

Latest news: Hybrid-closed loop guidance, cardiovascular death reduction and GDM incidence

Stay abreast of the latest news that could impact diabetes nursing.

New guidance on HCL devices for pregnant women with type 1 diabetes

Pregnant women with type 1 diabetes, and those planning pregnancy, should be offered pregnancy-specific hybrid closed-loop (HCL) technology, according to draft NICE guidance. The recommendation places the devices at the centre of safer preconception, antenatal and postnatal diabetes care.

The guidance would mean that all eligible women are offered systems that automatically monitor glucose and adjust insulin delivery through a pump, reducing reliance on finger-prick testing, manual injections and frequent treatment decisions. NICE states that these systems must be licensed for use in pregnancy, allow glucose targets within recommended pregnancy ranges and deliver at least 5% more time in range than standard care.

Tight glycaemic management before and during pregnancy is clinically important because both hyperglycaemia and hypoglycaemia can increase the risk of adverse outcomes for the mother and baby, including miscarriage, premature birth and complications during labour. Evidence from clinical trials shows that pregnancy-specific HCL systems help women maintain safer glucose levels throughout pregnancy.

The draft guidance recommends that HCL systems should be discussed with women with type 1 diabetes as soon as their diabetes or antenatal care team

becomes aware of the planned or ongoing pregnancy. Training and support should be provided by specialist multidisciplinary teams and tailored to the woman's needs and preferences.

The proposal builds on previous NICE recommendations by specifying that HCL systems used during pregnancy must have pregnancy-specific functionality to support glucose management during a period when insulin requirements change significantly and be licensed for this use.

Women can remain on their HCL system during labour and birth where this has been agreed beforehand and is considered safe. They should also be offered the choice to continue using a pregnancy-specific system for at least 6 months after childbirth. Clinicians are also advised to revisit the option with women who initially decline, as needs and preferences may change during pregnancy.

If accepted, the draft recommendations will be incorporated into an update of the NICE guideline on diabetes in pregnancy (NG3) and will align with NHS England's 5-year plan for rolling out HCL systems for type 1 diabetes. The draft guidelines can be read [here](#).

Diabetes a key priority in strategy to reduce cardiovascular deaths

Improvements in diabetes prevention and treatment are set to play a central role in the Government's new *Cardiovascular Disease Modern Service Framework*. Published

on 7 July, the framework aims to reduce premature deaths from heart disease and stroke in England by 25% within the next decade. Cardiovascular disease is one of the country's leading causes of premature mortality, contributing to health inequalities, avoidable pressure on the NHS and significant economic loss.

The modern service framework (MSF) calls for a shift from reactive, hospital-based care towards the proactive identification, prevention and management of cardiovascular-kidney-metabolic (CVKM) risk within communities and neighbourhoods. Diabetes features prominently within this broader CVKM approach, alongside hypertension, raised cholesterol, obesity, chronic kidney disease (CKD), atrial fibrillation and smoking.

The MSF reinforces the need for diabetes care to continue to move beyond a narrow focus on glycaemic control. It identifies hyperglycaemia, including pre-diabetes and type 2 diabetes, as a major modifiable risk factor for myocardial infarction and stroke, and emphasises the importance of managing overlapping conditions through integrated pathways, rather than separate disease-specific services.

A central priority is the identification of the "missing millions" of people with undiagnosed or sub-optimally managed CVKM risk factors. Nurses working in diabetes, primary care and community services are likely play a pivotal role in this agenda through opportunistic screening,

systematic recall, NHS Health Checks, proactive case-finding and targeted outreach to populations at greatest risk.

The importance of consistently delivering all nine diabetes care processes to prevent complications and identify deterioration at an early stage is also emphasised, alongside treatment optimisation. Priorities include improving management of blood pressure, lipids and kidney disease, together with the wider appropriate use of SGLT2 inhibitors for eligible people with type 2 diabetes, chronic kidney disease or heart failure.

The framework places a strong emphasis on health inequalities. It calls for targeted action in deprived communities and among populations with poorer outcomes, where diabetes and cardiovascular risk often develop earlier, are less consistently identified and may be less effectively managed.

Over the next three years, the immediate focus will be on driving improvements in priority areas where evidence for reducing premature mortality is strongest and performance is currently inconsistent. Nurses involved in the care of people with diabetes will be at the centre of driving and delivering this change.

The full policy paper can be read [here](#).

Incidence of gestational diabetes rises in England

More than one in eight births in England was affected by gestational diabetes (GDM)

by the end of 2022, after diagnoses rose by 60% in just five years, according to a major study published in *BMJ Medicine*. The research also reported profound inequalities in incidence and pregnancy outcomes by ethnic group and socioeconomic status.

Gestational diabetes is the most common complication of pregnancy and is associated with adverse obstetric outcomes, including infants born either larger or smaller than expected for gestational age, preterm birth and intervention during delivery. It is also associated with an increased risk of long-term cardiometabolic disorders for mothers and their offspring.

Estimates of the incidence of GDM in the UK have previously been determined through clinical audit but have varied greatly across regions, limiting their usefulness in planning maternity services. To address this gap in understanding, researchers from the University of Edinburgh and King's College London examined data from all NHS hospital births in England from 1 January 2018 to 31 December 2022. Over 2.3 million mothers and around 2.8 million births across 184 hospitals were included in the analysis.

The investigators identified 274 500 pregnancies with a diagnosis of GDM, representing 9.9% of all births during the study period. Although the total number of births fell, both the number and proportion of pregnancies affected by GDM increased. Prevalence rose from 7.5% in January 2018

to more than 12% by the end of 2022, a relative increase of 60% over five years.

Rates of GDM diagnoses increased for all socioeconomic and ethnic subgroups. In every year studied, GDM was most common among those experiencing the highest level of socioeconomic deprivation and those identifying as non-white; these groups were also at higher risk of adverse obstetric outcomes. The greatest absolute increase in GDM occurred in women from black and Asian ethnic groups, while the largest relative increase occurred among white individuals.

Rising maternal age, increasing rates of obesity and improved data capture each contributed to the increase in recorded GDM prevalence. Changes to screening methodology introduced during the Covid-19 pandemic did not meaningfully affect the overall diagnostic trends. The high rates of GDM and the inequalities revealed in the study underline the urgent need for strategies to improve maternity and follow-up care. This must include preventative measures to reduce the risk of future type 2 diabetes and cardiovascular disease.

The original article can be read [here](#).

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