



HEALTH AND SOCIAL CARE

Obesity Indicators

Progress Report - October 2018

Key points

- In 2017, 65% of adults aged 16 and over were overweight, including 29% who were obese. Levels of overweight and obesity for adults aged 16-64 increased between 1995 and 2008, but have remained broadly stable since then.
- Since 1998, the proportion of children aged 2-15 at risk of overweight (including obesity) has fluctuated between 26% and 33%. In 2017, 26% of children were at risk of overweight, including 13% at risk of obesity.
- At the end of 2016, there were 291,981 people diagnosed with diabetes in Scotland recorded on local diabetes registers. Of all cases, 88.3% (257,728) were Type 2 diabetes. Prevalence of Type 2 diabetes continues to increase steadily.
- In 2017, 65% of adults aged 16 and over met the current moderate/vigorous physical activity (MVPA) guideline. There has been no significant change to this proportion since 2012.
- In 2017, 67% of children aged 2-15 had participated in sport in the week prior to interview, similar to 2016 (68%).
- In 2015, the percentage of food energy contributed by free sugars (14.4%) remained higher than the Scottish Dietary Goal of less than 5% of energy.
- Between 2010 and 2017, the volume of sales of regular take home soft drinks reduced, while sales of cakes and pastries have increased since 2011. Sales of take home biscuits and confectionery remained stable.

About this publication

This publication reports the latest results against the obesity indicator framework originally developed to monitor progress against the Scottish Government's Prevention of Obesity Route Map¹ published in February 2010. The Route Map has now been overtaken by the [Diet and Healthy Weight Delivery Plan](#) and [Active Scotland Delivery Plan](#) published in summer 2018. We are establishing new monitoring and evaluating arrangements for these plans, including reviewing the future of this publication.

This is a compendium publication bringing together data mostly already published by various other sources.

Data are also available in the accompanying tables.

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¹ <http://www.scotland.gov.uk/Publications/2010/02/17140721/19>

Policy Context

The impact of obesity is profound. It affects not only our health, but also our ability to lead happy, fulfilling lives. It also leads to increased, unsustainable demand on the NHS and other public services.

Obesity is the second-biggest preventable cause of cancer, behind only smoking, and is linked to around 2,200 cases of cancer a year in Scotland². Being overweight and obese is also the most significant risk factor for developing type 2 diabetes³, and can result in increased risk of other conditions including cardiovascular disease and hypertension⁴. Poor diet and weight often also go hand in hand with other risk factors such as low physical activity, smoking and harmful drinking—compounding health harms⁵.

As well as health impacts, there are significant socioeconomic implications. The annual cost of treating conditions associated with being overweight and obese is estimated to range from £363 million to £600 million. The total annual cost to the Scottish economy of overweight and obesity, including labour market related costs such as lost productivity, is estimated to be between £0.9 billion and £4.6 billion⁶.

The pervasiveness of the obesity problem, and the health and economic consequences of obesity, mean that tackling it is a key priority and a major challenge for government and its delivery partners.

The Scottish Government is taking a joined up approach to addressing public health challenges and in June 2018, along with the Convention of Scottish Local Authorities' (COSLA), published and launched Scotland's [Public Health Priorities](#) which will aim to focus efforts to improve the health of the population. Included in these is a priority to create 'a Scotland where we eat well, have a healthy weight and are physically active'.

In July this year, the Scottish Government published [A Healthier Future – Scotland's Diet and Healthy Weight Delivery Plan](#). The plan sets out a vision for everyone in Scotland to eat well and have a healthy weight. More specifically, it also sets an ambition to halve childhood obesity by 2030, and to significantly reduce diet-related health inequalities. Actions to tackle childhood obesity start

² Katrina F Brown et al (2018) The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland, and the United Kingdom in 2015 <https://www.nature.com/articles/s41416-018-0029-6.pdf>

³ Hauner H (2010). Obesity and diabetes. in Holt RIG, Cockram CS, Flyvbjerg A et al (ed.) Textbook of diabetes. 4th edition.

⁴ Guh et al (2009) The incidence of co-morbidities related to obesity and overweight: A systematic review and meta-analysis <https://bmcpublihealth.biomedcentral.com/articles/10.1186/1471-2458-9-88>

⁵ Scottish Government (2017), The Scottish Health Survey 2016, volume 1, main report. <https://www.gov.scot/Resource/0052/00525472.pdf>

⁶ A Castle (2015) Obesity in Scotland. SPICe Briefing, 15/01. 7 Jan 2015. http://www.parliament.scot/ResearchBriefingsAndFactsheets/S4/SB_15-01_Obesity_in_Scotland.pdf

pre-pregnancy and continue throughout school years and into adolescence. This sits alongside broader, population measures to tackle the overall environment that makes it difficult to make healthier food choices. We published a consultation in October 2018 to consider the promotion of discretionary foods high in fat, sugar or salt with little or no nutritional benefit, and how such incentives encourage people to buy and eat more.

Recognising that the drivers of overweight and obesity are complex, multi-faceted and shaped by a broad range of factors, the delivery plan for improving diet and weight sits alongside a wide range of government policy and action. It is one of five linked public health strategies being published in 2018 for Alcohol Prevention, Substance Use, Tobacco Control, and [Physical Activity](#).

In particular, Physical activity plays an important part in maintaining a healthy weight and tackling obesity. The Physical Activity Delivery Plan, '[A More Active Scotland](#)' sets out what the Scottish Government, and a wide range of partners, are doing to encourage and support people in Scotland to be more active, more often. Progress towards the outcomes set out in the Delivery Plan is being monitored through a dedicated set of indicators linked to the Active Scotland Outcomes Framework.

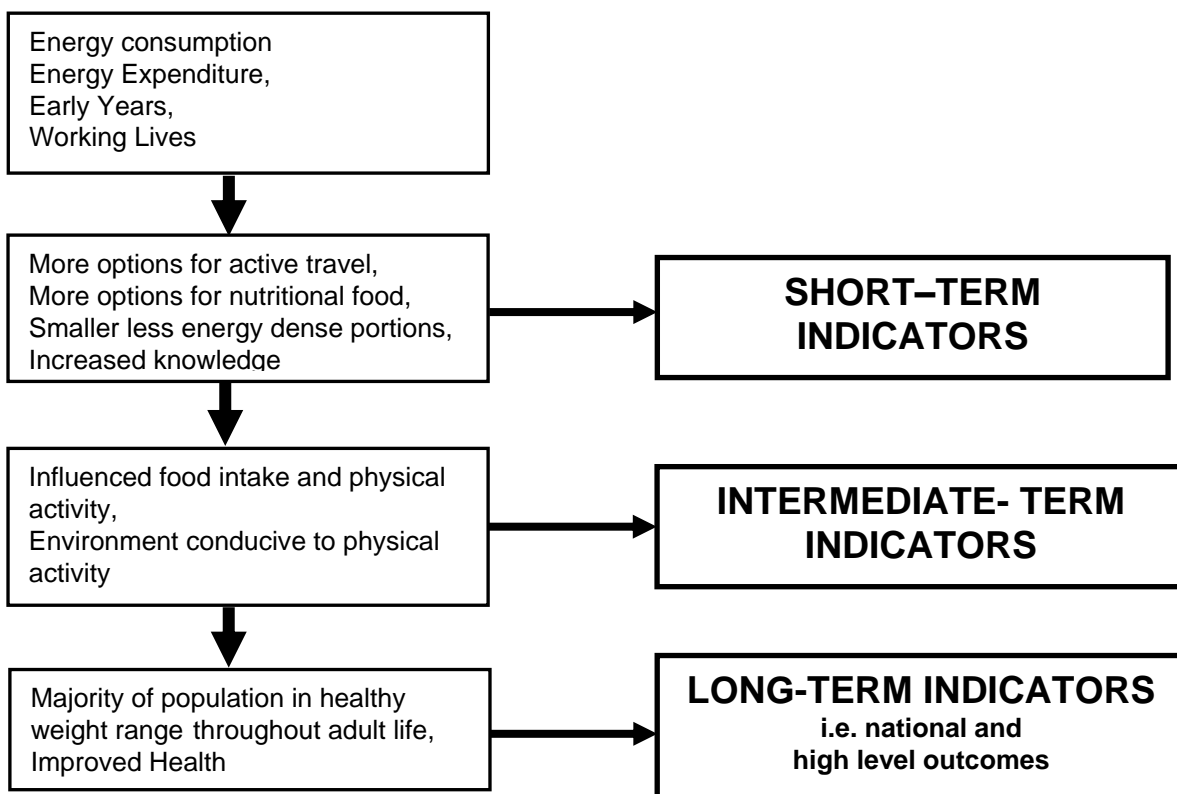
Obesity Indicator Framework

The indicator framework was informed by NHS Health Scotland’s healthy weight outcomes logic model and by the Scottish Public Health Network’s Route Map engagement process⁷.

Indicators in the framework are wide-ranging, including top-line measures as well as interim indicators of progress. Short-term indicators are presented for uptake of healthy food choices and options for active travel. Intermediate and long-term indicators are used to measure longer term outcomes including behaviour changes in diet and physical activity to securing goals of healthy weight population and health improvements.

The focus of the indicator set is on national measures of progress, but the process of selecting indicators included consideration of measures which could indicate progress at local level.

Obesity Indicator Model



⁷ Obesity- A Route Map towards a Healthy Weight Scotland Report of an Engagement Process, Hannah M, Connacher A, Tyrell L, Scottish Public Health Network, July 2010.

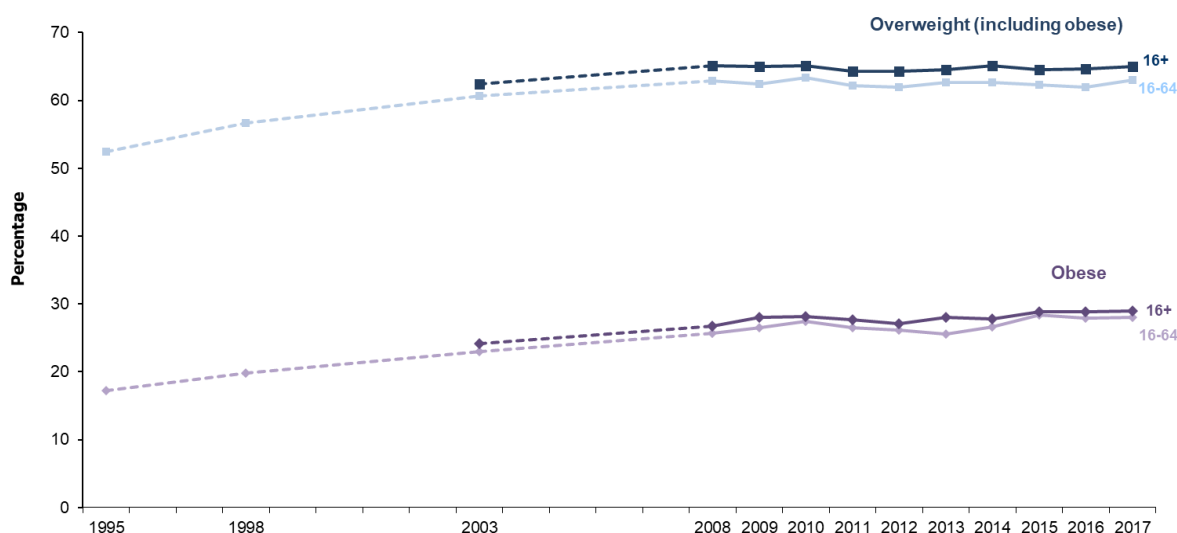
Adult overweight and obesity

Source: Scottish Health Survey

LATEST RESULTS

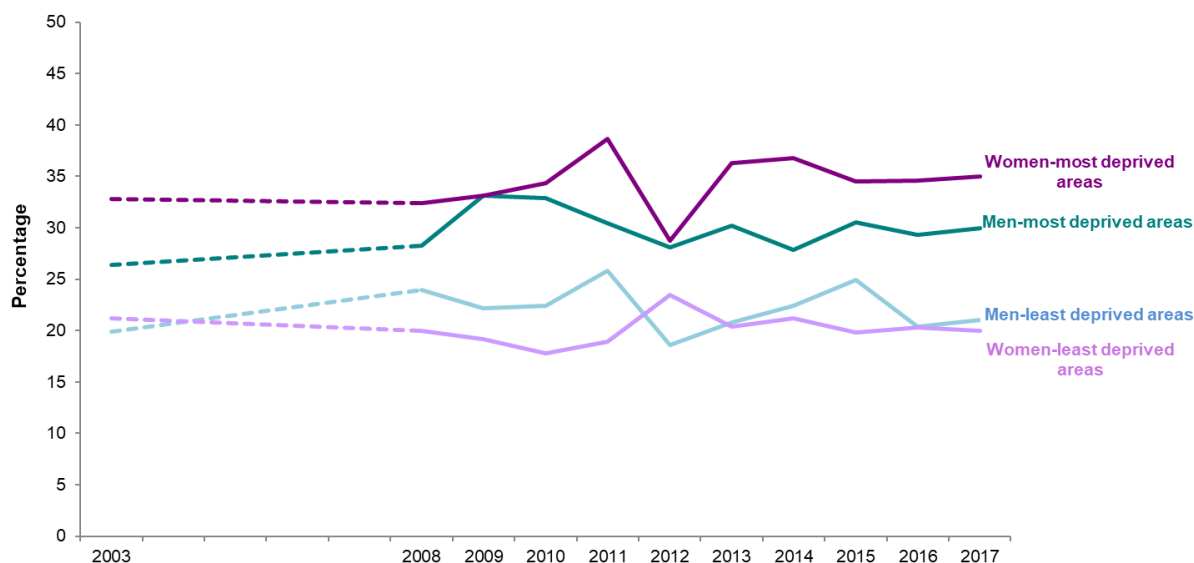
- In 2017, 65% of adults aged 16 and over were overweight, including 29% who were obese.
- There has been an increase in the proportion that are overweight or obese among both sexes (aged 16-64) since 1995, from 52% to 63%. Most of this increase was seen between 1995 and 2008, with figures remaining broadly stable since then.
- Men were more likely than women to be overweight including obese (67% compared to 63%), while obesity prevalence was higher for women than men (30% compared to 27%).
- Overweight (including obesity) prevalence was lowest among young people aged 16-24 (36%). A significantly higher proportion of those aged 25-34 were overweight (55%), with further increases with age up to age 65-74. More than three quarters of those aged 65-74 were overweight including obese (78%), and all age groups above 45 (except for 75+, 68%) had a prevalence of over 70%.

Figure 1. Proportion of adults overweight and obese, 1995-2017 (ages 16-64) and 2003 to 2017 (ages 16+)



- Although inequalities in overweight prevalence vary by sex and over time, obesity rates are consistently higher in Scotland's most deprived areas compared to the least deprived (Figure 2). The gap has been particularly pronounced for women in recent years - obesity rates in 2017 were 35% in the most deprived areas compared to 20% in the least deprived.

Figure 2. Proportion of adults (16+) obese by gender and area deprivation⁸, 2003-2017



Definitions:

Overweight – BMI 25+

Obese – BMI 30+

Geography available: National, Health Board.

Equalities data:

Breakdowns by most equalities groups are possible. Breakdowns by age, gender and disability (limiting long term illness) are available in SHeS 2017 supplementary tables (<https://www.gov.scot/Resource/0054/00540748.xls>). Further breakdowns, using SHeS 2008-2011 data, are available in the topic report on equality groups published in October 2012: <http://www.scotland.gov.uk/Publications/2012/10/8988>

Rationale for including adult overweight and obesity:

These data are useful to monitor changes in the proportion of Scotland’s adult population who are overweight and obese. Different patterns amongst men and women of different ages can be identified.

The 16-64 trend is included to allow comparisons with the 1995 and 1998 Scottish Health Surveys, as they did not collect physical activity data for all ages.

Factors influencing adult overweight and obesity:

- Diet, physical activity and sedentary behaviour are strongly associated with BMI.
- For women, obesity is significantly associated with area-level deprivation (SIMD) but not for men.⁹

⁸ Scottish Index of Multiple Deprivation. Chart presents most and least deprived SIMD quintiles.

⁹ The Scottish Health Survey Topic Report: Obesity, October 2011 (updated March 2012)

<http://www.scotland.gov.uk/Publications/2011/10/1138/0>

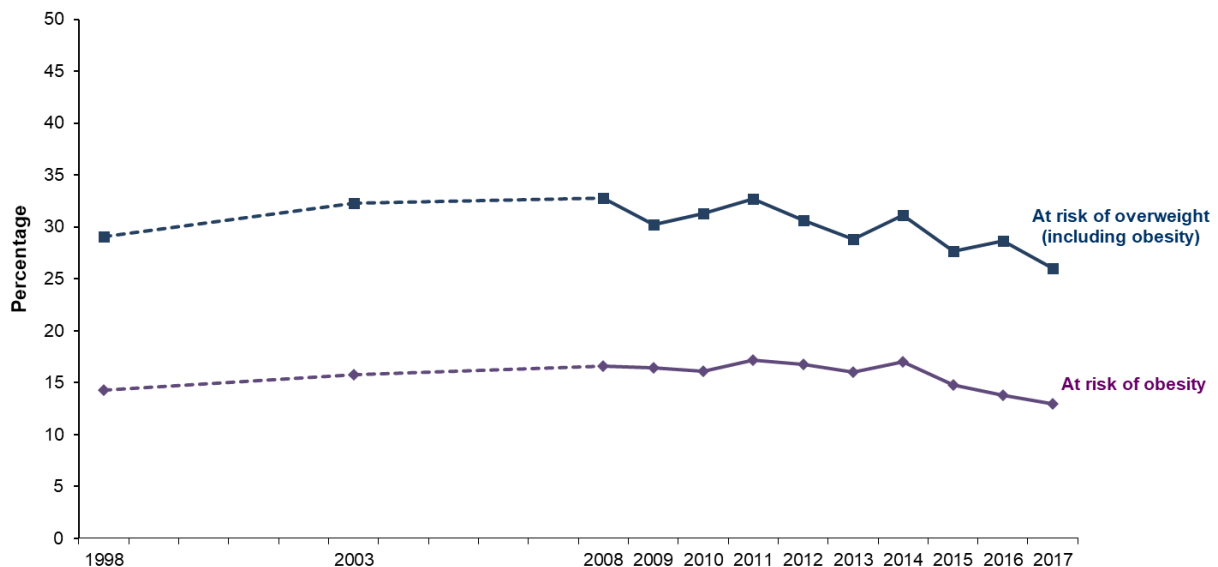
Children at risk of overweight and obesity

Source: Scottish Health Survey

LATEST RESULTS

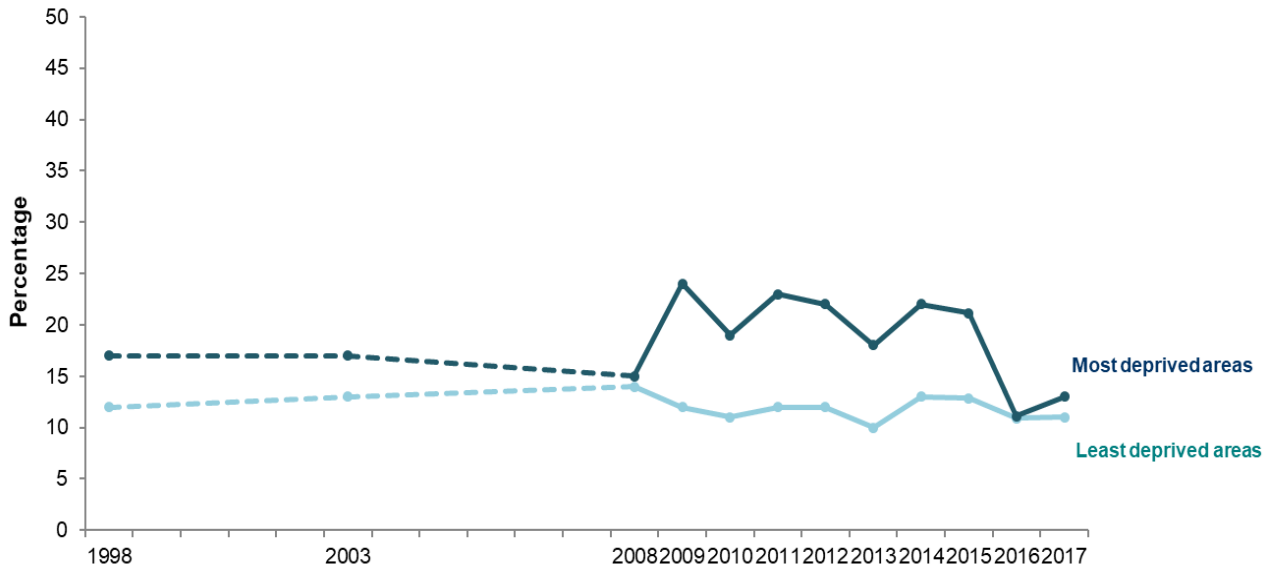
- In 2017, 13% of children aged 2 to 15 were at risk of obesity, with a further 13% at risk of overweight.
- Since 1998, the proportion of children aged 2-15 at risk of overweight (including obesity) has fluctuated between 26% and 33%, and was 26% in 2017.
- In 2017, the figure for those at risk of overweight (including obesity) in girls was higher than for boys (29% compared to 24%), though the reverse was true prior to 2014 - however these differences were not statistically significant. The figure for those at risk of obesity in girls was higher than for boys (15% compared to 12%).
- The figure for those at risk of overweight (including obesity) was highest among those children aged 12 to 15 (33%). Of girls this age, 38% were at risk of overweight including obesity. The equivalent figure for boys of the same age was 29%.

Figure 3. Proportion of children (2-15) at risk of overweight and obesity, 1998-2017



- A higher proportion of children are at risk of obesity in Scotland's most deprived areas (13%) that in the least deprived areas (11%). The gap between rates in the most and least deprived areas has fluctuated over time, with a high of 12 percentage points in 2009. In 2017, the 3rd most deprived areas¹⁰ of Scotland had the highest proportion of children at risk of obesity (16%).

Figure 4. Proportion of children (2-15) at risk of obesity by area deprivation¹¹, 1998-2017



¹⁰ Using the Scottish Index of Multiple Derivation (SIMD), this represents the 40-60% most deprived areas of Scotland.

¹¹ Scottish Index of Multiple Deprivation. Chart presents most and least deprived SIMD quintiles.

Definitions:

At risk of overweight (including obesity) – BMI at or above 85th percentile

At risk of obesity – BMI at or above 95th percentile.

(Based on UK 1990 reference chart cut-offs).

Geography available:

National.

Equalities data:

Breakdowns by age, gender, SIMD and long-term conditions may be possible, but not all are available annually.

Rationale for including children at risk of overweight and obesity:

These data are useful to monitor changes in the proportion of Scotland's children who are overweight and obese. Different patterns can be identified between boys and girls, between children who live in the most and least deprived areas and among children of different ages.

Factors influencing children at risk of overweight and obesity¹²:

- Diet, physical activity and sedentary behaviour are strongly associated with BMI.
- Parental BMI: children with an obese parent are significantly more likely to be at risk of being overweight including obese than both those with an overweight parent and those with no overweight parent. They are also significantly more likely to be at risk of being obese.
- Household income: boys in the lowest income households are more likely than those in other households to be obese. There is no clear association for girls.

¹² Based on information from the 2015 SHeS report (chapter 8) and 2011 SHeS Volume 2- children (chapter 5): See <http://www.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey/Publications>

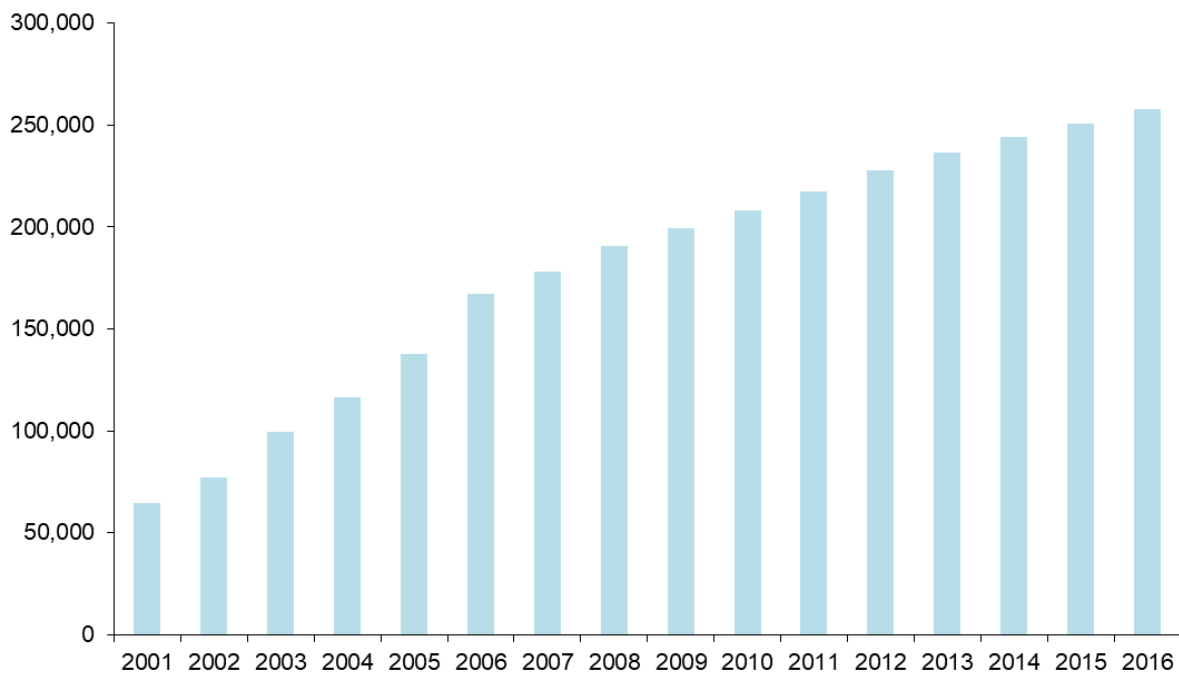
Prevalence of Type 2 diabetes

Source: Scottish Diabetes Survey

LATEST RESULTS¹³

- At the end of 2016, there were 291,981 people diagnosed with diabetes in Scotland recorded on local diabetes registers. This represented 5.4% of the population.
- Of all cases, 88.3% (257,728) were Type 2 diabetes.
- Prevalence of Type 2 diabetes continues to increase steadily¹⁴. There were 16,973 new cases of Type 2 diabetes in 2016 and 68,256 since 2013.
- In 2016, 31.6% of patients with a recorded BMI and Type 2 diabetes were overweight (BMI 25-30) and a further 55.6% were obese (BMI 30+).

Figure 5. Number of people with a Type 2 diabetes diagnosis, 2001-2016



¹³ Due to the Scottish Diabetes Survey being published later this year, 2017 data are not available yet.

¹⁴ Between 2001 and 2006, the increase in numbers was partly due to improved recording. The increase observed since 2007 is more likely to reflect a real increase in numbers.

Equalities:

Breakdowns by gender and age are included in the survey. Ethnic group is collected by the survey but subject to variable response rates and may require several years of data to be combined. Breakdowns by religion, disability and sexual orientation are not available.

Geography available:

National, Health Board from 2009.

Rationale for including prevalence of type 2 diabetes:

These data are useful to monitor changes in the proportion of Scotland's population who have Type 2 diabetes. The Scottish Public Health Observatory estimates that almost half of Type 2 diabetes can be attributed to obesity. Diabetes is an important cause of disability and increases the risk of coronary heart disease and other health problems. Complications associated with diabetes include peripheral vascular disease (foot ulcers), which can in turn lead to amputation and diabetic retinopathy- the commonest cause of blindness in working age people. Those with poor glucose control are at increased risk of developing complications.

Type 2 diabetes is more common in deprived areas, and becomes much more common with increasing age. Overweight and obesity are also important risk factors: the risk of Type 2 diabetes is around ten times higher among those with a BMI over 30 compared to those with a BMI under 30.

Factors influencing prevalence of type 2 diabetes:

- Poor diet (specifically excess energy intake), low levels of physical activity, and the resulting increase in levels of obesity.

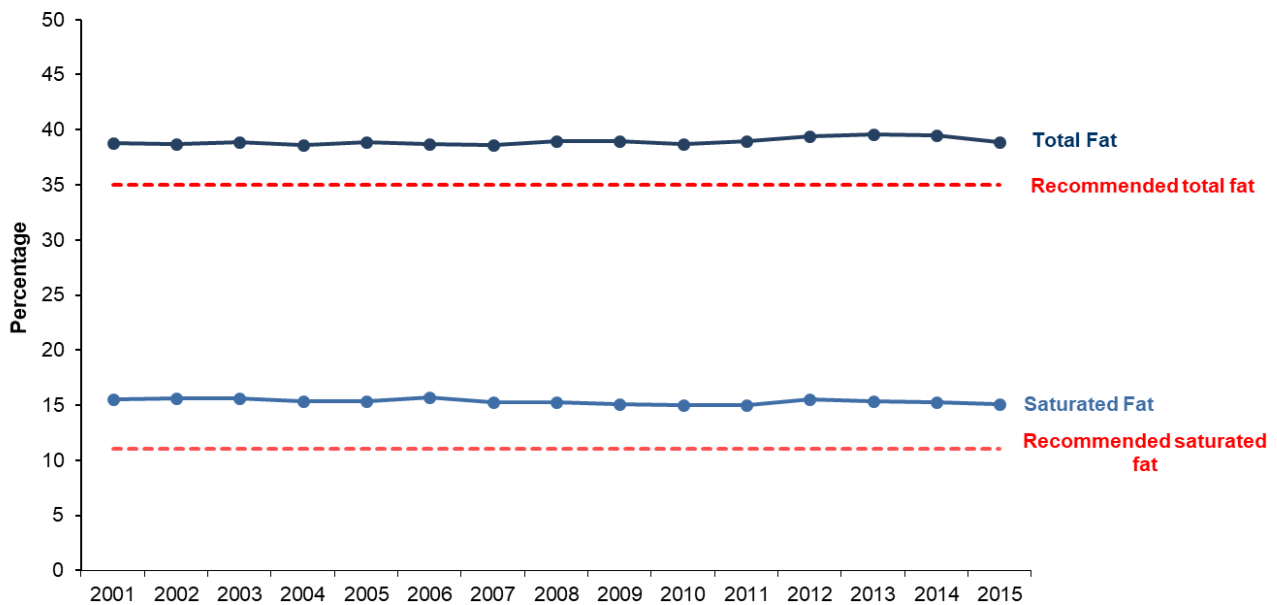
Total and saturated fat

Source: Food Standards Scotland

LATEST RESULTS¹⁵

- In 2015, the percentage of household food energy from all fats was 38.9%. This is above the recommendation of no more than 35% and has remained relatively stable over time.
- The percentage of food energy from saturated fat was 15.1%, compared with the recommendation of no more than 11%.

Figure 6. Proportion of household food energy from fat, 2001-2015



¹⁵ Due to changes to the reporting of the UK Living Costs and Food Survey, 2016 secondary analysis data are not yet available.

Source:

- Food Standards Scotland commissioned analysis of data from the ONS Living Cost and Food Survey. Estimated nutrient intakes are calculated from household food purchases following secondary analysis to convert purchase data to mean per capita consumption and nutrient intakes and to allow meaningful comparisons to be made between years.

Equalities:

Information is collected on differences in food and nutrient intake by deprivation (using the Scottish Index of Multiple Deprivation (SIMD)).

Geography available: Population level information is collected on differences in food and nutrient intake by urban/rural classification.

Rationale for including total and saturated fat:

These data are useful to monitor change in the proportion of the population consuming energy dense foods. Currently people are eating more saturated fat on average than is recommended (FSAS Barton et al, 2010). Prevalence of obesity indicates that energy intakes currently exceed energy requirements. Both these issues raise serious health concerns, particularly in relation to coronary heart disease, high blood pressure, stroke, Type 2 diabetes and certain types of cancers (SHeS).

Recommendations for food and nutrient intake are based on advice from the Committee on Medical Aspects of Food and Nutrition Policy (COMA) and the Scientific Advisory Committee on Nutrition (SACN). Published Dietary Reference Values cover a range of intakes for most nutrients and for fat and saturated fat are set as a percentage of daily energy intake for adults.

Factors influencing total and saturated fat:

- Availability, cost, and access to different food types.

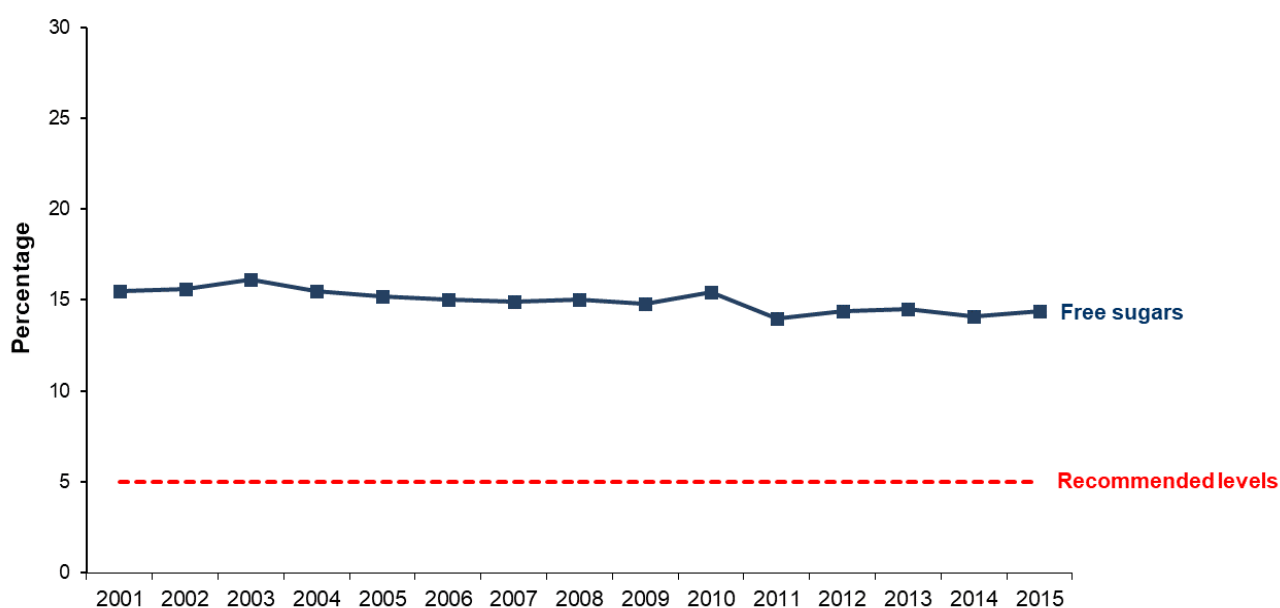
Free sugars

Source: Food Standards Scotland

LATEST RESULTS¹⁶

- In 2015, the percentage of food energy contributed by free sugars was 14.4%. This has decreased from 15.5% in 2001.
- Intakes remain higher than the Scottish Dietary Goal of less than 5% of energy.¹⁷

Figure 7. Proportion of household food energy from added sugars, 2001-2015



¹⁶ Due to changes to the reporting of the UK Living Costs and Food Survey, 2016 secondary analysis data are not yet available.

¹⁷ The Scottish Dietary Goal (SDG) has recently been updated (Scottish Government, 2016) and is now that no more than 5% of daily energy intake should be from free sugars. Data reported in previous years were based on recommended levels of 11%.

Source:

- Food Standards Scotland commissioned Scottish specific analysis of population level data from the ONS Living Cost and Food Survey.

Equalities:

Information is collected on differences in food and nutrient intake by deprivation (using the Scottish Index of Multiple Deprivation (SIMD)).

Geography available: Population level information is collected on differences in food and nutrient intake by urban/rural classification.

Rationale for including free sugars:

These data are useful to monitor change in the proportion of adults and children consuming energy dense foods. As noted above, prevalence of obesity indicates that energy intakes currently exceed energy requirements with associated health problems.

Factors influencing free sugars:

- Availability, cost, and access to different food types.

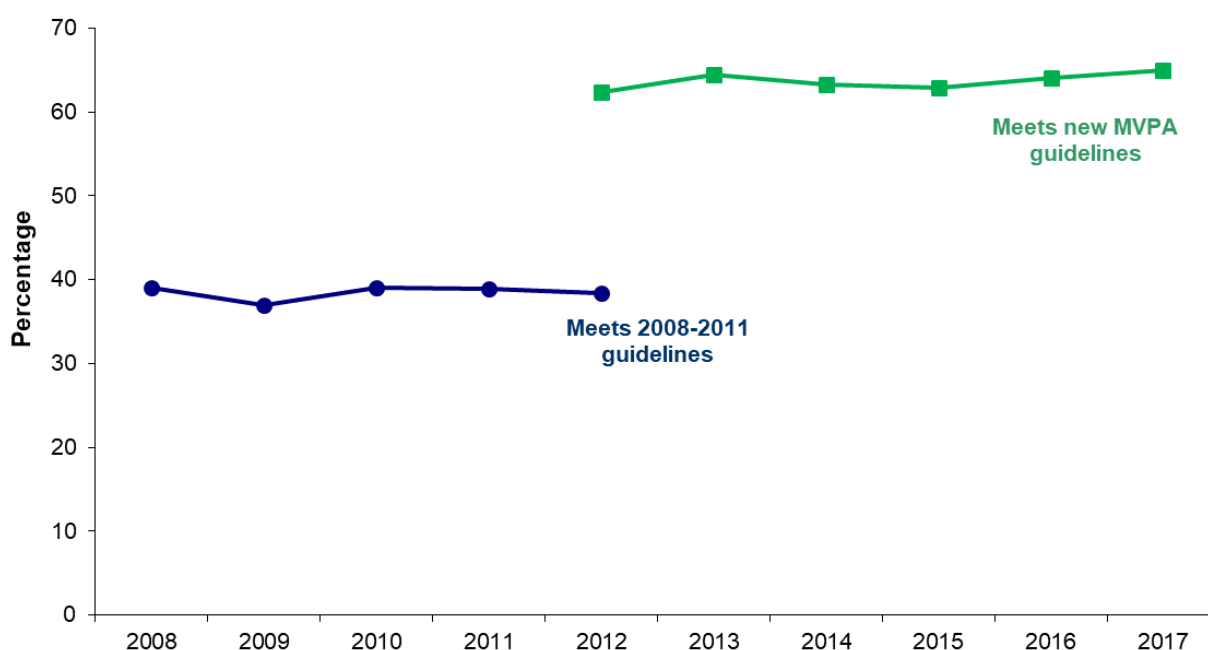
Adult physical activity¹⁸

Source: Scottish Health Survey

LATEST RESULTS

- In 2017, 65% of adults aged 16 and over met the current moderate/vigorous physical activity (MVPA) guideline. There has been no significant change to this proportion since 2012.
- Men were significantly more likely than women to meet the guideline (71% compared to 60%). The gap was widest within the youngest age group: 89% of men aged 16-24 met the guideline, compared with 67% of women of the same age.
- Physical activity levels among adults were significantly associated with age, with younger groups more likely than older age groups to meet the MVPA guidelines. Adherence to the guidelines was highest among those aged 16-44 (76-78%) and declined from 68% among those aged 45-54 to 28% among adults aged 75 and over.
- Between 2012 and 2017, the proportion of men meeting the guideline has varied between 67% and 71%. Over the same period adherence to the guideline has changed very little for women (between 58% and 60%).

Figure 8. Proportion of adults (16+) meeting physical activity guidelines, 2008-2017⁹



¹⁸ Note that physical activity guidelines changed in 2011. See chapter 6 (physical activity) in the 2012 Scottish Health Survey for more information: <http://www.scotland.gov.uk/Publications/2013/09/3684/10>

Definition:

Accumulation of 150 minutes moderate/75 minutes vigorous intensity physical activity (or a combination of both) per week, using 2012 definitions of walking pace, sports and time spent very active at work.

Geography available:

National, Health Board.

Equalities data:

Breakdowns by most equalities groups are possible. Breakdowns by age, gender and disability (limiting long term illness) are available in SHeS 2017 supplementary tables (<https://www.gov.scot/Resource/0054/00540741.xls>). Further breakdowns, using SHeS 2008-2011 data, are available in the topic report on equality groups published in October 2012: <http://www.scotland.gov.uk/Publications/2012/10/8988>

Rationale for including adult physical activity:

These data are useful to monitor change in the proportion of adults who meet physical activity guidelines. The current recommendation, detailed above, is designed to promote general health outcomes and weight maintenance. The recommended level of activity for weight loss is higher.

Factors influencing adult physical activity:

- Age and gender: Although men were more likely than women to meet the current guideline, adherence to this differs markedly by age.
- Deprivation: Adult activity levels are significantly associated with area deprivation. In 2017, the age standardised prevalence of adherence to the MVPA guideline was highest among adults in the least deprived areas (72%) and steadily declined with increasing deprivation to 56% among adults in the most deprived areas. This pattern was true for both men and women.

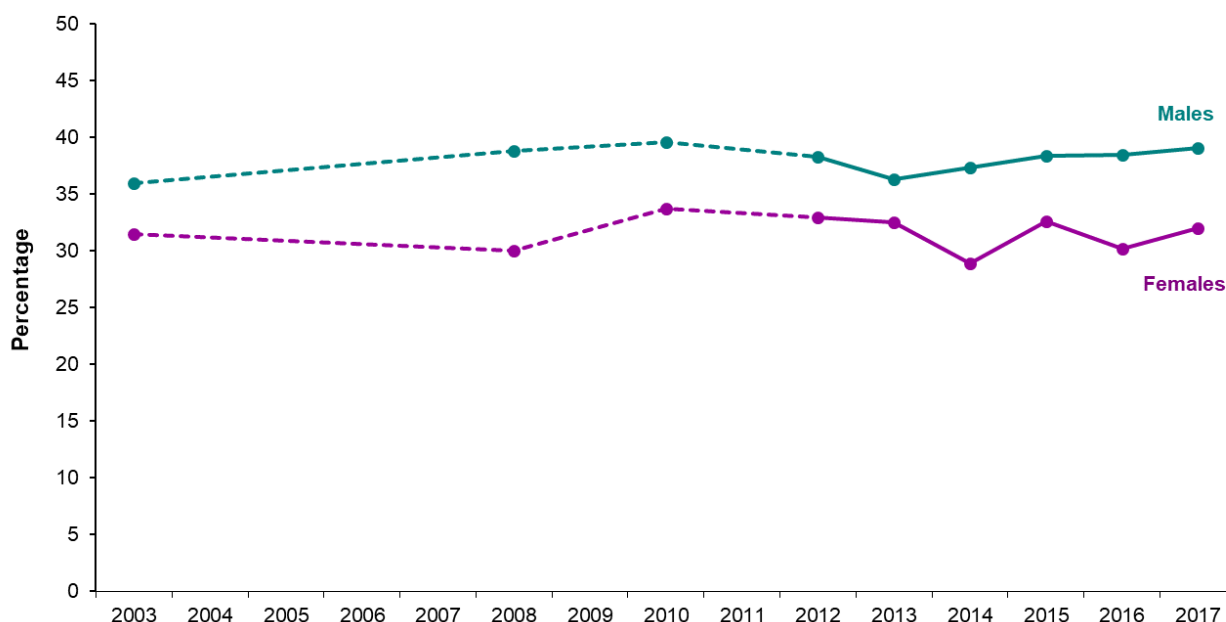
Adult sedentary activity

Source: Scottish Health Survey

LATEST RESULTS

- In 2017, adults reported sitting in their leisure time for a mean of 5.2 hours on weekdays and 6.0 hours on weekend days. Reported sedentary leisure time was slightly higher for men than for women (5.3 and 5.2 weekday mean hours, respectively, and 6.2 and 5.9 weekend day mean hours).
- Sedentary activity levels varied by age, with those aged 25 to 54 tending to spend the least time sitting both on weekdays and weekend days (mean hours ranging from 4.2 to 4.5 on weekdays and 5.3 to 5.6 hours on weekend days). Older people (aged 65 and over) were the most sedentary on both weekdays (6.5 to 7.1 hours) and weekend days (6.6 to 7.3 hours).
- The proportion of adults spending four or more hours sitting at a screen or similar display on an average day (excluding time at work) in 2017 was 35% (39% for men, 32% for women).

Figure 9. Proportion of adults (16+) spending four or more hours sitting watching TV/other screen, by gender, 2003-2017



Definition:

Time spent sitting during leisure time (including weekdays and weekends).

Geography available:

National, Health Board.

Equalities data:

Breakdowns by most equalities groups are possible as all are included in the survey. However, some may require several years of data to be combined.

Rationale for including adult sedentary activity:

These data are useful to monitor the proportion of adults engaging in sedentary behavior, such as hours spent sitting at a screen or reading during leisure time. Sedentary time at work is not included in the summary estimates.

Factors influencing adult sedentary activity:

- Choice and availability of leisure activities.

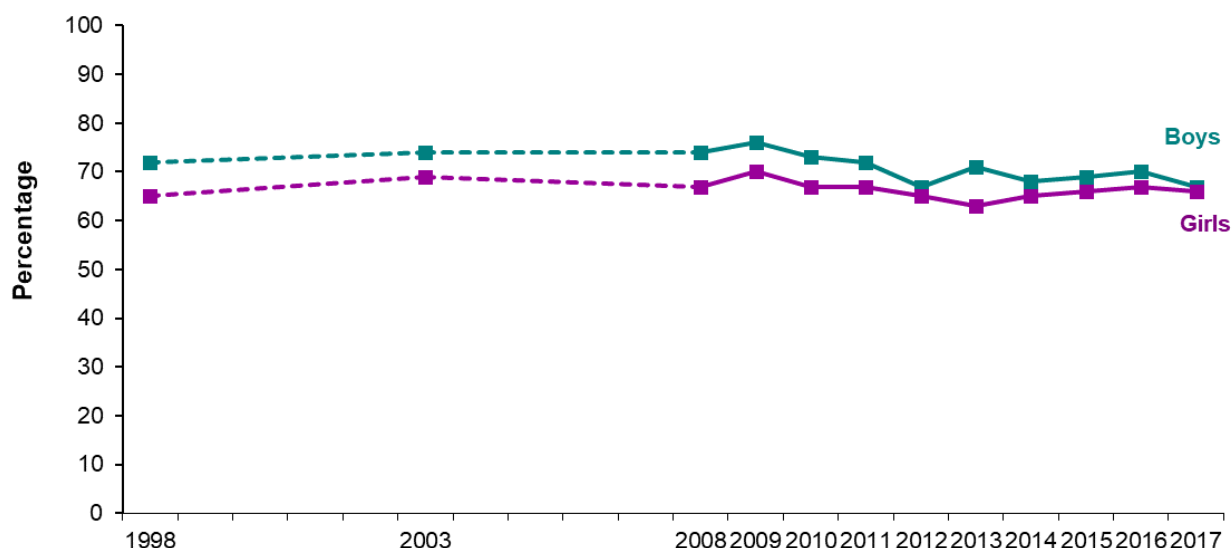
Children participating in sport¹⁹

Source: Scottish Health Survey

LATEST RESULTS

- In 2017, 67% of children aged 2-15 had participated in sport in the week prior to interview, similar to 2016 (68%).
- Overall sport participation rates in 2017 were similar for boys and girls (67% and 66% respectively).
- Rates of participation in sports both for boys and girls peaked at the age of 8-10 (76% for boys and 79% for girls) and then declined to 70% among boys and 69% among girls at the age of 11-12. The level of participation in sports among girls then declined by 24 percentage points between the age of 11-12 (69%) and 13-15 (45%) compared to only a one percentage point decline for boys (from 70% to 69%).
- In 2017, the gap in the proportion of children having participated in sport in the week prior to interview between the least and most deprived areas was 30% (82% and 52% respectively).

Figure 10. Proportion of children (2-15) participating in sport, by gender, 1998-2017



¹⁹ Previous versions of this report included figures on child physical activity. In 2017, the measure of child physical activity changed. Therefore, it was agreed to report on child participation in sport instead, in order to include time series.

Geography available:

National

Equalities data:

Breakdowns by age, gender, SIMD and long-term conditions are possible, but not all are available annually.

Rationale for including child participation in sport:

These data are useful to monitor the proportion of children (aged 2-15 years) participating in any sport.

Factors influencing child participation in sport:

- Access to opportunities to be physically active. This could include leisure facilities and programmes delivered by sports clubs that encourage young people to be active.
- Lack of skills and confidence to take part in sport and physical activity.

Child sedentary activity

Source: Scottish Health Survey

LATEST RESULTS

- In 2017, children (aged 2 to 15 years) spent a mean time of 2.2 hours sitting watching a television or other screen²⁰ on weekdays and 3.1 hours on weekend days (excluding time at school).
- The rates for all children have been relatively stable since 2003, at around 2.0 to 2.3 mean hours on weekdays and 2.7 to 3.1 hours on weekend days.
- Boys spent more time sitting watching a television or other screen than girls, particularly at weekends when the mean times recorded were 3.3 hours for boys and 2.9 hours for girls.
- The proportion of children spending four or more hours sitting watching a television or other screen on an average day (excluding time in school) in 2017 was 15% (16% for boys, 13% for girls). This was a slight increase compared to 2015 and 2016 (12% and 13% respectively), and remains lower than the proportion in 2003 (16%).

Figure 12. Proportion of children (2-15) spending four or more hours sitting watching TV/other screen, by gender, 2003-2017



²⁰ Such as a computer, games console or handheld gaming device.

Definition:

Time spent at a screen (TV or other screen such as a computer, games console or handheld gaming device) on an average day (including weekdays and weekends) excluding time at school.

Geography available:

National.

Equalities data:

Breakdowns by age, gender, SIMD and long-term conditions are possible, but not all are available annually.

Rationale for including child sedentary activity:

These data are useful to monitor the proportion of children engaging in sedentary behavior, such as hours spent sitting at screen on an average day.

Factors influencing child sedentary activity:

- Choice of leisure activities.
- Availability of alternatives to screen-based activity.
- Safe outdoor spaces to play.

HealthyLiving Awards

Source: NHS Health Scotland

LATEST RESULTS

- In October 2018, a total of 808 catering establishments held the HealthyLiving Award (HLA) or HLA Plus award.
- Of these, 183 are first term HLA awards and 385 are renewed awards. A further 240 establishments hold the HealthyLiving Plus Award.
- There has been an increase in the number of establishments holding an award every year since 2006, except between 2012-2013.

Table 1. Number of businesses with HealthyLiving Awards

Date	Current Awards	First Term	Renewals	Plus
October 2006	6	6		
October 2007	140	140		
October 2008	374	374		
October 2009	602	496	106	
October 2010	656	353	283	20
October 2011	675	295	291	89
October 2012	680	241	315	124
October 2013	625	185	315	125
October 2014	686	231	273	182
October 2015	757	260	294	203
October 2016	776	246	332	198
October 2017	798	214	352	232
October 2018	808	183	385	240

Geography available:

National

Equalities data: Not applicable

Rationale for including healthy living awards:

These data are useful to assess the take-up of HealthyLiving awards by companies. The HealthyLiving Award, introduced in 2006, recognises catering establishments for serving healthier food and finding ways of helping their customers make better food choices. The award is open to all kinds of catering places from sandwich shops to staff restaurants, and increasing the number of establishments with this award will play a part in improving diet across Scotland. For all organisations already participating, the HealthyLiving Award plus offers an opportunity to achieve step increases in the required ratio of healthy options to other options on the menus from participating caterers.

Evidence from existing literature²¹ suggests a low level of evidence for the effectiveness of consumer targeted incentives but with potentially high levels of population effectiveness.

Factors influencing healthy living awards:

- Exposure to high energy foods.

²¹ Environmental Scan of Potential Policy Interventions to Tackle Obesogenic Aspects of the Built Environment, Mooney et al 2010

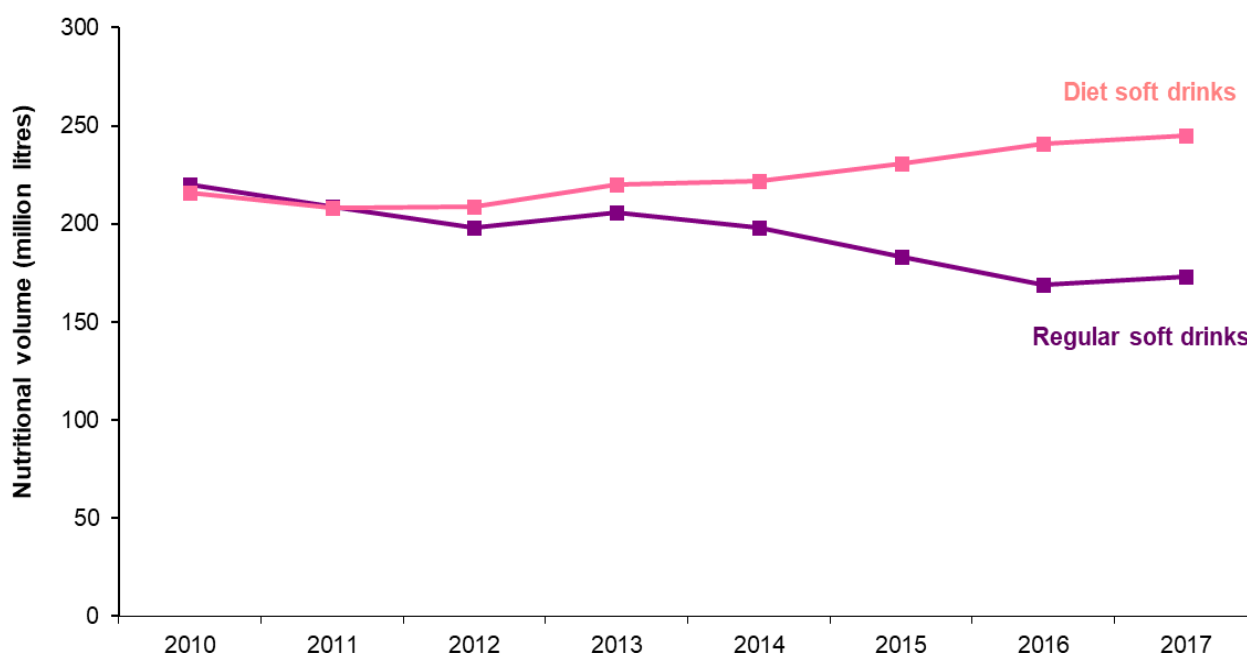
Volume of sales of soft drinks with added sugar

Source: Food Standards Scotland (Kantar Worldpanel)

LATEST RESULTS

- Between 2010 and 2017, the volume of regular take home soft drinks²² purchased by Scottish households dropped by 21.4% to 173 million litres²³.
- The calorie contribution of regular soft drinks reduced from 48 kilocalories per person per day in 2010 to 36 kilocalories in 2017.

Figure 13. Sales of soft drinks, 2010-2017



²² 'Regular soft drinks' includes juices/fruit drinks, carbonates, squash, and others (such as flavoured milk), but excludes chilled drinks, mineral water and all diet soft drinks.

²³ Following feedback from industry, Kantar Worldpanel made a significant change to the data on one of the major brands of cola in 2017 which affected the relative sizes of diet and regular products. The trends were reworked back for 5 years to reflect this update.

Geography available:

Scotland level only.

Equalities data:

Not applicable.

Rationale for including volume of sales of soft drinks with added sugar:

These data are useful to monitor the volume of sales of soft drinks with added sugar in supermarkets in Scotland. There is evidence of an association between sugar-sweetened soft drinks and prevalence of obesity and interventions in this area have been shown to be effective.

Factors influencing volume of sales of soft drinks with added sugar:

- Availability and affordability of healthy choices.

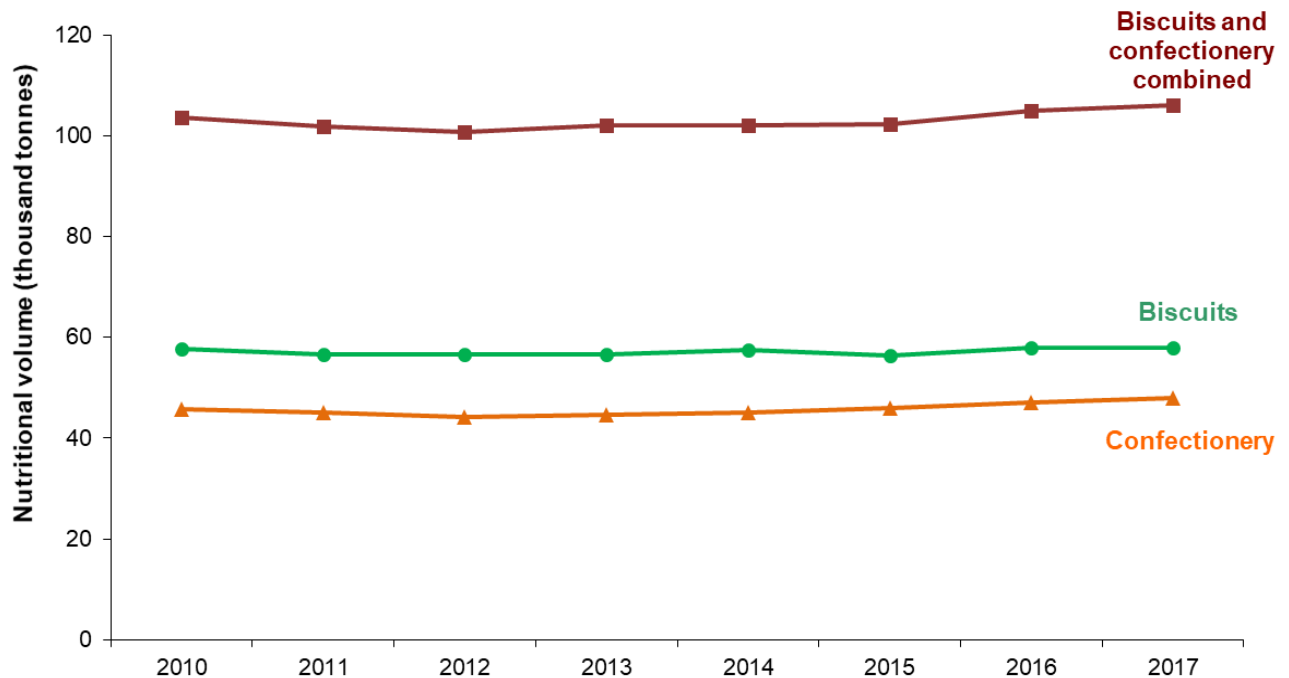
Volume of sales of confectionery, biscuits, cakes and pastries

Source: Food Standards Scotland (Kantar Worldpanel)

LATEST RESULTS

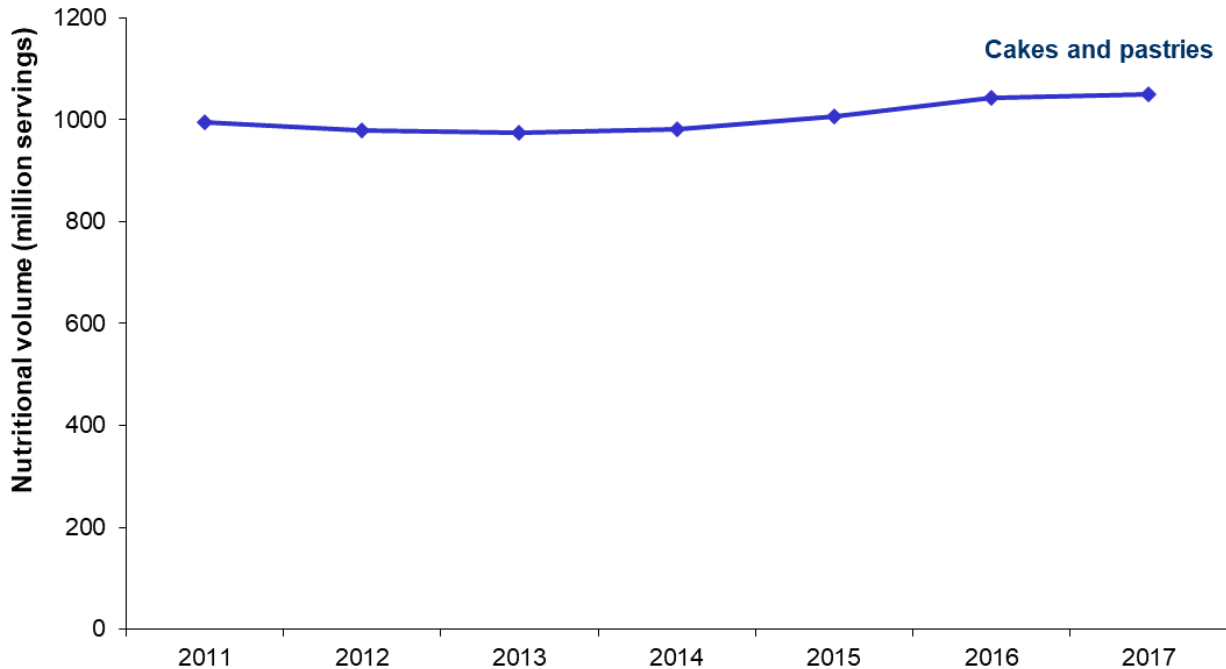
- In 2017, the total volume of take home biscuits and confectionery purchased by Scottish households was just over one hundred thousand tonnes (106,000). Sales volumes have remained stable since 2010.

Figure 14. Sales of biscuits and confectionery, 2010-2017



- In 2017, over one billion (1,050 million) servings of cake and pastries were purchased by Scottish households. Purchases have increased since 2011.

Figure 15. Sales of cake and pastry servings, 2011-2017



Geography available:
Scotland level only.

Equalities data:
Not applicable.

Rationale for including volume of sales of confectionery, biscuits, cakes and pastries:

These data are useful to monitor the sales by volume of confectionery, biscuits, cakes and pastries in supermarkets in Scotland.

There is evidence that obesity is associated with over consumption of energy dense snack foods such as confectionery, biscuits, cakes and pastries. Moderate evidence exists in the literature for interventions aimed at reducing availability and affordability of energy dense foods and with a moderate rating for potential population effectiveness.

Factors influencing volume of sales of confectionery, biscuits, cakes and pastries:

- Availability and affordability of healthy choices

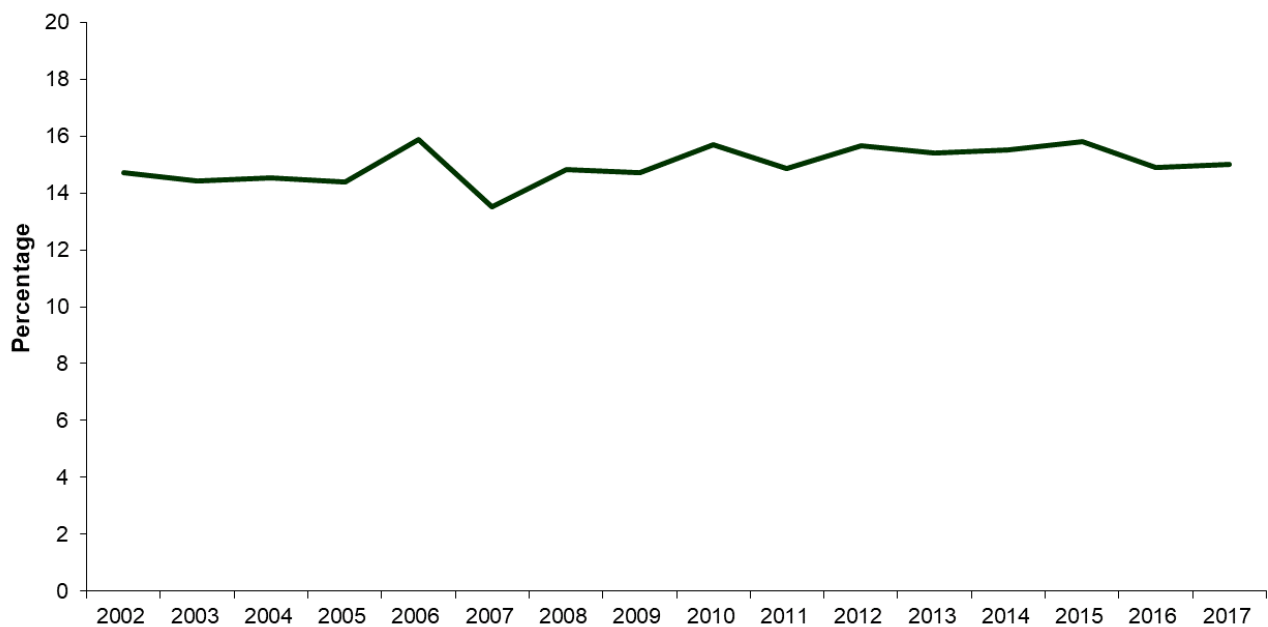
Adult active travel to work

Source: Transport Scotland (Transport & Travel in Scotland)

LATEST RESULTS

- In 2017, 15% of working adults travelled to work by walking or cycling.
- There has been little change in this proportion since 2002, with the figures fluctuating at around 14% to 16%.

Figure 16. Proportion of adults (16+) walking or cycling to work, 2002-2017



Source:

Transport Scotland: Transport & Travel in Scotland bulletin.
Employed adults' (not working at home) usual method of travel to work.

Geography available:

National, Local Authority.

Equalities data:

Breakdowns by gender, age and disability possible.

Rationale for including adult active travel to work:

These data provide a measure of the extent to which adults are choosing physically active means of travel to work (cycling or walking).

A low level of evidence exists in literature for the effectiveness of active travel incentives and facilities with a moderate rating for potential population effectiveness.

Factors influencing adult active travel to work:

- Availability of alternative transport options
- Employer incentives

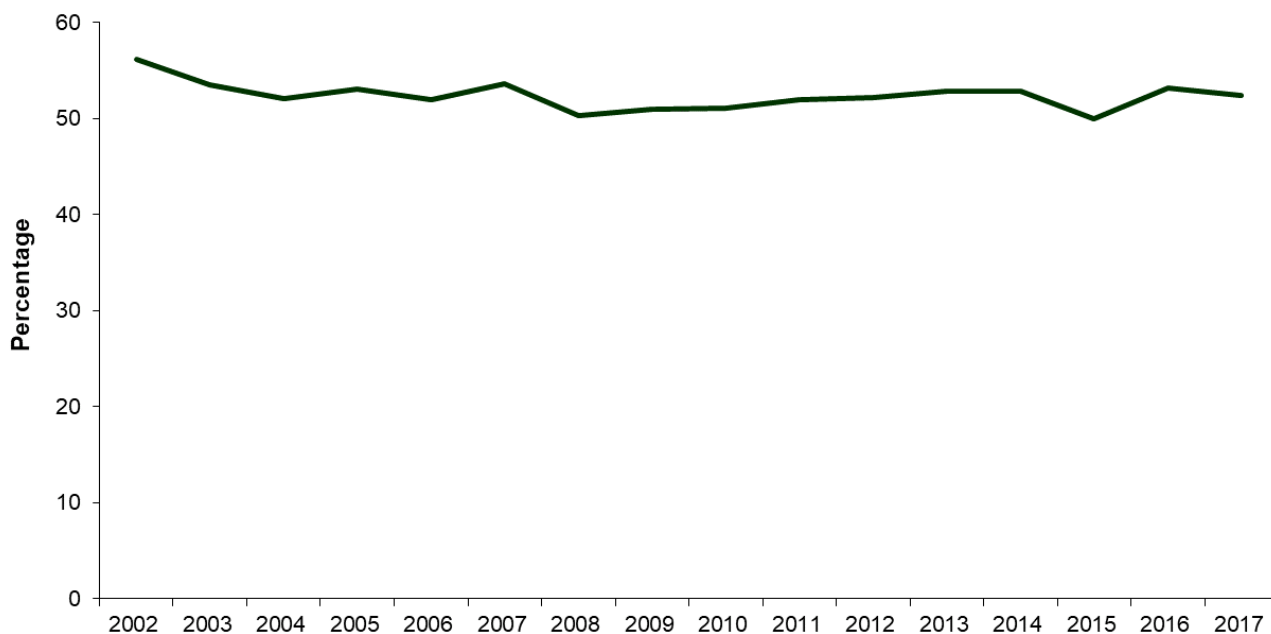
Child active travel to school

Source: Transport Scotland (Transport & Travel in Scotland)

LATEST RESULTS

- In 2017, 52% of school aged children travelled to school by walking or cycling.
- This proportion has fluctuated between 50% and 56% since 2002, with no clear trend.

Figure 17. Proportion of school aged children walking or cycling to school, 2002-2017



Source:

Transport Scotland: Transport & Travel in Scotland bulletin.
Pupils in full-time education at school usual method to travel to school.

Geography available:

National, Local Authority.

Equalities data:

Breakdowns by gender, age and disability possible.

Rationale for including child active travel to school:

These data provide a measure of the extent to which children are choosing physically active means of travel to school (cycling or walking).

Low level of evidence exists in literature for the effectiveness of active travel incentives and facilities with a moderate rating for potential population effectiveness.

Factors influencing child active travel to school:

- Availability of safe routes to schools.

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How to access background or source data

The data collected for this statistical bulletin:

- are available in more detail through Scottish Neighbourhood Statistics
- are available via an alternative route
- may be made available on request, subject to consideration of legal and ethical factors. Please contact scottishhealthsurvey@gov.scot for further information.
- cannot be made available by Scottish Government for further analysis as Scottish Government is not the data controller.

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