HOUSE OF COMMONS

Science and Technology Committee

Oral evidence: National Health Screening, HC 244

Wednesday 9 July 2014

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Written evidence from witnesses:

- Public Health England

Watch the meeting

Members present: Andrew Miller (Chair); Mr David Heath; Stephen Metcalfe; Stephen Mosley; Pamela Nash; Graham Stringer; David Tredinnick

Questions 237-305

Witnesses: **Jane Ellison MP**, Parliamentary Under-Secretary of State for Public Health, Department of Health, and **Professor David Walker**, Deputy Chief Medical Officer for England, Department of Health, gave evidence.

Q237 Chair: Minister, good morning and thank you very much for coming to see us today—we are giving you quite a lot to do at the present time—and welcome, Professor Walker.

May I first ask you, Professor Walker, which hat are you wearing today? Are you here as deputy CMO or as chair of the UK National Screening Committee?

Professor Walker: I am here as the chair of the National Screening Committee.

Q238 Chair: Minister, I presume that you will agree that the UK National Screening Committee provides you with independent scientific advice.

Jane Ellison: Yes. Obviously, the Committee has been looking at governance, and you are familiar with the structures. That is right, not least because of the process that any new advice goes through, so it is not just the Committee's own deliberations.

I ask what is the process by which a final decision or recommendation is made. It goes through a robust peer review process, with a lot of opportunity for external comment. At some point, it might be helpful to the Committee for David to talk through one of the processes, but that is the bit that can give me extra confidence about that independence of view, because it is so open to external comment.

Q239 Chair: Precisely. We are, in that sense, interested in the protocols that exist. Presumably, you are aware of the Government Office for Science code of practice for scientific advisory committees. It seems to me to be fairly obvious that, by any standards, the National Screening Committee is a scientific advisory committee and therefore it should follow that code of practice. Does it?

Jane Ellison: Not at the moment, I think for historical reasons. It is a reasonable question to ask, and part of the review that David is leading, as a relatively newly appointed chair, will be to look at that. I am quite open to comment on that, and I will be interested to see what the Committee's recommendations are.

It may not be part of that code of practice, as a result of that historical anomaly and different circumstances, but one cannot conclude from that that it is not robust and independent and all of those things. It is reasonable to ask whether governance in future might take a different route, but I have no reason to think that the current governance structure is leading to advice not being robust, evidence-based and independent. However, it is a fair question to ask.

Q240 Chair: In that context—equally, this is not a prejudiced question; it is seeking to flesh out this part of the discussion—the code of practice states that scientific advisory committees "should expect to operate free of influence from the sponsor department officials." Does this not mean that a CMO should not be the chair? I am not trying to do you out of a job.

Jane Ellison: Why don't I let David comment on that? When he was appointed, I was not in post.

From my point of view, the CMO team is independent and gives Ministers independent-minded advice. I do not see those two roles as one being independent and the other not. I take your point about the sponsor department, but it is not something that particularly troubles me. Perhaps David wants to comment further.

Professor Walker: The CMO has a statutory independent role and is allowed to take an independent view, separate from the Department. Therefore, it can act independently.

Q241 Chair: You are working on the same basis as my old boss, who used to tell me that if you cannot ride two horses at the same time you should not be in the circus. Is that the principle?

Professor Walker: All I am saying is that the CMO role is slightly different from the DH official role, in that it has statutory independence, and it can act as a statutory independent leader of the process.

Jane Ellison: In my experience, Chair, in the nine months that I have been Public Health Minister, there are a number of occasions on which the CMO or her deputies have given me advice—one way or the other, but which was quite independent—about whether I was getting it right or getting it wrong. That is great, and I value it. I have never had any sense that they were not fulfilling their independent role.

Q242 David Tredinnick: Why was the decision made to put the UK National Screening Committee within Public Health England? Does that not jeopardise its independence?

Jane Ellison: It is not actually within Public Health England. Public Health England provides the secretariat—I think that's right, David.

Q243 David Tredinnick: Perhaps subsumed is the correct word.

Jane Ellison: I would not use that word, Mr Tredinnick, but perhaps David will want to comment further.

Professor Walker: It is hosted by Public Health England—that is all.

Jane Ellison: PHE, of course, will often carry out a lot of the evidence finding and the further research that is needed; the expertise to do that will sit within PHE. It is quite logical, but it is only hosted by it with its secretariat. Its members are not part of PHE in that sense.

Professor Walker: Another issue is that it is a UK-wide committee, so the devolved Administrations are quite keen that it is not seen to be part of Public Health England but is a four-nation committee.

Q244 David Tredinnick: It is not an issue of independence. You think that there is no problem there, from what you say.

Jane Ellison: I am not aware of one. Public Health England also has a role in terms of giving evidence-based advice to Ministers. It is part of the Department of Health—it is an executive agency. Nevertheless, particularly in this sort of area, where you are looking at evidence-based advice and scientific study and all of those things that it gets involved with in supporting the committee, PHE has a role beyond that of an executive agency.

Q245 David Tredinnick: Who has authority in respect of a screening programme? If a decision is made to implement, amend or withdraw a screening programme, I put it to you that it is not clear if the decision rests with Public Health England, NHS England or the Secretary of State. Would you tell the Committee who has the authority?

Professor Walker: The committee makes a recommendation, but that is only an advisory recommendation. It then goes to Ministers. Then, there is the ministerial decision, and that is then implemented through the section 7 agreement of the NHS Act. It is an agreement between the Secretary of State and NHS England, and NHS England then has the responsibility to implement the programme.

Q246 Stephen Mosley: I move on to NHS Health Check. We have had some evidence on this. For instance, the Academy of Medical Science has pointed to the weak evidence on the benefits of these checks; and Dr Middleton highlighted a Danish study of health checks that found no difference between the tested and the not tested. Is there evidence to support NHS Health Check?

Professor Walker: First, this has not been through the NSC process. We have not done the rigorous evidence review that we would normally do before implementation of this kind of programme. It was implemented through a different route, but my view is that there is considerable evidence for all the components of the health check, based on NICE guidance and on the economic modelling that has been done by the Department of Health. What we have not done is to look at the current configuration of components within that health check programme, and looked at that in randomised control trials to see whether that provides benefit or not.

One of the difficulties of using comparable data from other countries is that they are not actually that comparable. Every country uses different components; they use different age ranges, and they do it at different times and different frequencies and so on. So it is quite difficult to draw those kinds of conclusions, and the best way would be to do a randomised control trial or some kind of post-implementation evaluation, which is what is actually happening. By the end of this year, we should have some firm evidence about the degree of effectiveness.

Most countries are now looking at this, because vascular risk is such an important issue for health in developed countries, so I would be very surprised if the evidence in the autumn does not show a significant benefit.

Q247 Chair: Before we move on, is there a reason why Health Check did not proceed through the normal screening programme?

Jane Ellison: It is not strictly a screening programme in the sense that the others are.

Professor Walker: In a sense, if you think of a screening programme as taking a population that has a low average risk and applying a test to identify a high-risk population, who then go on to have further diagnostic tests and potentially interventions, this is slightly different, in that we are not separating the population into strata of high risk and low risk. We are producing a composite risk, and therefore a risk management programme for each individual, which is slightly different. It is more of a vascular risk management programme than a screening programme. That may sound a bit technical and esoteric, but my personal view is that for every programme that looks like a screening programme it would be useful to put it through the NSC programme. I hope that in future that is the direction that we take.

Q248 Stephen Mosley: May I ask why it was not done in this case?

Professor Walker: That decision was taken before I was part of the Committee; I'm afraid I do not know.

Jane Ellison: I think this programme dates from 2008. Is that right?

Professor Walker: Yes.

Jane Ellison: May I just comment on NHS Health Check? There are two evaluations that the Departments commission, and we will have those in the autumn. We clearly need to have a good evidence base, and I believe that we are proceeding on a reasonable evidence

base and that that will be built on; I hope that it will be. However, it is also part of an important conversation that we have with individuals about their health. As Minister for Public Health, I think all the time about the points at which we can influence, particularly on lifestyle risk. When you look at the long-term risk of cancer and things like that, much of it is increasingly credited to lifestyle choices.

There are points at which you can have a conversation with individuals about risky behaviour that is not yet so extreme to put them in the health system but, if they carry on in that vein, is likely to, but the opportunity for those conversations is relatively limited. The evidence that I have seen around polling on health all points to the fact that people all think it is someone else's issue. Everyone thinks that everyone else is obese; everyone thinks everyone else is indulging in risky drinking, but not themselves.

We have to find a way of capturing the uniqueness of being able to have a conversation with people at a point in their lives where we might be able to set them on a different path. Those opportunities are relatively rare with the normally well, and having those important conversations at the right life stage is part of building the sustainability of our health system going forward.

Q249 Pamela Nash: I move on to the question of informed choice. Certainly the NSC is very clear in its remit. Please correct me if I am wrong, but its role is to give clear and unbiased information rather than encouraging people to get screened. Minister, I guess that you would agree that people should make an informed choice rather than being forced into it. How does the Department define informed choice, and how do you measure whether someone is informed enough to make that choice?

Jane Ellison: It is a challenge. There was a thorough process, for example, in looking at how the breast cancer screening leaflet was reviewed. It went through a very rigorous process involving large numbers of members of the public. Essentially, it was a public panel review.

It is a challenge, not least because the people that we do not reach through our screening programmes—I spend a lot of time worrying about this—are probably also the people who are in a less good position to take a view about informed choice. It is an ongoing challenge. Among well-educated, well-informed people, we have done a really good job of laying it out. The new breast screening leaflet, for example, does that well in laying out those choices, but we always have to look at new ways to explore that.

Some of that might be about clinicians explaining to people, as part of a dialogue with a trusted health professional, what those risks are. We need to make sure that people have that opportunity. For many of the groups not in a position to make a particularly well informed choice, the biggest problem is that we are not getting them through the door at all. That is a big challenge.

Professor Walker: May I add to that? There are two big problems. One is what information we should be trying to pass on and what the messages are that we need to be giving. Secondly, how good are the processes for transmitting that information?

The problem with the former is that screening is really complicated. Even health care workers and doctors struggle with some of the risk elements of these issues. If we ask the scientists to put together a leaflet that is accurate, what comes back is something so full of caveats and footnotes that it is impenetrable to the average person.

With the breast cancer example, we involved a citizens jury of women, and had a public consultation with over 1,000 people and 50 professional groups. The message that we got back was, "This doesn't work. We need simpler messages." We put together a leaflet with simpler messages, and the scientists then said, "Yes, but that's not quite accurate. You're not being fair. You are not informing people properly, because you haven't told them all the nuances around that particular message." We cannot, I think, keep everybody happy; there is always going to be a compromise, and we have to keep involving all of our stakeholders, particularly the public and the people who are going to be using the services, and try to make it as good as we can.

There is another issue, and that is about disseminating the messages. One of the things that we often hear is, "I didn't realise that I had a choice in getting this test. I thought it was something that I was required to do," or something like that. It is really important that the people who are delivering these tests and communicating with the people who might use them are really good at communicating what it is all about, and the fact that this is an informed choice and they do have a choice whether to take part or not.

Q250 Pamela Nash: The Committee has heard evidence that, for some screening programmes, there are financial incentives for GPs to ensure that quotas are tested. How widespread is that financial incentivisation, and what programmes does it cover? Is that compatible with the notion of informed choice?

Professor Walker: It covers a number of programmes. For example, it is through the target-setting thresholds for delivery, QOF and things like that. There is a potential conflict, in that clinicians might want to get the numbers as high as they can, but if you use a threshold type of approach that does not necessarily apply. What we want to see is everybody being offered the opportunity to make an informed choice. We want everyone to get the offer—that's the thing—rather than everybody having to decide whether to take up the process.

Q251 Pamela Nash: Just to be clear, would a GP be rewarded if he had offered the test to someone but the person declined the test or only if the person accepts the test?

Professor Walker: The arrangements are different for different programmes, but in some programmes that is the case and they have target levels to meet, yes.

Q252 Pamela Nash: Yes, but is that target the offer, or someone taking up the test?

Professor Walker: I believe it's taking up the test.

Q253 Pamela Nash: They are incentivised for someone to take the test and not just for the offer.

Jane Ellison: It is a reasonable point to put, but we have to balance this and put it in the context of the fact that clinicians have a wider duty to the people that they care for, to help them make the right choices and to look after them as a whole person. There is not an enormous risk of huge numbers of health care professionals trying to get people to do something that they do not think is the right thing for them. It is a delicate balance; we do want to incentivise people to make the offers, as David said, to get to the threshold, but they have a wider duty of care that overrides everything in terms of not forcing people to do things that are not right for them. It is a fair point.

Q254 Pamela Nash: I understand that. It reminded me that not that long before I became a Member of Parliament I worked in the House of Fraser, and we were not allowed to sell PPI—insurance—to people with cards, but there was a financial incentive if we did sell PPI. When I read the evidence of a GP from Glasgow, it reminded me very much of that: "You're not supposed to do this, but you're only going to get paid if you do it."

Professor Walker: There is a difference, in that we have a quality assurance programme as well for all of our screening programmes, which looks at issues around how the programme is delivered. I have to say that those issues never really arise.

Jane Ellison: If there was any evidence, if somebody reported that they had felt pressured, that is something that the committee would take extremely seriously. No one has reported that to me as a Minister, but if any colleagues said that they were aware that people were doing it, I would take it up immediately with David and his committee, and ask them to look into it.

Q255 Pamela Nash: My final point on this is about written consent. I know that there are different rules in Scotland around written consent for some tests, where verbal consent is acceptable in England. Has the Department considered introducing written consent or to increase the use of written consent?

Jane Ellison: I am not aware that it has been considered while I have been a Minister. It is not something that I have actively considered. I don't know, David, when it was most recently considered.

Professor Walker: No.

Jane Ellison: When we see your recommendations, we will obviously have a look at all of them and respond in the normal way.

Q256 Stephen Metcalfe: Professor Walker, I think that you just said—I hope I don't quote you wrongly—that you wanted everyone to get the offer of screening but you did not necessarily want everyone to take it up.

Professor Walker: Yes.

Q257 Stephen Metcalfe: Presumably you do want everyone to take it up, because there must be a benefit to this as far as you are concerned. So an ideal would be that everyone takes it up because you think there is benefit from screening.

Professor Walker: Yes, but there are many people who will understand that the evidence shows a clinical benefit, but will personally not want to take up a test. They should be free to do that. We are not talking about compulsion here, which is what I meant.

Q258 Stephen Metcalfe: No, but I am just checking that you think there is value to the test, and in an ideal world everyone would take it up.

Professor Walker: Absolutely, yes. We have a rigorous process for evaluating the evidence, and we would not make a recommendation to implement the programme unless there was a firm belief on the part of the committee that it offered a benefit.

Jane Ellison: We are not neutral on this; that is the essence of your question. We think that there is benefit, but we want to make sure that people have an informed choice.

Q259 Stephen Metcalfe: Absolutely, and informed choice is important. We have heard evidence about the way that the risks and benefits of screening are communicated. You talked about the breast cancer leaflet, which was held up as a good example of how to communicate it, although you said that there were some problems in that making it too accessible to the public meant that the scientists would not necessarily like it. Does that mean that coming up with a set of guidelines to improve all the material used to promote screening is in the "too hard to do" pile, or are you going to come up with some guidelines that nail down what you think is best practice?

Professor Walker: This is done all the time, and it is done in each individual programme. We do not necessarily do that at a national level over all the programmes. The lead for developing the breast cancer leaflet was in the breast screening programme itself. It is something that is regularly reviewed in each programme, and each programme has its own advisory board, with experts and lay members on it and also communications experts. They will work together to improve the communication and to deal with any communication issues that arise over time.

Q260 Stephen Metcalfe: Who is co-ordinating that at the high level and picking things out? All these advisory boards will be working in political isolation at the moment. Who is pulling together where someone has achieved a best practice result? How is that being communicated to the other boards?

Professor Walker: That is done through the programmes, which are based in Public Health England for England but based in national administrations for the other countries. There is an infrastructure to do that.

Jane Ellison: That conversation is obviously going on in a lot of other ways. If you take Public Health England, that is exactly the sort of process that will lead up to, say, a public health campaign. It is exactly the same issue about how you boil down a lot of complex science and the balances involved into a simple public health message. We need to do that,

and that is something that Public Health England and people who work in that field have to do all the time, so there is some expertise there.

Q261 Stephen Metcalfe: But there is no independent person or body who has oversight of all this. Would that be a useful addition to the landscape?

Jane Ellison: Instinctively, I do not see what it would bring. I am open-minded about looking at it, but the NSC itself has a lot of independent members. When you get down to the point about communicating with the public, you also need those communication professionals. We have some really significant expertise for England in Public Health England in doing that, because that, as I say, is also the same process we go through in putting together public health campaigns. I think the expertise is there.

Q262 Stephen Metcalfe: I am sure we all want the same thing, which is to improve the way that we communicate and improve the uptake, because there is obviously benefit associated with it. The question is whether or not there is a good way of doing it.

Professor Walker: May I add to that point? The conversation has focused a lot on the text of the leaflet and that sort of thing, but that is not the only way this is done. We do have quite an extensive educational programme targeted at everybody, from the clinicians who are delivering the programmes, the patients and the public who are going to receive them, and also the commissioners of services, who are going to be monitoring contracts and ensuring, for example, that they are delivered to high quality. We have everything from leaflets and videos to e-learning modules—and even university-accredited courses—for these people.

Q263 Stephen Metcalfe: I take that point, but it's finding what works best in each of those and then spreading it across as wide a field as possible.

Professor Walker: Yes.

Jane Ellison: That is right, but it is worth remembering the context in which the different screening programmes are offered and that the point of engagement with them is very different. If you take the population cancer screening programmes, you have a very different communication challenge there from the programmes being offered to newborns. There, you have someone who is already very much in the health system and at a point where the messages are being discussed with clinicians. They are in a different setting from trying to bring people in for breast cancer screening.

Context is important in this. There may not be the same read-across, particularly between programmes aimed, for example, at adult whole population versus mothers of newborns, because of the context in which the conversation happens.

Q264 Stephen Metcalfe: Thank you for that. Minister, you talked about having a conversation with individuals about changing their lives—the "everyone is obese other than me" type of conversation—but also about the hard to reach. It is probably the hard to reach

who may potentially benefit the most. How are you addressing that? What actions are you taking to get to the hard to reach?

Jane Ellison: It is one of the big challenges of my job. It probably comes up every single week in one context or another. An awful lot of work is under way more generally in public health, generally with Public Health England in the lead but with all agencies being involved, in addressing issues.

For example, when we look at the cervical screening programme, Public Health England has a programme for looking at areas of lower take-up, working with local teams and the local NHS to see what is going on there, to see whether it can be improved. They are not just waiting for the problem to come to them; they are actively going out to find areas of low take-up. The whole service is acutely aware of the challenge of people who, for example, have English as a second language and the BME communities where, across most screening programmes, there is a lower take-up. The whole service is very much focused on what we can do there.

What we are seeing, especially with public health being led at local government level now—it has now gone back to a local government lead—is real innovation from local government, from the health and wellbeing boards and public health directors in localities, where they know their communities best. They may already have cracked the communication problem with some of the harder-to-reach groups in other contexts, such as housing and education. By having the public health lead in local government, we are bringing to bear some of that expertise in reaching those groups, through local government.

It remains a challenge, but certainly as a Minister, and from my experience with everyone involved in the system, it is one that everyone is focused on. In many of the statistics that I see, there is generally a good population result, but buried within it is a much poorer result among certain sub-groups in our country. You are right to say that, for some of them, the screening potentially has a disproportionate benefit. So it is a big focus of our efforts.

Q265 Stephen Metcalfe: To measure the success of that outreach, if you like, you are not just looking at take-up over the whole population but targeting it down to BME and potentially the harder-to-reach areas, so that you are aware of whether you are being successful.

Jane Ellison: Absolutely. With all the statistics, we will of course have an overall picture, but we all ask ourselves the question and we all get the data broken down, usually by region, by different ethnic groups, by age groups.

I sat down with Jo's Cervical Cancer Trust recently, for example, and we looked in great detail at all the data that it has around take-up by age group and region. It varies around the country, but there are some consistent themes. It is never enough to look at the single population. I think you are very aware of that too, David.

Professor Walker: Absolutely. I would add that although NHS England has a responsibility for commissioning these programmes, which it does through its regional and local services, Public Health England puts public health input at all levels, so the data

around uptake and what can be done with that specialist public health knowledge will be fed in at local level. The Public Health England people are co-located with the NHS England commissioners. They are right there with them when they are making their decisions and that is in addition to the work done in local authorities.

Jane Ellison: We now have in statute the duty to have regard to health inequalities, and that is something that all of us, from me downwards, take extremely seriously. It has to be hard-wired into our approach.

Q266 Stephen Metcalfe: I'd like to move on to the role of private screening companies. Some of our witnesses have told us that the private screening companies' advertising material makes great claims but that the claims are not evidence-based. First, are you aware of that? Do you agree? Secondly, is there a role for Government, Public Health England or whoever to regulate that in some way?

Jane Ellison: I have not considered any form of regulation to date. Personally, in the time that I have been in the job, I have not had this drawn to my attention as a major problem. I know it is an ongoing concern, but no specific example has yet been brought to me nor has anyone said, "We need action on this." I remain open-minded on that.

Professor Walker: There are three forms of regulation. There is consumer regulation around the claims that they make. There is the practitioner regulation; if the health care workers are doing this, they are regulated through their regulatory bodies. The products that they use in the test have to be regulated as well.

Regulation is already in place, but there is a real problem. These are screening tests and not screening programmes that are being offered. A screening programme is everything from defining the population at risk and then inviting those people into a programme, offering them a test with all the information and informed choice, but then comes the follow-up. It is what you do with the result. If they get a negative result, can you reassure them that they are really okay? If they get a positive result, what should happen next? What do they need?

One of the problems with private testing is that they are just being offered a test without really understanding what it tells them. If they get a positive result, they then go off to the GP and say, "I have just been screened for this, and I am positive. What should I do?" The GP does not know, because he does not know why the test was done or sometimes really what the test means in that context, because it is not part of a programme with a proper pathway.

They are a problem, but we need to work with the people who are offering these tests and make them work in a more consistent way and in a way that helps people. There is a real danger in this country that we are going to introduce some of these private screening programmes through the back door without a proper assessment of their costs and benefits. When it is a major company, we can often talk to that company and ameliorate what it does by negotiation. Regulation would be extremely difficult, because it will be easy for them to produce a new product for next week that is completely different, and we will not know what they will be throwing at us next.

Q267 Chair: It would not be difficult to say to them, for example, that claims made in advertising must be independently verified by whatever process you want to devise.

Jane Ellison: I think that that test already exists.

Q268 Chair: It does in advertising.

Jane Ellison: Not in this context, but in other aspects of my role there are examples where claims made by independent providers have been found wanting by advertising standards, and they have been reprimanded and made to change them. So that does exist.

Q269 Chair: That's a reprimand; I am talking about something prohibitive that requires their advertising material to go through a process of validation. It is not difficult, is it?

Professor Walker: I do not know whether it would be difficult or not. The same proposal has been suggested for things like e-cigarettes; it is being discussed a lot at the moment.

Jane Ellison: Yes, it has been discussed a lot in that context.

Q270 Chair: We are keeping off that one at the moment.

Jane Ellison: That is another whole inquiry.

Q271 Stephen Metcalfe: I do not have a problem with the private sector having a role in this, because we do not have a monopoly on offering people ways of discovering how healthy they are or not. It is a question, as the Chair was saying, of making sure that the claims are not over-exaggerated.

Jane Ellison: I think David's point about the pathway is also important. When we were discussing this, we were drawing the distinction between a screening programme and a vaccination programme. The vaccination programme is a single intervention; you do it and that is the objective. A screening programme, to be effective and to care properly for the individual, has to be part of a care pathway. You have to have somewhere to refer that person to, whatever the result of the screening is.

Q272 Stephen Metcalfe: Is that a programme or a test? A screening test is going in and having an MOT, whereas a programme, as you said, is wider.

Jane Ellison: Even with a test, somebody needs to know what happens. People tend to go in for a test thinking they will be fine, but if they are given a result that is worrying, it is really important at that moment that someone is able to signpost them to the right clinical pathway to care for them. It might be extremely critical at that moment that they get the right care. That is one of the reasons, with the NHS programmes, why so much thought has gone into the whole programme beyond the point of screening.

Q273 Stephen Metcalfe: There is engagement going on between the NHS and the private sector to try to improve things.

Professor Walker: There is, yes.

Q274 Graham Stringer: Minister, during cervical screening awareness week, you said that 3 million women had been tested and that 4,500 lives had been saved. Where did the figure of 4,500 come from?

Jane Ellison: That was the figure advised to me by my experts, so I shall ask David to supply the detail on that.

Professor Walker: The way that this is done is by taking randomised control trial evidence, which gives you a relative risk of death from a particular cause with screening compared to without screening. You might come up with a figure, for example, that death rates are reduced by 20% or something like that. You can then apply that to the population screened. There are a lot of adjustments that you have to make for confounding factors that can change over time—age, coverage and that sort of thing. That is how you produce the figures.

Q275 Graham Stringer: Statistics is a complicated business. It is certainly non-intuitive. How are those statistics validated? Who does that?

Professor Walker: For the ones that we use for the NSC, we have a randomised control trial, which obviously goes through the usual study-design process and peer review before publication, to guarantee its quality. We would then normally look at several randomised control trials, and that will be done through a systematic review by an academic institution with particular expertise in that area.

We would commission a review, and that review would then go out to public consultation; then we would make a decision on screening based on the data in such a review. For breast screening, for example, we based our current recommendation on the Marmot review, which looked at a whole range of randomised control trials. There were 11 randomised control trials.

Jane Ellison: Cervical screening is an interesting example of where there is an awful lot of work going on, and one of the questions that I have asked is whether the committee will return to look at that data as the HPV vaccination is rolled out and becomes so much more widespread. We are hitting well over 80% of girls having all their jabs at the moment. That is definitely going to change the landscape.

It is really important that these views are not set in stone for ever. When the evidence changes, they have to look at it again. Because of the changes in the landscape with HPV and cervical cancer, it is definitely something that NSC has on its books to come back to.

Professor Walker: That is right. We have a rolling programme of reviewing all the evidence because of this sort of thing. What we would like to do ideally is to implement the programme and then look at the outcome data and say, "How many deaths have there actually been?" We do do that, and we can see the trends in reductions in mortality from

cervical cancer over time, but there may be other confounding factors that are contributing to that, such as better treatment and care, immunisation and lifestyle factors, which can all impact on mortality rates.

Q276 Graham Stringer: Given that statistics is a complex and technical branch of mathematics, do you not think that it would be a good idea if the stats were checked by the UK Statistics Authority? We have had some evidence that one professor thinks that the stats given out on breast cancer are based on an unsound mathematical model, for instance. This Committee is not in a position to know whether that is true, but do you not think that it would be good to get them validated by a body whose competence is primarily in statistics?

Professor Walker: The review that was done on breast cancer did involve an expert statistician—a very eminent statistician.

Q277 Graham Stringer: It is not the expertise but the independence that I am interested in.

Professor Walker: The breast cancer review only involved individuals who had not published in the field before. They, therefore, were independent but had specific expertise that would be useful to that kind of review, which goes beyond statistics. It is not just about statistical measurement; it is also about the epidemiology. It would be hard to find somebody more eminent and independent than Michael Marmot.

Q278 Graham Stringer: Do you not think that it should be tested by the UK Statistics Authority?

Professor Walker: I would have no objection to doing that, but I do not think it is a necessary step.

Q279 Chair: Before we move on, the figure that Graham used came from a letter that you sent out to all MPs, Minister.

Going back to your earlier observations about take-up, would it not have been valuable to tailor that letter down to either regional MPs or individual MPs, and point out to them areas that have particularly low take-up? I know that Professor Ashton, when he was director of the North West Regional Health Authority, mapped a lot of conditions down to super output areas. Presumably, you can do the reverse and say that in this super output area take-up is terribly low and it ought to be much higher in this case, for example.

Jane Ellison: Chair, I would absolutely love to have sent every Member of Parliament a letter tailored completely to their constituencies or areas, but I did not have the capacity to do so. However, the letter did link through to the data fall, which was broken down. It was only one click away, and charities such as Jo's Cervical Cancer Trust have area-level data available, which is why the letter was signposted to them.

I would love to, and it is something that we look at all the time, because I am trying to do more "Dear colleague" letters. One went out, hopefully this morning or last night, on national transplant week. I think parliamentarians are an underused resource in terms of

asking the right questions locally on health issues, and I know very well that they need local data to ask those questions.

Q280 Chair: Equally, as a Member of Parliament, you will be aware that a number of major charities will write to us saying, "Will you please flag up to your commissioning group or whatever the failure of this in your region? These are the stats here."

Jane Ellison: We work closely with many of those charities. As I say, with something like cervical cancer awareness week, I had previously met with Jo's Cervical Cancer Trust and talked to it about the best approach. Where I can, I make sure that we always link through to MPs—and in other areas, not the one that the Committee is looking at now. I have events planned for later in the year where I am going to ask specific Members of Parliament with specific demographics in their constituencies to events where we highlight issues for them.

The Committee knows, as I do, that MPs are busy, but we will keep plugging away because it is important. You cannot just look at the top-line stat; it is absolutely vital to look at the one for your own areas.

Q281 David Tredinnick: Minister, we have been told that the age range for routine breast cancer screening is going to increase to cover 47 to 73-year-olds. Is that right?

Jane Ellison: Yes. It has been expanded at both ends of the age range, but it is part of a large trial, essentially, and I shall ask David to comment further on it.

Professor Walker: It is a randomised control trial, a very large one, and it comes out of the Marmot review, which recommended that we look particularly at the 47-to-50 age group to ensure that every woman had the opportunity to be invited by the time they were 50, because there seemed to be benefits in that. We are doing a study to find out, but it will take a long time to get the answer.

Q282 David Tredinnick: Are you going to implement that before the trial is completed or are you going to wait for the results of the trial?

Professor Walker: That is being piloted at the moment. In effect, it is a randomised control trial. We are also looking at the older age group, and that is consistent with what happens in many other European countries. A lot of the data that are being used to determine whether this programme should be in place include that older age group, often up to 74 or 75.

Q283 David Tredinnick: Did you have advice from the UK National Screening Committee on implementing the age extension?

Professor Walker: We have not decided to implement the age extension, although we support the trial to see whether we should be implementing it. Once the trial is complete we will make a recommendation, but that will be some time in the future.

Q284 David Tredinnick: I want to ask a question about statins. There seems to be widespread confusion among the public about the use of statins now. Does that worry you? For example, there are conflicting reports in the press about their safety. Is that something that you think you need to address, Minister?

Jane Ellison: In more general terms, there is conflicting information in the media about lots of things in the health field.

Going back to the earlier part of our evidence, one of the reasons why it is so important to get scientifically backed expert advice translated into sound advice for the public is that we want to provide clarity when there is a lot of public discussion—but it is not easy. Obviously, as people come out with new studies and whatever, if they are newsworthy, they will tend to be minus all the footnotes and caveats that David was describing earlier when he receives new scientific advice.

Q285 David Tredinnick: It has been suggested that statins should be used by a wider range of people. NICE has been making recommendations based on evidence that it has received, but is it not a fact that the organisations that have provided the studies would benefit from an increase in the use of statins across the country?

Professor Walker: NICE reviews all the published evidence available, and some of that evidence will have been produced by individuals with links to companies that produce some of these products. When that is the case, they have to declare it. Any conflicts of interest are considered both in the peer review process and in the published articles. That is routine for any scientific study, so we should be aware of where there are such affiliations.

I would say that there is a scientific consensus that statins are valuable for people who are considered to be high risk. The discussion at the moment is where that cut-off should be. There is a grey area, and in that grey area the quality of the evidence being considered becomes very important. There is a serious debate at the moment, but NICE has made its position clear.

Q286 Mr Heath: With a screening programme we start with the premise that it will do good. That is tested by randomised control studies in the evaluation stage before going ahead, but the test at the end of the day is whether there is a health improvement outcome from the screening programme—whether there is an improvement in morbidity and mortality. It seems to us that the data that are collected look more at the coverage of a screening programme than those outcomes. Would you accept that that is the case, Minister?

Jane Ellison: There is a lot of focus on coverage, partly because it is such a challenge. In terms of the process that the NSC goes through of the rolling review of programmes, as David has mentioned, they have to look at the outcomes as well. Ultimately, we measure the value in lives saved or improved, and you therefore have to have that data.

Q287 Mr Heath: You do, but I don't think you necessarily have it for all the screening programmes. I do not expect you to carry around with you the list of all the data that is collected for each screening programme, but perhaps the Committee could be provided with that, so that we can see for ourselves whether the data collected actually supports the evaluation that you are suggesting. Is that possible?

Jane Ellison: Yes, it is a reasonable question. My own view is that we are not flying blind on this and that we do have a lot of data. I understand the point you are making, but the process that it goes through is a rigorous one. Perhaps David could comment further.

Professor Walker: We collect three kinds of data. First, pre-implementation, we have the randomised control trial data, which tells us whether something works or not. That is not unique to screening; if we are going to introduce a new operation or a new drug we do the same thing. We do not usually then go and test whether drug x works in the real population; we do not test it over and over again.

Q288 Mr Heath: That is another story.

Professor Walker: Indeed, but I am saying that it is not different in screening. So we do the trials. The next kind of data is to do with the implementation of the programme. Are we doing it properly? Is it done to a high quality? Is it done in a timely way? Is the coverage right? That's the sort of data we are talking about; it is about performance and quality in the programme.

Then the stuff you are really interested in is the outcomes. Is it actually doing the job? That is much more complex for some of these programmes. With the newborn hearing programme, we know that the benefits of that are, for example, that children whose deafness is recognised early have better education outcomes, social outcomes and better employment outcomes in the future, but those outcomes might be 20 or 30 years away, so you introduce the programme—

Q289 Mr Heath: You say that it is a benefit. Is it an assumption that that is the benefit?

Professor Walker: No.

Q290 Mr Heath: Or do you have evidence? You would need a longitudinal study of some kind, would you not, to show that?

Professor Walker: We do have studies that show that if deafness is identified early those outcomes are better. We have that outcome data. We have introduced a programme to test that, but the only way to be sure that those outcomes are really being achieved is to wait until they occur and then measure them. In effect, we use proxy measures of how many children are identified as deaf through the programme and we can then calculate what the benefit might be.

For some of these programmes, it is much more complicated than that. For example, with the breast cancer programme, at the same time that we had the breast screening programme implemented we had a treatment development in the use of tamoxifen. Since

then we have had a number of other improvements in treatment, but we have also had changes in the lifestyle factors. A lot of the risk factors for breast cancer have changed over the last 20 years, so simply measuring the number of deaths does not give us the answer. The only way to do that is by making comparative and observational studies. Those are less secure in providing us with the information that we need than randomised control trials. None the less, we do those and we do monitor them.

Q291 Mr Heath: Do you collect individual outcomes from somebody who has tested positive from a screening programme and follow it through?

Professor Walker: Yes, we do. A good example of that is the abdominal aortic aneurysm programme. We have data on every person who has been through the programme, including what happened at the operation.

Q292 Mr Heath: You are right—that is a good example of where it is done—but I suggest that not all programmes would have the same level of data collection.

Professor Walker: No, they would not because sometimes it is not practicable. All programmes are different, and it is an issue that is considered by the advisory groups and the individual programmes for every single programme.

Jane Ellison: There may well be some ethical considerations. What David is describing is the fact that sometimes you basically have to do it to be really sure that it makes a difference. Imagine me sitting as a Minister and saying, "Well, we're doing a trial where half the country is going to get this thing that we think is good for you. We have lots of really good scientific evidence to say this is a worthwhile programme, but we can't be 100% certain until we have actually done it. So half the country is going to get it and half isn't."

We have to make reasonable assumptions and then use the outcomes data that we get over time to constantly review that. That is why the NSC has a rolling review programme so we can feed into that, but we also have to take a reasonable view about the outcomes that we are looking for. We need to keep it under review.

I personally think that not that far into the future there may well be a time when I or somebody in my position might say to the NSC, "Would this programme benefit from being narrowed down to a particular cohort of the population who are most at risk? The statistical modelling is marginal for the whole population, but absolutely hard and fast for a sub-group of that population." That is a question that I would probably ask the NSC to look at in some programmes, particularly going back to the cervical one.

If we get, as we are getting now, good evidence about where we are achieving very high levels of HPV vaccination and equally we have evidence about the communities, the types of schools and the areas where we are not getting that HPV cut-through in terms of vaccination, it might well point toward that programme. At some point, I would probably ask the NSC to look at that programme and, in the light of the HPV information, review cervical screening and give recommendations on whether we should put our foot on the gas in some areas and perhaps take a different approach in others.

Q293 Mr Heath: There is an ethical dimension to applying a screening programme that we assume works but does not actually improve the overall public health, of course.

Jane Ellison: All I can say is that I have no evidence—no evidence has been presented to me—that any of the screening programmes are going ahead on that basis. David has explained the complexity in some cases. If it was presented to me, I would ask the questions and get the NSC to look at it. The point we are making is that it is not always black and white.

Q294 Mr Heath: Let me give you an example with chlamydia. Back in 2010, the Public Accounts Committee said that there ought to be a mechanism for measuring its impact. The level of infection is still rising four years later, so where is the evidence that this screening programme is having a beneficial effect on disease prevalence?

Professor Walker: We have evidence. First, we have the uptake evidence; we know how many people have been screened; we know how many positives there are and how many people have been treated. Therefore, their risk has been reduced. We also have antibody studies showing that the prevalence of previous infection has gone down over the last few years. Once again, this is not a screening programme that has been through the NSC process, and it is not strictly a screening programme in that it is more about opportunistic testing. We are not identifying a population at risk and offering them all screening in an informed way. What we are doing is making the opportunity for testing available to a particular age group, which is the 15 to 24-year-olds.

Q295 Mr Heath: You said that it has not gone through the NSC process. Unusually among intervention uses in the health service, screening programmes are not covered by NICE. NICE does not do an evaluation. Should it be involved in this process?

Professor Walker: NICE has an involvement in the assessment of treatment and care. The problem with the screening programmes from the NICE point of view is that you have a whole pathway to look at rather than—

Q296 Mr Heath: Is that not what they do? They frequently look at therapeutic pathways.

Professor Walker: They do, but this is more than a therapeutic pathway. This is about how you identify the risk population, and it is also about the pathways after treatment and care finish. NICE could do this, but I do not think that it has the resources.

There are many ways in which you can deliver this. It just needs to be done once, and nationally. The system that we have at the moment is comparable with that of any other country in the world. It is highly regarded internationally. It is a good process; it works; and it is cost-effective compared with those in other countries. It is a good way of doing things, but of course there are always more ways to do it.

Q297 Mr Heath: I have one last question. The UK National Screening Committee told us that it does not score the criteria that it uses to appraise screening programmes, but it brings

its judgment to bear in order to decide whether to implement a programme. Are you confident, in that case, that the advice you get is consistent? Judgment without a peer set of scoring against criteria is inevitably subjective. Do you believe you are getting consistent advice?

Jane Ellison: In the time I have been in this job, I have had no reason to date to think that I am not, but that does not mean that I am not open-minded to suggestions about different ways of approaching it.

Inevitably, I tend to talk about one screening programme at a time. Although we have had a couple of quite major meetings looking at all the programmes, one tends to look in more detail as the parliamentary timetable dictates. We recently looked in great detail at the cervical screening programme because that was answering a debate about it. It tends to come up like that. I have no reason to think not, but, as I say, I am extremely open-minded to what the Committee finds and recommends if there is another way. There are a lot of independent experts available.

Going back to a point I made earlier, because of the different contexts in which programmes are offered, I am not sure that it is possible to achieve perfect consistency because of the very different life stages and differently designed programmes, from the population adult programmes right down to the newborn. I am not sure that what you are describing is ultimately completely achievable, because they are just very different programmes. However, I accept the point and I am open-minded to it.

Q298 Mr Heath: I do not think that you answered me earlier when I asked whether you could provide the Committee with the data or the classes of data collected on each of the screening programmes. Presumably, if there is no problem, you can provide it.

Professor Walker: We can do that, yes.

Jane Ellison: Yes, there would be no problem.

Q299 Pamela Nash: On the back of that, I wonder, Minister, whether you could tell us a bit more about the process to look at new screening programmes or to expand existing screening programmes?

Jane Ellison: We have an example, and I am happy to supply it to Committee members afterwards. This was the extension of the newborn bloodspot policy review, and it shows all the stages that it goes through.

One has not come to me in my time as a Minister yet, as a recommendation, because they were in place before. Essentially, the committee will go through all the different stages, all the levels of peer review and everything else that was described.

Q300 Chair: For reasons that Professor Walker explained, while that is a template, it is not a rigid one. Is that correct?

Jane Ellison: Yes. Ultimately, although one has not yet come to me for a decision, that is the process by which I would get that advice.

Q301 Pamela Nash: Can anybody come to the committee and say, "I think you should institute this scheme"?

Professor Walker: That is a very good point. When I came into post as the chair, that was one of the things that I was most interested in. The current position is that we have a whole range of stakeholders, who are clinicians, patient groups, charities and including Members of Parliament, who can ask us to look at any programme at any time. Any one of the stakeholders can make that request. The proviso is that we have to go through a short process at the beginning to make sure that there is face validity to doing it.

In some other countries, such as in the United States, they call for proposals every year. They have a formal process whereby they invite people to make proposals and they then go through a rigorous triage process, which is long and expensive and probably not very good. However, the principle of having that annual call gives everybody the opportunity to put something in and to know that it is going to go through a proper process to be looked at. That is something that we are looking at through the current review of procedures.

Jane Ellison: I would encourage that. That speaks to openness and transparency, which people would welcome. I was pleased when David said that MPs are stakeholders too. If colleagues come forward with things that they want the NSC to look at, we will ask it to do so. I am really pleased that David and his committee are open to that.

Q302 Graham Stringer: If I can take you back to Stephen Mosley's questions about NHS tests, you gave a perfectly reasonable answer—that in future there would be randomised tests with a control to see if they work.

How could one not think that was sensible? Except that in the real world there is terrific pressure on GPs at present, there is some evidence that there is no difference in the outcomes for those who have the NHS test and those who do not, and we have had evidence given to the Committee that, really, we have a diabetes epidemic and other problems. The sensible thing to do, presumably, would be to replace those tests with more public health campaigns, advice on eating fruit and vegetables and exercising more. Although it is a reasonable response, is it the right response given what is happening in primary care in the country?

Professor Walker: That is a fair question. You have to do both. There is little doubt that we could do more in terms of prevention. There are lots of prevention interventions that are cost-effective.

One of the difficulties that we face is that we are fighting against social norms. If you take obesity as an example, the average person in the UK is now overweight. So what people see around them as normal and average is overweight. From a health point of view anyway, that is disadvantageous to them. Most people do not see the lifestyle factors around them as being abnormal or dangerous but as being what everyone else is. The same is true with alcohol.

Jane Ellison: It's all about someone else.

Professor Walker: Yes. We need to go through the process of identifying for an individual that there is something that they could do to improve their health. There is some validity in the health check type of approach, at least in advising people what the risks are, so that they can make some informed choices for their own lives.

Jane Ellison: It sits within a lot of other aspects. It is definitely not either/or in terms of the health messaging and the public health campaigns that you were describing. Those are happening too, and Public Health England goes through a pretty rigorous process of assessing the evidence base for the best place to spend public money on health prevention programmes and health education.

The other thing to say is that NHS Health Check is increasingly not being delivered by GPs. The responsibility for delivering it sits now with local government, in terms of driving it forward. I have seen examples of programmes, and I visited one recently in Southwark where it was being delivered in a pop-up shop in a shopping centre by health care staff but not GPs. Half the problem is getting people in who do not visit their GPs. The normally well are the people who do not really think about their own health, so what we are seeing is innovation in where and how that programme is delivered in order to reach the very people whom we would not otherwise reach. That should give you some reassurance that it is not falling. The GP might well be the person you signpost to it, if the health check throws up a problem or concern for the future.

The other area, just to give the Committee some assurance, is that a lot of work is going on with Public Health England on, for example, diabetes, looking at the data that we already hold to say what should be the population burden in a given area with diabetes, and how successful is the local health system in discovering and identifying that with a view to treating it. Again, we are trying to make sure that the data that we hold is made available and transparent, driving better performance in identifying and case finding.

Q303 David Tredinnick: Just following this theme, have you looked at the portion sizes on offer in fast food outlets? I put it to you that there has been a general increase in the amount of food that is offered. I had an experience myself one morning when I had to get off the M1 because there was a traffic accident, and I stopped at a so-called American diner for breakfast. I was served a plate that was clearly enough for three people. It was an astronomical amount of food. Following on from that, coffee cups used to be a certain size, and now people are being invited to drink half or three-quarter pint mugs of coffee. I just don't think that is necessarily very healthy. Would you like to comment on that?

Jane Ellison: It is a huge challenge—absolutely. It is what health experts call the rise of the obesogenic environment—I think that is the phrase. Portion size is a great public health challenge. It is certainly something that the Chief Medical Officer has spoken to me about on a number of occasions.

People like Public Health England and a lot of public health experts and clinicians spend a lot of time thinking about what we can do. Through the responsibility deal, with some of our responsibility deal partners, we have looked to address some of that in terms of calorie- labelling of meals. Work has been done, for example, to try to ensure that single-

serve portions of treats and snacks are below a certain threshold. What we do about that is a major challenge, but some of it is also about educating the public. Through NHS Choices, people can look at the eatwell plate and see the advice.

I am passionate about trying to drive the informed consumer and give people as much information as possible about making better choices in their own lives, but we all know that we are not there yet. That is a very non-clinical take on it, and David might want to add some science around it.

Professor Walker: No; that is very fair. The science is quite conflicting on portion size. Portions are increasing but the value of reducing them is disputed. Essentially, we have a society where exercise is being designed out of our lives and high-fat and sugar foods are being designed in, and we have to find ways of turning that around. This is difficult when it comes to informed choice, because we want to advise the public on what is healthy but we come up against other forces that are advising the public to act in unhealthy ways.

There is a balance to be struck between regulating or advising people to do things that are healthy as opposed to resisting commercial forces, usually, that are trying to encourage us to do unhealthy things.

Chair: Of course, all this is predicated on advice given by doctors to individuals. They are not advising a population. It reminds me of a conversation that I had with my now retired GP. He was doing the annual MOT and said, "Do you think you drink too much?" I said, "Well, what's too much?" He said, "More than me."

Mr Heath: I am reminded of a quote from Rabelais, who said that there are more old drunkards than there are old doctors.

Q304 Chair: I have one last tiny question for clarity. Minister, you talked about the extension of the newborn baby screening, which came in in May of this year.

Jane Ellison: It was before my time, Chair, in terms of the evidence base.

Q305 Chair: The process was that you had to accept what you inherited. Is that how it works?

Jane Ellison: That would be a slightly pejorative way of putting it. On the basis of the conversations that I had with the NSC and the expert advice that I have received, I have no reason to think that that programme was extended on any less good evidence base than any other.

As I said, there is a perfect example that the Committee might want for its records of the level of rigour that that process went through in terms of the different stages. That can assist Ministers who are not clinicians, as I am not; I am not an expert. I have to satisfy myself that we have a rigorous process and that we have the best minds feeding into that process, and I feel that we have.

Chair: Minister and Professor Walker, thank you both very much for your time this morning.