NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE quality standards

Equality impact assessment

Type 2 diabetes in adults

The impact on equality has been assessed during quality standard development according to the principles of the NICE equality policy.

### 1. TOPIC ENGAGEMENT STAGE

### 1.1 Have any potential equality issues been identified during this stage of the development process?

People from some minority ethnic groups, such as those from a black family background or an Asian family background have a higher prevalence of diabetes and are diagnosed at a younger age than people from a white family background. People from a black family background may also have higher prevalence of risk factors, such as hypertension and people from a South Asian family background are at risk of diabetes at a lower BMI ([Diabetes statistics](https://www.diabetes.org.uk/professionals/position-statements-reports/statistics?msclkid=2509405fcfb111ecaaa81dc37c343914), Diabetes UK 2022). People with a learning disability may be at higher risk of developing type 2 diabetes, and at an earlier age, than the general population due to higher rates of obesity or reduced physical activity and prescriptions of some medications ([NHS RightCare pathway: diabetes](https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/11/rightcare-pathway-diabetes-reasonable-adjustments-learning-disability-2.pdf), NHS England 2017). People from more deprived backgrounds face greater challenges in making healthy lifestyle choice ([Health matters: preventing type 2 diabetes](https://www.gov.uk/government/publications/health-matters-preventing-type-2-diabetes/health-matters-preventing-type-2-diabetes?msclkid=b6139baacfbc11ec94df9c59576d612e), Public Health England 2018).

Some population groups may face difficulty in accessing some lifestyle programmes for the prevention of type 2 diabetes, for example, people with a physical or learning disability or people in contact with the criminal justice system.

Treatment of type 2 diabetes in older people or those who are frailer may vary. An individualised approach to treatment should be adopted for people with type 2 diabetes and age and frailty as well as accessibility needs considered when planning care.

People from lower socio-economic backgrounds may experience difficulty in using some diabetes monitoring devices as they may require access to higher cost technologies such as smart-phones and computers.

### 1.2 Have any population groups, treatments or settings been excluded from coverage by the quality standard at this stage in the process. Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

Children and young people with type 2 diabetes and women with type 2 diabetes who are pregnant or planning to become pregnant are excluded from the quality standard. NICE quality standards for [diabetes in children and young people](https://www.nice.org.uk/guidance/qs125) and [diabetes in pregnancy](https://www.nice.org.uk/guidance/qs109) cover these populations.

Completed by lead technical analyst: Charlotte Fairclough

Date: 09 / 05 / 2022

Approved by NICE quality assurance lead: Mark Minchin

Date: 17 / 05 / 2022

### 2. PRE-CONSULTATION STAGE

### 2.1 Have any potential equality issues been identified during the development of the quality standard (including those identified during the topic engagement process)? How have they been addressed?

The QSAC noted potential inequalities in diabetes care associated with cultural differences and socioeconomic factors. Comments from stakeholders at topic engagement highlighted that health inequalities such as those due to socioeconomic factors could be tackled through tailored education and that addressing issues around access to care such as varying appointment times and types of appointment could also help to reduce some health inequalities.

Statements 1 and 2 in the draft QS on educational programmes for adults at high risk of type 2 diabetes and those with type 2 diabetes include equality and diversity considerations to allow for programmes to meet the needs of the local area and individual preferences, including cultural needs. Considerations have also been included for information provision to meet the preferences of the person, including those who do not speak or read English, and to make the information culturally appropriate. Statements 1, 2 and 3 in the draft QS sets out the way the statement measures can be used to focus on dimensions of equality, including socio-economic background.

Comments from stakeholders at topic engagement suggested that access to continuous glucose monitoring for eligible patients could help to tackle health inequalities. The QSAC advised that continuous glucose monitoring has a low uptake rate in people with a learning disability and other vulnerable groups. Statement 3 in the draft QS aims to address use of the technology in adults with a learning disability or cognitive impairment, and adults who would need help to monitor their blood glucose.

Statements 1, 2 and 3 in the quality standard includes information on how services could use measures to focus on dimensions of health inequality, for example by reporting data grouped by ethnicity or indices of deprivation.

### 2.2 Have any changes to the scope of the quality standard been made as a result of topic engagement to highlight potential equality issues?

No changes have been made to the scope of the quality standard at this stage.

### 2.3 Do the draft quality statements make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

Draft statement 3 aims to increase uptake of continuous glucose monitoring in adults with a learning disability or cognitive impairment, and adults who would need help to monitor their blood glucose. NICE additionally recommends the technology for adults with type 2 diabetes on multiple insulin injections, not limited to the population in the draft statement. The statement intends to increase uptake in vulnerable populations to address health inequalities.

### 2.4 Is there potential for the draft quality statements to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

No.

### 2.5 Are there any recommendations or explanations that the committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 2.1, 2.2 or 2.3, or otherwise fulfil NICE’s obligation to advance equality?

No.

Completed by lead technical analyst: Charlotte Fairclough

Date: 10 / 08 / 2022

Approved by NICE quality assurance lead: Mark Minchin

Date: 15/09/2022

### 3. POST CONSULTATION STAGE

### 3.1 Have any additional potential equality issues been raised during the consultation stage, and, if so, how has the committee addressed them?

Stakeholders noted that services have a legal duty to consider reasonable adjustments for people with disabilities, including a learning disability. The equality and diversity considerations in the quality standard have been updated to reflect reasonable adjustments suggested in the [NHS Rightcare pathway: diabetes: reasonable adjustments for people with a learning disability who have diabetes](https://www.england.nhs.uk/rightcare/toolkits/diabetes-pathway/).

Stakeholders commented on audit data that shows younger people have the least complete routine care, most adverse treatment target achievement rates and the greatest socioeconomic and ethnic inequalities. The process measures for statements in the quality standard have been amended to suggest that users could use the measures to focus on dimensions of health inequality including age.

Stakeholders noted the focus on communication needs in statement 1 and recommended further focus on cultural needs and delivery options including language and interpretation services. Specialist committee members highlighted that the environment and place of diabetic care and education may be used to reduce health inequalities. The equality and diversity considerations for statements 1 and 2 have been amended to include further considerations based on personal characteristics and social context. Statements 1 and 2 contain information on provision of programmes in a format suitable for the individual, including use of different venues and accessibility requirements.

### 3.2 If the quality statements have changed after the consultation stage, are there any that make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

The populations in statement 3 in the draft quality standard have been split into separate statements to ensure a focus on subgroups of adults with type 2 diabetes who are eligible for intermittently scanned continuous glucose monitoring (isCGM). Statement 3 has been updated to include all adults with type 2 diabetes on multiple daily insulin injections with a condition or disability that means they may not be able to self-monitor using capillary blood glucose monitoring to prevent increasing inequalities. Quality statements 3 and 4 aim to increase use of isCGM by the specific groups in the statements, but do not intend to make it more difficult for other eligible adults with type 2 diabetes to access the technology. Quality statements 3 and 4 include information on how the measures could be used by local services to focus on other groups that cannot self-monitor their blood glucose and diabetes, such as eligible adults with a learning disability or cognitive impairment. The QSAC heard that there is low uptake of isCGM in these particular populations.

### 3.3 If the quality statements have changed after consultation, is there potential for the recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

No.

### 3.4 If the quality statements have changed after consultation, are there any recommendations or explanations that the committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 3.1, 3.2 and 3.3, or otherwise fulfil NICE’s obligations to advance equality?

The measures for quality statements 3 and 4 include information on how they could be used by local services to focus on other groups that cannot self-monitor their blood glucose and diabetes.

Completed by lead technical analyst: Charlotte Fairclough

Date: 02 / 12 / 2022

Approved by NICE quality assurance lead: Mark Minchin

Date: 27 / 02 / 2023

### 4. After NICE Guidance Executive amendments – if applicable

###  4.1 Outline amendments agreed by Guidance Executive below, if applicable:

No amendments following guidance executive.

Completed by lead technical analyst: Charlotte Fairclough

Date: 01 / 03 / 2023

Approved by NICE quality assurance lead: Mark Minchin

Date: 01 / 03 / 2023

© NICE 2023. All rights reserved. Subject to [Notice of rights](https://www.nice.org.uk/terms-and-conditions#notice-of-rights).