Aneurin Bevan University Health Board

Management of Pregnancy in women with pre-existing Type 1 and 2 Diabetes

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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Owner: Maternity Services | ABHB/F&T/0738

Contents:

Introduction

This document is designed to support safe and effective practice for caring for women with Type I, Type II Diabetes.
Please follow All Wales Pathway for Gestational Diabetes on the intranet.

Policy Statement

This guideline is based on the NICE guideline NG3 published 25/2/2015 (updated Dec 2020). (*Diabetes in pregnancy: management of diabetes and complications from preconception to the postnatal period*)

Aims

To provide support for clinical decision making

Scope

- This guideline will relate to all maternity staff working within Aneurin Bevan Health board, giving care to pregnant women with Type I, Type II Diabetes.

Roles and Responsibilities

- Following wide discussion with all staff groups affected by this guideline, it will be ratified at the Maternity Services Clinical Effectiveness forum.
- The guideline will be placed on the health board intranet.
- Information relating to the guideline will be disseminated via the usual service cascade.
- The guideline will be highlighted to the staff looking after women with diabetes
- Monitoring of this guideline will be via the local risk management meetings and clinical incident reporting.

Training

Training for junior medical staff will be undertaken locally, training spreadsheets are maintained within the directorate

Audit

Audit is done via the quality Improvement plans within the directorate

Antenatal Diabetes Care teams

Royal Gwent Hospital

Lead Obstetricians- Pre-gestational	Mrs Lisa Pilkington Mrs Claire Hill
Lead Endocrinologist	Dr Dana Ershaid
Diabetes Specialist Nurse	Mrs Louise Tyler
Dietitian	Ms Tone Gundersen/Miss Amy Allen
Specialist Lead Midwife for Diabetes	Adele Baker
Lead Midwife	Mrs Margot Jones

Type 1 and 2 diabetic clinics are held on a Tuesday morning.
(Gestational Diabetes clinics are conducted on a Monday afternoon).

Nevill Hall Hospital

Lead Obstetrician	Mrs Anurag Pinto
Lead Endocrinologist	Dr Leo Pinto
Diabetes Specialist Nurse	Mrs Lynn Woolway
Dietician	Miss Amy Allen
Specialist Lead Midwife for Diabetes	Adele Baker
Lead Midwife	Mrs Anne Kershaw

The clinic is conducted on Tuesday mornings (includes care for women with pregestational diabetes, Gestational diabetes and endocrine disorders)

Preconception Care:

Women with Type I and Type II Diabetes who are planning pregnancy should consult their health care professional to optimise their diabetes control, and to make sure their medications are reviewed to ensure safety for pregnancy.
They should start folic acid 5mg once daily at preconception.
GPs may wish to refer these women to the specialist diabetes teams for preconception counselling, particularly if the glycaemic control is not optimised for pregnancy. Aim for HbA1C <48mmol/mol.

Antenatal Care:

Early referral:
Women with Type I and Type II Diabetes who become pregnant are referred by their GP (e- referral to endocrinologist) as early as possible once the pregnancy confirmed.
Often patients contact DSN when the pregnancy test is +ve and are booked to the medical antenatal clinic.
CMW are encouraged to email through the MANC referral forms (see appendix) for women, directly after first contact to minimise delay in first review.
Ensure women are taking 5mg Folic acid at first contact (arrange prescription if not on 5mg Folic acid) .

If women present to Emergency Gynae assessment unit (EGAU) or Early pregnancy assessment unit (EPAU) for early pregnancy problems- ensure they are taking 5mg Folic acid and if bloods are being performed add HbA1C. If viable pregnancy confirmed, commence 150mg Aspirin. Stop medications (ACE inhibitors, statins) and inform the diabetes clinic team via email (AMP-NHH/ LPI-RGH).

Gestational Diabetes (GDM):
Refer to All Wales GDM strategy document

Table 1 Timetable of antenatal appointments – guidance based on NICE recommendations

Early pregnancy visit ideally needs to see a member of the joint diabetes and obstetric clinic by 10 weeks.	**For women with Pre-gestational Diabetes** Discuss information, education and advice about how diabetes will affect the pregnancy, birth and early parenting (such as breastfeeding and initial care of the baby). If the woman has been attending for preconception care and advice, continue to provide information, education and advice in relation to achieving optimal blood glucose control (including dietary advice). If the woman has not attended for preconception care and advice, give information, education and advice for the first time, take a clinical history to establish the extent of diabetes-related complications (including neuropathy and vascular disease), and review medicines for diabetes and it's complications. Refer to Diabetic Eye Screening Wales (DESW) unless the woman has been assessed in the last 3 months. Offer renal assessment for women with pre-existing diabetes if this has not been performed in the last 3 months. Arrange contact with the joint diabetes and antenatal clinic every 1–2 weeks throughout pregnancy for all women with pre-gestational diabetes. (this includes telephone consultations) Measure HbA1c levels for women with pre-existing diabetes to determine the level of risk for the pregnancy. Confirm viability of pregnancy and gestational age at 7–9 weeks for women with pre-existing diabetes. Offer Aspirin 150 mg orally daily up until 36 weeks gestation.

16/40	Offer retinal assessment at 16–20 weeks to women, if diabetic retinopathy was present at their first antenatal clinic visit.
18-20/40	Offer an ultrasound scan for detecting fetal structural abnormalities.
22-24 weeks	For women who were on insulin at booking, arrange ECHO for the fetal heart (4 chambers, outflow tracts and 3 vessels)- this is performed in UHW (use the referral form in appendix).
28/40	Offer ultrasound monitoring of fetal growth, Doppler and amniotic fluid volume. Offer retinal screening - check HbA1C alongside routine 28 week bloods
32/40	Offer ultrasound monitoring of fetal growth, Doppler and amniotic fluid volume. Offer nulliparous women all routine investigations normally scheduled for 31 weeks in routine antenatal care.
34/40	No additional or different care for women with diabetes Consider repeating HbA1C in those with poor control
36/40	Offer ultrasound monitoring of fetal growth, Doppler and amniotic fluid volume. Provide information and advice about: - Timing, Mode and Management of birth - Analgesia and Anaesthesia - Changes to blood glucose-lowering therapy during and after birth - Care of the baby after birth - Initiation of breastfeeding and the effect of breastfeeding on blood glucose control - Facilitate breast milk harvesting if women are interested

	- Contraception and post-natal follow-up Birth plans will be made available on CWS and in the patient notes to include management intrapartum and postpartum.
	Consider elective birth before 37 weeks for women with Type I or II Diabetes if there are metabolic or any other maternal or fetal complication.
37+0 to 38+6	Offer induction of labour, or caesarean section to women with type 1 or type 2 diabetes; if mothers opt for spontaneous labour, facilitate if there are no complications.
39+	Ideally women should be delivered before 39 weeks, careful monitoring is continued until delivery in those women who decline elective delivery.

Intrapartum care: Management of Labour in Women with Type I, II Diabetes

It is essential that the midwives and the nursing staff looking after women with diabetes are familiar with safe administration of insulin and have received appropriate training

Women may have rare forms of diabetes, eg. monogenic diabetes or maturity-onset diabetes of the young (MODY), cystic fibrosis, pancreatitis related diabetes, and chemical or drug induced diabetes. The diabetes team looking after these women in the antenatal period will write specific instruction on their birth plan/individual care plan.

Induction of Labour

- The mode and timing of delivery will be decided by the joint Obstetric and Diabetes team in the antenatal period unless delivery is needed as an emergency.
  For planned admission, please review the birth plan/Individual Care Plan made in ANC.

- The standard IOL protocol will be followed (Propess/Prostin, maternal observations, CTG monitoring etc.)

- During the induction of labour, when the woman is on a normal diet, continue regular treatment for diabetes, including insulin. She will continue to check capillary blood glucose levels as she has been doing in the antenatal period.

In Established Labour

Once labour is established, woman should be transferred to the labour ward (LW) and have hourly capillary blood glucose (CBG) recordings maintained on the OBS VRIII chart. (appendix 1)
Treatment Target: 4-8mmol/l

All women with Type 1 diabetes and Type 2 DM on multidose insulin in the antenatal period will need Variable Rate Intravenous Insulin Infusion (VRIII) formerly known as sliding scale.

Women with Type 2 Diabetes, not on insulin but have 2 consecutive readings >7mmol/l (if a reading is >7mmol/l repeat after 30 minutes instead of 1 hour), commence VRIII.
For women on the insulin pump (CSII) see separate instructions at the end.

If there is delay to get to the LW, commence VRIII on the ward.

Check U&Es when starting VRIII and continue to monitor U&Es 6 hourly as long as on VRIII.

The basal (long acting) insulin should be continued when on VRIII (long acting insulin- Glargine/Lantus/Toujeo; Detemir/Levemir; Degludec/Tresiba, Insulatard; Humulin I).

The short acting insulin and Metformin are not taken in labour.

Inform Obstetric and Anaesthetic registrar to review the women for a management plan (take into consideration any other co-existing conditions such as Pre-eclampsia, PROM etc)

Standard Obstetric-led care monitoring is continued (i.e.- maternal observations, continuous CTG via STAN, maintenance of partogram) in addition to hourly CBG checks.

Check blood ketones if CBG >11mmol/l.
If blood ketones >3.0 mmol/l, arrange for an urgent medical review (DICE team 9am to 5pm) and follow the HB's DKA management policy.

Keep the on-call Obstetric consultant informed about the progress of labour, use of syntocinon for augmentation of labour and need for assisted delivery.

Anticipate shoulder dystocia at birth especially if assistance is required. Have a low threshold for trial in theatre for instrumental delivery.

Post Delivery

The insulin dose needs to be REDUCED to pre-pregnancy levels IMMEDIATELY after delivery. For some women with T2DM, this may mean stopping the insulin.
(The advice is available in the patient's notes and CWS)

Continue VRIII until they are back on regular meals. Check CBGs hourly, and U&Es every 6 hours, whilst on VRIII.

Instructions for switching from VRIII to subcutaneous insulin –
At the next mealtime, give the short acting insulin (pre-pregnancy dose OR as advised by the diabetes team OR if no information is available, then half of the current insulin dose) followed by a meal. Stop the VRIII and substrate infusion 30 min after the short-acting insulin dose.

Ensure the long-acting insulin is continued at their usual time (pre-pregnancy dose OR as advised by the diabetes team OR half the current dose, if the dose has not been documented).

If breastfeeding, the insulin dose may need to be reduced further (10-25%). Women should consider taking additional 10-15g of carbohydrate each time they feed/express milk to avoid hypoglycaemia, and they should be prepared to reduce insulin dose based on calorie and carbohydrate intake.

If there is frequent hypo/hyperglycaemia, inform the DICE team (or medical team OOH) and do not discharge from the hospital until the CBG readings are stabilised.

Women will continue to check their fasting (on waking up in the morning) and pre-meal, and 1hour post-meal CBG levels, until discharged. Women using continuous glucose monitoring systems (Dexcom/ Free style Libre) could continue using these postnatally.

Insulin dosage should be reviewed daily and in conjunction with the DICE team before discharge.

TREATMENT TARGET: 6-10mmol/l

Care of Baby

Neonate will be observed for signs of hypoglycaemia as per protocol (see appendix 3- Prevention and Management of Neonatal Hypoglycaemia)

Aim to minimise separation of baby from the mother through close monitoring and timely intervention. Feed the baby soon after birth (1st feed within 30 minutes) and continue to feed every 2-3 hours to maintain pre-feed plasma glucose >2mmol/l.

Babies in transitional care, need to be observed for at least 24 hours of age and only be discharged when feeding well and maintaining blood glucose levels.

Care of women on the Postnatal Ward and discharge planning

Women are advised to continue monitoring their blood glucose levels while in the hospital as instructed by the team looking after them during pregnancy.

Women are encouraged to adjust their insulin doses as per the capillary blood glucose recordings or Continuous Glucose Monitoring Systems (CGMS) and can seek advice from their DSNs. If women need additional help to maintain blood glucose levels, seek advice from DICE team (e-referral on CWS/ bleep)

Follow instructions as in the birth plan regarding advice for postnatal follow up.

Women should be reminded of the importance of contraception and the need for preconception care when planning future pregnancies.

Elective Caesarean Section

If the gestation at planned delivery by CS is < 35+6 weeks, women require Betamethasone or Dexamethasone along with supplemental VRIII, in the week prior to the CS date, if they have not already had the steroids. Sometimes it may become necessary to deliver before the steroid course is completed.
If delivery is planned by CS after 36 weeks gestation, consider the role of steroids in preventing RDS/NEC/IVH vs risks of worsening of diabetes control, increasing risk of RDS and ADHD – discuss with parents as per RCOG guidance and take into consideration the gestation and clinical urgency for delivery.
(see section on preterm labour below). Appendix-2

Women whose diabetes requires multidose insulin would be admitted the previous night unless they choose to arrive very early on the morning of the surgery.

Ensure that the long acting/basal insulin (i.e. Glargine/Lantus; Detemir/Levemir; Insulatard; Humulin I) is taken as usual on the previous day.

Short acting insulin and oral hypoglycaemic agents are not taken on the day.

Women will be fasted from midnight and will only need the VRIII commenced should their blood sugars become a problem overnight. Commence VRII on the morning of the procedure (between 6am-7am) in all women with T1DM and T2 women on multidose insulin.

Hourly capillary blood glucose readings to be checked from waking (including during the surgery- ½ hourly if general anaesthetic) and VRIII commenced if capillary blood glucose readings >7mmol/l in those with diet controlled T2DM or those on oral hypoglycaemic agents.

Check U&Es at the time of commencing VRIII and every 6 hours if on VRIII.

Continue VRIII and hourly capillary blood glucose monitoring until normal eating commences when **pre-pregnancy insulin** should be started as documented in the birth plan.

Switching from VRIII to subcutaneous insulin (bolus/short acting) involves giving the short acting insulin **(pre-pregnancy dose**- as advised by the diabetes team – if no information is available- half the current insulin dose) followed by a meal. The IV infusion is stopped after 30 minutes. Stop dextrose infusion at the same time as IV insulin

Nausea, vomiting and complications during or after surgery may necessitate a delay in the switch over from IV to S/C short acting insulin and this should be individualised. Additional fluids may be required based on clinical situation or restriction of fluids if there is pre-eclampsia when total IV fluid infusion may need to be taken into consideration to achieve fluid balance.

Basal/long acting insulin-(pre pregnancy dose) is continued on the day of the operation (along with VRIII, if patient has not commenced eating.) As long as patient is on VRIII, capillary blood glucose should be checked hourly.

Emergency Caesarean Section

Women may already be on VRIII. Continue to check CBGS hourly (½ hourly if GA). Follow the instructions as above for switching from VRIII to pre-pregnancy dose of short acting insulin and frequency of BM monitoring. The long acting (basal) insulin is continued with dose reduction after delivery.

Preterm Labour

Follow the Health Board's guidance for Diagnosis and Management of Preterm Labour.

In in preterm labour, offer steroids for fetal lung maturity if gestation <33^{+6} weeks and consider steroids for gestations between 34-35+6 weeks, with -
Betamethasone (12mg, 2 doses 24 hours apart - if labour is progressing 12 hours apart)
OR
Dexamethasone(6mg, 4 doses 12 hours apart).
Steroid use will usually be associated with rapid deterioration in maternal glycaemic control and can even precipitate DKA in women with T1DM. The most effective way to control steroid-induced hyperglycaemia is by VRIII.

Commence Supplemental IV Insulin (use the proforma –appendix 2) along with first dose of steroid.

Use the Supplemental IV Insulin Regime **in addition to their usual subcutaneous insulin as long as the patient is eating normally**. Dextrose infusion is not given in this regime.

Use the pro forma to record dose of insulin and hourly capillary blood glucose for 12 hours after the last dose of Dexamethasone or 24 hours after last dose of Betamethasone.

U&Es are checked at commencement of supplemental VRIII and every 24 hours for the duration of therapy.

Follow the HB's guidance for use of tocolysis during steroid therapy.

If needing in-utero transfer- follow All Wales in-utero transfer guideline. The supplemental VRIII can be safely continued during transfer whilst continuing to check hourly capillary blood glucose recordings.

* See GHT DIR 1221 Management of Diabetic Ketoacidosis in Adults (DKA) - ISSUE 2.PDF
** See GHT/DIR/Guide to the management of Hypoglycaemia in Adult

Steroid & Intrapartum Management of Patients on Continuous Insulin Infusion Pumps (CSII)

Type I Diabetes on CSII (Insulin Pump)

Managing steroid induced hyperglycaemia using CSII

Corticosteroids may be given to promote fetal lung maturation. Steroid treatment can significantly elevate blood glucose levels and women are usually admitted for 24-48 hours. The response to steroids is unpredictable with increases in insulin requirements potentially ranging from 20-100%. The effect on glucose persists for about 24 hours after the last steroid dose.

The key to successfully managing blood glucose levels over this period is frequent monitoring at least hourly during the day and two hourly overnight. The patient's CGM (Continuous Blood Glucose Monitor or FreeStyle Libre – Flash Glucose Monitoring) can both be used but a finger-stick glucose test must be done at least every 4 hours.

A discussion would have taken place in the antenatal clinic with regards to the patient using their own Insulin Pump to manage the steroid induced hyperglycaemia, and that she would be responsible for the management of her glucose testing and pump.

In the Antenatal clinic the woman would also have been advised with regards to the pump adjustments whilst on steroids:

Algorithm 1:

1. Check BG hourly daytime and 2 hourly overnight
2. If blood glucose >10 check capillary ketones.
3. Adjust pump as follows

    - Day 1 (on which 1st dose of steroid given): 6 hours after 1st dose use temporary basal rate of 125%

- Day 2: put the temporary increase on the basal rate up to 140%, and increase the patient's usual bolus doses by 40%
- Day 3: put the temporary increase on the basal rate up to 140%, and increase the patient's usual bolus doses by 40%
- Day 4: put the temporary increase on the basal rate down to 120%, and the patient's usual bolus doses by 20%
- Day 5 put the temporary increase on the basal rate down to 110%, and the patient's usual bolus doses by 10%
- Day 6: gradually reduce to pre-steroid levels

4. Use correction doses as required.
5. **VRIII without glucose should be added**:

    - If blood glucose is not within target after two correction boluses (assessed one hour after the 2nd correction)
    - If Ketones are > 0.5 mmol/l

6. Finger-stick glucose (NOT sensor glucose) should be used to adjust VRIII. Midwives are responsible for ensuring finger-stick glucose is checked hourly and for adjusting VRIII. The patient continues to be responsible for managing her CSII.

Algorithm 2:

1. Check blood glucose hourly in the day and two hourly overnight.
2. Target 4-8 mmol. Glucose can be monitored using the sensor or flash monitor but must have a finger-prick test every 4 hours.
3. At 4-6 hours after the first steroid dose, start a 50% temporary basal rate increase (150% of usual basal insulin infusion rate). This may need to be adjusted.
4. At 4-6 hours after first steroid dose, increase the mealtime bolus by 50%. This is best achieved by using the bolus calculator as normal. Then adding 50% to the recommended dose and overriding.
5. Additional corrective doses should be given using the patient's usual insulin sensitivity factor and target. Corrective doses may be given every hour if needed.
6. VRIII without glucose should be added:

    - If blood glucose is not within target after two correction boluses (assessed one hour after the 2nd correction)
    - If Ketones are > 0.5 mmol/l

Pre delivery

1. Birth plan discussion and documentation at 34-36/40
2. Some patients on CSII prefer to remain on the pump whilst in labour / C Section. A discussion with regards to this matter is usually had at 34-36 weeks and documented in their birth plan.
3. For those who wish to continue on CSII, they must be aware it is their responsibility as well as their partner's to manage the pump whilst in labour. **The patient must understand that most staff on the labour ward will NOT be familiar with insulin pumps.**
4. Post-partum settings programmed in the pump in advance as an additional basal profile ready for it to be used after birth.

Checklist for labour ward bag for woman using Diabetes technology

Hypoglycaemia treatment of your choice	
Carbohydrate and non-carbohydrate snacks	
Glucose meter and strips	
Hospital menu carbohydrate content	
Insulin pump users	
Spare sets of batteries x 2	
Reservoirs / cartridges x 2	
Vial of rapid-acting insulin x 1	
Infusion sets (including lines) x 5 and inserter device (if using)	
Insulin syringes x 10	
Vial of long-acting insulin	
Information about using insulin pump through birth (if applicable)	
Information about post-birth pump settings	
Sensor users	
Spare sensor and inserter device	
Transmitter charger (if applicable)	
Reader/receiver/phone charger	

CSII/Insulin pump- care in established labour

1. For those who wish to continue with their CSII, Continuous Glucose Monitoring (CGM) has been shown to be accurate during delivery. Women using CGM or Flash Glucose Monitoring (FreeStyle Libre), can continue to use this during delivery ensuring that the glucose level is checked at least hourly. However if the sensor glucose is out of target 4-7 mmol/L, a capillary blood glucose level should be checked before action is taken. In addition, capillary blood glucose should be checked at least 4 hourly.

2. ***The patient must be switched to VRIII immediately and the pump switched off if:***

    - She is unable to manage her own insulin needs.

- Capillary blood glucose >7.0 mmol/L on two consecutive occasions despite corrections.
- If she has urinary ketones ++ or more on urinary dipstick or high capillary blood ketones (> 1.5 mmol/L).

3. If a VRIII is started capillary blood glucose should be checked hourly (CGM or flash glucose monitoring SHOULD NOT be used to adjust intravenous variable rate insulin infusions). Use the Obs- VRIII chart.

CSII/Insulin pump- care after birth

1. Immediately after birth, basal rates should be reduced to the planned postpartum basal rates, or a 50% temporary basal rate can be used. As soon as possible after birth (and certainly before the first bolus), the patient MUST change the bolus calculator settings to her postpartum settings.

2. If the VRIII plus glucose is used, insulin rates should be halved at birth. CSII can be restarted once the patient is able to self-manage the pump. All settings should be changed to the planned postpartum settings. **The VRIII should continue for 60 minutes after restarting CSII.**

3. Insulin requirements drop immediately after birth, and women are at increased risk of hypoglycaemia in the first hours-to-days after birth. The emphasis should be on **avoidance of hypoglycaemia**.

Several factors may contribute to hypoglycaemia including

- Continued action of pregnancy insulin doses (due to large insulin doses and longer duration of insulin action in late pregnancy).
- Continuing to use pregnancy insulin doses/pump settings, which may be due to not changing the settings or not believing that the much lower recommended doses are enough.
- Continuing to aim for tight glycaemic targets of pregnancy.
- Reduced hypo awareness.
- Nausea and vomiting.
- Breastfeeding.

Box 5: Postpartum insulin pump settings

(Note for the first week or so postpartum glucose target range should be 6-10 mmol/l (to avoid hypoglycaemia) and post-meal glucose excursions up to 12-15 mmol/l are expected and acceptable.)

There are four key changes:

Insulin:carbohydrate ratio (I:C ratio)

- Pre-pregnancy settings (consider adjusting to give less insulin if tight glycaemic control pre-pregnancy)
- OR between 1:10g and 1:15g

Insulin sensitivity factor (ISF)

- Pre-pregnancy settings (consider adjusting to give less insulin if tight glycaemic control pre-pregnancy)
- OR 1 unit to reduce glucose by between 3 and 4 mmol/l

Target for bolus calculations

- Maintain single target at 5 mmol/l (consider increasing (e.g. to 6.5 mmol/l) if impaired awareness of hypoglycaemia)

Basal rate:

The basal infusion rate should be reset according to one of the following:

- pre-pregnancy basal rate profile (consider reducing if tight glycaemic control pre-pregnancy), reduced by 20% if breastfeeding
- 50% of the basal rate profile in late pregnancy (any time after 34 weeks of gestation), reduced by a further 20% if breastfeeding
- A total daily basal of 0.25 units/kg based on the woman's pre-pregnancy weight or 0.2 units/kg if breastfeeding

Appendix- Obs VRIII
Appendix- Chart to be used when receiving AN steroids

APPENDIX 4

EQUALITY IMPACT ASSESSMENT GUIDANCE

Aneurin Bevan Health Board

Flowchart for the Completion of the EqIA Paperwork

1. Complete **FORM 1** 'Preparation and Assessment of Relevance & Priority'

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2. Complete **FORM 2** 'Evidence Gathering'

↓

3. Complete **FORM 3** 'Action Plan'

↓

4. Complete **FORM 4** 'Assessment of Relevance and Priority Scoring Chart' **To be scored following consideration of relevant action to be taken**

↓

5. Complete **FORM 5** 'Outcome Report'

FORM 1

Equality Impact Assessment (EqIA)

Form 1

Part A: Preparation and Assessment of Relevance and Priority

Step1: Preparation

1. **What are you equality impact assessing?**

Diabetes in Pregnancy: Care Pathway for Management of Diabetes in pregnancy

2. **Policy Aims and Brief Description - What are its aims, give brief description.**

Guideline to provide support for clinical decision making

3. **Who Owns the Policy? - Who is responsible for the policy/work?**

Clinical Effectiveness forum Author / Mrs A Pinto

4. **Who is involved in undertaking this EqIA? - Who are the key contributors to the EqIA and what are their roles in the process?**

Sian Bailey Senior Midwifery Manager

5. **Other Policies- Describe where this policy/work fits in a wider context.**

Guidelines for Midwives giving care in community settings, Labour Ward guidelines, guideline for Postnatal Care of mother and infant

6. **Stakeholders – Who is involved with or affected by this policy?**

Pregnant Women with Type I, Type II Diabetes and Gestational Diabetes Maternity staff within ABUHB Diabetologists within ABUHB

7. **What factors may contribute to the outcomes of the policy? What factors may detract from the outcomes? These could be internal or external factors.**

Wide distribution and availability of guideline

Next Steps
For the next stage of the EqIA process please see form:
Part A, Step 2 - Evidence Gathering.

FORM 2

Aneurin Bevan Health Board
Equality Impact Assessment: Part A, Step 2 Evidence Gathering

Equality Strand	Evidence Gathered	Does the evidence apply to the following with regard to this policy/work? Tick as appropriate														
		Eliminating Discrimination and Eliminating Harassment		Promoting Equality of Opportunity		Promoting Good Relations and Positive Attitudes		Encouraging Participation in Public Life		Taking account of difference even if it involves treating some individuals more favourably						
Race	There is evidence that diabetes is more prevalent in the Asian population however this guideline is for all pregnant women presenting with Type I and Type II Diabetes		✓		✓		✓									
Disability	There is no evidence identified to demonstrate that a person's disability will affect operation of this guideline		✓		✓		✓									
Gender	There is no evidence identified to demonstrate that a person's gender will affect operation of this guideline as this guideline is specifically for pregnant women		✓		✓		✓									
Sexual Orientation	There is no evidence identified to demonstrate that a person's sexual orientation will affect operation of this guideline		✓		✓		✓									
Age	There is no evidence identified to demonstrate that a person's age will affect operation of this guideline		✓		✓		✓									
Religion/ Belief	There is no evidence identified to demonstrate that a person's religion/belief will affect operation of this guideline		✓		✓		✓									
Welsh Language	There are facilities for translation if required		✓		✓		✓									
Human Rights																

*This column relates only to disability due to the DDA 2005 specific duty

FORM 3

Aneurin Bevan Health Board
Equality Impact Assessment Action Plan

Name of Policy:

Recommendation	Expected Outcome	Divisional/Department Response	Responsible person	Progress to date
No additional actions required				

FORM 4

Aneurin Bevan Health Board: Equality Impact Assessment
Assessment of Relevance and Priority – Scoring Chart

Name of Policy:

Equality Strand	Evidence: Existing evidence to suggest some groups affected gathered from Part A Step 2.	Potential Impact: Nature, profile, scale, cost, numbers affected, significance.	Decision: Multiply 'Evidence' score by 'Potential Impact' score. ** please see bottom of the page for maths rule*
Race	1	3	3
Disability	1	3	3
Gender	1	0	0
Sexual Orientation	1 1	3	3
Age	1	3	3
Religion/ Belief	1	3	3
Welsh Language	1	3	3
Human Rights	1	3	3

Evidence Available	
3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Potential Impact	
-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Impact Decision	
-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

* Rule: Multiplication of a negative number by a positive number yields a negative result.
Multiplication of two positive numbers yields a positive result.
Multiplication of two negative numbers yields a positive result.

FORM 5

Aneurin Bevan Health Board
Equality Impact Assessment (EqIA) Outcome Report

Policy Title:	Diabetes in Pregnancy: Care Pathway for management of diabetes in pregnancy
Organisation:	Aneurin Bevan University Health Board
Name of policy Assessors:	Sian Bailey Senior Midwifery manager
Division/ Department:	Family & therapies division Maternity Services
Proceed to Full EqIA:	The assessors are satisfied that as there are no negative impacts identified in this assessment a full EqIA is not required.
Summary of the EqIA process and key points to be actioned:	This EqIA has been undertaken using the tool kit designed by the NHS Wales Centre for Equality & Human Rights. The tool kit gives due consideration to each statutory limb of the Equality Act (2010) and in keeping with an inclusive equality agenda also includes consideration of the Welsh Language Act and the Human Rights Act. This report is not intended to provide a definitive account of the content and outcome of the EqIA screening process but offers a summary of the findings. In this instance no negative differential is identified
Responsibility for validation of the EqIA:	Maternity Service Clinical Effectiveness forum
Date:	**10TH January 2024**
Monitoring Arrangements:	This Guideline will be monitored via the Maternity Services Clinical Effectiveness forum
Policy expiry: date:	**10th January 2027**

This information is available on request in a range of accessible formats, Welsh and other community languages as required.

For more information please contact:
Aneurin Bevan Health Board Policy Process Manager:-
01495 765460

APPENDIX 5

CHECKLIST FOR THE APPROVAL AND RATIFICATION PROCESS OF POLICIES AND OTHER WRITTEN CONTROL DOCUMENTS

CHECKLIST FOR THE APPROVAL AND RATIFICATION OF POLICIES AND OTHER WRITTEN CONTROL DOCUMENTS

Please note that no policies or other written control documents should be taken to the [enter sub-committee name] for ratification, unless they have been seen and approved by the [enter the name of the sub group or forum].

Name of Policy or written control document:
Diabetes in Pregnancy: Care Pathway for management of diabetes in pregnancy

Owner(s): Maternity Services
Expiry Date: 17 September 2018

1.	Please specify the date and name of person who carried out the policy or other written control document Equality Impact Assessment	Date: 17 September 2015 Name: Jayne Beasley Senior Midwifery manager
2.	Have you taken into consideration the relevant legislation that may be applicable to this policy or other written control document?	Yes ✓ No
	Comments: ……	
3.	Has a patient information leaflet been developed to assist this policy or written control document?	Yes ✓ No Not Applicable
	If yes, is the information available in the variety of accessible formats and languages? *(including welsh and other community languages as appropriate)*	
	Comments: .....……Translation services available…….……...	
4.	Where appropriate, have you consulted with the relevant services/personnel throughout the Aneurin Bevan Health Board when completing the policy or other written control document?	Yes ✓ No
	(e.g. Voluntary, Legal, Pharmacy, IT, Finance, personnel, etc.)	
	Comments: ……..	

5. If applicable, please state what training has been identified as a result of this policy or other written control document, and what has been taken:
(Has the training department been informed of any training needs?)

……..…Training is undertaken via the local junior medical staff

training forums……..

6. Have the necessary users been consulted in the development of this policy or written control document?

(e.g. Aneurin Bevan Health Board, Division/Locality wide, Third Sector, etc.)

Yes [✓] No [ ] Not Applicable [ ]

Please provide details: ……..
sent to all maternity staff, relevant medical staff and GP's for comment

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7. Has the necessary Equality Impact Assessment documentation been completed?

Yes [✓] No [ ]

If no, give reason(s):

……

……

8. Has the necessary Environment Impact Assessment been completed?

Yes [✓] No [ ] Not Applicable [ ]

If no, give reason(s):

……

……

Ratification

The [enter name of committee, group or forum] has considered the information and agrees/ratifies on [17 September 2015].

Chair signature ……Mrs J Singh
Maternity Services Clinical Effectiveness forum.

Comments:

……..……

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