Department of Health: 
The management of adult diabetes services 
in the NHS

Seventeenth Report of Session 2012–13

Report, together with formal minutes, oral and written evidence

Ordered by the House of Commons
to be printed 22 October 2012
Committee of Public Accounts

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Committee staff
The current staff of the Committee is Adrian Jenner (Clerk), Sonia Draper (Senior Committee Assistant), Ian Blair and James McQuade (Committee Assistants) and Alex Paterson (Media Officer).

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# Contents

**Report**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary</td>
<td>3</td>
</tr>
<tr>
<td>Conclusions and recommendations</td>
<td>5</td>
</tr>
<tr>
<td>1 Accountability for performance in delivering diabetes care</td>
<td>7</td>
</tr>
<tr>
<td>2 The Department’s approach to improving diabetes care</td>
<td>10</td>
</tr>
</tbody>
</table>

**Formal Minutes**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal Minutes</td>
<td>12</td>
</tr>
</tbody>
</table>

**Witnesses**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses</td>
<td>13</td>
</tr>
</tbody>
</table>

**List of printed written evidence**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of printed written evidence</td>
<td>13</td>
</tr>
</tbody>
</table>

**List of Reports from the Committee during the current Parliament**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Reports from the Committee during the current Parliament</td>
<td>14</td>
</tr>
</tbody>
</table>
Summary

In 2009-10, there were 2.3 million adults diagnosed with diabetes in England and a further 800,000 people suffering from diabetes who remained undiagnosed. The percentage of the population diagnosed with diabetes doubled between 1994 and 2009 and is continuing to increase. The Department of Health (the Department) projects that the number of people with diabetes (diagnosed and undiagnosed) will rise from 3.1 million to 3.8 million by 2020. The NAO estimates that, in 2009-10, NHS spending on diabetes services in England was at least £3.9 billion, although this figure is likely to be an underestimate. The projected increase in the diabetic population could have a significant impact on NHS resources.

Too many people with diabetes are developing complications because they are not receiving the straightforward care and support they need, either through access to high quality care from appropriately trained NHS professionals or through effective training and support for patients so that they manage their condition. Most alarmingly, the Department estimates that 24,000 people with diabetes die prematurely each year because their diabetes has not been managed effectively. An estimated 80% of the costs of diabetes in the NHS are attributable to the treatment and management of avoidable diabetic complications. Unless diabetes care improves significantly the NHS will continue to incur ever-increasing costs as the number of people with the disease rises and individuals will continue to die prematurely.

In 2001, the Department published the National Service Framework for Diabetes (the Framework). The Framework set out clear minimum standards for what constitutes good diabetes care, including nine basic care processes which check for the early signs of avoidable diabetic complications, such as blindness and kidney disease. The Department also set treatment targets for the management of blood glucose, blood pressure and cholesterol to minimise the risk of diabetic complications developing. Local NHS organisations determine locally how best to deliver diabetes services. The expected levels of care outlined in the national Framework were reinforced in 2011 by a National Institute for Health and Clinical Excellence (NICE) ‘Quality Standard’ for diabetes in adults.

Although there is consensus about what needs to be done for people with diabetes, progress in delivering the recommended standards of care and in achieving treatment targets has been depressingly poor. There is no strong national leadership, no effective accountability arrangements for commissioners, and no appropriate performance incentives for providers. We have seen no evidence that the Department will ensure that these issues are addressed effectively in the new NHS structure. Failure by it to do so will lead to higher costs to the NHS as well as less than adequate support for people with diabetes.

The improvements in diabetes services since the publication of the Framework have not been as great as we would have expected given that the Department set clear and clinically agreed standards 11 years ago and has had information showing that the NHS has not been delivering the expected standards of care for a number of years. Variation in the level of progress across the NHS also means that there is an unacceptable “postcode lottery” of
care, whereby the quality of diabetes care varies dramatically across the NHS.

On the basis of a Report by the Comptroller and Auditor General,\(^1\) we took evidence from expert witnesses and the Department about the management of adult diabetes services in the NHS.

\(^{1}\) C&AG's Report, *The management of adult diabetes services in the NHS, Session 2012-13, HC 21*
Conclusions and recommendations

1. **NHS accountability structures have failed to hold commissioners of diabetes services to account for poor performance.** When NHS Diabetes offered assistance to the 20 worst performing primary care trusts only 3 trusts took up the offer. Most primary care trusts delivered the nine care processes to more diabetic patients between 2006-07 and 2009-10 but the extent of improvement was highly variable and the performance in 11 primary care trusts got worse. The Department should set out how the NHS will deliver improvements specifically in diabetes care under the new accountability arrangements, setting out under what circumstances and how the NHS Commissioning Board will intervene.

2. **Only half of people with diabetes receive all the basic tests to monitor their condition.** There is very broad consensus around the importance of the basic tests in monitoring treatable risks for diabetic complications yet improvements in the percentage of people with diabetes receiving the nine tests have been lower than expected, increasing from 36% in 2006-07 to 49% in 2009-10. The Department should aim to achieve universal coverage and urgently set out clear outcomes it would expect to achieve by 2014/15 and beyond.

3. **Fewer than one in five people with diabetes have achieved the recommended levels for blood glucose, blood pressure and cholesterol.** Failure to carry out these simple checks heightens the risk of diabetic patients developing complications. If people develop complications they are more likely to die early and also cost the NHS more money. The Department should set out when it expects to increase significantly the proportion of people with diabetes achieving all three outcomes, and define what that proportion should be.

4. **The Department is not effectively incentivising delivery of all aspects of its recommended standards of care through the payments systems.** Although the Quality and Outcomes Framework for GPs initially improved diabetes outcomes in primary care, there has been little improvement lately and the current payment system is not driving the required outcomes. GPs are paid for each individual test they carry out rather than being rewarded for ensuring all nine tests are delivered. Similarly, the Payment by Results tariff system for hospitals does not incentivize the multi-disciplinary care required to treat a complex long-term condition such as diabetes. The Department needs to ensure that its payment systems effectively incentivise good care and better outcomes for people with diabetes.

5. **The Department has improved information on diabetes but this information is not being used effectively by the NHS to assess quality and improve care, and cost information needs to be improved.** The Department has improved data on diabetes to support those commissioning, planning and monitoring services. However, primary care trusts are making limited use of these data at a local level to inform how services are delivered or to benchmark and improve services. Estimates of the cost of diabetes also range from £1.3 billion to almost £10 billion a year. The Department should use its information to hold the NHS to account and should work with the
NHS to ensure that the costs of diabetes are fully captured and understood to promote appropriate services and better outcomes for patients.

6. Many people with diabetes develop avoidable complications because they are not effectively supported to manage their condition and do not always receive care from appropriately trained professionals across primary and secondary care. Primary care professionals are not carrying out regular checks and tests and diabetic patients are developing diabetes-related complications that could be avoided, often requiring hospital treatment, as a result of poorly managed blood glucose, blood pressure and cholesterol. In hospital, some people with diabetes experience poor care, with over a third having a medication error whilst an inpatient. There are also high rates of readmission to hospital for people with diabetes. The NHS Commissioning Board should build into national contracts for primary and secondary care a requirement for people with diabetes to receive multi-disciplinary care from appropriately trained staff and structured regular education and support to help them manage their condition. We received evidence about the impact of specialist diabetic nurses in improving patient outcomes and we conclude that this is a cost effective way of improving outcomes for diabetic patients.”

7. The projected increase in the diabetic population could have a significant impact on NHS resources. The number of people with diabetes is projected to increase from 3.1 million to 3.8 million by 2020. This will put pressure on NHS resources because of the high costs of treating related complications. The Department and Public Health England should set out the steps they will take to minimise the growth in numbers through well-resourced public health campaigns and action on the risk factors for diabetes, such as the link with obesity, and the complications they can cause.
1 Accountability for performance in delivering diabetes care

1. Diabetes is a chronic condition which arises where the body does not produce enough or any insulin to regulate blood glucose levels. The percentage of the population diagnosed with diabetes doubled between 1994 and 2009 and is continuing to increase. In 2009-10, there were 2.3 million adults diagnosed with diabetes in England and an estimated 800,000 people with the disease who had not been diagnosed. The NAO estimates that, in 2009-10, NHS spending on diabetes services in England was at least £3.9 billion, although this figure is likely to be an underestimate, due to a lack of good quality cost information in some areas. 80% of the costs of diabetes are estimated to come from the management and treatment of avoidable diabetes-related complications. The Department estimates that up to 24,000 people with diabetes are dying each year from causes that could be avoided through better management of their condition.

2. For much of the time, people with diabetes manage their condition themselves. However, they also need regular checks to monitor treatable risks leading to diabetic complications such as kidney disease, blindness and amputation; and diabetes patients need to be checked to detect any early damage so that treatment can be given to prevent deterioration. In 2001, the Department set clear minimum standards for diabetes care, including nine widely accepted basic care processes which involve checks for the early signs of avoidable diabetic complications. The Department also set treatment targets for the management of blood glucose, blood pressure and cholesterol which are essential to minimise the risk of complications developing. The Department gave local NHS organisations freedom to decide how to deliver diabetes services and did not introduce mandatory performance targets as it did for cancer, stroke and heart disease.

3. In 2009-10, 90% of people with diabetes received six of the recommended care processes, but fewer than half of people received all nine. Additionally, just 16% of people with diabetes have achieved the recommended levels for blood glucose, blood pressure and cholesterol leaving an unacceptably high proportion of people with diabetes at higher risk of developing related complications. Between 2006-07 and 2009-10, the percentage of people with diabetes receiving the recommended nine care processes increased at a slower rate than expected from 36% to 49%. Most individual primary care trusts improved
during the period but the extent of this improvement was highly variable with 11 primary care trusts getting worse. The Department told us that its target for primary care trusts to deliver all nine basic care processes to 100% of people with diabetes each year was unachievable and felt a more realistic target was 75%. At present two primary care trusts provide all nine basic care processes to less than 10% of people diagnosed with diabetes and the highest performing trust only achieved a figure of 69%.

4. The Department explained that there will always be some variation in performance because some populations have more people at risk of diabetes than others but recognised that variation is mostly driven by differences in how primary care trusts deliver diabetes care and in clinical practice between healthcare professionals. The Department considers that the new arrangements for commissioning primary care will reduce variation and increase consistency in the delivery of diabetes care.

5. The Department has not managed effectively the performance of primary care trusts in delivering diabetes services. It has not held providers of diabetes services to account for poor performance. The Department told us that its national performance management activities are focused on those areas covered by the NHS Operating Framework and that it is the responsibility of local NHS organisations to benchmark and monitor themselves against wider NHS performance. In cases where the performance of a primary care trust deteriorated the Department considered that, under the existing accountability structures, it was for the relevant strategic health authority to intervene rather than the centre.

6. To support improvements in diabetes care alongside the Framework, in 2003 the Department appointed a National Clinical Director and established a national service improvement team called NHS Diabetes. However, neither the Clinical Director nor NHS Diabetes have the power to direct locally controlled NHS organisations and the Department relies on those organisations and staff involved in diabetes care being willing to listen and engage with the advice and support offered. For example, in early 2012, NHS Diabetes wrote to the 20 worst performing primary care trusts measured by the number of deaths attributable to diabetes. NHS Diabetes offered those trusts assistance in examining the causes of their poor performance but only three primary care trusts have taken up this offer of assistance and received practical support.

7. The Department told us that sharper lines of accountability would be established through implementation of the changes to the NHS commissioning structures set out in the Health and Social Care Act 2012. The commissioning of primary care services will no longer be the responsibility of local organisations and will be the responsibility of the new
NHS Commissioning Board, which will also provide leadership for the new commissioning system as a whole.\footnote{Q 71-73, 115-116, 121} In April 2013 primary care trusts will cease to exist, with responsibility and resources for commissioning secondary care services devolved to local clinical commissioning groups comprising groups of GP practices, doctors, nurses, and other health and social care professionals.\footnote{National Audit Office, Departmental Overview: A summary of the NAO’s work on the Department of Health 2010-11, September 2011, para 11} The Department told us the NHS Commissioning Board will possess powers to directly hold clinical commissioning groups to account, including the right to assume responsibility for commissioning where performance is poor, although the Department did not specify what level of poor performance would trigger such intervention.\footnote{Qq 74-76}

8. The Department has improved data on diabetes to support those commissioning, planning and monitoring services and some of the best performance management data the NHS now holds is on diabetes care. However, these data are not being used by the NHS to improve performance.\footnote{Qq 6, 7, 13, 122}

9. The Department’s cost data suggest that the NHS spent £1.3 billion on diabetes care in 2009-10 but this is based on poor quality information for primary and community services, where the majority of diabetes care is provided.\footnote{Q47, C&AG’s Report, para 2.20} Other estimates put the total cost to the NHS of diabetes at almost £10 billion, or 10% of the NHS budget.\footnote{Ev 24} While the Department recognised that its cost information does not take into account all expenditure on diabetes, it did not accept the validity of this higher figure.\footnote{Qq 47-48; C&AG’s Report, para 11} A projected 23% increase in the number of people diagnosed with diabetes by 2020, means that the condition will have a major impact on NHS resources unless the efficiency and effectiveness of existing services is substantially improved. The Department, however, has not estimated the cost of treating diabetes over the next decade.\footnote{Qq 107-109}
2 The Department’s approach to improving diabetes care

10. The Department explained that it had sought to incentivise improvements in diabetes care through the Quality and Outcomes Framework, the system through which GP practices are rewarded for undertaking specified clinical activities and achieving specific treatment standards. The Quality and Outcomes Framework was initially effective in improving the delivery of care and outcomes for people with diabetes in primary care, but these improvements have since plateaued. In particular, the payment structure financially rewards GP practices for providing individual tests to people with diabetes rather than all nine of those recommended. The Department agreed with the Comptroller and Auditor General’s recommendation to review this payment structure. The Department told us that it had written to NICE to ask NICE to consider whether there is a better way to incentivise delivery of expected levels of care.

11. The Department acknowledged that its Payment by Results tariff system for secondary care, which pays healthcare providers for clinical activity and was designed to increase capacity in hospitals, is not appropriate for incentivising the care required to treat a complex long-term condition such as diabetes. Diabetes requires integrated multi-disciplinary care but the Payment by Results tariff has created boundaries between providers all of whom are responsible for delivering diabetes care. In these circumstances providers are competing for payments rather than attempting to create a seamless care pathway in the best interests of people with diabetes. The Department said that it was piloting two new payment tariffs for diabetes that seek to incentivise best practice and improve long term care. The Department expects that from 2013 a third of the NHS will be covered by alternative tariff systems. The Department also explained it was seeking to encourage local investment in community and preventative services in order to reduce costs in secondary care.

12. Too many people with diabetes are developing avoidable complications because they are not being effectively supported to manage their condition and do not always receive care from appropriately trained professionals across primary and secondary care. For example, the National Audit Office found that just 5% of those diagnosed in the previous twelve months received structured education in 2009-10. People with diabetes in hospital currently experience poor care, lack of involvement in managing their condition and lack of access to specialist inpatient diabetes services. Around one in three people with diabetes experience a medication error during their hospital stay. Following discharge from hospital, people with diabetes are also more likely to be readmitted as an emergency, when...
compared with discharged patients without diabetes.\textsuperscript{35} Patient education, which can save costs and improve outcomes for people with diabetes, should be part of the NHS mandate, since extending choice and control for patients requires patients with long term conditions like diabetes to know how to manage their own health.

13. Multi-disciplinary specialist diabetes teams improve care for inpatients with diabetes, with better control of blood glucose levels, reduced length of stay and lower rates of admission and readmission to hospital.\textsuperscript{36} Outside secondary care, diabetic specialist nurses provide primary care teams with expertise in supporting people with diabetes who have complex needs, and training for health care professionals in the care they provide. Funding for specialist diabetes posts, however, is being withdrawn in some locations without consideration of the long-term implications of removing people with specialist skills from local health communities. The Department promised us that it would make it a requirement of commissioners to demonstrate that any short-term cost-saving decisions will not result in detrimental long-term consequences for patients.\textsuperscript{37}

14. The number of people with diabetes is growing and the Department estimates that the total number of adults with diabetes will increase from 3.1 million in 2010 to 3.8 million in 2020.\textsuperscript{38} Whilst the prevalence of the majority of diabetes-related complications, including heart failure, diabetic eye disease and the need for amputation have remained relatively stable in recent years, the rapidly increasing prevalence of diabetes means that absolute numbers of people with complications is continuing to increase.\textsuperscript{39} As many diabetic complications can take a number of years to develop, local investment in tackling these complications has suffered from institutionalised short-termism whereby the benefits of short term savings are seen to override the long term costs of delivering poor diabetes services.\textsuperscript{40}

15. Unless action is taken to improve public awareness of the risk factors for diabetes, the projected increase in the diabetic population could have a significant impact on NHS resources.\textsuperscript{41} The Department explained that it will be the responsibility of Public Health England to coordinate public health campaigns and that it plans to ring-fence money specifically for this purpose.\textsuperscript{42}

\textsuperscript{35} C&AG’s Report, para 2.16
\textsuperscript{36} Qq 9, 15
\textsuperscript{37} Qq 2-3, 89-91
\textsuperscript{38} Q 1, 17; C&AG’s Report, para 1.12
\textsuperscript{39} Q 87; NHS Information Centre, National Diabetes Audit 2009-10, 2011.
\textsuperscript{40} Qq 1, 12
\textsuperscript{41} Q 15
\textsuperscript{42} Q 99
Formal Minutes

Monday 22 October 2012

Members present:

Margaret Hodge, in the Chair

Richard Bacon
Mr Stewart Jackson
Fiona Mactaggart
Meg Hillier

Mr Austin Mitchell
Nick Smith
Ian Swales

Draft Report (Department of Health: The management of adult diabetes services in the NHS), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 15 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Seventeenth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report (in addition to that ordered to be reported for publishing on 12 June 2012).

[Adjourned till Wednesday 24 October at 3.00 pm]
Witnesses

Tuesday 12 June 2012

Baroness Young, Chief Executive, Diabetes UK and Professor Roy Taylor,
Newcastle University

Ev 1

Dr Rowan Hillson MBE, National Clinical Director for Diabetes, Sir Bruce Keogh,
NHS Medical Director for England, Sir David Nicholson KCB CBE, Chief Executive
of the NHS in England and Una O’ Brien, Permanent Secretary, Department of
Health

Ev 6

List of printed written evidence

1 Diabetes UK Ev 24
2 Association of British Clinical Diabetologists Ev 28
3 Chief Executive of the NHS in England Ev 29
4 Dr Rowan Hillson MBE Ev 30
List of Reports from the Committee during the current Parliament

The reference number of the Government’s response to each Report is printed in brackets after the HC printing number.

**Session 2012–13**

<table>
<thead>
<tr>
<th>Report</th>
<th>Title</th>
<th>HC Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Report</td>
<td>The Government Procurement Card</td>
<td>HC 1915</td>
</tr>
<tr>
<td>Second Report</td>
<td>Mobile Technology in Policing</td>
<td>HC 1863</td>
</tr>
<tr>
<td>Third Report</td>
<td>Efficiency and reform in government corporate functions through shared service centres</td>
<td>HC 463</td>
</tr>
<tr>
<td>Fourth Report</td>
<td>The completion and sale of High Speed 1</td>
<td>HC 464</td>
</tr>
<tr>
<td>Fifth Report</td>
<td>The Regional Growth Fund</td>
<td>HC 104</td>
</tr>
<tr>
<td>Sixth Report</td>
<td>HM Revenue &amp; Customs: Renewed Alcohol Strategy</td>
<td>HC 504</td>
</tr>
<tr>
<td>Seventh Report</td>
<td>Immigration: The Points Based System – Student Routes</td>
<td>HC 101</td>
</tr>
<tr>
<td>Eighth Report</td>
<td>Managing early departures in central government</td>
<td>HC 503</td>
</tr>
<tr>
<td>Ninth Report</td>
<td>Preparations for the London 2012 Olympic and Paralympic Games</td>
<td>HC 526</td>
</tr>
<tr>
<td>Tenth Report</td>
<td>Implementing the transparency agenda</td>
<td>HC 102</td>
</tr>
<tr>
<td>Eleventh Report</td>
<td>Improving the efficiency of central government office property</td>
<td>HC 288</td>
</tr>
<tr>
<td>Twelfth Report</td>
<td>Off-payroll arrangements in the public sector</td>
<td>HC 532</td>
</tr>
<tr>
<td>Thirteenth Report</td>
<td>Financial viability of the social housing sector: introducing the Affordable Homes Programme</td>
<td>HC 388</td>
</tr>
<tr>
<td>Fourteenth Report</td>
<td>Assurance for major projects</td>
<td>HC 384</td>
</tr>
<tr>
<td>Fifteenth Report</td>
<td>Preventing fraud in contracted employment programmes</td>
<td>HC 103</td>
</tr>
<tr>
<td>Sixteenth Report</td>
<td>Department of Health: Securing the future financial sustainability of the NHS</td>
<td>HC 389</td>
</tr>
</tbody>
</table>
Oral evidence

Taken before the Committee of Public Accounts

on Tuesday 12 June 2012

Members present:
Margaret Hodge (Chair)
Stephen Barclay
Jackie Doyle-Price
Chris Heaton-Harris
Meg Hillier
Mr Stewart Jackson

Fiona Mactaggart
Austin Mitchell
Nick Smith
Ian Swales

Amyas Morse, Comptroller and Auditor General, National Audit Office, and David Moon, Director, NAO, gave evidence. Gabrielle Cohen, Assistant Auditor General, NAO, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

Department of Health: The management of adult diabetes services in the NHS (HC 21)

Examination of Witnesses

Witnesses: Professor Roy Taylor, Newcastle University, and Baroness Young, Chief Executive, Diabetes UK, gave evidence.

Chair: Welcome, and apologies that we are a little late.

I will start by explaining our procedures. You are not our main witnesses this afternoon; we like to have a session before we come to holding the accounting officers to account. Experts in the field, which is where you both come from, give us some hints as to where they think the most important issues lie. It is a question of your trying to support the Committee and help us, and then we decide what line of questioning to take as we move to the accounting officers.

We try to hold this session in about half an hour. It is important that you tell us everything that you think is critical in our consideration of this very important area. I will start with you, Baroness Young. Tell us what you think of the Report and where you think the key issues are.

Baroness Young: We were pleased with the Report, because we think it reflects issues that we have been concerned about for some time—particularly the size and scale of diabetes as a condition and the fact that it is rising almost without abating. It is a serious condition; it is now the principal cause of blindness, amputation, stroke and kidney failure, and it is about 10% of the national health service budget, of which 80% is spent on the serious complications rather than on investment in the earlier part of early diagnosis, education for patients and good standards of care to meet the NICE standards.

We believe that the Report has fixed on the right issues and that there is a need to examine the priority with which diabetes is seen right across to the new national health service, from the Secretary of State going through the NHS Commissioning Board to the new commissioning arrangements at local level and to the new delivery arrangements at local level. We were pleased with the Report.

Professor Taylor: The Report is very impressive and draws attention to some really important matters. Perhaps cutting to the quick, the seminal information contained on page 30, in figure 11, lists the various costs attributed to diabetes. There may be a slight discussion about what exactly is in each cost heading, but I would like to point out that the huge cost of what is labelled ‘inpatient care’, but is really caring for the complications of diabetes, dwarfs all the rest.

We have to ask who these people who are costing so much are. If we look back a few pages to page 25, we see that of the number of people with complications who are costing so much, by far the costliest complication is chronic renal failure. There it is—third from the bottom. We find that only 0.08% of people with diabetes have it. Putting those two figures together leads to an inescapable conclusion that it is a moderately small proportion of people who are causing the major costs. Of course, we have a huge base of a pyramid in the population, but the Report tends to focus on that very high proportion of people who are the most costly, but by far the costliest complication is chronic renal failure. There it is—third from the bottom. We find that only 0.08% of people with diabetes have it. Putting those two figures together leads to an inescapable conclusion that it is a moderately small proportion of people who are causing the major costs. Of course, we have a huge base of a pyramid in the population, but the Report tends to focus on that very high proportion of people with Type 2 diabetes.

Of course, we must achieve the process of care, and that is important, but when we come to the nitty-gritty of cost we are actually looking at the people who are largely in specialist care: people with Type 1 diabetes, for whom complications affect their whole life and change their economic activity, which must be another focus; and people with complicated Type 2 diabetes.

That brings us to the process of specialised care, which involves an integrated team in any locality. There is a consultant clinical diabetologist and specialist nurses. There have to be close links with general practice and the diabetes foot service specialist nurses.

1 The correct value is 0.38%
The reason why I point that out so specifically and immediately is that that is what goes wrong when we look at the unevenness of care and the matter of failure of provision in some localities. We are looking at the necessary provision of integration and that has clearly failed under the current commissioning arrangements—in some areas more spectacularly than others. It will continue to fail with the new commissioning arrangements unless we have specified levels of commissioning for diabetes, specified by the new National Commissioning Board. Unless we specify what is to happen we should not be surprised if we perpetuate the postcode lottery that this Report reflects.

Q1 Chair: To be honest, this was one of the most depressing Reports I’ve read in the two years I have been Chair. It is depressing because everybody understands the enormity of the problem; nobody is arguing with the figures; everybody accepts both the nature of the checks and the treatments to prevent complications that should be done; money or lack of it has not been an issue; there appears to be a structure within the Department of Health with a tsar and a group of people whose job it is—and yet we are failing. Why?

Professor Taylor: The answers can be separated out. On the one hand, the nine processes of care are not being universally applied and they should be. However, the improvement over the past few years is reasonable, though slower than would be ideal. To see an effect of that improvement we are looking at a disease where the complications develop over years or decades, so we are too early to see that. You have to understand the nature of the disease: it is a long-term condition.

Q2 Chair: So, if nothing changed, if you were to look at the figures again in 10 years’ time, would they be better?

Professor Taylor: There would be some improvement at the rate of development of the major complications, yes, but only a modest improvement. Because over the past few years there has been a steady reduction in the number of specialist diabetologists, the ability of specialists to organise care at the sharp end—that has to be the locality integrated network—has just fallen apart in many places.

Q3 Chair: Why?

Professor Taylor: Sometimes the commissioners have withdrawn funding. I point out the example of Southampton where there has been a complete disintegration of specialist care to a disgraceful degree. The integrated service that used to be there, organised by the consultant diabetologists, has been split asunder. The consultants have been removed from the team where they perform effectively, with all sorts of bad effects for this small number of people with diabetes. However, as I pointed out, those are the individuals who get complications. That results in people from that area having to beat a path to other doors. I know, from my colleague in Bournemouth, that they receive referrals for, for instance, pump therapy. The standard of care that these individuals have received, just over the last little while, while commissioning has taken a wrong path and there has been a big problem at the centre of care—not in primary care or in the delivery of the nine processes, but at the sharp end, where the complications are. So you see, there is a major problem that isn’t really highlighted in this Report.

Q4 Ian Swales: Can you say more about the organisational aspects of that? You were saying that there has been a disintegration. That’s an important learning point for us. Can you say more about why you think that has happened and how it might have been different? Where are the, if you like, managerial responsibilities for the situation that you describe?

Baroness Young: May I put it into a slightly broader context, because I think that that casts light on it? It seems to me that part of the issue with diabetes is, if you look at cancers, stroke and heart disease, there have been big, national, high-profile awareness-raising campaigns. Priority has been given in the NHS operating framework. There has been a real push through national processes and supported local networks to address areas where there has been failure.

We have never had that in diabetes, partly because stroke, heart disease and cancers are life-shattering events that occur suddenly, and are therefore seen as life-threatening. In fact, diabetes reduces life expectancy anywhere between six and 20 years. It causes 24,000 avoidable deaths every year, which is the size of a small town.

I think that part of the problem of disintegration of local networks and wrong turnings taken by commissioners has been because there has been none of that system-wide focus on diabetes, where if that was beginning to happen and poor outcomes were beginning to come through, both in delivery of the nine recommended NICE standards and in terms of the outcomes, there would be action taken to remedy that. At the moment, the only co-ordinated national action that really has had priority has been to produce better information about how we are failing to have the standards delivered.

Q5 Ian Swales: Are you saying that national commissioners need national and central direction?

Baroness Young: I certainly think that there need to be strong signals. We need there to be a strong signal that diabetes is truly seen as a priority. For many avoidable deaths, diabetes is the root cause. It is now the biggest root cause of death by stroke, heart disease and end-stage kidney failure. The reality is that showing that diabetes is a priority is the first step. There needs to be something in the mandate to the Commissioning Board. The Commissioning Board needs to be very clear about its expectations in the commissioning outcomes framework. There needs to be some process for watching the data on the delivery of the standards and on the outcomes. If they are not being met with individual commissioning groups, the Commissioning Board needs to be very clear as to what sanctions it will use and what levers it can deploy. For the Commissioning Board simply to set an outcomes framework that is
guidance to commissioning groups and then not have a clear answer as to what it would do if diabetes care continues to be poor, would really be a denial of their responsibilities.

Q6 Ian Swales: May I ask just one final question? You have some statistics there of acute conditions that you said were caused by diabetes—deaths and so on. Are you confident that those kind of data are available within the NHS and to the management of the NHS, or are those data collected by your charity—and therefore you might have a different picture to NHS management?

Baroness Young: Diabetes information is probably one of the best developed information systems in this country. It is very much a shared system, where we all play our particular role in the gathering and management of that information, so we are all working from the same hymn sheet.

Q7 Ian Swales: So the enormity and urgency that you talk about should be transparent to the management of the NHS, and all those data and so on should be clear. Can you represent?

Baroness Young: Certainly, over the past four years since we have had the national diabetes audit, the quality of the data has been improving about comparative performance. We certainly, on an annual basis, shine a spotlight on it by our state of the nation report that shows what the variation in performance is across the country.

Q8 Meg Hillier: I have one question that you might want to cast light on. I understand that if a woman is sugary when she conceives, there is a much higher risk of disabling the child. That is not included in the figures for complications. I wonder whether both of you, or perhaps Professor Taylor, could give us an idea of the level of incidence so we can extrapolate from that the cost to the public purse long term.

Professor Taylor: The cost of this is very considerable. Let me just specify that this relates largely to pre-existing diabetes. There are particular risks there, especially failure of proper development of the child, with huge costs for society. That is specifically insulin-treated or pre-existing diabetes. However, gestational diabetes comes on in pregnancy and really is a forerunner of Type 2 diabetes.

This is something that has been fanned by the obesity epidemic and is becoming a major issue. It causes problems in childbirth, increased length of stay and increased pressure on special care baby units. Our own data show that the admissions with Type 2 diabetes mothers to special care baby units are more common than with the other kind. It is very common, and it is highly important.

Q9 Meg Hillier: Can you give us a rough figure for how many women with Type 1 would then go on to have problems with their birth or with disability in their children?

Professor Taylor: It is difficult to give a precise overall figure. I can tell you from national data that the level of complications, meaning congenital malformations, rises from about 7% with reasonable control—from, incidentally, almost 2%, which is the background with very good control—to about 25% if control is poor. That reflects on my point about the integrated locality team; we have to have that team. The team involves the GP, who is at the sharp end dealing with a lot of people and able to give information; we have to have the specialist nurse, who is able to give hands-on advice and to advise; and we need the consultant physician, dealing with this really difficult and specialised area. That has to be there.

In a way, my answer to that reflects on a comment on the previous question. The components of this locality team, which have to be specified by the commissioners—in other words, the central commissioning body—are quite simple. We need this body to be in place. It will have a different shape in different localities, because of the different nature of each particular area. However, it is a relatively simple matter to improve the health of women and their babies, which is of profound importance.

Q10 Meg Hillier: In the past, there were targets and incentive payments to GPs to do some of the testing, and my local hospital team have said what a difference that made. That was in Hackney, where we have some very innovative working at primary care level. Do you have any comments about whether that worked and whether, under the new models in the NHS, you think that would continue to work?

Professor Taylor: Just very briefly, yes, it has worked. It has made quite a difference. However, the structure of the QOF targets and the payment is such that it does not encourage achievement of almost 100%. The structure could be revisited, but the impact of payment for results in this respect has been a big success.

Baroness Young: Perhaps I could just qualify that, because I think it has been a success in so far as more people are now being offered the nine care processes. Two things: one is that there are still an alarming large number of people who do not get all their care processes, so I do not think we should celebrate too much the success of QOF. Also, the care processes themselves are not enough to achieve the outcomes. We are still seeing a considerable number of people across the country who are failing to reach targets for three key outcomes: their glucose control, their cholesterol and their blood pressure.

At the moment, in terms of even the basic care processes that QOF incentivises, we are seeing fewer than half of people with Type 2 and less than a third of people with Type 1 getting all their nine care processes every year. Although QOF has been an improvement on what was in existence previously, it still has a very long way to go both in delivering those care processes and delivering the treatment targets—the outcomes.

Q11 Meg Hillier: Just to be clear on the procedures, with the new commissioning arrangements, will the QOF targets continue?

Chair: I think we have to ask our other witnesses that.

Q12 Mr Jackson: Following on from what Miss Hillier said, isn’t the central issue that the costs of establishing a multi-disciplinary, clinician-led diabetes...
team in PCTs and acute district hospitals are such that, short term, it is more difficult to establish that sort of thing set against the benefits of preventing blindness, stroke, heart attacks and amputation all those years ahead? So there is a sort of institutionalised short-termism. Is that not really the story of clinical frameworks across the NHS, full stop, in that we all agree that clinical frameworks are a good idea, but when it comes to cash and recruitment and retention in individual PCTs, it is very difficult? Following on from what Meg said, how do you see that developing and improving with the new clinical commissioning groups?

**Baroness Young:** I will comment first on that; but I am sure that Roy will have something more to say. It seems to me that you must divide the benefits of getting these integrated care pathways in place into two chunks: short term and long term. There is no doubt that if we can get the right sort of specialist care in hospitals as part of an integrated care pathway, there are ways in which you could see a rapid reduction in the lengths of stay of people with diabetes. At the moment, if you go into hospital with diabetes, even if you are going in to have your sinuses drained, you will stay for an average of two or three days longer, and that is a real cost. If we had that integrated care pathway, and proper specialist care as part of it, we would see less foot pathology developing as a result of in-patient care. These are comparatively short-term improvements that would begin to produce cash.

To be frank, I do not think that setting up the integrated teams locally is a huge expense. Many of the professionals are there. It is a question of how you get them together with a little bit of management and administrative support to ensure that the network functions effectively and of how you actually give that network the responsibility for planning and delivering the shape of care, for monitoring their performance against the national performance indicator set and for making changes if they are not coming up to scratch on particular performance indicators. A bit of support on that can make a huge difference and can produce some very fast savings.

In terms of the longer-term reduction in complications, as Professor Taylor says, that is a much longer proposition. I would say, however, that if we are going to get locked into a system in the new NHS that can only make short-term decisions, we have the wrong solution, because, quite frankly, it is the decisions that we make now to get better care for the people who are going to be diagnosed next year and the year after that will have the big impact on these longer-term complications. We have to start now, because we have a shed load of trouble waiting in the wings already.

**Q13 Mr Jackson:** Following on from that, a quick supplementary: do you think that the Department is doing enough to provide qualitative and quantitative data—particularly quantitative data—to each PCT, or clinical commissioning group in the future, to show the cost-benefit analysis of this particular course of action?

**Baroness Young:** I think that the data that is available and that is being presented to PCTs should drive performance. Unfortunately, it is not driving performance, so we believe that there are several things that need to happen for the future. We need priority setting by all the levels to give diabetes its place in the priority list, and that needs to drive action on four things locally. The first is an effective risk-assessment and early-diagnosis process through the national health service vascular health check, where only about a third of those who should be screened are currently being screened. We need proper education for people with diabetes. For many days, weeks and months, they self-manage, so less than 20% of people get education at the moment. Everybody who is diagnosed with diabetes should get some education to help them self-manage their condition. We also need proper processes to ensure that the delivery of those key care processes that NICE has recommended does actually happen for all patients across the country, and that should be delivered by these integrated pathways of care, underpinned by networks.

The NHS Commissioning Board needs a process to ensure that that happens. It needs a process of priority setting. It needs a process of taking action. There is absolutely no point in doing what, to some extent, happens at the moment, which is that we have better and better information about a failure to deliver the nine key processes and achieve improvement in the outcomes.

**Professor Taylor:** May I add an important rider on there? The question is the really important matter of the dislocation between in the short-term input and the long-term nature of complications. This has led to some unfortunate commissioning decisions, but also brings up a really important point. Diabetes is very much a Cinderella speciality—its importance is not fully recognised by other specialities. That might seem a curious thing, but the heart doctor for example is focused on the heart—for instance, there are various causes of the disease, but it has to be dealt with at the moment. With all the competing priorities for funding, diabetes drops down the list. That is why we need very clear specification of what each locality must do, with teeth to follow it up.

Even when there is not a long period of lead-in for complications, there is still the same problem. I would point out the recent in-patient audit of care of diabetes in this country, which is a complete shame on the country. For instance, one person in three suffers a medication error. Of that group of error patients, the risk of severe low blood glucose attack is twice as much as anyone else. Now, you might think a low blood glucose attack will pass. Well, no, it might cause a fractured hip, a fractured arm—a much longer stay in hospital not captured by the statistics. Do hospitals respond to this individually? Well, they don’t for the same reason—we’re dealing with a Cinderella. Unless there is central specification by, for instance, the new Commissioning Board, of minimum care
expected—this is part of the integrated team I mentioned before—then we will continue to see this.

Q14 Fiona Mactaggart: Professor, I specifically wanted to ask about that point—the number of medication errors for in-patients. Why do they happen? It is in the Report, but it is an extraordinarily high number and I am wondering if you could just explain to the Committee why, in this area, we have such a hugely high number of medication errors.

Professor Taylor: One of the prominent causes is the fact that we are dealing with an agent that is prescribed in infinitely variable amounts, different kinds of this agent and an agent that is not understood by those using it—I am talking about insulin. Insulin, of course, has been brought to the popular attention by Claus von Bulow, Beverley Allitt—this is a lethal drug. So it is both lethal and it is properly prescribed in anything from two units to several hundred units. The individual nurse on the ward may not completely understand the difference between NovoMix and NovoRapid, for instance—two very different insulins. It is a problem of education of staff. Why haven’t we cracked this? Of course, we have, but this rate of turnover of the general staff on the ward is such that it is very difficult to do this.

I have been a consultant for 27 years. I have taken a particular interest in in-patient care and I used to be proud of the system that we had in the Royal Victoria Infirmary in Newcastle. However, with the changes of staffing, which have happened for other reasons, there is more rapid turnover of both the junior medical staff and ward staff. We are dealing with a rapidly flowing river that we are attempting to regulate. So, it is the nature of the beast. It is a really difficult thing to control. How can we do this better in a cost-effective manner? Well, we can have adequate levels of diabetes specialist nurse input and the appropriate level of recognition of specialist input, especially specialist podiatry input in hospital. People who develop foot ulcers in hospital are not really picked up in the statistics as being major disasters, but these are major complications that have been caused by the health system. Again, we have short-term production of complications for lack of really quite a simple system.

Baroness Young: May I give a bit of credit to NHS Diabetes on this one? The tsar and NHS Diabetes have been working hard to try and train up the national health service to understand insulin better and to understand insulin safety better. There have been improvements as a result, but there is still quite a long way to go, as Professor Taylor says. We should commend NHS Diabetes and the tsar for the excellence of the information that has been produced in the past few years that allows us to know about some of these things. The big problem is, how do we get to a point where that good information about some of these difficulties is actually translated into action nationally and locally?

Q15 Nick Smith: I want to come back to that. I have been hurriedly taking notes for the last 15 minutes or so, given your evidence—thanks very much—but Baroness Young, at the start, you talked about the need for a system-wide focus on diabetes, and then you mentioned the success of stroke campaigns and others. We all hear what you have to say about integrated teams, but what are the three or four top learning points that you think colleagues have to concentrate on?

Baroness Young: They are about getting national awareness campaigns going so that the public understand the priority of diabetes, and so professionals understand it too. It is about making sure that the new commissioning system is clear what it has to achieve—that is, the delivery of the NICE recommended care standards and the delivery of improved outcomes, and ensuring that that is built into the tasking of the new commissioning arrangements, the monitoring and the—whatever you like to call it—sanctions, controls, corrections or whatever, where there is failure in the system. I do not mean abject failure; I mean for the bottom 30% or 40% of the performance array that is totally unacceptable at the moment.

The four key deliverables for us are a better early diagnosis and risk assessment process; universal education for nurses and patients; putting in the safe system; and making sure that there are these integrated pathways of care with multi-disciplinary teams underpinning them on a local basis—not regional networks or high-flown thinking at a much higher level. It is about patients, nurses, doctors, podiatrists and dieticians who actually deliver the service getting together, looking at what is needed, looking at their data, and making improvements, and being tasked with that job of making improvements.

Q16 Chair: Professor Taylor, do you want to add anything to that? I am conscious that we probably ought to move on.

Professor Taylor: Just to opine that the National Audit Office report is remarkable for what it does not emphasise—in other words, the central role of a specialist team approach, which is really rather low-cost, but it just has to be recognised. When that very simple matter goes awry in a district, then we have real problems or complications. There are the short-term complications of disastrous foot ulcers developed in hospital and of hospital errors, and also the longer-term complications that will be with us for a while, so integration and organisation cannot be achieved without that being specified from the top. If we leave clinical commissioning groups to their own devices, we will continue to see the patchiness that we have at the moment.

Chair: Ian, a very tiny last question.

Q17 Ian Swales: I understand, it will be a very quick one. There is an area we have not touched on at all, because obviously, we are talking about cure rather than prevention. Can you say very briefly how you see the prevention side of this, in terms of the new public health responsibilities? Obviously, we want fewer people to be entering the net and clearly, as you said earlier, the numbers are rising. I wonder whether
the feedback loop from all this back towards prevention can be improved, and how we might do that.

**Baroness Young:** It seems to me that prevention falls into two categories. One is primary prevention—dealing with obesity, getting people more active, and getting them to eat more healthily—and that issue is going to be shared across diabetes, cardiac disease and a variety of other conditions. It will be really crucial for the public health function and for the health and well-being boards to grip that.

We are choosing, at Diabetes UK, to focus on a slightly different issue, which is the 7 million people who are out there at risk. Unless they get good lifestyle advice and are shown what their risk factors are, they could well progress to developing diabetes.

If we can find those people by having a good NHS vascular screening health check that really brings hard-to-reach people into the screening process and detects them early, they can be given lifestyle and activity advice if they are pre-diabetic, and if they already have diabetes, they can get early treatment to avoid complications wherever possible. At the moment, 50% of people who are diagnosed have already developed complications. That is unacceptable.

**Q18 Chair:** Fifty per cent?

**Baroness Young:** Fifty per cent of people diagnosed already have signs of complications.

**Professor Taylor:** I would see it as two particular areas, one of which is a matter of food policy. We really need seriously to consider a sugar tax, which works effectively in other countries. For each 10% increase in tax you get an approximate 10% decrease in consumption of a product. We need to approach the matter of portion size and the labelling of goods. I point out that Starbucks is doing extremely well because that small, innocent little cake is more than 400 calories. Those are important points.

Food policy is one side of it. The other side, which is often neglected, is transport. Why transport? Well, it is all about energy expenditure, because we are talking about a balance. There is no doubt that many of us might like to do more exercise, but people tend not to. However, if people have to walk or cycle to work, or whatever, that actually makes a profound difference to the energy balance of a population, and balance is what we are on about. This is not a matter of dressing up in lycra and gong running. Few people do that, although it benefits them. We are dealing with a population. We need to grasp transport policy for energy expenditure, and we need to grasp food policy for the input side.

**Q19 Nick Smith:** I note that the Mayor of London, following the mayor of New York, has talked about banning mega-size sugary soft drinks at entertainment venues. Do you support that?

**Professor Taylor:** I think Mayor Bloomberg is absolutely correct in pointing out that there is a real problem with portion size, expectations and habits, which can be changed. That is relatively simple, and it can be done. Such a ban would be highly effective.

**Baroness Young:** We would very much like the Committee to recommend that the National Audit Office has another look at this in a couple of years, because we believe that in the period of change that we are going through with the NHS commissioning arrangements there is a real risk that diabetes goes back, rather than forward, in the intervening period.

We would very much like a repeat visit.

**Amyas Morse:** We will certainly keep that under consideration.

**Chair:** That is the non-answer. We will try to come back to it in two years’ time.

Thank you very much. That was very clear and very helpful, so a grateful thanks to you.

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**Examination of Witnesses**

**Witnesses:** Dr Rowan Hillson MBE, National Clinical Director for Diabetes, Sir Bruce Keogh, NHS Medical Director for England, Sir David Nicholson KCB CBE, Chief Executive of the NHS in England, and Una O’Brien, Permanent Secretary, Department of Health, gave evidence.

**Q20 Chair:** Welcome.

**Sir David Nicholson:** Thank you.

**Q21 Chair:** I am going to start with Dr Hillson. I am grateful, because I know you have come at very short notice. As I understand it, you have been in the job for four years. That is right, isn’t it?

I want to pick up on where I was with the previous witnesses. We know what works, and I don’t think money has been a constraining issue. You have been in post, you have your unit and you have a policy group within the Department of Health, so why do you think you have not been able to do better than you have? I accept that there has been some improvement, although nine trusts have gone backwards. You look at this as a lay person—you are not the lay person, I am—and you think, “Why, with all that knowledge and everyone’s general acceptance of what needs to be done, haven’t we done better?” What is your view after four years in the job? Why have you not done as well as cancer, heart or stroke?

**Dr Hillson:** Thank you. First, it is like climbing a very steep mountain that gets higher every day. We are quite a long way up the mountain, but we have got a long way to go, because the number of people with diabetes has doubled since the national service framework started. The numbers are going up all the time.

There have been differences between what was available for diabetes and for cancer and for other specialties in that they have recurrently funded local networks, which have not been available to diabetes, although we have got support from the national NHS diabetes team. We have made improvements. The numbers of people who have had—
Q22 Chair: Can I stop you? On the networks, do you mean that if there had been money around to enable you to bring people and specialists together, you might have had a bigger impact on changing behaviour within PCTs and providers?
Dr Hillson: That would certainly have helped. We have been doing work with the national network that we have and we have been working with the PCTs.

Q23 Chair: Okay. I should have said this at the start, because it is such a complicated subject—I accept that there has been some improvement, but the thing that shocks us, if I am honest, is, because it is as area where it is so blodden obvious what needs to be done, why have we not been better at doing it? One is that you did it in the national networks. What else inhibited you?
Dr Hillson: The numbers going up definitely made it more challenging, because the numbers have literally doubled. There are variations in practice and organisational practice. There are variations in how PCTs organise themselves.

Q24 Chair: Why have you not been able to get in there to do something?
Dr Hillson: The PCTs were all offered help by NHS Diabetes—all 151—in commissioning of care and in looking at their results.

Q25 Chair: And why did some take it and not others?
Dr Hillson: I think that that is up to the PCTs. Some 78 took up the offer.

Q26 Chair: But what levers did you have?
Dr Hillson: 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. It might be sensible to ask Bruce or David about that. What I can do is encourage, support and lead.

Q27 Chair: Would you have liked to have sanctions?
Dr Hillson: It can sometimes help.

Q28 Chair: Would you have liked to have targets of some sort, or would that have been anathema to you?
Dr Hillson: We do have targets. We have the targets that NICE has set, which are clinical ones. We have those already. We have the NICE quality standard, which I very much encouraged and supported, and which has reinforced those targets. So we do have targets. We have the Quality Outcomes Framework, which has helped to drive up some of the improvements, although we do now need to look at how it can be encouraged to drive up further improvements. There were mechanisms and that is one of the levers.

Q29 Stephen Barclay: Can I just clarify something? You just said that all PCTs were offered help, but it is up to the PCTs.
Dr Hillson: It is, yes.

Q30 Stephen Barclay: So from your point of view, if you have significant outliers and if you have PCTs where the performance is getting worse, that is an issue for the local management of the PCT, not the centre.
Dr Hillson: It is an issue for both. The PCTs were offered help and they are always given their figures each year with the audit. Also, the SHAs were given direct access to the figures.

Q31 Stephen Barclay: Sure, but if they are not acting, they are getting worse and the evidence shows that they are getting worse. If we take Barking and Havering, the Chair’s very own PCT, that is just one example of where the performance deteriorated. They have been offered help and the trust is getting worse. What are the steps that you then take?
Dr Hillson: They are offered more help and, as I have said, the SHAs have been informed.

Q32 Stephen Barclay: But from the centre? Is there a role—perhaps this question is more for Sir David—because there are value for money implications on this? We have discussed this in a previous hearing, where your evidence, Sir David, was that it was an issue for the foundation trust board to address outliers, not for you as accounting officer. I think that that is a fair summation of what you said in the previous hearing. Could you clarify what you see as the role of the centre in addressing outliers?
Sir David Nicholson: In terms of diabetes or generally?

Q33 Stephen Barclay: Diabetes as a specific. Sir David Nicholson: The way in which the NHS management is set up at the moment—as you know, it is changing—is that we have an operating framework, which we set out at the beginning of every year, which sets out those things that we take national action on and interest in and which we perform manage rigorously through the system. It then has a series of issues where it is for local organisations to benchmark themselves and identify their continuous improvement progress. If that does not happen—if people go backwards—it is the responsibility of the SHA in those circumstances to intervene with that organisation.

Q34 Stephen Barclay: So it is the SHA in your view, not the Department or you as accounting officer?
Sir David Nicholson: Well, they are all part of my system. I do not personally intervene. It is unusual for me to intervene personally although, interestingly in Barking, Havering and Redbridge I have personally intervened.

Q35 Stephen Barclay: This goes to the crux of the accounting officer responsibilities. Of course no one expects an accounting officer to intervene personally, but your duty, as I understand it, is to have the right

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2 The name of the PCT is ‘Barking and Dagenham’.
3 The factual accuracy of this statement depends on the area being discussed—if the performance measure is delivery of care processes then Barking and Dagenham’s performance did not deteriorate between 2006/07 and 2008/09. However Havering’s performance did.
processes to pick up where there is a failure. What we have in this Report is outliers where performance has got worse in successive years but there has not been any intervention from the centre. What you are saying, if I understand you correctly, is that that is an issue for the SHA not for you as accounting officer.

Sir David Nicholson: I would expect the SHA to intervene in those circumstances.

Q36 Stephen Barclay: And not you as the accounting officer?

Sir David Nicholson: No. Chair: But the SHA—

Q37 Stephen Barclay: Sorry, Chair, could I just finish this point? I raised this with Sir Nicholas Macpherson, the Permanent Secretary to the Treasury. He said: “I think if there was a persistent set of outliers and there was no sign of improvement, that sounds to me that you have got a system problem and at that point, rather like with local authorities, which Bob has been very much involved with, you would begin to turn up the volume and maybe take action. In extremis you should be able to step in.” So he as the Permanent Secretary to the Treasury said that and Sir Bob Kerslake gave a very similar view that where there is systemic weakness you need to look at how the system works. That does not seem to be your approach as accounting officer.

Sir David Nicholson: No. For those things that we identify as national priorities that is exactly the case. I would expect the centre to intervene in those circumstances. But as you know, health care is wide ranging and geographically and population wise, quite different in different parts of the country. For those other areas we expect local action to be taken or the SHA should take action. You cannot possibly intervene from the centre every time a number goes in the wrong direction in a particular locality.

Q38 Jackie Doyle-Price: In that case, Sir David, can I just ask for your reflections on para 3.12 of the Report? It deals with the specific point that neither the clinical director nor NHS Diabetes have the power to direct NHS organisations. Dr Hillson has just set out that all the trusts were offered support. But this part of the Report says that in 2012 NHS Diabetes wrote to the 20 worst performing primary care trusts, measured by the number of deaths. We have been talking about serious evidence. Only three responded to that offer of assistance with only one receiving practical support. Where is the accountability there?

What has gone wrong? Why are they not responding to the challenge?

Sir David Nicholson: I cannot comment on the individual cases because—

Q39 Stephen Barclay: Why did the Department write if you were not responsible?

Dr Hillson: Forgive me, but NHS Diabetes wrote. We have now had responses from six and we would write if reports come in where there are outliers. We have done the same with in-patient mortality before the results were published offering them a chance to look at the results and offering them help.

Q40 Jackie Doyle-Price: Which is the one that has taken practical support?

Dr Hillson: I cannot tell you at the moment but I can let you know later about all of them.

Q41 Chair: Ian wants to come in as he has to go. But it is shocking that in a sense you are being very—I don’t usually feel it from you—but it is a very bureaucratic question that you are giving us.

Sir David Nicholson: I was asked a bureaucratic question.

Q42 Stephen Barclay: It was a question about where accountability sits for value for money. You are the value-for-money officer, Sir David.

Chair: The Report says 24,000 people are dying a year who should not die. That is a pretty shocking stat. Yet you come to us and say, “It is not a priority so I’m not going to take action on it.”

Sir David Nicholson: No, I am not saying any of that. There are two things. First, I do believe that the Report is unbalanced. I know you don’t want to talk about how well some of these services have done because there is a really good story in terms of service improvement underneath all of this as well. But on the other side, what I am saying is that in terms of the way the system works—there are rules around it—national action is taken. Either it is escalated to us or there are particular issues that we identify as national priorities.

Q43 Chair: We will come to the future in a minute, but, as I understand your answers to my two colleagues, you, as ultimate accounting officer, have said today that this is not a national priority, and it would be better if you didn’t intervene. It is almost as though you are saying you don’t give a toss that 24,000 people die unnecessarily.

Sir David Nicholson: Anyone who knows anything about me, or what I do, would say that this is not true.

Chair: Quite. So why have you said that?

Sir David Nicholson: I have not. If you take the 24,000, for example, that is a calculation of excess deaths across the country. We genuinely do not know how many of those were avoidable.

Q44 Chair: I thought that you accept the figures, and that is why I started this whole inquiry. The NAO Report, Diabetes UK and the academics are at one on the figures and the stats.

Sir Bruce Keogh: I am sorry, I have to intervene.

Q45 Chair: Why didn’t you say when the Report was written that you did not accept its figures? I hate it when that happens.

Sir Bruce Keogh: If you will let me say what I’d like to say, which is—

Chair: Well as long as it does not contradict—

Sir Bruce Keogh: There are 24,000 excess deaths. That means that there are 24,000 people more with diabetes who die than an equivalent population who do not have diabetes. It does not mean that they are avoidable, and we need to be very, very clear about that.
Amyas Morse: We are not saying anything different from that. We are not saying that everyone in the UK—
Sir Bruce Keogh: I know that you aren’t, but Diabetes UK are. The term “avoidable” was used in a previous—
Chair: I don’t know what “excess deaths” means. That sounds to me like another bureaucratic response.
Sir Bruce Keogh: It is a statistical term that is well recognised epidemiologically. It is not a bureaucratic term.
Chair: Well, it might be epidemiologically, but just as a lay person who cares about people living or dying, “excess deaths” strikes me as people who should not have died.

Q46 Stephen Barclay: How many more people would need to die for it to be of national importance to the centre, Sir David?
Sir David Nicholson: Many years ago, we identified nationally what were described as the big killers—
those conditions that had the biggest impact on mortality. We have been going through that list systematically; so, we started off with coronary heart disease and cancer, and we moved on to stroke, COPD and liver disease. We have looked at each in terms of where our action could have the biggest impact on mortality. Tackling the issue of mortality is what we have been doing over the past few years.

Q47 Ian Swales: Can I come at this from a slightly different angle? I think it was Baroness Young who said that she believed that 10% of the whole NHS budget is spent on this. Do you recognise that figure?
Sir David Nicholson: No.
Ian Swales: So what is your figure?
Sir David Nicholson: In our programme budgeting the figure is just over £1 billion, but does not take into account all the money that is spent on people with diabetes. The NAO has come up with a figure that is significantly more than that, but certainly nothing like 10% of the NHS budget.

Q48 Ian Swales: Why would Diabetes UK have anything like that figure in their mind? Is it because they see the whole end-to-end cost and perhaps you are not looking at it like that?
Sir David Nicholson: My understanding is that they have taken social care costs of diabetes into account.
Chair: I’m afraid that, behind you, Baroness Young is saying “No”.

Q49 Ian Swales: I asked the question because mortality is clearly incredibly important in terms of priorities, but we are also the value for money Committee, so how the NHS spends its money and whether that is avoidable in any way is a key criterion for us. What assessments have you made of the spending on diabetes and the extent to which you could manage that better and reduce that expenditure as a result of better processes and better care?
Sir David Nicholson: We have done the analysis. You can see some of the figures here. We believe that it can be managed much better. We believe that the investment in community, primary care and preventive services needs to be increased, and that the amount of money spent on hospital care needs to go down. So we are absolutely at one. The issue is: how do you do it?

Q50 Chair: You have had 10 years. Why haven’t you done it in the last 10 years?
Sir David Nicholson: We have done it in the last 10 years. If you think about 2004, 16,000 people had all nine of the things done to them. In 2010, it was nearly 1 million. There are very few bits of the developed world that can say they have made that kind of progress in diabetes in relation to that particular thing. There has been significant progress in doing all of this. Over 1 million people now have that. The rate of amputation across the NHS has gone down during that period.

Q51 Ian Swales: May I add one point to that? Clearly anyone watching this hearing who has diabetes or who might get it will be very interested in this question of priorities. Dr Hillson said earlier that the number of sufferers has doubled and we are in a sort of—I do not think she used the word “exponential,” but I think she said that the mountain was getting higher and higher. Where is diabetes in your priorities now, and where do you see it going in terms of action?
Sir David Nicholson: As you know, we are in a transition between two systems at the moment: from the operating framework that indentified a series of national targets—waiting lists, money and all those sorts of things—to an outcomes framework set of processes. So we are halfway through that change in process at the moment. If you think about diabetes and the outcomes framework—I do not know how much you know about the outcomes framework—
Chair: You told us a lot about it previously.
Sir David Nicholson: Excellent. There are five elements to that, and diabetes is in each one of those, so it is important.

Q52 Chair: Is it mentioned? Are you mandating action by anybody in your draft outcomes framework on diabetes? Is the term mentioned?
Sir David Nicholson: When you get the outcomes framework, what you get—
Chair: You get more people have got to survive.
Sir David Nicholson: What you get from the outcomes framework is a set of arrangements in relation to mortality and what our ambition is for reducing mortality.
Chair: But that does not mention diabetes.
Sir David Nicholson: No, no, but the point I am making is that you do all of that and then you start to think about how do you make that more specific. The first thing you do is to identify a NICE quality standard for diabetes, which we have done.
Chair: Ten years ago.
Sir David Nicholson: No, no. How long ago?
Sir Bruce Keogh: Last year.
Sir David Nicholson: There is a NICE diabetes evidence-based quality standard, which you publish and put in everybody’s hands. Then you measure people according to whether they achieve that.
Stephen Barclay: The SHA is—
Sir David Nicholson: It is a national system.

Q53 Chair: Let me get this clear. Are you telling me on the neurological conditions, you also gave us a spiel on this, which your response does not seem to bear out—that when you establish the outcomes framework, there will be in there something on diabetes that says, “You will be expected to do the checks” or “You will be expected to do the treatments”? What is going to be in there with the term “diabetes” in it?
Sir David Nicholson: I am sure that someone will talk about more of the clinical detail than I can, but what will come out of that is a series of commissioning guidance that will set out what we expect commissioners to do.

Q54 Chair: On diabetes? I am trying to tie you down—not on generalities, but on diabetes?
Sir David Nicholson: We have not finally worked out how this is going to work at the moment. We are still working through that. It could be, for example, that you have commissioning guidance around mortality that includes diabetes. You could have commissioning guidance in relation to the management of long-term conditions, in which you would put diabetes. It may be that there is not something called “diabetes commissioning guidance” but you put it in others. We have not come to a conclusion yet on how best we should organise that. But, inevitably in those circumstances, given the scale of the avoidable admissions and the evidence about what works, diabetes will be a priority for the NHS going forward.

Q55 Chair: Sir David, the only reason I am asking—I am hogging things too much, so I will next go to Stewart and Fiona—is we had you up on neurological conditions and I thought, “He’s going to go away, take up some of these recommendations and we’ll see them.” Actually the report then comes back—and we will have you back on that in a separate session—totally refusing to implement any of our recommendations. I want to hear something clearly on this. I do not want to hear whether it is going to be mortality. From what I read in this Report on diabetes, everyone knows what the problem is, everyone knows what works and there is not an issue about there not being enough money for it. In this outcomes framework, will there be mandation down the system for people to do both the tests to see whether people have diabetes and the treatments to stop the risk of complications? Will that be in there—yes or no?
Sir David Nicholson: There will be all of those things that come out of the—whatever arrangements we have.

Q56 Chair: Saying “diabetes”. I am trying you down because of our failure to get this on the—
Una O’Brien: The NHS outcomes framework is already out there and was published some time ago. What is about to happen, to help the Committee, is that before the summer recess we will be going out to consultation on the mandate.

Q57 Chair: Will you mandate around diabetes?
Una O’Brien: The NHS outcomes framework is part of the mandate and we are going out to consultation on it. As we explained before, the outcomes framework has five domains. Within each of those are improvement areas.

Q58 Chair: I understand that. I am just trying to get a specific answer to a specific question, because it would help the Committee to know whether there will be mandation in the system—whether to commissioning bodies, to GPs or foundation trusts—that thou shalt do.
Una O’Brien: We can answer that at the end of the consultation process. There are, as you know from the previous hearing, a lot of other people who want their bit mandated.

Q59 Chair: That is waffle. Is it in the consultation document? Are you consulting that there will be mandation around the risks? It is the nine things and then the three—it is so bloody simple. Will there be a mandate around that in your consultation document?
Una O’Brien: As I explained, we will be going out to consultation. There are many patient groups from a different range—

Q60 Chair: Will it be in there, Una? All I want to know is yes or no.
Una O’Brien: At the moment, I cannot say whether it is in there or not, but diabetes is covered by all five domains.

Q61 Chair: No, it is not.
Una O’Brien: It is.

Q62 Chair: The history that comes out of this is that because it was not prioritised in all your previous outcomes frameworks, things did not happen. Standards were too low and people died. Whether it is excess deaths or whatever you want to say, people died who should not have.
Una O’Brien: It is very important from my perspective that I put on the record that while I think there is absolutely no disagreement that there is much improvement to be made. I simply cannot accept that there has been no improvement. The improvement in 2003 into the latest audit data has been dramatic.

Q63 Chair: We don’t think it is enough. This is one of the simple areas in which it is absolutely obvious what you have to do, and it is not being done down the system. Whether it is PCTs, doctors or hospitals—they are not doing what everyone knows works.
Sir Bruce Keogh: Can I put some of this in perspective, please, because we are getting a little bogged down in some of the detail? If we look at the OECD, we see that we have the third lowest incidence of diabetes; we have the third highest prescription rate of diabetic drugs; we have the third lowest amputation rate; we have half the OECD average admission rate for uncontrolled diabetes and we spend only 60% of the average—
Question 64: Chair: You are happy with that, Sir Bruce? You are content?

Sir Bruce Keogh: Let me finish. What I am saying is that the position is not quite as bad as one might like to assume. However, there is room for a lot of improvement. Over the past 10 years, a number of initiatives have been put in place: we have had the national service framework, we have appointed an NCD, we have the best data on diabetes—Chair: I am going to stop it, because it is waffle and I can’t stand it.

Question 65: Mr Jackson: First, if we are looking at contents, there is a real-terms increase in NHS expenditure that is unprecedented, both across Europe and domestically. You would expect there to have been a better set of outcomes. Secondly, as an observation, I am slightly disturbed that there is not a consensus about the indicative cost of diabetes to the NHS. We have a very helpful written submission from the Association of British Clinical Diabetologists. My understanding is that that figure comes from the report “Estimating the current and future costs of Type 1 and Type 2 diabetes in the UK” by York Health Economics Consortium.

You have had a debate today with Mr Barclay about your responsibility vis-à-vis strategic health authorities, primary care trusts and, in future, clinical commissioning groups. Can I bring you back to a more fundamental question that I would like you to answer? It is about what you are responsible for: the funding regime and funding architecture. The Association of British Clinical Diabetologists said in its written response that the way in which services for people with diabetes are funded needs a thorough overhaul. It said that the payment by results tariff, which placed a set cost for each clinical encounter, has created a perverse disincentive to seek specialist assessment, and as a result, many people with diabetes are deprived of access to the specialist team. It said that payment by results is not an appropriate funding model for long-term conditions such as diabetes, as it disrupts a seamless cross-boundary care pathway, which is the essence of success in a long-term condition. It said that there is a number of better alternatives for commissioning of diabetes care, such as the year of care model, which should be explored. What is your direct response to that observation?

Sir David Nicholson: I agree with it.

Question 66: Mr Jackson: You are in charge of changing things, so why are you not changing that?

Sir David Nicholson: We are changing it; we are getting slightly confused. The position is not quite as bad as one might like to assume. However, there is room for a lot of improvement. Over the past 10 years, a number of initiatives have been put in place: we have had the national service framework, we have appointed an NCD, we have the best data on diabetes—Chair: I am going to stop it, because it is waffle and I can’t stand it.

Sir David Nicholson: We have recently asked for volunteers for piloting the year of care model and we have been overwhelmed by the number of people who want to do it.

Question 67: Mr Jackson: But is not the lack of compulsion in this the problem? You have on page 41 of the Report, appendix 2, as far as I can see, six primary care trusts—Swindon, Mid Essex, Medway, Stoke-on-Trent, Berkshire West and Bolton—that are pitifully underperforming in terms of the nine care processes. You should be saying to them, “Payment by results tariff is not working in your area. You are by compulsion going to switch over to a new system.” Why haven’t you done that?

Sir David Nicholson: We are going to switch over when we get the process working properly and get the information and the financial regime in the right place. It will be for everybody. What we are trying to do is work it out to get the best model that we possibly can that is workable. That is why we have the pilots.

Question 68: Mr Jackson: How long is that going to take?

Sir David Nicholson: From next year, when it will be CCGs, a third of the country could be covered in this way. It traditionally takes us about two or three years to get a payment by results model embedded properly in the system, but there is nothing to stop people locally trying to move it sooner than that if they want to. But I agree: the payment by results model was designed originally to drive capacity in the acute sector. If you remember, in early 2001, 2002 and 2003 we needed to increase capacity, and payment by results is a great way to increase capacity, because the more you treat, the more patients you get. As we are getting into more cash-constrained arrangements and as we understand better the way in which costs fall across the system—you can see here where investment in community and preventative services and disinvestment in secondary care is the way you do it—then you have to change your funding model. That is precisely what we are doing.

David Moon: We are getting slightly confused. The table in the back is around primary care trust performance against delivery of the nine care processes. Payment by results does not impact on that at all. Payment by results, as Sir David has quite rightly explained, is all about what you get paid when you get seen at an out-patient appointment by a consultant diabetologist and what you get paid as an in-patient if you get admitted as an emergency. That is a slightly different issue. That table at the back is about primary care trust performance of the nine care processes.
we sort of move forward five years, if the national diabetes audit publishes its results in 2014–15, where will the average be around the nine care processes and the delivery of the treatment targets? Arguably, the treatment targets are more important than the delivery of the nine care processes, to a greater or lesser extent. So where do we think we will be, given that we are at 49% average for nine, and less than a fifth on the treatment standards?

Chair: It is 16% on treatment.

Dr Hillson: I think we will be improving.

Q70 Chair: Why?

Dr Hillson: Because we are continuing to make the effort. We have also now put in a primary care team. PCPs are, of course, going. We have put in a primary care lead and a team through NHS Diabetes to work directly with GPs. NHS Diabetes is also working closely with CCGs to get the nine care processes up.

Every person may not need all nine; they may decline some of them, because you don’t have to, as a patient, accept all nine. We have put in steps to improve them, and we know that they are already improving, from the early results from the most recent audit.

Q71 Stephen Barclay: What happens to those that do not deliver improvement?

Chair: In the future.

Dr Hillson: I will have to ask my senior colleagues.

Sir David Nicholson: The future is different from the present, in the sense that the accountability is different. For example, the commissioning of primary care will not be the responsibility of local organisations, but the responsibility of the NHS Commissioning Board. So that direct accountability is very sharp.

Q72 Chair: So what will you do if you see a pattern away a whole series of their powers.

Sir David Nicholson: In the future model, the centre will intervene?

Chair: We will intervene.

Q73 Stephen Barclay: So the role of the centre is going to change. What else? At the moment, you do not intervene because you see it as a role of the SHA.

Sir David Nicholson: The future is different from the present, in the sense that the accountability is different. For example, the commissioning of primary care will not be the responsibility of local organisations, but the responsibility of the NHS Commissioning Board. So that direct accountability is very sharp.

Q74 Stephen Barclay: That is very heartening to hear. In that case, pursuing the very good question from the NAO, how are we going to assess it? At what point are you going to intervene? What is your model showing in terms of what we are aiming for, so that we can assess? Have you modelled this as yet? If so, what is the improvement you are expecting? If you have not modelled it, why not?

Sir David Nicholson: We have not modelled it yet.

Q75 Stephen Barclay: Why not?

Sir David Nicholson: We are doing a lot of things at the moment. Well, first of all, because we have to think about another lever that we have, which is the commissioning outcomes framework. It is a mechanism by which we set out the important national indicators that we want clinical commissioning groups to deliver in order to get rewards through something called the quality premium. We have just been out for consultation about those measures, and we have to make some final conclusions about which of those measures we are going to go for, because they are all NICE-approved and they are evidence-based. That is the first.

Q76 Stephen Barclay: Accepting that a lot is going on in the Department, by when might we be able to get visibility as a Committee on that?

Sir David Nicholson: We will be expecting the developing clinical commissioning groups to develop their plans, starting about October or November this year. They will start to develop their plans for 2013–14, 2014–15 and 2015–16. By the end of March 2013 we will have a set of plans from the clinical commissioning groups and from the Commissioning Board itself in terms of how it is delivering improved primary care commissioning. At that stage we will have a good fix on what people think from the bottom up is possible to deliver.

Q77 Chair: Will the word diabetes be in any of these plans you are describing?

Sir David Nicholson: Inevitably, they will be—

Q78 Chair: The word. I know it is all very general about “fewer people will die.” I keep coming back to it, because this is an area where, unlike some other areas, you know what needs to be done to ensure that there are not excess deaths.

Sir David Nicholson: Undoubtedly, the word diabetes will appear in all those plans.

Q79 Chair: So it will be mandated?

Sir David Nicholson: One of the things that the CCGs are currently doing is identifying with their local authorities what their local priorities are, going through the joint strategic needs assessment. Given the numbers that we can see here and given the work that Diabetes UK has done, I would be amazed if those that had high prevalence of diabetes did not have diabetes in the centre of their plans. It is part of our responsibility to look at those plans and see whether they are ambitious enough.

Q80 Mr Jackson: Can I just ask you about the role of the public health and wellbeing boards in the new architecture of the Health and Social Care Act 2012? I agree with the implication of what you are saying,
that localism and local autonomy are very important for people who make local decisions on local health outcomes, but how do you see there being an imperative from the centre for those clinical commissioning groups to work with health and wellbeing boards to replicate the success you have had on things such as stroke, heart disease and smoking cessation? The point that Diabetes UK is making is that this is infinitely bigger in terms of the number of people it will potentially affect now and in the future, but there do not seem to be the levers to make the changes necessary to affect the long-term condition. What are you practically going to do to up the ante for the health and wellbeing boards, for instance?

Sir David Nicholson: We are going to set out as a Commissioning Board what the priorities are for 2013–14 by October or November of this year. We have a systematic way to do that, which has been developed by the National Quality Board.

Sir Bruce Keogh: Yes, this is actually key. We are trying to bring a transparent and evidence-based approach to how we prioritise stuff for the NHS. The way we will be looking at things in the future, broadly speaking, is at the burden of disease behind that. We will measure that burden according to mortality, morbidity and economic burden. We will then look and see how amenable it is to improvement with the existing levers that we have. We will also look to see where we stand in terms of international comparisons. Finally, we will look to see what the contribution of that particular disease makes to social and health inequalities.

Of course, diabetes runs through all of those, like writing through a stick of rock. It underpins some of the major causes of death. Sir David mentioned the five big killers; the first big killer—not only in this country but in the world—is heart disease, then stroke, then cancer, then lung disease and then liver disease. Diabetes has a major impact on all of those. I am a heart surgeon by background and I have done some research on diabetes in the past, and it is quite clear to me that impacting on diabetes will have a major impact on saving lives in all those categories to a varying degree, but predominantly in the main killers.

Our NHS outcomes framework is divided into five different areas, which, if you will forgive me, I will describe very briefly. The first domain is to try to reduce deaths that the NHS can influence; the major determinants of death lie outside the jurisdiction of the NHS, as you will have heard from Roy Taylor before. Secondly, we need to treat people with long-term conditions well. Thirdly, we need to treat people well who have short-term conditions. Then we need to treat people appropriately—patient experience. Finally, we need to do that safely.

You can see how diabetes runs right across all of those. There is early mortality. Diabetes is a long-term condition, where there will be a major focus, and we are looking at quality of life as an outcome measure for that. There are short episodes of care. There are issues of death in diabetics, so diabetic ketoacidosis is something that we will need to tackle. We also need to ensure that people who come into hospital with diabetes are treated well, and there are some issues with that, as you know. Patient experience is clearly very important with a long-term condition such as this. Many people spend maybe less than an hour a year in contact with health care professionals and have to live with a condition for the rest of their life.

You have already raised the issue of drug errors and safety, and I would just like to say a little about that. We are keen not only to focus on drug errors and serious errors but to learn from the airline industry that by focusing on minor things you prevent the big things. Of the drug errors that are reported to the national diabetes in-patient audit, only a very small proportion have a significant impact on the patient. The way to reduce the errors that do have a significant impact is to address the smaller issues. The issues related to drug errors are mainly either people getting their medication at the wrong time or a failure to recognise that those errors can do serious harm. And there are some things that are simply down to people writing their prescription inaccurately. There are one or two other things that you heard about earlier.

I think that diabetes automatically evolves as a priority. Indeed, Barbara Young and I have met the SHA medical directors. You will be aware that we have had a major approach on venous thromboembolism over the past couple of years that has been very successful. We have learnt a number of lessons from that about how we change the system, and we have agreed that diabetes will be seen clinically as a very significant priority in the NHS.

Sir David Nicholson: We want to get this right, and we want to make sure that we put everything in place to make the new system as right as it can be. Hence, we do not want to rush to a conclusion here and now, today.

Amyas Morse: It would be unfair to accuse you of that—I am sorry, that sounded sharper than I meant. What I want to be clear about is that you have made higher than you put those clinical standards in place 10 years ago. We have an agreed report here, and the only bit you disagree with is our level of assessment of VFM, so let us not go back over the whole thing now, please.

The concern I find myself with—I thought your explanation was masterly; thank you very much—is that we can all agree that the mountain is getting higher. This is a very serious situation. We hear all these good reasons why you have to stop at a certain boundary. You give advice, but if they don’t take it, you can do nothing, and all that stuff. That has been going on for a long time. Has the effort and priority been given to this? You should have been, against your own measure, further forward at this point in time. You have acknowledged that, so what I am not clear about is whether this has really been given the level of effort and, frankly, the level of support that you would have expected.

What we are now hearing is, “We have a new system, and it is all going to be okay under the new system.” Why wasn’t it okay? Is this new system going to be magically better than the old system? Wasn’t it a matter of putting more effort into the old system and giving it more resolve? Will you be able to drive anything more convincingly under the new system when we are back in a few years’ time? Having been
involved in this report all the way through, I am left asking myself that question. I am not trying to score points. I am really asking you something. If all we are going to do is sit here and say, “Yes, yes, that’s it. It’s all going to be fine,” is that really the result that you want from this hearing? As a matter of conscience, is that really what you want to come out of the hearing—that it’s all okay?

Sir Bruce Keogh: No. I think you made some really legitimate points. We have made some very significant steps forward, and a lot of the focus has been on the nine care processes. As I mentioned earlier, we have established NHS Diabetes, we have put some pay-for-performance measures in place and we have put diabetes in the operating framework. You reasonably say, “Well, why has not even more happened than has happened?” What makes things different as we move into the future is the fact that we now have more than 10 NICE guidelines and have had some technology appraisals, which have been distilled into a NICE quality standard.

If I may take a few seconds to explain what that is, a NICE quality standard is a document that runs to about 10 pages and has about 10 things in it that describe what “good” looks like for any given condition. We are going to be producing a lot of NICE quality standards to underpin each of the five domains of the outcomes framework. What makes it different from previous guidelines is that the new legislation in the Health and Social Care Act says that parties engaged in treating that condition—whether providers, commissioners or the Commissioning Board—have to have due regard to NICE quality standards, so there is a legal requirement to take note of something, which we have never had before.

Q82 Fiona Mactaggart: How can you do better than a person having to sue a doctor for not delivering a legal requirement?

Sir Bruce Keogh: With the NICE quality standards.

If I may say something about the nine care processes, they really are a good thing. They have been developed by NICE on the basis of international evidence. We are actually making quite good progress, because the vast majority—

Q83 Chair: Fewer than half the people with diabetes get it.

Sir Bruce Keogh: Please. You are absolutely right, but may I please come to the point that I am trying to make? Most people who have diabetes die from cardiovascular disease. The major determinants of cardiovascular disease are related to your diabetic control, your blood pressure, your body mass index and your smoking. Over 90% of people are getting those care processes in that area. We do have room for improvement in one or two other areas.

At the risk of being accused of being a bit statistical, if you have nine processes—actually, I think we only have seven here, because three of them are one; they are just a blood test—or seven processes, and you have a 95% take-up in each one of those, so 5% of patients, for whatever reason, do not have the test or it is not documented and that is distributed randomly, that actually means that you can only ever achieve a target of about 75% and, actually, we are at close to 55% now. When we start to look at the individual measures, you can see on haemoglobin that we are at 92%, body mass index 90%, blood pressure 95%, blood creatinine 92% and cholesterol 92%. So the areas we have to work on are eye screening, which is 82%; foot exam, which is 84%; and urinary albumin, which is the Cinderella at only 75%, and we are doing significant work on that.

Q84 Chair: Why are these stats different from the ones you have in the Report?

David Moon: Our stats are based on the 2009–10 national diabetes audit, which is the last thing that has been published. I assume—

Sir Bruce Keogh: I have given you slightly updated figures, but they are not significantly different.

Q85 Stephen Barclay: Have those figures been shared with the NAO before today?

Una O’Brien: Yes. If you have access to the audit—

David Moon: No, we only have the 2009–10 audit. I assume that is based on the 2010–11 audit, which will be coming along shortly.

Sir Bruce Keogh: Well, the 2009–10 audit had 91%, 90%, 94%, 91%, 91%, 77%, 83%, 86% and 71%, so the difference—

Q86 Stephen Barclay: Just to be clear, the figures you were quoting have not been shared with the NAO before today’s hearing? It is a yes or no answer.

Una O’Brien: The 2009–10 audit figures have been shared. Bruce also referred to the 2010–11 audit figures, which are going to be published on Thursday—

Chair: Wonderful that you can give us those figures, but you cannot tell us whether you are actually going to mandate anything around diabetes because you are consulting on that.

Q87 Fiona Mactaggart: I am struck first of all that you said that the retinopathy process is relatively low compared to the others, and this is an area where, according to the Diabetes UK audit, there has been an increase in unnecessary complications of 118%—that is, it’s the highest. So it seems to me that we are right to focus on these gaps. I was a teacher and I see how the Department for Education actually changed the behaviour of teachers by saying that it did not count if you got five A to C GCSEs unless they included English and maths, and behaviour just changed. I do not think I really understand why I am not hearing from you, Una or David, that you are going to do something that is the equivalent of that in terms of the way you pay GPs in relation to both the outcome indications and the nine processes. It seems like a no-brainer.

Sir David Nicholson: Can I just say I think you are absolutely right on that? We have now written to NICE setting out the very point that you make there and asking them to look at the grouping of these to see whether there is a better way that will give a better incentive to ensure the right things are done. We agree with your point.
Q88 Fiona Mactaggart: So if we were to come up with a recommendation that you should find an incentive that improves the outcomes and the processes in the way that GPs are paid, you would be happy to receive that and we might see some action?
Sir David Nicholson: Absolutely right.

Q89 Fiona Mactaggart: Good. I am very glad to hear that. One of the things that you will recall from earlier conversations about long-term conditions and so on is that I am really struck by the value of specialist nurses in some of these long-term conditions. I am concerned that the report on specialist nurses, which was jointly produced by the Department and Diabetes UK, suggested that there had been a decline in the number of specialist nurses, and if we look at paragraph 3.23 in this Report, it shows that activities, including “training for NHS staff... are among those currently being cut by the NHS... commissioners of diabetes services, the decision to decommission, or leave vacant, diabetes specialist nurse posts did not appear to have been made in light of consideration of the long-term cost implications of removing such specialist skills from local health economies.” How can we stop that?
Sir David Nicholson: It is undoubtedly an issue for us as we get into a more tightened financial place that people take short-term decisions that have a long-term—

Q90 Fiona Mactaggart: But you are going to be in charge of this primary care.

Q91 Fiona Mactaggart: So what are you going to do?
Sir David Nicholson: What we are doing is, in terms of the planning guidance we set out, we are going to specifically look at this set of issues with people. They need to be able to prove to us that they are not taking these short-term decisions that have a long-term consequence. That is quite difficult for people to do, because, as you know, some parts of the country in particular are very financially constrained, and our worry is the point that you make. So we are going to go through the planning process to assure ourselves that they are not doing that. How successful we will be, no doubt you will be able to see as we go through it. But you are absolutely right.

Our real worry at the moment, generally across the NHS, is that people take short-term decisions to reduce costs when actually there are some big decisions that need to be taken about restructuring the way that we do health care. For example, if we did everything that was suggested in terms of in-patients, it would be the equivalent of closing five district general hospitals across the country. The shift here in the way and the nature of health care delivery in this country is really a big issue for us as we go through the next planning cycle, given the financial constraints that we have. I say that as an illustration to show you the scale. I am not saying that five hospitals are going to close.

Q92 Fiona Mactaggart: It is huge. As Sir Bruce pointed out, and as you responded earlier, you have very clear national guidelines on the big killers—heart disease, stroke and so on. Diabetes—my constituency has a terrifying incidence of it—is what kills people. We have one of the highest incidences, for a relatively prosperous town in the south-east—or we used to be. We managed to get it down by very focused work, including specialist diabetes care nurses, but we used to be in the top 10 in the country for early male deaths from heart disease. What that tells me is that any strategy on dealing with early deaths from heart disease has to have diabetes care at the heart of it. Any strategy on stroke has to have diabetes care at the heart of it, yet you are saying you cannot mandate something on diabetes. I think you can. Silence. You think you can, too?
Sir David Nicholson: Well, I—

Q93 Fiona Mactaggart: I thought you were saying that, Sir David. If I am putting words in your mouth, take them out.
Sir David Nicholson: No, no. I suppose it is the word “mandation” that I struggle with, because the progress you had in your town was not through mandate; it was local people operating in an environment that was conducive and supportive to them to make the change that was needed for that locality. That is what we are trying to create. If was as easy as just telling them to do it, I would do it. But it isn’t. The world isn’t like that.

Q94 Chair: But the most interesting this is that where you did mandate, around cancer, stroke and heart—where you did much more mandate—you had much better success, and here you are just saying, “Oh, well, it’s all localism,” and we have seen stats that are—

Sir David Nicholson: The point about all that is that the criticism given to us about what we did in cancer and coronary heart disease is that other places suffered, so diabetes and other specialities suffered because we focused so much on those. So that is why you need part of the system—

Q95 Chair: So don’t focus on anything because you might upset another lot.
Sir David Nicholson: No, no.

Q96 Fiona Mactaggart: On that, specifically, let’s look at paragraph 3.13, which is quite interesting about the difference in understanding in the relationship between Dr Hillson and what’s being delivered locally and, for example, Mike Richards and what’s being delivered locally, because the report says clearly: “We... found little evidence that primary care trusts’ decisions on how to deliver diabetes services in those areas we visited had been influenced”—and “influenced” isn’t a strong word—“by the work of NHS Diabetes.... Actually, where you do not have something with some welly in it, people do not even feel influenced. That must be a problem, mustn’t it? I am sure Dr Hillson is doing her best. We have good processes here. We heard from Diabetes UK that we have good information, and that is partly the
collaboration between NHS and Diabetes UK, but if the people on the ground don’t feel any influence from the centre, then there is a problem, isn’t there? **Dr Hillson:** Forgive me, could I just point out that these questions were asked at a time when the NHS was changing rapidly? Primary care trusts have been clustered and many of the staff have moved, so NHS Diabetes has found that over half the staff they were working with—remember, they had been going round the PCTs and actually had contacts with every PCT—had moved or gone on to other things. It is a different scenario from if you had asked a PCT about this perhaps a few years ago. Things are moving very quickly.

Q97 Fiona Mactaggart: I understand that.

**Dr Hillson:** To be fair.

Q98 Fiona Mactaggart: I understand that change is going to disrupt any specialist care, but I do think it would still be different in cancer, at present. That is just a reality. We need to think about what we can learn about the way that cancer collaboratives have worked, about the role of the tsar and so on, and duplicate it in respect of this condition, which is such a precursor to so many deaths that could be avoided—I won’t use other language. We know that so many diabetes deaths could be avoided, yet we are not doing the early intervention stuff that would save the three hospitals. I shall not name which ones you might suggest to close, Sir David. Nevertheless, it is clearly going to save people money, but more importantly, it is going to save lives. We’re not using what we’ve learned in one area enough in another area. I am not saying we have learned nothing—we have made some progress here—but it doesn’t feel to me that it is adequate, really.

**Sir David Nicholson:** We’ve still got quite a way to go on cancer as well, as it happens.

Q99 Fiona Mactaggart: No, I accept that.

**Sir David Nicholson:** We’ve got many lives that can be saved in relation to cancer, but I think the progress, as we have set out, is internationally quite significant. It is not an insignificant set of changes that have been happening, the tick-tick-down that we need to ramp up our approach to it all. Hence the work with NICE around the incentives we want to put in the system. Hence the way we want to change the nature of primary care commissioning to enable it to be much more consistent across the country in relation to that, and particularly in relation to the development of the standards and the tariff and all those incentives around to make it work. We think that we need to do all those things to increase our performance in terms of diabetes.

**Una O’Brien:** And if I may, this is one very important dimension to add to that: this is part of the more comprehensive nature of the new framework. In the creation of Public Health England and in the decisions to have ring-fenced money for public health and to give that whole arena of activity a higher priority, there is a much broader end-to-end approach to saying, “We can’t just sit here and accept that there is an inevitable pipeline on this issue.” We have to get much more serious about what needs to be done, particularly on physical activity and particularly on diet and food intake, because at least 80% of Type 2 diabetes is fundamentally avoidable.

Q100 Chair: We look forward to you mandating that, Una.

**Una O’Brien:** Well, I would welcome your support in that. That would be very interesting.

Q101 Fiona Mactaggart: I am sure you are right about that, because one of the ways—

**Una O’Brien:** Physical activity mandated, exactly.

Q102 Fiona Mactaggart: One of the ways we made a difference in Slough was by making sure that the public knew. There was a moment when the Chair of the Slough Tenants Federation grabbed me and said, “Fiona, do you know we die 10 years younger than the people of Maidenhead?” That was the moment when we got change. I was very interested in what Sir Bruce said about prescribing errors, and this goes beyond the width of this particular Report, but I wonder if you have an estimate of what the cost of prescribing errors across the NHS actually is. I suspect that this is an area that the Committee should be seriously worried about.

**Sir David Nicholson:** I am sure that somewhere we have a review. I am sure we have a figure.

Q103 Fiona Mactaggart: Could you give it to us, because I have a feeling that it is something that we should be looking at? I have a final question, which is to ask Dr Hillson about the point that I raised about the difference between how people respond to NHS Diabetes and so on. Do you think that you have the levers that, for example, Mike Richards has, or other clinical directors have? If you do not, are there any levers that you would like that you haven’t got?

**Dr Hillson:** You mentioned how things are mandated and obviously there have been different pressures on improvement—over many years, we are talking about—for cancer and heart. They were earlier NSFs than ours. It is helpful to have recurrent funding for local networks. Of course, if people ask me if I want more, I am an enthusiast—I am always going to want more. I am always going to want more funding and more prioritisation, but I am a realist. We are in a time of international and national financial stringency, so I have to be careful what I ask for.

**Chair:** But it is interesting that you want mandation.

Q104 Meg Hillier: Chair, we have been accused of not talking about the positives, so before I start I want to mention the good news from City Hackney PCT, which has been acknowledged by the NAO as one of the most improved diabetes teams in the country, based on interviews taken last year. There is good stuff going on with a lot of outreach to GP surgeries by dieticians and nurses, so going down, not all at specialist level, but actually preventing all but the most serious cases being treated in hospital. That is the good news, but the bad news is that, in spite of that, my PCT—as was, of course, because, as Dr
Hillson indicated, they have all changed around a lot—has only half of patients receiving all nine care processes. That demonstrates that, even where there is good practice, there is still a very long way to go. Perhaps that puts more balance in, Sir David. You were suggesting that we weren’t being positive; I think we have acknowledged the positives.

May I touch on the points—Una touched on this—about prevention? In terms of value for money, it is much cheaper, surely, in the public health sphere to deal with this. In the new regime in the NHS, with public health going to local authorities, you talked about ring-fencing money, but how are you, in the Department of Health or the NHS, going to get local government to deliver on prevention, which will save the NHS and the taxpayer a lot of money? That is a big challenge, isn’t it?

Una O’Brien: How I would see it is as follows. First and foremost, one of the really powerful things about these reforms is bringing GPs into contact with local politicians. I have heard up and down the country of conversations taking place. Very often these people had never met one another and for the first time they are engaged about place and about the needs of people in that place; about sharing all the data that is available to the local authority and, through the public health observatories, to the CCGs; and about the needs of that particular population. We should not underestimate the power of that. It is a real opportunity that exists for coming together in a locality to address the needs of place. First and foremost, that is where I see it happening.

There is a requirement to have a joint strategic needs assessment, which is jointly owned by the clinical commissioning groups and the health and wellbeing board, so they have a common view about the needs of the local population and the need to have a joint strategy about how they are going to address those problems encompassing both public health interventions and the clinical commissioning group, and, obviously, social care. The idea behind that is to get a much more holistic approach than we have ever had in the past. It is new and it is different and a huge number of people are going to come to it for the first time and are coming to it for the first time. We will have some brilliant early adopters, some people in the middle and others who are struggling. That is what I expect to happen in the first year, but the evidence already on health and wellbeing boards is extremely encouraging, because this completely plays to the ambitions of local authorities and local councillors. That is the first thing.

Nationally, you will have seen that Public Health England recently announced that Duncan Selbie has now been appointed as the chief executive. He comes into place on 1 July. This will be an organisation that can mobilise behind that. Those are the main changes with the reforms.

Of course, it is not for today’s discussion necessarily, but work is going on in the Responsibility Deal and all the actions to try to work in a different way with industry to get participation. One great example is that we are now getting calories on menus. We are getting calories in takeaways. A number of chains have now agreed to display calories. We have lots of other changes, but we should not underestimate this; no country in the world has turned around this disease with success—obesity. That is really the fundamental thing that we are reaching to do. We need local government to really step up and take some bigger responsibility around the physical activity space.

Q105 Meg Hillier: That is great. The danger is that in places like mine and, from what I gather, Slough, it might be a priority to deal with diabetes because of its high incidence level. But in areas where it is lower down the priority list, how can you be sure from the Department of Health or the NHS in public health terms that it is going to be a priority enough for GPs and public health people in the local authority to make this a local priority? There may be other issues that are a higher priority and they may decide to downgrade diabetes and then that shoots the national targets, doesn’t it?

Una O’Brien: Well, obviously we will be—what you are trying to do here is to get the right and the best balance between setting national priorities but allowing for local differentiation where there are, at a population level, much more important issues facing the totality of that population. At the same time, if you have diabetes it should not matter where you live—Meg Hillier: Exactly.

Una O’Brien:—as to whether you get the quality of care that you need. The outcomes framework and the improvement areas is a very new idea. We are trying to set a more comprehensive framework that allows for every locality to ask, “What is it that we need to address here to reduce avoidable mortality?” In some localities, the thing that they can do most significantly is to tackle diabetes, but every locality will have diabetes and an element of action that is linked to that presence, regardless of the number of people in their area. I find it very hard to see how it would not be relevant to that fundamental outcome I, notwithstanding all the others that Bruce has mentioned, where I think action on diabetes is absolutely central to making progress.

Q106 Meg Hillier: I think, Chair, that there is a bit of future work for us to see where people balance it. A number of other points that I wanted to raise have already been covered, so I will be brief because of the time. I talked earlier about women who are sugary at the point of conception, and the doctor indicated that—these figures ring a bell with me—there would normally be a 7% rate of genetic disorder in a child conceived in that way, but it increases to 25% if the woman is sugary. This is a relatively small number of the population of women who fall pregnant, but that
is a very big issue in terms of distress for the parent and the child and also for the costs across the system. Is any work being done through the centre to try to tackle that? Clearly, it tends to be poorer, less well educated women who are affected, so there are all sorts of issues. It has a big effect in my area, and it is an ongoing cost not just to the NHS, but to the taxpayer in many other ways as well.

**Dr Hillson:** I am happy to answer that. It was outside the scope of the NAO’s Report, but I was very concerned about pregnancy in women with diabetes. One of the workstreams that we have had with NHS Diabetes, which was actually developed by an open space event—in other words, asking people with diabetes, professionals and everybody involved what they wanted—actually looks specifically at that. One of my main tasks has been to produce information to hold as a mirror to the NHS, and that is one of things that we did with the Diabetes Information Service. What was asked for, and what we have done for pregnancy, is to produce what will now be a national audit of pregnancy and diabetes, so that we are again building up national information to hold as a mirror.

The other thing that we have done is to work with the Royal College of Midwives to ensure that there are competencies for midwives who deal with diabetes. We have been working with GPs and with a project in the south of England about how we can increase awareness among a whole range of health professionals about the need to counsel women with diabetes before they get pregnant about the need to control their glucose. Indeed, I am having some discussions with our GP lead about how we could automate that for surgeries. We know that there are well over 40,000 women of childbearing age with diabetes in this country, so, yes, it is very important to me. I actually do a pregnant diabetic clinic.

**Q107 Stephen Barclay:** Sir David, the Report says that the percentage increase in the number of people with diabetes is likely to be 23% over the next eight years. What is your projected cost associated with that increase?

**Sir David Nicholson:** We haven’t got a projected cost in relation to all that, partly because we are not sufficiently clear yet about what the model of care is going to be going forward. For example, if you think that we are going to have less dependence on in-patient hospital care and more investment in community services, you can see that the costs would be relatively contained. If we think that the 23% relates to more and more in-patient activity and hospital care, the costs will go up significantly.

**Q108 Stephen Barclay:** As anyone from the financial services sector knows, past performance does not always indicate future performance, but if you look at the drugs budget alone, it has gone up 42% in four years, and this is at a time when, as I understand it, the NHS has to deliver record efficiencies way above anything it has delivered before. You are passing targets down to a local level at a time when the centre has not been challenging. You are not setting a target or sharing with the Committee any expectation of where you expect this to get to, but we know that our starting point is that the majority of people do not get the right treatments, and you are saying that you have not modelled your estimate of the potential cost.

**Sir David Nicholson:** No. I do not agree with all those points. Could you go through the list of them, and I will explain why?

**Q109 Stephen Barclay:** What we have here if we look at the key facts document is a Report projecting a significant increase in cost on what is already a significant budget impact area. There is a record of the drugs budget going up by 42%. What I am saying is: surely that must be a red warning light on your risk register. What modelling have you done on that future cost to mitigate the risk?

**Sir David Nicholson:** I understand. That cost has gone in with a whole set of other costs in relation to our projections that we need to generate about 4% of free money every year for the NHS for the next four years.

**Stephen Barclay:** The next four years.

**Sir David Nicholson:** The next four years. That means we can reinvest in the kinds of ways that you have just described.

**Q110 Stephen Barclay:** What is the best the NHS has done to date? Is it 2%?

**Sir David Nicholson:** This year, we will have done £5.8 billion.

**Q111 Stephen Barclay:** As a percentage. You said 4% in each of the next four years, so what is the percentage we have done—otherwise, we are not comparing like with like, are we? What is our best percentage to date from an efficiency point of view?

**Sir David Nicholson:** Well, this year we have delivered the demand on the service and the totality of the financial position. So we have done the equivalent of 4% this year. Last year, the Audit Commission review said that we did £4.3 billion, so 4.3% the year before. Our projections for the year we are in are, again, another 4%. So there is a separate issue, and we broadly know the areas that we need to tackle to make it happen. Post-2015, I have not got those answers.

**Q112 Stephen Barclay:** Right. And you do not foresee incentivising GPs as having a cost?

**Sir David Nicholson:** Well, regarding incentivising GPs around this, we think that we can do that within the existing resources available for QOF. What we plan to do is to make the arrangements in such a way that they have to produce whatever it is—I do not know whether it is four or five—of those care processes in order to get their money. We are asking NICE to do that for us, so we expect that to be within the total amount of money in terms of the pay for the GPs.

**Q113 Stephen Barclay:** Why does the Report say on page 32 that there are shortcomings in how the quality and outcomes framework incentivises GPs at present?

**Sir David Nicholson:** Yes, there are shortcomings in it. We are currently reviewing it. We currently have
NICE looking at the figures and we are negotiating with the GPC around the future of it, so we accept all that.

Q114 Jackie Doyle-Price: Can I direct you to paragraph 2.9 of the Report? I have heard Sir Bruce Keogh talk about the nine care processes with some pride and I have heard you, Sir David, describe that programme as internationally quite significant. But what that paragraph illustrates is that fewer than one in five people are having ongoing management of the risks to their condition—in other words, high levels of blood glucose, blood pressure and cholesterol. Surely that is nothing but poor.

Dr Hillson: It is poor, and I am very unhappy with it. Various steps have been taken to improve that. I have said that we have already got a GP lead going around with 10 champions with these data. With the National Diabetes Information Service, we have also developed a GP tool that will produce the National Diabetes Audit results, with drugs, and outcomes—for the patients, including the risk factor outcomes you are talking about, for that practice compared with other practices like them. That is being tested with GPs at the moment, and will be out to GPs very shortly to show them exactly what is going on.

The other thing is that we have the National Prescribing Centre, which has produced guidance on the use of diabetes drugs aligned to NICE. The national prescribing service has moved into NICE and so is closer to QOF. There is work going on, because it is important that people with diabetes get the right treatment according to current guidance and in discussion with the patient.

Q115 Jackie Doyle-Price: This illustrates that too many are not getting that. Coming back to the beginning of the hearing, what we found was that you were doing this work, but really, there were no teeth, because you could not force GPs or PCTs to take it up. How can we be confident that you are really going to drive an improvement in that figure?

Dr Hillson: Well, we are working with GPs, but again, I have to ask my senior colleagues, because it will be related to the Commissioning Board and the new arrangements.

Sir David Nicholson: The new system is very different from the old one, in the sense that the accountability chain is much shorter. If you think about the distance, at the centre at the moment we have a Department then a whole set of statutory bodies—strategic health authorities. We then have a whole set of other statutory bodies—PCTs—all with their own accountabilities, responsibilities, accountable officers and all the rest. So if you are thinking from the centre about having visibility on primary care commissioning, you are operating through two different statutory bodies before you get to it.

In the new world, the commissioning of primary care is done by one organisation, the NHS Commissioning Board. In terms of the connection or accountability between the direct commissioning of primary care and me as the accounting officer, there are no statutory bodies between us, so the accountability is much sharper.

Q116 Jackie Doyle-Price: So the buck definitely stops with you, Sir David?

Sir David Nicholson: Absolutely. That accountability is much sharper in the new system, and will involve us at the centre being much more engaged in that kind of process, rather than working through different statutory layers in the system.

Q117 Jackie Doyle-Price: In terms of delivering value for money, obviously the more you can front-end that treatment, the more significant the cost savings will be.


Q118 Jackie Doyle-Price: I actually think the estimate in the report of £170 million is quite conservative. Can we look at figure 10 on page 29? It goes into the vast discrepancy between the cost of drugs, and there is considerable variation. The cost of insulin items varies from £78.84 to £175.88 across various PCTs. Is there an explanation for why there is such a big gap in the average cost?

Dr Hillson: This is part of the work that we have been doing with the National Prescribing Centre. One thing I did when I came into post was to ensure that the report from which these data were taken was actually published and updated every year—it is called “Prescribing for Diabetes in England”. One issue is that there are different types of insulin—older and newer insulins—and the newer ones are very much more expensive. They may be appropriate for certain patients, and NICE has made it clear which patients should have which.

There are big differences in cost between some of the diabetes drugs for Type 2 diabetes as well. If somebody needs an expensive drug, because that is the right one for them according to NICE guidance and in discussion with the patient, obviously they need it, but what needs to happen is for GPs and patients to look at which is the most appropriate and whether it follows NICE guidance. That is part of the work being done by the National Prescribing Centre. One thing I did when I came into post was to ensure that the report from which these data were taken was actually published and updated every year—it is called “Prescribing for Diabetes in England”. One issue is that there are different types of insulin—older and newer insulins—and the newer ones are very much more expensive. They may be appropriate for certain patients, and NICE has made it clear which patients should have which.

Q119 Jackie Doyle-Price: It just seems like a very significant range.

Dr Hillson: It is very variable.

Q120 Jackie Doyle-Price: Particularly when you look at what Steve just outlined, where you have had an increase in expenditure on medication of 42%, compared with 6% generally across the board. Is there an explanation for why there has been such a massive increase?
Dr Hillson: Part of the increase in expenditure is the increase in numbers. The total numbers have gone up, so the total amount spent will go up, but even so, there is variation between PCTs and of course, they need to look at it. People with diabetes should have the right medication, in discussion with the patient, but it is very important that organisations such as PCTs and CCGs look at what is going on and ensure that GPs are using up-to-date NICE guidance and looking at what they are prescribing.

Q121 Jackie Doyle-Price: Coming back to what we just discussed about the buck stopping fairly squarely with you in this system going forward, it looks to me as though we have set up a framework of outcomes that we want to achieve, and the strategy is all there, but Dr Hillson has developing expertise and tools that do not really have teeth. I want to be confident that what we see here, where we have got all this strategy that is delivering nothing, really will change. Can you give me some comfort?

Sir David Nicholson: Well, it is theory, at the moment, in the sense that there is a new system coming into place. Hopefully I have described, particularly in relation to the development of primary care, how accountability is much sharper. In those circumstances you can get for the first time a level of consistency in commissioning primary care that we have never been able to do before. We have always been operating either through 100 separate statutory organisations or 150. In these circumstances it is literally one organisation. I think that that gives you a power in the development of primary care that we have never seen before.

We have got a system where we have—you have seen it yourself and diabetes is probably leading most of the places—all the bits in place. We have the quality standard, we potentially have the commissioning outcomes framework, we have the financial incentives for GPs, we have the national clinical director and we have information like no other bit of the system. For outcomes framework, we have the financial incentives for GPs, we have the national clinical director and we have information like no other bit of the system. For a whole variety of reasons, at this moment in time a whole series of things have come together. The question is how you then make it happen. We believe that, through the development of commissioning guidance and focusing on the outcomes framework, we can make a big difference here on diabetes.

Q122 Jackie Doyle-Price: There is another end to it though, of course, and Una O’Brien was referring to it earlier with the health and wellbeing boards, because getting the information in a way that it is easily understandable by them will bring some accountability at the coal face and increase performance.

Sir David Nicholson: That is absolutely right. As you know, we have published the atlas of variation, which makes it very clear, benchmark-wise, for different parts of the country. Different health and wellbeing boards with the local politicians involved will be much more alerted to where they sit in comparison with other parts of the system and how their population is doing. That strengthens, it seems to me, accountability. Those two things together—the development of local accountability and the political involvement and what I have described—give us a really good chance of doing something very exciting.

Q123 Jackie Doyle-Price: Without disparaging my colleagues in local government, can we be clear that what we need is information that is really clear and idiot proof? It is all very well producing acres of statistics and saying, “Here is your information”, but it has to tell a story and it has to be simple.

Sir David Nicholson: I agree. General practice would say the same.

Una O’Brien: On the other hand, one of the strengths of local government is that it has a much richer picture of what is going on for local people in terms of education, social services, housing and so on. It is bringing that entire picture together. The public health observatories that have the data about what is happening in local populations are becoming part of Public Health England. They will be directly in dialogue with the directors of public health, who are now based in local authorities, which is a major shift. I agree with you, however, that being able to take that sometimes quite scientific analysis into real time and working out what it means for people living there on a daily basis and what needs to be done is a critical task for those DPHs.

Dr Hillson: I am aware that sitting behind me is one of the drivers for the National Diabetes Information Service, Naomi Holman. We have diabetes community health profiles for every PCT in the country. There will be similar things for CCGs. They have pictures of where it is and what is happening. We have those for every patch. We have foot care profiles and we have profiles for children.

One of the things that we discussed when I chaired the Diabetes Information Service board was how we can make information look easy to read for everybody, because if the information is just sitting there in big tables blinding you with science, it is useless. It has to be easy to use.

Q124 Austin Mitchell: I am sorry that I missed the excitement of Sir David’s ritual defences of the status quo. I heard you apologise for that. We must be your equivalent of the Leveson inquiry, hanging over your head. I want to ask you a very simple question. I was quite surprised by the evidence from Diabetes UK, so I went to both the Princess Di hospital and the Care Trust Plus to ask about it. They are making pretty splendid efforts to catch up. The appendix shows that we are kind of there, in the middle of the pack, which is reassuring—for Grimsby, at any rate.

It is primarily a public health issue, isn’t it? What are the potentials and possibilities of having a big advertising campaign on television, as we have for strokes, to scare the bejesus out of people about their lifestyles?

Una O’Brien: Obesity, which is the primary cause of Type 2 diabetes, is a very complex issue to tackle. If it were simple to get people to keep to a normal weight, every country in the world would be doing something about that right now. What we are doing, and what we are very focused on—particularly this year—is to harness the energy
and interest in physical activity around the Olympic games. In fact, there was a big launch for the Games4Life initiative yesterday. Even in these hard times, with all the pressures on public spending, the Government have maintained a commitment to the Change4Life initiative. I am happy to let the Committee have the evaluation of that. We have an incredibly high return for the money and high recognition. Hundreds of thousands of families with children are involved. We are particularly focused on reducing levels of obesity in children, and there is some evidence that we are being successful.

We are less successful with adults, because the truth is that we like sugary food and we like sitting down in front of the computer and the television. That is a major social and cultural issue. Speaking personally, even in preparing for this Committee, when you go back to the fundamental biology of what happens—from eating too much sugar and drinking too much gorgeous alcohol with your friends and how it could lead you to be at risk of diabetes—it is a real wake-up call.

I agree that we need to do more to demonstrate the connectedness between what seems to be a relatively benign issue into something that can give you long-term health problems. You have made a very strong point. I am sure that, with Public Health England, we want to do more about that, but I would not want to underestimate how difficult it is to break into this problem, because people do not like being told what to do in terms of their food and drink. We always get that reaction, and I can understand why. We have to provide education, and help people to make better choices.


dr hillson: Diabetes education is really important. It needs to be tailored to the patient. There are some excellent structured diabetes packages.

Q127 Chair: What are you doing to improve diabetes education?

Dr Hillson: Again, we are encouraging people with diabetes to ask for it and encouraging health care professionals and PCTs to deliver it. It has improved. Astonishingly, a Healthcare Commission survey showed that only one in 10 people with diabetes was having education; a few years later, a survey showed that more than two thirds had some diabetes education. I want everyone to have diabetes education that suits them.

Q128 Chair: The figure in the Report is 20%.

Dr Hillson: There are various sources of information, but one of the difficulties is counting it.

Q130 Chair: I understand. We all know it is a good idea. It is a bit like the diet stuff. It is a key—

Dr Hillson: At the moment, it is an item under consideration by QOF. In other words, it may go into the incentive payment for GPs. We have been successful in obtaining a treatment function code for it for secondary care, so the activity can be coded. The figures that are being quoted and we are all talking about do not have the same rigour as some of the other figures in our various data. But if we can count it in QOF and it is incentivised, and if we can count it in secondary care—I know that I am banging on about information—we can really see who is doing it and who isn’t, and then focus on the people who aren’t and help them to improve.

Q131 Mr Stewart Jackson: Are you mindful of the need to make contact with the south Asian community? We know that Slough and Peterborough have an issue simply because of diet. Many people in this country eat too many cheeseburgers and kebabs and so on, but many are culturally predisposed to eat a lot of curry, and that is cultural through many generations. The number of older south Asian people will increase substantially, and they will be at risk of diabetes. Are you doing any specific work in those pockets, and in those PCTs to help to educate that group in the community?

Dr Hillson: One of the things I would like to talk about is Diabetes UK’s programme. It has trained local champions, including in areas where culture and languages are different. It is an excellent programme, and my first task in this job was to go to Coventry, which was launching a specific dietary education programme for people from the south Asian communities. We have been working with the South Asian Health Foundation, for example, so I am mindful of that.

I have visited the Peterborough Healthy Living Centre, which is an excellent resource, working with specialist care, community care and general practice
to improve care for the whole of its population. It seems to be very successful.

Q132 Chair: Can I just sweep up on questions that we have not covered? The diabetic eye screening programme was supposed to reach 100% by 2007, but according to the report, 72% were screened in 2010–11, so nearly 700,000 people were not included. Are you learning from that, and what are you doing about it?

Dr Hillson: We are indeed. It is the world’s largest national retinal screening programme. The last quarter’s figures show that 99% of those eligible have now been offered screening, and 81% of those who were offered it took it up. It has been improving year on year. It is a major success, supported by the Department of Health. It is the world’s largest national screening programme, and I was delighted to have the most recent quarterly figures. Of course I want everyone who is offered screening to take it up, and we are doing work on finding out who does not take it up, and why.

Q133 Chair: Finally, Sir David, we have a postcode lottery at the moment. Will there be a postcode lottery under your new system?

Sir David Nicholson: There will always be variation. The nature of our population is that there are variations. The prevalence of diabetes is between 5% and 11%. You will not get rid of variation completely. As has been described, some populations need extra help and support to make it happen, so there will always be that variation. But the new system, in terms of how primary care is commissioned, enables us to be consistent across the whole NHS and to reduce variation in that way, and with the use of the quality standard and the measurement of that quality standard, we can get more consistency nationally. You can see how in those circumstances you will get a much more consistent level of service across the service. You will never get exactly the same in every place.

Q134 Chair: Are you willing to say today that you will develop an outcome figure for the reduction in excess deaths?

Sir David Nicholson: We need to explore that figure—the 24,000 that is identified. It is an important figure, and one to think about. We need to analyse it and work out, of those, which are the ones that are avoidable by the kinds of actions that we can take. When we do that, we need to set ourselves an ambition in terms of how we reduce it.

Q135 Chair: When will we see that?

Sir Bruce Keogh: Some work is already under way, which will appear in the mandate, and it relates specifically to the first domain of the outcomes framework. Work is currently looking at what the natural reduction in mortality would be for a series of major killers, which we have in the outcomes framework. We will then add on to that a stretching level of ambition. So although it may not specifically say diabetes, there is absolutely no way you will reduce mortality from cardiovascular disease—that is heart disease and stroke—liver disease and, to a lesser extent, lung disease without taking very serious account of the way you handle diabetes.

Q136 Jackie Doyle-Price: Will you get coverage of the nine care pathways up to the maximum, and what level do you think that will be?

Q137 David Moon: You mentioned earlier, Bruce, which we understand completely, that you are never going to get 100%. It is not possible, and we understand that. You have done a calculation—I am not sure quite how you did it, but I am sure at some point you will tell us—that shows that 73% of the population could get all nine. Is that right?

Sir Bruce Keogh: I meant to say about 75%. I can give you the exact figures—

Q138 David Moon: No, that is fine. It does not really matter whether it is 73% or 75%. Fundamentally, you think it is possible to get to 75% for nine of the care processes.

Sir Bruce Keogh: I think it is possible to get to the mid-seventies.

Q139 David Moon: It is an important point. If that is an accepted given, given where we are at the moment in 2009–10—I have not seen the 2010–11 figures—we have not got anybody who is currently delivering more than—

Chair: Mid-seventies.

Q140 David Moon: Nobody is at mid-seventies; the best is 69%. If that is where we are intending to get to, that clearly would make sense. The follow-on question from that is: would we also get an equivalent improvement in the treatment standards? The treatment standards are a long way from that.

Q141 Amyas Morse: Given that you are going to be accountable for it, will you get us to that some time in the reasonably near future? Are you going to take that as a target in the next few years, Sir David, since it is you with whom the buck stops?

Sir David Nicholson: I do not think it is right for Bruce to do a quick calculation and then for me to say that, on the basis of that brilliant analysis—

Amyas Morse: No, but you are going to aim to get it to a realistic maximum level—

Sir David Nicholson: We want to get it as high as we can. Why would you think we wouldn’t? For heaven’s sake!

Q142 Chair: Of course you want to. Nobody is asking whether you want to. The reason we have been pressing you so hard on these issues is that this is one of the few areas we deal with where it is common sense what needs to be done. It is not that difficult. Cancer is a much tougher thing, because you are trying much harder to find treatments that work. Here, we know what bloody well works.
Sir Bruce Keogh: I agree. More than 90% of patients receive the six care processes, and 76% receive eight. The ones that are over 90 are the really key ones. So, you are quite right to raise questions about how we are going to get up to nine, but do not underestimate the progress that has already been made.

Q143 Chair: In our previous evidence, the academic said that identification is partly the risk, but that on the three tests—or whatever it is; the three treatments that ensure that you do not develop the conditions associated with diabetes—we are at the 16% mark. There, we are really rotten. Have I got that right?
Dr Hillson: I think we are continuing to make progress. If we are able to continue with the progress with the measures we have put in place, I think the numbers will continue to go up, because we are actually seeing them go up.

Q144 Chair: I hear that, and I hear that there has been improvement. What is so frustrating is that in this particular area, you could go from 16 to 75, it seems, very quickly, because you know what works. We are critical because although there has been some progress, it is an area where we know what works. We know that it would save money. We know that money has not been a constraint. Yet it hasn’t happened. That’s the frustration that some of us in the Committee have felt this afternoon.
Sir David Nicholson: I am as frustrated as you are.

Q145 Chair: Mandate it.
Sir David Nicholson: But that won’t do it.

Q146 Chair: Well, it has done better in cancer and heart. It has worked. We know. That’s why Fiona bangs on about learning from what has worked.
Sir David Nicholson: But in cancer and coronary heart disease, we took two thirds of the country’s GDP. We hypothesised, absolutely took money from the centre, and we forced it down the system completely.

Q147 Chair: But it worked. It stopped people dying.
Sir David Nicholson: But what happened was that other parts of the system suffered from it. We didn’t get the benefit that we could get. That’s why it’s so important to look at mortality and long-term conditions in the round to see how you invest to get the best benefit for the population out of it, and not specifically look at a particular condition.

Q148 Chair: I just leave you this thought, Sir David: if you don’t mandate on this, and you just go for in the round to get fewer people dying, you won’t get the action on the ground. That is what has been proved over the past 10 years, when Dr Hillson, I have no doubt, was putting valiant efforts in. But she hasn’t succeeded as well as elsewhere, and I think you just have to learn from that. It is no good telling us—
Una O’Brien: It is precisely because we have learned that this framework is being designed in the way that it is.

Q149 Jackie Doyle-Price: But the reality is that unless you start managing blood pressure, cholesterol and glucose, you are going to cost the NHS more money. It is that simple.
Una O’Brien: Yes. If I might just connect back with something that Bruce said earlier, this thing that is highlighted in the report, around the way that QOF works, is something that we recognise needs to be changed. The work that we are now going to do with NICE is really significant. That incentive system does drive systematic practice, and we have learned from the Report and the analysis that you have done that some changes to that would enable us to make quite a big difference quite quickly.
I know that it’s frustrating to hear us bang on about progress, but from my point of view, the tens of thousands of people who have benefited from the progress, and the doctors, nurses and dieticians up and down the country have put a massive effort in, what they have achieved in six years has been phenomenal, if you look at the data from 2003 to 2009. It is not nearly as good as we want it to be, but it is a phenomenal effort. A huge amount has been done, and I think this figure about the numbers of people who receive all nine processes needs to be acknowledged. This is not a system in crisis, but a very significant issue. We need to properly acknowledge the progress that has been made, to support the staff who are putting in a huge drive, effort and energy to do it. We are very focused and proactive on what needs to be done, and the sincerity of the points that have been made today, we completely take on board. We absolutely understand the passion that people feel about this, and we share it.
I also want to re-emphasise the point that the new system will help, taking away some of the layers and enabling us to have a direct line of accountability. It is a much stronger system for the future. We are not under any illusions about what needs to be done, but I think we have to get it in a proper context, and not talk ourselves down, or the huge effort that people up and down the country have put in. They deserve to be acknowledged.

Q150 Chair: I don’t think anyone is attacking individual doctors and nurses. I think the frustration here is that we think more lives could be saved.
Una O’Brien: We absolutely share that view.
Q151 Chair: That’s the frustration. We don’t think the action has been sufficient. That is why I freeze at international comparisons. We know here what is doable, and it just should be done.
I am going to stop there, because it is six o’clock, and we have to get going. Thank you for your evidence, and we look forward to seeing you back on why you have decided not to reject many of our recommendations on neurological conditions.
Sir Bruce Keogh: May I say that we use international comparisons so that we can aspire to be the best, not aspire to mediocrity?
Chair: Good.
Written evidence from Diabetes UK

DIABETES: THE BIGGEST HEALTH CHALLENGE OF OUR TIME—A SYSTEM IN CRISIS

1. THE RISING TIDE OF DIABETES AND THE CHALLENGE FOR THE NHS

1.1 Diabetes has become one of the biggest health challenges of our time. Diabetes is big, it is growing, it is serious and it is expensive. Its rising costs threaten the NHS budget. The time for action is now. The reformed NHS needs to deliver:

— Effective risk assessment and early diagnosis.
— Education for all people with diabetes soon after diagnosis to help them self-manage their condition.
— Delivery of the NICE quality standards for diabetes care.
— Integrated (joined up) care between primary, community and secondary care.
— An implementation plan with outcomes and timescales to deliver all this.

1.2 Diabetes is big and growing

— 3.7 million people live with Type 1 and Type 2 diabetes and 7 million people at risk of developing Type 2 diabetes in the UK.
— Prevalence of diabetes has trebled over the last 10 years. 140,000 new diagnoses happen each year and it is estimated that over 5 million people in the UK will have diabetes by 2025.
— Prevalence of diabetes is nearly 4 times higher than all cancers combined and is still rising. (Figure 1)

Figure 1
NUMBER OF PEOPLE WITH DIABETES AND AT RISK OF DIABETES IN THE UK 2001–11 AND ESTIMATED IN 2025

Diabetes is serious

— If poorly managed, it can lead to significant health problems and death.
— A person with diabetes faces a reduced life expectancy of between 6 and 20 years.
— Each year diabetes is associated with 75,000 deaths, 24,000 more than would be expected in this group.
— In the UK diabetes is the leading cause of blindness in the in working age people, caused by retinopathy affecting the blood vessels at the back of the eye.
— Diabetes is a main cause of kidney and heart disease, stroke and amputations.
— Retinopathy, stroke, kidney failure, cardiac failure, angina and amputations have increased dramatically between 2006 and 2010 in England. (Figure 2)
PERCENTAGE INCREASE IN UNNECESSARY COMPLICATIONS OF DIABETES BETWEEN 2006 AND 2010—NATIONAL DIABETES AUDIT

— Every week, 100 people in England suffer an amputation as a result of diabetes and this is rising. 80% of these amputations could be avoided. The likelihood of someone with diabetes dying within five years following amputation or foot ulcers is greater than colon, prostate and breast cancer.

1.3 Diabetes is expensive
— NHS spending on all aspects of diabetes care was almost £10 billion in 2011—approximately 10% of the NHS budget spend across the UK.
— 80% of NHS spending on diabetes goes on managing avoidable complications.
— Around 19% of hospital inpatients have diabetes, spending three days longer in hospital on average than those who do not have diabetes. Most of Type 2 diabetes costs are due to hospitalisation.

2. Diabetes is Fixable
2.1 It does not have to be like this. The increase in devastating complications is unnecessary, wasteful, and causes significant distress to people living with diabetes. Effective risk assessment, early diagnosis, and good care and self-management support can reduce these complications and risk of death can be reduced by 20%.

2.2 There is wide agreement about what needs to change and improve:
— Ensuring all people with diabetes can get the 15 healthcare essentials they should expect and ending the wide geographical variation in standards of care to stop the continued rise in life threatening complications.

2.3 Putting an end to the waste in the NHS by delivering cost effective care:
— Reducing the expensive complications such as blindness, amputations, kidney failure and heart disease.
— Reducing admissions into hospital by improving care, education and support for people with diabetes and education of healthcare professionals in primary care.
— Reducing expensive hospital length of stay and costs by having diabetes specialist teams in place in all hospitals.
3. Variation in Standards and Outcomes of Care

3.1 Evidence shows that people are not getting the care and support they should.
- Two-thirds of adults with Type 1 diabetes and half of people with Type 2 diabetes fail to get the annual checks recommended by NICE.
- In 2010, the number of people receiving the nine tests and investigations recommended ranged from 6 to 69%, depending on where they lived.
- There is also variability in the key outcomes of long-term blood glucose (HbA1c), blood pressure and cholesterol results achieved—the key clinical outcomes that need to be maintained at good levels to reduce the risk of developing kidney disease, stroke, heart disease or foot ulcers leading to amputation.
- People achieving the recommended blood glucose (HbA1c) measurement level ranges from only 50% to 72%. For blood pressure the proportion of people achieving recommended blood pressure levels range from 41 to 61% and for cholesterol this ranges from 31 to 49%. This means that on average 27% of all people with diabetes in England who have had their blood glucose measured are not able to attain recommended target levels due to lack of education and support.
- Half of people with diabetes are not meeting their blood pressure target, meaning that more than 1.4 million people have high blood pressure, in contrast to 30% of the general population.

4. Why are Standards of Care Still Failing?

4.1 Prevalence of diabetes is continuing to increase and growing more than cancers, heart disease and stroke (Figure 3). These conditions have had public information campaigns, targets to monitor and incentivise improvement, support for networks to deliver care, national leadership and support across national policy programmes to make improvement happen where monitoring has shown lack of progress. As a result, these conditions are no longer growing dramatically. Diabetes has not had this focus.

Figure 3

PREVALENCE OF DIABETES COMPARED WITH PREVALENCE OF CANCER, CORONARY HEART DISEASE AND STROKE BY YEAR

4.2 The Diabetes National Service Framework (NSF) has been in place since 2001. It has helped deliver improvement in retinopathy screening, reducing risk of blindness. There is also better information now
available for services to measure standards achieved but it is clear that good information alone does not drive improvement.

5. What Needs to be Done to Change this Situation?

5.1 There is an overwhelming consensus about what needs to happen. The priority must be to determine how the reformed NHS will deliver the agreed pattern of care:

- Effective risk assessments to ensure early diagnosis of Type 2 diabetes through the NHS Vascular Health Check—this is only reaching one third of those scheduled for risk assessment.
- Structured education for all people with diabetes and families to help them manage their condition—fewer than an estimated 20% of people receive education.
- Delivery of NICE agreed standards of care across the country. The Year of Care provides an approach to improving the delivery of care processes and personalisation of care to deliver this.
- Diabetes services which are integrated, joined up across primary, community and secondary care to ensure the year on year care needs of people with diabetes are met.
- Specialist diabetes teams available locally supporting primary care to deliver quality routine care, managing people with diabetes with complex needs and providing specialist inpatient care—32% of patients experienced at least one medication error while in hospital and 51% of hospitals do not have any Diabetes Specialist Nurse time.
- A national system of properly funded and supported local diabetes delivery networks with clear diabetes leadership across the whole system of care.

5.2 The levers needing to be in place to make this happen are:

- Diabetes outcome improvement to be mandated in the Mandate from the Secretary of State to the NHS Commissioning Board.
- The NHS Commissioning Board to give clear priority to improving the standards of diabetes care in its Commissioning Outcomes Framework and Commissioning Guidance to the Clinical Care Commissioning Groups.
- Development by the NHS Commissioning Board of mechanisms for dealing with those CCGs who fail to commission effective standards of diabetes care.
- The NHS Commissioning Board and Monitor (the economic regulator) to develop incentives for the delivery of the NICE quality standards including diabetes tariffs.
- Clinical Commissioning Groups to commission integrated, joined up care pathways across primary, community and secondary care, underpinned by multi-disciplinary local clinical networks.
- Outcome indicators for diabetes care included in all outcomes frameworks (the Commissioning Outcomes Framework, the Public Health Outcomes Framework) to enable monitoring of all NICE diabetes quality standards.
- Review the GP Quality Outcomes Framework (QOF) to deliver clinical outcomes, not just care processes, and removal of exclusions which mask poorer performance.
- An implementation plan with outcomes and timescales to deliver all this.

6. Review in 18 Months

In view of the lack of progress made to date and the lack of continuity resulting from NHS reforms, we ask the Public Accounts Committee to request the NAO to revisit to check on progress in 18 months.

Annex 1

Key Questions for the Committee

Suggested questions to be answered by the Department of Health:

1. What will the Department of Health and the NHS Commissioning Board do to reduce geographic variation in delivery of the NICE quality standards across the UK and ensure the delivery of all the standards?

2. What are the blockages to standards being delivered locally and what will the Department of Health and the NHS Commissioning Board do to overcome these blockages?

3. What levers will the DH and NHS Commissioning Board use to improve poor standards of care for diabetes in the reformed NHS?

4. What action will the NHS Commissioning Board take if Clinical Commissioning Groups fail to achieve the NICE quality standards through their commissioning?

5. The National Service Framework has been published for 11 years and good comparative national information on poor standards of care for diabetes has been increasingly available for the last six years. Why
has a clear standard and information on comparative performance not driven significant change and improvement? What further action to produce change is required and why will that work when the previous system clearly hasn’t?

6. DH aims to tackle diabetes as part of its long-term condition strategy and vascular strategy. Diabetes as a condition requires more regular clinical management than many long-term conditions. For example, it needs effective monitoring and detection of developing complications and day on day management of glucose levels. Since many more people have, or are at risk of diabetes than other long-term conditions, doesn’t diabetes merit an action plan of its own?

7. If diabetes is not to be given priority in the mandate from the Secretary of State to the NHS Commissioning Board, why not? Isn’t something that accounts for a significant proportion of the NHS budget and kills 24,000 people unnecessarily every year, important?

8. Where will the responsibility lie in the reformed NHS for ensuring that the increase in diabetes prevalence, increase in complications and poor quality care is tackled now?

9. Why has the Department spent millions on public education campaigns on other conditions such as cancer, stroke and heart disease but not on diabetes which affects four times more people than all the cancers combined and results in 24,000 avoidable deaths a year?

10. What will the Department of Health do to hold Public Health and Wellbeing Boards to account for effective delivery of the NHS Vascular Health Check to reach the 7 million people at high risk of diabetes and the 1m people who currently have undiagnosed diabetes? What sanctions are available if the health check is not delivered effectively?

11. How will the Department of Health ensure that people found to be at high risk through the Health Check will receive effective lifestyle advice to avoid developing diabetes and those who are diagnosed with diabetes are referred to NHS treatment and not lost in the system?

June 2012

Written evidence from the Association of British Clinical Diabetologists

1. The Association of British Clinical Diabetologists (ABCD) is an organisation which represents Consultants and Trainees specialising in the care of people with diabetes. Its members are therefore well placed to observe the problems associated with the management of diabetes in the NHS. The conclusions of the national Audit Office report are welcome, and reflect the frustration felt by our members who strive to deliver good care, despite the constraints of the current NHS. There are a number of points we would make in addition to those highlighted in the report.

2. While welcoming the drive to ensure that all recommended checks are carried out in all people with diabetes, we would stress that due attention must be given to the mechanisms which would allow action to be taken as a result of those checks. The NHS has a recent history of ticking boxes for targets but finding means to avoid change in practice. The final recommendations need to go beyond the targets and arrive at better outcomes for people with diabetes. The costs of dealing with the complications of diabetes (heart attack, stroke, blindness, renal failure and amputation) vastly outweigh the costs of early intensive therapy: early treatment results in better outcomes and lower costs for the NHS. Currently 10% of NHS resources are expended on this one condition, with the ratio of the cost of complications to the cost of treatment exceeding 3 to 1. The figure is expected to rise to 17% of NHS resources by 2035–36 (1).

3. The way in which services for people with diabetes are funded needs a thorough overhaul. The payment by results tariff, which placed a set cost for each clinical encounter, has created a perverse disincentive to seek a specialist assessment. As a result many people with diabetes are deprived of access to the specialist team. Payment by results is not an appropriate funding model for long term conditions such as diabetes, as it disrupts the seamless cross boundary care pathway which is the essence of success in a long term condition such as diabetes. There are a number of better alternatives for commissioning of diabetes care, such as the year of care model, which should be explored.

4. We would strongly support further empowerment of primary care by utilising consultant led multidisciplinary diabetes team to provide leadership and support for community locality wide diabetes services. This would be an effective intervention both in terms of quality and finance. Within the hospital setting “clinical studies suggest that specialist diabetes inpatient teams can reduce prescribing errors, improve patient outcomes, reduce length of stay, increase day case rates and reduce the number of admissions.....the savings from introduction of such teams can substantially outweigh the cost of the team” (2). However, despite this, an inpatient diabetes team has not been commissioned within all hospitals. We argue strongly for a more effective use of the skills and time of the multidisciplinary diabetes team, led by consultants specialising in diabetes, both in the community and within hospitals (3).

5. In summary, therefore, we would suggest the following points. We would stress that these measures would not require additional funding and would be cost effective in the longer term.
5.1 In order to reverse the negative impact of recent years we strongly advocate the development of a fully commissioned and resourced specialist service in every locality, enabling integrated diabetes care in all settings and ensuring that people with diabetes have access to specialist care when clinically appropriate.

5.2 Adequately supported, resourced and managed local diabetes networks with clinical leadership from specialist care are mandated to intervene in all areas. Such networks should have strong representation from people with diabetes and carers, and have well defined reporting arrangements to local Clinical Commissioning Groups and Health and Wellbeing Boards.

5.3 There should be access for all people with diabetes to high quality, accredited, structured education for better self management.

5.4 All type 1 patients should be enabled to see a consultant-led specialist team. Models should offer a range of options for those less engaged (eg adolescents, institutionalised and housebound). Uniform access to an insulin pump service in all localities is urgently needed.

5.5 All acute trusts should have a fully operational consultant-led in-patient diabetes service with moves to offer 24 hour on-call specialist support.

5.6 Financial models of payment should be developed to fit in with the clinical service in each locality, rather than imposing a “one size fits all” PBR payment by results tariff which creates perverse incentives and disincentives.

5.7 As more than 80% of diabetes is managed within primary care, education of Health Care Professionals (HCPs) by the local specialist team should be part of commissioned integrated care. Clinical commissioning groups and acute trusts need strategies to address the widespread deficiencies in the skills and competencies of HCPs involved in the care of those with diabetes.

5.8 The capacity of services in all settings needs to be planned for the year on year increase in diabetes.

5.9 Effective integrated Diabetes IT systems are vital to enable all of the above and to deliver and record the returns of better care, fewer complications and better value for money.

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June 2012

Written evidence from the Chief Executive of the NHS in England

RE: Q102: FIONA MACTAGGART: DO YOU HAVE AN ESTIMATE OF WHAT THE COST OF PRESCRIBING ERRORS ACROSS THE NHS ACTUALLY IS?

In 2004, the Department of Health estimated the costs of medication-related admissions to hospitals to be in the order of £200–400 million a year.¹

In 2007, the Patient Safety Observatory of the National Patient Safety Agency estimated that preventable harm from medicines could cost more than £750 million each year in England. The Patient Safety Observatory judged that this figure was likely to be conservative as the best estimates of rates of harms from medicines among hospitalised patients were based on available evidence, which did not include administration errors and other key safety categories. In addition, there was very little literature on harms occurring in the community where the majority of drugs are prescribed, dispensed and administered, apart from those resulting in hospital

admissions. Service costs associated with these harms include the costs of increased GP consultations, further prescriptions and community nursing visits.  

*June 2012*

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**Written evidence from Dr Rowan Hillson MBE**

Information from NHS Diabetes in response to Q’s 38–40 of the oral evidence taken on 12 June 2012.

PCTs among higher mortality outliers in the National Diabetes Audit Mortality Analysis that have requested and received support from NHS Diabetes are Stockton, Sandwell, and Heywood, Rochdale & Middleton. Nottingham PCT enquired about assistance but has not requested further help.

Other PCTs that have recently sought service improvement support from NHS Diabetes but not specifically as a result of the mortality audit are NHS Suffolk, Telford & Shrewsbury, Hastings & Rother, and Southampton, Isle of White & Portsmouth. These PCTs were not in the higher mortality group.

*24 July 2012*

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