

Petitions Committee

Oral evidence: Petition on the meningitis B vaccine, HC 852

Tuesday 27 February 2018

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Members present: Helen Jones (Chair); Martyn Day; Steve Double; Mike Hill; Damien Moore; Liz Twist.

Questions 1-54

Witnesses

Steve Brine, Parliamentary Under-Secretary of State for Public Health and Primary Care; Chris Mullin, Chief Economist, Department of Health and Social Care; and Dr Mary Ramsay, Consultant Epidemiologist and Head of Immunisation, Public Health England.

Examination of witnesses

Witnesses: Steve Brine, Chris Mullin and Dr Mary Ramsay.

Q1 **Chair:** May I welcome our witnesses, Steve Brine, Parliamentary Under-Secretary of State for Public Health and Primary Care; Chris Mullin, the chief economist from the Department of Health and Social Care; and Dr Mary Ramsay, who is head of immunisation at Public Health England? May I also welcome the members of the public who have come to listen this afternoon?

Minister, thank you for coming today. Our petition on the meningitis B vaccine was started in September 2015, and since April 2016 I and the Chair of the Select Committee on Health and Social Care have written to successive Ministers asking for the publication of the CEMIPP report. In fact, we have gone through three Ministers so far, and it was published yesterday with two hours' notice to this Committee. Is that coincidental?

Steve Brine: Thank you very much for inviting us, and thanks to your Committee and your Health and Social Care Committee colleagues for their constant attention to this. I know that there are, and have been, frustrations, to put it mildly. The CEMIPP report has taken a long time to be published. When you take over a brief as a Minister, there are things that you inherit and there are things that you pass on. Judging by the weight of correspondence, this was most certainly something that I inherited.

Jane Ellison, when the Minister, gave a commitment that we would publish, and I have always been clear that we would honour that commitment. When the report was submitted to the Department in July 2016, your then second Minister in this trio, Nicola Blackwood, wanted the appraisal alignment working group advice before CEMIPP was published. She asked for their advice by the end of November 2017, to allow them to consider the research that was due to report that summer. Chris can comment on the research more. I know that many did not agree with the decision to defer publication of CEMIPP, but rightly or wrongly that was the decision taken at the time.

I became Public Health Minister after the election in June 2017. I did not think it appropriate then to overturn the decision to await the AAWG advice before publishing CEMIPP. I made it clear to you in correspondence—I have seen the long history of correspondence—that I would prioritise looking at the issue once the working group's advice was received. I received its advice on 31 January, less than a month ago. As promised, I prioritised it, and the report was published for consultation yesterday. The Committee should not underestimate that it had a role in pushing this, but since I have been the Minister I have been very aware that I need to get this out, and I have.

Q2 Chair: The report deals with very complex issues.

Steve Brine: You're not kidding.

Chair: The Committee has not yet had much chance to study it in full. This is, at the very least, discourteous, and it gives people the impression, rightly or wrongly, that the Government are trying to avoid parliamentary scrutiny, doesn't it?

Steve Brine: No, I don't believe so. If the criticism is that the report was not published soon enough, I agree, but I have given you the reasons why that was. The important thing is that it is now published and being consulted on. We are here now; we can discuss the report with the officials that I have. Of course, we did not have to go ahead with today if you did not want to; but it is out there, and that is the important thing, I would suggest.

Q3 Chair: Well, I think we might differ on that. When it has had further time to study the report and to discuss it with our colleagues on the Health and Social Care Committee, the Committee may want either to raise issues with you in writing or to call you before the Committee again, because we simply have not had time to study the report in full before today.

I want to go back to you referring the report to the AAWG for advice. Of the six academics on that committee, four are from York. The methodology used by the health economists in York has been questioned by a number of other people in the field. Do you think it was wise to have your committee so weighted towards one particular point of view? Would you not have got more balanced advice if you had included on it some health economists with different views?

Steve Brine: I will pass this on to Chris in just a second, but the group is chaired by the Department's chief economist, who is sitting to my left, and has representatives from the Department's arm's length bodies that have a particular interest in the cost-effectiveness analysis: NICE, NHS England, NHS Improvement and Public Health England. There are also academic health economists in the group from Brunel, the London School of Hygiene & Tropical Medicine, York University and Sheffield University. That includes the chair of CEMIPP, Professor John Cairns. You are saying that it is overly heavily weighted in favour of York. Chris, do you feel it is overly heavily weighted?

Chris Mullin: Can I just clarify that—

Q4 Chair: Just a minute, I want to come back to the Minister first. I asked you as the Minister whether you think you would have got more balanced advice with a better range of health economists. York is not a very big university, yet it has four people on this committee. Does that not seem rather unbalanced to you?

Chris Mullin: Sorry, there is a factual clarification that it might be helpful to make. There is only one member of the AAWG committee who is from York University. All the other academics are from a range of others.



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Q5 **Chair:** Well, you have a lot of advisers from York, don't you—four of them?

Chris Mullin: We have one member on the committee, and the committee occasionally hears from members of York University who are working on relevant pieces of academic research.

Q6 **Chair:** You have other attendees on your list. There are four from the University of York on there.

Chris Mullin: They attend when they are talking about their work, but they are not members of the committee and they do not attend all the committees.

Q7 **Chair:** Even if they do that, they are attending your committee. Do you not think you would have been better to have a wider range of attendees? Why are there four from York?

Chris Mullin: There is one committee member, and there is a particular piece of work that has four people working on it who joined for that part of the discussion.

Q8 **Chair:** Which is contested by other people in the field, is it not?

Chris Mullin: Which is why, in terms of the membership of AAWG, we have members of those other universities that the Minister has mentioned, so there is only one York member and four others from elsewhere.

Q9 **Chair:** It is still heavily weighted towards York, is it not?

Chris Mullin: I would argue that it is not heavily weighted towards York, with one member of the committee being from York.

Q10 **Chair:** And four of the attendees?

Chris Mullin: It just so happens that York has done a piece of work that is particularly relevant to our considerations, so we hear about that, but that is not membership of our committee.

Q11 **Chair:** It has done a particularly relevant piece of work that is contested by others in the field, is it not?

Chris Mullin: Yes.

Q12 **Chair:** Yes. Would you not have been wiser to have heard from them as well in greater numbers?

Chris Mullin: We did try to engage with others in the field in our work. The York piece of work is not the only thing that we looked at. We have had discussions with the Office of Health Economics, for example, about its work that looks at a similar issue to the York work but has some different conclusions. We try not to be influenced by any one piece of academic literature.

Q13 **Chair:** It certainly looks like that when you look at the list, let me say.

Can I come to another point, Minister? The CEMIPP report was originally



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requested by the Joint Committee on Vaccination and Immunisation because it was concerned about the difficulty of assessing the impact of severe and rare diseases, especially in children, and it called for a working group specifically to address that issue. Do you now believe that you have enough information in this report to address that issue?

Steve Brine: It is an incredibly complex and detailed piece of work. I would say no, in a one-word answer to your question. The summary message from the CEMIPP report is that the current system to assess the cost-effectiveness of the vaccination programme is broadly okay, but if it were to be changed, that should happen only as part of wider changes to assessing cost-effectiveness across the health system. If and when wider changes might occur is not specific to public health—that is something the AAWG is considering more generally.

CEMIPP identifies a small number of significant recommendations related to discounting—we may come on to the timescale for evaluation and the cost-effective threshold, which could be considered for immunisation alone. I am sure that Chris can explain those recommendations, if that is of interest to the Committee. We ask questions on that package of recommendations in the consultation, so I would say that the Government have not reached a view on whether to accept any of the CEMIPP recommendations. We want to get the results of the consultation before making any decisions.

I want to emphasise—I suspect I will say this once or twice today—that we have a world-leading vaccination programme in our country. It is something that other countries look on and look to. I am totally committed to that, and we should think very carefully before we do anything that harms it. But no, I do not think we have the full picture, which is why we have done this incredibly detailed piece of work—or rather, CEMIPP has and then the working group has—and put it out for consultation.

We say in the consultation that, obviously, anybody is welcome to comment on it, including members of the public, but it is incredibly technical, and I suspect that those who comment on it in great detail will be industry and the charities that had a personal phone call from Department officials yesterday to say that it was out there.

Chair: So, in summary, that was a no.

Steve Brine: Well, I gave you a no at the start and then blathered on with some more.

Q14 **Chair:** No one is suggesting we have a poor vaccination programme, Minister. It was a question of whether this helps take us forward in any way.

One of the other issues that the joint committee was concerned about was that the incremental analysis might not really have properly assessed the other benefits, such as control of disease or disinvestment in the vaccine programme. This report tells us that the avoidance of an epidemic ought to be considered in any analysis, but it doesn't tell us

how. Is there any work going on in the Department of Health to take that forward?

Steve Brine: That is probably one for you, Chris. But yes is the answer.

Chris Mullin: Yes, and this is not a one-point-in-time project. There is constant work going on in Government, not just in the health and social care sphere, but in the whole of the appraisal sphere, to constantly re-evaluate the approaches being taken, to take account of new evidence as it comes on track and then to reflect on whether current methodologies are the best methodologies, given the increasing knowledge base that we have. It is very much a live project, and we in the appraisal alignment working group sit and view all of that work. We commission some of that work ourselves. At such point as we consider that the evidence merits consideration by Ministers for changing the methodology, then we will bring that to Ministers' attention.

Q15 **Chair:** One of the important issues in deciding any cost-benefit analysis has to be procurement, yet procurement was outside the remit of this committee. Can you tell us what work is going on in the Department to address the procurement issues?

Chris Mullin: I am not well versed on the procurement side of the Department. I think what was meant in the report is that the work of CEMIPP focuses on the cost-appraisal methodology, on which the recommendations are made to the Department. Then it is the Department's call on how it makes procurement activity. It was seen as outside of the role of CEMIPP to be commenting on the procurement approach.

Q16 **Chair:** It was indeed. What I am asking the Minister is whether there is any further work going on in the Department of Health to look at procurement and how costs of vaccines can be reduced, because that clearly affects the cost-benefit analysis.

Steve Brine: Yes, discussions are ongoing with industry on the new medicines prices scheme. We expect the way that NICE assesses new medicines to be one of the topics for the discussion. I guess our objective is to ensure that patients have access to the best-value treatments in a way that is affordable and sustainable for a publicly funded health system.

Chris Mullin: I would add to that that the Department has been taking steps to focus increasingly on procurement. With that very issue in mind, we have a new executive director role on our executive committee, which we didn't have previously, that is specifically focused around the commercial and procurement space on both the immunisations and the medicines side, to ensure that we are getting the maximum value for money.

Q17 **Chair:** Okay. Could I briefly ask you about discount rates? The CEMIPP report recommends a 1.5% discount rate for health benefits and so on. That would have in fact made a catch-up programme for a meningitis B vaccine likely to be cost-effective, wouldn't it, under your rules?



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Steve Brine: I don't know—

Chris Mullin: I don't think you could infer that from that statement, and I don't think we are able to go into the precise situation around that programme, because of the commercial sensitivities.

Q18 **Chair:** Do you know whether it would have been cost-effective or not?

Dr Ramsay: It would have been more cost-effective at a lower discount rate. I think there is no doubt about that.

Chris Mullin: Whether that makes it cost-effective or not cost-effective—

Dr Ramsay: Depends on the price.

Q19 **Chair:** Of course, which is why I asked you about procurement. They recommend that you stick with the 3.5% discount for non-health benefits. That is really interesting. The JCVI was originally asking about the cost of bringing up a child with disabilities. Is the cost of caring for that child as they grow up not likely to increase, rather than decrease? So why the 3.5% discount?

Chris Mullin: The world of discount rates is quite a complex world for us economists. You don't get agreement on discount rates when you put two or three economists in a room. The 3.5% and the 1.5% both come from the Treasury's Green Book, which is the—

Chair: Yes, I know what the Green Book is.

Chris Mullin: It is the Government document on cost-effectiveness. The Treasury Green Book says 1.5% for health benefits and 3.5% for other benefits, and it relates to different elements of time preference in the way that people perceive the value of their health benefits versus other benefits. The normal rate for most economic decisions across Government is 3.5%; we just have a slightly special case for some health benefits, in terms of 1.5%.

Q20 **Chair:** Do you think that any of these discount rates work when you are talking about children? Is it reasonable or sensible to apply the same discount rates to children as you apply to adults?

Steve Brine: Chris can disagree, as economists often do with politicians, but I would say that not everything can fit into a single formula. That is how bodies such as JCVI and NICE make these decisions. In assessing cost-effectiveness they try to take as many of the quantifiable aspects, which I think is what you were referring to, into account as possible. That absolutely includes, I would say, the JCVI taking non-standard factors into account when it thinks that it is appropriate. For example, when considering meningitis B, they took into account the losses in quality of life for young children and those who have to care for children, and for others who are disabled by the complications of meningitis and septicaemia. I know that that has been a cause of great anxiety and interest to the Meningitis Research Foundation. I am sure that they would be pleased



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with recommendation 3.1 in the CEMIPP report, which says, "Health impacts...should be discounted at 1.5%." Is that a fair comment?

Chris Mullin: Yes, in principle the concept of a discount rate would not differentiate between people at different stages of their lives. Rather, you are discounting the benefits of a child in the future, just as you would discount the benefits of an adult in the future. There is a separate line of economic discussion around the weighting of different groups. There is an ongoing debate about that, but in the health and social care sphere, we measure benefits in terms of quality-adjusted life years. That effectively means that you score impacts on children more than impacts on adults, because children have so many more years of their life to live, hopefully.

Q21 **Chair:** But the discount you apply to various things will still affect the conclusion that you come to. Saying that it is in the Treasury Green Book is not really an answer, because there are lots of things in the Treasury Green Book that lots of people disagree with. Do you think that it is appropriate to apply two different discount rates to the health benefits, when you are talking about vaccinations in particular, and the non-health benefits, given the costs of care, social services involvement and so on?

Chris Mullin: It is based on research on preferences over time, which showed that people have relatively constant health preferences over time. They care almost as much about their health in 30 years' time as they care about their health now. That is experienced to a lesser degree in other aspects of the economy, where there is more scope to invest money to get more money back later, and therefore you apply a higher discount rate to other areas. It is based on research of people's preferences.

Q22 **Chair:** Preferences, not costs?

Chris Mullin: Yes.

Q23 **Chair:** Yes. Thank you. Can I ask you one final question before I hand the questioning over to one of my colleagues? Should vaccines be assessed in the same way as other medical interventions, or is it the case that vaccines provide gains to other members of the population besides those who are vaccinated—for instance, where you get herd immunity and so on—and those ought also to be taken into account? Can I ask the Minister to answer that?

Steve Brine: I would repeat, and perhaps expand on, what I said earlier. The key message I get from the CEMIPP report is that the cost-effectiveness of our vaccination programme in this country is in a good place. If it were to be changed, that should happen only as part of wider changes assessing cost-effectiveness across the health system. That is one of the reasons we asked the AAWG to look much more widely across the piece.

Mary may have a view on this, but I would say that you cannot look at it in isolation; that is probably the answer to your question, and CEMIPP do say that. They say that you should not cherry-pick bits of our report and decide which bits you like and which bits you don't. That is why it is so



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complex and why we have put it out there for, I would say, expert analysis via the consultation, which closes later in May.

- Q24 **Chair:** But we don't yet have a clear way of assessing the benefits of things like immunity in the wider community or impact on families, particularly if a child becomes ill or seriously disabled, do we? Have we got an economic model for that?

Dr Ramsay: I think we do actually. Generally, most of our economic modelling for vaccination is based on transmission modelling in the population, which does try to account for herd immunity, so the fact that one child is less likely to pass the infection on to another is taken into account. The difficulty with that is that it is a much more complex and uncertain process. Whereas most drugs are studies in controlled trials where you can measure that, with vaccines the impact is more profound. Therefore, although we have a good track record of trying to incorporate that, it is something that needs to be reviewed. Once a vaccine is in and you see that it is working differently, perhaps you have to go back to the cost-effectiveness, which may well show that a different way of using the vaccine might be more effective or more cost-effective.

- Q25 **Chair:** But we don't—I think as the report says—have a way of measuring the psychological benefits, the impact on a family as a whole. Currently, there is no way of taking that into account, which I think was perhaps one of the things that the Joint Committee on Vaccination and Immunisation had in mind when it asked for this report.

Dr Ramsay: Yes. I think we count the number of cases prevented by that herd protection. What we do not count for is the "peace of mind" concept that was brought up, but that is something that CEMIPP recommended research on, to see if we could actually work out what the value of that was to the vaccinated individual and the vaccinated community in that sense.

- Q26 **Damien Moore:** Why was it so important for the Government to have the advice of the AAWG before publishing the CEMIPP report?

Steve Brine: My immediate predecessor decided that she wanted to do that. I think her term was that to publish the CEMIPP report before the working group had looked at it would provide miscommunication. I have seen that in her letters. I cannot look into the mind of previous Ministers who are no longer Members of Parliament; I can only let their words speak for themselves, and you have seen the correspondence trail. I think—in fear of casting my mind into the unknown—maybe what she meant by that was that the pharmaceutical industry might start to lobby against the cost per QALY threshold, which would make it harder for vaccines to be cost-effective, and the industry plus the charities might also then argue for the discount recommendation, which we have just talked about with the Chair, which could make it easier for vaccines to be deemed cost-effective. So I think the CEMIPP report was a piece of work in its own right, but we wanted to take a much wider system view, and that is why we asked the AAWG to do its work. That is what you have done—you picked up the baton and ran with it, is that right?

Chris Mullin: Yes, I think that's right. We were asked to take a slightly broader perspective: if these are being considered for immunisation, what does that mean for the rest of the system? Is it right to go ahead with that immunisation if not in other areas? Also to take account of ongoing academic work that was happening—we mentioned the York work earlier, and that was ongoing at the time, so we had to consider that—and to help explain to Ministers the consequences of the CEMIPP report.

Steve Brine: Mr Moore, CEMIPP was looking at whether methods the JCVI—the independent body that advises us as Ministers—used to evaluate the cost-effectiveness of immunisation programmes, which are based on those that NICE then used to evaluate medicines, continue to be appropriate, or at whether there are some special characteristics, which I suppose is the term I would use, of vaccinations that warrant a change to the methods we used. So the AAWG was convened by my predecessor to discuss appraisal issues across the much wider health system. As has been said, a number of contributors to CEMIPP were also members of the AAWG, and they work as a team.

Q27 **Damien Moore:** Sounds good. Why did they need more than a year to reach their conclusions?

Steve Brine: Why did you need more than a year to reach your conclusions? As I said on opening, they said they would report to me by the end of November. There was a slight delay to that, but I got it this month and got it straight out. When you put a group of economists in a room together, they have lively debate, and it went on longer than I had hoped. Maybe they thought—maybe you could explain why it took you a bit longer, Chris?

Chris Mullin: It is a slightly challenging job corralling 12 economists—or around that number—to come to an agreed piece of advice. But also the point I mentioned about academic research being ongoing—that was coming out around the autumn, so we needed time to consider that. I think that was part of the thinking—again, it was before my time—when AAWG was commissioned.

Q28 **Damien Moore:** Okay. So what did the AAWG do to ensure that the views of external experts, including charities, were heard from parents' advice?

Chris Mullin: The AAWG was clear upfront that this was not a full-blown public consultation—indeed, we had not published the CEMIPP report yet. So it was never the intention for AAWG—indeed, for a group of economists that probably would not be the right forum—to get the wider views of the whole of society into the thinking. Rather, AAWG was advising on the analytical elements of the CEMIPP report and Ministers specifically asked us to talk to the meningitis charities and to the pharmaceutical industry, so we had conversations and ongoing dialogue with both of those groups.

Q29 **Damien Moore:** Okay. There have been concerns from the Meningitis Research Forum that the membership of the AAWG is heavily weighted towards health economics. So, what are you doing to ensure that public health concerns are properly taken into account in the Government's



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response to the CEMIPP report?

Steve Brine: That is why we never published it for a consultation. But it is fair to say that the AAWG—there is no finite end to their work. I do not now terminate their existence; there are still pieces of work that are ongoing and Chris may want to touch on that. That is why we put it out there for a consultation.

Q30 **Liz Twist:** Coming on to consultation, Minister. For over a year, the Petitions Committee and the Health Committees have both been urging the Government to commit to a formal consultation on their response to CEMIPP; but as recently as 18 January you said you were unable to commit to that. Given that you are now consulting, why were the Government so reluctant to give that commitment earlier on?

Steve Brine: Just because I do not make commitments to do things on certain dates that I do not think I can live up to. I appreciate that your job is to press Ministers and scrutinise Ministers, and you are doing that very well; but my job is to make sure that I have my ducks in a row before I get on the pond. I was not in a position to give you a date when I last wrote back to the Committees. As soon as I was in a position, I did it—I got it out there. If it was not out there, I suspect we would be having a very difficult conversation right now.

Q31 **Liz Twist:** But it wasn't just about the date, was it? In previous correspondence there has not been a commitment to consult, at whatever date.

Steve Brine: I'm not sure that is right. I said at the start that Jane Ellison had said that we would eventually get this out there and consult on it. There was always an understanding on my part, certainly when I took over the job. I cannot speak for everybody else, but my understanding when I took on the job was that this piece of work had to get out there, into the marketplace among the companies and charities. That is exactly why I have done that, and it is going to be fascinating to see what comes back. I have a funny feeling that quite a lot is going to come back.

Q32 **Chair:** Can I just read you something, Minister, which you said in your letter of 15 January? "In terms of whether there will be any wider consultation, this has not been ruled out but it would not be prudent to commit to this until I have considered the CEMIPP report, the AAWG's advice and other relevant factors." So you were not actually committing to a consultation there.

Steve Brine: I refer to my previous answer. I did not rule it out. If I had written to you and said, "I am not going to consult on this, full stop," then I suppose I would now be performing a U-turn, but I did not rule it out because I didn't want to rule it out.

Q33 **Liz Twist:** Can I ask what the hesitation was about the principle of committing to consultation?

Steve Brine: I do not think there was any hesitation about it. In my mind, that was always going to be what we would do, because that is what



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Governments do. We do not sit there in DH with all the answers; we consult experts. I have two very prominent experts with me today. We put it out to wider society and wider industry, and to the charity sector—that is why we have done it. It has always been clear in my mind that we would seek wider advice on this, Ms Twist, and we have.

Q34 Liz Twist: Okay, but as far as the Committee is concerned, our reading of your letter—

Steve Brine: There was obviously a miscommunication between us there, but in my answers to you I cannot be clearer that that was my intention, and that is why I have done what I have done. I could have continued not to publish it, but I suspect that you would be even more irate than you were yesterday.

Q35 Liz Twist: We have already talked about the letter of 15 January. Was there something in particular that persuaded you to consult?

Steve Brine: No, it was just once I had the AAWG's report and had time to look at that and discuss it with officials. As you know, these things go across Government for write round; we have to do that for all these things. It was as soon as I had that back, within a matter of hours of getting the final notification from the write round, was when I put it out there.

Q36 Liz Twist: So a miscommunication.

Steve Brine: I fear so; there is no discourtesy meant on my part, I assure you. I am many things, but certainly I am not that.

Q37 Liz Twist: The consultation will last three months, will it?

Steve Brine: Until the end of May, yes.

Q38 Liz Twist: What is the Government's planned timetable for considering the responses to the consultation and deciding whether and how to improve?

Steve Brine: I fear I am going to be accused of being vague again, so I will try to be as clear as I can. We are holding a three-month consultation. How long it will take to consider the responses and to make a final decision—you know what I am going to say—will depend on how many responses we receive and the level of detail that is provided. I suspect that we will get quite a lot of responses and some incredibly detailed responses, because the CEMIPP is a massive piece of work—it goes in lots of different directions and it has lots of different recommendations. Then, you have the AAWG's summary report, which has been published alongside the consultation. When you see the report—or if you have already had the chance to read it or at least its recommendations—I think you will agree that it is a pretty comprehensive piece of work. There will be a range of different and—dare I say it—perhaps contradictory views in response to what the consultation will flush out.

It is impossible to make a decision that everyone will agree with in any subject in Government, but certainly in this one. The key for me will be to



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understand the disparate views and then end up with rules for immunisation that are fair in a publicly funded health system, transparent above all, and justifiable to the people whose money we are spending, who are ultimately our constituents.

At this stage I cannot give you a final date for when a final decision will be made and we will publish the result of that consultation, because it would be disingenuous of me to do so. It will depend on what we receive back.

- Q39 **Liz Twist:** Do you have a kind of target timetable for when you are looking to do it?

Steve Brine: No, I absolutely do not.

- Q40 **Liz Twist:** Petitioners will be concerned that it has already taken us a hell of a long time to get to where we are now, and that this is just pushing it further into the long grass.

Steve Brine: I know. Your fear is that it will disappear again, and then there will be another lengthy exchange of letters. As long as I stay in this job, that is not what is going to happen. This issue has gone on long enough. We need to consult, because that is the right thing to do. It may not be how Ministers did things in the long distant past, when they would have just made a decision with their expert advice and that would be it, but it is absolutely the right thing to do.

I assure you that I do not want to hang around on this; I do not like things hanging around on my desk. This has not hung around on my desk; it is an issue I have inherited that has been hanging around, and as soon as I have been able to grip it, I have gripped it and got it out.

- Q41 **Liz Twist:** Will you be making that clear to people who are inquiring? The petitioners, for example, will be very concerned about the time that has been taken. Is there a way in which you can keep people informed of what has happened?

Steve Brine: Yes. I try that very hard on social media channels, but I think they will read what I have said today and I do not think that I can be clearer.

- Q42 **Liz Twist:** The consultation paper and questions are very technical and clearly are aimed at health professionals. However, you will know from the size of the petition that there is massive from the public. How are you going to capture that wish of the petitioners and others to be able to comment in a meaningful way?

Steve Brine: I might bring Mary in on this but I think you are right. I said at the start that it is technical, and that it is aimed at the big players in industry such as the pharma companies and the big charities like Meningitis Now and the Meningitis Research Foundation, who will obviously have a view on this. They are phenomenal organisations. I place on record my thanks to them and the work they do for our constituents, because ultimately that is what this is all about. I hope that they will help people, but maybe there is a way that we can talk and that Public Health England

and the Department can help with accessibility of response. We want to capture as wide a view as possible.

Dr Ramsay: We can certainly look into that. Working very closely with the charities over many years, they do a job of translating that for us. There are other items such as the peace of mind issue where formal research with the public may be more helpful in looking at societal preferences, for example: whether or not people genuinely feel that prevention should be valued differently from treatment. Those are items that are subject to research, and that would be a good way to take a step forwards.

Chris Mullin: There is research on those subjects. Sheffield University has been commissioned by the National Institute for Health and Care Excellence to look at ways of taking a broader perspective on health costs and benefits.

Steve Brine: I would just add that I am not necessarily looking for quantity. What comes back comes back. I am looking for quality of response, and now that this is out there I hope that the charities will come and see me and talk to me. I will be in listening mode. I hope that they will come and do that, and I am sure that they will be devising ways of collecting views from the families with whom they work and the supporters that they have. They can then put these views into one substantive response. It is not like a planning application where the number of people who write and say, "I don't want to see that built there," matters. That is not what we are interested in. We are interested in quality of response.

Q43 Mike Hill: On the issue of quality-adjusted life years: could I ask if the AAWG has been considering the latest evidence on the marginal cost of quality-adjusted life years in the NHS? Could you tell us more about that work?

Chris Mullin: Yes. I think the work you are referring to in particular is the York University work mentioned earlier. Essentially, that attempts to estimate what is called the opportunity cost of healthcare expenditure. So if you are spending money on one thing, what are you not able to spend money on elsewhere? We have a finite budget. That attempts to look across the NHS and the health spectrum in different areas of spend and to look at incremental spending in those areas, where budgets have changed over the years and where outcomes have changed in those areas, and to try to map the changes in spending to the changes in outcome across the different areas to get a sense for the average QALY level at the margin in those areas. That work leads them to estimate that, approximately, across the NHS at the margin it costs about £15,000 to deliver one QALY across those different areas. That is the premise of their work. There are advantages and disadvantages, and accuracies and inaccuracies of their work.

Q44 Mike Hill: We'll drill down more into those figures in a moment, but what is the working group doing to ensure that it has the widest range of academic views on this?



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Chris Mullin: That work has been published and peer-reviewed, so that is an important way in which a wide range of academic views can be brought to bear on that piece of work. To its credit, York University has been transparent in showing its workings, publishing incremental papers to show the strengths and weaknesses of its work. In addition, we talk to other academics working on other pieces of work in related areas. I am meeting the Office of Health Economics tomorrow to talk about their latest work in this field. Different economists have different perspectives on the York work and on the concept of opportunity cost and the threshold. I have tried to bring those different views to the Ministers' attention.

- Q45 **Mike Hill:** The reason I ask is that there is clearly disagreement among academics about how marginal costs on quality-adjusted life years should be calculated. I notice that the range is from £20,000 to £13,000 and back over to £15,000 in terms of thresholds. That is quite diverse, isn't it? How will the Government react and make a judgment on that? How would you decide which one counts?

Chris Mullin: That is something I have tried to draw to Ministers' attention. Indeed, the current thresholds are not set explicitly with reference to marginal cost across the NHS. That is a step that the CEMIPP report proposes taking to link the threshold that we use for immunisations more explicitly to this sort of analysis, but that is not what we currently do. That would be a decision in itself.

I have tried through my work to bring the level of uncertainty to Ministers' attention. York University is trying to look at the level of uncertainty and articulate that better and yes, that needs to be weighed up, and whether to make a change or not.

- Q46 **Mike Hill:** This is the last question. Will the same value for a quality-adjusted life year be used in all cost assessments in the NHS? Or is it possible that a different value could be used for assessing the cost-effectiveness of vaccines, for example?

Chris Mullin: That gets you back to the point we touched upon earlier, which is whether you have differential weightings for different groups. The concept of the QALY is quite compelling, in that it tries to put everyone on an equal footing to a certain extent. A life is a life. That is the theory of it, rather than getting into quite a murky world of differentiating between different groups. You could make the case that there should be extra emphasis on children, or you could make the case that there should be extra emphasis at end of life or on other groups within society. It is a difficult world, but research is ongoing to look at people's preferences in those areas and to see whether society really does have a genuine preference to favour one group more explicitly than another. If such evidence comes through that society has a different view of this, that is the point at which it will be considered for methodological reasons.

- Q47 **Martyn Day:** The AAWG's conclusions look at the CEMIPP report recommendations taken together and suggest that it could result in a more cost-effective price for vaccines. Is that of concern to you?

Steve Brine: To me or to the AAWG?

Martyn Day: To yourself in Government.

Steve Brine: The Government have not formed a view on that. I was focused on getting this seemingly never-ending issue out there. There is no point in my sitting here and saying that we have formed a view on that. From the advice I have been given, for instance, it does not look like the CEMIPP report would make a difference to the current decision on meningitis B vaccinations for older children. I said at the start to your Chair that I am acutely aware, since I have been doing this public health job, that we have a vaccination programme that is the envy of the world, and I don't want to do anything that is going to damage that—and I am not going to do anything that is damaging that. It will be very interesting, won't it, to see what comes back in the consultation around the QALY threshold.

- Q48 **Martyn Day:** Have Government given any consideration to future changes to the cost-effectiveness methodology and how that would have affected previous JCVI decisions?

Steve Brine: No, we have not sat and looked back historically and tried to work out what would be the result if—

- Q49 **Martyn Day:** The JCVI flagged that up in its minutes back in June 2016, so that is certainly something to be looked at.

On a final point, regarding the peace of mind benefits that have been suggested by Meningitis Now and the Meningitis Research Foundation, have Government commissioned any research into that or are you looking at doing that?

Steve Brine: Some witnesses from the charities—I think I am right in saying—have had an opportunity to make their points around peace of mind directly to the AAWG as part of its consideration. Now that the consultation has been launched, they will obviously be able to do that more formally. I have already said I will invite them to come in and do that. Mary has already touched on peace of mind. It is incredibly difficult to bring that in. I am a parent of very young children myself. One person's peace of mind could be another person's outright panic. I guess that goes right to the heart of the challenge here. Mary may wish to comment further on peace of mind.

Dr Ramsay: The other thing is that obviously you would have to try to translate that into a health benefit in order for it to be counted as part of the QALY, which was how it would be in the current system. It is probably quite complex research. I believe one of the charities has been doing some pilot work in that area that may allow a future research programme, but I don't think anything has been formally commissioned at the moment.

Steve Brine: A correction: the economist has corrected the politician—not for the first time, I am sure. We did do some modelling, apparently, of the impacts on previous things and Chris has got a few here.



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Chris Mullin: I have got them but I cannot give them out, because they are commercially sensitive, but I want to make it clear that we have analysed the impact of CEMIPP, and different interpretations of CEMIPP, on existing programmes but because the prices are all commercially sensitive I cannot give details.

Steve Brine: One of the great challenges of this process is that we are dealing with commercial decisions.

Chair: It is interesting that we are in the position now where the price is commercially sensitive from the people who pay for them.

Q50 **Steve Double:** We have heard concerns from the Meningitis Research Foundation about the low level of take-up of the Meningitis B booster in some areas, particularly in the less affluent parts of the country. What are the Government doing to increase take-up of vaccine in these areas?

Steve Brine: This is definitely one for Mary.

Dr Ramsay: Overall, the uptake of MenB has been very good. It almost immediately went up to the same sorts of levels of the vaccines we see at that age. MenB, as you will see from the petition, is a very popular, acceptable vaccine that parents want. So I don't think it is anything to do with acceptability. I think it reflects a broader issue with delivery of the programme in some parts of the country, where the population are, for whatever reason, less able to access services. That is an ongoing piece of work that we are doing—in London, in particular, where most of the lowest measurement is found. NHS London is spending a lot of time trying to make the system work better, particularly for people with disadvantaged backgrounds who may not be accessing immunisation, and probably other health care services, as effectively as we would wish.

PHE supports that as much as we can with research and data. We measure coverage in this country very frequently and very accurately, so we do have a good handle on it and we can pick up very small changes that we have been very concerned about in the last few years. It is an ongoing piece of work, but sustaining an immunisation programme is not a one-off thing, it is something you need to do long term. It really needs long-term system management and control and monitoring. I am hoping that that is all under way. I cannot promise to turn things round immediately, but it is part of a broader aim.

Q51 **Steve Double:** It's obviously something that you are alive to. Can you give us any more examples or details of what sort of thing you are doing to try and increase take-up?

Dr Ramsay: Most vaccines for young children are delivered by general practices; and general practitioners, as you know, are under immense workload pressure. We are looking at issues around call and recall, which is one of the most effective things for improving uptake—you send someone an invitation and if they don't turn up you send them another one. We know that those systems are not working universally across every single practice. London has made a big effort in changing that system.



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We also monitor, as you know, attitudes and acceptability so that we can pick up very early if there are any concerns about vaccine safety or vaccine hesitancy, which is the term that people use now for low-coverage populations where there may be particular cultural issues that prevent people coming forward. We are doing research in those areas. A lot of work is going on, but it is something that needs sustained effort, and it needs to be sustained long term.

Steve Brine: I think that is right. It is important for us, as the experts in this, to say this today. I think we should also be quite cautious about peace of mind—vaccination being the silver bullet. It does not prevent all cases of meningitis, for instance. We don't want to give false reassurance. Parents, including me, need to be ever mindful of the signs and symptoms of meningitis, don't we, even if our children have been vaccinated? It is important to say that.

- Q52 **Liz Twist:** Thinking about the consultation that I was asking about, would it be possible for you to develop a programme or plan of engagement with the non-medical field—with that wider field—so that they can know where their input will be and how that will be made? Would that be possible?

Steve Brine: I will pass this to Mary because she did not comment on this the first time.

One of the takeaways from this session has been your very useful suggestion, Ms Twist, about that. The charities are very good at collating feedback from their supporters and members, but I am sure there is more engagement we can do with them. They know the door is open to come and talk to me, but the offer is very publicly there from me today to come and see me and Mary and talk about how we can do that better.

Dr Ramsay: Perhaps we need to think about some other charities. I know the meningitis charities are here today but there are other charities that have an interest in vaccination. Maybe we need to reach out to those more formally in the next few days.

- Q53 **Chair:** Before we wind up, Minister, you will know that over 840,000 people signed our original petition. Is there anything in particular you would like to say to those petitioners about the way this work is going and what outcomes you are looking for?

Steve Brine: Some of the people who set up the petition have been in that position that parents have nightmares about. As a parent and a Christian, my heart goes out to them. Everybody in Government, and all the officials who work for me—all we are ever trying to do is the right thing. We are trying to get better health outcomes. We are trying to do better prevention. That is what this piece of work is about. For all the arguments around letters and delay—and economists arguing with economists—ultimately that is the bottom line.

When the Secretary of State recently met some of the families, he was very, very clear that we need to base our vaccination programmes on expert advice. He said that if new evidence came forward we would always



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pass that on to our expert group at the JCVI. I repeat that offer. You know that he set up the Secretary of State's working group to establish what best practice looked like in diagnosing and treating meningitis: what is currently done and how that can be improved. One of the parents who came to that meeting is a member of that group. I think that is really important. That group is due to report by the end of March. We look forward to seeing their report and recommendations in due course, as I know does the Secretary of State.

What I would say to them is that we all have the right motives. We have produced this incredibly complex, incredibly detailed piece of work; it is now out there. We have had some really good suggestions today about how you think we should better engage with the people below the charity level, and we will do that. We will get this feedback back and, as long as I am in this job, we will consider it as quickly and efficiently as we possibly can, and then we will make a decision.

Q54 **Chair:** Thank you very much.

Dr Ramsay, Steve Brine, Chris Mullin, thank you very much for your evidence today. As with all these sessions, if, once you have left here, you think of anything that you would like to have said and did not get the chance to say, please let us know. We will be notifying our petitioners that the report is now out for consultation. Thank you very much.