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Equality and health inequalities assessment (EHIA) NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE guidelines

Diabetes in pregnancy: management from preconception to the postnatal period

The considerations and potential impact on equality and health inequalities have been considered throughout the guidance development, maintenance and update process according to the principles of the NICE equality policy and those outlined in Developing NICE guidelines: the manual.

This EHIA relates to:

1) Managing type 1 diabetes (T1D) using hybrid closed loop systems (HCLs) in people who are planning to become pregnant, are pregnant, or in the postnatal period.

STAGE 4. Development of guideline or topic area for update

(to be completed by the topic team before consultation on the draft guideline or update)

Diabetes in pregnancy: management from preconception to the postnatal period

Date of completion: 03 March 2026

Focus of guideline or update: Managing type 1 diabetes (T1D) using hybrid closed loop systems (HCLs) in people who are pregnant, planning to become pregnant or in the postnatal period.

4.1 From the evidence syntheses and the committee's considerations thereof, what were the main equality and health inequalities issues identified? Were any **further** potential issues identified (in addition to those identified during the scoping process) or any gaps in the evidence for any particular group?
Protected characteristics outlined in the Equality Act 2010 **Age** • The committee noted a lack of evidence about the impact of HCL systems on neonatal outcomes, with trials included not powered to detect these outcomes. **Disability** • The committee were aware of the potential challenges faced by people with physical or mental impairment to competently and safely use HCL systems. They noted that the focus should be to enable all people to competently and safely use HCL systems. **Gender reassignment** • As discussed in Stage 2 of this EHIA, many healthcare systems use gendered language (e.g., "maternal care," "women's health"), which can alienate trans men and nonbinary people who are pregnant and may create additional barriers to accessing healthcare such as HCL systems if they are described as being for pregnant women. When drafting recommendations the committee were mindful not to use gendered language. **Pregnancy and maternity** • The committee discussed the impact of living with type 1 diabetes during the pregnancy and postnatal periods. As discussed in Stage 2 of this EHIA people with T1D are more at risk of poor maternal and neonatal outcomes and managing it

during pregnancy can impose a large cognitive and emotional burden. SBLCB (2025) noted that people with Type 1 diabetes have persistently high perinatal mortality, stillbirth occurs in 10·4 per 1,000 births, with neonatal death occurring in 7·4 per 1,000 livebirths.

Race

- No further equality and health inequalities issues noted.

Religion or belief

- The committee were aware of the challenges faced by some in terms of planning for a pregnancy when their religion or belief prohibits contraception. They discussed the benefits of people staying on HCL systems postnatally to benefit from improved blood glucose control for future pregnancies.

Sex

- Inequalities were highlighted for people who cannot become pregnant and therefore cannot access and benefit, via this route, from HCL technology.

Sexual orientation

- No equality and health inequalities issues noted.

Socioeconomic deprivation (for example, variation by area deprivation such as Index of Multiple Deprivation, National Statistics Socio-economic Classification, employment status, income)

- As discussed in Stage 2 of this EHIA, people from 'lower quintiles' are less likely to engage with healthcare when planning to become pregnant, so will receive a pump later in the pregnancy. Good glycaemic control in the first 8 weeks is important to reduce the risk of congenital abnormalities, especially affecting the heart, brain, and spine which form during this period. The committee discussed the benefits of people staying on HCL systems postnatally to benefit from improved blood glucose control for future pregnancies.

- The committee noted that people with low levels of literacy may find using HCLs difficult due to the highly technical nature of the device and the need to be able to access and utilise online support. The committee stressed that this should not serve as a barrier to people being offered HCL systems, rather people should be supported and enabled to use the device safely. The committee noted the need to

ensure people receive information in their preferred format, consistent with NHS Accessible Information.

Geographical area variation (for example, geographical differences in epidemiology or service provision- urban/rural, coastal, north/south)

- While recognising the importance of a multidisciplinary team (MDT) to support the safe use of HCL systems, the committee were mindful not to be too prescriptive in terms of constituency. Flexibility in the composition of the multidisciplinary team was considered important, because, if the composition of the multidisciplinary team was strictly defined, it may not be possible for some smaller teams to meet the requirements to constitute an MDT. This would then lead to health inequalities for women or people who are cared for by these teams.

Inclusion health and vulnerable groups (for example, vulnerable migrants, people experiencing homelessness, people in contact with the criminal justice system, sex workers, Gypsy, Roma and Traveller communities, young people leaving care and victims of trafficking)

- The committee noted that the automation offered by HCL systems could help reduce inequalities for people who struggle to maintain adequate glycaemic control due to language barriers, lower levels of education or learning difficulties, for example, dyscalculia. While ‘carbohydrate counting’ should be the first line approach, the committee discussed the merits of preset small/medium/large meal dosing functions which would enable those unable to ‘carb count’ to benefit from HCL systems.

4.2	How have the committee's considerations of equality and health inequalities issues identified in 2.2, 3.2 and 4.1 been reflected in the guideline or update and any draft recommendations?

The committee's discussions about equality and health inequalities issues are included in the evidence review under section 1.1.9.4 Equity. The committee agreed that HCL systems have the potential to either reduce or widen health inequities, depending on how they are implemented. When drafting recommendations the committee:

- were mindful that wording should support equitable access for all who can become pregnant, and that gendered language should be avoided.
- noted that the focus should be to enable all people to competently and safely use HCL systems.
- recognised the benefits of people staying on HCL systems postnatally to benefit from improved blood glucose control for future pregnancies.

The committee made several recommendations that noted the need for individualised and tailored care to meet the specific needs of each person, and to help ensure all have the opportunity to maintain their blood glucose in optimal target ranges:

- Recommendation 1.9.2 notes the need for training provided on how to use a HCL system to be tailored to the individual to ensure it is accessible.
- Recommendation 1.14.5 notes that, in discussion with the person, an individualised diabetes management plan should be agreed.
- Recommendation 1.15.3 notes that individualised blood glucose targets should be agreed with the pregnant person, taking in to account the risk of hypoglycaemia.
- Recommendation 1.20.5 notes that a person's individualised diabetes management plan should be updated at each appointment.
- Recommendation 1.22.1 and 1.22.2 note the need for individualised diabetes management plans to be updated to reflect decisions around using a HCL system during labour, birth and after birth (until discharged) and the agreed HCL settings they will use to maintain their blood glucose in optimal target ranges.

In addition, the committee amended the BMI thresholds for overweight and obesity according to ethnic background, in existing recommendation 1.5.2, to bring it into line with NICE guideline NG246, Overweight and obesity management.

As noted in the Rationale and impact section in the updated guideline, when making recommendations the committee:

- agreed it is important that the information given is consistent across care centres to avoid inequalities. To support this, they specified which points it should cover.
- discussed the recommendations in NICE's technology appraisal guidance on hybrid closed loop systems for managing blood glucose levels in type 1 diabetes. They were keen to ensure that people with type 1 diabetes who are pregnant or planning to become pregnant are supported to meet the training and competency requirements set by these recommendations. They agreed that this should be done in a way that is adapted to the needs of each person, so that health inequalities are avoided.
- highlighted that, while expertise on some topics is key, flexibility in the composition of the multidisciplinary team is also important. This is because, if the composition of the multidisciplinary team was strictly defined, it may not be possible for some smaller teams to meet the requirements to constitute an MDT. This would then lead to health inequalities for women or people who are cared for by these teams.

4.3 Could any draft recommendations potentially increase inequalities?
• It is not expected that the recommendations will increase health inequalities. The committee noted that the automation offered by HCL systems could help reduce inequalities for people who struggle to maintain adequate glycaemic control due to language barriers, lower levels of education or learning difficulties, for example, dyscalculia.

4.4 How has the committee's considerations of equality and health inequalities issues identified in 2.2, 3.2 and 4.1 been reflected in the development of any research recommendations?
• The Committee noted that there was a lack of clinical evidence showing the effectiveness of hybrid closed loop systems to improve fetal/neonatal outcomes compared with standard insulin. The Committee acknowledged that the association

between maternal glucose and pregnancy outcomes is well established. Therefore, they were confident the evidence from the AiDAPT and CRISTAL trials, for improved maternal glucose from early pregnancy onwards, will have clinically relevant health benefits both for pregnant people and their babies. However, they considered that it would be valuable to do research using routinely collected real world data, including audits, to examine the effective of hybrid closed loop systems compared to other forms of insulin delivery, on fetal and neonatal outcomes, including:

- preterm births
- large birthweight
- neonatal care admissions

Based on this, the committee made the following research recommendation:

6 Hybrid closed loop and fetal and neonatal outcomes

'Based on routinely collected real-world data, in women, trans men and non-binary with type 1 diabetes, who are planning to become pregnant, are pregnant, or are in the postpartum period, what is the effectiveness and cost effectiveness of using hybrid closed loop systems to improve fetal and neonatal outcomes, compared to other forms of insulin delivery?'

4.5 Based on the equality and health inequalities issues identified in 2.2, 3.2 and 4.1, do you have representation from relevant stakeholder groups for the guideline or update consultation process, including groups who are known to be affected by these issues? If not, what plans are in place to ensure relevant stakeholders are represented and included?
• We have reviewed the list of stakeholder organisations to ensure that key patient groups are included.

4.6 What questions will you ask at the stakeholder consultation about the impact of the guideline or update on equality and health inequalities?
• No specific questions will be asked about equality and health inequalities, but we will ensure that any comments from relevant stakeholders are considered and discussed with the committee, and changes will be made where necessary.

Completed by topic team: Clare Wohlgemuth

Date: 27/03/26

Approved by committee chair: Gita Bhutani

Date: 23/04/26

Approved by NICE CFG topic hub associate director: Simon Ellis

Date: 30/04/26