POLICY BRIEFING
NOVEMBER 2026

Assessment and Management of Gestational Diabetes: A Postcode Lottery?

Summary

- Effective and equitable identification and treatment of gestational diabetes (GDM) is vital to improve short- and long-term clinical outcomes for mother and baby and to reduce perinatal mortality rates, birth complications, and mounting health service costs.
- The Bump2Baby and Me project researched gestational diabetes screening, testing, diagnosis and care practices in England & Wales and Ireland. The team conducted qualitative interviews with key healthcare professionals, which informed our cross-sectional, online, healthcare professionals survey of maternity, neonatal and diabetes services in England & Wales and Ireland.
- The survey showed large variation in how women are screened, tested for and diagnosed with gestational diabetes. The variation was seen not only between countries but also units within each country. The findings highlight the existence of a potential 'postcode lottery' when assessing and managing gestational diabetes, which can lead to inequitable care and outcomes.

Policy Recommendations and Actions

Variance and adherence to gestational diabetes guidance needs to be better understood. Policymakers could also consider:

- Developing a personalised risk prediction approach to increase the accuracy of predicting those at risk of gestational diabetes.
- Undertaking research into the management of gestational diabetes to identify the most effective healthcare practices.
- Exploring how health care practices in gestational diabetes can be consistently adopted.
- Undertaking research to explore how to optimise both the integration and reach of gestational diabetes lifestyle interventions, for the pre-conception, antenatal and postnatal periods.



1 in 6

live births globally are affected by gestational diabetes[1]



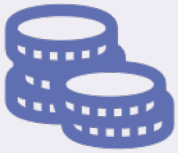
Women who have had GDM are almost

10x

more likely to develop type 2 diabetes[2]



Older women and Black, Hispanic and Asian women are at higher risk of gestational diabetes[3]



Gestational diabetes increases the cost of an individual's maternity care by[4]

34%

Background

Gestational diabetes is raised blood glucose in pregnancy. This can cause life-threatening complications in pregnancy or at birth for both the mother and baby. Irish and UK gestational diabetes prevalence estimates range from 13% to 23% and are increasing[1]. It is known that gestational diabetes is associated with pregnancy complications for mother and baby and increases the cost of an individual's maternity care by 34%[4].

Effective identification and treatment of gestational diabetes is vital to improve short- and long-term clinical outcomes, such as future obesity and type 2 diabetes (T2D), for mother and to reduce perinatal morbidity and mortality rates, and birth complications, alongside mounting health service costs.

Non white ethnic groups are at higher risk of gestational diabetes and therefore equitable screening and treatment for those most at risk is vital to reducing perinatal morbidity and mortality, that is also shown to be higher in this population[5].

Pregnancy is a window of opportunity to educate and support women to make sustainable health behaviour changes while they are invested in their health and the health and development of their unborn child. The first 1,000 days, from conception to age two are considered the most significant in a child's development[6]. Providing women with the opportunity for self-care practices can enable them to take charge of their condition, reducing the burden of gestational diabetes on the healthcare system and the wider economy.



Figure 1. First 1,000 days concept

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Bump2Baby and Me Project

The Bump2Baby and Me project used a randomised controlled trial to test the Bump2Baby and Me mHealth Coaching Programme. This novel healthcare intervention provided women, at high risk of developing gestational diabetes, with evidence-based healthy eating and exercise information, both during pregnancy and for the first year after birth, via a smartphone app and real-life health professional health coach.

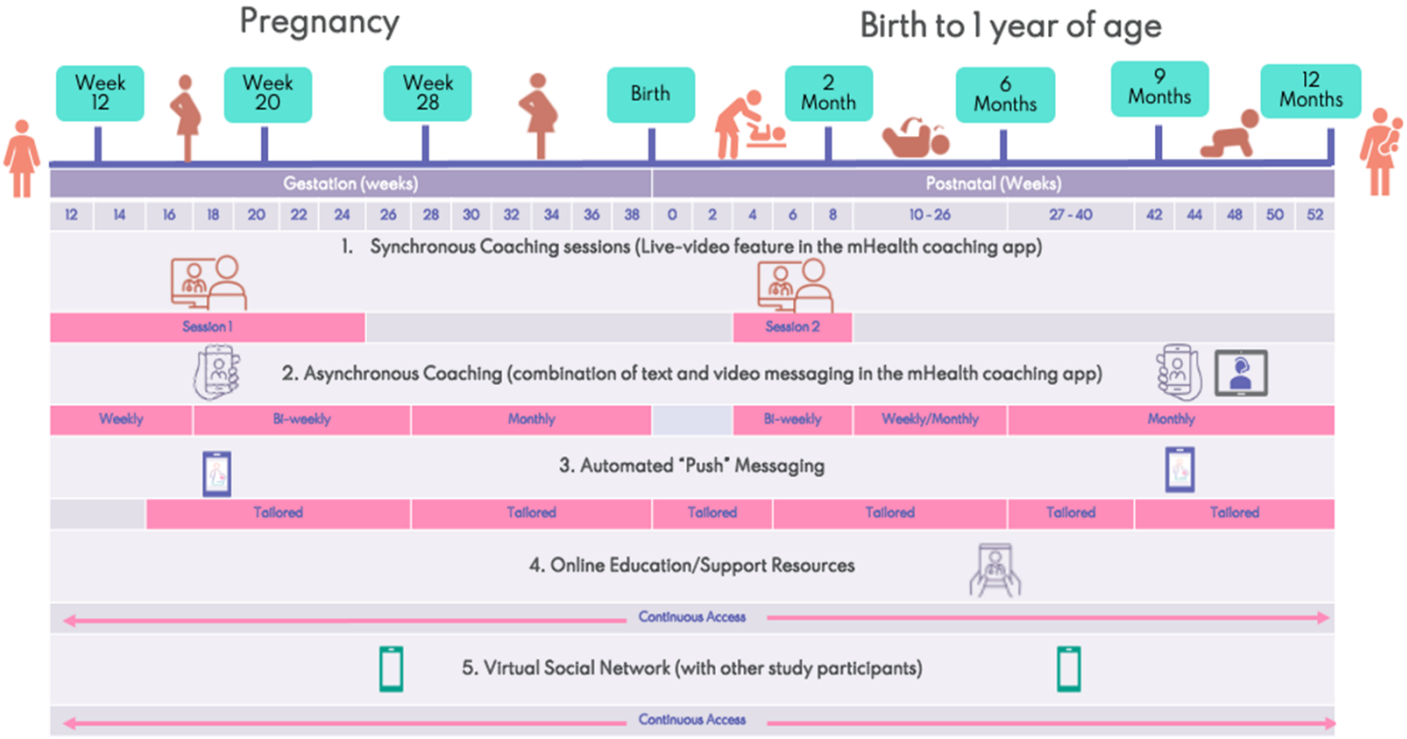


Figure 2. Bump2Baby and Me mHealth Coaching Programme intervention components

The trial results were published in The Lancet Digital Health* in November 2026. A new project which builds on our research, Bump2Baby and Me+, is exploring whether the trial results will translate into new countries and whole maternity hospitals. It is hoped that this can enable the development and roll out of a future sustainable prevention programme that empowers women, supports clinicians, and integrates directly into routine maternity care.

*O'Reilly S, McAuliffe F, Teede H et al. Personalised mobile health coaching from early pregnancy to 12-months postpartum for females at risk of gestational diabetes (Bump2Baby and Me): a multicentre, randomised controlled trial. *The Lancet Digital Health*, 2026; 0.

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Mapping Current Practice

The Bump2Baby and Me project research team wanted to understand the gestational diabetes screening, diagnosis, testing and care practices to determine where and how an mHealth intervention might fit within the current care pathway in England & Wales and Ireland. The team conducted qualitative interviews with key healthcare professionals, and they informed our cross-sectional, online, healthcare professionals survey of maternity, neonatal and diabetes services in England & Wales and Ireland. The online survey was distributed widely across the UK and Ireland using the project's network. A total of 83 healthcare professionals from 47 maternity units (35 from the UK and 12 from Ireland) participated in the survey. The survey questions covered gestational diabetes guideline use, screening, diagnostic tests and antenatal care pathways.

Key Findings

Guideline Use

Clinical guidelines are designed to support healthcare staff to deliver the best possible care to patients. They use the best available evidence, and different organisations produce different guidelines, which vary depending on who they are designed for, and the types of evidence considered.

We found that units in both England & Wales and Ireland most commonly used their national guidelines (NICE and HSE Ireland respectively) to determine which women should be screened for gestational diabetes. However, Ireland used a wider range of gestational diabetes screening and diagnosis guidelines, and this included NICE, the International Association of Diabetes and Pregnancy Study Groups (IADPSG) and World Health Organization (WHO) guidelines.

Ireland used a wider range of screening and diagnosis guidelines than their national ones



Figure 3. Gestational diabetes screening and diagnosis guideline use across England & Wales and Ireland

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Key Findings

Screening Practices

Universal screening remains a controversial issue[7]. The UK NICE guideline recommends selective screening based on known risk factors, which include previous gestational diabetes, body mass index above 30kg/m^2, previous large for gestational age baby, family history of diabetes or at-risk ethnicity[8]. The Irish HSE guideline also recommends selective screening but uses a wider range of risk factors (including maternal age over 40, long-term steroid use and polycystic ovary syndrome)[7].

Risk factors	Screening recommended by NICE guideline	Screening recommended by HSE guideline
Previous gestational diabetes	✓	✓
BMI above 30kg/m2	✓	✓
Previous large for gestation baby	✓	✓
Family history of diabetes	✓	✓
Ethnicity	✓	✓
Maternal age over 40		✓
Long-term steroid use		✓
Polycystic ovary syndrome		✓
Previous unexplained perinatal death		✓
Current glycosuria (>normal glucose in urine)		✓

Figure 4. Risk factors and recommended national screening practices

We found that early pregnancy screening (14-16 weeks pregnant), was mostly selective in both countries using risk factors but a minority of participants indicated that they screened all women in early pregnancy. Risk factors varied greatly in their use, examples of this include two thirds of units in England & Wales and one quarter of units in Ireland were not using ethnicity as a risk factor, and less than half of units in England & Wales and around a quarter in Ireland were not using BMI, despite these being guideline informed risk factors[7,8].

There was increased use of universal screening and testing of all pregnant women for gestational diabetes in later pregnancy (24-28 weeks) in Ireland (50% of units), however, 100% of units in England & Wales reported that they selected women with risk factors for testing in line with the NICE guidelines[8]. One unit in England & Wales indicated that they screen and test all women (3%).

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Key Findings

Diagnostic Tests

An oral glucose tolerance test (OGTT) is the currently recommended way of testing women who are identified as at risk for gestational diabetes in England & Wales and in Ireland[7,8].

The OGTT was the most commonly used test in early pregnancy, both in those with and without previous gestational diabetes. However, a wide range of other tests are employed outside of national guidelines, including two-step oral glucose tolerance tests, HbA1c, fasting blood glucose (FBG) and random blood glucose (RBG) tests.

There was a greater variety of tests used in Ireland compared with England & Wales for women with previous gestational diabetes; over 50% of units in Ireland indicated they use a two-step glucose tolerance test, HbA1c, random or fasting blood glucose for diagnosis.

In later pregnancy (24-28 weeks gestation), for women with and without previous gestational diabetes the OGTT was the most commonly used test in England & Wales (87-88%), but a two-step glucose tolerance test is more commonly used in Ireland (78%). There was a wider range of tests used in both those with and without previous gestational diabetes in Ireland compared with England & Wales.

There is wide variation in the tests used for screening and diagnosing women for gestational diabetes despite the guidelines

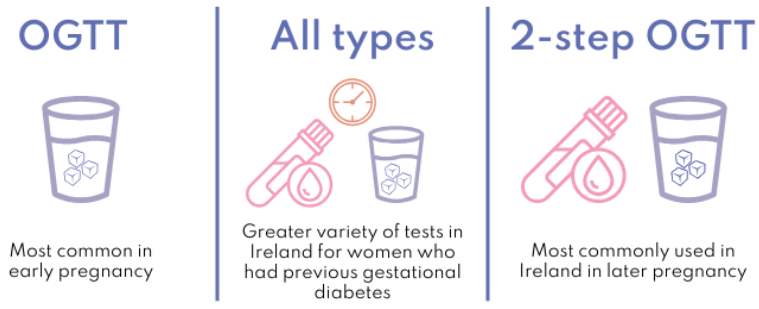


Figure 5. Variation in tests used for screening and diagnosis of women with gestational diabetes

Post-diagnosis Care

Maternity units typically followed their national guidelines for the care offered and nearly every unit provided advice or training around diet, physical activity and blood glucose testing. They also offered medication and additional foetal growth scans to women with gestational diabetes.

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Key findings

Post-diagnosis Care

In England & Wales the first line medication for gestational diabetes treatment is Metformin[8] and most units were following the NICE guidelines on this (85.7%). However, nearly 10% were opting for insulin as a first line treatment. Ireland's guidelines advise insulin as the first line treatment for gestational diabetes[7] and around 40% of units were following this, however a large proportion (71.4%) of units in Ireland chose to follow the more up to date NICE guidelines and use metformin as their first line treatment.

First line medications	England & Wales	Ireland
Biguanides (Metformin)	86%	71%
Insulin	9%	43%
Sulphonylureas	5%	0%

Figure 6. First line medication used across nations

The gestation at which women are offered induction of labour (IoL), or caesarean birth (c-section) is expected to vary depending on the management strategy used. However, we also identified variation in when IoL and c-section are offered according to gestation and management strategy between and within countries.

What do our findings mean for women?

The research highlights that women experience considerable variation in:

- whether they are screened and/or diagnosed with gestational diabetes
- how they are cared for if they have gestational diabetes.

The care pathway variation between countries and maternity units ultimately indicates that a 'postcode lottery' may exist for women as to whether they are screened for gestational diabetes, the treatment offered in terms of medications and lifestyle-related support and timings of birth interventions. This means that the clinical impact of gestational diabetes for a mother and her baby, during pregnancy, will likely vary according to which country she lives in, and what maternity unit she attends.

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Policy Recommendations and Actions

Why investing in equitable gestational diabetes care matters



Health equity: Gestational diabetes disproportionately affects marginalised communities, widening health disparities. Equitable care is not just the right thing to do; it is essential for a healthier, fairer society.



Preventive power: Effective gestational diabetes management reduces risks for mothers and babies, preventing long-term health complications and saving healthcare costs.



Boosting productivity: Healthy mothers and their offspring contribute to a healthier, more productive workforce, now and in the future.

Action 1

Standardise gestational diabetes care

Identify barriers to implementing guideline-informed care and ensuring consistent use of evidence-based gold standards for screening, diagnosis, and management across all maternity services. This ensures consistent high-quality care for all women, regardless of their background or the maternity hospital or unit attended.

Action 2

Personalise risk prediction

Develop tools to accurately identify women at risk of gestational diabetes, ensuring optimal care without overburdening the healthcare system.

Action 3

Optimise gestational diabetes management

Research best practices for medication, timing of birth, and other interventions to achieve better outcomes for mothers and babies.

Action 4

Boost health behaviour change interventions

Research how to effectively deliver and integrate health behaviour change interventions before, during, and after pregnancy to improve gestational diabetes management long-term.

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> *Essentially there are no national data to measure whether the provision of gestational diabetes care is in line with NICE recommendations either across diabetes maternity specialist services or in primary care.*
>
> **NHS England**

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