NHS decision-makers

UNBIASED
breaking barriers in diabetes tech_

From evidence to action: key recommendations from the UNBIASED study

Despite NICE TA943 mandating free NHS access to hybrid closed-loop (HCL) systems for all children and young people (CYP) under 18 with Type 1 diabetes in England, significant inequities persist. Black and ethnic minority CYP and those from lower socioeconomic backgrounds continue to have the lowest uptake. The UNBIASED study shows us why, and what needs to change.

Evidence base: Recommendations draw on the full UNBIASED programme: qualitative interviews with 29 HCPs across 15 NHS sites in England (Dlugatch et al., Diabet Med, 2025a; 2025b); participatory interviews and co-design workshops with 32 CYP and families from ethnic minority and low-income backgrounds (Tonga et al., 2026); and the study overview (Ng et al., Diabet Med, 2024). This document summarises the recommendations paper: Ng et al., Diabetes Technology & Therapeutics, 2026.

Awareness and Communication

Many CYP and families, particularly those with language barriers or limited prior contact with services, do not know that HCL systems, insulin pumps and CGM are available free on the NHS. The UNBIASED research found this gap was especially pronounced in Black African families and those in the most deprived areas.

Communicate entitlement proactively: At every clinical encounter, confirm in plain language that technology is free under NICE TA943. Do not wait for families to ask.

Provide multilingual, accessible resources: Avoid unexplained acronyms (CGM, HCL). There are a range of digital platforms used across NHS diabetes services that provide translated content. UNBIASED found that Black and Asian communities remain underrepresented in these materials. This needs addressing.

Co-design national awareness campaigns: Campaigns must be designed with ethnic minority and low-income communities (not simply translated for them) to be credible and reach beyond existing clinic networks.

Normalise the conversation: Cultural and linguistic factors shape how families understand and engage with technology. Technology discussions should be standard practice, initiated by clinicians, not triggered only when families ask.

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System and policy reform

NICE TA943 is legally binding, but implementation is managed through Integrated Care Boards (ICBs) on 5-year plans. During this transitional period, UNBIASED research found that variation in commissioning practices creates a de facto postcode lottery — with some ICBs routinely refusing applications even when CYP met NICE criteria.

Monitor TA943 implementation rigorously: National oversight of ICB delivery timelines is essential. A child's access should reflect clinical need, not postcode.

Use NPDA data to direct commissioning: National Paediatric Diabetes Audit data should drive workforce investment and commissioning decisions, identifying communities with the lowest technology uptake and targeting resources accordingly.

Increase digital access: Some HCL systems require a smartphone for caregiver remote monitoring. For low-income families this creates a practical barrier; government- or charity-funded device provision is needed.

Streamline prior approval processes: Where ICBs operate prior approval systems, these should be simplified and monitored for consistency with NICE guidance.

Workforce and support

Staffing shortfalls are not a neutral resource problem: they actively generate inequity. When pressed for time, HCPs reported prioritising families perceived to need less support, which in practice favoured those who were more educated, native English speakers, or already on pump therapy.

Increase staff:patient ratios at high-need sites: Sites serving higher proportions of disadvantaged CYP need proportionately more clinical staff. Current ratio recommendations do not account for the additional time required to support families with language barriers or complex social circumstances.

Fund non-clinical roles: Diabetes care technicians, administrators, and youth support workers free up clinical capacity for complex cases, and are effective at improving engagement among teenagers.

Embed culturally competent training with protected time: HCP training must address unconscious bias and social determinants of health, not just clinical skills. Evidence from UNBIASED shows bias becomes more likely, not less, under staffing pressure.

Use NPDA data for team reflection: Regular team review of site-level data helps identify patterns of under-referral that may not be apparent case-by-case. Structured team discussions are among the most effective tools for challenging entrenched assumptions.

Community and peer networks

HCPs consistently reported that peer support was among the most powerful levers for technology uptake; more persuasive than clinical recommendation alone. Yet many of the community outreach initiatives described in UNBIASED depended on one-off NHS England grants and staff working unpaid hours.

Fund structured peer mentoring: Establish funded programmes connecting CYP and families from similar backgrounds. Hearing directly from a parent who has navigated the same barriers is qualitatively different from clinical advice.

Take outreach to communities: Technology roadshows and events in community settings (rather than clinics) have demonstrably increased uptake. These require dedicated, sustainable funding.

Involve trusted community figures: Community leaders, faith organisations, and those with lived T1D experience can bridge cultural divides and normalise technology in communities where visible devices carry stigma.

Build sustainability into plans: Outreach and peer support cannot rely on goodwill and unpaid time. Long-term, ring-fenced funding is required for these initiatives to become standard rather than exceptional.

Implementation challenges to acknowledge

The UNBIASED research is clear that motivation among HCPs is high, but individual commitment cannot substitute for systemic change. Several challenges require honest acknowledgement: many effective strategies identified (outreach, peer support, elective admissions for pump starts) currently depend on short-term grants or unpaid hours. Bias training is most effective in well-resourced sites; in under-staffed settings, time pressure itself creates conditions for inequitable prioritisation. And during the transitional period of TA943 implementation, there is a real risk that CYP who are most disadvantaged will be the last to benefit, as teams move first to those perceived as easier to initiate. These risks must be monitored and named, not assumed to resolve themselves.

References

This document summarises: Ng SM, Darko N, Tonga E, Lawton J, Dlugatch R, Rankin D, Evans M, Oliver N. Recommendations from the United Kingdom UNBIASED Study to Address Diabetes Technology Access Disparities for Children and Young People. Diabetes Technology & Therapeutics. 2026. doi:10.1177/15209156261417292

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