LONDONASSEMBLY

Health Committee

Blood Sugar Rush

Diabetes time bomb in London

April 2014

Health Committee Members

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The Health Committee is tasked with reviewing health and wellbeing across London, including progress against the Mayor's Health Inequalities Strategy, and work to tackle public health issues such as obesity and alcohol misuse. The Committee will consider the Mayor's role as Chair of the new pan-London Health Board and the impact that recent health reforms are having on the capital, notably NHS reconfiguration and the decision to devolve public health responsibilities to local authorities.

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Chair's Foreword

Almost half a million Londoners are living with Type 2 diabetes and the figure is set to increase exponentially over the coming years.

Driven by genetic and lifestyle choices, the growing number of adults and young Londoners contracting Type 2 diabetes is putting ever more pressure on limited NHS services. Half of all Londoners are overweight or considered clinically obese, with children as young as seven now being diagnosed.

It would be easy to blame the individual. But the burden for the ticking diabetes time bomb must be borne by all, including the NHS and government. The strong correlation between obesity prevalence rates to communities with low employment prospects, poor housing, limited and access to health and social care services reflect the challenge households face in making health-conscious decisions. Families cannot be to blame for making both time and financially rational decisions to buy cheap, quick, but nutrition poor food.

If the public are to be co-opted into making positive lifestyle choices in order to combat Type 2 diabetes, we must create the opportunities for them to do so and also bring about the end of practices that rationalise poor diet choices. London boroughs are already leading the way with examples emerging across the city of health and planning policy coming together to shift the priority and focus of local government from treatment to prevention.

Around £10 billion of the national health spend is used to treat the consequences of diabetes. With a heavy price tag, this is the cost of failure felt by the public because of the lack of focus on preventing the causes of ill health. Instead, great sums of public money are spent medically treating the consequences when the collective priority and focus should be on helping people live longer, healthier lives.

For those who have Type 2 diabetes, we must put power back into their hands in helping them treat their condition. By removing artificial barriers for them within the NHS we can connect them directly to effective help that speaks to their needs, without them having to navigate the complex

web of NHS primary, community and acute care systems even clinicians find confusing.

The devolution of public health powers to local government presents a huge opportunity. For a city like London however, strong leadership will be required to ensure that those tasked with improving the health and well-being of Londoners, alongside those responsible for ensuring equal access to health services, are able to work together to solve this city-wide concern.

Local action and leadership can only go so far in providing a counterbalance to the growing problem, one in which the food and drinks industry ought not to drag its heels. The efficacy of the government's 'responsibility deal' has already been called into question. It must seek to have the strength of willpower in applying stricter controls, and bring about the rapid reduction in the role sugar plays within the daily diet of Londoners, and the nation alike.

Dr Onkar Sahota AM MBA FRCGP
Chair of the Health Committee

1. The scale of the problem

Cases of Type 2 diabetes have increased markedly in London over the last decade and more quickly here than elsewhere in the country, presenting a growing challenge to treat and manage the condition in hospital and community settings. The rise in obesity fuelled by sedentary lifestyles, often exacerbated by poor diet, is contributing to the rise in Type 2 diabetes we are seeing in the capital.

Robust action is needed at all levels of government to drive up standards of care for diabetes and manage the growing obesity problem – a key driver for Type 2 diabetes in London.

More than one in 20 people in the UK has diabetes.[1] In London, there are an estimated 475,000 people diagnosed with the condition. Up to a further 200,000 people could be living with diabetes by 2025.[2]

In undertaking this review, the London Assembly Health Committee has sought to tease out what is driving the increase in Type 2 diabetes across London, and how the delivery of diabetes care is managed and where improvements can be made in providing that care.

The London picture

There has been an estimated 75 per cent increase in Type 2 diabetes in the capital over the last decade. [3] The demographics of the London population make the capital particularly susceptible to higher numbers of people with Type 2 diabetes. People of Afro-Caribbean descent are three times more likely to develop the condition than their white counterparts and South Asians six times more likely. Over half of London's 40 per cent Black Asian and Minority Ethnic (BAME) population is made up people of Afro-Caribbean or South Asian descent. As the condition tends to present at a younger age in these ethnic groups, there is potentially a higher risk of developing diabetes-related long-term complications.

[1] This includes diagnosed and undiagnosed cases.
[2] Yorkshire and Humber Public Health Observatory Diabetes Prevalence Model for Local Authorities 2012. The data provides estimates of the number of people aged 16 or older with diagnosed and undiagnosed diabetes.
[3] Diabetes guide for London, NHS Healthcare for London, March 2009

More than half of the adult population in London is either overweight or obese.[4] Expert guests told the Committee that while ethnicity, age and deprivation all have a part to play, in their opinion the rise in obesity is by far the most prominent factor contributing to the increase in Type 2 diabetes in London.

An emerging crisis for the National Health Service

The rise in the number of diabetes cases is placing huge strain on healthcare budgets. Diagnosed cases have more than doubled since 1996, rising from 1.4 million to 2.9 million people. A further 850,000 people are estimated to have the condition, but have not been formally diagnosed.[5] Five million more people are expected to be living with the condition within the next 10 years.

Diabetes accounts for around 10 per cent of current national health spend,[6] four-fifths going towards treating complications. Diabetes-related health spend in London is also estimated to be around 10 per cent of the overall budget.[7] It is estimated that the proportion of spend could rise to 17 per cent over the next 25 years.[8] Diabetes is now the biggest single cause of amputation, stroke, blindness and end-stage kidney failure in the UK.

Barbara Young, Chief Executive of Diabetes UK has warned that unless the issue is addressed:

"this unfolding public health disaster will only get worse."

Focus on integrated care and joined up policy

The following two chapters of this report focus on the importance of integrated care services in driving up the quality of diabetes care and improving patient outcomes, and of joined-up policy approaches to help manage key drivers for Type 2 diabetes, such as obesity.

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[4] Public Health England, www.lho.org.uk/LHO_Topics/Health_Topics/Lifestyle_and_behaviour/Obesity.aspx#4

[5] Figure based on data from the Association of Public Health Observatories diabetes prevalence model. The data provides estimates of the number of people aged 16 or older with diagnosed and undiagnosed diabetes.

[6] State of the nation 2012, Diabetes UK

[7] Direct spending on diabetes accounts for approximately 1.3%, but when diabetes-related spending in areas such as vision, renal failure and circulation is factored in, it rises to around 10%. See, Talking diabetes: joining up policy and practice in London, London Health Forum, 2011

[8] *Impact Diabetes,* Diabetes UK, the Juvenile Diabetes Research Foundation and Sanofi Diabetes, April 2012

What is diabetes?

Diabetes mellitus is a condition in which the amount of glucose (sugar) in the blood is too high because the body is unable to process it properly. There are two main types of diabetes:

Type 1 diabetes develops if the body cannot produce any insulin, the hormone which helps glucose to enter the cells where it is used as fuel by the body. Type 1 diabetes is the least common of the two main types and accounts for around 10 per cent of all people with diabetes. People tend to develop this type of diabetes before the age of 40.

In Type 2 diabetes the body can still make insulin, but not enough, or the insulin it does produce does not work properly. This type of diabetes is the more common of the two main types, accounts for around 90 per cent of people with diabetes and generally appears in people over the age of 40. But for some ethnic groups Type 2 diabetes can appear earlier; it often appears from 25 years upwards in people of South Asian origin, for example. Over recent years, more children are being diagnosed with Type 2 diabetes, some as young as seven. According to Diabetes UK, most cases of Type 2 diabetes are linked with being overweight. [9]

[9] State of the Nation 2012, Diabetes UK, May 2012

2. An integrated approach to care

Better use should be made of existing local mechanisms to prioritise diabetes. Early prioritisation through local Joint Strategic Needs Assessments and Health and Wellbeing Strategies will help focus the efforts of the multi-disciplinary range of partners represented on the Health and Wellbeing Boards (HWBs). This focus can, through better communication and alignment between the Boards and their local Clinical Commissioning Group (CCG), generate improved outcomes for patients.

Service re-design and integration has already been successful in some boroughs and this approach should be adopted more widely. NHS England needs to help support this change.

Consistent, structured education for patients and for professionals will be fundamental to the successful delivery of integrated care, to improving the quality of care provided to patients, and to improving patient outcomes. There are roles for Public Health England, Diabetes UK and the Mayor in driving improvements in educating patients, professionals and the wider community.

Integrated care is a term that reflects a concern to improve patient experience and achieve greater efficiency and value from health delivery systems. The aim is to address fragmentation in patient services, and enable better coordinated and more continuous care, frequently for an ageing population which has increasing incidence of chronic disease.[10]

Making best use of local mechanisms

The Committee heard that opportunities to improve outcomes are being missed because diabetes is not being prioritised in many local health plans across London.[11] Our own simple analysis of these plans revealed only two of the 33 plans had made specific reference to diabetes as a local priority. Local prioritisation can yield dramatically improved outcomes. Lambeth and Southwark CCGs have seen marked improvements in achievement rates for nationally-set treatment targets,

[10] What is integrated care? An overview of integrated care in the NHS, Nuffield Trust, June 2011

[11] Transcript of Health Committee meeting dated 26 November 2013

under the Diabetes Modernisation Initiative (DMI).[12] Their results are now among the best 25 per cent in the country. Tower Hamlets now ranks among the top 25 per cent for the provision and follow-through on diabetes care.

Successful prioritisation is dependent on well-developed communication networks between all partners. There is also considerable room for improvement in cross-communication between HWBs, who are responsible for putting the health plans together, and the commissioners of services – the CCGs. An alignment of identified priorities and planning for them is crucial. NHS England's planning guidance issued to CCGs in December 2013 advocates joint working:

"with providers and partners in local government to develop robust and ambitious five year plans to deliver improved outcomes within the resources that will be available to the NHS."

While there may well be a need for refinement of existing local mechanisms, there is still scope to make better use of them. Early prioritisation of diabetes through local Joint Strategic Needs Assessments, the documents that inform the local Health and Wellbeing Strategies, will help focus the efforts of the multi-disciplinary range of partners represented on HWBs.

Recommendation 1

We recommend that Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards (HWBs) build on the improved cohesion and coordination that a joint Health and Wellbeing Strategy should bring in identifying and planning for local health priorities, putting the patient at the centre of this approach. This could be achieved by:

a) seeking to further improve cross-communication between CCGs and HWBs;
b) better alignment and coordination in future planning; and
c) developing common goals to boost opportunities to improve early detection rates and ongoing care and management of diabetes.

[12] A three-year change programme that is due to end in June 2014.

Driving up quality and improving patient experience

The wide variance in the quality of diabetes care across and within borough boundaries is unacceptable: *"a postcode lottery that is letting down huge numbers of Londoners with diabetes"*.[13] The National Diabetes Audit shows that six of the top 25 per cent performers in England and Wales are in London,[14] while 12 fall within the bottom 25 per cent. [15] Patients and their carers told us that access to appropriate care and support is difficult. We were told by one carer that getting hold of someone at the weekends or bank holidays, even if just for advice, was an impossible task.[16]

The Committee heard that fragmented and uncoordinated diabetes care is a big part of the problem. Continuity of care is crucial, and more likely to happen when the patient's care package is integrated, that is care which is coordinated, comprehensive, and seamless. Patient experience is significantly improved when care is designed to fit around them, allowing for the least number of attendances, uniformity of information and instant access to that information. Integration, we heard, is needed across the piece – between the wide range of professionals involved in delivering the care, in the approach to, and design of the care package, and in accessing information about the patient's care and treatment by patients and professionals alike.

Integrated care models will need to be worked out on the basis of best fit for the local area. The Committee visited the Gracefield Gardens Neighbourhood Resource Centre, the hub of the Lambeth and Southwark DMI. This model, founded on a multiple partner and provider landscape, exemplifies successful integration of primary and community care provision. The diabetes centre located at Homerton University Hospital in Hackney provides an extensive range of on-site diagnostic and treatment services, for out-patients and in-patients. GP networks are a key feature of the Tower Hamlets integrated care model.

A more integrated approach to care can result in improved care outcomes and experiences for patients. An integrated care approach is best suited to frail older people, to those living with long-term chronic and mental health illnesses, and to those with medically complex needs or requiring

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[13] Diabetes UK

[14] Bexley, City & Hackney, Islington, Lewisham, Newham and Tower Hamlets - achieving 67% or more of patients receiving all eight care processes *(note: only eight care processes were audited, results for eye screening were omitted from the most recent audit)*

[15] Barking & Dagenham, Hammersmith & Fulham, Havering, Hounslow, Kingston, Lambeth, Merton, Redbridge, Richmond, Waltham Forest, Wandsworth, and West London. Less than 56% or their patients receive all care processes

[16] Transcript of the Health Committee meeting, dated 25 June 2013

urgent care. It is most effective when it takes into account the holistic needs of patients.

Regardless of how the integrated care model is devised there is consensus that GPs will be pivotal to delivery of that care. The NHS England (London) review document on transforming primary care recognises the pivotal role GPs play and the barriers to them maximising their role; expert guests also told us:

"General practice remains the building block for your care and … you should not be…escalated, whether it is into more specialist teams or into hospital for whatever reason, if it can be avoided and you can be supported to stay at home and supported by your GP."

"General practice should be the bedrock of diabetes care, but…seamless care should be there when you go through the various tiers of care, up to specialist care and back down again."[17]

Service re-design and integration has already been successful in some boroughs and this approach needs to be adopted more widely. NHS England needs to help support this change. Our review has uncovered some good models of integrated care as noted above. We are told there are more.

The key challenge going forward is to draw on these exemplary models and be able to translate them across London. Mechanisms are in place for disseminating good practice and improving care provision but we understand they are temporary. Strategic Clinical Networks established by NHS England, to lead on specific health areas, such as diabetes are tasked with reducing "*unwarranted variation in services"* but are mandated for up to five years only. Academic Health Science Networks, an arm of NHS England also have a role to play. The core objectives of the Networks are to improve clinical outcomes and patient experience, but there is a limited flow of information and sharing of good practice across the three that exist in London.[18]

We would recommend that NHS England (London), in its on-going review of primary care, identifies successful models of integrated care provision that could be applied to diabetes care and the care and management of other long-term conditions. This will help guide local decision-makers in

[17] Transcript of the Health Committee meeting dated, 26 November 2013
[18] The three are Imperial College Health Partners, South London Health Innovation Network and University College London Partners

developing models of care to meet the needs of the local population. Consideration should also be given to making the Strategic Clinical Network for diabetes a permanent feature of the existing health structures. The Network, in partnership with the Academic Health Science Network, should look to promote and disseminate good practice models of integrated care provision.

A strategic overview for diabetes care would provide a critical analysis of how well care is being delivered across the capital. Benchmarking and monitoring against a common set of indicators would help achieve the overview needed. Alongside this, regular reviews of how well the elements of the new health economy are working together would help facilitate an improved flow and exchange of good practice - this could be a role for NHS England (London).

Strengthening support to self-manage the condition

Integrated diabetes care provision, as with any other integrated care pathway, is as much about empowering the individual to manage their condition as it is about system and structural change. The majority of people living with diabetes are either supporting themselves or being supported by their GP. There are weaknesses in adequately educating both patients and professionals. Getting the education right is fundamental to the successful delivery of integrated care and to improving the quality of care provided to patients, and their outcomes.

The offer of structured education for individuals self-managing the condition is improving, but is still low and the uptake even lower. Just 12 per cent of diabetes patients are offered structured education programmes about the condition, and two per cent take up the offer. No specific evaluation of why uptake is as low as it is, seems to have been undertaken, but anecdotal evidence suggests there are issues with the design, promotion and delivery of the structured education programmes, particularly in respect of how accessible or inclusive they are.

Expertise to diagnose, treat and provide on-going care and support for diabetes is variable, and currently there is no minimum standard of training or education for GPs or practice nurses involved in delivering diabetes care. This is particularly worrying given the pivotal role of the GP. Developing guidelines on a minimum standard for the education of GP and practice nurses would be an important step towards delivering better quality care and improving patient outcomes. Public Health England (London), in partnership with Diabetes UK, the Royal College of

General Practitioners and Royal College of Nursing, would be best placed to progress this.

Recommendation 2

NHS England, London should:

a) In its on-going review of primary care, identify successful models of integrated care provision that could be applied to diabetes care and/or the care and management of other long-term conditions. This will help guide local decision-makers in developing models of care to meet the needs of the local population;

b) Make the Strategic Clinical Network for diabetes a permanent feature of the existing health structures and through it, in partnership with the Academic Health Science Networks, and Diabetes UK, look to promote and disseminate good practice models of integrated care provision;

c) Lead on work to develop a common set of indicators against which providers of diabetes care can benchmark their performance. A strategic overview of diabetes care at pan-London level would usefully provide a critical analysis of how well care is being delivered; and

d) In partnership with Public Health England (London), Diabetes UK, the Royal College of General Practitioners and Royal College of Nursing, develop guidelines on a minimum standard for the education of general practitioners and practice nurses involved in delivering diabetes care.

The Mayor could be instrumental in raising public awareness and driving improvements in educating professionals and patients alike. Public education programmes can lead to improved detection of diabetes – the Lambeth and Southwark DMI now has an unprecedented 96 per cent level of engagement with GPs across the two boroughs and an eight per cent increase in the number of patients between 2012/13. The Mayor, through the London Health Board, should lead on a pan-London publicity programme that informs the public of the potential risks of undiagnosed diabetes, encourages individuals to be tested and increases awareness of how they can effectively manage the condition once diagnosed and the support available to them to do so.

International examples such as the New York health-driven initiative, *Creating Healthy Places* are used to raise the profile of obesity and Type 2 diabetes. Similarly, employer health plans enable employees to see a doctor and get programmes or services that prevent obesity and Type 2 diabetes. The Mayor's current initiative *London Healthy Workplace Charter* could also be a useful vehicle for raising awareness.

3. Joining-up policy

The rise in obesity has significantly contributed to growth in the number of people in the capital with, or at risk of developing, Type 2 diabetes. Joined-up policy approaches at local level could help create an environment in which individuals are encouraged to make responsible dietary choices and lifestyle changes to avoid or manage obesity and help reduce the risk of developing Type 2 diabetes. Local measures should be reinforced at a pan-London level.

The Mayor should set out his approach to London's obesity problem. This should be augmented by a more robust national strategy to tackling obesity. Voluntary measures, such as the 'responsibility deal', may need to be complemented by tougher action to achieve better outcomes for people in London and across the country.

London has seen a year-on-year rise in adult obesity since 1998. One in five adults is now obese. Twenty-three per cent of both men and women in London are obese, and a further 39 per cent of men and 30 per cent of women are overweight. Black or Black British groups, representative of the largest BAME group in London,[19] have the highest prevalence of obesity of any ethnic group.[20]

Being overweight increases the likelihood of developing Type 2 diabetes. The risk is further intensified if an individual is obese. An obese woman is 13 times more likely to develop Type 2 diabetes than a woman who is not obese, an obese man five times more likely than a man who is not.[21]

Obesity is increasingly becoming a problem for the young. Recent research points to rising obesity as the main driver for the higher prevalence of Type 2 diabetes in under 40 year olds.[22] The National Child Measurement Programme is reporting the trend that at 11 years of age, children are increasingly weighing more. There has also been a

[19] London Councils key facts and statistics
[20] Public Health England, http://www.lho.org.uk/LHO_Topics/Health_Topics/Lifestyle_and_behaviour/Obesity.aspx#4
[21]Statistics on Obesity, Physical Activity and Diet: England, 2013, The Health and Social Care Information Centre, NHS
[22] The research was published in the Journal Diabetes, Obesity and Metabolism.

quadrupling in the number of children admitted to hospital for obesity-related problems in England and Wales between 2000 and 2009.[23]

Overweight and obesity in adults

Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health.

Body mass index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m2).

The World Health Organisation definition is:

- a BMI greater than or equal to 25 is overweight
- a BMI greater than or equal to 30 is obesity.

BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages of adults. However, it should be considered a rough guide because it may not correspond to the same degree of fatness in different individuals. (The World Health Organisation)

Overweight and obesity in children

A child's BMI is not interpreted in the same way as an adult's BMI. Instead, their BMI is charted on special growth charts. These charts can show how a child's BMI compares with the normal range for children of a similar age, sex and ethnic background. For infants between the ages of 2 weeks and 4 years, the UK-WHO charts are used. For 5-19 year olds, the WHO centile charts are used.

Children living in the capital are more likely to be obese than elsewhere in England. Twelve per cent of children in London aged 4-5 years and 22 per cent of children aged 10-11 years are at risk of being obese. This is higher than the national average for both age groups. The growth in the number of obese children in London is driving up demand for extreme courses of treatment to manage their obesity. One expert guest told the Committee,

"I work at King's College Hospital and I came there eight years ago. When I first came, there was no obesity clinic. I am [now] *having to offer*

[23] Rising Obesity-Related Hospital Admissions among Children and Young People in England: National Time Trends Study, Imperial College London, June 2013

bariatric surgery to some adolescents because there is no other treatment. … [to help them] *..lose significant amounts of weight*..[and prevent] *diabetes in those young people later on."* [24]

Joining policy at local level

There is a worryingly strong correlation between deprivation levels, and overweight and obese children in London. Children most at risk of developing Type 2 diabetes live in the capital's most deprived areas. The risk is even higher for children of Bangladeshi, Black Caribbean and Black African origin.[25]

The correlation is further amplified by the increasing density of fast food outlets in areas of acute deprivation in London. Several of our expert guests confirmed that the more deprived the borough, the greater the proliferation of fast food outlets. Their view is supported by research from the National Obesity Observatory which identifies a strong association between deprivation and the density of fast food outlets. A study by the University of Leeds found that takeaways tend to be clustered in parts of the city where unemployment is highest.[26] A mapping exercise in the London Borough of Tower Hamlets, one of the most deprived local authorities nationally, identified 627 fast food outlets, newsagents and grocery stores classed as selling 'junk food'.[27]

Our expert guests stressed the importance of joint working between borough health and planning departments. There are examples within London where this approach is already being utilised. Barking and Dagenham has implemented planning policy changes to limit the number of fast food outlets around schools, restrict them to town centre locations and manage their concentration and clustering.[28] The Committee was also told of initiatives in other parts of London - Tower Hamlets (following on from the mapping exercise mentioned above), Hackney, Waltham Forest and Lambeth – as well as outside London. Salford City Council, for example, has developed a policy that restricts planning permission for fast food outlets within 400 metres of its schools and confines opening times to after 5pm.

[24] Transcript of the Health Committee dated 25 June 2013
[25] The England average is 10 and 19 per cent respectively. Childhood Obesity in London, GLA Intelligence Unit
[26] Takeaway 'clusters' linked to childhood obesity, September 2010
[27] The School Food Shed, City University 2010
[28] See the supplementary planning document

On the basis of what the Committee has heard, and the submissions received, we are convinced that joint policy working at local level is a pragmatic response, and a key element of the overall approach needed to tackle obesity. We would argue that a closer alignment between local health and public health policy makers, and those concerned with the wider determinants of health, in this case, social and planning policy, can serve to facilitate a consistent and coherent approach to improving the health outcomes of Londoners. We are mindful that taking the steps to create the changes needed to make real inroads into addressing the obesity problem and impending diabetes crisis, is a medium to long term aspiration.

Across London, HWBs do not generally include representation from the council planning department. The multi-disciplinary boards are well-placed to facilitate joint policy working. Joined up policy approaches at local level could help create an environment in which individuals are encouraged to make responsible dietary choices to avoid or manage obesity and help reduce the risk of developing Type 2 diabetes. To aid this process, we would recommend that boroughs take the practical step of ensuring close co-ordination, where appropriate, between the HWBs and the borough's chief planning officer.

Recommendation 3

There is a need for the development and application of local planning policy and policy on health, public health and social care to:

a) be more closely aligned, and

b) facilitate a consistent and coherent approach to encouraging individuals to make responsible lifestyle choices that will improve their health outcomes.

To aid this process we recommend that boroughs ensure there is close co-ordination, where appropriate, between the Health and Wellbeing Board and the borough's chief planning officer.

The need for a pan-London response

Local measures should be reinforced by a pan-London strategic response to London's obesity problem. The Mayor's Health Inequalities Strategy,[29] acknowledges that "*London is facing an obesity epidemic",* and that "*childhood obesity is a particular cause for concern*,*"* representing *a*

[29] Published April 2010

"future burden of chronic ill-health and premature death". The London Health Commission established by the Mayor in 2013,[30] has identified both obesity and diabetes as pressing challenges going forward.

The Committee welcomes the focus on obesity and diabetes in the Mayor's Strategy and the work of the London Health Commission. We acknowledge the range of Mayoral initiatives and programmes that have been put in place to help address childhood obesity, such as the healthy schools awards programme. Additionally we encourage work being done to embed active travel, such as the Mayor's Cycling Strategy and Transport for London's Transport Action Plan, as well as to improve working environments through the London Healthy Workplace Charter.

But we remain concerned by the delay in translating headline objectives outlined in the Mayor's Strategy into a coherent strategic response to the obesity problem, underpinned by clear quantifiable deliverables. The delivery plan published alongside the Strategy in April 2010 set out initial actions to 2012. Further commitments were given to develop the final delivery plan and delivery structures with partners by September 2010, and to publish a suite of themed briefings setting out action on specific challenges, such as obesity. The Committee can find no evidence that these documents have been published.

Also worrying is the omission of any strategic focus on obesity in the London Health Board's priority commitments. The pressing need for an obesity strategy was highlighted in the Assembly report, *Tipping the Scales* published in 2011. The report recommended that the Mayor should develop a strategy, as well as develop processes to evaluate obesity interventions and share good practice through the London Health Improvement Board, [31] by April 2013.

It is our view that local measures to tackle obesity should be supported by pan-London co-ordination from the Mayor. The Mayor should set out how this can best be approached.

[30] Established in September 2013

[31] The London Health Improvement Board was a strategic mechanism through which the Mayor in partnership with London boroughs and other partners sought to respond to health and public heath priorities that would benefit from a pan-London response.

Recommendation 4

Local measures to tackle obesity should be supported by pan-London co-ordination to tackle the rising obesity problem in the capital.

We recommend that the London Health Commission's research and deliberations under the work stream Healthy lives and reducing inequalities consider the recommendations of the London's Assembly report on childhood obesity, and particularly the recommendation that the Mayor lead a co-ordinated obesity approach for London. The Commission should set out its findings in its published report later this year.

A robust response driven at national level

A more robust strategy to reverse the upward trend in obesity is needed nationally.

Key stakeholders have raised questions about what voluntary measures such as the government's 'responsibility deal' can realistically achieve. The voluntary scheme, launched in March 2011, is intended to promote action within the food industry to encourage people to eat more healthily, for example, by committing to reduce calorie levels in their products. Currently 21 businesses are signed up to the pledge to *"adopt and implement the UK Governments' 2013 recommended Front of Pack Nutrition Labelling Scheme"* launched in June 2013.[32]

Among those raising concerns is the Department of Health National Obesity Forum, which says that too little progress has been made. The consumer group Which? is calling for companies slow on the uptake of the 'responsibility deal' to be named and shamed. Which? has also called for more ambitious pledges to be set by government, for example, to reduce saturated fat, sugar and salt use.

Internationally, it is also believed that voluntary measures such as the 'responsibility deal' may achieve too little, too slowly.[33] Tougher action may need to be explored, if the pace of commitment to improve outcomes is to be expedited. We recognise that this will require further research to understand the likely impact more strict controls, could have on health outcomes.

[32] 636 businesses are signed up to the responsibility deal across a range of 37 pledges

[33] Marketing of foods high in fat, salt and sugar to children: update 2012 – 2013, World Health Organisation

Recommendation 5

We recommend that the Department of Health National Obesity Forum explore interim measures that can be taken to strengthen the impact of the 'responsibility deal' for example, by setting more ambitious pledges with clearer targets for supermarkets and manufacturers to reduce the saturated fat, sugar and salt contents of foods and drinks.

The ability to mitigate the risk of developing Type 2 diabetes on account of age or ethnicity is limited. More can be achieved through actions to address the wider determinants of health inequalities, such as poor housing, low employment prospects and limited access to health and social care. But such actions are constrained by the need for longer term planning. By far a greater return, for individuals and for the health service in London, will be gained by getting to grips with the rising obesity in the capital as a means to curbing the rise in Type 2 diabetes. As the Committee heard:

"There are definitely some things we can do …and we should not be complacent that we cannot solve this problem."[34]

Rapidly rising numbers of overweight and obese people will, according to Diabetes UK, help drive the rise in Type 2 diabetes. They say:

"If we are to curb this growing health crisis and see a reduction in the number of people dying from diabetes and its complications, we need to increase awareness of the risks, bring about wholesale changes in lifestyle, improve self-management among people with diabetes and improve access to integrated diabetes care services."[35]

The Committee hopes that this report will go some way to heighten awareness of diabetes, the importance of early diagnosis and the need for care that is built around the patient. We would also hope that efforts are made to ensure that the quality of care that some diabetes patients receive in London can be accessed irrespective of where an individual lives in the capital. Reducing the risk of developing Type 2 diabetes and improving patient outcomes will require action from a range of partners and at all levels of government.

[34] Transcript of Health Committee meeting dated 25 June 2013
[35] Diabetes in the UK, 2012

Recommendations

Recommendation 1

We recommend that Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards (HWBs) build on the improved cohesion and coordination that a joint Health and Wellbeing Strategy should bring in identifying and planning for local health priorities, putting the patient at the centre of this approach. This could be achieved by:

a) seeking to further improve cross-communication between CCGs and HWBs;

b) better alignment and coordination in future planning; and

c) developing common goals to boost opportunities to improve early detection rates and ongoing care and management of diabetes.

Recommendation 2

NHS England, London should:

a) In its on-going review of primary care, identify successful models of integrated care provision that could be applied to diabetes care and/or the care and management of other long-term conditions. This will help guide local decision-makers in developing models of care to meet the needs of the local population;

b) Make the Strategic Clinical Network for diabetes a permanent feature of the existing health structures and through it, in partnership with the Academic Health Science Networks, and Diabetes UK, look to promote and disseminate good practice models of integrated care provision;

c) Lead on work to develop a common set of indicators against which providers of diabetes care can benchmark their performance. A strategic overview of diabetes care at pan-London level would usefully provide a critical analysis of how well care is being delivered; and

d) In partnership with Public Health England (London), Diabetes UK, the Royal College of General Practitioners and Royal College of Nursing, develop guidelines on a minimum standard for the education of general practitioners and practice nurses involved in delivering diabetes care.

Recommendation 3

There is a need for the development and application of local planning policy and policy on health, public health and social care to:

a) be more closely aligned, and

b) facilitate a consistent and coherent approach to encouraging individuals to make responsible lifestyle choices that will improve their health outcomes.

To aid this process we recommend that boroughs ensure there is close co-ordination, where appropriate, between the Health and Wellbeing Board and the borough's chief planning officer.

Recommendation 4

Local measures to tackle obesity should be supported by pan-London co-ordination to tackle the rising obesity problem in the capital. We recommend that the London Health Commission's research and deliberations under the work stream Healthy lives and reducing inequalities consider the recommendations of the London's Assembly report on childhood obesity, and particularly the recommendation that the Mayor lead a co-ordinated obesity approach for London. The Commission should set out its findings in its published report later this year.

Recommendation 5

We recommend that the Department of Health National Obesity Forum explore interim measures that can be taken to strengthen the impact of the 'responsibility deal' for example, by setting more ambitious pledges with clearer targets for supermarkets and manufacturers to reduce the saturated fat, sugar and salt contents of foods and drinks.

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Hindi

यदि आपको इस दस्तावेज का सारांश अपनी भाषा में
चाहिए तो उपर दिये हुए नंबर पर फोन करें या उपर दिये
गये डाक पते या ई मेल पते पर हम से संपर्क करें।

Vietnamese

Nếu ông (bà) muốn nội dung văn bản này được dịch sang
tiếng Việt, xin vui lòng liên hệ với chúng tôi bằng điện
thoại, thư hoặc thư điện tử theo địa chỉ ở trên.

Bengali

আপনি যদি এই দলিলের একটা সারাংশ নিজের ভাষায় পেতে চান,
তাহলে দয়া করে ফো করবেন অথবা উল্লেখিত ডাক ঠিকানায় বা
ই-মেইল ঠিকানায় আমাদের সাথে যোগাযোগ করবেন।

Greek

*Εάν επιθυμείτε περίληψη αυτού του κειμένου στην γλώσσα
σας, παρακαλώ καλέστε τον αριθμό ή επικοινωνήστε μαζί
μας στην ανωτέρω ταχυδρομική ή την ηλεκτρονική διεύθυνση.*

Urdu

اگر آپ کو اس دستاویز کا خلاصہ اپنی زبان میں
درکار ہو تو، براہ کرم نمبر پر فون کریں
یا مذکورہ بالا ڈاک کے پتے یا ای میل
پتے پر ہم سے رابطہ کریں۔

Turkish

Bu belgenin kendi dilinize çevrilmiş bir özetini
okumak isterseniz, lütfen yukarıdaki telefon
numarasını arayın, veya posta ya da e-posta
adresi aracılığıyla bizimle temasa geçin.

Arabic

الحصول على ملخص لهذا المستند بلغتك،
فرجاء الاتصال برقم الهاتف أو الاتصال على
العنوان البريدي العادي أو عنوان البريد
الإلكتروني أعلاه.

Punjabi

ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਸੰਖੇਪ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲੈਣਾ
ਚਾਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਇਸ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਜਾਂ
ਉਪਰ ਦਿੱਤੇ ਡਾਕ ਜਾਂ ਈਮੇਲ ਪਤੇ 'ਤੇ ਸਾਨੂੰ ਸੰਪਰਕ ਕਰੋ।

Gujarati

જો તમારે આ દસ્તાવેજનો સાર તમારી ભાષામાં
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પર અમારો સંપર્ક કરો.

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