

<b>NHS Greater Glasgow and Clyde</b>	<b>Paper No. 24/156</b>
<b>Meeting:</b>	<b>NHSGGC Board Meeting</b>
<b>Meeting Date:</b>	<b>17 December 2024</b>
<b>Title:</b>	<b>Obesity and Prevention and Early Intervention for Type 2 Diabetes (T2DM) Update</b>
<b>Sponsoring Director:</b>	<b>Dr Emilia Crighton, Director of Public Health Beatrix Von Wissman, Interim Deputy Director of Public Health</b>
<b>Report Author:</b>	<b>Anna Baxendale; Head of Health Improvement &amp; Inequalities Linda Morris; PH Programme Manager</b>

## 1. Purpose

**The purpose of the attached paper is to:**

- Update the NHS Greater Glasgow and Clyde Board on key aspects of Obesity and Prevention and Early Intervention for Type 2 Diabetes (T2DM) within GGC.

## 2. Executive Summary

Prevention of overweight and obesity within the population requires multi-level action; working at a societal level to address the obesogenic environment; adopting a life stage approach whereby interventions are tailored to different age groups, as well as providing a comprehensive approach to weight maintenance, weight management and supported lifestyle changes to address the chronic relapsing nature of the condition.

- Levels of overweight and obesity continue to rise in the child and adolescent population with levels of obesity in children overtaking levels of overweight in the most deprived communities.
- Two thirds of all adults across NHSGGC are overweight and obese, with over half of all pregnant women being in the overweight or obese category at the start of their pregnancy.
- The demand for weight management and exercise on referral services continues to increase annually.

To reduce cardiovascular disease and the impact of long term conditions such as T2DM, it is imperative to reduce population overweight and obesity.

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The prevalence of T2DM continues to steadily increase across Scotland and locally. Across NHSGGC, there are currently 69,513 patients diagnosed with T2DM (an increase of 2,836 since last year when there were 66,677), and treatment for people with T2DM has significant cost at around 9% of the NHS budget.

Diagnosis of T2D has increased post pandemic, with approximately 600 newly diagnosed patients monthly. Diabetes is closely related to deprivation and ethnic background and whilst 5.5% of the NHSGGC population are currently diagnosed, estimates suggest significant unmet need with prevalence is closer to 10%. Obesity is the single biggest driver of T2DM however, evidence highlights that a combination of structured education, weight management interventions and increased physical activity are effective in improving self-management of the condition, delaying or avoiding complications and, in an increasing number of cases, supporting disease remission.

To address the impact of obesity within our population, our five priorities are:

- Universal and targeted delivery of HENRY to families with pre-five children.
- Delivery of tailored Weight Management Services for adolescents (Weigh to Go)
- Development of robust local Community Food Networks to build community capacity; cookery skills and food literacy and reduce food insecurity for vulnerable families including Thrive under 5.
- Provision of weight management services at a size and scale to impact across the population and address clinical need.
- Provide early intervention education and weight management interventions to newly diagnosed patients with T2DM or Gestational Diabetes with a view to increasing remission rates.

### 3. Recommendations

**The NHSGGC Board is asked to consider the following recommendations:**

- Advocate for the 5 priority areas of action on obesity.
- Support and maintain investment in the 5 priority areas described.

### 4. Response Required

This paper is presented for **Assurance**.

### 5. Impact Assessment

**The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:**

- |                        |                               |
|------------------------|-------------------------------|
| • Better Health        | <b><u>Positive</u> impact</b> |
| • Better Care          | <b><u>Positive</u> impact</b> |
| • Better Value         | <b><u>Positive</u> impact</b> |
| • Better Workplace     | <b><u>Neutral</u> impact</b>  |
| • Equality & Diversity | <b><u>Positive</u> impact</b> |
| • Environment          | <b><u>Neutral</u> impact</b>  |

## **6. Engagement & Communications**

**The issues addressed in this paper were subject to the following engagement and communications activity:**

- The paper describes a range of stakeholder engagement programmes and discrete activities have been informed by wider service partners and user engagement/ participation.
- Governance for this programme of activity is through Public Health and Inequalities Group and T2DM Executive Group & Programme Board. Scottish Government reporting requirements are overseen by Director of Public Health

## **7. Governance Route**

**This paper has been previously considered by the following groups as part of its development:**

- Informal Directors Group
- Senior Management Team
- Public Health Inequalities Group
- Child and Maternal Services Co-ordinating Group / HoCs – in part
- T2DM Exec Group – in part
- Corporate Management Team
- Population Health and Wellbeing Committee

## **8. Date Prepared & Issued**

Prepared on 4 December 2024

Issued on 10 December 2024

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## 1. Introduction

- 1.1 This paper reports on the progress of obesity and diabetes programmes of work within the Public Health Directorate to mitigate the continued rising levels of overweight and obesity (delivered in line with the prevention and early intervention work stream of the Scottish Government: [‘A Healthier Future: Diet & Healthy Weight Delivery Plan](#) and [Type 2 Diabetes Prevention, Early Detection and Intervention frameworks](#)).
- 1.2 Interviews with over 10,000 NHSGGC residents for our most recent Health and Wellbeing Survey (HWB Survey), shows the significant population health challenge post-pandemic, which means we need to re-consider what and how we deliver services.  
In NHSGGC:
- By the time children reach primary 1, a quarter of children are already overweight and obese.
  - By the time young people are becoming young adults, 30% of 16-24 year olds enter the adult population, overweight and obese.
  - Adult overweight and obesity now affects over 2/3rds of the population.
- 1.3 This represents a significant increased need for health care services:
- The annual full costs of obesity are estimated to be £5.3 billion, which corresponds to 3% of Scotland’s annual GDP<sup>1</sup>
  - Diabetes has an annual cost to NHS Scotland of around £1billion each year
  - Around 1/5<sup>th</sup> of all inpatients to hospital have diabetes and diabetes medications account for around 8% of primary care medicines costs in Scotland<sup>2</sup>.

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- Adiposity now accounts for more deaths in Scotland than smoking<sup>3</sup>.
- Overweight and obesity is the single biggest driver of increasing T2DM.

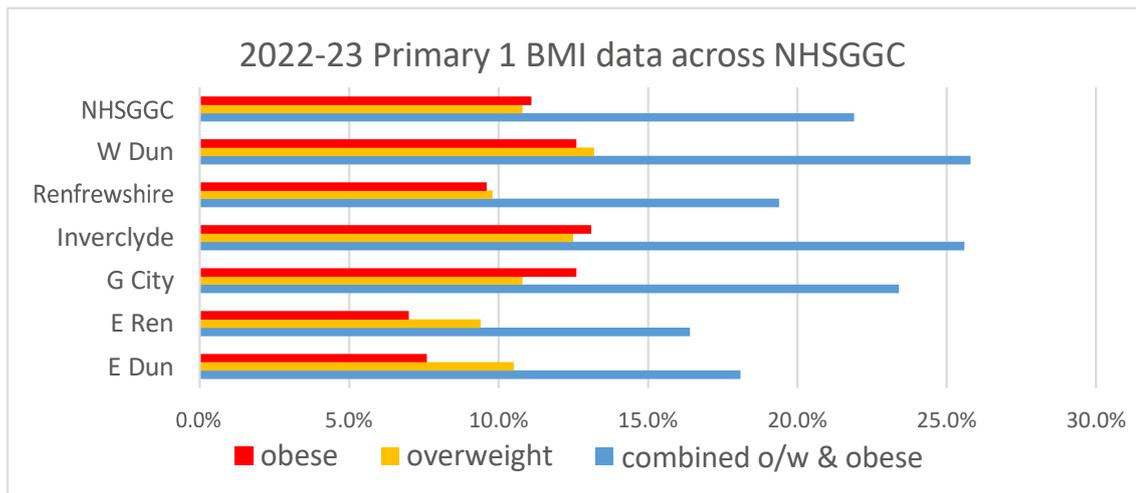
1.4 Despite this challenge, the Public Health Directorate continues to engage people in self-care and self-management activities through the delivery of high quality weight management, physical activity and diabetes management programmes. These programmes will continue to reduce need for health care services whilst also making a significant impact on individual outcomes and life expectancy.

1.5 The latest burden of disease study (June 2024)<sup>4</sup> highlights:  
“Any projected increases in prevalence and burden are likely to affect the sustainability of services in the future. However, these projected increases are not inevitable. We can reduce the rate of new cases of diabetes occurring through effective primary prevention. And in people living with diabetes or those at-risk of diabetes, we can through deploying effective secondary and tertiary prevention strategies, reduce complications of diabetes and their impact on health-related quality of life (i.e. disability), and risk of early death.”

## 2. Background: Understanding the Scale of the Challenge

### 2.1 Children & Early Years

- The most recent data gathered during 2022-23 demonstrates that 33% of children aged 27-30 months were overweight and or obese, indicating that unhealthy weight begins in the early years (and although many will grow into their weight, there are a significant proportion who will continue to be overweight and or obese).
- Whilst 22% of all children across NHSGGC are overweight and or obese, there are stark differences across the socio-economic gradient, with children living in the most deprived areas, more likely to be obese (*Primary 1 child health surveillance system*<sup>5</sup>).



Graph 1: Primary 1 BMI data 2022/23 across NHSGGC by locality planning area

### 2.2 Adolescents

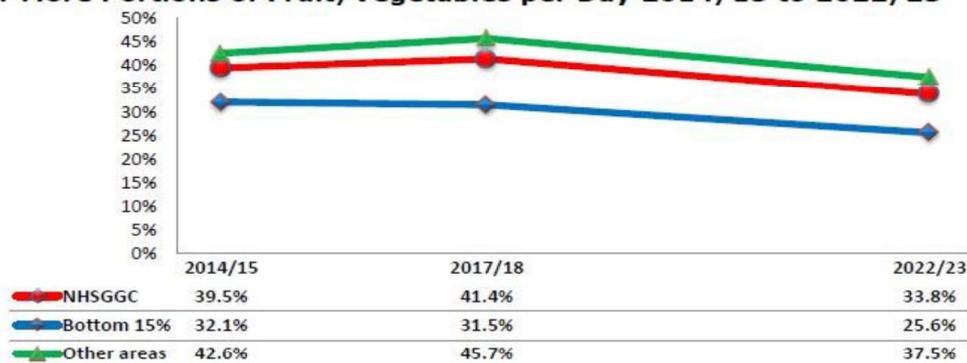
- A systematic review of evidence highlights that around 55% of obese children go on to be obese in adolescence, and around 80% of obese adolescents will still be obese into adulthood.

- Children and adolescents living with obesity experience breathing difficulties, increased risk of fractures, hypertension, early markers of cardiovascular disease, insulin resistance, T2DM, and psychological effects<sup>6</sup>

### 2.3 Adults

- Recent GGC HWB Survey data shows that eating habits and patterns of consumption are changing. There is a significant decrease in the proportion who meet the target of consuming fruit and veg daily and this is common across all socio-economic groups.

**Figure 3.16: Trends for Proportion Meeting the Target of Consuming Five or More Portions of Fruit/Vegetables per Day 2014/15 to 2022/23**



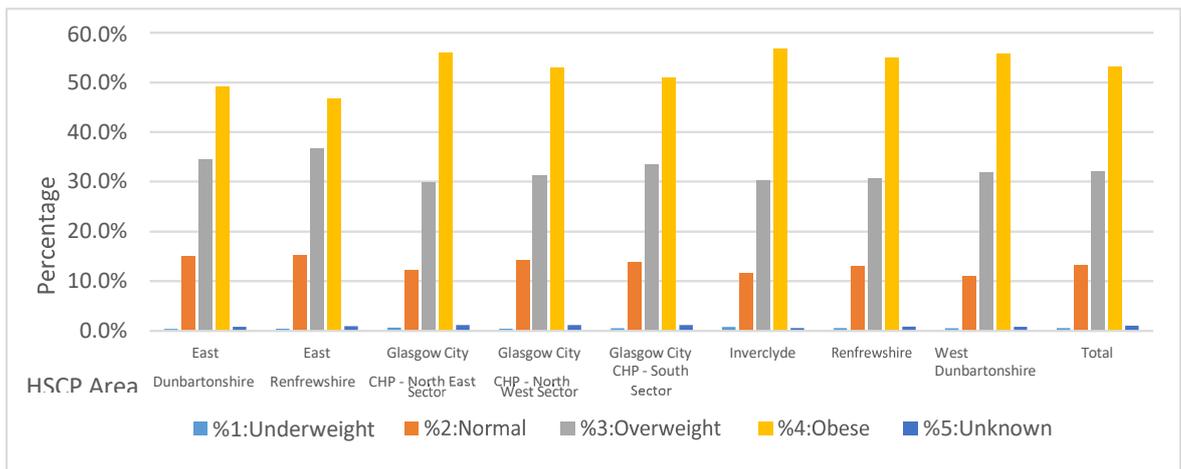
**Graph 2: Trends for Proportion Meeting the Target of Consuming Five or More Portions of Fruit/Vegetables per Day 2014/15 to 2022/23**

- Data highlights that eating habits and patterns of consumption are changing. There is a significant decrease in the proportion who meet the target of consuming fruit and veg daily and those living in the most deprived areas are more likely to consume ultra-processed convenience foods such as pies & pastries, and are less likely to:
  - eat lean meat or fish,
  - consume wholegrains, nuts or seeds
  - eat home made food every day
  - cook from scratch using fresh ingredients )relying instead on pre-prepared food that is high in fats, salts and sugars, ordering takeaways and eating out of home)

### 2.4 Type 2 Diabetes Mellitus (T2DM)

- Overweight and obesity is the single modifiable risk factor for the development of T2DM. In Scotland, 87.1% of those diagnosed with T2DM were classed as overweight or obese at the end of 2019; the graph below shows the breakdown of weight category across HSCP for 2022-23.

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**Graph 3: Proportion of adults diagnosed with T2DM by weight category and HSCP for NHS GGC**

- The incidence and prevalence of all types of diabetes has been steadily growing in the past 10 years. Within NHS GGC, there are 69,513 patients diagnosed with T2DM equating to 5.5% of our population. This is a rise of 2,836 cases from last year, and translates to 130 - 150 new diagnoses of every week.
- Similar to overweight and obesity, prevalence of T2DM follows a socio-economic gradient with a strong correlation between deprivation and prevalence across NHS GGC.
- Prevalence of T2DM is also strongly correlated with ethnicity, particularly with people of South Asian and Black origin where prevalence is approximately four to six times higher than in the white British population<sup>7</sup>. In addition onset of T2DM in these groups is often at younger age with a significant proportion diagnosed before the age of 40 years<sup>8</sup>.
- It is estimated that around 10% of cases of type 2 diabetes remain undiagnosed<sup>9</sup>. Diabetes Scotland also estimates that over 500,000 people in Scotland are at high risk of developing type 2 diabetes<sup>10</sup> therefore significant unmet need within the GGC population would be anticipated.

### 2.5 Gestational Diabetes Mellitus (GDM)

- Overweight and obesity is associated with a range of complications for pregnant women, both during their pregnancy and beyond. Having a BMI > 25 increases the risk of Gestational Diabetes (GDM), thrombosis, pre-eclampsia, induction of labour and caesarean birth, while a raised BMI also increases the risk of having a miscarriage, early birth or stillbirth.
- In addition to risk of complications during pregnancy, overweight and obesity also increases the risk of women developing GDM in subsequent pregnancies or T2DM later in life. Evidence shows that up to 50% of women diagnosed with GDM go on to develop T2DM within five years of the birth of their child.
- Analysis of a cohort of 18,119 women who were pregnant between January 2022 and May 2023 highlighted that 57.4% (n=10,938) were overweight or obese at the start of their pregnancy. In the same period, 1,045 women were diagnosed with GDM.

### 3. NHSGGC Healthy Weight Delivery Programmes

#### 3.1 Children, Early Years and Adolescents

- Recognising that overweight and obesity begins early, NHSGGC child healthy weight strategy approved in 2016, advocates for a life stage approach to prevention.
- By taking a population approach to child and adolescent overweight and obesity, support can be matched to the age and stage of child’s development allowing interventions to be delivered at the size and scale required across GGC. This requires a combination of universal support alongside the delivery of targeted services; recognising that for the majority of younger children a healthy eating and activity focus, effectively allows ‘children to grow into their weight’ rather than interventions seeking to achieve weight loss.
- Targeted weight management services supports children, young people (aged 12-18 years) and families to lose weight and adopt a healthier lifestyle, and are provided in the context of wrap around support. An important element of the approach is building community capacity for food literacy and cooking skills to enable long term change to eating habits and increase access to affordable healthy foods including Best Start benefits.
- Therefore, the strategic approach adopted by NHSGGC is 2-fold:
  - Intervention to support families to adopt healthy eating, increase physical activity and reduce impact of food insecurity through awareness raising, skills development, practical support and access to affordable foods for families
  - Targeted intervention at key stages:
    - refer families with children aged between 0-12 years to targeted HENRY Families support<sup>11</sup>
    - engage overweight adolescents in weight management support – as an effective and efficient strategy in reducing adult overweight<sup>12</sup>.

Tier	Initiative	Activity	Age	Locality
1	Your Body Matters	Primary education resource aligned to C4E outcomes	5 - 12	GG&C
	Community Food Network	Community Cooking; Food literacy sessions; equipment support; Pantry memberships	Families	GG&C
2	Growth and Nutrition Advisory Service	Professional advisory service to C&F teams for children <12 months with growth concerns.	0-12m	GGC
	Thrive under 5	Pilot programme in communities. Aimed at reducing food insecurity whilst increasing healthy food availability (& purchasing power) and reducing food miles to maximise opportunities for children to have a healthy diet and be physically active	0 - 5	Glasgow City, Inverclyde, Renfrewshire, East Renfrewshire
	HENRY	EY settings approach delivered through the universal pathway. Training being rolled out to HVs, SNs, Children & Families Teams and EY Educations staff to deliver universal approach	0 - 5	GG&C

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	HENRY Healthy Families Growing Up	HENRY training being delivered to PEEK & EYS to deliver programme. Will also be offered to education staff, SNs and TSOs.	5 - 12	GG&C
	Community Dietetics	Children with complex need being referred to community dietetics on a 1:1 basis	5 - 12	GG&C
	Weigh to Go	GHSCP YHS support for YP to access YHS support (12-16 years) and commercial weight management services (16- 18 years) with onward transition to adult pathway at 19 years.	12-18	GG&C xs 19 venues
3	Specialist Services	Currently provided through Paediatric services	N/A	GG&C

### 3.2 Adults (Healthy Weight and Diabetes)

- As overweight and obesity rises, so too does the burden of disease from type 2 diabetes (T2DM) and associated co-morbidities. Overweight and obesity is the single modifiable risk factor for the development of T2DM, therefore weight management interventions are a priority. Increasing evidence of T2DM remission as a result of weight loss interventions offer the best opportunity to impact on population health outcomes<sup>13</sup>.
- Targeted delivery of Community Weight Management Services (CWMS) in local communities and online, are able to support service delivery at a size, scale and reach to meet both the geography and diversity of the population across GGC and have population impact.

Level	Intervention	Adult Healthy Weight	T2DM (including GDM)
1	Public health awareness and early detection <ul style="list-style-type: none"> <li>Public Health campaign</li> <li>Targeted messaging with core messages</li> <li>'At risk' stratification</li> <li>Case finding</li> <li>Local level action</li> </ul>	<ul style="list-style-type: none"> <li><a href="http://www.nhsggc.scot/your-health/manage-your-weight">www.nhsggc.scot/your-health/manage-your-weight</a> - healthy weight information resources for patients</li> <li>Glasgow City Food Plan</li> <li>Local Food Policy Networks</li> <li>Self-Management Resources (Weight Management)</li> </ul>	<ul style="list-style-type: none"> <li><a href="https://www.nhsggc.scot/t2diabeteshub">https://www.nhsggc.scot/t2diabeteshub</a> - healthy weight / T2D prevention information resources for patients</li> <li>Pre-diabetes education modules</li> </ul>
2	Early intervention (for those at moderate or high risk) • Pre-diabetes education programme <ul style="list-style-type: none"> <li>Metabolic antenatal clinics</li> <li>Maternal and infant nutrition pathways</li> <li>Weight management programmes</li> </ul>	<ul style="list-style-type: none"> <li>Community based physical activity opportunities</li> <li>Walking Groups</li> <li>Community Food Network</li> <li>Community BME Access Programme</li> <li>GP Exercise on referral</li> </ul>	<ul style="list-style-type: none"> <li>Community BME Access Programme</li> <li>Digital support for patients</li> <li>Pre Diabetes intervention resources / CWMS pathways</li> <li>Community Food Framework</li> <li>Maternity pathway</li> </ul>
3	Targeted intervention (for those diagnosed with type 2 diabetes, at high risk, with pre-diabetes or gestational diabetes) <ul style="list-style-type: none"> <li>Structured education for those with diabetes</li> <li>Intensive weight management for remission</li> <li>Weight management programmes</li> <li>Psychological support</li> </ul>	<ul style="list-style-type: none"> <li>Referral management /Motivational appointing</li> <li>Tier 2 Community WMS (WW &amp; Slimming World)</li> <li>Post-natal referral pathway</li> <li>Specialist Weight Management services</li> <li>Onward signposting / social prescribing</li> </ul>	<ul style="list-style-type: none"> <li>Opt out referral pathway /motivational appointing for newly diagnosed patients (WMS / Control It Plus)</li> <li>Control It Plus (CIP) T2DM education programme</li> <li>Maternity GDM Education / GWMS pathway</li> <li>Onward signposting / social prescribing</li> </ul>
4	Complex case management Advanced weight management input and specialist interventions	<ul style="list-style-type: none"> <li>Specialist Weight Management services -Bariatric pathway</li> </ul>	<ul style="list-style-type: none"> <li>Specialist Weight Management services-</li> <li>Bariatric pathway</li> <li>Low Calorie Liquid Diet Pilot (Counterweight)</li> </ul>

## 4. 2023/24 Programme Performance

### 4.1 Overall Performance Summary

Across 2023/24, in line with the increasing prevalence of overweight and obesity, referral to and engagement with both child and adult weight management and lifestyle interventions has increased, with adult weight management services now receiving over 16,000 referrals during 2023/24.

### 4.2 Children, Early Years and Adolescents

During 2023/24, there has been considerable investment in establishing a trained workforce to deliver HENRY core messages consistently to all families with children under 5. In addition, and in parallel, commissioning third sector organisations to deliver HENRY Families groupwork sessions has been completed and we now have both Early Years Scotland and PEEK undertaking HENRY training in readiness to launch targeted family support in August 2024. Impact evaluation of the HENRY programme will be evaluated.

#### 4.2.1 HENRY

- To date, **267 children & families staff** have been trained in HENRY Core, comprising:
  - 237 Health Visitors
  - 11 Early Years Education staff
  - 18 Third Sector Organisation staff
- HENRY core messages will be delivered through the HV universal pathway
- During 2023-24, **two local third sector organisations** were commissioned to deliver HENRY Families Growing Up; PEEK and Early Years Scotland. Delivery of this programme will provide additional targeted support for those families in greatest need.

#### 4.2.2 Thrive Under 5 (Tu5)

- Referrals to Tu5 pilot sites across all active areas have **exceeded the capacity** of the programme each year, reflecting the extent to which deprivation impacts on food insecurity and the high level of need for support. In Glasgow city **816 families** and in Inverclyde, **230 families** have benefitted from support. Renfrewshire and East Renfrewshire data is less than a year old and have still to be quantified.
- Data collected for Tu5 highlights a **high uptake of free fruit and veg** for children as well as use of pantry vouchers.
- In addition, this year Glasgow City has gained **£286,707** for families as part of FI pathway with a further **76 families receiving energy vouchers** to alleviate fuel poverty.

#### 4.2.3 Specialist Services

- Targeted clinical support for those children identified with more complex overweight/obesity issues e.g. autistic spectrum, fussy/faddy eating, Prader-Willi, presence of co-morbidity etc., is provided on referral pathway by either Community Dietetics or specialist paediatric services.

**4.2.4 Weigh To Go**

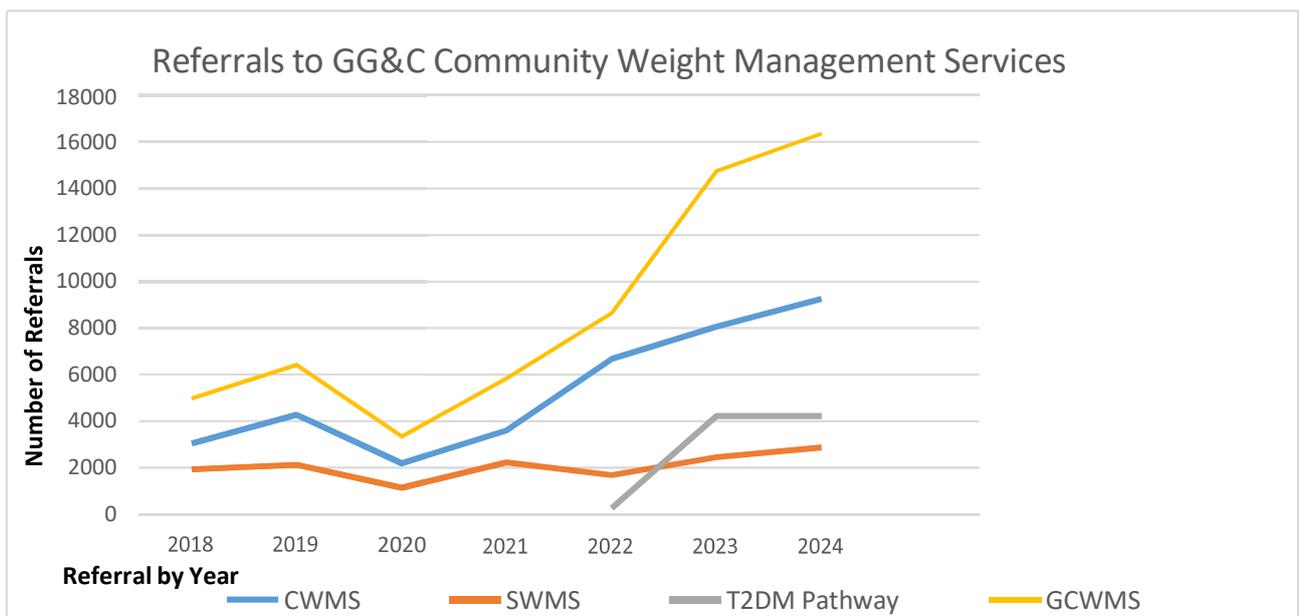
The service is hosted and delivered by Glasgow HSCP Youth Health Services (based in primary care), across all 6 planning localities in NHSGGC, and from 19 local health venues. During 2023/24, 128 young people successfully engaged with this service. Staff recruitment challenges have resulted in a waiting list of 76 patients currently.

**4.3 Adults (Healthy Weight and Diabetes)**

4.3.1. During 2023/24, Glasgow & Clyde Weight Management Services (GCWMS) received 16,352 referrals. This is an 89% increase on the number of referrals received during 2022. Trends can be seen in the table below:

Numbers of patients referred to GCWMS by year				
Year	Tier 2 CWMS	Tier 3 SWMS	T2DM Pathway	GCWMS
2018	3045	1931		4976
2019	4282	2129		6411
2020	2194	1152		3346
2021	3605	2234		5839
2022	6678	1696	268	8642
2023	8062	2460	4230	14752
2024	9256	2876	4220	16352

4.3.2 Whilst implementation of the T2DM opt-out referral pathway during 2022 has increased the number of referrals by just over 4,000, it does not account for the overall 8,000 increase in referrals during 2024, highlighting the increased general demand for AWMS illustrated in graph 4 below.



**Graph 4: Annual referral numbers by service**

#### 4.3.3 Community Weight Management Services

- In April 2023, a new multi-supplier framework commenced, substantially increasing the number of in-person community based service coverage across the whole of the GGC area.
- During 2023/24, there were over **16,000 referrals** of which 9,256 were for tier 2 CWMS, equating to over 2,300 referrals per quarter; representing an **89% increase** on referrals in the two years since 2021/22.
- The majority of referrals (80%) come from **primary care**, and work to improve both referral and engagement rates through clinical reinforcement with patients is ongoing and monitored through the NHSGGC assurance framework.
- Data from the last two quarters of 2023/24 highlights significant improved outcomes for a larger number of patients, with 70% of those opting for tier 2 weight management going on to complete ten out of twelve weeks of the programme, with **two thirds of them achieving a 5% weight loss**. These figures exceed national benchmarks/ comparator studies for weight loss outcomes.<sup>14,15</sup>

#### 4.3.4 Type 2/Gestational Diabetes Service

- Implementation of an **'Opt Out' referral pathway** for Control It Plus (the structured education programme with GGC), including an 'opt out' referral to GCWMS and other lifestyle interventions. Of the 6,200 patients newly diagnosed with T2DM during 2023/24, **4,220 were eligible and referred** to GCWMS
- Evaluation of Control It Plus highlighted **very high patient satisfaction** for those who participated. The evaluation identified a range of significant impacts including weight loss and improvement in blood sugar levels or diabetes patients going into remission as a result of changes patients had made following the education sessions, weight management services and/or physical activity sessions. Feedback from patients has included:  
*"The programme was informative and helpful in explaining the nature of diabetes, the causes, the dangers and the treatment. I discovered that diet was a major factor in reducing the dangers and helping to live as normal as possible life."*
- In order to increase awareness of T2DM within BME / South Asian communities, a programme to train and support a cohort of **T2DM Community Champions** is being implemented. The training (in conjunction with Diabetes Scotland) aims to support and empower participants to promote messages and services in their communities, building on their existing community links and networks. An online forum has been established to provide a platform for peer support amongst the Champions, with in person touch points and a programme of activity scheduled for 2024/25.
- Activity to enhance the care for women with GDM during and following their pregnancy is being rolled out across all maternity units with **three Diabetes Specialist Midwives** recruited to support its implementation.
- An **opt out post-natal GDM referral pathway** has been implemented for women with BMI>30 and a diagnosis of GDM. Around 16 weeks after the birth of their baby women are automatically contacted and offered weight management support; women can choose to engage earlier or later than this point, depending on when they feel ready.

## 5. 24/25 Programme developments

5.1 Currently lifestyle services including GCWMS, Live Active GP Exercise on Referral Scheme (including community rehab services), and 'Control-It Plus' structured education for Type 2 Diabetes patients receive over 27,000 referrals per year and are coordinated and managed by HI staff through the activity of two administration hubs. Increased demands on each of the respective management hubs has highlighted weaknesses in the current arrangements and in order to meet current and future demands and ensure efficiency and effectiveness across the whole system, a review of the administration function and arrangements, including skill mix and capacity is now required. To improve efficiency and ensure the quality of patient experience, a business case detailing revisions to improve the service will be submitted to the Board during 2024.

5.2 Key to our strategy to address obesity within GGC population, we will have a continued and consolidated focus on our 5 main priorities:

1. Universal delivery of HENRY to families with pre-five children with targeted support for families with children 0-12 years.
2. Delivery of tailored Weight Management Services for adolescents (Weigh to Go)
3. Development of robust local Community Food Networks to build community capacity; cookery skills and food literacy and reduce food insecurity for vulnerable families including Thrive Under 5.
4. Provision of weight management services at a size and scale to impact at population level and address clinical lead.
5. Provide early intervention education and weight management interventions to newly diagnosed patients with T2DM or Gestational Diabetes with a view to increasing remission rates.

5.3 Actions to further develop these programmes in the coming year include:

Priority	Actions
Lifestyle hub development	<ul style="list-style-type: none"> <li>• Business case to be submitted July 2024</li> </ul>
HENRY programme	<ul style="list-style-type: none"> <li>• GGC Training for Trainers approach is being adopted to sustain training longer term.</li> <li>• Launch of HENRY Families service Aug 2024.</li> </ul>
Weigh to Go	<ul style="list-style-type: none"> <li>• Recruit nursing staff to reduce current waiting list</li> <li>• Resume service in areas challenged by staff shortages</li> </ul>
Community Food Networks including Thrive Under 5	<ul style="list-style-type: none"> <li>• Tu5 formal evaluation (report expected Autumn 2024).</li> <li>• Develop Tu5 funding agreement with Glasgow City (funded until 2026 as part of HWB Fund &amp; children's service plan).</li> <li>• Secure alternative funding for other areas.</li> </ul>
Adult Weight Management Services	<ul style="list-style-type: none"> <li>• Strengthened focus on prevention (including development of a pathway to GCWMS for women who were overweight during their pregnancy).</li> </ul>
Diabetes Services	<ul style="list-style-type: none"> <li>• Review of CIP delivery mechanisms to increase patient engagement</li> </ul>

## 6. Conclusion

- 6.1 The prevalence of T2DM continues to steadily increase across Scotland and locally. Diabetes is closely related to deprivation and ethnic background and whilst 5.5% of the NHSGGC population are currently diagnosed, estimates suggest significant unmet need with prevalence is closer to 10%.
- 6.2 Obesity is the biggest driver of T2DM and a combination of structured education and weight management interventions are effective in improved management of the condition, delaying or avoiding complications and in an increasing number of cases supporting disease remission.
- 6.3 Significant programmes of work to reduce (and prevent) rising levels of overweight and obesity within the population are being delivered through the Public Health Directorate. These programmes will improve self-management and contribute to reducing the burden on health care services.

## 7. Recommendations

NHSGGC Board is asked to:

- Advocate for the 5 priority areas of action on obesity:
  - Universal & targeted delivery of HENRY to families with pre-five children
  - Delivery of tailored Weight Management Services for adolescents (Weigh to Go)
  - Development of robust local Community Food Networks to build community capacity; cookery skills and food literacy and reduce food insecurity for vulnerable families including Thrive Under 5.
  - Provision of weight management services at a size and scale to impact at population level and address clinical lead.
  - Provide early intervention education and weight management interventions to newly diagnosed patients with T2DM or Gestational Diabetes with a view to increasing remission rates.
- Support and maintain investment in the 5 priority areas described.

## References

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- <sup>1</sup> [Costs of obesity in Scotland Frontier Economics.pdf\(nesta.org.uk\)](#)
- <sup>2</sup> [https://www.thelancet.com/journals/landia/article/PIIS2213-8587\(20\)30124-8/fulltext](https://www.thelancet.com/journals/landia/article/PIIS2213-8587(20)30124-8/fulltext)
- <sup>3</sup> [Counting the cost of obesity in Scotland | Nesta](#) accessed 5<sup>th</sup> September 2023
- <sup>4</sup> [2024-06-04-scottishburdenofdisease-diabetes.pdf\(scotpho.org.uk\)](#)
- <sup>5</sup> [2022-12-13-p1-bmi-statistics-publication-report.pdf\(publichealthscotland.scot\)](#)
- <sup>6</sup> [Counting the cost of obesity in Scotland | Nesta](#)
- <sup>7</sup> [https://www.diabetes.org.uk/resources-s3/2017-11/south\\_asian\\_report.pdf](https://www.diabetes.org.uk/resources-s3/2017-11/south_asian_report.pdf)
- <sup>8</sup> Goff LM. Ethnicity and Type 2 diabetes in the UK. Diabet Med. 2019 Aug;36(8):927-938. doi: 10.1111/dme.13895. Epub 2019 Jan 23. PMID: 30614072
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- <sup>10</sup> <https://www.diabetes.org.uk/professionals/position-statements-reports/type-2-diabetes-prevention-early-identification>
- <sup>11</sup> [Effective family support | HENRY](#)
- <sup>12</sup> [Predicting adult obesity from childhood obesity: a systematic review and meta-analysis - PubMed \(nih.gov\)](#)
- <sup>13</sup> [Research spotlight – putting type 2 diabetes into remission | Diabetes UK](#)
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