

Public Accounts Committee

Oral evidence: The management of adult diabetes services in the NHS: progress review, HC 563

Monday 16 November 2015

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Members present: Meg Hillier (Chair); Mr Richard Bacon; Kevin Foster; Mr Stewart Jackson; David Mowat; John Pugh; Karin Smyth.

Sir Amyas Morse, Comptroller and Auditor General, National Audit Office, Adrian Jenner, Director Parliamentary Relations, NAO, Robert White, Director of Health Value for Money, NAO, and Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

Witnesses: Dame Una O'Brien, Permanent Secretary, Department of Health, Simon Stevens, Chief Executive, NHS England, Professor Jonathan Valabhji, National Clinical Director for Obesity and Diabetes, and Jonathan Marron, Director of Strategy, Public Health England, gave evidence.

Q1 Chair: Good afternoon, everyone, and welcome to the Public Accounts Committee on Monday 16 November 2015. Today we are looking at diabetes care, following on from a Report that the National Audit Office did three years ago, which the Committee looked at. We are now looking at an update from the NAO on whether there has been progress since then. Our witnesses, from my left to right, are, first, Jonathan Marron, director of strategy at Public Health England. Welcome, Jonathan. I think this is the first time you have appeared before this Committee.

Jonathan Marron: It is. Thank you. Good afternoon.

Chair: You may be a repeat visitor; we'll see how you do today!

Dame Una O'Brien is the permanent secretary at the Department of Health and one of our most frequent visitors—we are going to give you frequent flyer points at this rate, Dame Una. Simon Stevens is the chief executive of NHS England and also one of our regular customers. Welcome,

Simon. Then we have Professor Jonathan Valabhji, who is the national clinical director for obesity and diabetes at NHS England. Welcome to all of you.

To give a bit of context, especially for those who are watching but have not read the full Report, by 2030 nearly 9%—8.8%, I think—of the population will have diabetes, and the Report shows very clearly that the treatment pathway is what one might politely call patchy. However, all the evidence, including NICE guidelines, shows what works. In other words, it's not rocket science to tackle diabetes. You, and in particular Professor Valabhji, know what needs to be done, but it is not happening universally on the ground. The variation is immense across the nation. As I said, we looked at this three years ago, and it's a bit disappointing that progress has been so slow. The NAO talks about it stalling. That may be a polite way of putting it. We are here today to find out why it has gone so slowly and what can be done next.

First, I want to touch on the variation, because that seems to me to be one of the biggest issues coming out of the Report, and to ask you how you are planning to tackle that. CCGs have their own freedoms locally, but they are clearly taking different approaches. I suppose I should start with Dame Una and Simon Stevens. What do you think the centre should be doing to make sure that whoever has diabetes is getting the right treatment wherever they live?

Dame Una O'Brien: Thank you very much for the opportunity to come back and discuss this. I think I'm the only one of the witnesses here today who was here in 2012. This was at the time and remains now a huge passion of mine, and it is a very, very important priority of the Department of Health and the health and care system.

You have asked specifically about variation, and I think the Report and the maps in the Report demonstrate the degree of variation not only geographically, but in care for people with type 1 and type 2 diabetes and also with regard to age and, in some cases, gender and ethnic origin. These are all matters of deep concern to us. We have been working on them and will continue to work on them. We have some important new developments that were signified in the NAO Report. Others will talk about them in more detail than me, but from the Department's perspective, in terms of greater transparency on the quality of and the outcomes from diabetes care in individual CCG areas, the CCG performance framework that we are working on currently will have a significant benefit in enabling direct area-to-area comparison.

Q2 Chair: Can we just be clear on when that will kick in? When will we be able to see the evidence from that?

Dame Una O'Brien: The work is already in train, and various elements of it get implemented progressively from the next financial year. Simon can talk in much more detail about how that will work.

The efforts to tackle variation are very serious and very thorough. I want to touch on one point, though, about the need for a completely rounded picture in understanding where we are. In January, we will have two years of data published from the national clinical audit for diabetes, which will cover 2013-14 and 2014-15. I notice that the NAO Report, understandably, was only able to go up to 2012-13, so in effect you have only really got the national diabetes audit data for a few months

after the last hearing; we have not got the full amount of data available to us yet on the intervening period.

Q3 Chair: But didn't the number of GPs participating in that go down dramatically between those two periods?

Dame Una O'Brien: There are some issues with participation. I do not know if I would term it as going down dramatically, but—

Q4 Chair: From memory, wasn't participation down from 88% to 72%? That is quite dramatic.

Dame Una O'Brien: There has been an issue about participation and we will absolutely be focusing on that when we get the full outcome from the report in January. But, if I may, the final point I wanted to make before I shut up and let others come in is that, in the period between 2009 and 2012, while, as the Report says, we are seeing the percentages for the care processes for people with diabetes plateauing, we have to factor in that nearly a quarter of a million more people received that care in 2012 than in 2009. So the percentages mask very significant increases in the quantum of people receiving care. I want to put that on the table right at the beginning so that, when we are looking at percentages, we also recognise that the system is coping with a significant increase in numbers of people.

Q5 Chair: Dame Una, you must have had a glass to the wall, because we were discussing that and we will come on to that in our questioning later. Simon Stevens, do you have anything to add, in particular about the participation rates of GPs in the survey?

Simon Stevens: I agree with Una's overall description of the situation—

Chair: For the audience, can we refer to people not by first name, but by title or full name? That is helpful for people watching.

Simon Stevens: I completely agree with Dame Una's remarks. On the audit, as I understand it, the issue here is that something called the confidentiality advisory group changed its mind on the question of whether opt-in or opt-out was required and, rather than there being an opt-out provision for GP practices, instead it is required that they now have to opt in. That may be understandable, but it is regrettable inasmuch as it appears to have had a dent in the participation rates and, given that this is one of our flagship international audits, I think that is something that we need to look at again.

Q6 Chair: Can you do something about that, Simon Stevens?

Simon Stevens: Well, as I understand it, it was this confidentiality advisory group that withdrew the previous section 251 provision—

Q7 Chair: Can you just be clear—this is the confidentiality advisory group to whom?

Simon Stevens: To the Department of Health.

Q8 Mr Bacon: Who do they report to?

Simon Stevens: To the Department of Health.

Q9 Mr Bacon: And who is the boss at the Department of Health?

Simon Stevens: The Secretary of State.

Q10 Mr Bacon: Right. Who are the two principal advisers of the Department of Health for the NHS?

Simon Stevens: This, having come to my attention, is something that we clearly do want to take up, because I think it is a very unsatisfactory situation.

Q11 Mr Bacon: So, just for the avoidance of doubt, the answer to my question is “us”.

Chair: You two.

Dame Una O'Brien: Yes.

Simon Stevens: Yes, absolutely.

Q12 Mr Bacon: It is just that, when you mentioned this group, you made it sound like some sort of extraterrestrial movement of the planets over which you had no control.

Simon Stevens: Since they are independent, we have no control, but obviously this is something that, with the Department, we now need to take a tight look at.

Chair: I hope that you can, because I think you have picked up that we are anxious about this.

Q13 Mr Jackson: Did they not do an impact assessment that planned ahead as to the likely ramifications of changing the regime from opting out to opting in? It does seem to be a cock-eyed way to run a system. You have got a flagship health programme that seeks to be as good as any international comparators and some faceless bureaucrat who in theory is answerable to Dame Una comes along and says, “We won’t worry about the impact this’ll have on data collection”—

incidentally, that is referenced on page 23 as being one of the issues by the all-party parliamentary group on diabetes. And they say, “We’ll change the rules to completely”—forgive my French; this is unparliamentary—“bugger up the whole data collection.” Didn’t anyone think this through? Didn’t you think this through, Dame Una?

Dame Una O'Brien: There is an unintended consequence from their decision. Participation has always been voluntary, let us just be clear about that. I think it is an unacceptable consequence, and it is not one that I am happy about and we will certainly be acting to raise the participation rate in this audit.

Q14 Mr Jackson: Because you are the accounting officer, you get the flak. So, however much you try to do best, which I am sure you do, you say it is voluntary, but effectively it is outside your control, which is an issue of fairness. The responsibility comes back to you. People like me are concerned about this issue, yet you are saying there is really nothing you can do about it, because it is voluntary.

Dame Una O'Brien: The participation in this audit has always been voluntary. I am not happy that the participation rate has fallen off, as an unintended consequence of the confidentiality advisory group seeking to do the best it can to protect the confidentiality of patient information. Clearly, we will now need to look at that in light of the fall-off rate. And we will take action, have further discussions and reconsider the issues, so that we can up the participation rate in the audit in future, because, as you have quite rightly said, it is a flagship audit, and known around the world for the sheer numbers of people involved. And the other thing that is really fantastic about it is that it considers the care progress across boundaries—

Q15 Chair: It is fantastic only if people participate.

Dame Una O'Brien: Absolutely. We are in agreement on that.

Q16 Mr Jackson: So you are saying, effectively, that it is not the CCGs and the GPs that are at fault; it is this group of people who have unilaterally decided to change the regime. That is not good for the GPs, not good for the patients, and not good for you as the accounting officer. If I may, I will suggest that, instead of having another meeting and another review, you bring forward new guidelines, or even regulations, to effect a change back to the original situation. And let us just see if it scrubs its face.

Q17 Chair: I do not want to go down this path for too long, because I think that people are gathering that we may want to make a recommendation on this; I say that without revealing our report, but I think you are seeing where we are going.

You have an independent committee, but we have all worked with such committees in Government. Surely you have some direction over them? What would be the procedure that would mean that we could quickly resolve this matter? Simon Stevens certainly nodded in agreement when

Mr Jackson used the phrase, “cock-up”; he is nodding again. What would be required to make this happen better next time around?

Dame Una O'Brien: First, we have to understand why so many GPs, given the way that the decision architecture was reconstructed, pulled out of it, because there may be other reasons at play here. Then, I think that we want to refer that back to the confidentiality advisory group, in the knowledge of the consequences of that decision, and ask for it to be reconsidered.

Q18 Chair: How quickly could it be done if they changed—?

Dame Una O'Brien: I can't answer that right now—

Q19 Chair: If you could drop us a note, that would be very helpful.

Aside from the point that Mr Jackson has rightly pursued, GPs have had a varying degree of participation. Do you think GPs have taken their eye off the ball in tackling this issue? Perhaps I can ask Professor Valabhji.

Professor Valabhji: No. I think there is a number of reasons why participation has fallen off. The other thing to disentangle is that the PCTs invested quite a bit of manpower resource in supporting GP practices to upload the data. While that support has not all disappeared, the institutional memory was lost, to some extent, when the PCTs were broken up. So we saw some fall-off in participation that was attributable to the fact that PCTs are no longer in existence, and we have new organisations to take their place.

Then, superimposed on that, we now have this second factor, if you like. It is very geographically determined. We can see from the data at the moment that, of the CCGs that have invested quite a lot of time, money and personnel in supporting GPs to upload the data, some are achieving 100% participation; others, who have not invested that resource, are way down the table. If we look at a map of England, it is coincident with the geographical boundaries of CCGs.

Q20 Chair: That brings me on, probably to Simon Stevens, but tell me, Simon Stevens, if it should be someone else. Is NHS England sighted on the issue? Are you content? And what would trigger your intervention if you think that a CCG is not performing well enough, both on the audit and the participation? It is a bit of a proxy—not entirely—for treatment and how seriously they take the issue.

Simon Stevens: For 2016-17—in other words, next year—we have said, as Dame Una identified a moment ago, that a new CCG scorecard will include, among other things, a specific domain on diabetes. As part of that, the score that the CCG attracts in terms of its performance on diabetes will feed into its overall rating. We will be using the same rating methodology for CCGs that is currently used for provider trusts by the CQC. How they are doing on the diabetes rankings will be independently assessed, in the same way that they will be independently assessed by outside

patient groups on cancer, mental health, dementia, learning disabilities or maternity care. That will be the mechanism that triggers intervention where needed.

Overall, my assessment is that NHS performance has improved dramatically on diabetes care over the course of a decade or more. As Dame Una said, the proportion of people with diabetes has doubled over 15 years. More patients are getting high-quality care, as—

Q21 Mr Bacon: Could you stop for a second? You are about to go off on a wonderful paean about how marvellous things are, although the Report in front of us says that things are getting worse.

Simon Stevens: Does it? Where does it say they are getting worse?

Q22 Mr Bacon: Well, I think it says that the number of people with diabetes is going up, but let us stick with the point that you made about the scorecard. You said that is the mechanism that will trigger intervention. When will the scorecard trigger intervention?

Simon Stevens: The scorecard goes live on 1 April.

Q23 Mr Bacon: Once the scorecard has gone live, when will the score be sufficiently poor to trigger the intervention?

Simon Stevens: Next year, beginning in April, is when the quarterly oversight of CCG performance against that scorecard will occur. Then we are required under the Health and Social Care Act 2012 to produce an annual assessment of how each CCG is doing against those criteria.

Q24 Mr Bacon: You still haven't answered my question. What I am trying to find out is what will trigger it. Obviously, the scorecard is the metric that you hold and look at. When you have a bunch of scorecards in front of you for different CCGs, what is the score on them that will cause you to say, "We'll intervene in that one and that one, but not in that one."

Simon Stevens: We will be consulting on the criteria—

Q25 Mr Bacon: Is it numbers?

Simon Stevens: Yes.

Q26 Mr Bacon: So you haven't got the criteria yet.

Simon Stevens: The Secretary of State announced this approach to CCG scorecards within the last several weeks. We will be consulting before the start of the new financial year on the

metrics to be applied in each of the six care domains. We will then use that to mark the CCGs before—

Q27 Mr Bacon: You will be consulting, in other words, before 31 March next year?

Simon Stevens: Exactly.

Q28 Mr Bacon: When will it be announced what the metrics are?

Simon Stevens: By 1 April, obviously, because we will need CCGs to apply them then.

Q29 Mr Bacon: So there will be a number in there, and if a CCG falls below it, then you will intervene?

Simon Stevens: Yes. We have to apply human judgment to these matters, in just the same way that the CQC does in respect of provider trusts, but as the report rightly says, there is a trailing edge of performance in some CCGs. It also points out that the bottom 10% of areas have improved the fastest—by 22 percentage points—so there are signs of progress, but we need to accelerate that.

Q30 John Pugh: What will the intervention consist of?

Simon Stevens: As in the current CCG oversight regime, we have a range of measures at our disposal that are calibrated to the nature of the issue that needs to be sorted out.

Q31 John Pugh: What would be the appropriate one here?

Simon Stevens: In the first instance, it will be support and ensuring that a CCG has appropriate action linked to its particular gaps.

Q32 John Pugh: A word in their ear.

Simon Stevens: Well, no. Certainly marking their card, but the whole point of having a prospective quantified framework that people can—

Q33 John Pugh: But no financial penalty or anything?

Simon Stevens: Not so much a financial penalty. Ultimately, we are able to intervene, issue legally binding directions to CCGs that are not delivering and change the management where required, and we have done so in a number of cases.

Q34 Chair: How quickly would that trigger? In the first quarter or the second quarter, or does it have to be at the end of the first year?

Simon Stevens: As Dame Una said, the data are now 2.5 years old, but assume that when we get the more up-to-date information in January, we will still see a spread of performance; of course we will. I think it would be unreasonable to say, “Within 13 weeks, sort out what has been a decade’s worth of a problem, and if you don’t we’ll send in the equivalent of the 101st Airborne.” Of course not. It clearly illustrates the size of the improvement that individual CCGs will need to make with their GPs. Ultimately, a lot of the measures tracked here are about the quality of primary care performance, and we know that primary care is under stress. You cannot have an argument about secondary prevention of diabetes-related conditions without having a conversation about the overall functioning of the primary care system in that geography, too.

Q35 Mr Bacon: Will the scores be publicly available?

Simon Stevens: Yes.

Q36 Chair: Professor Valabhji, you are the clinical lead for this. We have a report on what targets have been set and on the care pathways. What would you see as the role of the centre in making sure that GPs who are not doing this start doing it? Why do you think some GPs are embracing it more than others? There are clearly financial incentives for them to do this. Are those incentives no longer as useful as they were?

Professor Valabhji: The incentives, via QOF, have done a huge amount both for the care processes and for the treatment targets. If you look at the plots right from the inception of QOF, 6.5% of people with diabetes had all the care processes and now we are at around 60%, which is a huge achievement. We plateaued, and I suspect that QOF, as a lever, has done what it can. We need an additional lever if we are to move beyond 60%. Personally, I think the logical way to go—Simon Stevens has been alluding to this—is to look at the distribution and tackle the variation. That is an important way to do it.

The QOF incentives can shift the entire distribution, let’s say, of people with diabetes in terms of, for instance, their sugar control, and we have to be quite careful there because, if we reduce the sugar of everyone with diabetes, we could do significant harm. There is harm at the lower end of the spectrum. If I, in my clinic, increased someone’s insulin dose too much, they develop hypoglycaemia, which can be associated with harm and even death, so we have to be careful in how we tackle it. The right way to do it is to look at those lower than the median. You would then be bringing the high values of sugar towards the median without endangering those who already have fairly low sugars by taking them into the danger range. QOF has probably done a great job, and what you see is what you get now—that is the effect of QOF.

Chair: I certainly hear that that is what is happening locally.

Professor Valabhji: The next step is to tackle the variation, more importantly, at the worst end of the distribution, rather than shifting the entire distribution.

Q37 Chair: As you have all highlighted, the variation is very wide. How is best practice shared through the system? Why is it that some GPs and CCGs are seemingly content to oversee a very poor level of hitting the nine care pathways and the three test targets? What can you do, and what can you ask the Department and NHS England to do, to make sure that the worst are coming up to the standards of the best?

Professor Valabhji: We have gold-standard clinical pathways, and I should point out that the pathways do not just involve primary care. You need the whole spectrum of primary, community and secondary care, and we tend to get better outcomes across the piece, including on foot amputations and things like that, where that interface works particularly well. We now have a system, the Right Care programme, that defines the gold-standard clinical pathway. If a local health economy requires help, it can call in the Right Care programme to benchmark where its current service provision is compared with the gold standard and look to reduce the difference, so driving better outcomes. We have some mechanisms in place. There is also professional responsibility and knowledge. We all go to conferences x times a year—GPs and specialists both do—and a huge amount of sharing good practice goes on as a result of that.

Q38 Chair: That is what puzzles me because you talk about people wanting to do well professionally, but the variation is immense. It wasn't looking good three years ago, so I don't understand why the worst aren't trying to do better to get to the level of the best. What levers are there in the centre? Basically, with whom does the buck stop when it comes to making sure that, wherever you live in the UK, this national crisis of 200,000 extra diagnoses a year is being tackled? Who does the buck stop with, and why aren't the worst doing better?

Professor Valabhji: I think you are mixing up two things. As a professional in diabetes for more than two decades, I have seen two major differences that disentangle the two things to which you are alluding. First, I have seen massive improvements in the standards of care over two decades. In the data that we have from the national diabetes audit to date—the last three years alluded to in the Report—we are seeing significant reductions in the risk of complications per individual with diabetes. So we know that the risk of mortality is falling and that any individual with type 2 diabetes is less likely to die. That has been a big change since you sat three years ago, when—having read the transcripts over the weekend—that was a big focus for the Committee. We have done a lot to reduce the excess mortality. So the outcome per individual is much, much better, the clinical endpoints that matter to people: heart failure is reduced; major amputation is going down; and kidney failure and going on to dialysis is going down. That is the first observation I would make as a professional in the field.

That has to some extent been swamped by my second major observation, which is the explosion in prevalence: more and more people are developing diabetes. On that score, in the last 12 months we have been making strides to tackle it through a national programme for type 2 diabetes prevention. So looking at the evidence base internationally, there is strong evidence that if

you give those identified as high risk, but who as yet do not have diabetes, a prescriptive intervention—which we are developing as a national offer—you can reduce the risk of progression to diabetes by up to 60% over three years.

In terms of my two observations, therefore, the outlook per individual is much better. The volume of complications that we as an NHS are dealing with is greater, but only because the number of people who have diabetes has gone up. We are now particularly strong on that, because we will probably be the first country in the world to scale up at national level a type 2 diabetes prevention programme.

Q39 Chair: You talked about this gold standard, and that is great. From a clinician's point of view, I can understand why you are aiming for that, but it is not supposed to be a theoretical standard; it is actually supposed to be something that is implemented. So notwithstanding what you said about the progress, the number of people getting diabetes is a pathway that has been, and is, predictable. What will happen to make this gold standard not theoretical, but practically delivered? As I asked earlier, where does the buck stop? Where do you think that there needs to be more intervention—NHS England, the Department of Health or perhaps Public Health England—in terms of prevention?

Professor Valabhji: Two fundamental mechanisms will tackle the rising prevalence—the year-on-year increase—in the number of people with diabetes. First, the NHS health checks, which are a cardiovascular assessment for all members of the population between the ages of 40 and 74. Importantly, part of that assessment is a diabetes filter, which identifies through two stages those at high risk of developing type 2 diabetes. To date, we have lacked the appropriate offer for those individuals. While we have been identifying them through the health checks over the past few years, we have not necessarily across the country been empowering them to do something about that when they receive the information. The NHS type 2 diabetes prevention programme will do exactly that. So the first stage of national roll-out is scheduled for 1 April 2016.

Q40 Mr Jackson: May I clarify something? Unless I misheard you, Professor Valabhji, you said that heart failure had gone down, but figure 14 on page 33 shows that angina, heart failure, stroke, heart attack, end-stage kidney disease and both types of amputations have all gone up—in fact, heart failure has gone up by 25% in the two financial years up to 2011-12. Are you saying that it has plateaued and gone the other way since?

Professor Valabhji: This is a table showing the glass half empty, which is the total number of cases that we as the NHS have to deal with. What I am talking about and what is more important to individuals with diabetes is, “What is my risk as a person with diabetes of developing heart failure?” and that risk has clearly gone down for people both with type 1 diabetes and with type 2 diabetes.

Q41 Mr Jackson: But you said specifically that complications with respect to heart failure have gone down, but the figures do not show that.

Simon Stevens: Your chances as a patient of having heart failure and, indeed, your chances overall of dying early from diabetes have gone down from 44% to 34%, such that we are now the lowest in the industrialised world, but there are just more people with diabetes, so the absolute numbers have gone up.

Sir Amyas Morse: So your chances of getting diabetes have gone up, but your chances of what your outcomes might be once you have got it have gone down.

Simon Stevens: That's right.

Sir Amyas Morse: Very comforting.

Chair: This Report would be a good exercise in statistics for an A-level student.

Simon Stevens: Rates versus volumes.

Q42 Mr Jackson: Madam Chair, the Report does say: "The estimated number of diabetes-related complications continues to rise." Heart failure is up 25%. Sorry if I am being obtuse, but—

Professor Valabhji: This is the difference between the total number of cases that the NHS has to deal with and the risk of any individual developing that complication. As a professional, I sit and have a one-to-one relationship with my patients every day of the week. I can honestly tell the person in front of me that their risk of developing heart failure is a lot lower now than it was x years ago, which is significant.

Simon Stevens: But you have more people in your clinic.

Professor Valabhji: True.

Q43 Mr Jackson: It would be uncharitable not to concede that you are dealing with a massively increased cohort. In fairness, these figures are more mixed than they look because you are dealing with much bigger numbers.

Professor Valabhji: Sure, but as I said, we have jumped into the space of doing something about the rising numbers.

Dame Una O'Brien: It might help to look at figure 13, which illustrates the point you are making, if I have understood it correctly, Professor Valabhji.

Professor Valabhji: If you look at heart failure, the orange bar, which is for 2009-10, is the biggest. The yellow is intermittent, for 2010-11, and the latest data, which is for 2011-12, is the smallest. This is the absolute risk of—well, actually, it is a bit more complicated than that, statistically. If you look at the whole population, with or without diabetes, all of us, fortunately, are less likely to have heart failure, a heart attack or a stroke, but what this says is that the relative gain for an individual with diabetes is even greater than for the background population.

Q44 Mr Jackson: I am asking you to comment on a Report you did not write, which is slightly unfair. May I ask the NAO to clarify this for those of us who do not have degrees in statistics?

Robert White: I think what has been said is correct. In figure 14, the right side shows there are more people with complications because there are more people with diabetes. The left shows that your chance of developing some of those complications has gone down, but let's be clear: it has gone down in all areas—some of them are slightly down and some more so. We have seen an increase in minor amputations; I will probably ask the clinician to clarify whether that is a good or a bad thing, given that major amputations have fallen, but with some of the other ones, like renal replacement therapy—kidney failure—there was nearly a 293% chance of developing a complication. That has fallen to 274%. That puts it in perspective; it is moving in the right direction.

Q45 Karin Smyth: I want to return to the incentives discussion. I accept that the numbers are going up and that clinical standards have certainly improved, but we should look at how the system can make a difference and improve in this area. You talked, Professor Valabhji, about QOF having been a successful lever but really having done what it could. I accept, with the cohort of patients who came through at that time, that that is possibly true, but what is not now left in primary care is an incentive similar to QOF to drive that behaviour in primary care, given that most of the savings in terms of amputations and so on are further upstream in secondary care. Given the turnover in GPs in primary care, the destabilisation we have seen in primary care and the increasing numbers of different patients coming through primary care, what is the driver for primary care to deliver this part of the programme now?

Professor Valabhji: In a health economy, we all feel a shared responsibility for the outcome of our people with, let's say, diabetes—that is the theme of the day. I think GPs are very concerned about the risk of one of their patients losing a leg, so I do not think there is a lack of incentive from a clinical perspective. The cost savings are actually shared across the health economy. If you look at the cost savings to be had through avoidance of a major amputation, they are huge. The exact number is somewhere between £15,000 and £30,000 per major amputation saved, but that is felt right across the health economy and also across the whole economy. Often, with type 1 diabetes, you see people of working age succumbing to one of these awful complications. They can no longer work if they are not walking, so there are all sorts of consequences. The financial gains, which I think is what you are alluding to, are shared right across the health economy.

Q46 Karin Smyth: Okay, but they are not really shared—they are not being put back into primary care or held at the CCG or in the trust. Perhaps we can come back to Mr Stevens. If we look at an entire health economy, where you perhaps could save £3 billion of spend in one area, those savings are divided between different parts of the health economy. In a fractured and financially focused health economy, where are those savings really realised, and how will you ensure that all parts of the system are driven on the same goal?

Simon Stevens: That will be done by implementing the NHS five-year forward view, which is essentially a solution to the precise issue that you raised, which is that we have fragmented funding

streams. We have disconnects between primary and specialist services, between physical and mental health services and between health and social care. Those parts of the country that have got going on the redesign of services are, under the so-called vanguard programme, joining up those services and, as a result, joining up the funding flows. They do not have the issue that you described.

In fairness, we should acknowledge that there are a number of parts of the country that have found workarounds to the current regime and done well on the back of it. Northumberland for a long time has had a good integrated specialist and primary care diabetics service. In Portsmouth, South Eastern Hampshire CCG and its consultant diabetologists and GPs have, for their type 1 diabetes service, found a way of producing integration and sharing the savings across the care boundaries. In a sense, what you are describing is a specific instance of a broader problem that the NHS five-year forward view will tackle.

Q47 Karin Smyth: But most of the country is not under the vanguard programme, is it?

Simon Stevens: There are 50 vanguards, and we obviously want to be able to roll out more.

Q48 Karin Smyth: For those parts of the country that are not in the programme, and will not be in the next couple of years, how would you show the improvement, if you came back to the Committee in two years' time?

Simon Stevens: The cost of a diabetic-related amputation is a cost to the CCG, and investment in avoiding that by the CCG will therefore produce downstream savings for the CCG. The incentives are aligned in that respect. One piece we have not paid sufficient attention to so far is what is happening in primary care and the pressures on GPs. The reality is that, over the last several years, diabetes cases have increased by 4.8% a year, but the number of GPs has been increasing by 1.8% a year. Part of what we have got to do is change the relative investment in GP services and primary care and look at new ways of providing primary care, such as with multidisciplinary teams. That is a big part of what the health service has got to get right over the next three years.

Q49 Chair: Sorry, you just very neatly skipped over an important point on new ways of doing things in primary care, such as, I suppose, workforce planning. Could you give us a bit more detail on what is being planned and how quickly—

Simon Stevens: Yes. It is workforce planning, but also GPs are coming together in a number of places in federations or super partnerships or other ways of moving beyond the individual two, three or four-person practice. As a result, they are able to bring in a wider array of primary care professions, including clinical pharmacists, more nurses and others. That, with the ability then to provide a wider range of primary care services, will be part of how we will tackle the gaps in care that we still see on some of these eight care measures.

It is not just about the financial engineering; it is also about the investment in and resilience of general practice in this country. If we do not get that right, we are on a hiding to nothing when it comes to dealing with the vast increase that we are continuing to see and are bound to see in the

number of people with type 2 diabetes. It also emphasises that the NHS is on this treadmill. We are running to stand still by virtue of the huge obesity problem in this country, and that is why we have to tackle that at source, not only through such things as the diabetes prevention programme that Professor Valabhji talked about, but through broader action to tackle obesity. We cannot, as a country or as the NHS, afford to deal with the downstream consequences that show up with such things as type 2 diabetes and cardiovascular disease.

Chair: We are going to come on to that downstream in our hearing with Mr Marron from Public Health England.

Q50 John Pugh: There are two areas of concern. One is on prevalence, and the other is responsibility. One accepted fact in the background to the whole Report is that the percentage of the adult population with diabetes has doubled over the past two decades. Has the number of people with diabetes doubled, or is that due in part to the better diagnosis of diabetes? Can you just clarify to what extent this is a genuine doubling or perhaps a better identification of those people who have diabetes?

Professor Valabhji: It is a very real phenomenon in terms of the rising prevalence. There are more people with glucose within the diabetes range. I think you do bring up an important point. When I started in the field, we would talk about a decade's lag time to diagnosis of diabetes. When I saw people for the first time with a new diagnosis of diabetes they often had some of the complications present and that does not really happen any more. So we can model how many we think are out there with diabetes who do not yet have a diagnosis. You model it by working out the age of your population, the ethnicity and their body mass index—how much they weigh. Whereas the mismatch was 750,000 when I started in post two and a half years ago, the Report now talks about a 400,000 gap. So we have got much better at earlier diagnosis of type 2 diabetes. Sooner or later they will all feed into the—

Q51 John Pugh: Could, say, a third of that increase just be down to better diagnosis rather than higher incidence?

Professor Valabhji: Not a third.

John Pugh: Less than that.

Professor Valabhji: Less than that—well less than that. But it is a significant contributor.

Simon Stevens: And there are perhaps 5 million people on the cusp of having type 2 diabetes—the total pre-diabetic population—on top of the 3.2 million who Professor Valabhji was talking about.

Q52 John Pugh: Okay. I look at the other stat I am provided with, and it says that by 2030 the percentage of the adult population with diabetes is expected to rise to 8.8%. That is up from 7.4%. So you have what looks like quite a meagre increase projected for the next 20 years, as

opposed to the increase you have seen in the past 20 years. What do you think is going to happen to slow the rate down?

Professor Valabhji: Our intervention, which I have mentioned—our diabetes prevention programme.

Q53 John Pugh: Right. The public health programme.

Professor Valabhji: Yes. So at the moment we are looking at a 4.8% increase per annum in the number of people with diabetes. I am not aware of any modelling that suggests that that will plateau, which I think is what you are suggesting with those figures.

Q54 John Pugh: Well, it seems to indicate a plateau.

Professor Valabhji: The thing to bear in mind is that when you try to project into the future the number who will have diabetes in 2030, 2050 or 2080, the margins of error get wider and wider for every year ahead you go. At the moment, for the past three years we have seen a fairly consistent 4.8% per annum increase.

Q55 John Pugh: So what you are saying, as the clinical director here, is that the figure of 8.8% could be a very conservative estimate unless something works effectively.

Professor Valabhji: It could be, yes.

Q56 John Pugh: Okay. Looking at diabetes as a whole, apparently it consumes 11% of NHS expenditure. One in seven hospital beds are diabetes-related—*[Interruption.]* One in six, with £5.6 billion of costs. If all the CCGs, or whoever we regard as responsible in this case, performed at optimum level, or as well as the best performers, what sort of savings—I am asking this question to Mr Stevens—would that engineer for the NHS? You are sweating over the NHS budget at the moment—you are warning us about it. Around the table, different constituencies have figures on the incidence and the variety is quite shocking, but if everyone got it all right, or got it as near right as they possibly could, and you could eliminate that variety and get performance up near the better performance, what would the NHS save?

Simon Stevens: If you take the £5.6 billion figure that you mentioned, which I think related to 2010-11, I believe the estimate was that 69% of that related to the complications of diabetes, which was £3.9 billion.

John Pugh: Some of which would occur anyway.

Simon Stevens: Thinking of it from first principles, the answer is some share of £3.9 billion multiplied by the increasing prevalence that may or may not occur to 2030. It is certainly going to be a seven-figure number, and it may well be an eight-figure number.

Q57 John Pugh: It is a highly laudable objective. Would early diagnosis help us get to that objective?

Professor Valabhji: Yes, we know that if you get in quick with a diagnosis—

Q58 John Pugh: It can be done well, and we know the sort of things that will make it go well, therefore it is a desirable objective. Who is accountable for achieving that objective at the end of the day? Is it NHS England? Is it you, Mr Stevens? Is it the Secretary of State? Who is really accountable? It is obviously an achievable goal. We all want it. The community wants it; society wants it; patients want it. Who ultimately has to see it delivered?

Simon Stevens: The three treatment goals that have been adduced around HbA1c's—blood glucose, blood pressure and serum cholesterol—are the three that it is thought should be the principal focus. Obviously, we do not have compulsory medication or treatment in this country, so at the end of the day some of this will depend on the response of individual patients and what GPs do to them. I do not think we can pretend that we will have—

Q59 John Pugh: The GPs we can put pressure on to get rid of the unacceptable variety and also to get everybody up to the performance of the better, if not the best. Is that your responsibility?

Simon Stevens: Yes.

Chair: Wonderful. Two yeses.

Simon Stevens: Well, it is a shared responsibility.

Q60 Chair: We should get Mr Marron to explain how, in terms of meeting the target, a lot falls on Public Health England. Jonathan Marron, but perhaps Professor Valabhji and Dame Una might want to comment, you are the obesity and diabetes clinical lead, although type 1 is not down to obesity. Is there any issue there? You might want to pick up on that. Do you want to explain what you are doing?

Jonathan Marron: Certainly. The focus of Public Health England is on prevention. There are three major things. First, along with NHS England, we are running the diabetes prevention programme, which will be the first time anyone has introduced a national behaviour modification programme for people at higher risk of diabetes. It should make a significant contribution to slowing down the growth in the number of diabetics. That is the first part.

Secondly, we have a real responsibility as the nation's expert public health body to bring forward the evidence on the things that we know would work to help tackle the growing obesity crisis. Indeed, our recent report on sugar and the evidence-based interventions for how we might cut sugar in our diet are leading to a reduction in obesity. It sets forward a very clear menu. Taking that forward, we are working closely with the Secretary of State for Health on developing the

Government's obesity strategy, which we expect to see early in the new year, and we are hoping for significant progress on action in tackling obesity.

Finally, we have a set of responsibilities to the public. We work closely with social marketing campaigns to try to influence behaviour. We also have regular debates in public health about how effective that is versus reducing sugar in food reformulation. We have a duty to help people understand what is in their diet—what they eat—and we have had some success. The sugar swaps campaign that you might have seen is largely aimed at mums. It has been very successful in getting people to think about changing diet.

Q61 Chair: When you say successful, how do you measure that?

Jonathan Marron: When it was first introduced in the summer of 2014, we used the Kantar Worldpanel data. It collects data on what people actually buy. We used that to look at people who had signed up for Change4Life versus those who had not, and we saw a 6% reduction in the amount of sugar eaten over the period of the study.

Q62 Mr Bacon: This is in people who have signed up for Change4Life.

Jonathan Marron: Change4Life is the broad campaign.

Q63 Mr Bacon: Can I sign up to change my life?

Jonathan Marron: You can sign up on our website.

Mr Bacon: I'd be delighted.

Chair: Richard and I are offering ourselves as guinea pigs.

Jonathan Marron: This particular campaign was about sugar swaps. We encouraged people to swap high sugar food for something healthier: if you drink sugar-sweetened beverages, swap to water or milk. Really simple, practical things.

Q64 Mr Bacon: What about Diet Coke?

Jonathan Marron: That's fine as well. You have certainly taken calories out of your diet.

Simon Stevens: That is not a product endorsement.

Jonathan Marron: We have done really good work with families. The Change4Life campaign is family-orientated. From next year we have got a new campaign to launch—we are calling it One You—trying to get at adult health, aiming at people around 40 and a little over. Are we thinking properly about our health and how we get people to start thinking about their habits?

Q65 Mr Bacon: How much money are you spending on this campaigning?

Jonathan Marron: The total spend for Public Health England on social marketing is around £50 million.

Q66 Mr Bacon: So less than £1 per head of population.

Jonathan Marron: Yes. It has significantly reduced over the last four or five years.

Q67 John Pugh: Going back, I was quite impressed by Mr Stevens accepting responsibility for being £5.6 billion down, but he does not have sole responsibility; Professor Valabhji helped him. Something you said quite distressed me earlier. You said, “Patients I see every day of the week in my practice”. Is your job a part-time job?

Professor Valabhji: Yes. Well, I work full time. I am seconded for five sessions to my NHS England role, and in the rest of my time I do clinical work.

Q68 John Pugh: So you are the man delegated by Mr Stevens to get a £5.6 billion budget under control and you do five sessions. How many people are in your department with you?

Professor Valabhji: Which department? The NHS England end?

Q69 John Pugh: Well, presumably you have a department, a desk and staff—people who are working with you on the strategy.

Professor Valabhji: We have a whole team dedicated to—

Q70 John Pugh: How many?

Simon Stevens: The team of the medical directorate and Bruce Keogh’s medical directorate are—

Q71 John Pugh: No, I mean the team specifically devoted to dealing with obesity and diabetes in NHS England.

Simon Stevens: May I just interpose to suggest something? If you want a conversation about how an individual CCG is doing, we have a geographically-based team that is in charge of having that discussion with the CCG. Jonathan does not have 209 people scattered, each one talking about the CCG. He makes use of the full structure of NHS England.

Q72 John Pugh: No, but it is a very important, significant objective for the health service. I would like to believe that when you went in for these five sessions a week, you had a team of people who briefed you immediately and made up for what you can obviously not do yourself if you are involved in a serious clinical practice for the rest of the week. I ask you again: how many people do you work with on a day-to-day basis?

Professor Valabhji: I can't give you that answer because it depends which bit of diabetes work I am working on that day or that hour. Take the diabetes prevention programme as an example. A good 20 of us are working on that.

Q73 John Pugh: Twenty people report to you.

Professor Valabhji: Well, there is a partnership between NHS England, Public Health England and Diabetes UK. The core management team is a sizeable team from the different organisations. If you ask me who I have to help with some other aspects of the treatment and care of diabetes, the answer would be different because it depends which part of the organisation—

Q74 John Pugh: No, I am not asking you that. I am asking who you have helping you to drive this strategy.

Simon Stevens: The whole organisation.

John Pugh: But specifically?

Q75 Mr Bacon: You said a sizeable team. How many?

Professor Valabhji: For which bit—prevention?

Q76 Mr Bacon: Well, the bit that you described as a sizeable team—the partnership of Diabetes UK, Public Health England and you. How many are in that sizeable team that you referred to?

Professor Valabhji: I said about 20.

Q77 David Mowat: To finish Mr Pugh's line of questioning—this £3.9 billion times a factor would give you a saving if every GP practice was as good as the best. I suppose what I am interested in is that if the GP practices that were failing or were not so good were here now, what would they say? Would they say, "The data is not reliable and therefore the conclusions are not good" or would they say, "We've got other priorities"?

Simon Stevens: I think they would say that they are working under tremendous pressure because the rate of increase in funding for general practice relative to other parts of the health service has been far lower. The consultation rate is higher. They would say, in contrast to the suggestion that somehow they are not able to provide good quality care overall, more patients are getting high-quality care than was the case five years ago. Some 230,000 more people are getting the NICE eight care processes, and 180,000 more are getting—

David Mowat: I understand all that.

Simon Stevens: They would say, “My surgery is really busy. We are doing a good job. Give us extra resources. Get more GPs in and we will be able to do better.”

Q78 David Mowat: But your job then is to say to them, “Is your surgery differentially busier than another GP surgery that, for some reason, has good statistics?” Is there an issue with the coherence and validity of the statistics?

Simon Stevens: I think in the early days, there probably was.

David Mowat: The professor is shaking his head—so you think they are solid.

Chair: Speak, professor.

Professor Valabhji: I think the data are valid. If you look at the determinants of poorer performance, they are not what you might predict. They are not driven by socio-economic factors.

Q79 David Mowat: So, on the face of it, it is possible to have conversations with these GP practices at the moment, saying, “Based on this metric and only this metric, you are letting your patients down.”

Professor Valabhji: When you try to disentangle the determinants of the variation, much of it is down to practice-level organisation factors, even down to the make of IT system used in the practice.

Q80 David Mowat: Yes, but my question was about the validity and coherence of the data. When you say that it might be because the IT systems are different—I can understand that that may well be the case—that implies to me that the data might not be—

Professor Valabhji: Sorry, I have misled you. I did not mean to say that the collection of data on the IT system was unreliable. There are essentially four different packages that GPs can use for their IT system—

Mr Bacon: And the GP extraction service can’t use any of them.

Professor Valabhji: For example, in the most commonly used package there is a module, which you can choose to turn on or off, that will create a register of people at high risk of developing diabetes. Some practices have turned that on, and others have not. Some have done so because they see it as a priority; others haven't simply because they are inundated with other things. My point is that the data are robust, but the determinants of the variation are things related to practice organisational factors, rather than the socioeconomic factors that drive the demographics in that area.

Q81 David Mowat: Okay, so you have just said to me that it is not about a clinical difference in performance but because of whether they have flags switched on in the various computer systems that might collect the data.

Professor Valabhji: There will not be a single cause, and there are clinical factors that come into play.

Q82 David Mowat: What I was getting at was that Mr Pugh's analysis struck me as being right. If you could free up this amount of money by increasing the performance to the best, it matters quite a lot that the data on which we judge them all are accurate. I was just trying to get a feel for that.

Professor Valabhji: I think the answer is yes. I think the data are accurate.

David Mowat: I am not sure that your answer before that was quite the same.

Q83 Chair: I will bring in the Comptroller and Auditor General on this point.

Sir Amyas Morse: I too was fortunate to be present at the previous hearing, Dame Una, and I recollect that one reason given was that some local care pathways were very inconveniently and badly organised. Given the fact that the growth in patients has been going on for years—it is hardly a novelty—when will you achieve 80% coverage? Is that still your target, or have you gone away from it?

Simon Stevens: No, I don't believe it is, but do you want to talk to that, Una?

Sir Amyas Morse: When will things start to improve materially over what they are now? I am interested in how that will happen. When should we expect it to happen?

Dame Una O'Brien: I think a number of different factors will come together to drive the improvement. The first thing to say is about the greater focus on these three particular treatment areas. The thing that has really struck me about that—I want to emphasise it for everyone's recollection—is that it is about the individual person setting the targets on glucose, blood pressure and cholesterol for the individual person. We are now gearing up to really focusing on the thing that will make the greatest difference, and doing that systematically with, as Simon Stevens said earlier, a combination of the right care programme where there is actual capacity for NHS England to go into

individual CCGs and—these things have to come together—much clearer data about performance. What is care like for people with diabetes in a particular locality? We have to make that visible and evident.

Sir Amyas Morse: Just to stick to the point, when you made these plans and decided that you were going to analyse how people were doing in different areas and put considerable investment into that, don't tell me that you did not have a plan for how effectively or how soon it would have an effect. I just cannot believe that.

Simon Stevens: What are you talking about?

Sir Amyas Morse: When you made the plans to evaluate how effective the different commissioning groups were being, starting in April, you must have evaluated what impact you thought that would have—for example, what were your goals for that programme in terms of driving up better performance?

Simon Stevens: Yes, exactly.

Sir Amyas Morse: So you do know that. Presumably you can share it with us.

Simon Stevens: As I think I mentioned earlier to Mr Bacon, we're going to consult publicly on that, so we will certainly be sharing it. Our point of view is that when we see the results of the 2013-14 and 2014-15 audit, we need to use the up-to-date information on where each CCG is, set improvement goals based on where they have got to and, frankly, decompose the challenge a little more forensically, given that a lot of variation is masked by the national average figure.

To be specific about it, if you look at your excellent Report, you will obviously see that the clinical goals are much worse for people with type 1 diabetes, for younger people and for people of black or south Asian heritage. If we are going to be serious about inequalities, the lifetime exposure to uncontrolled diabetes and the particular challenges associated with type 1, we actually have to do something other than just set some aggregate national glob of a goal.

Sir Amyas Morse: I suspect that if you knew informally that things were getting considerably better, you would have found a way to convey it to us today—

Simon Stevens: I didn't think that we were allowed to.

Sir Amyas Morse: Do you actually think as a clinician that things are being pursued with the level of urgency that they ought to be?

Professor Valabhji: Yes, I do. It's overly simplistic just to look at the nine care processes and the three treatment targets. We have covered that in some of the other bits, but to take a brief example, we mentioned foot care earlier. One of the nine care processes is having a foot check. I think that that is very important, but am I confident that if we can get that up to 100%, we will have done the job for amputations? Absolutely not. It is one piece in a very large jigsaw. We have invested something like £94 million per annum on financial incentives for GPs to deliver on the care processes, so there isn't an insignificant amount of investment in this. If you asked me whether I would invest more in that pot to drive more foot checks, I think I would prefer to have a

multidisciplinary foot protection team to cover every part of the country to ensure that, once a check has happened, the clinician is actually doing something about an abnormal result.

The care processes are important. I would love to see 100% acquisition of them all, but I don't think we will. I also don't think that if we did achieve 100%, we would have solved the problem. We have to be mindful of the need for the whole pathway.

The other thing that we alluded to and that Dame Una has brought up are the treatment targets themselves. Going forward, I would prefer us to focus on those three targets, rather than the nine care processes. I would like to focus on both, but if we have to choose and to weigh investment relatively, I would go for the three treatment targets because they are nearer to the end points that count. Achieving sugar, blood pressure and cholesterol targets is closer to preventing your index heart failure case or heart attack or amputation than just checking the blood test or the feet.

The other thing to say is that everyone is very different. What NICE has come out with in this latest tranche of guidelines around diabetes—three or four updates were published in August—really stressed the need to individualise the targets. That was predominantly borne out of data that came out in about 2008 or 2009. We all assumed that, to protect our people from complications, the lower the sugar, the better. We then found in a proper and well-conducted trial that the ones with really tight control were dying more often due to hypoglycaemia, so you have to individualise care.

At the beginning it was said that we know what works, so why aren't we doing it? I don't know that I would wholly agree with that. The pathways are very clear to optimise outcomes, but you cannot achieve perfect outcomes. For example, we have the same treatment goal for the sugar level for type 1 and type 2 diabetes. It is infinitely more difficult to achieve a target for people with type 1 than for type 2. You could say the same for type 2, because the determinant of sugar control in type 2 diabetes is duration of diabetes. I can achieve a target very easily for someone who was diagnosed five years ago, but with much greater difficulty for someone diagnosed 30 years ago.

Chair: Those were some very good points and we will be coming back to type 1 diabetes.

Q84 David Mowat: I want to finish on what we were talking about and then perhaps talk briefly about international comparisons. As for the data and the differences that we are seeing between commissioning groups and the GPs within them, you mentioned that there were four computer systems that were pulling this data up. Just to put my mind at rest, would there be any correlation between which system was pulling the data up and which GPs were good, bad and indifferent, or is it entirely random? Have you looked at that?

Professor Valabhji: I am not wholly familiar with the dataset, but I know that one or two of those four are much easier—within the new opt-in system, it is a much easier task for practices using one or two of those four compared with the others, so there are differences.

Q85 David Mowat: So if I was a practice using one of those systems, I would be getting better numbers, which are being reported up to Mr Stevens to make the decisions that he has to make? If that is true, it undermines the whole basis of what we are talking about.

Professor Valabhji: It is not just the make. It is using the facilities and being IT-savvy as a practice.

Q86 David Mowat: No, exactly. There are the business processes around it as well, but if it is true that it depends on which of the four applications are being used and that will determine which GPs have good outcomes, versus bad outcomes, versus mediocre outcomes—i.e. that is a correlated factor—it undermines all the data that we are looking at and that the NAO has done a report on.

Simon Stevens: That is obviously a critical question. I am pretty confident the answer is that that is not what is going on, but let Professor Valabhji have a look at that subsequent to this hearing and write to you very shortly if it is.

Q87 David Mowat: You understand the point that I am making.

Simon Stevens: Indeed.

David Mowat: Because if that was the case, it means that the data integrity of the whole thing is weak.

Simon Stevens: Yes, but given—

David Mowat: And that is why I asked you at the start why some GPs—

Q88 Chair: If you can't answer it now, will you write to us?

Simon Stevens: I think our answer is that we do not think that is going on, because the national diabetes audit has standardised for all those kinds of variables, but if it turns out on further inspection that there is a question there, we will write to you straight away.

Q89 David Mowat: That would be great. Finally, Mr Stevens, in one of your earlier answers, you mentioned international benchmarking. There was the Murray report, I think in 2013, talking about 2010, which you came out quite well in.

Simon Stevens: Indeed.

David Mowat: Have you got a feel for how it has moved since then?

Simon Stevens: As you say, that showed that we have the best performance relative to early deaths for diabetes-related causes of 19 countries. There have been other international studies since then. The OECD published a study in June on diabetes and cardiovascular disease showing that we had one of the lowest hospital admission rates for diabetes. It showed that our prescribing by GPs to manage high cholesterol was 40% higher than the OECD average, that prescribing medicines for diabetic-related conditions was 20% higher than OECD average, and when you look at the

amputation rate caused by diabetes, we were one of the best in the industrialised world, and certainly better than France, Germany or America. By international standards, we have an awful lot to be proud of, notwithstanding our ambition to do better across England.

Q90 David Mowat: So your view is that the Murray report and its conclusions—which said that you were the best, actually—are still the case.

Simon Stevens: Yes, there is no basis for thinking that that is not the case.

Professor Valabhji: The data collection for that went up to 2010 and the three data points on mortality that we have in the National Audit Office Report show that we have continued to make good headway on that, with statistical significant reductions in mortality beyond 2010.

Q91 David Mowat: Let me ask the question another way then. What are we doing right that other countries are not doing to be so much worse than us?

Simon Stevens: I think there are several things. There is the fact that we have had a focus on this in the national health service at least since 2001, when the first national service framework for diabetes was produced. We then had a strong set of incentives for primary care through the quality and outcomes framework, which on average, is putting about £12,000 extra into practices to help them with the costs of meeting those QOF targets for diabetic care, and we have continued since 2009-10, on the back of the NICE-based focus, to track improvement transparently. That combination—good primary care with strong incentives and clear clinical evidence fed back to people on how they are doing—is a winning formula.

Professor Valabhji: In terms of that international benchmarking, one thing that we have not mentioned is the lag time between good care today and better outcomes tomorrow. That is around a minimum of a decade, so I think it is highly likely that the positives that we dwelled on, in terms of the statistical issues earlier in the hearing, are very real returns. Better outcomes per individual almost certainly relate to the inroads that we made through QOF and through the national diabetes audit, which actually, is the biggest audit of its kind in the world, dating back to 2003, so I think we are reaping the benefits now of the investments that we put in back then. There are no international benchmarking systems that I am aware of. We cannot compare how we are doing with nine care processes with any other country, because no other country really collates data in that way, so we are very advanced in that respect. It is the same for the three treatment targets. I can give you a little more comparative data on sugar control, but not on the combination of sugar, blood pressure and cholesterol.

Our data are fantastic, really, comparatively speaking. What we are seeing in terms of the better hard clinical outcomes that matter to people, including mortality, relates to all that we have put in place, going back 12 years or more.

Chair: Okay. We could go into a lot more detail, but I will hand over to Stewart Jackson.

Q92 Mr Jackson: Mr Marron, may I ask you a brief, straightforward question about the debate on the sugar tax? In terms of the Department and your organisation, where are we on that debate at the moment, formally?

Jonathan Marron: We are very clear on our position. We have published our review of the evidence. We found that there is evidence to support the idea that a sugar tax of 10% to 20% would reduce sugar consumption. That is our contribution to the debate, if you like. It is one of a range of measures. We also looked at reformulation, restricting advertising and restricting promotions, and the things we could do to help people make better choices. The Secretary of State for Health is considering the obesity strategy in his responses. My understanding is that to date the Government have ruled out a sugar tax—Una might say more on that—but we continue to work with them on an obesity strategy that we hope will see a broad range of measures to help tackle what is a very urgent problem.

Another thing worth saying is that there is no silver bullet on this, and a sugar tax on its own is unlikely to have a significant impact on tackling obesity. We need a whole range of measures that help us change the environment that we live in, reduce the unhealthy choices that are available to us, help us understand the harm that we are doing by consuming so much sugar and having high-fat diets, and so help us change. We will need a broad range of actions.

Q93 Mr Jackson: May I also ask you and Professor Valabhji about the implied criticism in the Report that the conflation of obesity and diabetes has not been good for retaining the profile of the latter as possibly the major healthcare demographic issue in the next 20 years—do you have a specific response to that?

Jonathan Marron: We have two challenges, which are linked. The first is the broad population challenge: we are just getting more and more overweight. Long term, if we want a sustainable health service, we need to do something about that. The most effective way of reducing the long-term cost of diabetes will be to not have the number of obese and overweight people that we see today. That is definitely part of the solution, but is obviously quite a long-term task.

In the short term, we have focused on the other things that we can do. With the new process of the national diabetes prevention programme, can we identify those people most at risk of developing diabetes, intervene early and prevent them from moving along the disease pathway and becoming diabetic? That is well worth doing: not only will it be beneficial to the patients themselves, but over the long term it should save costs to the NHS. Finally, we have had a long discussion today about the things we can do to make sure that we get high quality care for diabetes. I do not think that it is a choice between those areas; we need to make progress in all of them.

Q94 Chair: Professor Valabhji is the clinical lead for both obesity and diabetes—the connection is to type 2 diabetes. Perhaps you could answer Mr Jackson's question, Professor.

Professor Valabhji: Whenever I am speaking I am very clear that I see myself as having three hats: national clinical director for type 1 diabetes, for type 2 diabetes and for obesity. That is

important, because people take great offence if there is any implied association between obesity and type 1 diabetes, as there is no association. The association is with type 2.

Has it been useful, having the obesity part of my portfolio married up with the type 2 part of it? I would say yes, actually. I mentioned the two major changes in my career, in terms of the two changes in clinical observations, namely better outcomes, but higher numbers; 80% of the variation causing those higher numbers is down to lifestyle. It is due to exercising less and eating more, and higher rates of obesity—62% of the adult population are overweight or obese now.

It is difficult to disentangle the two. When you are practising in a clinical scenario, focusing on weight as well as on sugar control is very important, and your choice of medication for the individual in front of you will be based on their weight as well as their average sugar level.

For type 2 diabetes and obesity, the two are intrinsically related. Personally, it has been very helpful to have both in the portfolio, but I can see why a proportion of the stakeholders were upset about obesity being in the title at all. There is an implied association—which isn't there—with type 1 diabetes.

Chair: Can we keep it quick-fire, because of the time?

Q95 Mr Jackson: I am mindful of the time. Mr Stevens, can I briefly ask you two operational questions? One is about the criticism in the Report that staffing levels of diabetes specialist nurses have not changed in the past two years, and that a third of hospitals in England taking part in the audit have no specialist in-patient nurses. How are you going to tackle that issue? It seems to me that with massive increases in the cohort you are going to have to deal with it.

Simon Stevens: The care that hospital in-patients with diabetes get has nevertheless improved, as shown in the Report, on a whole range of measures, including access to foot services in the hospital. A lot of the pressure that is showing up will obviously force different approaches to staffing. Diabetes specialist nurses have a very important role to play, but there is no magic wand. There are obviously huge pressures across the health service, and we cannot conjure extra nurses out of thin air; that is not going to be on offer in the next 12 or 24 months, given everything else that hospitals are confronting in relation to their nurse staffing.

Q96 Mr Jackson: Finally, I am obviously very disappointed to see that my own CCG is bottom for care processes, the three bespoke treatments, treatment standards, complications and mortality. Apart from that, it's doing great.

Chair: Just to be clear, is it bottom of the Committee members' constituencies?

Mr Jackson: It is flagged red.

Chair: Not necessarily nationally.

Q97 Mr Jackson: Yes. That begs the question—I do not want to steal the Chair’s thunder, because I know that she wants to touch on this issue—how are you going to get rid of the huge variations between different parts of the country, which Mr Pugh mentioned earlier? One of the illustrations shows that if you draw a line from the Bristol Channel to the Wash, the performance is pretty poor—apart from inner London—particularly in the south-west. I think it is the one on—

Chair: There are two maps.

Mr Jackson: Yes, there are two or three of them. It seems that the north-west and inner London are doing quite well.

Chair: Do you mean figure 3 on page 14?

Mr Jackson: Yes, and figure 10.

You talk about the new framework, but how are you going to close that gap in a timely way, bearing in mind that, as I mentioned earlier, the all-party group was critical of the culture? It said that “many healthcare professionals do not value, or are unaware of, the benefits of education programmes, leading to a lack of referrals and where referrals are made they are poorly explained, meaning that the patient is less likely to attend”. That is a culture question.

Simon Stevens: You are talking specifically about the structure of patient self-education.

Q98 Mr Jackson: Well, that and how you get the best CCGs’ practices to everyone. That seems to be how to deal with regional differences.

Simon Stevens: We have got a huge task in front of us across the national health service over the next four and a half years, in terms of the extra headroom we need to create over and above whatever resource the Government are able to make available through the spending review. As part of that, and as well as driving efficiencies in the individual hospitals, provider organisations and so on, we have got to get industrial in our approach to taking out clinical practice pattern variation. That is no longer just nice to have for the health service. We have run out of road on much of the other salami-slicing. Right Care has been mentioned a couple of times; it is the name of the process we are using in each CCG to say, “Here’s what our best practice would look like for your people and your area. Here’s how you’re doing. This is the gap, and this is therefore”—this relates to Mr Mowat’s question—“what that is worth in pound notes and lives saved for the people of Peterborough.” That is our task through CCGs for the next four and a half years.

Q99 Mr Jackson: Finally, is someone in NHS England or the Departments modelling the opportunity cost of different disciplines? You cannot stop people getting old and falling over and breaking their hip—it is always going to happen—but you can stop people getting more ill than they already are. Are you looking at that? Are you planning ahead as part of that plan? It seems to me that the cumulative savings for clinicians and the NHS as a whole are enormous if we get this right.

Simon Stevens: Precisely; and that is one of the reasons why we have to have a particular focus on type 1 diabetes, as well as type 2, given that the standards that are being achieved are often worse, and given that the age at which people get a type 1 diagnosis means that they can be living with it for decades. To go back to the conversation with Sir Amyas a little earlier, that is why a type 1 focus on the three treatment goals and the disparities that exist has got to be one of the central things that we do in this next phase of our action, alongside the work on diabetes prevention, and the other programme that we have launched with Diabetes UK.

Q100 Mr Jackson: With young people? Because that came up—young people and type 1.

Simon Stevens: Precisely. That has got to be a specific focus of what the Right Care programme will bring about.

Q101 Mr Jackson: And that will be in the methodology that you would develop, or that you are going to consult on next year?

Chair: We are approaching 5.30, so we are getting to our quick-fire round. I say this to the witnesses as well as the Committee—the Committee knows this, but the witnesses may want to bear it in mind. We have had quite a lot of background already, so we can take it, and what is in the Report, as read.

Q102 Karin Smyth: I think, Dame Una, you said that NHS England had the capacity to support this programme going forward. I am interested to know if, Mr Stevens, you think that NHS England on the ground in regional areas has the capacity to refocus now on driving this agenda forward.

Simon Stevens: Well, when everything is a priority, nothing is a priority, so that is why we have said that for the CCG scorecard we will be putting particular focus on six clinical areas for 2016-17 and beyond, and one of those is diabetes. So yes, we are going to marshal our forces to have an impact in that area and the others that we have identified, against the backdrop of a 50% reduction in the administrative costs of running the commissioning system over the last five years. So there are

fewer people now than there were five years ago, but we are going to focus our efforts and get it right.

Q103 Karin Smyth: Can I put one question to Jonathan Marron: you talked about the social marketing work that your Department is involved in. Is that social marketing work with patients aligned to the marketing work and public health work that people are doing across the local authorities in this country?

Jonathan Marron: Yes, we put on national programmes and normally make available materials for local authorities to run—

Q104 Karin Smyth: I understand that. My concern is for patients in my constituency to get one message.

Jonathan Marron: Yes, so let's think about the campaigns we have run—from Change4Life, which was very much family lifestyles, and so not really about patients, to the Act FAST on Stroke campaign. I hope that we managed to get those perfectly aligned with the NHS messages in similar areas.

Q105 Kevin Foster: In 2012 when we did the review, it noted that payment systems for hospitals did not encourage multidisciplinary care. Given that if someone is obese they are likely to have other health issues, and noting that the current funding models still do not support the delivery of integrated diabetes services, how do you see that being changed?

Chair: Professor Valabhji looks keen to intervene.

Professor Valabhji: I think the vanguard sites are our route into proper integrated care. The financial disincentives to be all pulling in the same direction across primary, community and secondary care are quite real, when you have a funding scenario that is based on payment by results. So the concept that I and my GP colleagues will all be employed by the same organisation pulling in the same direction is the major route forward to address that.

Q106 Kevin Foster: Let us say that in three years' time we are looking at this again; what specific difference might we see?

Simon Stevens: Can I just add one other thing since the Committee last met, which I think is an important example of the kind of payment innovation that has responded to the Committee's findings previously; and that is the introduction of a best practice tariff for hospital admissions. For emergency admissions of patients with ketoacidosis or hypoglycaemia, the hospital gets an extra payment on top of the index payment if that patient is seen by a diabetic specialist team at the point of admission, has an education review, sees a diabetic specialist nurse or a diabetologist, gets a written care plan and receives structured education on discharge, and so on. That is an example of putting an extra payment on top of the tariff to bring about precisely the kind of difference that you are describing.

Q107 Kevin Foster: That has been done, or is being done?

Simon Stevens: That has been done from 2013.

Q108 Kevin Foster: Okay. I see in the conclusions "do not support", so what is the next thing that you have done?

Simon Stevens: Sorry?

Kevin Foster: I see in paragraph 14 in the findings on page 9 that funding models do not support it. That has been done so far, in 2013, and was presumably taken into account in this Report. What is going to be done to address that remark specifically?

Simon Stevens: It does come down to implementing the five-year forward view, in that we are saying to those parts of the country that have combined primary and community services that we will delegate to them the full population budget for their people. We will say in places such as Yeovil or Harrogate where the hospital and the CCG are coming together that they will get the full budget, crossing all the boundaries, so that they can make those kinds of trade-offs or reinvestments. But some parts of the health service will still be buying care per item, as it were, probably for some hip replacements, cataract extractions and so on. So it is going to be horses for courses in terms of the blended payment model, but that is what NHS England and NHS Improvement will be embarking on, beginning in April.

Professor Valabhji: You also mentioned the multidisciplinary team working, and the cardinal example would be the multidisciplinary foot services that we know reduce amputation rates by about 50%, which is really significant. In 2011 when we audited, I think about 60% of hospitals had such a service. In 2013, it was 72%. We just collected data in September this year, and I do not have the results yet. It is on the up.

Q109 Chair: Do you know when you will get the results?

Professor Valabhji: That is the in-patient part of the audit, so I think it will probably be around April.

Chair: Oh, so not in time for our Report.

Q110 Mr Bacon: Professor Valabhji, you said that some people felt offended when obesity was linked with type 1 diabetes; fair enough. On the other hand, it is true that that is only 10% of the total cohort of people with diabetes, isn't it?

Professor Valabhji: Type 1 diabetes is, yes.

Q111 Mr Bacon: So type 2 is 90%. When you used the phrase “prescriptive interventions”, did you mean the issuing of a prescription, at which point a patient has to go and get something, or did you mean the issuing of a prescription to eat more cauliflower and carrots, and fewer Mars bars?

Professor Valabhji: The latter. I made that comment in the context of the diabetes prevention programme; we have done a very detailed literature review for the international evidence of what works to prevent diabetes. Where we can be prescriptive around an intervention, we are being. The three dimensions are weight loss, more physical activity and better quality of nutrition, so we are being as prescriptive as possible about what the interventions should look like.

Q112 Mr Bacon: Can you say those three again? Weight loss—

Professor Valabhji: Weight loss, more physical activity and better nutritional content of the food that is being consumed.

Q113 Mr Bacon: In other words, the same message that everyone has been getting already for quite a long time without its necessarily having the right effect. It is all good stuff, but it is not novel, is it?

Professor Valabhji: It is not novel, but if you deliver it as part of a behavioural change programme, we have got good evidence, as I mentioned earlier.

Q114 Mr Bacon: Indeed. Mr Marron, that brings me straight to you. Behavioural change, behavioural modification—how are you going to deliver all this? A lot rests on your shoulders, and you have had quite a light outing this afternoon.

Jonathan Marron: Thank you for being gentle with me first time.

Q115 Mr Bacon: We did notice that you had been private secretary to Mr Simon Burns—now Sir Simon Burns—and the fact that you survived that is, in itself, a mark of considerable strength and resilience on your part, so we thought we would give you a light outing.

Jonathan Marron: It was an absolute pleasure, that period. I can't remember what you asked me now.

Mr Bacon: You didn't stop him smoking, did you?

Jonathan Marron: I must admit that I did not stop him smoking. On the diabetes prevention programme, we have really good evidence from high-quality trials across the world that a sustained intervention does reduce—

Q116 Mr Bacon: What does “a sustained intervention” mean in English? Is it bombarding people with television adverts and leaflets?

Jonathan Marron: The criteria for a sustained intervention are: over at least nine months, with a significant amount of face-to-face contact time, either individually or in groups—we think around 16 hours—and a substantial number of sessions, around 12 or 13.

Q117 Mr Bacon: Meaning what? That the patient comes in to the GP?

Jonathan Marron: The patient comes in to see the provider of the service. That will not be done by the GP—

Mr Bacon: They are referred to that by the GP.

Jonathan Marron: They are referred to that by the GP, yes, or indeed through the health check programme.

Q118 Mr Bacon: And we are talking about people who are at high risk who have not yet got diabetes.

Chair: Mr Bacon and I.

Jonathan Marron: Yes. So they will go through a risk assessment and then the blood glucose test will show that you are at high risk. Those people will then be referred to the programme.

Q119 Mr Bacon: I assume that they have had face time with the GP and have thus been in a position to get referred. What if, like me, you are as healthy as a horse and you do not go anywhere near your GP if you can possibly avoid it, but you are still fat? How do you target those people?

Simon Stevens: Tread carefully, Jon. *[Laughter.]*

Mr Bacon: I did not mean “you”; I meant one—actually, I meant me.

Jonathan Marron: And I mean one back, just to be very clear. The health check programme will be a major way in. As you know, anybody between the ages of 40 and 74 who is not already on a cardiac risk register is currently being invited for health checks. The aim is to get everybody over a five-year period. We are doing okay. We have now got all local authorities taking part. The numbers in the Report—actually, we report in a very funny manner, so we say that 38% have been offered over the two years covered in the report, but that is 38% of the 40% we expect of that period. So the offers are pretty good—

Q120 Mr Bacon: Is the £50 million an annual number?

Jonathan Marron: £50 million for the health check, yes.

Q121 Mr Bacon: So over five years, over a Parliament, that is a quarter of a billion pounds.

Jonathan Marron: Yes.

Q122 Mr Bacon: How much of that money is going on commercial advertising of one kind or another?

Jonathan Marron: Sorry, I have got two numbers. We spend £50 million a year on social marketing—that is everything that you are seeing from the Change4Life campaigns to the stop smoking campaign and the smoking in cars campaign you see at the moment. The health checks are run by local government. They are paying again around £59 million a year to deliver health checks.

Q123 Mr Bacon: So the £50 million is purely for what you call social marketing.

Jonathan Marron: I mentioned two numbers of £50 million—

Mr Bacon: I did not mean the £59 million; I meant the £50 million.

Jonathan Marron: The £50 million is on social marketing, separately, yes.

Q124 Mr Bacon: When you say social marketing, do you mean marketing through social media, or do you mean marketing of all kinds to society?

Jonathan Marron: Of all kinds to society, yes.

Q125 Mr Bacon: Right. How is that split? Where does that money go? Does it go on radio, TV or print?

Jonathan Marron: Radio, TV, print, leaflets that are found in GP practices—

Q126 Mr Bacon: Can you send us a note on how it is split out?

Jonathan Marron: Yes, certainly.

Q127 Mr Bacon: Do you get the advice of professional, commercial advertising agencies?

Jonathan Marron: Yes.

Q128 Mr Bacon: To what extent do you attempt what one might call shock tactics? Forgive me, you may have done this already, but it has not hit me because I do not watch a lot of television. I remember some very effective campaigns on seatbelts in the back of a car, which were very shocking but, I imagine, very effective. Do you do that, or are you going to do that?

Jonathan Marron: I think it depends on the issue and what the evidence suggests works. So if you think about smoking, I think we would all agree that some of our smoking adverts have been pretty shocking—the tar in the cigarettes. That, we believe, is effective for smoking. On obesity and diet, we have tended to run a slightly gentler, more positive message of, “You can do something about it.” The evidence, in our professional interpretation, is that shock messages do not help at this stage. So the One You campaign that I have talked about will be a much more positive campaign, almost highlighting the challenges of daily life in our modern society: the damage it does, but the steps that you can take to get control and make better choices. A much more positive story on how you take control of your choices, rather than a shock.

Q129 Mr Bacon: You said that the evidence shows that it does not work, but the evidence at the moment shows that the number of people with type 2 diabetes, or diabetes full stop, is going up by 4.8%, and 90% of those with diabetes are type 2. So whatever we are doing at the moment is not working sufficiently, is it?

Jonathan Marron: And indeed we have not really targeted the adult population with messages about their health for a long time. The move from families and children, which have been the focus of our activities over the last few years, and of course smoking, which we have a long history of targeting, to adults—how you look after yourself, diet, obesity and exercise—is a change that we will bring out next year.

Just interestingly, for background, in *The Lancet* last month we published a global burden of disease study. One of the things I found most interesting about it is that it looks at what causes disease in this country—what are the attributable risk factors?—and 40% of the total burden of disease is attributable to potentially avoidable causes: diet, smoking and exercise. Actually, diet is now the leading risk factor in this country, slightly ahead of smoking. So I think we are reaching a time when we have to have a different and more serious conversation with the public about diet and exercise than we have in the past.

Q130 Mr Bacon: I have one more question. You put your point forward about the sugar tax—I tried to pull it up on my phone, but it was just too small—and the work that has been done on this so far. I should say that I have some people who farm sugar beet in my constituency. It is a major crop in East Anglia, although I am sure they could grow oilseed rape instead; it is a lot healthier. Were this to happen, I can imagine that in a finished, packaged good, the proportion of the sugar

that got taxed would not really be significant enough to have a disincentive effect, so where would you levy the tax?

Jonathan Marron: Most of the work that has been done on this—although it is popularly called a sugar tax—has generally been about a tax on sugar-sweetened beverages.

Q131 Mr Bacon: Not on Mars bars.

Jonathan Marron: Not on Mars bars.

Mr Bacon: Why not?

Chair: And biscuits.

Mr Bacon: Biscuits and chocolate—they are just as important as sugary drinks.

Jonathan Marron: The Department of Health has done good work in recent years on trying to look at portion size and control of the calories in confectionery, which I think is interesting and maybe can be looked at further. Sugar-sweetened beverages are the area that people have experimented with. That is what Mexico introduced their tax on; it is what most of the existing—

Q132 Mr Bacon: When you say “people have experimented”, do you mean that people have tried these taxes elsewhere in the world?

Jonathan Marron: Yes.

Q133 Mr Bacon: But they haven’t tried them on chocolate, just on drinks.

Jonathan Marron: It has largely been on sugar-sweetened beverages.

Q134 Mr Bacon: It’s just that there is very clear evidence from tobacco, from wines and beer and from spirits of course. The proportion of a bottle of spirits that is duty is—I forget the exact number, but it is in the 80 per cents. It has a very significant effect on total consumption of those products, so presumably the same would be true for these other products.

Jonathan Marron: Yes. The key thing, of course, is the price on the actual product. Again, with a sugar-sweetened beverage, we think that a 10% to 20% tax on the product price would have a significant incentive—

Q135 Chair: We will leave that there, because we are not the Committee that determines these policy issues or comes to opinions on them. Nevertheless, it is a very important part of the debate. I am going to do some fairly quick-fire stuff now. We have not touched much on the

structured education model. It is quite shocking that even when people are offered it—we need to remain quorate, folks—not very many take it up. I will not go through all the figures, but page 24 gives the example from Hull and so on. And there are still waiting lists—this is page 23—in some places. So I suppose my simple question to Dame Una and maybe to Simon Stevens is this. Will you provide stronger guidelines to CCGs on something that is known to work—Jonathan Marron has just given quite a clear example of what can happen—to make sure it happens in places where it is not happening well enough and to reduce waiting lists?

Simon Stevens: First, as the NAO Report says, “recorded take-up of patient education may not be a true picture of actual take-up.” The NAO was using the data that were available, but we believe that in practice it is probably a rather higher offer and take-up rate. We will have to see what subsequent—

Q136 Chair: Do you track, then, the outcomes? Going to one education session is not enough, we know, from what everyone has said—what Mr Marron said—so it is about—

Simon Stevens: Notwithstanding the fact that I suspect these under-represent the actual position, we know that whatever the actual position is, it is not good enough. That is because the model of delivering structured patient education is clunky and antiquated and does not work for teenagers who have just got a new type 1 diagnosis. The photocopied leaflet from the health education department in the portakabin at the back of the hospital car park, inviting you to come for four days’ worth of education—

Chair: There’s a man who’s been to those portakabins!

Simon Stevens: Indeed. Four days’ worth of education, weekdays from 9 to 5 when, as a kid, you’re supposed to be in school or, if you’re a grown-up, you might be at work—that model does not work. So in just the same way as we are procuring this diabetes prevention programme with Diabetes UK and partners, I think we are going to look at doing something similar for a type 1 patient education programme, using new technology, peer group support and other online vehicles. We have begun some informal conversations with some of the patient groups about that. We have to think about what is the modern way of engaging people who otherwise are just left cold by—

Q137 Chair: So you are thinking about that. Are there any answers, Professor Valabhji, about how to modernise this so it works?

Professor Valabhji: We are very interested in online access. The group-based setting, behaviourally, seems to translate into quite a lot of benefit. We have the first clinical trial reporting on a web-based platform for delivery of structured education. That reports in, I think, January or February time. At the moment, we do not have hard evidence that it works as well as the face to face, but in terms of people getting there who are of working age, it is clearly a space we have to move into. In terms of the uptake, you have it in the booklet. What that does not reflect, of course, is the impact of QOF. We introduced an extra QOF incentive that started to work on 1 April 2013, so the 2013-14 and 2014-15 audits, which will be published in January, will tell us the impact of the

QOF incentive on ensuring that people are referred to structured education programmes. I gather that it has had quite a marked effect, but obviously the data are not out there yet.

Q138 Chair: We will look at that with interest. Page 21 of the Report says that up to 10,000 people are getting the diabetes prevention programme and that, on the NHS health check, 4,000 people are prevented from getting diabetes, or are screened for it. Will you write to us with an up-to-date figure on the number of people who have gone through both programmes? Obviously, the Report will be lagging a bit behind, and I think this is important.

Simon Stevens: The DPP is only just getting going. That was one of the commitments we made in the forward view. We are just in the process of procuring the national roll-out. Seven local NHS sites have done the beta version.

Q139 Chair: My point is that these are quite low numbers, given that 200,000 people a year are being diagnosed with diabetes.

Simon Stevens: Sure, but our aim is to get to 100,000 a year by 2020, if we can. Obviously, that will partly depend on the unit costs of doing it, which will be a function of the procurement—we will know the results of that in the next couple of months.

Q140 Chair: There is a question hanging to which we will no doubt return. As I think I have already told Dame Una, we will be calling more people back if we do not like the response.

Simon Stevens: We are here in two Mondays' time on cancer, or something, so we can tag it on then.

Q141 Chair: I am sure we will see you often enough that we do not need to do a recall. We can just add it at the end of the session.

We are running late, but we have not touched on type 1 very much. I have talked to various people about this. I did not know much about type 1 before preparing for this hearing, but it is very much a red-flag process—a flag is raised if there is a problem. Things like getting a continuous glucose monitor or a pump to deliver insulin automatically are expensive at the beginning but make life much better for the patient. I think it is £3,000 to £4,000 for a pump. Is that right? Has there been any work looking at the cost savings of giving a patient, particularly a patient with type 1, such support early on in order to save money down the line and make their lifestyle easier?

Professor Valabhji: Type 1 diabetes is very different, and it is much more difficult to achieve sugar control targets simply because they are exquisitely sensitive to hypoglycaemia, so low sugar levels, which can be very difficult. There is evidence that pumps transform people's lives for the better. They lower the average sugar. They can be life transforming for people with debilitating low sugars. When we last audited in 2012-13—this is being included next time round as part of the

national diabetes audit—we saw around 20% of children and 6% to 7% of adults having pumps. That was a few years back, but the figures have gone up impressively since we first looked in 2008.

Q142 Chair: That is still quite low—6% or 7% is still quite low. Clinically, how many people would benefit?

Professor Valabhji: I was just leading on to the fact that, as part of that audit, we looked at people who qualified for the technology under NICE guidance and how easily they achieved funding. The truth was that 95% of people who fulfilled the NICE criteria achieved funding, but that was dependent on their team actually thinking to discuss pumps with them. We are seeing that go up and up. At the turn of the millennium, there was also an issue with even specialist teams having the necessary experience to be able to talk to people about pumps and put them on pumps. That is now mainstream in terms of specialist diabetes care.

You mentioned continuous glucose monitoring, and it is probably worth mentioning that that has only been formally available on the NHS as of 26 August, so for just a few months. The technology has come in over the past few years, so many of us, as specialists, have developed experience of using that technology in just the past few years, and we have been funding it out of soft pots of money—sometimes the companies will throw a few at us to gain experience—but it is only as of the last set of NICE guidance revisions in August that we can prescribe it on the NHS.

Q143 Chair: None of you can particularly speak for NICE today—I suppose Dame Una would be the nearest person on that—but if more of these were being used by the 10% of the diabetes population with type 1, surely the product price would go down and there might be savings downstream.

Simon Stevens: That is an issue that we are going to take a look at, given, as Professor Valabhji says, the change in NICE guidance about how we procure and whether we can use some kind of national purchasing muscle to bring down unit price. Also, frankly, we are hopeful that the technology will continue to develop over the next several years, so that the links between the continuous glucose monitors and the pumps are made and there is an integrated version that is easier to use than the two bits separately.

Q144 Chair: It seems to me, although maybe I am wrong, that as with many of these things, if clear guidance is set—I suppose Professor Valabhji will be key to that, but obviously also NHS England and Departments, in terms of the taxpayers' money involved—there would be a consequential impact on the supply chain. You are nodding. Is that something you are discussing with the industry?

Simon Stevens: Yes. For children's services, they are directly passed through on the specialised commissioning, so—

Q145 Chair: From what I have heard from people, it transforms their lifestyle. We are obviously in favour of things that work for the people who get the services as well as the taxpayer. Briefly, NHS Diabetes finished a couple of years ago, just after our last report. What happened to that, and why did it go?

Simon Stevens: I was not here at the time, but I picked up the pieces.

Q146 Chair: We understand people get paid very well—

Simon Stevens: All I can say is that there was heady nostalgia for NHS Diabetes after the event, although again, Professor Valabhji, reading the transcript of your 2012 hearing, this is what the NAO said at the time: “We...found little evidence that primary care trust decisions on how to deliver diabetes services in those areas we visited had been influenced by the work of NHS Diabetes.” That is what the report found three years ago.

Q147 Chair: Okay. We haven’t got time at this point to go into that, because we have Professor Valabhji now. That brings me to the issue of the future of clinical leads. Dame Una, I think it is in your bag. I have heard that there is discussion about amalgamating clinical leads in the NHS. We already have Professor Valabhji on obesity and diabetes, although I can see there is a connection with type 2. Is this a plan of the Department of Health? If so, what is the plan?

Dame Una O'Brien: When we established NHS England in 2013, the decision was made that the national clinical leads would be transferred to NHS England, and they are now the responsibility of NHS England. Simon can comment on the detail, but obviously, new developments are occurring, and we have to organise the national advice in the best possible way. I am confident that NHS England will go about that in a sensible way. We do not have a fixed template in the Department that will somehow—

Q148 Chair: Simon Stevens, do you have a template for what is happening to the clinical leads? Pick up the ball and run with it.

Simon Stevens: One legacy of the Health and Social Care Act 2012 was that in statute, various advisory mechanisms were put in place. Having now taken them out for a test drive for a couple of years, Bruce Keogh is doing a review to ensure that we both strengthen and rationalise elements of the way in which we get our clinical advice. At the moment, we have myriad national clinical directors. We have something called clinical reference groups, which have unpaid part-time chairs. We have strategic clinical networks, AHSNs and clinical senates. We think this is the right moment to take stock of which of those have been dignified and efficient.

Q149 Mr Bacon: The word “myriad” suggests too many. How many do you have?

Simon Stevens: As I said, we have 73 or 75 CRGs—

Q150 Mr Bacon: CRGs?

Simon Stevens: Clinical reference groups. We have 20-plus—

Chair: How many clinical leads?

Q151 Mr Bacon: I am sorry; I meant how many national clinical leads?

Simon Stevens: It is over 20, and then on top of that there are the main directors. There are directors of individual areas of work—

Q152 Chair: Just to be clear, though, the clinical leads, like Professor Valabhji, have a practice and typically, two days a week, are doing the—

Simon Stevens: Exactly.

Q153 Chair: So they are not very expensive, relatively. They are quite cheap.

Simon Stevens: So we want to start remunerating for a higher work time in areas where we can see, given our focus, that we need more clinical—

Q154 Chair: Can I be clear? Would that mean, just to take a present and live example, that you would want Professor Valabhji or someone of his ilk to do more than two days a week as a clinical lead, perhaps on diabetes and another area of work?

Simon Stevens: Yes. In the case of Sean Duffy, the national clinical director for cancer, given the focus that we are putting on cancer, we increased the share of his working week devoted to NHS England work. If Jonathan comes to Bruce and me and says that he now feels that he needs—

Q155 Chair: I think we should say who Bruce is, for those who don't know.

Simon Stevens: Sir Bruce Keogh, the medical director of NHS England, who is doing the overall review of the way these arrangements work.

Mr Bacon: Like Andrei Gromyko—one of those people who is always there.

Q156 Chair: Let's not go there. Professor Valabhji, would you be wanting to do this full time if that were offered? The danger is surely that you lose the clinical sensitivity.

Professor Valabhji: I would not want to be without the clinical contact, and that balance has to be struck. On where it sits, I will be open to discussion, but I would not want to give up—I would not want to be doing this role full time without any clinical commitment. I think you would lose quite a lot in terms of what someone like me—a national clinical director—brings to the party.

Q157 Chair: Would you feel comfortable taking on overarching responsibility for another clinical area, if that was what it came to?

Professor Valabhji: It would depend how affiliated it was to my own, I suppose. For example, I sit on several committees, including the clinical reference group for vascular surgery. We do not have a national clinical director for vascular work—the arteries in the legs—but it is so closely affiliated to diabetic foot disease that I take on some of those roles. So where there is overlap, yes.

Simon Stevens: We are not actually going to be asking Professor Valabhji to expand. He has, as has been pointed out, a fantastic job of work ahead of him with his current responsibilities. Again, in case nostalgia should descend on the Committee at this late hour, it is worth recalling the testimony given by the previous national clinical director, who said at your hearing on 12 June 2012: “I do not personally have any levers in that I do not personally have any sanctions or rewards. I am not part of the NHS management team....What I can do is encourage, support and lead.” I think Jonathan is actually in a stronger position than his predecessor, as a result of the creation of NHS England and the structures we put in place.

Q158 Mr Bacon: The same was true at the time of Professor Mike Richards, as the national clinical director for cancer. He didn’t have any “levers” and yet was achieving significant results by a process of the right kind of influencing, communication and dialogue.

Simon Stevens: Well, Mike had hundreds of millions of pounds of dedicated funding to disburse in the early 2000s, as the first of our national clinical directors.

Q159 Chair: We are approaching the end. I want to highlight—the figures are thanks to Diabetes UK—that 20% of all people admitted to hospital for heart failure, heart attack and stroke have diabetes, and we have heard the figure about one in six acute beds being taken by people with diabetes. I don’t think any of us here are under any illusion about this being a serious public health and critical health issue for our country. However well you have told us we are doing, there is still a lot more to do. We will be producing our report, possibly in January, because we have a bit of catching up to do with reports; we have had a lot of hearings. Our uncorrected transcript will be put straight up on the web in the next two or three days, for anyone who wants to have a look. Dame Una wants a final word—I will be indulgent, as you are such a regular visitor.

Dame Una O'Brien: Thank you very much. I just have three things I want to say, if I may.

Chair: Okay—three final words.

Dame Una O'Brien: Two are factual and one is a comment. First, we do have the 2014-15 QOF indicators, which were published just a few days ago and which I can make available to you. We also have the data on the percentage of patients offered a structured education. Obviously, we do not have the follow-through, but as I understand it, it is between 72%, which is the lowest in England, and 97%.

Chair: If you could provide us with that information, it would be very helpful.

Dame Una O'Brien: Secondly, I am sorry we did not have a chance to talk more extensively about Cambridgeshire and Peterborough, but, just for the sake of the CCG in Cambridgeshire and Peterborough, it is not quite as bad as was perhaps suggested earlier on, in that some of their schools are really doing quite well.

Chair: Perhaps you could send us that data.

Dame Una O'Brien: Thirdly, on Mr Mowat's point, one of the reasons we are doing well, if you look at the last 15 years, is consistency of purpose and a willingness to shift according to the research and the evidence as it emerges. You can track over time that investment in research and development, investment in gathering evidence and then the ability to adapt what we do in the light of that are the strength of the programme.

Chair: I agree with that. Certainly, clinicians in my local hospital, Homerton, such as Dr Anderson—who I thank very much for his time in preparing me for this hearing—would, I think, agree with you. There may be consistency of purpose, but there has not been consistency of structure within the NHS, and as the Report highlights, that concern has been raised on the ground. It is not our job to discuss the policy of the shape of the NHS, but it has had an impact. We will be looking at all of this when we draft our report. Thank you very much indeed for coming.