HOUSE OF COMMONS

Science, Innovation and Technology Committee

Oral evidence: Life sciences investment, HC 1369

Tuesday 28 October 2025

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Watch the meeting

Science, Innovation and Technology Committee members present: Dame Chi Onwurah (Chair); Emily Darlington; Dr Allison Gardner; Kit Malthouse; Dr Lauren Sullivan; Adam Thompson; Martin Wrigley; Daniel Zeichner.

Health and Social Care Committee member present: Joe Robertson.

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Witnesses

I: Dr Sam Roberts, Chief Executive, NICE.

II: The Lord Vallance of Balham KCB, Minister for Science, Research and Innovation, Department for Science, Innovation and Technology; Dr Zubir Ahmed MP, Parliamentary Under-Secretary of State, Department of Health and Social Care; and Steve Bates, Executive Chairman, Office for Life Sciences.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witness

Witness: Dr Roberts.

Q1 **Chair:** Good morning. In this session of the Select Committee we will be looking further at life sciences competitiveness, which follows from our session in September and the progress we have made since then. I am going to ask our first witness, Dr Sam Roberts, to introduce herself when she answers my first question.

NICE is responsible for the cost-effectiveness of medicines and making them available on the NHS. This is not an easy job; it can be quite literally a matter of life and death, and the NHS must provide value for money. However, we as a Committee have also heard evidence that your decisions are reducing the competitiveness of the UK for life sciences investment. This is part of what we are looking at this morning. I want to start with QALYs, or quality-adjusted life years. What are they, and how effective are they for assessing medicines and medical technologies?

Dr Roberts: Thank you so much, Chair, and Committee members, for having me here today. My name is Sam Roberts. I am chief executive of the National Institute for Health and Care Excellence, shortened to the acronym NICE. I am going to start with some general comments on medicines access and then zoom in on what QALYs are.

As we are talking today, it is important to anchor ourselves in where we are, where we want to be and whether we have enough to get there. On where we are, NICE says yes to 91% of medicines that we look at. That means that the vast majority of patients in this country get the medicine they need. That has been so for many years and we have not seen any decline in that recently. Where does 91% put us? It puts us sixth in Europe, out of 37 countries. We are in the top quartile. We are not the best; we are definitely not the worst; and there has been no deterioration in that over the past five years.

Where we want to be in the life sciences sector plan is a bigger question: top in Europe by 2030 and top three in the world by 2035. All questions are answered with that duality. We are where we are, which is top quartile—not too bad—but we have much bigger ambitions. Is what we are doing now enough to get to those ambitions?

Within that framing, in looking at quality-adjusted life years, we take very seriously the fact that when we make a decision at NICE we are making a decision on how to allocate the taxes that people have paid. It is really important to us that we make those allocations in a way that the public would make themselves if they were given the money. We base all parts of our calculation on how you would decide if you were the public. One thing that emerges quite clearly from asking the public what they would spend money on is that the two most important things for them are length of life and quality of life. That is basically what a quality-

adjusted life year is. It combines the two ideas of length and quality into a single number.

Should I stop there? I could talk about it for a long, long time.

Q2 **Chair:** That is a great summary at a high level of what a QALY is, but it also has a price to it or threshold of £20,000. I read that the founding chairman of NICE admitted that that threshold was not based on any empirical evidence, but the collective judgment of health economists. I have to say I was dismayed. That hardly seems a scientific basis on which to make such decisions. We have received evidence that the QALY cost-effectiveness threshold, for example, has remained static since 1999. Should it rise with inflation, or would that just embed an unscientific basis to increase its value? Are you happy with a threshold of £20,000 that seems to have no scientific underpinning?

Dr Roberts: There is so much in that, I will talk quickly about the history, where we are now and why the idea of it being static for 25 years is only half of the story.

As to where it came from, you are exactly right. It emerged from committee deliberations not based on any evidence. However, having said that, after NICE had been in operation for about 10 years, some evidence was collected which looked at how much health you got from the NHS for every pound spent. That number came up as roughly £15,000 per QALY. The NICE threshold is £20,000 to £30,000. More broadly, I think the sense was that we were paying a little bit extra for innovation. We were paying £20,000 to £30,000, whereas for most of NHS money you spend £15,000 per one QALY, but that was fair because we were paying a slight premium. You are right that it started in the absence of evidence and then evidence emerged that people became comfortable with.

I think why it is half of the story to say that it hasn't changed at all—

Q3 **Chair:** When did the evidence emerge?

Dr Roberts: I think it was in about 2008.

Q4 **Chair:** How did it emerge?

Dr Roberts: Health economic researchers looked at all the health expenditure in different categories, like expenditure in cancer care and expenditure in cardiovascular care, and then they looked at the number of quality-adjusted life years—it wasn't quite that—or how much health was gained through that expenditure in the NHS. On the basis of that, they said that, roughly, across all different types of spend, the NHS paid about £15,000—

Chair: Per year.

Dr Roberts: —for a quality-adjusted life year.

Q5 **Chair:** Should that continue to be the basis? That £15,000 was what we were paying in 2008. Is that what we are paying now?

Dr Roberts: At the moment, we are paying £20,000 to £30,000.

Q6 **Chair:** That is what NICE is paying, but what is it in terms of the average of all NHS health expenditure?

Dr Roberts: We do not know because that study has not been repeated. The last data we have on that is 2008. What has happened between 2008 and now is that the headline number of £20,000 to £30,000 has stayed the same, but the ingredients of the number have changed. Just remember that the number is a ratio of cost on the top and benefits—quality-adjusted life years—at the bottom, and we have changed both of those as time has gone by.

On the top, we think of all the healthcare that has been saved by the person getting that medicine. If you get a medicine that stops you from hospitalisation, we count the costs of that hospitalisation that have been saved. Those have increased with inflation. The costs bit keeps track with how costs change in the NHS. As for the bottom bit, the benefits, over the years we have been given a number of freedoms about how we interpret them. I will give you a couple of examples. For example, society thinks that we should pay more for severe disease than for non-severe disease. We were given some freedoms in 2022 that said we could weight those benefits and pay about 20% to 70% more for severity. For rare diseases, where it is really hard to get the right data, we are allowed to pay three to 10 times more. So you see what I mean: the headline figures stay the same, but the ingredients that go into it have changed.

Q7 **Chair:** You have been given freedoms in exceptional or specific cases, but the actual basis remains around £20,000. My background is in tech. We generally see that tech costs go down—

Dr Roberts: Indeed.

Chair: Exponentially over time, in fact. Is it your view as chief executive of NICE that we should be paying more or less for a quality-adjusted healthy year than we were in 2000?

Dr Roberts: In our view, this is a decision for Government to make, because just considering the threshold in isolation does not fully capture the costs of changing it. The reason we think it is for Government to decide is that, should Government decide to increase the threshold, yes, that would mean more patients would get access to more medicines. That is a fantastic thing, but it would also mean that that money would have to be taken away from somewhere else. That may mean a person who was going to get a hip replacement doesn't; a person who is on a waiting list for talking therapy doesn't get that therapy. If that money comes from broader Government, it may mean there is less money for education or prisons. It is not really for an agency like NICE to say where

Government should spend the most money; it is more for Government to set the direction and then we transact it.

Q8 **Chair:** I am not suggesting that you should say where Government should spend their money. We will have a ministerial panel after you. Minister Ahmed has said that there is an argument for re-examining certain components and I would like your view on that. I am asking for your view on the value of an extra year of healthy life and whether the cost of enabling that should have or has changed in the past 25 years.

Dr Roberts: We look at the overall data. We say yes to 91% of medicines—the top quartile—so we feel that the threshold as it stands enables that level of medicines access. We also completely accept that the Government may want more medicines access or to prioritise that, but it is not something where there is lots of technical data we can apply. It is a resource allocation choice.

Q9 **Chair:** I am not quite sure you have answered my question as to the basis for making that decision on £20,000. I think what you are saying is that it is up to Government to decide what they want to pull through in terms of medicines, and £20,000 seems to be doing okay at the moment.

Dr Roberts: I can say that the basis as it currently stands—but Government may want to change it—is that.

Q10 **Chair:** Do you think Government should change that basis?

Dr Roberts: It is really not for us to say.

Q11 **Dr Gardner:** First, I have to say that I used to work for NICE prior to becoming an MP, although I did not work in health technology assessment but within the AI and Digital Regulations Service. You did try to teach me about this and I did not take to it, and I have some real questions about how QALYs are calculated. I want to clarify one point. You stated that previous research indicated that the NHS was spending 50 k per—

Dr Roberts: Fifteen—one five.

Dr Gardner: One five; thank you. Okay, I wanted to double-check that I hadn't misheard. The way that QALYs have been calculated is by cost utility analysis. When you look at managing the utility you use the five-level EQ-5D approach.

Dr Roberts: Yes.

Q12 **Dr Gardner:** I worry that these are very subjective. I know that they measure various types of things. How people identify whether they have mobility issues, anxiety or depression on a five-point scale can be very subjective, so I do worry that there is bias injected into the assessment process. There are limitations in regard to that, because when you are looking at the number of life years gained rather than quality of life years gained, in how you calculate it, that impacts people with chronic illnesses

and the number of years living with a disability. I prefer DALYs over QALYs. Do you agree with me on that? Are you questioning the use of QALYs? The citizens panel that you had raised this, saying they should not be used. Have you been looking at alternative measures to deal with these limitations?

Dr Roberts: As you say, any measure will simplify a situation. The tool that we use for measuring QALYs looks at whether you can undertake activities of daily living. You are right that in certain population groups—for example, in children—these may not be a very great measure; they may not fully capture the benefits of reducing health inequalities. We take that as the core measure and then look around it, asking, "Where do we think the weaknesses are and how can we bolster our system around that?" For example, we always get patient and clinician evidence in all of our committee deliberations so that we can fully understand the impact beyond just the measure of the QALY on a person's life and the life of their family. That is something the committee can take into account. We can pay more for addressing health inequalities.

So we do not think we should move away from the QALY measure. In fact, we are just at the end of relooking at how people in the UK value these things. We have a good dataset on how much this is valued in the UK, so we think we should keep that; and we should be honest about where it has weaknesses and bolster our process, and give our committees the flexibility to listen to those alternative voices and act on them, and not be kept in a straitjacket. That is what we do.

Q13 **Dr Gardner:** That is good to hear. Thank you for raising age disparities and children. That was one of the limitations. I still feel there are issues with chronic illnesses. I have talked to you before about this. I have one that is not currently recognised by NICE. When you are doing the cost utility analysis of treatment with people with chronic UTIs and antibiotic treatment, that cost utility analysis fails. I do have some issues there.

Can I ask about your citizens panel which was removed? Now you use a statement of procedural principles and NICE Listens. The citizens panel suggested that you do not use QALYs and you are now using NICE Listens. I am quite interested in how the two processes—the citizens panel and NICE Listens—work. Could you update me on that?

Dr Roberts: I am sorry that I cannot talk in detail about the citizens panel because that predated me, but we can give you further written evidence on that. As to how NICE Listens works, this is based on the fact that every time we make a decision we need to do so as close as possible to how a member of the public would make it. What do we know? We know that the public care about length and quality of life, and we use the instrument you have talked about to measure that, but there may be evolving societal preferences. Do people feel differently about environmental sustainability? Do people feel differently about health inequalities? Whenever we think there is a preference that may be changing in society, we use NICE Listens as a specific investigation to get

together a panel of people and have that conversation with them. It starts more generally. Do you think there is a difference here? Then it goes into it more specifically. If you ask people whether we should pay more for environmental sustainability, everybody will say, "Yes, of course," but then we ask whether they would pay more for this or this, or for that or that. We ask members of society to do the trade-off. If we find there is something that they would persistently pay more for, like severity, we say we need to do more detailed work on how much more we would pay for severity.

Q14 **Dr Gardner:** I was quite interested in how we are going with the NICE mandate. There were some updates in July 2024, which was in your time. I know you are looking at improving that pathway, and there will be no approvals in 2025-26 while you develop those changes. In trying to get medicines into use in the NHS, can you tell me about the work you are doing on that and the NICE mandate?

Dr Roberts: Are you talking about the joint process within MHRA?

Dr Gardner: The MedTech Funding Mandate policy.

Dr Roberts: Everything we have talked about so far has been largely about medicines. What you are rightly saying is that, in life sciences, devices, diagnostics and digital are an equally big employer; they are equally important for patients. In this country, unlike medicines, they do not get mandated funding. When NICE says yes to a medicine, the NHS has to fund it; when NICE says yes to a device, diagnostic or digital product, nobody needs to fund it. We were delighted that in the 10-year NHS plan that was released, in areas of greatest need NICE can make a recommendation for a diagnostic device or digital and that will have mandated NHS funding.

We are now going through the process. We have spoken to lots of clinicians, patients, et cetera, to say, "Which topics shall we start looking at?" We have gone from over 200 and prioritised them down to six. Those are going through our prioritisation board. A couple—maybe two or three—will be referred to us by the Secretary of State in December, we hope, and then the NICE process will start in February next year.

Dr Gardner: To make a very quick final point—I know this is slightly out of scope—when that happens and you are talking about scaling up such technology, you can also scale up the risks. I think that is something you need to look at as those potential risks can be elevated. I will leave that; thank you.

Chair: Thank you very much, Allison. It has been remiss of me not to introduce two new members to the panel. First, Joe Robertson MP is guesting on today's session from the Health and Social Care Committee; secondly, Daniel Zeichner has joined as a Labour member on the Select Committee. We celebrate their presence with us today and I will ask Joe to come in on this.

Q15 **Joe Robertson:** Thank you, Chair. You referred to the process by which you come to understand society's views over quality-adjusted life years and similar. Are you confident with that process?

Dr Roberts: That is a great question. Yes, we are confident with the process, in that there is quite a good body of literature on eliciting societal preferences. As to how we do it, first, we take a broad-brush approach, which is what we are speaking about with NICE Listens. We do not speak to a huge number of the public, but enough to get a sense of whether there is something really here. Once we get a sense that there is something here, we do a very detailed, absolutely best-practice primary research study.

To give you some sense of how big this is, in working on severity, we take 1,000 people and in person talk them through whether they would pay more for this or this, or that or that. That is where you get the actual weights from. Are we confident that we are using the best and most rigorous academic approach? Yes. Do we also recognise exactly what Dr Gardner just said, which is that sometimes science does not get the human nuance? Sometimes it does not understand what it is like as a parent when your child is sick and the impact it has on the family. So we bolster that with hearing from the human beings who are living with these conditions through our process.

Q16 **Joe Robertson:** I would suggest that even with that human process—it goes with any focus group research of this kind—how you frame a question influences how it is answered, so there is an inherent risk around that process.

Dr Roberts: Exactly. That is why I think it is really important for us to have safety nets in the process. We have three ways that we make sure we are hearing from people. The first is that we invite people, or their carers, with specific lived experience into the committee to describe the impact on their lives and what the medicine would mean. The second is that we have lay members of the committee who ensure that the committee is properly hearing the layman's perspective. Thirdly, every time we make a negative decision we put it out for consultation. Anybody who is an interested stakeholder can say to us that they do not agree with our decision for X, Y and Z reasons. Those considerations need to be brought back to the committee.

Q17 **Dr Sullivan:** Thank you for joining us today, Sam. My question is linked in a way to one of your answers to Allison. It is all great to hear from members of the public, focus groups and changing opinions. Can I have some assurance that, if a section of society said they did not want vaccines to be invested in by NICE, there would be checks and balances in place to ensure that we still can vaccinate people?

Dr Roberts: That is a great question, and it is also why we do not ask people whether they want a medicine for covid or heart disease, because there is inherent bias in that. Rather, we step back and say that NICE will

look at 100 medicines in a year. What are the attributes of those medicines we should pay for? We talk about attributes: length and quality of life, helping people to live with severe conditions and addressing health inequality. It is almost as if you are not choosing an apple or pear; you are looking at the number of calories or nutrition. Do you know what I mean?

Q18 **Dr Sullivan:** Leading on from that, the Government are very focused on prevention and changing long-term things. There has always been a problem about the preventive argument; that is, this particular thing will prevent so many things in the future. How do you quantify or calculate that? How is that folded into the mix, and is there potentially some refinement that needs to happen to the algorithm?

Dr Roberts: Yes. Remember, what we look at are the costs divided by the benefits. Those costs and benefits we model for the whole life of the human being. Let us take weight-loss medicines as an example. We know that weight loss will lead to a reduction in stroke, heart attack, diabetes and certain types of cancer. All of that we model. We say, "If you take this, you will get all those health benefits from the things that have been avoided, and the NHS will save all that money." We are pretty confident that we capture all the health benefits in the future.

Q19 **Dr Sullivan:** We heard from some companies that may have suggested it is quite narrow when it comes to the wider benefits and fitting into them the cost reductions. Obviously, companies will always try to push this. Do you think they have a point in some cases?

Dr Roberts: When we read the evidence to this Committee, there was a lot of talk about NICE measuring the costs and benefits to the health and personal social services system. It does not measure the benefits to the broader economy. Having said that, we do have the power to do that, but we need to be explicitly instructed by the Secretary of State. To give an example, when we looked at cochlear implants, those have a big impact on children's attainment at school. Not only did we consider the cost of cochlear implants but the savings from school attendance, et cetera. We have the methods to do it. They are very well described; there is absolutely no problem in doing it, but we need to be specifically instructed by the Secretary of State.

Dr Sullivan: That may be a request that we make.

Q20 **Chair:** To clarify that, you need to be specifically instructed by the Secretary of State to do what?

Dr Roberts: To include broader societal matters.

Q21 **Chair:** That was what happened in the case of cochlear implants.

Dr Roberts: Yes. Every single medicine we look at gets referred to us by the Secretary of State. When they refer it, they say, "This is the perspective we want you to take."

Q22 **Adam Thompson:** Good morning, Sam. Thank you for joining us. NICE has a number of commitments within the life sciences sector plan, but I think that only one of these can really be considered truly measurable. Do you think this approach is good enough for addressing the ambitions of the plan?

Dr Roberts: There are three commitments. We measure all of them and report to Ministers on all of them, but I think I know which one you mean that is only measurable. The three are: first, faster access to medicines through a joint NICE-MHRA pathway. That is the one that has a measurement. We are aiming to make our decisions three to six months sooner, which means a patient would get a medicine three to six months sooner.

The second is what we have talked about before: faster and fairer access to health tech by giving it a funding mandate. There, we measure the uptake of our guidance. Let me take an historic health tech we have looked at: the artificial pancreas with a hybrid closed loop. NICE made a recommendation and then tracked how often it is used. Between us giving the recommendation and now, about a year and a half later, 65% of the people who should be getting it are doing so. We will track the uptake of the health tech.

The third one is dynamic assessment by NICE to drive smarter spending. Everything we have talked about up to now is NICE making a decision when an innovation enters the market, but a lot happens after that. There can be new evidence; there can be other new innovations. The commitment in the 10-year plan is that, where we see the evidence changing, NICE will do an updated assessment. To give you an example, one we have just done is on type 2 diabetes, where we said you can use one type of medicine much earlier and that could save 22,000 lives, so we track that. That is a long way of saying there are three things. One is a headline thing we track, but we are tracking everything.

Q23 **Adam Thompson:** I appreciate that. Thank you for outlining the three commitments. Do you think they are going the full way to addressing the ambitions in the plan?

Dr Roberts: On speed of access, yes. When we said we wanted to be in the top three access markets in Europe, if we do what we are doing with the MHRA, there is no reason why we shouldn't be. Trying to get the exact wording, as for being the leading life sciences economy in Europe by 2030, that has a lot of other elements that are beyond NICE, like inward investment, et cetera, so I cannot really speak to those elements.

Q24 **Adam Thompson:** I suppose the bottom line is: how confident are you in achieving those goals?

Dr Roberts: Of NICE achieving our part of the plan?

Adam Thompson: Yes.

Dr Roberts: We are 100% confident. There are some things that are not in our control. If a company does not tell us that a medicine is coming we cannot give very timely guidance, but we are doing our utmost to know that a medicine is coming to the country two years in advance, so for everything under our control we have programmes in place. We are already implementing them. The MHRA-NICE pathway launched on 1 October, so it is already happening.

Q25 **Chair:** One hundred per cent confidence is not something one hears regularly. You are 100% confident of achieving what?

Dr Roberts: The three programmes that NICE is responsible for and therefore the headline metrics.

Q26 **Chair:** In the life sciences sector plan?

Dr Roberts: Which are exactly the same three as in the 10-year plan.

Q27 **Chair:** That includes being No. 1 for access to medicines in Europe.

Dr Roberts: The third fastest market for access to medicines in Europe. That means we need to get about 60 days faster. We are pretty confident that with the new process we are doing with MHRA we can get 90 days or so faster, so that is why we feel pretty confident.

Q28 **Chair:** One hundred per cent confident?

Dr Roberts: I did say 100% confident. I hope I can strike that from the record.

Q29 **Dr Sullivan:** What are you doing differently? What are the processes?

Dr Roberts: Historically, NICE and MHRA travelled like two trains in their own tunnels and we were not permitted by law to share any information about what was happening on each other's train tracks. NICE could not have a committee in public, or go out to consultation, until MHRA had made up its mind. We have changed those two things. One way is that we can now see each other's trains as they travel. Industry has opted in and consented to that. Secondly, we are doing our committees and going out to public consultation before MHRA has decided so that we can make a final decision as soon as it has.

Q30 **Dr Sullivan:** This question is related to terminations and restrictions. Do you think there needs to be a change in the way that NICE evaluates medicines, or in the development of pharmaceutical products?

Dr Roberts: I think this pertains to the fact that, every year, about 18% of medicines just don't make it through the full NICE process. We have looked in detail with the industry association at why that is. It is really for two reasons. One is that there is not sufficient evidence of clinical and cost-effectiveness to make the case to NICE. The second is that the commercial return would not be sufficient for going through the process.

When we speak to our counterparts overseas—this is common in every jurisdiction that looks at it—not all medicines make it all the way through the process in every country, but we are vigilant in seeing whether that number is going up, going down or staying the same. There will always be medicines that can't make it through the process, but we want to make sure that that stays pretty constant. It has stayed pretty constant over the past five years, at about 17% or 18%. Two years ago it went up to 24%. We had a bit of a panic. We went and did lots of detailed analysis and we realised that was just because we were clearing a bit of a backlog. Other than that year, it has stayed pretty constant. It is a feature of the system; it is common in all countries, and it is definitely not getting worse.

Q31 **Emily Darlington:** I have a couple of rapid-fire questions. I am cleaning up on what we have just discussed. Let us talk about terminations. Terminations are also about medicines. They are now not the most effective in their particular areas. As much as you track adoption, how much do you track prescribing practice or continued take-up of medicines that are less effective than the new ones on the market?

Dr Roberts: That is such a great question. We track the uptake of lots of different NICE-recommended medicines, both new and older ones. The 10-year plan now gives us the power to say where we are seeing that one medicine should have superseded another, or one medicine is not being used in the right order. Earlier, I gave the example of type 2 diabetes. We have also done something recently on heart failure. There are two medicines which we usually gave to patients. We gave them the first and the second one, and gave them the third one only after a year. New evidence shows that you do not need to wait for that year. We have given new guidance: bring that third medicine up much sooner and it will save about 2,000 lives and 3,000 heart attacks. That is a long way of answering the question. When the evidence moves, in our clinical guidelines we can reorder things to make sure we get the most health for every pound that we spend.

Q32 **Emily Darlington:** Your answer worries me a bit because what all of us around this Committee want is the best effective medicine getting to the patient at absolutely the right time. We know that particularly GPs' prescribing practices do not shift. I did a great piece of work for Nesta—of course I would say "great"—looking at prescribing practices of GPs, the lack of take-up of innovation and the reliance on what they are used to. What is NICE's role in getting those primary prescribers to change their behaviour? What programmes do you have? How are you tracking various different GPs in doing that? The prescribing data is now all available, so you have access to it. Do you see that as your role? What are you doing to change that behaviour?

Dr Roberts: Uptake of a medicine—that is how many people get it and who prescribes it—is not NICE's role; that is the role of NHS England. We wanted to truly understand what our part in this was, so we did a case study with NHS England and the Department of Health and Social Care

looking at what really drives increasing uptake, to your point, and we came up with 10 ingredients. One ingredient is for NICE, which is that we need to update our guidance as soon as evidence changes, and we need to communicate it in a clear way. We do lots of work with prescribers to say, "Do you understand what we've said? Can you use our tools?", et cetera. Some of the other things that you are talking about like tracking prescribing data, making sure formularies have the new medicine, et cetera, are the responsibility of NHS England. The 10-year plan has given NHS England—before now it was the Department of Health and Social Care—additional powers through things like the single national formulary where it will be able to be more prescriptive on that.

Q33 **Emily Darlington:** Do you think that is right? Some of the costing data and some of the costing calculations are based on take-up. We would get better deals from pharmaceutical companies—they have been very clear about this—if they could be confident of the size and take-up of the market that they are going into. That would get us a better financial deal on those medicines. You say you want value for money for the taxpayer. We absolutely agree with that. If your role is not to ensure that take-up and that the size of the patient pool is receiving that up-to-date medicine, how can you properly calculate the cost and have those negotiations?

Dr Roberts: The vast majority of medicines, 85%, do not have a complex relationship between the volume and the price; we are happy to give a discount. For the remainder, the people who negotiate the price, that price/volume relationship, are NHS England—the same folks who are responsible for take-up of the medicine. That is why the responsibility all sits in one place. It is not us shirking our responsibility because we do not think it is important. Take-up of innovation is hugely important, but what we have learnt from all the literature plus all the recent experience in the NHS is that it is a hugely resource-consuming exercise to increase take-up of innovation. You have the health innovation networks, you have the Transformation Directorate in NHS England and Getting It Right First Time. You have the workforces in ICBs and Providers. NICE is tiny in comparison to that workforce that is dedicated to improving quality and take-up of innovation, and that is why it is right that it sits in NHS England, which commissions all those things.

Q34 **Emily Darlington:** Okay. It does raise the question about whether NICE should sit apart from those other institutions—controversially. You talked about promoting take-up and you monitor take-up. What does "good" look like in terms of take-up? You talked about one being 65%. In your assessment as NICE, what does a good rate of take-up of new innovations and medicines look like?

Dr Roberts: This is kind of a controversial topic because I do not think that there is a settled position across Government on what good take-up looks like. We therefore refer to the Office for Life Sciences' competitiveness indicators. It compares a basket of medicines and says, "What is our take-up one year after NICE approval versus other

countries?" The last data on that said that our take-up is about 50% of other countries at one year and about 70% of other countries at three years. It would be reasonable to say that we would want to improve that.

Q35 **Emily Darlington:** Right, okay. I have some last questions about the streamlining of the MHRA and NICE processes. When you say it is going to cut 90 days, how long would the average process be?

Dr Roberts: At the moment, the average—how should I answer this? When everything goes according to plan and we are aligned with the MHRA, there is a gap of 48 days. That is a month and a half between when the MHRA says yes and NICE says yes. Everything has to go right for that.

Q36 **Emily Darlington:** That is not my question. How long on average—not in a best-case scenario—does it take a new medicine or a new technology to go through the current process?

Dr Roberts: It takes 240 working days on average. That is what the basic process should be.

Q37 **Emily Darlington:** Should be?

Dr Roberts: Yes.

Q38 **Emily Darlington:** How many meet that "should be"?

Dr Roberts: At the moment, it is about 60%, but I can get you the more up-to-date figures.

Q39 **Emily Darlington:** You are taking 90 days off 240 days.

Dr Roberts: Can I get into this in a little bit more detail, or should I give more—

Q40 **Emily Darlington:** You can write to us. I have a final question. You talk about us being the third in Europe. We have seen quite recently, and we have heard evidence at this Committee from, pharmaceutical companies that are making decisions to move elsewhere in Europe. Do you think it is the right ambition for us to be third in Europe and not first in Europe? What is the gap between third and first?

Dr Roberts: There are two different ambitions. The one that relates to NICE's responsibility in the life sciences sector plan is to be third in Europe on speed of access. The second is to be—I am going to read directly from the life sciences sector plan—the leading life sciences economy in Europe by 2030. That is the broader picture. Speed of access is only one of a number of dimensions on which we could be the best in Europe.

Emily Darlington: Sure. It is probably a question for the next panel.

Chair: Yes, exactly.

Emily Darlington: It does seem to not align. We are the biggest health

sector and should be the easiest if we are one NHS. The third seems to be lack of ambition. Thanks, Chair. I will leave it at that.

Q41 **Chair:** Thanks very much, Emily. Just a quick-fire question on the discount rate that affects how future health benefits are valued now. NICE is clear that there is a case to change it from 3.5% to 1.5%. Have you had discussions with the Government on that?

Dr Roberts: Yes. We have some flexibility at the moment to use the 1.5% discount rate where the medicine is curative. We have used it about three times.

Q42 **Chair:** Yes. You wish to see it changed for all.

Dr Roberts: Yes.

Chair: Great, thanks.

Q43 **Kit Malthouse:** I want to clarify the political involvement in your process. You said that every drug you look at is referred to you by the Secretary of State. Are you aware of drugs out there that could be but that are not referred to you?

Dr Roberts: No. That changed in 2019 when it was agreed that pretty much all new active substances and significant licence extensions would be referred to NICE. There are only a few examples where that is not the case.

Q44 **Kit Malthouse:** When you say "agreed", agreed by what mechanism?

Dr Roberts: Sorry, in the voluntary pricing and access scheme.

Q45 **Kit Malthouse:** The Secretary of State, you are saying, still retains discretion to say, "Well, we're not referring this drug."

Dr Roberts: Yes, that is right.

Q46 **Kit Malthouse:** In theory, a Secretary of State could be saying, "My NHS budget is constrained. There's a knockout drug out there that is easily going to make its way through NICE but is going to cost me a fortune. I'm just not going to refer it." That is possible.

Dr Roberts: It is theoretically possible, but it would be in contravention of the voluntary pricing access and growth agreement, because that states—

Q47 **Kit Malthouse:** Yes, but, as we are discovering, the VPAG is flexible and may not last much longer if the industry has its way, so all of that may well be redrawn. If a Secretary of State came to power subsequent to a general election who was an anti-vaxxer, could we be in the same situation as the United States where drugs are specifically not being referred to you or you are being instructed to stop the examination of drugs part way through their process? Is that possible?

Dr Roberts: There is no power for the Secretary of State to stop a NICE appraisal once it has started. Once it has been referred to us, that is that; it goes through. We don't look at vaccines, so that would not really affect what is referred to us.

Q48 **Kit Malthouse:** Okay, but some other drug could be denied referral through that process, like personalised medicine of whatever it might be.

Emily Darlington: The morning-after pill.

Dr Roberts: I suppose, theoretically, yes, but we have the counterweight of the voluntary pricing and access scheme. It lays out what should be referred.

Q49 **Kit Malthouse:** The reason for the question is that we are in a volatile political situation at the moment. None of us knows quite how the next election is going to go, and people need to appreciate the impact that might come about, that certain drugs may not make it on the market because of beliefs held by whoever might come to power. You said also there is political input on your discount rate and that you are in discussion with the Department, so therefore that must be going across a Minister's desk at some point.

Dr Roberts: I will answer this briefly, Chair.

Chair: Very briefly.

Dr Roberts: Any time that NICE speaks to the public and understands that there is a new preference or there is some evidence that the way we do our calculations should change, if it would incur any cost to the Government, we cannot implement it ourselves. We then go to the Department of Health and Social Care and the Treasury, and it is for them to make the "on balance" decision whether these things should be implemented.

Q50 **Chair:** Thank you. Thanks, Kit. I really have had the impression from this evidence session that, rather than evaluating the cost-effectiveness and the contributions of medicines and treatment, your role is to judge what people would prioritise and then filter the given amount of money from Government on that basis. Would you agree?

Dr Roberts: Yes, and we would define your first thing and your second thing as the same thing, if you know what I mean. That is the same as considering the clinical and cost-effectiveness of medicines.

Chair: Not necessarily, I think, because cost-effectiveness and the treatment in medicine have a scientific basis that the opinions of people and particularly the political input that we have just discussed may not reflect. We will have to leave it there. We have the Ministers waiting outside. I want to thank you very much for your contribution. It has been a fascinating discussion. You can see that the entire Committee was very interested in your responses. We will be taking it up with the Ministers

now. Thank you very much.

Examination of witnesses

Witnesses: Lord Vallance, Dr Ahmed and Steve Bates.

Q51 **Chair:** Welcome to the second evidence panel in our session on the competitiveness of the life sciences sector. I am very pleased to welcome the Ministers and Steve Bates.

I am going to start with you, Steve Bates, and ask you to introduce yourself as you answer this question. You previously served as chief executive of the BioIndustry Association, and now in the Office for Life Sciences you are part of the Government. In previous evidence sessions, we heard from the ABPI, AstraZeneca and MSD. They were all clear in indicating that there was a lack of confidence in the UK delivering on its promises and that that was impacting on investment in our life sciences sector. How quickly, in your view, can this be resolved?

Steve Bates: A good deal with the USA can quickly resolve it. That is the simple answer to that. I had the privilege when I was at the BIA to work with a number of companies. For different companies, different aspects of the competitive analysis of the UK situation are more or less important. If you are a medtech company that is not involved in the VPAG deal, the opportunities that we have talked about with NICE, about the new systems and the new regulatory environment, are important. That is why, when I went to AdvaMed, the medtech conference, a couple of weeks ago in the US, it was fantastic that they were excited about the opportunities that the MHRA have in medtech regulation, which should give us a competitive advantage. It was fantastic to see that proven by Convatec investing £500 million in Manchester in Citylabs, where I had the privilege in my previous job to go and see that as an empty shell. So I think it is possible to turn it around.

We have to build the best domestic business environment, some of which is through great people. We have 300,000 great scientists. That is three Wembleys full of great scientists working in the life sciences industry. We have great science, which we can talk about more, and I hope we get the chance to. We have great IP protections and a great business environment. We need to make sure that we make it a great commercial environment as well. We must ally that with the best access to global markets for UK companies. You may want to talk about the US a bit further. Northern Ireland, as Members have said in the Chamber, has the best of both worlds with regard to the EU deal. The rest of the world is really confident in UK science because, if you look at the underpinning of the analytical science that makes sure that products that come from the UK are world class, that is something that we set standards for around the world.

Q52 **Chair:** Thank you very much for that. You have talked a little bit about pricing and access. We have talked about issues of uptake. Would you

agree that the key issues are pricing, access and uptake for the life sciences sector? Would you say a little bit more about how the US deal, which you said is critical to resolving this, can impact them?

Steve Bates: What factors matter most for you as a business depend on where you are and what type of business you are. When I talk to investors—and I have obviously spent a lot of time working with venture capitalists—they are excited by the opportunity of getting early science turned into translational science turned into early-stage products very fast through the UK environment. For them, the domestic environment in terms of sales in the UK, which is never going to be the biggest market in the world, is not the primary factor. It is for key companies like AstraZeneca and MSD, but for others it is not. The number of people who are coming into the UK for London Life Sciences Week in the next month to look at the opportunities that we have in the sector is testament to that vision.

I am struck by the opportunity that we have in the UK with techbio, which is at the intersection of both the AI supercompute power that we have developed and the people who can do that, with some of the genomic and other health data that we have in the UK. If you think about Google DeepMind and the fantastic science that has been done there about how we deliver new approaches to protein folding and understanding that, there is a whole bunch of companies like Relation Therapeutics, which is pioneering in that space, partnering with global players like GSK and others. Those are the opportunities that we must put front and centre as we talk about what the companies and the types of science that will make a real difference in life sciences going forward will be, and also come and champion the north-east, where we are seeing fantastic new ways of doing bioprocessing and making antibody-drug conjugates in a way that was unheard of in the past.

Q53 **Chair:** Steve, you are absolutely right to champion UK science, the life sciences sector and of course the north-east, but I did ask you the question about the US deal and what the impact was. You said it was critical to the competitiveness and the confidence of UK life sciences. Can you tell me what the key points of that deal are that are critical?

Steve Bates: Well, I am not doing the deal.

Q54 **Chair:** Why did you say it was critical?

Steve Bates: The US is the largest market by both volume and price of the life sciences market. Access to that global market is critical for any business that is looking to grow in a global market. That is why if we can get to a preferential outcome for UK businesses to access that market it would be a fantastic opportunity.

Chair: I am going to bring in Joe briefly and then go to Kit.

Q55 **Joe Robertson:** Thank you, Chair. Unless I am mistaken, when you asked Steve Bates the question that led to the US deal being the answer,

the question was about improving confidence in the UK in delivering on its promises. It sounds like that US deal is overwhelmingly the key to unlocking that confidence.

Steve Bates: People in different parts of the sector have different things that are important to them. Obviously, a trade deal with the US would have the potential to encompass many aspects of life sciences products, far beyond those that are regulated or within the VPAG deal, and there has been some confusion between those two things. I am not doing the US deal. You will know that I have been in this job under a month. So there are probably people on this panel who are in a better position to answer the question about the nuts and bolts of it. All I am saying is that, if the UK can build a fantastic domestic business environment allied to access to global markets, that is a fantastic base from which any companies would want to grow for the world.

Q56 **Chair:** Okay. Lord Vallance or Dr Ahmed, would you like to say anything briefly on the US deal?

Lord Vallance: There is a lot of confidence in certain things that go on in the UK. There is a lot of confidence in the science, a lot of confidence in the people and a lot of confidence in the bits in the plan that must be delivered. Delivery is the right thing to focus on. It has to be about delivery. I think the US deal is crucial for commercial confidence. We have to get this right for commercial confidence. Companies tie those things together. If we do not get the commercial environment right, it is very difficult to get the rest to build confidence with those global companies. We will still see it with biotechs and others, as Steve said, but that is why the deal is important.

Q57 **Chair:** That would be access to the US market.

Lord Vallance: Two things are important in the deal. One is that it is about making sure that we don't end up with tariffs in the UK that become difficult for export. The second is something that the President of the US has been clear about, which is that he thinks the rest of the world doesn't pay enough for the innovation, the innovation is paid for by the US, and he wants the prices to increase as a result of that. That is the second part of the negotiation that is ongoing at the moment. Obviously, we cannot get into the details of that, but that is what is very active, and we are having very constructive discussions.

Dr Ahmed: I would add, Madam Chair, to Lord Vallance's point that what we are trying to negotiate is a bidirectional relationship. Clearly, there are some unique geopolitical overtones right now that we have to navigate as well as the commercial relationship. These have merely brought into sharp focus some of the issues that were already there over the last decade around medicines pricing. I just want to reassure the Committee that as a Government we are working across Departments in No. 10 intensively to try to conclude this as soon as possible. We are getting there. The outline and sketch of that when it comes—of course, we

cannot give you blow-by-blow accounts in this Committee, as you will understand—is something that will give equitable access to medicines for our patients and citizens in this country, and open up and give confidence to a long-standing relationship commercially for our life sciences sector and the brains in this country to be able to carry on what they have been doing for the last 20 years very successfully, and preload the science on to clinical medicines that are then developed elsewhere.

Chair: There are a number of issues there that we will be coming back to in more detail.

Q58 **Emily Darlington:** I want to ask a question on uptake. We have consistently heard from businesses making investment decisions in the UK about uptake. We have heard of the limited role that NICE plays on that. It says that it is NHS England's role to monitor uptake of new innovations. I am trying to understand exactly what we are doing on this particular issue. We discussed it before. If you know that you are going to have a larger market, you can have a better pricing mechanism within that because you are selling in bulk rather than one-offs, quite frankly. We do not seem to have heard any more about how we are doing the uptake. Is it right that NICE sits outside the monitoring and pushing of uptake of new and better innovations that would serve our patients?

Dr Ahmed: You are right. It goes to the heart of a more fundamental issue, which is the large degree of variation as to how medicines are accessed by different people; just because they happen to be in different parts of the country, some are benefiting more than others from certain medicines. That is why I have been deeply committed since I came into my role to really champion the single national formulary. For the first time that is going to change the landscape, harmonise it across England and allow uptake to increase, especially of the core medicines that prevent cardiovascular disease and kidney disease, and control blood pressure and diabetes. That should give the commercial sector some confidence that we are serious about uptake. We can then enter—you are right—into other conversations about buying in bulk. We are not only talking about specialist novel medicines but also generics. I would be very keen in my ministerial role to make sure that that single national formulary comes to fruition as soon as practicably possible, because, ultimately, other than commercial concerns, it is the right thing to do for patients in our country.

Q59 **Emily Darlington:** Is it currently written into the GP contract? GPs tend to be the longest laggers.

Dr Ahmed: I cannot speak to whether it is specifically written into the GP contract at this moment because it is not part of my direct remit on contractual negotiations. We are certainly pushing hard that the single national formulary is not simply a vague guide; it is something that needs to be adhered to, as it is in other parts of the UK, by the way. This is not something novel in other parts of the UK.

Q60 **Chair:** Perhaps you could write to us on that question.

Dr Ahmed: I can do that.

Lord Vallance: Can I just make one comment on that? I am sorry, I am old enough to remember the origins of NICE. One of the things that it was there to do was ensure that once a NICE decision was made there was rapid, ubiquitous uptake. We are not in that situation now and we need to get back to that situation. It is very important.

Chair: That was the point that Emily was making. In the earlier session, it was quite clear that NICE did not see that as being its responsibility. I am sure we may come back to that point.

Q61 **Kit Malthouse:** I have a series of questions, but I want to bring you back briefly if I can to the deal with the Americans. I think I heard you, Patrick, say that prices will go up, and you are negotiating by how much they are going to go up in the UK to compensate, effectively, for prices falling in the States. That is one of the moving parts of the deal. You also said that there will be preferential access. That is contemplating that there will be some level of tariff, even though historically pharmaceuticals have attracted no tariffs at all. But both of those things together are likely to cost, first, the industry and, secondly, the Government, more money for drugs in the UK. Is that broadly where we are? It is just a question of how much.

Lord Vallance: Some degree of price increase is inevitable.

Q62 **Kit Malthouse:** In the UK.

Lord Vallance: In the UK.

Q63 **Kit Malthouse:** Across the board.

Lord Vallance: I think there is some degree of increase. It is not across the board, actually, because there are all sorts of things around existing medicines, generics and so on, so I cannot predict the prices there. For brand-new innovative medicines, it is likely there will be some price increase.

Q64 **Kit Malthouse:** What about medicines that are currently still on patent?

Lord Vallance: We do not know the details of the negotiation, but the negotiation is very focused on innovation and new medicines.

Q65 **Kit Malthouse:** So who is doing the negotiation?

Lord Vallance: It is being led out of No. 10.

Q66 **Kit Malthouse:** Right, and advised by anyone who understands the life sciences industry?

Lord Vallance: I think I understand it.

Q67 **Kit Malthouse:** But you implied that you are not participating in the

negotiation and that you didn't know what was happening.

Dr Ahmed: We are not directly having a conversation with the US Government, but we are certainly part of the team that sets out the framework and the terms of reference of those negotiations.

Q68 **Kit Malthouse:** So this is a fair question to ask you. You should know the answer to my questions then. You prefaced the answer to my questions by saying you do not know what is going on in the negotiations but—

Lord Vallance: No, I did not say I did not know what was going on. I said that I am not going to start giving out commercially sensitive information on precisely where the negotiations are. We are not going to give a running commentary in the middle of a negotiation.

Q69 **Kit Malthouse:** Right, but prices are generally going to go up and there will be some—

Lord Vallance: Not generally.

Kit Malthouse: —level of tariff on UK pharmaceuticals going to the States.

Lord Vallance: No, I do not know whether there will be—

Dr Ahmed: You have to wait for the outcome of the negotiations. We will be very happy to come back and outline that for you.

Q70 **Kit Malthouse:** Right, okay. Is there any sense of whether this negotiation is going to be time limited? Is it permanent? Is it a "Let's wait and see"? One of the things we are learning about President Trump is that he changes his mind overnight about these things. The Canadians are learning that he changes his mind pretty much every week. It is quite a fragile pillar to found our industry on. Are they giving any indication about longevity?

Dr Ahmed: Presidents and Prime Ministers come and go. The relationship, as you know better than me, lasts longer than that. That is the length through which we are negotiating this current commercial relationship. It is for the long term. It is to stop the back and forth every single year that perhaps we have been having for the last two or three years around medicines pricing. It is certainly to give some certainty and stability to the sector so that we can then take it forward and have some proper discussions about investment into this country.

Q71 **Kit Malthouse:** So the outcome is going to mean more money needs to go into the health service to compensate, effectively, for higher prices to maintain the same level of activity.

Lord Vallance: We made this point last time. If you go back to 2015, the percentage of NHS spend on medicines was about 12%. If you go back earlier, it was higher; it used to be about 14%. It is now about 9%,

towards 10%. There is a possibility of increasing percentage spend to get both access and uptake, and potentially on some price for new medicines.

Q72 **Kit Malthouse:** I was going to ask you about that. You said at the last meeting that the percentage was going to have to rise from 9%. How is that going?

Lord Vallance: We are in the middle of negotiations with the US at the moment. There is a very clear—

Q73 **Kit Malthouse:** The percentage of the NHS spend is 9% absent the US. You are saying it would have to rise 1% just because of price rises or that they will have to spend more money and volume.

Lord Vallance: Ubiquitous uptake and rapid uptake are the other two features.

Q74 **Kit Malthouse:** How is that going to happen?

Dr Ahmed: Part of it is the answer I gave earlier about a single national formulary harmonising what we do across the country, giving that a focus.

Q75 **Kit Malthouse:** Are there targets?

Dr Ahmed: Targets on a particular percentage spend?

Q76 **Kit Malthouse:** On the percentage spend.

Dr Ahmed: No, there is not a target on the percentage spend. It would be unwise to put the cart before the horse in that sense. We have to look at the fact that the percentage spend might indicate other issues such as the one Emily mentioned about uptake and variation.

Q77 **Kit Malthouse:** What would be a good number, then, Lord Vallance? It is 9% at the moment. That is too low. Is 12% a good number?

Lord Vallance: If you look at what others are doing and you say, "Let's assume that if you benchmark you get to some reasonable figure," many are above 12%. I think 12% is historically where we were for some time. We are headed in that direction over time.

Q78 **Kit Malthouse:** The concern of the Committee might be that, because of the US negotiation, we end up spending more money but actually deploy fewer pharmaceuticals within the NHS because of a more widely constrained budget given the financial problems that the Chancellor is facing. I guess we would be looking for some kind of indication or key indicators that would imply to us that that is not the case, and that actually there is more output as well as, if that is the formula, more money going in.

Lord Vallance: I think that has to be the aim. We know, if you look back over the past 20 years, the things that have dramatically changed health have been medicines.

Q79 **Kit Malthouse:** It would be helpful for us to understand how you might measure that rather than what would be the natural inclination of the organisation to do what we do not desire. Can I ask, Minister, about the VPAG? At the last session we talked about the VPAG, and we expressed to you the concerns of industry about it and the concerns that we have all taken our balls home and weren't talking to each other. You said your door was always open. Has it been used?

Dr Ahmed: It has been, yes, multiple times. I met the representatives from the ABPI on multiple occasions and talked this through. It is an umbrella body for quite a number of different types of businesses. Within it, they have different views about VPAG. This is of course now intricately interwoven into the negotiations we are having with the US. You will know that we put a reasonable offer, we thought, on the table. Its own members could not get to a consensus on it and therefore did not vote on it. Of course, events have somewhat overtaken us since then with the US negotiations. Ultimately, whatever negotiation comes out, there will need to be some form of adjustment to the VPAG to ensure that that generates an increase in the price of certain medicines that allow us access to them.

More longer term for me—this is what I really want to focus on—is that I have sent that signal strongly to industry face to face that, whatever comes next after the US negotiations in this current situation, it is not business as usual; it is not to close the door; it remains open and we co-create a new system of remuneration that looks at other things other than just medicines pricing, such as outcomes and investment into the country.

Q80 **Kit Malthouse:** But, as it stands, the VPAG still persists in its current form. There is no variation to it.

Dr Ahmed: The VPAG currently persists in its current form—

Q81 **Kit Malthouse:** If there are significant percentage rises in drugs costs going into the NHS and the growth cap that has previously been agreed is busted through, in theory, unless you waive it, huge rebates will be payable by the industry purely on the mechanism that you agree with the Americans.

Dr Ahmed: Yes, but it is not so much the theory any more; it is about the practicality of the negotiation and what adjustments we make in the VPAG to make sure the negotiation works for the commercial sector and for us. More importantly, it is talking about what happens afterwards to stop us getting into this situation again.

Q82 **Kit Malthouse:** Right. How quickly after the US negotiation is confirmed will you be able to agree a new VPAG? The industry is left with two options. It can either stick with the VPAG, which may produce a weird result because of what you have negotiated with the Americans, or it goes on to the statutory system, which will probably be even worse.

Dr Ahmed: The current VPAG will run till the end of 2028. I am keen to use that time in the intervening period.

Q83 **Kit Malthouse:** You would wait till the end of 2028 to adjust it.

Dr Ahmed: No, I am not saying we would wait. I think there will have to be some kind of adjustment based on what we are negotiating at the moment.

Q84 **Kit Malthouse:** On the current scheme.

Dr Ahmed: On the current scheme.

Q85 **Kit Malthouse:** So you would not wait till 2028.

Dr Ahmed: The system itself is obviously in place till the end of 2028. The pharmaceutical industry accepts that the system is in place till the end of 2028. It and I both want to use that window of opportunity and time to work out what the next iteration of a scheme—the totality of that scheme, not just the clawback rate—looks like for the benefit of commercial investment into the country and patient benefit in terms of medicines access.

Kit Malthouse: It might be helpful once those two things start to come into view, so critical are they to the future of the industry, for us to hear from you again about the moving parts.

Q86 **Chair:** Would you just clarify if VPAG negotiations are going on now?

Dr Ahmed: The VPAG negotiations have largely been usurped in some ways.

Q87 **Chair:** We need to move on. We have a lot of questions. Are they going on now? Are the negotiations with the—

Dr Ahmed: Not in the form as they were before because the US negotiations have superseded that, and it would be impractical to have an isolated VPAG negotiation at this moment when we are having these conversations about medicines pricing with the US.

Q88 **Emily Darlington:** I have a quick question. I am trying to understand the role of DSIT through Lord Vallance and the Office for Life Sciences in trying to get to both the deal in the US and this domestic deal. I hear what you are saying, Zubir, and great, but obviously we have talked about how it is wider than just the pricing. I am trying to understand how the three of you are working together. Maybe Steve and Patrick can comment on that.

Lord Vallance: We are meeting on a weekly basis as a group of Ministers together with Lord Stockwood, the Minister from DBT, so that we have all three Departments represented. We are obviously in regular discussions as well in relation to the US deal, so it is an almost daily discussion at the moment on this.

Q89 **Martin Wrigley:** I may be a little confused because this area is not my specialty. I have been reading the recently published NHS England medium-term planning framework, which has the grand total of three paragraphs describing genomics, life sciences and innovation, where it talks about medical trials. It does talk about your single national formulary, which I have now understood following your discussion on it, but it is only very limited and it talks of three areas within that. Is that sufficient within this, or is this not the document that we should be looking at as to what you are actually making changes in the NHS with?

Dr Ahmed: This is the document in its totality that we send into the system to give it some idea of what we wanted to do, whether it comes down to clinical care or science. In that context, some of the statements that have been made in the life sciences component are pretty strong. It is the first time that we have made such a strong statement ever about clinical trials, having a target of 150 days and pushing that target. In that sense, I appreciate that you might not think it is voluminous enough in terms of the life sciences component, but what is said about life sciences in this planning guidance is in much better shape than previous iterations of this guidance.

Steve Bates: Those of us who follow it in great detail will be delighted to see the clinical trials target in the NHS planning guidance. It has not been there in previous iterations.

Q90 **Martin Wrigley:** Don't get me wrong, that is a good thing. I am just surprised that there isn't anything to do with all the rest of the stuff that we have been talking about in terms of improving the use of medicines, using new medicines coming through and all the rest of it. It does not even mention those at all.

Dr Ahmed: The implication in the single national formulary is that that is the vehicle by which we are talking about ubiquitous utilisation of evidence-based medicines.

Q91 **Martin Wrigley:** Prioritising three very probably distinct but obscure and nonsensical to me areas that do not seem to cover what we are discussing in this meeting at all.

Dr Ahmed: What we are largely discussing here is commercial negotiations, and you would not expect that to turn up in NHS planning guidance.

Q92 **Martin Wrigley:** No, I understand that, but it is the emphasis on using innovative and effective medicines.

Dr Ahmed: With respect, the emphasis is backed up by clinical evidence. What we are doing in the planning guidance is giving tacit permission and, in fact, strong signals that through the vehicle of a single national formulary we want NHS bodies to follow the clinical evidence and deliver on it.

Q93 **Chair:** Perhaps you could write to us to set out how the NHS formulary is going to drive access—

Dr Ahmed: I am very happy to do that, Madam Chair.

Chair: —because we have identified pricing access and uptake as three key issues.

Dr Ahmed: I am very happy to do that.

Chair: Martin, your point is that that is not reflected.

Q94 **Dr Sullivan:** Before I ask you a little bit about medtech, I would like to follow the theme that Martin has been asking on medtech and other innovative technologies, medicines and new industries. Innovate UK funds the existing industries. How can we make sure that medtech and new things that we have not even thought of today have a chance of getting some of that innovation support and proof-of-concept funds?

Lord Vallance: UKRI spends about £1.5 billion per year on things relating to health. Only a portion of that goes through the Medical Research Council. Some of it goes through the Engineering Council for exactly that reason. There is a lot of money in the UKRI and Innovate UK system targeted towards emerging companies, tech companies and biotech companies. There is money in NIHR as well. There is £2 billion allocated to the life sciences sector plan itself. There are three pots of Government-funded money that they can go for. I have been very clear that there are three things that UKRI needs to do: it needs to fund basic curiosity-driven, investigator-led research and make sure that is looked after; it needs to fund work that is relating to Government societal priorities, which has a shorter timeline and clear outcomes with private sector leverage; and it needs to fund companies—start-ups, scale-ups and R&D intensive big companies—to do things that the private sector would not do in order to leverage it. There is a lot of focus on trying to get money to those sorts of companies.

Q95 **Dr Sullivan:** Unicorn and new disruptive companies, brilliant. Last month, Dr Ahmed, you announced a move towards value-based procurement for medtech. This links in a little to the beautiful innovation that could be happening. How do we ensure that that is going to make a difference?

Dr Ahmed: Absolutely. It almost seems ridiculous to say this, but we have not really been purchasing equipment in the National Health Service based on outcome. We have been purchasing it at rock-bottom prices almost like a penny-wise, pound-foolish model. We are now sending signals and guidance into the system as to how you can calculate long-term value and long-term outcomes. We have 20 trusts up and down the country that are piloting this kind of procurement.[1] That does not simply mean they buy the cheapest product on the shelf, but one that has

[1] Correction requested by witness – the actual figure is 13 pilot trusts.

clinical and societal value. I had a visit to St Bartholomew's Hospital to see one of these products, which was an antibiotic-coated mesh that covers a pacemaker. It costs a few hundred pounds. You would think it is quite expensive for something that looks and feels so cheap, but, actually, if you target it in the right patients, you reduce those infections that are absolutely disastrous for a patient if they get an infection in their pacemaker. You are saving £300,000 per infection per patient. I am very keen to make sure that is rolled out across these 20 trusts when it comes to medical technology procurement in particular.

More widely with medical technology, in the last few weeks I have given three or four major keynote speeches into the sector to give it the confidence that we take this sector very seriously. It is the largest employer in UK life sciences more generally. In the UK, although we have discussions about medicines and it seems like perhaps there are issues there that we need to overcome, with medtech the future and the landscape is very bright, particularly when it comes to regulatory innovation. The MHRA is the world's leading organisation in regulatory innovation. If we carry on at the speed we are going with our regulatory frameworks at the moment, the world will be looking to us for sensible and safe adoption of novel medical technologies.

Lord Vallance: Can I add one thing to that? If I am allowed to be a little bit cheerful, we are heading to the highest amount of VC investment ever this year in the UK, of which healthcare is a major part. Healthcare VC investment went up by about 80% last year. There are a lot of signals that that early-stage investment in tech and biotech is looking on the up.

Q96 **Dr Sullivan:** Brilliant. Is there a bonus or a prioritisation for British-based, British-built companies that are feeding into our NHS, or is it a case of costs and outcome focus?

Dr Ahmed: One of the reasons I was appointed was the Prime Minister wanted to champion British business and tell a growth story about our National Health Service. It is totally a partnership between British businesses. We have committed to hosting a senior ministerially led medtech summit early in 2026 precisely with that focus.

Q97 **Dr Sullivan:** I have one last question. We heard from NICE in the panel just before this not about medtech but medicine, where it can include other factors in the calculation of whether a drug is taken on board, such as whether it is made in the UK or just the wider benefits business/economy-wise. Is that something that you might want to pursue or have a think about in the grander scheme of how we help to keep science innovation in the UK?

Dr Ahmed: It is important to remember that the current iteration of NICE has existed largely very successfully for more than a quarter of a century, and its terms of reference and methodology have been largely unchanged in that time while society around us has changed quite a lot. I am not one who engages in large-scale "reform" for no reason and I do

not want to break something that largely works, but there is certainly an argument when it comes to some of the health economic calculations—I am not a health economist, so I have no specific expertise in the matter—to think about how we lead the world into the next iteration of calculating value. We did that last time around 1999, and the world followed us and used our methodology and mechanisms by which to select medicines that were good for their countries. We have an opportunity again, a bit like with the medtech sector, to lead the world on how we calculate value for medicines.

Q98 **Martin Wrigley:** I really appreciate your approach of value over cost. That is a very good and significant step forward. I was sightly confused, however, to see something in this medium-term planning framework about mandating trusts. I met with my own trust just yesterday morning. It told me how it was struggling to find the money to pay for implementing an electronic patient record, which seems fundamental to me. We are now mandating that trusts have to switch all their data warehousing systems over to using the Palantir Foundry system and a variety of tools thereafter with that. Is that not something that should have gone through consultation before it is rolled out everywhere to use? I understand that, before, they were all mandated to connect to it but not mandated to use it.

Dr Ahmed: You are saying we are mandating all trusts up and down the country.

Martin Wrigley: Yes, you are.

Dr Ahmed: There are different components to medical health records. There is the front end. There is the back end.

Q99 **Martin Wrigley:** This is on the Palantir warehousing system that sits on top of all that stuff.

Dr Ahmed: The Palantir system, using the federated data platform, is working in a number of trusts up and down the country. We are not nationally directing people on to the FDP.

Q100 **Martin Wrigley:** You are.

Dr Ahmed: Not the FDP.

Q101 **Martin Wrigley:** Yes, you are.

Dr Ahmed: The federated data platform?

Martin Wrigley: Yes.

Dr Ahmed: Contractual negotiations are happening trust by trust as to how they use that.

Q102 **Martin Wrigley:** It is in here, in the medium-term planning framework. They must do it.

Dr Ahmed: I am the Minister responsible for data. We are still trying to work out the best way of getting to a single patient record. We are in no way suggesting that we have decided that a company is a preferred partner in terms of getting to a single patient record in England.

Q103 **Martin Wrigley:** I will send you the quotes from the document.

Dr Ahmed: I am very happy to look at that, but I have to be clear that we are not doing that at the moment. We have been very strongly appraising what we need to be doing before we make a final decision as to what we think are, at the national level, the building blocks that we want to see and the commercial partners that we want to have for the single patient record. I am aware that Palantir does what it does with its federated data platform on a trust-by-trust basis.

Martin Wrigley: I am delighted to hear that, thank you.

Q104 **Chair:** This is a real issue for the Committee because we heard evidence from health practitioners in a previous session, as part of the inquiry into the digital centre of government, about a lack of trust in the Palantir system. Could you please write to us and set out how what Martin will be sending you right now reflects the Government position and the tensions there?

Dr Ahmed: I am very happy to reassure the Committee that when it comes to a single patient record we have not made any final decision.

Q105 **Emily Darlington:** Do you have any concerns that so much of our health data is being held and processed by a US firm whose chief exec does not believe in the NHS?

Dr Ahmed: We have multiple partnerships with firms all across the world when it comes to our clinical systems. That has always been the case. It has been the case certainly the whole time I have been in medicine. The fundamental issue for me is and always will be who owns the data, where it is held, who controls it and who accesses it. We are very clear for all of those domains that it is the UK Government and UK patients who do that. Processing is quite a different matter from who holds the data, controls the data and has access to the data. All of that is also audited, by the way, so we have a paper trail.

Chair: I agree with you on the issues that you raise as being key, but take-up is also an issue. We heard evidence that lack of trust in Palantir as an organisation was impacting take-up. Perhaps when you write to us with regard to your intentions on the federated data platform, you could address that issue as well. Now I am going to move on to Daniel.

Q106 **Daniel Zeichner:** Thank you, Chair, and good morning to all of you. First of all, Lord Vallance, thank you for coming to Cambridge last week. Your announcements were very welcome.

My questions are to Dr Ahmed. I would like to take you back to the discussion about NICE. In your previous evidence to the Committee, you

said there is an argument that we re-examine certain components of how we quantify benefit within the NICE QALY mechanism. You made references to this a few moments ago. Could you say a bit more about what you are thinking about in terms of that? What is under consideration?

Dr Ahmed: I suppose I am really thinking about how you widen the parameters, because at the moment quality-adjusted life years is very health-focused. It is in terms of societal value, economic benefit, ability to get back to employment and the ability to perhaps not rely on the state in other forms and from other Departments. These are the parameters that I am thinking about and how they then intersect with the health parameters themselves, perhaps in a way that is not prejudicial. It is complex. I do not believe any country in the world has ever tried to do this yet. That is why I think this arena is ripe for Britain to step into it from a very academic perspective—again, I have no academic expertise in this matter—to explore that. For most people now, especially some of the new medicines, the preventive medicines, when we are talking about value, we are not just talking about it in terms of a few extra years of life; we are talking about decades of not only extra life but healthy life, and that changes the dial as to how we should think about calculating that benefit.

Q107 **Daniel Zeichner:** I suspect those comments will be broadly welcome, but that is a very big change. As we heard from the evidence earlier, NICE works very closely within a framework set by Ministers. Can you say a little bit about the process by which you might engage others within these changes, because they are quite substantial?

Dr Ahmed: I work very closely with the current chief executive of NICE, Sam Roberts. The first place we have to go is that people like Lord Vallance, the NICE board and I need to have a discussion as to what we think needs to happen in the future. Like I say, I am not one for just tearing up organisations and reforming them for the sake of reform. NICE is certainly one of those that I would put in that bucket. Maybe some tinkering to get it right for a new age is what is required rather than wholesale reform.

Steve Bates: I can add to that, having been a student of the data that is available to give you evidence for how health evidence generation has changed since Mike Rawlins was established in NICE. That is why NICE has been flexible around things like ultra-orphan disease and has thought differently. The data and mechanisms by which you can now turn the microscope up and understand with greater detail what has happened in a clinical trial are available now for certain types of interventions that were not available a while ago. At what level you want to take those into consideration is the type of serious discussion that should be thought about.

If you take NICE in the long view, it has also worked in a context where there have been workarounds at different times: the Cancer Drugs Fund,

ultra-orphans, what happened with Herceptin. If you take the long view, the UK has had an adaptive approach to this, understanding how evidence generation has changed. If you look at some of the UK companies that have helped to deliver that, a great company in Wrexham is now using video capture to make a difference with the six-minute walk test, a common way in which you understand how people with rare diseases can function and what difference a drug intervention makes for them. Particularly for children and others, we are at the forefront of the life sciences sector. We have to take the learnings from that type of intervention and work out, as generating evidence costs money, what is the appropriate level of evidence generation in a risk environment. That has always been a dynamic discussion that the UK has been part of.

Daniel Zeichner: This is a big subject we may want to come back to, Chair.

Q108 **Chair:** Yes, I think you are right, Daniel. NICE was very clear to us that any decisions about QALYs and how value for money was evaluated were for Government. Are Government being clear to us now that that is something that you are looking at? Just a yes or no, Zubir.

Dr Ahmed: At a ministerial level, Lord Vallance and I are open to looking at how we get NICE fit for the future, for sure.

Q109 **Chair:** That is a very general response, Dr Ahmed, I am afraid. You are open to looking at it, but you are not actually looking at it in any detail at the moment.

Dr Ahmed: We are always having conversations about NICE and about evidence. If you are asking me if there is a formal, current open review that is going on to look at the totality of NICE at the moment, no, there is not, but we have certainly had conversations and meetings with NICE being in the room about how we get it fit for a new age.

Q110 **Dr Gardner:** I have one question, but there are multiple parts to it. I will be quick. I used to work for NICE but not in HTA. I have to admit to not being a big fan of QALYs. From your answer, I picked up that you may be looking in-depth at the utility score component of the QALYs: mobility, visual activity, pain, discomfort, anxiety, depression and self-care. In that respect, QALYs are quite good at assessing acute conditions, but the health profile of the country is moving towards chronic conditions. I worry that QALYs are very subjective and then we have biases. First, do you agree with my assumption that the health profile of the UK population is shifting toward more chronic long-term conditions? If so, is it time to dump QALYs? It is not just NICE, this is global: is it time to dump QALYs and consider alternative processes such as disability-adjusted life years?

Dr Ahmed: To the first part of your question, yes, clearly, we are entering an era where, because we have done so much work on helping people live longer from diseases that were basically a death sentence and turned them into chronic illness, we have the challenge of managing a significant disease burden of chronic illness. There is no doubt about that.

That is one reason why the 10-year health plan was conceived—to meet those challenges.

In terms of your question around QALYs and quality of life, it is probably EQ-5D scoring you are getting at. I make the disclaimer again: I am not by any means a professor of health economics, so I am not going to get into a deep dive on QALYs, but I certainly think there is a role for other adjuncts, like the EQ-5D and other things, to play a part. Again, that needs to be guided by evidence. I understand there are academic manuscripts in process right now about how we can use such scores.

Q111 **Dr Gardner:** NICE currently uses EQ-5D.

Dr Ahmed: 3D, I think.

Q112 **Dr Gardner:** It uses the five-level determination. That is part of the utility analysis of developing a QALY. That is something that is already done. What I am asking is: would we be better off looking at disability or DALYs, which is not quite the inverse of QALYs because it looks at disease burden, which you mentioned? I am being mean to you because I am asking you a detailed question.

Dr Ahmed: You are. I once knew exactly what DALYs were, but at the moment medical school seems a long time ago. The answer to your question is: if we are looking at certain classes of medicines, it could be appropriate, but this is a conversation that Lord Vallance and I need to have with the NICE board.

Q113 **Chair:** Can I suggest that the Ministers, as part of the correspondence we have already agreed, set out the thinking on QALYs and other ways of measuring value for money in terms of treatment? You have said a number of times that you are not a health economist. I am not one, either, but I have been somewhat surprised by the lack of scientific basis for some of these measures, and it would be good to have the Government's cross-departmental view.

Dr Ahmed: We can write to you jointly on that particular topic because we have discussed it at length with NICE before.

Chair: Good. Does that work for you, Allison?

Dr Gardner: Yes.

Q114 **Adam Thompson:** I want to look at patient access and uptake of medicines specifically. Compared to other countries, access is reasonably low in the UK. I am interested in all three of your opinions on why you think that is.

Steve Bates: It is variable rather than low. You heard the evidence on the adoption of smart insulin pumps. The UK, if you look globally, has been at the front end of that. If you look at the adoption of Kaftrio, the Vertex drug for cystic fibrosis accessible by 95% of the eligible population in the UK, it is again an area where the UK is at the front of the pack

rather than at the back. I accept that it is a variable picture. I am not happy with where we are in the European league table for some access to cancer medicines, and I can understand why certain companies are particularly concerned about access to those medicines that are regularly available and in routine use in other European countries. To go from relegation position to winning the premiership is quite hard in a season, but we should set our ambitions to be qualifying for Europe or being in the top positions quite soon.

Q115 **Adam Thompson:** What do you think is the underlying reason, Steve? For those areas where you accept that we are behind, why is that, and how are we changing that?

Steve Bates: I am not a clinician. Established clinical practice is often a place where we start. Sometimes drugs are disruptive and they need quite a lot of things to be changed in a hospital in terms of both how people work and the physical infrastructure of a hospital and how it works. That is not easy if you are running hospitals very hot. There are probably some of those reasons. If we are not the great market for a company, is it going to put lots of efforts into training doctors and people understanding it? It is probably not going to be top of the shop. It will be second or third order down. In some of these places, we may also not be getting the best out of the medicine because we are not diagnosing patients soon enough, which is also a challenge, and therefore you are not going to get the most out of it. Those would be some of the reasons I would posture.

Lord Vallance: As I said earlier, if I go back to the origins of NICE, one of the aims was that when a NICE approval came there was immediate and ubiquitous uptake, and we have drifted from that position. We need to go back to that position where a NICE approval means that we are going to take it up on the NHS and do that quickly, and do it fairly and equitably across the country. That is a big win at the end of this because we need to be in a position where the latest medicines have been through a very rigorous assessment. You can argue about QALYs or DALYs. There are many other health, economic and macroeconomic approaches that you might take. Whatever system we have to do that, my view is that when we get that approval we need the NHS to be plugged into it to say we now rapidly take that up, and that is increasingly going to require more than just paying for a drug. It may require an infrastructure such as nursing in order to deliver those medicines or physical infrastructure in some cases when you think about things like cell and gene therapy as to how that is done. That is the challenge now: to get into quick uptake of what is an era of remarkable discovery in new medicines that are dramatically changing the outlook for prevention, treatment and—a word that has not been used for a long time—cures. We have not had cures, and we are getting them now. It is extraordinary.

Dr Ahmed: The story that has been told about the inconsistency of the uptake of medicines in the NHS is the same story of inconsistencies in

other parts of the NHS over the last 14 years. Partly, it is a lack of strategy and oversight, the system just doing what it thinks is best in its own little bit and not thinking about the global requirements of it. One of the ways to get that consistency right is to identify the variation where it is. The league tables in hospitals are part of that as well to try to reduce it, to get that best of the NHS to the rest of the NHS. Very much so the story of medicines uptake is one of getting the best of the NHS to the rest of the NHS.

Q116 **Adam Thompson:** In the written evidence that we had submitted as part of this discussion, several of those submissions criticised the Government's focus on the cost of the planned single national formulary for medicines. Ministers, I wonder how you might alleviate some of those concerns that were raised.

Lord Vallance: Criticised what?

Adam Thompson: They criticised the Government's focus on the cost of the planned single national formulary for medicines.

Dr Ahmed: Listen, if we get this right, it is going to be a cost-saving exercise because it is going to make sure the best evidence-based medicines get to the patients who need them.

Q117 **Chair:** I think it was being criticised for being cost-based rather than value-based in the national formulary.

Dr Ahmed: A lot of that is to do with the fact that there are many generics that are just as good as the branded medicines, and therefore it is reasonable and indeed responsible for clinicians and prescribers to be using the generic form of medicines.

Q118 **Chair:** From what you have said to the Committee, you support a move to value-based prescribing.

Dr Ahmed: In that context, I do not see the difference because the underlying drug is the same. It is just about the packaging.

Lord Vallance: That is an important point. Part of the original idea of NICE, which I really agree with, is that you have to say no to things and you have to do generic substitutions in order to drive down the rest of the drugs bill in order to be able to afford the new, innovative things that are coming through, and that is what we should be focused on.

Dr Ahmed: Exactly. If we are not responsible there, we do not create the fiscal headroom to deliver the novel drugs that patients need.

Q119 **Chair:** In the two minutes we have left, I have a couple of follow-up questions. First, Dr Ahmed, you said to us that the VPAG negotiations have been superseded by the US trade negotiations. It is a matter of a little concern to the Committee that a UK agreement on pricing is now part of US trade discussions. Is the UK life sciences sector part of those discussions then on US trade? Are we going to have VPAG negotiations

suspended until a trade agreement?

Dr Ahmed: Absolutely, we take soundings from all the commercial partners that are players here.

Q120 **Chair:** Are they in the room in the trade negotiations?

Dr Ahmed: They are not in the room. It would not be appropriate.

Q121 **Chair:** But they are in the room for VPAG negotiations.

Dr Ahmed: They are definitely in my room whenever they want to be in my room, and they are often in my room. I pass on their worries, concerns and expectations to other members of the Government and to No. 10. In terms of your concerns, to flip it round the other way, if we started to fixate on a very niche discussion about VPAG to the neglect of this wider issue of how we sort out medicines pricing with the US Government, it would be pretty irresponsible of us. We are taking the responsible measures and doing it in the right way, in the right order.

Q122 **Chair:** The evidence we have taken from the life sciences sector does not say that it has regarded VPAG negotiations as niche. It regarded it as a substantive part of competitiveness in this country.

Dr Ahmed: I totally get that. At the moment, if we do not sort out this stuff with the US negotiations, the VPAG cannot be sorted out in isolation.

Q123 **Chair:** My point is that therefore it is an issue of chronology.

Dr Ahmed: Correct.

Q124 **Chair:** So VPAG negotiations will resume after the US trade negotiations.

Dr Ahmed: The VPAG system itself will need to be adjusted in some form to reflect the US negotiations, and that will be done very much in partnership with the pharmaceutical industry and the ABPI.

Q125 **Chair:** Directly after US trade negotiations.

Dr Ahmed: We are talking to them all the time now, but, yes, we will certainly be talking to them even more after that.

Q126 **Chair:** Right. I am not quite sure that is the reassurance that I was looking for, but I will accept that as a response. I would like to come to Lord Vallance now because, as has been raised, you have had an acceptance that medicine pricing is going to rise for innovative medicines, I think you said. Do you see that as requiring additional funding for the NHS? Are you in discussions with the Department for Health and Social Care and the Treasury, particularly in the run-up to the Budget? I know you are not going to anticipate what is in the Budget, but are you discussing the requirement that you set out quite clearly that medicine pricing will need to rise?

Lord Vallance: Yes. Of course, we have discussed the fact that, if there is a rise in price for innovative medicines, that comes with a cost load and

that needs to be met. I have described the percentage change of spend on medicines. There is an overall Budget question, and that is really for DHSC to consider how it is going to deal with that. Yes, there will be an increased cost. You cannot escape that.

Q127 **Chair:** Great. Finally, Steve Bates, we have heard a lot about the political pressure and input on NICE's direction and how it evaluates medicines and what medicines it can evaluate. As you are leading the Office for Life Sciences, is that something that you support, or do you see the need for changes in terms of that political relationship?

Steve Bates: That is one for Patrick.

Lord Vallance: That is a political question. I do not think Secretaries of State or any Ministers should be involved in individual decisions on NICE.

Q128 **Chair:** Secretaries of State determine whether NICE makes a decision.

Lord Vallance: They refer medicines to NICE. NICE does an evaluation, and they have to make the decision. I do not think it is right that the decision-making process in NICE is one that is then interfered with by Ministers.

Q129 **Chair:** We have heard that the decision-making process is determined by the Secretary of State's referral and by the parameters of QALYs. Those are all political decisions.

Lord Vallance: The second thing absolutely is a Government decision, as we have discussed in this Committee. What do you want NICE to do? That is, the parameters as to what you want on cost per QALY threshold, whether you are going to move to DALYs and whether you are going to take a wider health economic consideration. That of course is a Government decision. Once that decision is made, the process of NICE considering it must be independent, robust and evidence-based. It would be quite wrong to have political interference in those individual decision-making processes.

Dr Ahmed: It would not command the confidence of the public if a Minister or a Secretary of State were to interfere with the individual decision making of an approval of a drug.

Lord Vallance: I do think it is absolutely the ministerial and Government position to say what you want NICE to do and what criteria you want it to use to get the best benefit for the UK and UK patients. That is indeed, of course, a Government responsibility.

Q130 **Chair:** Thank you. As part of that drive for competitiveness of the UK life sciences sector, you recognise that relationship.

Lord Vallance: That is an important consideration in all of this. It has to be. It is worth reflecting that, if we are in a situation where companies do not want to sell their medicines in the UK, that is not great for anybody. It is not great for life sciences.

Q131 **Chair:** I do not think that is part of NICE's remit to consider.

Lord Vallance: It is not part of its remit. I am just saying that if you do not get these things right—the commercial environment particularly in an era of comparative pricing going on in the US—then you do not get medicines launched in the UK, and patients suffer. That is why we have to get this price point—this ability to be competitive in the commercial arena—right at the same time as doing all the other things that we are doing in the life science plan.

Chair: All right. Thank you very much to Dr Ahmed, Lord Vallance and Steve Bates. We appreciate very much you spending your time with us this afternoon.