The published policy statement says that "MRC's overarching policy aim for data-sharing is to maximise the life-time value of research data assets for human health and to do so in a way that is timely, responsible, with as few restrictions as possible, and consistent with the law, regulations and recognised good practice".⁸

In the case of the PACE trial, disclosure of anonymised data was made through freedom of information legislation. This is a matter for the courts and, now that the tribunal has published its conclusion, in my view there is little more that the Committee of Public Accounts could usefully add.

Patients' access to evidence-based and cost-effective NHS treatment

You highlight a concern that, because of NICE placing reliance on the PACE trial, recommended treatments for people suffering ME or CFS may be ineffective or, in some cases, harmful.

The NHS Choices website refers to cognitive behavioural therapy (CBT), graded exercise therapy (GET) and medication as available treatments. NHS Choices does also say, however, that "the use of CBT doesn't mean that CFS is considered to be a psychological condition" and that, although there is no medication available to treat CFS, some medicine can help alleviate some of the symptoms.⁹ I also note that the NHS Choices website does not distinguish between ME and CFS, saying: "CFS is also known as ME, which stands for myalgic encephalomyelitis. There's some debate over the correct term to use for the condition, but these pages will refer to the condition as CFS".¹⁰ NHS Choices acknowledges that, although the World Health Organisation

⁶ Committee of Public Accounts, 35th report of session 2013-14, *Access to clinical trial information and the stockpiling of Tamiflu*, HC 295 2013-14,

⁷ Medical Research Council, *MRC policy and guidance on sharing of research data from population and patient studies*, November 2011,

⁸ Medical Research Council, *Data sharing policy*, September 2016,

⁹ NHS website, Chronic fatigue syndrome - Treatment

¹⁰ NHS website, Chronic fatigue syndrome - Introduction

classifies CFS as a neurological condition, NICE clinicians "could not agree that this classification is the right decision".¹¹

I share your concern, in light of criticism of the robustness of the PACE trial you forwarded with your letter, that NICE-recommended treatments may not be appropriate for all patients. I am particularly concerned by the suggestion that the value for money claimed for NICE-approved NHS treatments may be significantly lower than has been claimed up to this point. Patients should be able to access evidence-based treatment, and taxpayers need to have confidence that approved treatments are good value.

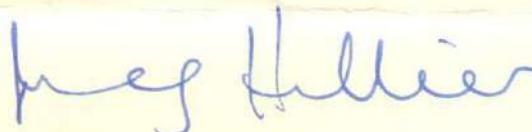
That said, the Committee of Public accounts is not, itself, best placed to comment on the robustness or clinical evaluation of trial data that is now subject to scrutiny by the wider scientific community. I am aware, however, that NICE has announced that it is checking whether the current clinical guideline needs updating. NICE has also said that it has been made aware of new information about the PACE trial, and that it will consider that information as part of its check.¹²

The National Audit Office has been in contact with NICE to clarify the nature of the review of the clinical guidance that NICE has announced. In response, NICE noted that the guideline recommends offering CBT and GET in the context of a specialist service and an individualised care programme, under the control of the person with CFS/ME, and that it recommends that CBT and GET should only be offered to those who agree with this approach. NICE advised that it was in that context that it considered the results of PACE to be consistent with the guideline.

NICE has confirmed that the review of the guideline will consider eligible evidence published since 2011. It has committed to reviewing the need to update the guidance earlier than the originally anticipated review date of 2019, since it became aware of the reports from the USA proposing changed diagnostic criteria for CFS/ME and a boost to research activity in the field. NICE has not released a detailed timetable for the review, but expects to have decided on the appropriate course of action by summer 2017.

Since NICE is examining evidence subsequent to the PACE trial as part of its review of the clinical guidance, there would be limited benefit to patients from further scrutiny by the Committee of Public Accounts while that review is underway. I have therefore asked the National Audit Office to keep a watching brief on the scope and progress of the NICE review, and to advise this Committee if further intervention to help patients and protect public funds is needed at any point in the future.

Yours sincerely,



MEG HILLIER MP
CHAIR OF THE COMMITTEE OF PUBLIC ACCOUNTS

¹¹ NHS website, Chronic fatigue syndrome - Causes

¹² NICE, Chronic fatigue syndrome/ myalgic encephalomyelitis (or encephalopathy): diagnosis and management, Clinical guideline (CG53), August 2007