

House of Commons Committee of Public Accounts

Management of adult diabetes services in the NHS: progress review

Seventeenth Report of Session 2015–16



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Report, together with formal minutes relating to the report

Ordered by the House of Commons to be printed 13 January 2016

The Committee of Public Accounts

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The current staff of the Committee are Stephen McGinness (Clerk), Mark Ewbank (Second Clerk), James McQuade and George James (Senior Committee Assistants), Sue Alexander and Ruby Radley (Committee Assistants) and Tim Bowden (Media Officer).

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Summary

Since the previous Committee of Public Accounts reported in 2012, the Department of Health and NHS England have made progress in improving outcomes for diabetes patients. International evidence now available also suggests that the UK performs well compared to other countries in terms of outcomes for diabetes patients. However, there are significant variations in the routine care and support that diabetes patients receive, and in outcomes for diabetes patients. We are concerned that the witnesses from the Department and NHS England painted an unduly healthy picture of the state of diabetes services in England. Although an individual diabetes patient's prospects are getting better, the number of people with diabetes is rising by 4.8% a year, and performance in delivering the nine care processes and achieving the three treatment standards, which help to minimise the risk of diabetes patients developing complications in the future, has stalled. In addition, very few new diabetes patients are taking up education that could help them manage their condition, and the number of diabetes patients experiencing complications (which account for over two-thirds of the cost of diabetes to the NHS) continues to rise. This all means that the costs of diabetes to the NHS will continue to rise. In order to control these costs, the Department and NHS must take significant action to improve prevention and treatment for diabetes patients in the next couple of years.

Introduction

Diabetes is a chronic condition where the body does not produce enough insulin to regulate blood glucose levels. In 2013–14, there were an estimated 3.2 million people aged 16 years or older with diabetes in England. There are two main types of diabetes. Around 10% of people diagnosed with diabetes have type 1 diabetes, which occurs when the body produces no insulin. The remaining 90% have type 2 diabetes, which occurs when the body cannot produce enough insulin to function properly, or when the body's cells do not react to insulin. Being overweight is the main modifiable risk factor for type 2 diabetes and 90% of adults with type 2 diabetes are overweight or obese.

With education and appropriate support most people with diabetes can manage their condition themselves. They also need regular checks to monitor treatable risks for diabetic tissue damage and to detect the early damage itself, so that treatment can be given to prevent deterioration. The risk of developing diabetic complications can be minimised by early detection and management of high levels of blood glucose, blood pressure and cholesterol. The cost of complications accounts for over two-thirds of the £5.6 billion a year that diabetes is estimated to cost the NHS. The Committee of Public Accounts last took evidence on diabetes services in 2012. In its report, the Committee concluded that too many people with diabetes were developing complications because they were not receiving the care and support they needed.

Conclusions and recommendations

There are unacceptable variations in the take up of education programmes, 1. delivery of recommended care processes, achievement of treatment standards and in outcomes for diabetes patients. There are significant geographic variations across clinical commissioning groups. For example: in different parts of the country the percentage of people achieving the three treatment standards for blood glucose, blood pressure and cholesterol levels ranged from 28% to 48% in 2012-13; and the additional risk of death among people with diabetes within a one-year follow-up period, ranged from 10% to 65%. There are also significant variations between different groups of diabetes patients; for example, younger people with type 1 and type 2 diabetes and people with type 1 diabetes of all ages receive fewer of the recommended care processes and are less likely to achieve the three treatment standards. The extent of these variations illustrates that best practice is not being spread effectively. NHS England told us that some of the variations may be down to how GP practices use their IT systems, with some practices not using the full functionality of these systems to support the delivery of local diabetes care. The Department of Health (the Department) told us that new data for 2013-14 and 2014-15 will be available in January 2016. In response to our previous report on diabetes, the Department set targets are that by 2018, 80% of patients should receive all nine recommended care processes and 40% should be achieving all three of NICE's treatment standards. In its evidence to us NHS England seemed not to know for certain whether it is still working towards the 80% target.

Recommendation: The Department and NHS England should:

- By April 2016, use the new diabetes data available in January to identify those clinical commissioning groups that are performing poorly in comparison to the national average and establish interventions to help them improve their performance.
- By July 2016, set out a timetable to reduce geographical variations and variations between different patient groups.
- Clarify which diabetes targets remain in place.
- Develop a strategy for sharing best practice, including on using GP IT systems effectively to support the delivery of diabetes care, and report back to us within six months.
- 2. The Department and NHS England have allowed a system to develop that has reduced GP practice participation in the National Diabetes Audit, potentially undermining one of the most comprehensive clinical audits in world. NHS England told us that the National Diabetes Audit is one of their flagship international audits and is the largest of its kind in the world. The level of GP practice participation in this audit is falling—71% in 2012–13 compared to 88% in 2011–12. The Department and NHS England told us that the participation rate had fallen as an unintended consequence of changing participation from an opt-out exercise to an opt-in exercise. The action was taken by an independent group that reports to the Department. The Department and NHS England recognise that they need to revisit this matter. We

are very concerned that the Department and NHS England failed to think about the consequences of moving from an opt-out model to an opt-in model. While participation in the audit remains voluntary, the full extent of variation across the system will not be known.

Recommendation: NHS England should make it mandatory for GP practices to submit data for the National Diabetes Audit and should report back to the Committee on progress by the end of 2016.

3. We welcome the introduction of the new NHS Diabetes Prevention Programme but, by itself, this will not be enough to stem the rising number of people with diabetes. An estimated 200,000 people are newly diagnosed with diabetes every year. In March 2015, NHS England, Public Health England and diabetes UK launched the NHS Diabetes Prevention Programme, which targets people at high risk of developing type 2 diabetes. In 2015–16 the programme aims to support up to 10,000 people, through local initiatives on weight loss, physical activity and cooking and nutrition. NHS England told us that the programme will eventually help 100,000 people a year. The Department, NHS England, and Public Health England will need to move at pace and at scale to stem the rising number of people with diabetes.

Recommendation: NHS England and Public Health England should, by April 2016, set out a timetable to ramp up participation in the national diabetes prevention programme to 100,000 people a year, set out what it will cost, and how the programme will target those areas with the highest prevalence of diabetes. Public Health England should also set out how its other public health activities, such as marketing campaigns, will contribute to preventing diabetes.

4. Current payment mechanisms do not incentivise secondary and primary care clinicians to work together to deliver integrated diabetes care. NHS England told us that the NHS has fragmented funding streams and that it has established 50 'vanguard' sites to test new delivery models that aim to tackle the disconnections between primary and specialist services, between physical and mental health services and between health and social care. NHS England also told us about best practice tariffs that are encouraging different clinical teams to work together within hospitals. However, there are no financial incentives to encourage secondary care clinicians to work with primary care clinicians. Some areas outside of the vanguard sites, have found workarounds to the current funding arrangements and are delivering integrated diabetes care.

Recommendation: Whilst vanguard sites are testing new models of delivery, NHS England and Monitor should examine whether the current tariff arrangements support secondary and primary care clinicians to deliver integrated diabetes care. If they are a barrier to integrated care, NHS England and Monitor should develop a proposal in the next 12 months on how to resolve this.

5. Few newly diagnosed diabetes patients are taking up education programmes that can help them manage their condition effectively and reduce their risk of developing complications. Education programmes help patients to manage their condition themselves by providing information on eating a healthy diet, monitoring their blood glucose levels and taking insulin or glucose-lowering medication as

needed. Structured education has been shown to be effective in reducing the risk of people with diabetes developing complications. In 2012–13, 16.4% of newly diagnosed diabetes patients were recorded as being offered structured education and 3.6% were recorded as taking up the offer. There have been problems with poor recording of the take-up of education programmes by GP practices, and in April 2013, an incentive to record whether a patient has been offered education was introduced in the Quality and Outcomes Framework for GPs. Data for 2014–15, suggests that this incentive has had an impact with the percentage of patients having a record of being referred to a structured education programme increasing. But, the percentage of patients still varied between 25% and 90% across clinical commissioning groups. No data is available on whether these patients actually attended the education programmes. NHS England recognised that the current model for delivering structured patient diabetes education is clunky and antiquated and needs modernising.

Recommendation: NHS England needs to develop a better and more flexible range of education support for diabetes patients and set out by when this support will be available. To support the development of education services, NHS England also needs to improve the quality of data on take up of education programmes.

6. Diabetes specialist staffing levels in hospitals are not keeping pace with the increasing percentage of beds occupied by diabetes patients. The percentage of beds in acute hospitals in England occupied by people with diabetes continues to rise, from 14.8% in 2010 to 15.7% in 2013. However, the level of diabetic specialists has not significantly changed over this period. In 2013, nearly one-third of hospitals in England taking part in the audit had no diabetes inpatient specialist nurse and 6% did not have any consultant time for diabetes inpatient care. NHS England told us that an increase in nursing numbers isn't likely in the next year or two.

Recommendation: Given that the level of diabetic specialists in hospitals is unlikely to rise in the short term, NHS England should ensure that all clinical staff have at least a basic level of training and knowledge about diabetes so that these patients can receive the best care possible given the limitation on resources.

1 Progress in delivering diabetes care

- 1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department), NHS England and Public Health England on the management of adult diabetes services in the NHS.¹
- 2. Diabetes is a chronic condition where the body does not produce enough insulin to regulate blood glucose levels. In 2013–14, there were an estimated 3.2 million people aged 16 years or older with diabetes in England, of whom 2.8 million were diagnosed and 400,000 were undiagnosed. The number of people aged 16 and older with diagnosed diabetes is, on average increasing by 4.8% a year. There are two main types of diabetes. Around 10% of people diagnosed with diabetes have type 1 diabetes, which occurs when the body produces no insulin. The remaining 90% have type 2 diabetes, which occurs when the body cannot produce enough insulin to function properly, or when the body's cells do not react to insulin. Being overweight is the main modifiable risk factor for type 2 diabetes and 90% of adults with type 2 diabetes are overweight or obese.²
- 3. With education and appropriate support most people with diabetes can manage their condition themselves. They also need regular checks to monitor treatable risks for diabetic tissue damage and to detect the early damage itself, so that treatment can be given to prevent deterioration. The risk of developing diabetic complications can be minimised by early detection and management of high levels of blood glucose, blood pressure and cholesterol. The estimated cost of diabetes to the NHS in England was £5.6 billion in 2010–11. The cost of complications (such as amputation, blindness, kidney failure and stroke) accounts for 69% of these costs.³ The Committee of Public Accounts last took evidence on diabetes services in 2012. In its report, the Committee concluded that too many people with diabetes were developing complications because they were not receiving the care and support they needed.⁴

Care processes, treatment standards and outcomes for diabetes patients

4. Outcomes for diabetes patients are improving—there have been reductions in an individual diabetes patient's risk of mortality and risk of complications, such as heart failure. NHS England told us that these improvements are the result of improvements in diabetes care in the previous decade. However, the absolute number of diabetes patients with complications continues to rise.⁵ A review of international data published in 2013, showed that the UK had the lowest rates of early death due to diabetes of the 19 countries covered. NHS England cited other international evidence that also showed the UK performing well compared to other countries, such as an OECD study published in June 2015 showing that the UK has one of the lowest hospital admission rates for diabetes.⁶

C&AG's Report, The management of adult diabetes services in the NHS: progress review, Session 2015-16, HC 489, 21 October 2015

² Q 129; C&AG's Report, paras 1-3

³ Qq 56, 67-68; C&AG's Report, paras 4, 5

⁴ Committee of Public Accounts, The management of adult diabetes services in the NHS, 17th report of Session 2012-13, HC 289, 6 November 2012

⁵ Qq 38, 40-44; C&AG's report paras 2.32, 2.34, and Figures 13 and 14

⁶ Qq 89-91; C&AG's report para 2.35

- 5. In response to recommendations in the previous Committee's report on diabetes, the Department set targets that by 2018, 80% of patients should receive all nine recommended care processes and 40% should be achieving all three of NICE's treatment standards for blood glucose, blood pressure and cholesterol levels. When pressed on progress against the 80% target, NHS England told us that it did not "believe" that it was working towards this target anymore, but seemed uncertain, and the Department was non-committal. NHS performance in delivering the nine care processes has not improved since we last reported on diabetes services, with about 60% of patients now receiving all the care processes, except eye screening which is now reported separately. The Department told us that although performance is plateauing, in 2012–13 about 230,000 more people were receiving these care processes compared to 2009–10. The percentage of patients achieving all three treatment standards has also stalled at about 36%.
- 6. There are significant geographic variations across clinical commissioning groups. For example: the percentage of people with diabetes receiving all the recommended care process, apart from eye screening, ranged from 30% to 76%; the percentage of people achieving the three treatment standards for blood glucose, blood pressure and cholesterol levels ranged from 28% to 48% in 2012–13; and the additional risk of death among people with diabetes within a one-year follow-up period, ranged from 10% to 65%. There are also significant variations between different groups of diabetes patients. For example, younger people with type 1 and type 2 diabetes and people with type 1 diabetes of all ages receive fewer of the recommended care processes and are less likely to achieve the three treatment standards. ¹⁰
- 7. NHS England told us that much of the variation is down to GP practice-level organisational factors rather than socioeconomic factors in that area. For example, it told us that some of the variations may be down to how GP practices use their IT systems, with some practices not using the full functionality of these systems to support the delivery of local diabetes care. GP practices can use one of four IT systems. NHS England was confident that the type of IT system being used had no impact on outcomes for diabetes patients.¹¹
- 8. In terms of spreading best practice to tackle these variations, NHS England told us that if a local health economy requires help, it can call in the Right Care programme to benchmark where its current level of service provision is compared with the gold standard clinical pathway and look to reduce the difference. Best practice is also shared through attendance at conferences.¹²
- 9. NHS England is accountable for ensuring that clinical commissioning groups deliver their statutory functions and improve outcomes for their populations, and it does so through an assurance framework.¹³ NHS England told us that it is developing a new performance framework, or scorecard, that will provide an overall rating for each clinical commissioning group, using the same rating methodology that the Care

⁷ Qq 83; C&AG's report paras 2.14 and 2.20; Committee of Public Accounts, The management of adult diabetes services in the NHS, 17th report of Session 2012-13, HC 289, 6 November 2012

⁸ Qq 1, 4, 77; C&AG's report paras 2.16 and 2.20

⁹ Qq 1-2, 96-97; C&AG's report para 17 and Figures 10, 12 and 16

¹⁰ Qq 99-100, 141; C&AG's report para 16

¹¹ Qq 79-82, 84-88

¹² Qq 37, 83, 98

¹³ C&AG's report para 1.13

Quality Commission uses for NHS trusts. The scorecard will have a specific 'domain' on diabetes, with performance independently assessed, and scores being publicly available. NHS England will consult on the metrics to be used to assess performance and plans to introduce the scorecard in April 2016. The scorecard will be used to trigger interventions by NHS England where performance is poor.¹⁴

Patient education

- 10. Education programmes help patients to manage their condition themselves by, for example, providing information on eating a healthy diet, monitoring their blood glucose levels and taking insulin or glucose-lowering medication as needed. Structured education has been shown to be effective in reducing the risk of people with diabetes developing complications. In 2012–13, 16.4% of newly diagnosed diabetes patients were recorded as being offered structured education and 3.6% were recorded as taking up the offer. NHS England told us that the current model for delivering structured patient diabetes education is clunky and antiquated and needs modernising. Currently, education is delivered over a number of days during the week, when most adults are either at work, in school or further education. NHS England told us that they are exploring a web-based platform for the delivery of structured education. ¹⁵
- 11. There have been problems with poor recording of the take-up of education programmes by GP practices, and in April 2013, an incentive to record whether a patient has been offered education was introduced in the Quality and Outcomes Framework, a voluntary annual reward and incentives programme for all GP practices in England. The Department told us that data recently published for 2014–15 showed that between 72% and 95% of patients were being offered structured education. However, we note that these figures exclude exceptions, such as where the GP deems the intervention inappropriate or the patient refuses the intervention. Therefore the actual percentage of patients newly diagnosed with diabetes who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register varied from 25% to 90%. No data is available on whether these patients attended the education programmes.¹⁶

The National Diabetes Audit

- 12. The National Diabetes Audit collects data on care processes and outcomes from GP practices and secondary care. NHS England told us that it is one of its flagship international audits and is the largest of its kind in the world. The level of GP practice participation in this audit is falling. In 2012–13, 71% of GP practices in England participated compared to 88% in 2011–12. The Department told us that new National Diabetes Audit data for 2013–14 and 2014–15 will be available in January 2015.¹⁷
- 13. The Department and NHS England told us that the participation rate had fallen as an unintended consequence of changing participation from an opt-out exercise to an opt-in exercise. This action was taken by an independent advisory group that reports to the Department and seeks to protect the confidentiality of patient information. The

¹⁴ Qq 20-35, 102

¹⁵ Qq 135-137; C&AG's report paras 2.9-2.13

¹⁶ Qq 135, 159; C&AG's report para 2.13; QOF 2014-15: prevalence, achievement and exceptions at CCG level, Health and Social Care Information Centre, 29 October 2015

¹⁷ Qq 2-5; C&AG's report para 2.2

Department and NHS recognised that this was a very unsatisfactory situation and that they need to revisit it. NHS England also told us that NHS reorganisation had disrupted participation, and that some clinical commissioning group areas have better participation than others, depending on how much resource has been invested in supporting the GP practices to upload the data.¹⁸

2 Supporting the delivery of diabetes care

Prevention of diabetes

- 14. An estimated 200,000 people are newly diagnosed with diabetes every year and by 2030, the percentage of the adult population with diabetes is set to rise to 8.8%, up from 7.8% in 2013–14. NHS England told us that this percentage could be higher unless effective action is taken to reduce the number of people being diagnosed with diabetes. Being overweight is the main modifiable risk factor for type 2 diabetes, and the most effective way of reducing the long-term costs of diabetes will be to reduce the number of obese and overweight people. Description of the set of the set
- 15. Since April 2013, local authorities have had to offer an NHS Health Check, a cardiovascular assessment, to those aged 40 to 74 who have not been diagnosed with a existing vascular disease or are being treated for certain risk factors, every five years. NHS England told us that while these health checks identify those at risk of developing type 2 diabetes, the NHS has not been empowering those at risk to do something about it when they receive this information.²¹
- 16. In March 2015, NHS England, Public Health England and Diabetes UK launched the NHS Diabetes Prevention Programme, which targets people at high risk of developing type 2 diabetes. Public Health England told us that the programme aims to build on international evidence that a sustained intervention, over at least nine months with a significant amount of face-to-face time, can reduce the risk of developing type 2 diabetes. In 2015–16, the programme aims to support up to 10,000 people, through local initiatives on weight loss, physical activity and cooking and nutrition. NHS England told us that the programme will eventually help 100,000 people a year.²²
- 17. Public Health England told us that it was working closely with the Secretary of State for Health on developing the government's obesity strategy, which is due to be published in early 2016. Public Health England also told us that it had published evidence that indicates the introduction of a sugar tax of 10% to 20% would reduce sugar consumption, noting that to date the government has ruled out introducing such a tax.²³
- 18. Public Health England also told us that it plans to take broader action to tackle obesity, such as using social marketing campaigns to try to influence behaviour around changing diet and exercise. In 2014–15, it spent £53 million on social marketing £38 million was spent on individual campaigns, such as Smokefree and Change 4 Life, with the rest spent on infrastructure, including evaluation. Individual campaigns use a range of different channels including TV, radio, print, digital, and billboards. Public Health England acknowledged that it had not targeted the adult population with messages about

¹⁹ Qq 38, 52-55, 139; C&AG's report para 2.3

²⁰ Q 93; C&AG's report para 1.3

²¹ Qq 39, 119-122; C&AG's report paras 2.5, 2.6

²² Qq 38-39, 49, 52, 60, 72, 93, 111-119, 136-137

²³ Qq 60, 92, 130-134

their health for a long time, with the focus in recent years being on smoking, families and children, but plans to target adults with messages on diet, obesity and exercise in 2016.²⁴

Financial incentives to deliver better diabetes care

19. NHS England recognises that the NHS has fragmented funding streams with disconnections between primary and specialist services, between physical and mental health services and between health and social care. It told us that implementation of the NHS five-year forward view aims to address this issue and that it has established 50 'vanguard' sites to test new delivery models that join up these services and funding flows. Best practice tariffs are encouraging different clinical teams to work together within hospitals, but there are no financial incentives to encourage secondary care clinicians to work with primary care clinicians. Some areas outside of the vanguard sites, have found workarounds to the current funding arrangements and are delivering integrated diabetes care.²⁵

20. The reward and incentive scheme for GP practices, the Quality and Outcomes Framework, is based on the percentage of patients at GP practices receiving recommended care and achieving specific clinical indicators, including diabetes, to improve health outcomes. NHS England told us that these incentives had helped to improve performance in delivering the nine care process, from 6.5% in 2003–04 to 60% in 2010–11, and achieving the three treatment standards, but to improve performance further an additional lever would be needed to tackle variation across the system.²⁶

Quality of care in hospitals

21. The percentage of beds in acute hospitals in England occupied by people with diabetes continues to rise, from 14.8% in 2010 to 15.7% in 2013. However, the level of diabetic specialists has not significantly changed over this period. In 2013, nearly one-third of hospitals in England taking part in the audit had no diabetes inpatient specialist nurse and 6% did not have any consultant time for diabetes impatient care. NHS England told us that an increase in nursing numbers isn't likely in the next year or two. Although many aspects of diabetes care in hospital are improving, the percentage of patients with a severe low blood sugar episode requiring injectable treatment—a life-threatening event—has remained at just over 2%, and patient satisfaction has not improved.²⁷

²⁴ Qq 60-66, 103-104, 122-129; Written evidence from Public Health England, 25 November 2015

²⁵ Qq 45-48, 108; C&AG's report para 14

²⁶ Q 36; C&AG's report paras 2.35, 3.3 and Figure 9

²⁷ Qq 56, 95; C&AG's report paras 2.28 and 2.29

Formal Minutes

Wednesday 13 January 2016

Members present:

Meg Hillier, in the Chair

Mr Richard Bacon Nigel Mills

Deidre Brock David Mowat

Chris Evans Steven Phillips

Caroline Flint John Pugh

Mr Stewart Jackson Mrs Anne-Marie Trevelyan

Draft Report (*Management of Adult Diabetes Services in the NHS: progress review*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 21 read and agreed to.

Introduction 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.

[Adjourned till Monday 18 January 2016 at 3.30pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page.

Monday 16 November 2015

Question number

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

Q1-159

Published written evidence

The following written evidence was received and can be viewed on the Committee's <u>inquiry web page</u>. DIA numbers are generated by the evidence processing system and so may not be complete.

- 1 Department of Health (DIA0005)
- 2 Diabetes UK (DIA0002)
- 3 Dr P J Donnelly (DIA0004)
- 4 Novo Nordisk (DIA0001)
- 5 Public Health England (DIA0003)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the Committee's website at www.parliament.uk/pac.

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