PUBLIC HEALTH

Severn Diabetes and Obesity Conference 2026

Report to the Shropshire Health and Wellbeing Board

Healthy Population and Partnerships

Report date	30 October 2026
Report authors	Mr Bernie Bentick, Dr Probal Moulik
Report purpose	Information, assurance and partnership development
Conference date	25 September 2026
Conference attendance	Approximately 250 delegates

Key messages

Prioritisation and dedicated funding, stronger prevention, earlier action and closer collaboration across services are essential to reduce the growing burden of diabetes and obesity and improve outcomes across our communities.

1. Executive summary

Diabetes and obesity are major and closely connected public health challenges. The figures supplied for this report indicate diabetes prevalence of approximately 7.1% in Shropshire and around 8% in Telford, while approximately 67% of adults, around 180,000 people locally, are living with being overweight or obese. Nearly one in three children in Year 6 is described as overweight or very overweight.

The Severn Diabetes and Obesity Conference (SDOC), held on 25 September 2026, brought together approximately 250 delegates for a full day of education, practical training, patient experience and discussion. Demand exceeded venue capacity. The programme covered prevention, inequalities, modern diabetes treatment, cardiovascular and kidney protection, liver disease, hypertension, neuropathy and foot disease, lipid management, obesity treatment, bariatric surgery, continuous glucose monitoring and insulin therapy.

The central conclusion was that diabetes and obesity cannot be addressed by individual services working in isolation. Prioritisation, dedicated funding, earlier case identification, healthy weight across the life course, integrated physical and mental healthcare, community-based prevention, clear referral pathways and closer working between primary, community and hospital teams are required.

The conference is intended to continue annually. Severn Diabetes Network CIC is also being established to support work between conferences, including community engagement, fundraise and support the proposed Severn Pumpers Financial Hardship Fund for people with type 1 diabetes experiencing financial disadvantage.

Key Messages and Recommendations

1. Note the scale and interrelationship of diabetes, obesity, cardiovascular disease, kidney disease, liver disease and health inequalities across the local population.
2. Note the successful delivery and strong professional engagement achieved by SDOC 2026.
3. Support closer collaboration between Public Health, primary care, community services, secondary care, patients and voluntary and community partners.
4. Support a stronger emphasis on prevention, earlier identification and healthy weight across the life course.
5. Encourage the development of shared, equity-focused outcome measures covering prevention, access, inequalities and clinical outcomes.
6. Welcome continued professional and community engagement through SDOC and Severn Diabetes Network CIC, while maintaining clear governance and organisational boundaries.

2. Purpose of the report

This report provides the Healthy Population and Partnerships meeting of the Health and Wellbeing Board with an overview of the population-health context for diabetes and obesity, the delivery and learning from SDOC 2026, and the opportunities arising for prevention and partnership working.

The report is intended to support discussion about how the momentum generated by the conference can contribute to a coordinated local response across Public Health, primary care, community services, secondary care, the voluntary and community sector, patients and wider partners.

3. Population-health background

3.1 Scale of diabetes and obesity

Diabetes prevalence is approximately 7.1% in Shropshire and around 8% in Telford. Diabetes is closely associated with obesity, and approximately 67% of adults, representing around 180,000 people locally, are living with overweight or obesity. The cost to NHS services is about 6% of the UK health budget (Diabetes UK), equivalent to £68.5 million of the core revenue allocation to Shropshire, Telford and Wrekin NHS ICB for 2026/27 (NHS England).

The impact on younger people is a particular concern. Nearly one in three children in Year 6 is overweight or very overweight, reinforcing the need for prevention and healthy-weight action throughout the life course.

3.2 Cardiovascular risk and undiagnosed diabetes

Diabetes and obesity are strongly associated with cardiovascular disease, including heart attack and stroke. The figures supplied for the conference report indicate that approximately 25% of people presenting locally with acute cardiovascular events have diabetes, and around one in six of those with diabetes are diagnosed for the first time at presentation. This illustrates the continuing burden of undiagnosed disease and the opportunity for earlier identification.

3.3 Inequalities and mental health

The burden is not evenly distributed. Obesity is approximately twice as common in the most deprived communities as in the most affluent, making diabetes and obesity important contributors to health inequalities.

There is also a two-way relationship with mental health. The figures presented for this report indicate that people living with obesity have around a 50% increased risk of depression and anxiety, while people living with mental health conditions are approximately three times more likely to experience obesity. Physical health, mental health and the wider determinants of health should therefore be considered together.

4. The whole-system case for action

A meaningful response to diabetes and obesity requires coordinated action across the health and care system. Public Health, primary care, secondary care, community services, the voluntary and community sector, patients, local communication channels and the media all have a role in prevention, earlier identification, effective treatment and sustained self-management.

SDOC was developed as a practical contribution to this agenda. The annual conference was started 3 years back by Dr Probal Moulik, Consultant endocrinologist, as the Severn Diabetes Conference and was renamed this year as SDOC (Severn Diabetes and Obesity Conference) to reflect the central importance of obesity in the development and management of type 2 diabetes and related metabolic disease.

Its purpose is not only to raise awareness but also to equip healthcare professionals with current knowledge and practical skills, facilitate exchange of ideas, build relationships and strengthen collaboration across organisational boundaries.

5. SDOC 2026: delivery and reach

SDOC 2026 was held on 25 September 2026 at the Wroxeter Hotel, Shropshire, as a full-day event. Approximately 250 delegates attended, and demand exceeded the capacity of the venue. The level of interest demonstrated strong appetite among healthcare professionals for education and collaboration in diabetes and obesity.

As an annual event, SDOC can build cumulative reach across the workforce. Professionals unable to attend in one year may participate in subsequent years, progressively extending learning and relationships across the local health and care system.

6. Opening session: inequalities and prevention

The conference opening placed diabetes and obesity within the wider context of population health, inequalities and prevention. Shrewsbury Mayor and former NHS Consultant Bernie Bentick highlighted the Marmot principles and six objectives for a healthier society:

1. Give every child the best start in life.
2. Enable people to maximise their capabilities and have control over their lives.
3. Create fair employment and good work.
4. Ensure a healthy standard of living.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill-health prevention.

The opening discussion emphasised that health inequalities have widened and cannot be addressed by healthcare acting alone. It also emphasized three strategic shifts within the NHS 10 year Plan: care from hospital

to community, analogue to digital systems, and sickness treatment to prevention. These shifts need to operate together rather than in isolation between and within the local Healthcare system and wider partners.

Proposed Shropshire Prevention Compact

- Prioritisation and dedicated funding to achieve measurable outcomes.
- Earlier identification of risk and clear referral pathways.
- A healthy-weight approach across the life course.
- Place-based support where need is greatest and barriers to access are highest.
- Integrated physical health, mental health and community support.
- A shared, equity-focused outcomes dashboard.

7. Clinical education and practical learning

7.1 Modern treatment and cardiorenal protection

Professor Vinod Patel discussed updated NICE NG28 guidance for type 2 diabetes and the role of modern glucose-lowering treatment. Particular emphasis was placed on SGLT2 inhibitors and incretin-based therapies, reflecting the need to consider cardiovascular and kidney protection alongside glucose control.

Dr Jayesh Makan, consultant cardiologist, addressed optimal management of hypertension in diabetes. Dr Rob Chand, Consultant Nephrologist, examined the interrelationship between cardiovascular, renal and metabolic disease and described strategies for earlier recognition of kidney disease and reduction of long-term risk.

7.2 Liver disease and metabolic complications

Dr Ulrich Thalheimer, Consultant Hepatologist, discussed MAFLD ie fatty liver disease associated with obesity and metabolic dysfunction. Fat deposition in the liver can be associated with inflammation, progressive liver damage and, in some individuals, cirrhosis. The session reinforced the need to address obesity, type 2 diabetes and liver health together.

7.3 Complications and prevention of avoidable harm

Dr Dimple Jain, Consultant Dermatologist, presented the dermatological manifestations of diabetes. Dr Prashant Singh, Consultant endocrinologist, provided a practical discussion on diabetic neuropathy and its consequences. Neuropathy may cause pain and disability, but loss of protective sensation also increases the risk of foot ulceration and amputation. Prevention requires a joined-up pathway: community services identifying people at higher risk and providing surveillance, education and preventive care, with timely access to hospital-based multidisciplinary diabetic foot services for active ulceration.

7.4 Lipid and obesity management

Dr Helen Ashby, Consultant in metabolic medicine, discussed management of dyslipidaemia and cardiovascular risk in diabetes, including established and newer lipid-lowering therapies.

Dr Probal Moulik presented on the medical management of obesity and current challenges associated in delivering the services. Newer medicines are highly effective but are expensive and should be combined with sustained lifestyle measures. With finite resources, equitable prioritisation of people at greatest risk of obesity-related complications is important. The role of bariatric and metabolic surgery was also explored by Mr Umesh Parampalli, Consultant Upper GI/Bariatric Surgeon.

7.5 Practical workshops

Parallel workshops provided hands-on education and practical workshops in continuous glucose monitoring and insulin therapy. These sessions supported the translation of knowledge into practical skills for everyday clinical care.

8. Patient voice and primary care perspective

8.1 Patient experience

Patient representative Mr John Clark described his experience of fatty liver disease, followed later by diabetes. He explained the substantial changes he made through exercise, weight loss and healthier eating. His diabetes is now well controlled and his liver function tests have normalised.

His account illustrated the close relationship between obesity, liver disease and diabetes, the value of sustained lifestyle change, and the importance of ensuring that people living with long-term conditions have a meaningful voice in service development.

8.2 Primary care

Dr Abigail Kinmond, local GP from Newport, discussed the growing complexity of long-term-condition management in primary care. Practices vary in their capacity to deliver expanding and increasingly complex services. Movement towards prevention, earlier intervention and care closer to home must therefore be accompanied by appropriate workforce development, resources and funding.

9. Conference conclusions

Dr Probal Moulik emphasised that SDOC is not simply a forum for discussing science. It is also a place to exchange ideas, build relationships and strengthen collaboration between primary care, community services and hospital teams.

The closing discussion identified the following shared priorities:

- Earlier prevention and intervention before diabetes, obesity and complications become established.
- Explicit action on health inequalities and barriers to access.
- Integrated cardiovascular, renal and metabolic risk management rather than glucose control in isolation.
- Recognition of obesity as a chronic health condition requiring lifestyle, medical and, where appropriate, surgical treatment.
- Earlier identification supported by screening and clear referral pathways.
- Closer working between primary, community and specialist services.
- Continuing professional education and practical training.
- Meaningful patient and community involvement.
- Commissioning, resourcing and evaluation that support prevention.

The day closed with shared emphasis on earlier action and closer integrated working across services.

10. Developing a sustainable local network

The intention is to continue SDOC as an annual conference, enabling professionals to update their knowledge, exchange ideas and strengthen working relationships. The wider opportunity is to use the conference as a catalyst for collaboration throughout the year.

Severn Diabetes Network CIC is currently being established By Dr Moulik and his team as a community-focused not for profit organisation to support work beyond the annual event. Its proposed activities include prevention, education, community engagement, professional networking and fundraising, arranging annual SDOC conference and other training events and supporting the Severn Pumpers hardship fund. Appropriate governance and clear separation from statutory commissioning and NHS service delivery will be important as the organisation develops.

11. Severn Pumpers Financial Hardship Fund

A proposed initiative within Severn Diabetes Network CIC is the Severn Pumpers Financial Hardship Fund, focused particularly on people with type 1 diabetes who are experiencing financial disadvantage.

Although NHS care addresses many direct treatment costs, living with diabetes can generate additional and less visible financial pressures, including:

- Travel to hospital and primary care appointments.
- Parking and other costs associated with attending healthcare.
- Loss of working time to attend appointments.
- Self-funded items used to treat hypoglycaemia.
- Higher costs in areas such as insurance.
- Other day-to-day costs associated with managing a complex lifelong condition.

For people already experiencing hardship, these costs can accumulate and become a barrier to effective self-management. The proposed fund is intended as a community-supported response to this aspect of the wider determinants of health, subject to robust eligibility, governance, confidentiality and financial-control arrangements.

12. Opportunities for Healthy Population and Partnerships

SDOC provides a potential platform for linking professional education with wider population-health objectives. Areas for future collaboration include:

- Professional education in diabetes, obesity and prevention.
- Earlier identification and clearer referral pathways.
- Population engagement and education to promote healthy lifestyle including diet, regular exercise and healthy weight across the life course, from pre-schoolers to pensioners.
- Closer links between Public Health, primary care, schools, community and specialist services.
- Place-based approaches for communities experiencing greater need and barriers to care.
- Integration of physical health, mental health and community support.
- Greater patient and community participation.
- Engagement with local media and community communications to support prevention.
- Development of shared measures for prevention, access, equity and clinical outcomes.

13. Proposed next steps

No.	Proposed action	Suggested lead	Status
1	Develop a concise shared prevention proposition covering education, nutrition, exercise, mental health and behaviour patterns, earlier identification, healthy weight and referral pathways.	Public Health, schools and system partners	For partnership discussion
2	Explore an equity-focused outcomes dashboard for diabetes and obesity, particularly in communities and populations at high risk	Public Health, primary care and specialist services	Scoping
3	Strengthen year-round professional links arising from SDOC.	SDOC leads and partner organisations	Ongoing
4	Continue annual SDOC planning, including consideration of venue capacity and wider workforce reach.	SDOC organising team	Annual cycle

No.	Proposed action	Suggested lead	Status
5	Develop Severn Diabetes Network CIC governance, partnerships and fundraising arrangements.	Severn Diabetes Network CIC	In development
6	Establish robust rules and controls for the Severn Pumpers Financial Hardship Fund.	Severn Diabetes Network CIC	In development

14. Matters for the Board

The Board is invited to:

7. Note the report and the main learning from SDOC 2026.
8. Endorse the principle of earlier action, prevention and integrated working across diabetes and obesity pathways.
9. Support exploration of a shared, equity-focused approach to outcomes and evaluation.
10. Encourage continued engagement between Public Health, primary care, community services, secondary care, patients and voluntary and community partners.
11. Note the development of Severn Diabetes Network CIC and the proposed Severn Pumpers Financial Hardship Fund as independent community initiatives.
12. Prioritise diabetes and obesity with dedicated funding to achieve measurable outcomes.

Appendix 1. Headline conference themes

Theme	Board relevance
Population engagement and education Prevention and earlier identification	Opportunity to reduce avoidable disease and complications.
Health inequalities	Need for place-based action where disease burden and barriers are greatest.
Healthy weight across the life course	Requires action from pre-schoolers to pensioners.
Cardiovascular, renal and metabolic protection	Supports integrated risk reduction rather than glucose-only care.
Community and specialist integration	Clear pathways are required for prevention, escalation and complex care.
Professional education	Rapidly changing treatment requires continuing workforce development.
Patient voice	Services should be shaped with people living with diabetes and obesity.
Shared outcomes	Progress should be measured across prevention, access, equity and clinical outcomes.

Appendix 2. Data note

The prevalence, population and risk figures in this report have been reproduced from information supplied for the preparation of the paper. They should be checked against the latest agreed local Public Health, NHS and programme datasets before formal publication or external circulation. Speaker names, professional titles and organisational details should also be checked against the final conference programme.