Science and Technology Committee

Oral evidence: Work of the Chief Medical Officer, HC 779

Tuesday 2 February 2016

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Watch the meeting

Members present: Victoria Borwick; Chris Green; Dr Tania Mathias; Carol Monaghan; Graham Stringer

In the absence of the Chair, Graham Stringer was called to the Chair.

Questions 1-56

Witness: **Professor Dame Sally Davies,** Chief Medical Officer, Department of Health, gave evidence.

Q1 Chair: Welcome to the Science and Technology Committee, Professor Davies. You have been here many times before to help us with our inquiries. As I am sure you have noticed, I am not Nicola, who is poorly, so I will be chairing this session. Can we start with the proposals on alcohol guidelines you have issued for consultation? Is this a precise science? Is it possible to set guidelines that can be applied across the board to all sorts of different groups of people by age, sex and so on?

Dame Sally Davies: The role of guidelines is to inform people, including the public, patients and clinicians, so that you can have a constructive discussion and they are aware of the issues. This is the first time any country has done a major review of the science in Europe in over 20 years. Australia and Canada did good, big reviews three or four years ago, and we have ended up in much the same place—that the science has moved on. It has moved on in two areas. One is that we know a lot more about the impact of alcohol on the development of cancer and on the risk of cancer. The other, in part because of societal changes that I will come back to, is the so-called protective effect of alcohol. In the past, it was believed that low doses of alcohol protected people's hearts: the cardio-protective impact.

There are two sides to that. First, does it really happen? If you review the literature very carefully, it is not as robust as people thought 20 years ago. The second is whether people's hearts need protecting that much, because we have done so very much with statins, maintenance of blood pressure, stopping smoking and the NHS to reduce bad heart outcomes. A third issue is balancing that risk against others, be they short or longer term.

The scientific group that advises the four CMOs advised that we should go for telling the world—our world—that we had low-risk guidelines: that is, a 1% risk of dying related to alcohol. Remember it is advice, not an instruction, and I would be done if I did not tell people the science. I have to tell the truth and make sure it is out there. It should be 14 units spread over a few days for both men and women.

Q2 Chair: There are a number of points in that answer. You said very clearly that it was to inform. Is it also to influence?

Dame Sally Davies: I hope it influences. We know that 25% of people drink over those guidelines; we know that two thirds of people drink at home, and many of those are in that 25%. I would like people to make their choice knowing the issues, and do as I do when I reach for my glass of wine and think, "Do I want the glass of wine or do I want to raise my risk of breast cancer?" I take a decision each time I have a glass.

Q3 Chair: There seems to be an inverse correlation between countries that have higher guidelines and those that have lower ones. The countries with lower guidelines seem to have a higher incidence of alcohol-related diseases, and vice versa. What evidential basis have you looked at in assessing whether or not guidelines influence people?

Dame Sally Davies: For the first time ever in developing health guidelines we used two groups initially. One was a behavioural science group, chaired by Dame Sally Macintyre from Glasgow, and the other looked at the science underpinning what should be the levels, and then they came together to make them. They found remarkably little evidence about the impact of guidelines, but we did not do them to have direct impact so much as to inform people and provide the basis for those conversations and for any campaigns that, for instance, Public Health England and others might run in the future.

Q4 Chair: When you published the proposals, both the president and the president-elect of the Royal Statistical Society wrote to you to complain about the guidelines. They said they did not accurately reflect what the expert group had been advising you. What is your response to that complaint?

Dame Sally Davies: I am sure you have seen my response on their website, but let me explain. They looked at the protective effect called the J-shaped curve. They looked at that out of context with other issues. From the picture, they concluded that at one unit a day—half a standard glass of wine—there was a very small overall benefit for men and a larger overall benefit for women. I do not know many men who drink half a glass of wine every day. In discussion with the guideline group, we looked not only at those curves but at the short-term harms that impact men particularly. I can probably find you the data. Essentially, in England every year there are nearly 1,000 deaths related to alcohol—acute suicides—from intentional self-harm, of which 840 are in men. Therefore, we have to balance the J-shaped curve, which is half a glass of wine a day, with the short-term and long-term effects. That is why, between all of us, we came to the conclusion that for women aged over 55 drinking up to five units in a week there is some cardio-protective effect. By the time they drink more than five units and get to 14 units, which is the recommended lower risk upper level, they have lost that cardio-protective effect.

Q5 Chair: That is very clear. I mentioned earlier that different countries using the same scientific evidence come to different recommendations on levels of use. How do you account for that?

Dame Sally Davies: We are not using the same evidence. We are the most up to date. We are the ones who have done the biggest and most recent review. Canada and Australia are otherwise the most recent—three and four years ago; they are in a relatively similar range, and our group talked to them. This is terribly important. Today, ONS put out the latest alcohol-related death figures. In 2013, there were 14 per 100,000 of the population; it was 14.3 per 100,000 of the population in 2014. Our alcohol-related deaths are going up, not down. We have to inform people, and I hope that through the media and campaigns it will have an impact.

Q6 Dr Mathias: Based on the previous question, is it correct that a lot of this work is done on meta-analysis? What kind of research do you think would be useful moving forward? The public message is very blurred. People are talking about different studies and different conclusions. Going forward, what do you think would be useful?

Dame Sally Davies: It is a problem of science overall, not just the science underpinning alcohol, that, first, studies flip a bit from side to side, so the best thing is to do a meta-analysis, and, secondly, the media are apt to print the latest study.

Q7 Dr Mathias: You would not advocate doing anything different going forward.

Dame Sally Davies: We will keep an eye on the science as it develops, but I have not been informed that we need to do more on the clinical side. Clearly, there is more work to be done about the behavioural aspects.

Q8 Dr Mathias: What is your opinion about calorie labelling? What evidence is there for that opinion?

Dame Sally Davies: I do not believe there is much evidence. Alcoholic drinks are currently exempt from this under European law. Some businesses have chosen voluntarily to label calories. It is under discussion at EU level, but I am not aware of actual evidence.

Q9 Dr Mathias: There is no evidence as to what effective calorie labelling on alcohol would achieve or not achieve.

Dame Sally Davies: I would like to test it and see, but that is a personal opinion. It would be worth testing.

Q10 Dr Mathias: That is a research project that you would advocate.

Dame Sally Davies: Potentially. Someone may bid to do exactly that.

Q11 Dr Mathias: That is a different way of investigating it going forward.

Dame Sally Davies: That is calories. I thought we were talking about the harms of alcohol to the liver and cancer rather than obesity. I would be interested to know the impact just as you appear to want to know.

Q12 Dr Mathias: The impact of calorie marking on behaviour?

Dame Sally Davies: Yes.

Q13 Dr Mathias: Would you, therefore, be interested in research on compulsory labelling of health warnings? I don't know how possible that would be.

Dame Sally Davies: Personally, I would.

Q14 Dr Mathias: In your position.

Dame Sally Davies: I think it is helpful. Alcohol manufacturers and supermarkets have labelled quite a lot—I think it is about 90%[1]—of alcohol that is on sale. The trouble with a lot of that labelling is that it is terribly small. The label for pregnancy is not terribly visible. I would like to see it larger and clearer.

Q15 Dr Mathias: Would you advocate a research project on behaviour? Do you think that is possible?

Dame Sally Davies: You can do research on everything. We have limited money and we have to choose which we are going to do, if someone puts forward a good proposal. The trouble is that you would probably need quite a big study.

Q16 Carol Monaghan: In July last year the Department of Health told us that combining the two big posts of chief scientific adviser and chief medical officer worked well. Two months later the posts had been separated again, and the chief scientific adviser post was advertised. What happened during those two months?

Dame Sally Davies: It is a very good question. Prior to my appointment as CMO I was director general for research. I set up the National Institute of Health Research and acted as the chief scientific adviser reporting to the CMO. That had been the position since the early '90s. We agreed to amalgamate the posts while I was in them. I continue to have my statutory role and specific task of providing independent advice, but I am extraordinarily busy, particularly with antimicrobial resistance and the international agenda that we as a nation have decided to play to try to solve it. Meanwhile, NIHR has got to 10 years, and my judgment was that it needed more energy and time than I was able to put in going

[1] Note by witness: 93% of drinks are understood to be labelled with a warning on health risks to pregnancy, with 79% having more complete health labelling with agreed content (unit content, lower-risk guidelines and pregnancy warning).

forward, so for those reasons it seemed a good moment to get in someone extra to do half of the job.

Q17 Carol Monaghan: In your letter advertising the post of chief scientific adviser you stated that "the appointment process will be conducted through limited competition." What does limited competition mean, and why did you suggest that approach?

Dame Sally Davies: It was discussed with the civil service commissioners. There are relatively few people who can run a research budget of over £1 billion and have the competencies to be a chief scientific adviser. With the support of Sir Mark Walport and the civil service commissioners, we agreed on that. I had been saying for about a year that at some point I would have to give up, in the hope that people would show an interest, not that I knew when it would be. A number of people had shown an interest. We wrote to them; we put that letter on the NIHR website; we told the Academy of Medical Sciences; we told everyone where there were pools of people whom we thought would be interested and invited them to apply. A number of people I did not speak to applied, so clearly it worked.

Q18 Carol Monaghan: Do you feel that the process was open enough?

Dame Sally Davies: I believe so, and we got the best candidate.

Q19 Carol Monaghan: At the last count the Department of Health had over 20 scientific advisory committees delivering advice, the largest of any Government Department. Has the Department given any thought to our predecessor Committee's recommendation to have a science advisory council to co-ordinate the work of advisory committees? As chief scientific adviser, will Professor Whitty be providing oversight of those committees? If not, who might do that?

Dame Sally Davies: I think we share oversight, because the advice is both horizon scanning, which now legitimately sits with him, and about what we should be doing in the public health sphere, which sits with me and Public Health England. Of course, we will be sharing it. As the first chief medical officer in over 100 years to be a fellow of the Royal Society, clearly I am unlikely to give up my interest in science. Everything I do I want to be science based.

Q20 Chris Green: There is a huge amount of concern at the moment about the Zika virus outbreak in south America and the connection between the virus itself and microcephaly—small head—and associated brain damage that babies are suffering. Do we know what the connection is, or is it just circumstantial at the moment?

Dame Sally Davies: There is a temporal association. I understand that a few preliminary studies show the virus growing in amniotic fluids—the fluids surrounding the baby. A classic similar example is rubella, or German measles, where a virus infects early in pregnancy and you can get microcephaly and the same consequences. It looks as if the association is so close that, as we get more science, we are likely to find a causative link. It

is sufficiently strong not only to be very upsetting for those mothers, and for Brazil, which has this particularly horrible outbreak, but that we have given travel advice that pregnant women and women trying to get pregnant should think hard before they travel, and anybody going to an area where it is happening should be very careful to protect themselves from mosquitoes, which is smelly stuff, mosquito nets and long clothes. One thing I have learned is that this particular mosquito, Anopheles aegypti, can be around in the day time, not just at dusk.

Q21 Chris Green: Which people normally associate with mosquitoes.

Dame Sally Davies: Yes, for malaria and nasty ones in France or Italy. We are giving advice. Yesterday, the emergency committee of the World Health Organisation announced a PHEIC—a public health emergency of international concern—and we awaiting, either this evening or tomorrow evening, more detailed advice as to whether they think anything else should be put in place.

Q22 Chris Green: In terms of the World Health Organisation, it has not escalated to something where we in Britain need to get more involved; we are just waiting for advice.

Dame Sally Davies: By calling a PHEIC they have made sure it is on everybody's radar; that Brazil and other countries must report their data through the international health regulations, which is very important; that travel advice is much more available; and that, as usually happens—I am sure it will here—much more money flows into developing the diagnostics. There are diagnostics such as reverse PCR or even antibody tests, but what we really need is a vaccine, so it is getting people talking about that.

Following the comprehensive spending review, we were given money, with DFID, to set up a UK vaccine network, as you probably know. A couple of months ago we had already started saying that Zika was on our list, and were thinking about whether we had expertise that could develop or work in that field. I met one of Brazil's senior health leaders at the WHO executive board last week, because he and I both sit on it. I had an hour's one-to-one conversation about those issues. They are running a vaccine summit. Professor Chris Whitty, our chief scientific adviser, who chairs our UK R and D network for vaccines, will go or send a colleague. We are absolutely on top of where we need to be in Britain. Let me emphasise that there is no risk to people in Britain now, nor in the future, because the particular anopheline, Aedes aegypti, cannot overwinter in Britain; it dies off. There is not a risk to us; it is a risk to our people travelling, but that does not mean we cannot help in developing vaccines and diagnostics.

Q23 Chris Green: Will there be any particular advice issued given the large numbers of people travelling to Brazil for the Olympics? We have seen the spike in Zika cases recently. Will there be additional advice to reinforce the messages?

Dame Sally Davies: The advice is updated regularly and has been only this week, and we will keep it under review. Public Health England takes that role with the Foreign Office, but I keep an eye on it.

Q24 Chair: When we looked at the Ebola crisis, we received a lot of evidence that the World Health Organisation was not as effective as it could be. Are you satisfied that the World Health Organisation is up to speed and will do a good job in this case?

Dame Sally Davies: There are two parts to that question. The first is about what is happening on WHO reform. The second is about Zika itself, so let me take that one. They called a PHEIC early. I had not thought they would yesterday; I thought they would probably let it run, but it is a good call because it means there will be more data and more countries going in to provide support. There are already people on the ground from Public Health England, and CDC has people there. I think that, having called it early, they will be able to co-ordinate what they need to co-ordinate. Brazil has a well-developed health system. I was visiting with Lord O'Neill in October. There is a social health system, and treatment and support is available even for poor people. The bit they now have to look at, as well as developing a vaccine, on which two of their institutes are working, is getting rid of the vectors—like you, I read in the newspapers that they have 220,000 military killing off the mosquitos—and how they are going to support women who, sadly, have microcephalic babies.

Q25 Chair: That is a good point. There is a balance between vaccines and getting rid of mosquitos. Mosquitos do not have just the Zika virus; they have all sorts of other nasty diseases that infect people. Do you think there is a case for a major international attempt to eradicate mosquitos by the use of insecticides or genetic modification? From your expression, you think that is a hopelessly naive question.

Dame Sally Davies: No, I do not. I think it is one of those unwinnable answers, isn't it? You will have seen that the Chancellor announced last Monday that, in partnership with Bill Gates, extra money will be going towards eradicating malaria. Clearly, the best way of eradicating malaria is to get rid of the mosquitos, but it is a different type of mosquito. We know that flavivirus, the Zika one, is carried by Aedes aegypti which also carries West Nile, dengue, yellow fever and tick-borne encephalitis. If we could eradicate them, we would be saving people a lot of disease, but we have not been successful until now. That is why I smiled. I would love to see it happen. It is proving very difficult. Is there a greater political will that may make it happen?

Q26 Chair: There are two points, aren't there? One is the worldwide ban on DDT, which probably has not helped a lot, and there is now evidence, admittedly from small trials, that genetic medication of one sort or another can either stop the virus developing or stop mosquitos proliferating. Given the non-advance with DDT and the advance on genetically modified mosquitos, do you think it is worth trying it now?

Dame Sally Davies: I think we should explore it. You would need to make a plan that involved scientists who are expert, not me. One of my strengths is knowing when to ask others.

Q27 Victoria Borwick: That is a good, ambitious target. It is excellent, and I am sure it would be very welcome. I want to move back to your recent annual report focusing on

women's health, obesity and so forth. You call for the Government to include obesity. Having worked on the London Health Commission, I know how important that was and what a flag it was to everybody. What has been the response to the recommendation? Inevitably, there was mixed press coverage, yet many of us feel it is of obvious importance, so this is an opportunity for you to talk a little about that.

Dame Sally Davies: Thank you. It is now clear that we live in an obesogenic environment and it is impacting on our population. In schools, about 12.5% of toddlers going into reception are obese or overweight; it is double that in year six. As I tried to explain when I was launching the report, people have moved beyond normal and healthy weight; 50% per cent of men who felt their weight was about right were actually overweight—45%—and 5% were obese. A third of children under 18 are overweight or obese, yet three quarters of parents did not even recognise that their child was obese. We know more and more about the impact of obesity. We risk having a generation that will live shorter lives than my generation. We are beginning to understand the epigenetic impacts: that is, the impact that a woman's obesity has on the foetus and, from rodent studies, on the grandchild. If you look at all that, at the financial or economic impact on society—16 million sickness days were attributed to obesity in 2014—and at McKinsey's report, which you will have seen, we have to take action. But this obesogenic environment is not in the hands of the Department of Health; it is about active travel, food and the way we educate our children. It is about everything. The reason for asking for obesity to be raised to the level of a national risk was to try to get at the issue and get everyone focused on their role to try to change the environment and make it easier to lose weight, or not gain it in the first place.

Q28 Victoria Borwick: Surely, that is even more important. One comes back to labelling and things other people have said. Your point about schoolchildren is, surely, very important.

Dame Sally Davies: I believe that very strongly, but even helping older people to lose weight is very important because it will reduce their risk of diabetes and all sorts of things. We know from Public Health England evidence that resizing and reformulation and advertising and promotions are important, and we need to attend to those as well as to active travel, education and everything else.

Q29 Victoria Borwick: In the past, there was more emphasis at school level on buying and learning to cook healthy food and learning about calories. Various registers were kept of shopping surveys and other things. We have talked about pointing out to people very easily what causes them to be overweight or fat and what to do more or less of in a looser sense. What particular emphasis do you think you could give in guidance as to what we should be doing particularly at school level, because that is when children first come into it, or educating parents? In my previous role when I visited a lot of schools I was horrified. Children genuinely said, "We don't really know where to start. We come home to a pre-packaged meal."

Dame Sally Davies: That is why it is so very difficult, because it is every bit of our lives. We try to get it right in schools. Change4Life, school clubs and games clubs are very important. Jamie Oliver is playing a role. The good schools, of which there are many, have healthy food and they do behavioural economics. If you put the healthy salads at the front, children will take those and they may have chips only once a week.

Q30 Victoria Borwick: I believe that over 1,000 have now signed up to Healthy Schools.

Dame Sally Davies: Which is great, and we need to spread that. The impact children have on their families when they go home and say, "Mummy, we shouldn't do this. It's bad," is very important. I was perpetually entertained when my children told me what their schools had indoctrinated them with, and they were generally very sensible things. This is sensible. We need to promote how people can take better exercise, too. Parkrun is fantastic, and there is a children's run as well. These things encourage children to have healthier lives.

Q31 Victoria Borwick: That is very helpful. You touched on women's health—of interest to at least 50% of us here. Do you think that using your report to focus on things that possibly are not always talked about is a good idea?

Dame Sally Davies: I do my reports differently from my predecessors. I have split the report into two volumes: one is surveillance and about data, trying to show in interesting and different ways what it might mean; the other is an advocacy report. I get experts to write the chapters, to make sure they are truly evidence-based and we have references from the data. I choose subjects—children's health, public mental health, women, and genomics, which I am doing at the moment—in which I have a particular interest, either because they are Cinderella and people do not talk about them or because I feel that something is coming that people should talk about, hence the genomics. I felt there were a lot of taboos in the women's field that needed talking about, but it clearly resulted in commentators having absolutely different views—whether or not we should talk about the menopause publicly. But, looking at the data, if women discuss it with their managers and are given effective support, they can absolutely change how they work and be much happier members of our society. Why wouldn't you talk about it? But I am famous for talking about anything, including death.

Q32 Carol Monaghan: In November, we published our science budget report. Then we had the spending review, with essentially a ring-fenced budget for science over the next few years, rising with inflation. Has the health research budget, including the NIHR budget, been protected in the same way? Has its funding been settled yet through spending across the period of the spending review?

Dame Sally Davies: I am happy to tell you that it has now. Essentially, it is like the research councils' flat cash; it is just over £1 billion, with some inflation, but actually over inflation by the addition of £400.5 million official development assistance, so we are in a similar position to our sister research councils.

Q33 Carol Monaghan: To what extent does medical research funded through the BIS science budget overlap the Health Department research budget? Are they clearly marked out?

Dame Sally Davies: It does not overlap; they interdigitate. We work very closely under the umbrella of the Office for Strategic Coordination of Health Research—OSCHR—chaired by Sir John Bell, one of the Prime Minister's life science champions. Essentially, the

Medical Research Council funds infrastructure in the universities, basic science and the grant costs of experimental medicine. We fund infrastructure in the NHS for clinical research and evaluative research, so we fund clinical trials and evaluations, but not hypothesis-driven basic science.

Q34 Carol Monaghan: Can I ask you about the funding of science infrastructure? The Crick Institute is about to open. It is a hugely impressive place, and there has been a lot of capital investment there. Do you feel that there is a danger, however, that, with such massive capital investment in one geographic area, other parts of the country could lose out in terms of bringing in expertise and longer-term spending?

Dame Sally Davies: I am very proud that the Department of Health contributed over £200 million of capital to the Crick. If you look at how Sir Paul Nurse has set it up, it will service the whole nation because he has the concept that people will come in, work there and then rotate back to the regions. As a nation we cannot afford lots of Cricks all around the place. We from NIHR are contributing by putting into the contracts of our NIHR biomedical research centres and units that they will fund PhD students and postdocs who rotate in, if there are people in the Crick interested in those areas, from all round the place to do their PhDs with co-sponsorship and co-supervision, and then go back out to make good the links. For NIHR funding, we do not have a rhetoric of concentration or of regionalisation, but of funding the best. We fund all over England, because the best is distributed, even though there is quite a concentration in the golden triangle. I think that is what we need to do.

Q35 Carol Monaghan: Do you feel there are any particular gaps in health research that are not being adequately addressed just now? There is focus now on joined-up health and social care. Is social care getting its fair share of funding?

Dame Sally Davies: The NIHR budget generally came from the NHS and it is about health. We have increased our research portfolio in public health. We fund an NIHR school of social care, but that comes into the research councils as well. Where I think we need to do things differently is, first, in the training of our clinical researchers of the future. We train them superbly to do the job at the moment, but what about 10 or 20 years ahead? We have started a programme that looks at how to put in structured bioinformatics, digital and even anthropological training for our clinical lecturers so that they are prepared for a different world where they work much more in teams and platforms.

The other area, which is an additional reason why I am delighted that Professor Whitty is joining us, because he has much more time and energy, is that we do not do enough research into multi-morbidity—we do very little, because researchers do not think that way—yet people usually do not have just one disease. As we get older, we have more problems and diseases and we need to do research about that. That is one big area he wants to look at to see if he can stimulate more research. It will be fantastic for those of us who are getting older.

Another thing, which came up earlier, is the behavioural area where, with ESRC, we need to stimulate much more work. We do evaluative work, so I hope we will be able to fund more evaluations of whether or not this or that behavioural approach worked in practice,

whether for public health or within the healthcare service. But it is a perpetually changing landscape, and we need the energy and foresight to make sure we stay ahead as a nation, and for patients, which is very important.

Q36 Chris Green: The Government have commissioned an accelerated access review looking at innovative drugs, devices and diagnostics and how they can be made available more quickly. Where would you say the current causes of delay mostly lie? Is it with the pharmaceutical companies themselves? Perhaps it is red tape.

Dame Sally Davies: This is being run by a different part of the Department, so I am not expert on it. If you have detailed questions, we can submit a response. They have done quite a bit of work looking at barriers. We have historically delayed adoption in the NHS, so that is one issue. We all know that some doctors, nurses, physios and whatever are faster. Some are laggards, but why is it we do not have a greater number of faster ones? I do not think we have the answer to that. We know it is an issue.

Q37 Chris Green: It is a curious situation, because the pharmaceutical industry naturally has a limited patent life in which it can make its profits, or most of them, and the NHS and other organisations want new and better treatments as soon as possible. It seems peculiar that both sides want everything to speed up, but it is taking a while to make progress.

Dame Sally Davies: It is a conundrum. The other side is the changing model of producing new drugs, and the role of MHRA and the EMA in PIM designation—promising innovative medicine. Can we develop a system to work through those more quickly? There is a lot of work going on, but the life sciences Minister and his team lead on that. I think we have the research bit fairly well sorted. We have shifted over the past three or four years from an average of 120 days to set up a clinical research study in the NHS to 22 days now, but I will send you the data.

Q38 Chris Green: I appreciate that. The clinical trial process takes quite a lot of time, but we have to get the right balance and reassure the public that we are doing the right thing without jeopardising patient safety.

Dame Sally Davies: Absolutely; and being active in clinical trials. Over the past couple of years we have built up quite a significant quiverful of first global patients in studies and things like that. We will send you some of the data, because I feel proud of what we have managed to do in that area through NIHR.

Q39 Chris Green: The European Union debate is now raging, and we all want to be part of it.

Dr Mathias: The debate.

Chris Green: Yes, part of the debate. In terms of approving medicines, how much of it is to do with EU rules and how much UK rules?

Dame Sally Davies: I am glad you did not ask me my politics, because I cannot debate that here. You would have to ask the MHRA. Do you want me to ask them for you, or will you get them to come and tell you? We work in a European system.

Q40 Chair: Perhaps you could ask them and write to us. That would be very helpful.

Dame Sally Davies: We will get that for you.

Q41 Chris Green: In implementing the findings of the accelerated access review, do you think a shadow will be cast over it from the perspective that we are trying to make savings in the national health service, and there will be fears that shortening the process and reducing scrutiny is perhaps a mechanism to save some money?

Dame Sally Davies: I sincerely hope not. I hope it is getting better medicines to patients quicker; otherwise, we have not got what we need.

Q42 Chair: Every time we look at this question, which we have done a couple of times while I have been on the Committee, we are lobbied by charities fighting Duchenne muscular dystrophy and other uncommon diseases. Quite reasonably, they say that the testing of new medicines when there are not many patients is difficult. Is any progress being made on making it easier to get drugs for those rarer diseases into hospitals?

Dame Sally Davies: I really am not expert on that, so it would be inappropriate for me to respond. I am sorry.

Q43 Victoria Borwick: I want to go back to the Academy of Medical Sciences review of medicine safety and efficacy. I understand you asked them to do a review of medicine safety. Presumably, you had some underlying concerns that caused you to ask for this review. Was it just about statins, Tamiflu and so on, or did you have wider concerns that you want to share with us?

Dame Sally Davies: This is an independent review, which I precipitated but did not commission. My concern was predominantly about how the public would cope with the debate about Tamiflu, with which I am quite well versed, where there was the purist Cochrane view based on healthy adults, versus the view of a number of experts who had data from the 2009 pandemic. That was not a randomised controlled trial, but they were ill people and children who showed some impact from it. How do the public hear that and make a decision? Then you get to the statins where there is again a split but a slightly different debate. NICE is saying, "They are so good and they have relatively few side-effects, so let's raise the number of people who are offered them because it will save a lot of lives."

Q44 Victoria Borwick: You lower the barrier.

Dame Sally Davies: That is a better way of putting it. Against that is a lobby that says, "But do we know all about the side-effects? That's medicating people, and we should not

medicalise health and over-medicate people." How does that sound to the public out there? It is one thing for me, with high cholesterol, to debate whether or not I want to take statins and what the side-effects are. But if people are just told by their GP, who may not have a lot of time, how do they hear it? I am worried about that. There was also a false dichotomy made by another commentator in a medical journal about obesity: "Well, either it's calories or it's exercise." No, it is not. We need both, and they play different roles. I felt it would be worth teasing out some of this, looking at it and thinking about the impact on patients and the public and how they view the medicines, treatments and advice they are offered. It is very complex.

Q45 Victoria Borwick: That is very sensible. Will the work come to you or will you share it? How will it happen?

Dame Sally Davies: It will not formally come to me. I met the new president of the Academy of Medical Sciences yesterday, Sir Robert Lechler, and was updated on where it is. It is clearly proving quite difficult within the academy to reconcile the different views in those different areas, but I hope it will be useful to everyone, and I will read it with interest.

Q46 Victoria Borwick: Taking us back briefly to Tamiflu and Relenza, there was a great debate at the time about stockpiling these things and being prepared—even under-prepared, one might say after the outbreak of swine flu. The view afterwards was that they ease the symptoms, but there were some doubts about their efficacy. Do you think it was right for the Government to stockpile those drugs? Did it reflect your advice? What was the advice at the time? Has it changed? What would you like to tell us about that?

Dame Sally Davies: I have done two PACs on this, and there is no new literature that would make me change my mind. Tamiflu and Relenza shorten the symptoms by anything from half a day to 1.3 days; that looks to reduce hospital admissions and some severity in those who are in hospital or who may be ill; and the drugs can play a role in prevention. I continue to advise the Government that they should stockpile Tamiflu, and we should be prepared.

Victoria Borwick: That is good advice.

Q47 Dr Mathias: Some clinicians are worried about over-medicalising, especially in prevention. You referred to messages to people. Do you have a particular view on that?

Dame Sally Davies: I would prefer all of us to lead such healthy lives that we do not need medicines, because every medicine carries a risk of side-effects.

Q48 Dr Mathias: So you think we are over-medicalising.

Dame Sally Davies: No, I did not say that. If you cannot control your cholesterol, either because it is an inherited abnormality or because you cannot find a way to modify your diet, it would be wrong to withhold a statin to give you a longer, better and safer life. It is a balance. I would prefer not to have a tablet to manage obesity, but if someone comes up

with a safe tablet to manage obesity that prevents all the sequelae, and helps the economy, as a doctor I would prescribe it. It is not that I want to medicalise it, but if there are effective, safe and affordable treatments, I do not think we can withhold them.

Q49 Dr Mathias: Do you think the NHS will be able to get evidence on the balance? I am talking about people on statins who have not changed their lifestyle and still eat high cholesterol foods, or the person who may take an obesity pill but does not change their calorie intake. Do you think the NHS can get evidence on that?

Dame Sally Davies: The only obesity one I am aware of is orlistat and that family. By the time it is prescribed there has been a lot of work by dieticians, and patients have tried. Some people have morbid obesity. If it is about checking where people are trying and trying to help them, we come back to the behavioural issues we talked about that we do not understand well enough. We have not got enough evidence, and we will have to do more work on it.

Q50 Dr Mathias: It is very similar to the alcohol guidelines.

Dame Sally Davies: They are all interrelated. Behavioural economics is in its infancy, and we will have to explore it more and more, and what it means for our health. We cannot rush that, because we do not have enough people who are good at researching it, but we can take it steadily and develop it.

Q51 Dr Mathias: Do you mean good at researching behaviour?

Dame Sally Davies: Yes, but we can develop that, and Professor Whitty intends to.

Q52 Dr Mathias: The review of medicines safety and efficacy by the Academy of Medical Sciences talks about conflicts of interest. Is that a concern?

Dame Sally Davies: We have reached a situation where I understand that, if an academic or a clinician is on a trial steering group on behalf of a company, they are not allowed to sign an editorial or commentary in the *British Medical Journal.* I can see that there is an interest that should be declared. Is it a conflict? What they are doing is sitting on a trial steering committee to protect patients and make sure it is pukka research, and that it goes forward when it should and stops when there is an answer, or if it is unsafe. Yet they are precluded. It is beginning to be a debate where any association with the private sector is seen as dirty and conflicted, rather than a debate about transparency and when people are paid to be consultants and have a voice, which should be excluded, versus a respectful relationship that should be declared.

Q53 Dr Mathias: It is transparency to help get science information out.

Dame Sally Davies: Yes.

Q54 Chair: The progress report on the Government's antimicrobial resistance strategy has not been published. Can you give the Committee any insight into why, and when we can expect publication of the report?

Dame Sally Davies: I did not know until I came to see you that it was delayed, but I have been briefed on it. It is in draft, and we hope it will be published in the next couple of months. It is written, as you know, around three pillars: prevent, protect and promote. I understand it concludes that we have made considerable progress in putting in place the building blocks, but we have not yet got enough evidence that we are making a difference. It will be the next stage in what we are doing, but there is more to do.

Q55 Chair: That partly answers my next question. Are any areas developing that are particularly effective at the moment?

Dame Sally Davies: We did a behavioural study. I wrote to half of the highest prescribing GPs and pointed out that they were high-prescribing. The paper has been written up and accepted by *The Lancet*. I cannot tell you the results, but because it has been accepted you can assume that there is an impact and it should come out quite soon. We are looking at that sort of feedback. The NHS has a prescribing premium in place that it thinks is having an impact.

Q56 Chair: You have predicted my next question—twice no less. One of the Committee's concerns was the overuse of antibiotics in animals, leading to resistance in the community. There is a huge dispute between farmers and scientists on the issue. Is any progress being made, and is there likely to be a change of policy?

Dame Sally Davies: In this country we follow the EU regulations. You will have to ask the chief vet for the details of those. When I look at the data for Europe, we are among the lower users in Europe. We are not as good as Scandinavia but much better than southern Europe. Clearly, we are following the regulations, but I share your concern about overprescribing. Prescribing for growth promotion is a significant issue in the United States, the BRIC countries and the developing world. In our work internationally we are trying to raise awareness of that and to see whether, through a likely meeting of the UN General Assembly in September, we can get heads of state to say they will phase out growth promotion use.

Chair: Professor Davies, you have been here for just about an hour. We have ranged far and wide, as ever. Thank you for helping the Committee on a range of issues.