

Health Needs Assessment: Gestational Diabetes in Tower Hamlets 2026

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Context



Anecdotal service pressures

- Local clinical teams in both primary and secondary care have **reported rising numbers** of women diagnosed with gestational diabetes particularly after the Covid-19 pandemic.
- Tower Hamlets has a **unique population profile** that contributes to high levels of gestational diabetes in the borough.

Maternity scrutiny

- Recommendation for a needs assessment on gestational diabetes to develop a project proposal in partnership with health, academic and community partners and stakeholders.

Maternity JSNA 2024

- **Tower Hamlets has the highest rates of diabetes in pregnancy** compared with neighbouring localities
- There is limited local data about gestational diabetes
- High numbers of women with gestational diabetes not coded correctly in primary care systems and therefore do not get recalled each year for review.



Aims and Purpose of HNA



1. To determine the **prevalence of gestational diabetes** in Tower Hamlets and conduct a data analysis to explore the role of sociodemographic factors in shaping these patterns
2. To assess the **trends** in gestational diabetes prevalence over the last 7 years
3. To assess the availability and effectiveness of **prevention initiatives** including:
 - lifestyle intervention for women at risk of developing gestational diabetes
 - lifestyle interventions for women diagnosed with gestational diabetes
4. To **understand the experiences of women** diagnosed with gestational diabetes including:
 - management and support and whether there are any gaps or unmet needs
 - health beliefs and understanding of gestational diabetes
5. To examine **post-partum follow up in primary care** for women with a history of gestational diabetes including annual HbA1c screening uptake and whether this is sufficient
6. To identify the **availability and accessibility of Type 2 diabetes prevention initiatives** or programmes for women with a history of gestational diabetes



Methodology



To provide this insight, we conducted:

- Data analysis of local health records and databases
- Review of policies and guidelines for gestational diabetes
- Engagement with stakeholders involved in the care of women with gestational diabetes
- Focus groups and interviews with women who previously or current have gestational diabetes to understand their experiences



Gestational diabetes data



Key findings

How common is gestational diabetes?

- Around **1 in 5** pregnant women were recorded with gestational diabetes in 2024. These figures are lower than expected due to inconsistent recording of data.

Who is most affected?

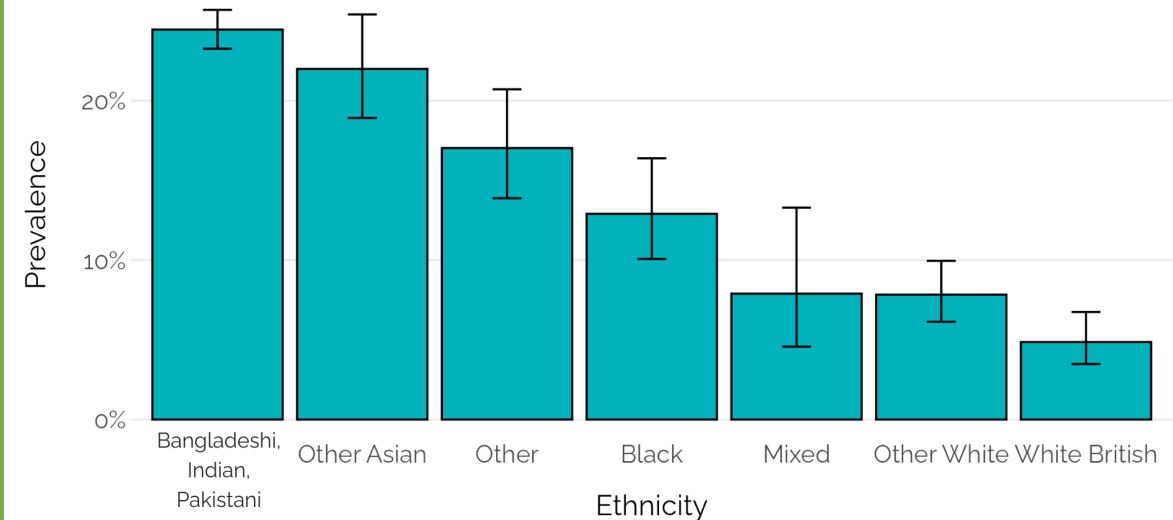
- Highest rates among Asian women – particularly from a **Bangladeshi background**.
- **Over half** of women with gestational diabetes live in the **most deprived areas** of Tower Hamlets.
- In 2024, 32% of pregnant women were obese and 34% were overweight.

Overweight and obesity

- In Tower Hamlets, among females aged 20-44 years **28% are obese, 25% are overweight**. Rates are significantly higher in Black ethnic groups and South Asian groups.

Prevalence of gestational diabetes diagnosis in pregnant women

Tower Hamlets residents, 2023-2024

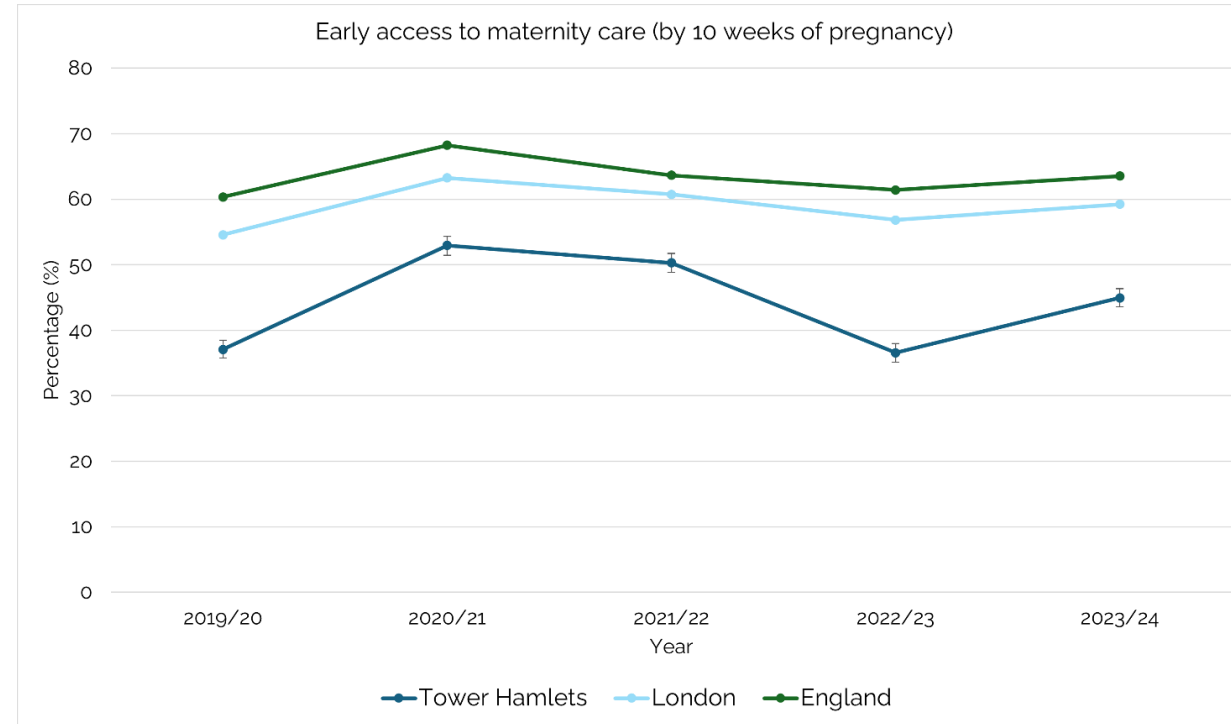


Source: Maternity Services data provided on request, NHS Barts Trust



Access to care and follow up

- **44.9% of women booked with a midwife** by the recommended **10 weeks** of pregnancy, missing out on early access to care. This is lower than London and England figures.
- **17.7% of women had a HbA1c test** after delivery of the baby to check blood sugar levels had returned to normal.
- In Tower Hamlets, engagement with the **NHS Diabetes Prevention Programme** after pregnancy is **very low**. This programme is recommended nationally after pregnancy to help reduce the risk of Type 2 diabetes in the future.



Qualitative insights



Focus groups



To understand the lived experiences of women diagnosed with gestational diabetes, we collaborated with local voluntary and community sector organisations:

- **Women's Inclusive Team**, who support **Somali** and other ethnic minority communities;
- **Limehouse Project**, who work with ethnic minority communities in East London (particularly the **Bangladeshi** community);
- **Social Action for Health**, who work with groups most affected by health inequalities.



A focus group was held with each organisation, and a total of 27 women were interviewed. These organisations were selected to ensure that voices of communities who face disproportionately higher health inequalities were meaningfully represented.



Emotional impact of diagnosis

"I had tension on my mind and fear the baby was going to be big"

Prevention

"I didn't know what gestational diabetes was and I didn't know you could get it just in pregnancy. If they gave me that information, I could control my diet from the beginning. When you don't get that information, you're just eating whatever you're craving."

Interventions

"There should be walking exercise groups so when you go and meet other mums who are in the same boat as you, you might be more likely to pick up good habits"

"More information is needed about risks even after birth."

Post-partum care

"We need a women's workshop after giving birth that give out prevention information and to inform people, so they know their rights"



Focus group findings

- **What women want:**

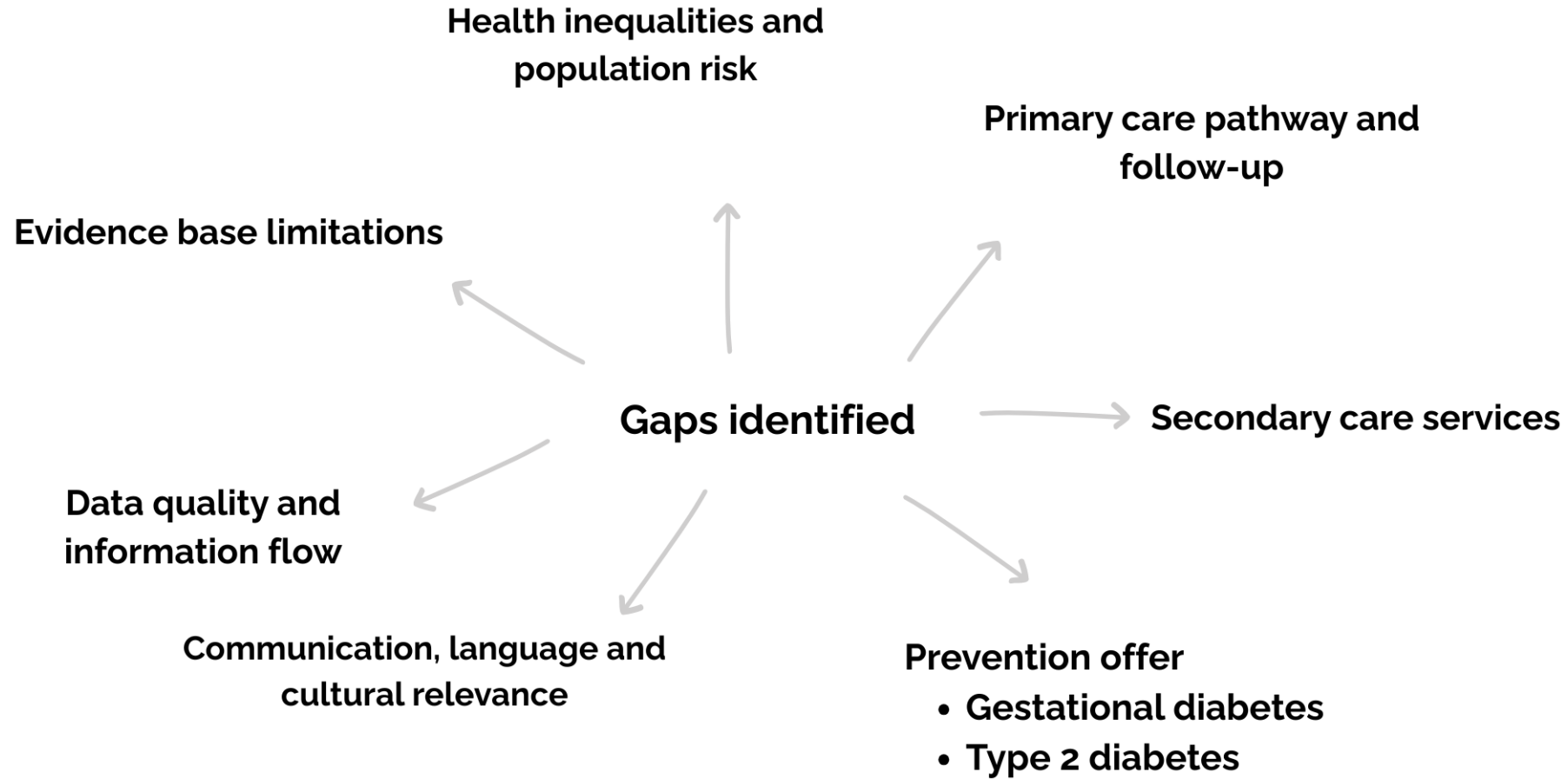
- Early, clear explanations of risk from booking onwards.
- Materials in multiple languages and formats (leaflets, audio, video, visual guides), with interpreters.
- Culturally relevant meal plans and diet advice.
- Affordable, accessible exercise options (community-led, women-only, home-based resources for those with childcare).
- Peer and community support during and after pregnancy.
- Postnatal guidance on Type 2 diabetes risk and automatic reminders for HbA1c tests.



Recommendations



Gaps identified



Recommendations high level summary



1) To reduce the number of women developing gestational diabetes and to address local health inequalities, aim to provide earlier support. This includes:

- Helping women improve their health and weight before pregnancy
- Encouraging earlier booking with a midwife and offering tailored lifestyle advice as soon as possible especially for those at higher risk
- Embed prevention into routine antenatal conversation
- Explore local gestational diabetes prevention pilots to understand what works best for women in Tower Hamlets. Explore the role of funding from sources such as NIHR.

2) Ensure women receive the follow-up care they need to reduce their future risk of Type 2 diabetes. This means:

- improving HbA1c tests checks after birth by aligning with other points of contact
- strengthening the handover between maternity and GP services  Ensure there is a named lead in General Practice
- ensuring a clear referral pathway into diabetes prevention programmes, that are accessible, effective and culturally relevant.
- Explore the role of health visitors in delivering messages around postnatal follow-up

3) Throughout the care pathway, aim to improve coding and data quality. Strengthen discharge communication by ensuring clear and consistent discharge summaries from maternity services to primary care and use of the correct SNOMED codes.

4) Explore with local voluntary and community sector organisations:

- the development of culturally tailored materials
- Peer support groups or community-led workshops with a focus on gestational diabetes/ Type 2 diabetes education and prevention



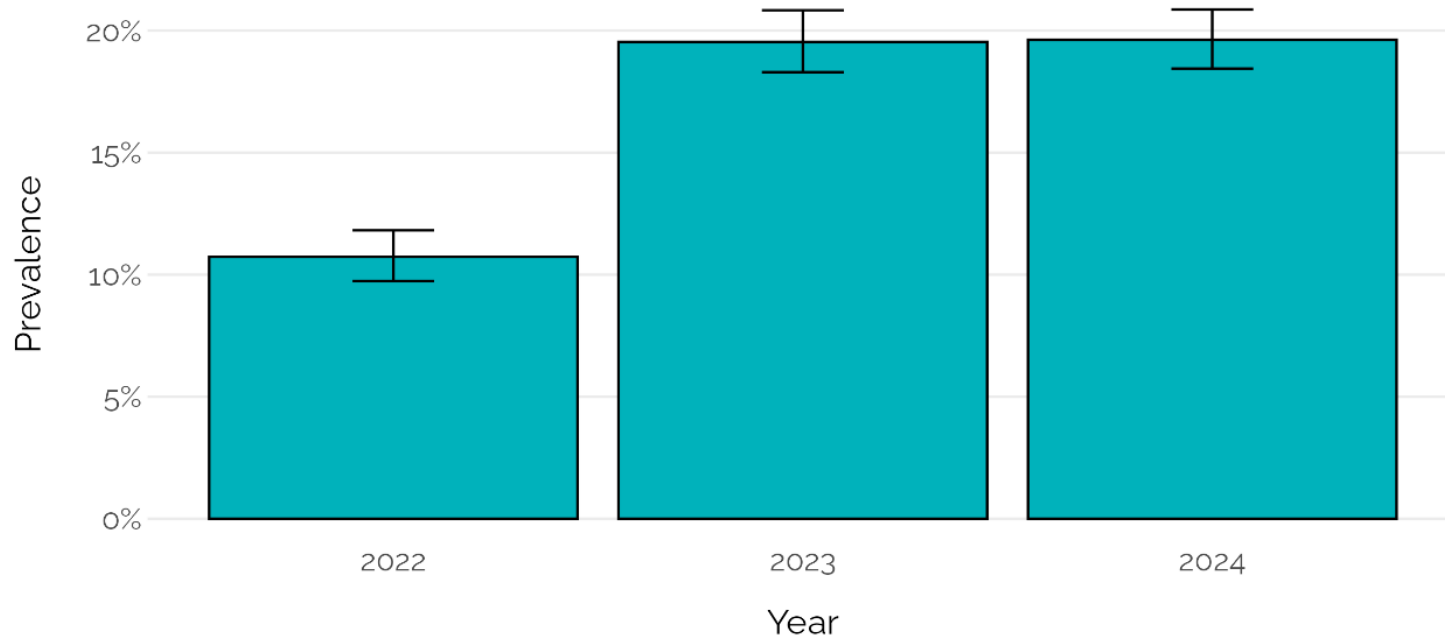
APPENDIX



Prevalence

Prevalence of gestational diabetes diagnosis in pregnant women

Tower Hamlets residents



Source: Maternity Services data provided on request, NHS Barts Trust

In Tower Hamlets, the prevalence of gestational diabetes among pregnant women was **10.7%** in 2022, **19.5%** in 2023 and **19.6%** in 2024.

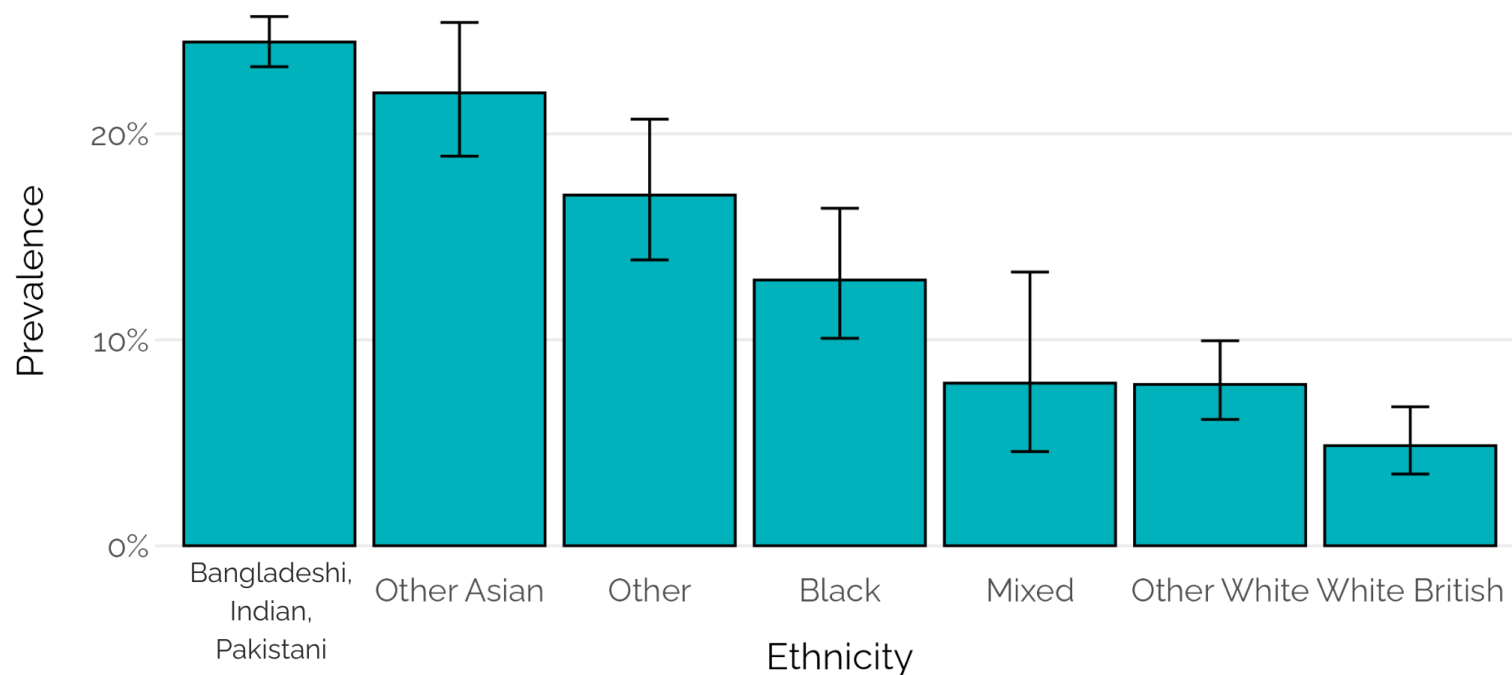
While the sharp increase between 2022 and 2023 is difficult to attribute to a single cause, it is likely influenced by incomplete or inconsistent recording of gestational diabetes status in earlier years



Ethnicity

Prevalence of gestational diabetes diagnosis in pregnant women

Tower Hamlets residents, 2023-2024



Source: Maternity Services data provided on request, NHS Barts Trust

The prevalence of gestational diabetes varies considerably across ethnic groups.

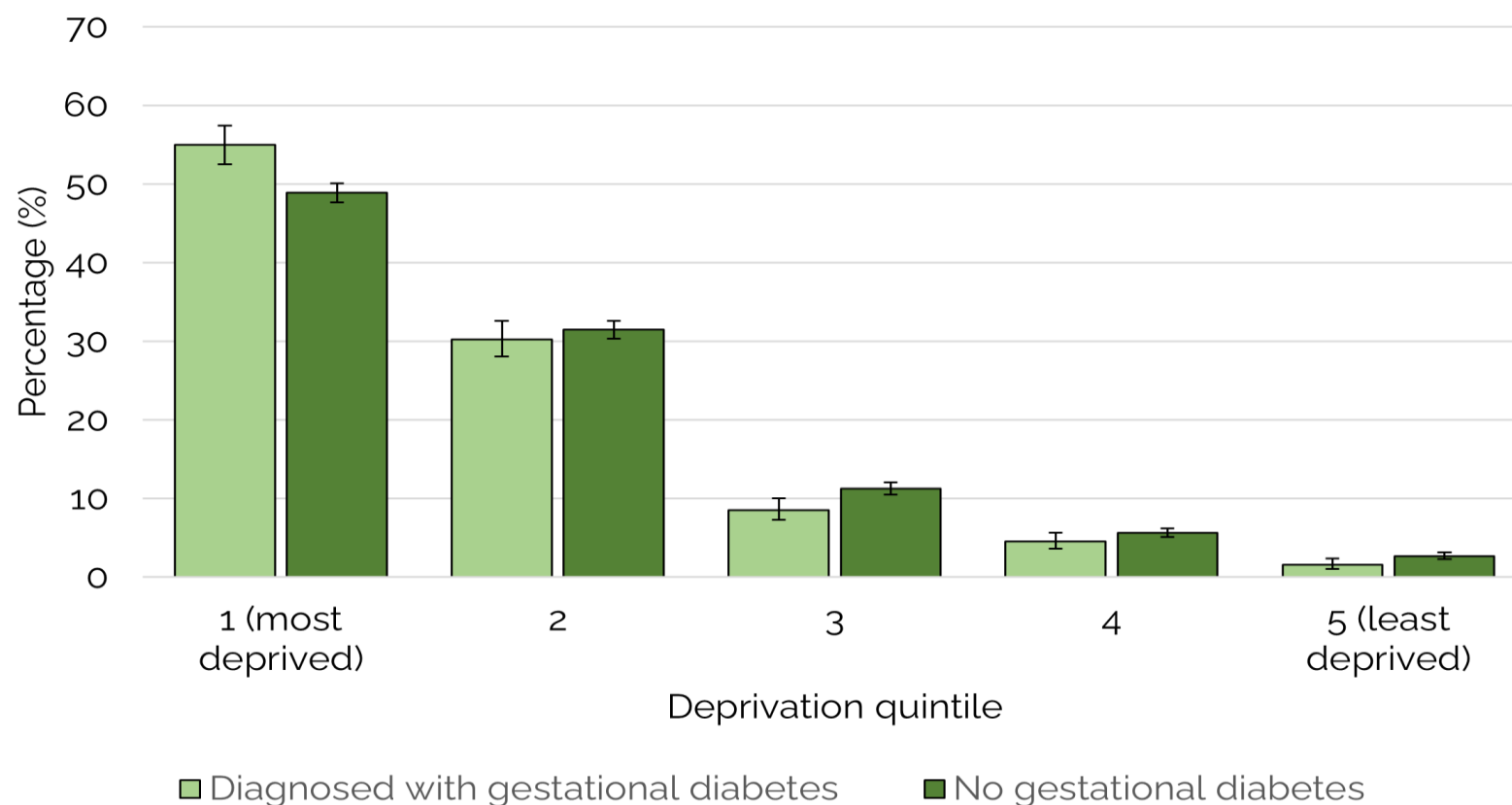
- Bangladeshi, Indian, or Pakistani 24.4%.
- Other Asian backgrounds 22.0%
- Other ethnic groups 17.0%
- Black ethnicities 12.9%.
- Mixed backgrounds 7.9%
- Other White groups 7.8%
- White British 4.9%



Deprivation

Gestational diabetes by deprivation quintile

Tower Hamlets residents 2023-2024



- 55% of women diagnosed with gestational diabetes were in the most deprived quintile, compared to 48.9% of women without gestational diabetes.
- These figures reflect overall high levels of deprivation in the borough that affects most pregnancies.

Source: Maternity services data provided on request. NHS Barts Trust

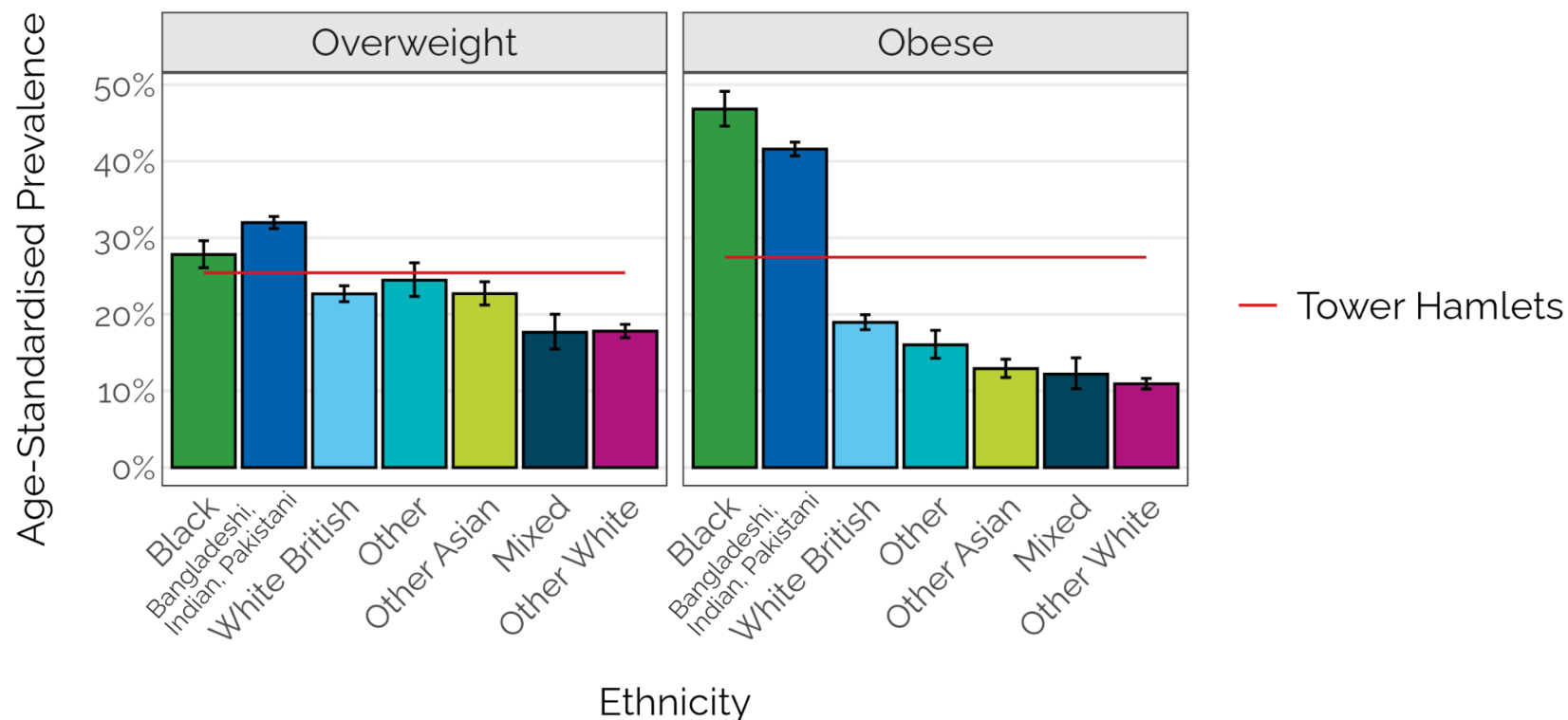


Overweight and obesity

Overweight and obesity prevalence by ethnicity in Tower Hamlets



Female, 20-44 years, 2025



In Tower Hamlets, among females aged 20-44 years **28% are obese, 25% are overweight.**

The prevalence of overweight and obesity among women aged 20-44 varies considerably by ethnicity, with rates significantly higher in Black ethnic groups and South Asian groups.

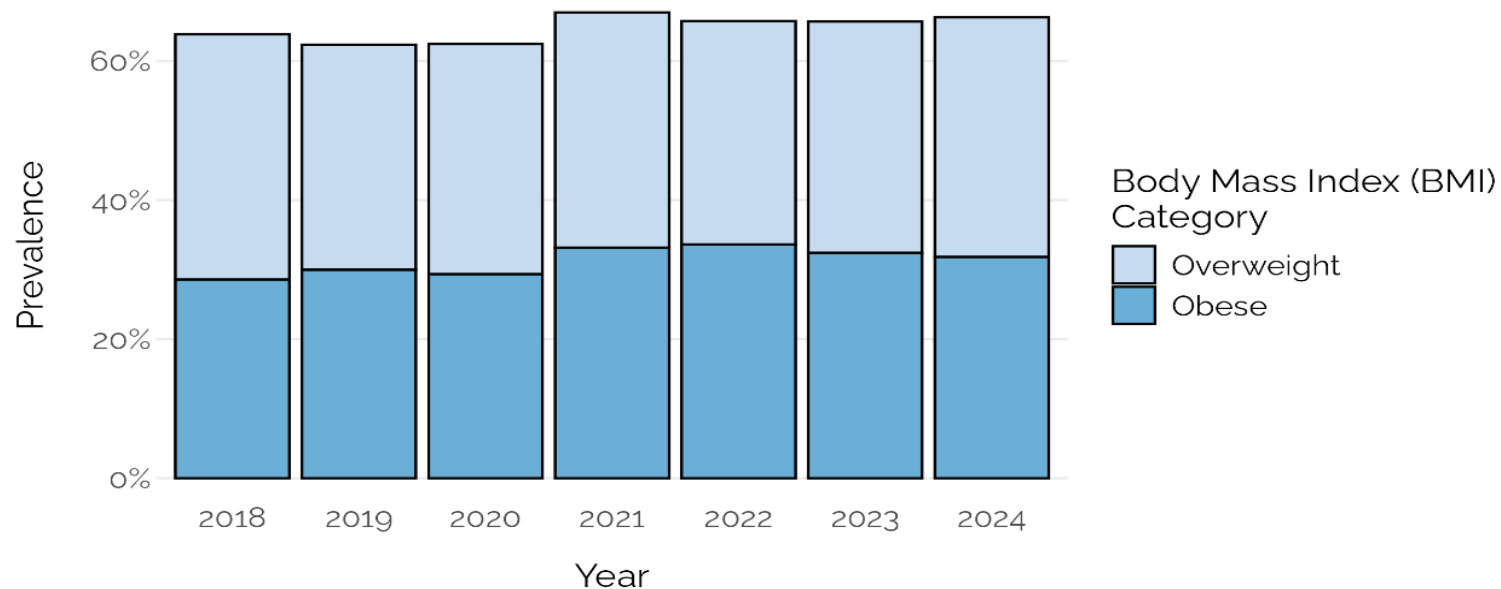
Note: BMI thresholds adjusted based on ethnicity using NHS guidelines
Source: East London Database (2025)



Maternal weight

Overweight or obesity prevalence in pregnant women

Tower Hamlets residents



Note: Adjusted ethnicity thresholds for BMI have been applied to prevalence estimates
Source: Maternity Services data provided on request, NHS Barts Trust

- The prevalence of overweight and obesity among pregnant women in Tower Hamlets is high.
- In 2024, the prevalence of obesity reached 32%, while 34% of pregnant women were overweight.

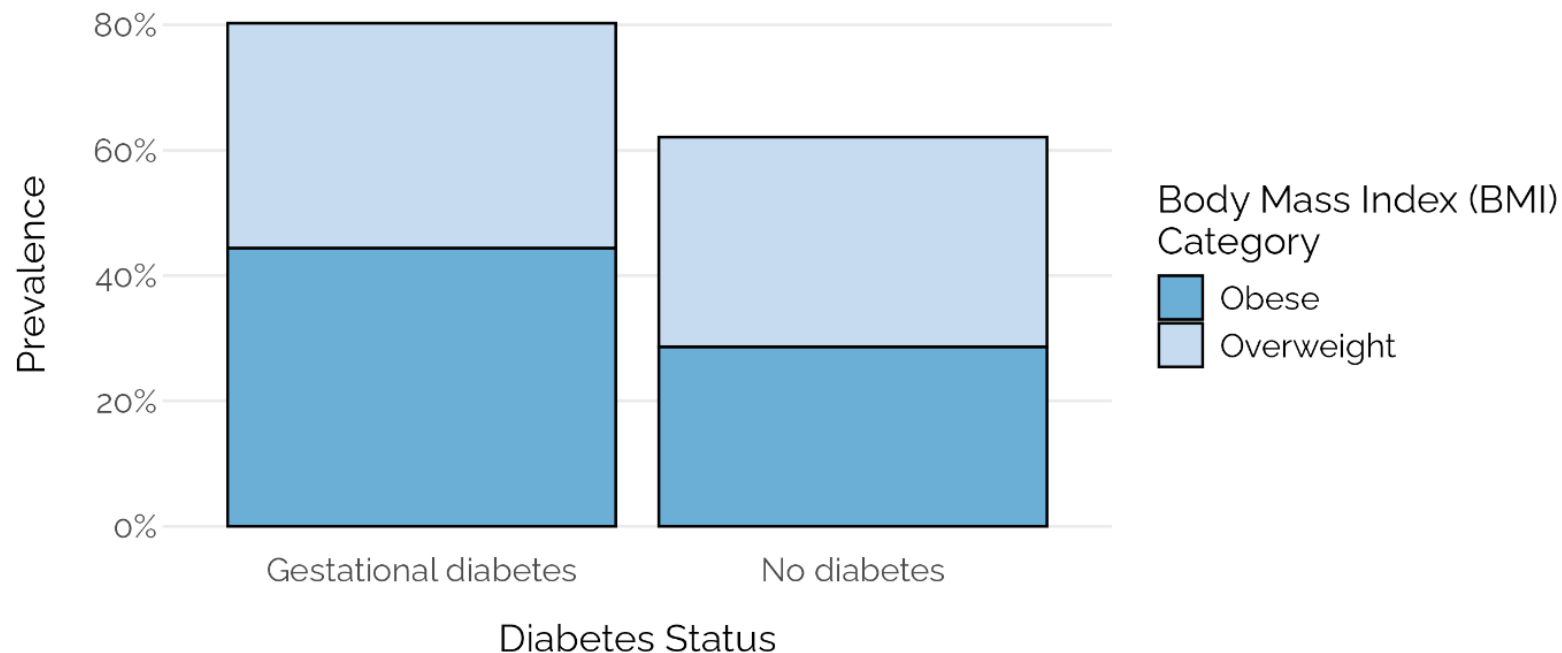


Maternal weight by diabetes status



Overweight or obesity prevalence in pregnant women
by diabetes status

Tower Hamlets residents, 2023-2024



Note: Adjusted ethnicity thresholds for BMI have been applied prevalence estimates
Source: Maternity Services data provided on request, NHS Barts Trust

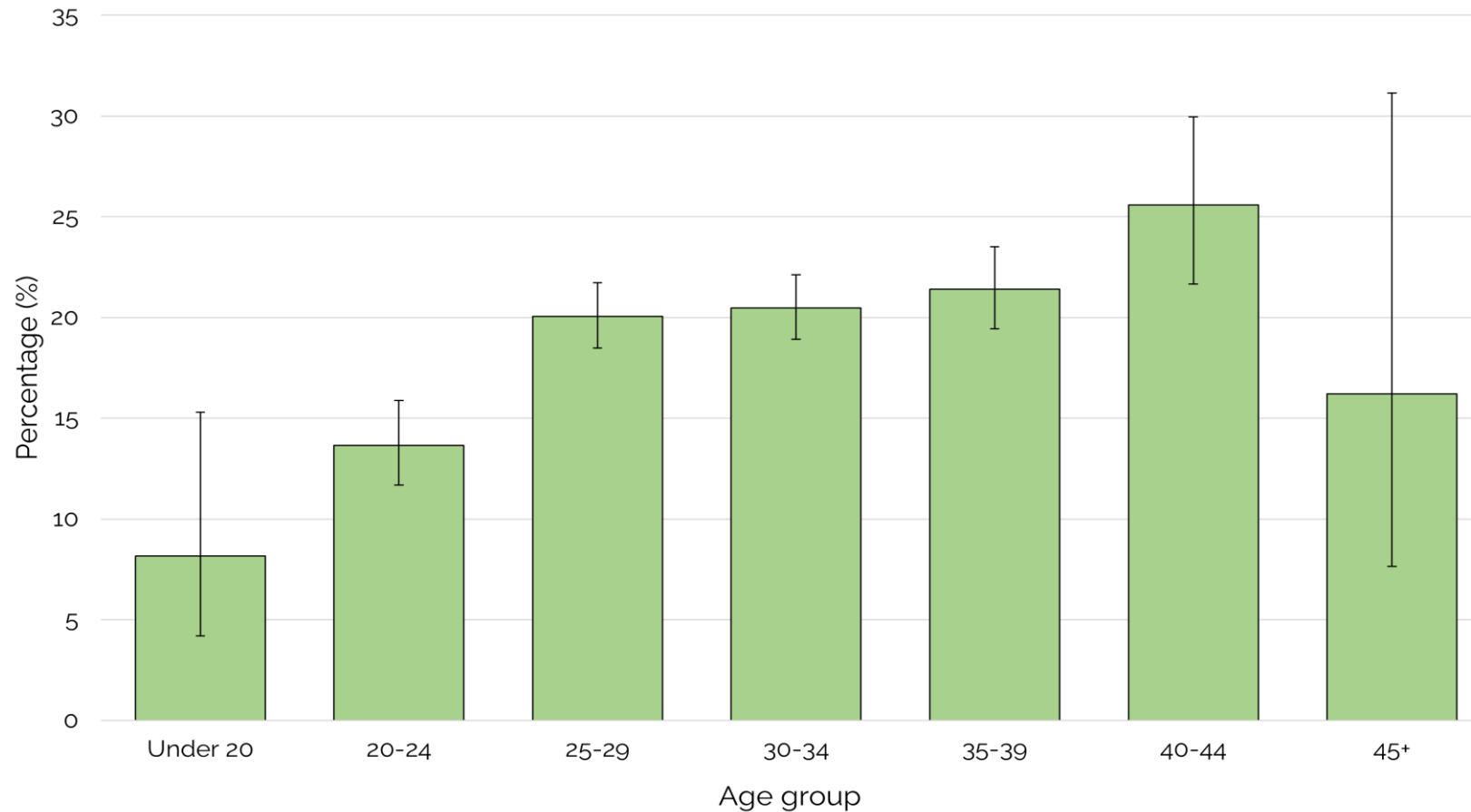
- Among women diagnosed with gestational diabetes, 35.6% are overweight and 44.4% are obese.
- In comparison, among women without gestational diabetes, 33.5% are overweight and 28.6% are obese.



Maternal age

Percentage of women diagnosed with gestational diabetes by age group

Tower Hamlets residents 2023-2024



The highest proportion of gestational diabetes occurred in the 40-44 age group (25.6%).

Source: Maternity services data provided on request. NHS Barts Trust



Early booking



Early access to maternity care (by 10 weeks of pregnancy)



In 2023–24, 44.9% of pregnant women in Tower Hamlets booked early (by 10 weeks of pregnancy), significantly below the London and England average.

This impacts early screening and the allocation of appropriate care.

Source: Fingertips. Public Health Profiles



Primary care postnatal follow-up



Primary care findings

- **17.7%** received a postnatal HbA1c test 12–52 weeks after delivery.
- Among women whose gestational diabetes was diagnosed between 15 months and 10 years ago, and who do not have a diagnosis of type 2 diabetes, **53.6% had an HbA1c test within the last year.**
- In Tower Hamlets, **11.8% have had a Type 2 diabetes coded** after having a gestational diabetes diagnosis.
- Referral and uptake of the Diabetes Prevention Programme (DPP) is low.



Health inequalities and population risk



Main issues or gaps	Recommendations
1.1 Ethnic disparities: There is a disproportionate burden of gestational diabetes amongst Asian women, particularly those of Bangladeshi ethnicity. 1.2 There are high rates of maternal excess weight (with most pregnant women overweight or obese). 1.3 The prevalence of overweight and obesity among women aged 20–44 varies considerably by ethnicity, with rates higher in Black ethnic groups and South Asian groups. 1.4 Most women diagnosed with gestational diabetes were from the most deprived quintile. 1.5 Low early booking rates (before 10 weeks of pregnancy) in Tower Hamlets.	1.1 Use population health data to focus outreach and prevention initiatives at those most at risk of gestational diabetes (such as Bangladeshi women, those living in high deprivation, and older mothers), working through trusted community organisations. 1.2 Raise awareness of the importance of pre-conception health which includes achieving a healthy weight through healthy eating and regular physical activity, taking folic acid and adopting other positive health behaviours that can help reduce the risk of gestational diabetes. Deliver these messages through the right channels such as a borough-wide communications campaign, health champions or local community groups. 1.3 Address weight management before pregnancy by strengthening access to pre-conception weight management support using existing free exercise offers and community-based services within the borough. Consider a tailored postnatal weight management service for women with a history of gestational diabetes. 1.4 Improve early booking rates (by the recommended 10 weeks of pregnancy) to ensure women receive timely care and, where they are at higher risk of gestational diabetes, that this risk is identified and communicated early.



Primary care pathway and follow up



Main issues or gaps	Recommendations
2.1 Postnatal HbA1c testing is too low and not in line with NICE guidance 2.2 Longer-term monitoring is better but still incomplete 2.4 Referral and uptake for the DPP is low both in the general population and for women with a history of gestational diabetes. 2.5 The current DPP offer is not tailored to local culture and needs. 2.6 In primary care, the DPP is not included in the postnatal check template to flag and encourage referral by GPs. 2.7 Ongoing system changes and NHS restructuring present challenges in identifying appropriate leads for service implementation and delivery.	2.1 Improve postnatal HbA1c testing rates by ensuring there is a strong automated recall systems in primary care for: - An initial HbA1c test at 13 weeks post-delivery as per NICE guidance and the annual HbA1c testing thereafter. This should include text message reminders and follow-up prompts for non-attendance. - Consider aligning the initial postpartum HbA1c test with points of contact (e.g. routine childhood immunisations at 12- or 16-weeks) to minimise the number of separate appointments and improve convenience for mothers. 2.2 Support current public health work to tailor the DPP to local Tower Hamlets residents. Then strengthen referral to the DPP by embedding automatic referral prompts for women with previous gestational diabetes into GP systems at postnatal checks. 2.3 Monitor outcomes and equity by regularly reviewing HbA1c testing, DPP referral, and uptake data by ethnicity, deprivation, and GP practice to identify variation and target improvement. 2.4 Ensure there is a Tower Hamlets wide named clinical lead in General Practice to oversee the implementation of changes for the delivery of postnatal care. This may be dependent on public health support due to system wide changes. 2.5 Improve postnatal communication and ensure women receive clear postnatal guidance on Type 2 diabetes risk. For instance, use postnatal GP checks to have conversations around healthy eating, exercise and planning for the next pregnancy.



Secondary care services

Main issues or gaps	Recommendations
3.1 Secondary care teams report increasing gestational diabetes diagnoses and growing pressure on maternity and diabetes services. 3.2 Appointment availability and staffing are key challenges due to rising demand. 3.3 Women found the gestational diabetes education classes (delivered at the Royal London) helpful and wanted similar classes at the start of pregnancy to make changes to diet and exercise earlier. 3.4 Primary care teams report that not enough women are being coded with gestational diabetes.	3.1 Plan for rising demand by using local trend data to inform workforce and capacity planning within maternity and diabetes services to reflect increasing gestational diabetes prevalence. 3.2 Expand group education sessions and digital education resources. This includes working with dietetic services to ensure there is sufficient capacity to expand the number of available sessions. 3.3 Strengthen discharge communication by ensuring clear and consistent discharge summaries from maternity services to primary care. Follow national guidance and use SNOMED code 11687002 (Gestational diabetes mellitus (disorder)) and put it in the MSD106 Diagnosis (Pregnancy). Discharge letters should outline the need for HbA1c postpartum and annually, as well as referral to the NHS DPP. If patients develop Type 2 diabetes under the age of 40, then refer to the '<i>T2Day: Type 2 Diabetes in the Young</i>' programme to provide more intensive targeted care to this age group.



Prevention offer for GDM and T2D



Main issues or gaps	Recommendations
4.1 Gestational diabetes prevention evidence is limited: There is a lack of robust, actionable preventative interventions in national guidance. 4.2 Missed early opportunities: Women in focus groups wanted to know their personal risk early in pregnancy, with practical advice on diet and physical activity. Many reported interventions arrived too late, after diagnosis. 4.3 Type 2 diabetes prevention not tailored: While prevention initiatives exist such as the DPP, few are designed specifically culturally tailored for local Tower Hamlets residents. The DPP does offer a programme specifically for women who have had gestational diabetes, but uptake is very low.	4.1 Consider a Tower Hamlets specific gestational diabetes prevention pilot, informed by the wider literature and co-designed with key partners in healthcare services, public health and community partners. This should focus on early pregnancy, diet and physical activity and ensure cultural relevance and accessibility. Explore the role of funding from sources such as the National Institute for Health and Care Research (NIHR). 4.2 Intervene earlier in pregnancy and embed preventative conversations at booking and early antenatal appointments, particularly for higher-risk women, to allow time for behaviour change before gestational diabetes develops. This should include aiming to improve early booking rates to allow for timely information and conversations. 4.3 Ensure there is an effective and accessible Type 2 prevention offer. This could be achieved by tailoring existing services such as the DPP or the pre-diabetes education sessions at Mile End Hospital. 4.4 Address practical barriers that were identified in focus groups and ensure prevention initiatives account for: childcare needs, time constraints, cost of living pressures, and family dynamics



Communication, language and cultural relevance



Main issues or gaps	Recommendations
5.1 The gestational diabetes focus groups identified the following gaps relating to communication, language and cultural relevance: - Awareness gaps: Many women had never heard of gestational diabetes before diagnosis. - Risk not discussed early: Risk factors such as South Asian background or family history were not discussed enough on early in pregnancy and prevention advice was limited. What women wanted: - Culturally relevant meal plans and diet advice. - Peer and community support during and after pregnancy. - Postnatal guidance on Type 2 diabetes risk and automatic reminders for HbA1c tests. - Focus groups emphasised the value of supportive environments for exercise (such as community walking groups), and safe, accessible exercise options during pregnancy.	5.1 Improve early awareness and understanding by introducing consistent, plain-language explanations of gestational diabetes and risk at booking, supported by written and verbal information. 5.2 Explore with local voluntary and community sector organisations the development of culturally tailored materials in key community languages using multiple formats (leaflets, videos, audio, visuals), alongside interpreter support. Co-produce messages, meal plans, and lifestyle advice that align with lived experiences. 5.3 Strengthen peer and community support by developing: - Peer support groups or community-led workshops with a focus on gestational diabetes/ Type 2 diabetes education and prevention - Women-only exercise and wellbeing activities. 5.4 Explore the role of health visitors in supporting postnatal follow-up for women with gestational diabetes, including providing reminders for HbA1c testing and offering guidance on Type 2 diabetes prevention—such as healthy eating, physical activity, and planning for future pregnancies. For this approach to be effective, maternity services data must be routinely shared with health visiting services.



Data quality and information flow



Best practice	Main issues or gaps	Recommendations
Follow national guidance and use SNOMED code 11687002 (Gestational diabetes mellitus (disorder)) and put it in the MSD106 Diagnosis (Pregnancy).	6.1 There is inconsistent gestational diabetes recording before 2022 in secondary care. Recording of gestational diabetes increased after 2022 but remain slightly below anecdotal levels. Therefore, data does not accurately reflect need because it's incomplete. 6.2 Possible under-coding of gestational diabetes in primary care, which can lead to missed postnatal follow-up. Currently, secondary services use SNOMED code 1220319015, which is a synonym of the nationally recommended SNOMED code 11687002. Primary care services use SNOMED code 11687002.	6.1 Improve coding consistency by implementing clear guidance and training for gestational diabetes coding across primary care and secondary care to reduce under-recording. This involves working with doctors, midwives, dieticians and all healthcare professionals involved in the care pathway. 6.2 Use data from primary care and maternity services to produce a joint dashboard for quality improvement and to monitor: • Gestational diabetes prevalence • Postnatal HbA1c testing • DPP referral and uptake



Evidence base limitations

Main issues or gaps	Recommendations
7.1 Prevention evidence gaps: National guidance offers limited recommendations for primary prevention of gestational diabetes in high-risk groups. Recommendations are centred around having a healthy pregnancy through healthy eating and physical activity. Large studies in the literature have shown that lifestyle interventions can reduce risk of gestational diabetes. 7.2 There is uncertainty on whether first or second trimester screening is best. NICE guidance recommend research on when screening should occur.	7.1 Generate local evidence base on what works for diverse populations in Tower Hamlets, particularly a gestational diabetes prevention pilot (as previously mentioned recommendation 4.1).



Issues with data accuracy



- Most of the data presented in this chapter on gestational diabetes was sourced from Maternity Services records at Barts Health NHS Trust. The dataset covers pregnancies, both with and without gestational diabetes, from January 2023 to December 2024.
- When interpreting this data, several considerations should be noted. A comparison between the number of pregnancies recorded at Barts Health for Tower Hamlets residents and civil birth registration data shows a lower-than-expected count in the Barts Health records—approximately 25% fewer births. This discrepancy may be explained by women accessing maternity services outside Barts Health as well as incomplete data recording.
- Additionally, gestational diabetes counts prior to 2022 were found to be very low and no evidence of a corresponding decrease in overall birth counts within the maternity dataset. This suggests that the issue relates to incomplete or inconsistent recording of diabetes status before 2022.



National gestational diabetes audit

24-25 findings



- GDM prevalence is difficult to ascertain due to under-reporting both in primary and in secondary care settings
- Gestational diabetes is disproportionately higher among women from ethnic minority groups and those experiencing social deprivation
- In 2024–25, only 57.4% of women with GDM received an annual HbA1c measurement, despite NICE NG3 guidance.
- Within five years, 10.8% developed non-diabetic hyperglycaemia (NDH) and within 10 years 15.2% progressed to type 2 diabetes.
- Despite NICE NG3 guidance, only 4.5% of women with a GDM diagnosis have ever participated in the DPP.



NICE guidance

Best practice



Diabetes in pregnancy: management from preconception to the postnatal period (2015)

- Postnatal care for women with gestational diabetes includes offering a fasting plasma glucose (FPG) – blood sugar test - 6 to 13 weeks after the birth to exclude diabetes.
- **After 13 weeks** offer a FPG if this has not been done earlier, or a **HbA1c test**. Based on the results of the FPG or HbA1c test, offer advice and guidance in line with NICE guidelines on preventing type 2 diabetes or **offer a referral into the NHS Diabetes Prevention Programme**.
- Women with gestational diabetes who have a negative postnatal test for diabetes should be offered an **annual HbA1c test**.



Type 2 diabetes prevention: population and community level interventions (2011)

- Diabetes prevention should aim to promote a healthy diet and physical activity at a community and population level. Services should be tailored for people in ethnic minority communities and other groups who are particularly at risk of type 2 diabetes.
- Recommendations include culturally appropriate interventions take account of the community's cultural or religious beliefs and language and literacy skills.



Postnatal care (2021)



- There should be effective and prompt communication between healthcare professionals when women transfer between services, for example, from secondary to primary care, and from midwifery to health visitor care. This should include sharing relevant information about the pregnancy, birth, postnatal period and any complications, the plan of ongoing care, including any condition that needs long-term management.

