NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Diabetes in pregnancy

NICE quality standard

Draft for consultation

July 2022

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| **This quality standard covers** managing diabetes and its complications in women who are planning a pregnancy or are already pregnant. It includes care for women with pre-existing diabetes before and during pregnancy, and diagnosis and management of gestational diabetes. It describes high-quality care in priority areas for improvement.The quality standard uses the term 'women' throughout. This should be taken to include people who do not identify as women but who are planning a pregnancy or are already pregnant.This quality standard will update and replace the existing [quality standard on diabetes in pregnancy](https://www.nice.org.uk/guidance/qs109) (published January 2016). The topic was identified for update following a review of quality standards. The review identified:* changes in the priority areas for improvement
* updated guidance on diabetes in pregnancy

For more information see [update information](http://www.nice.org.uk/guidance/qsXXX/chapter/Update-information).This is the draft quality standard for consultation (from 5 July to 9 August 2022). The final quality standard is expected to publish in January 2023.  |

# Quality statements

[Statement 1](#_Quality_statement_1:) Women with diabetes who are of childbearing potential are offered pre‑conception planning advice at diabetes care reviews. **[new 2022]**

[Statement 2](#_Quality_statement_2:) Women with pre-existing diabetes are seen by members of the joint diabetes and antenatal care team within 1 week of informing their healthcare professional they are pregnant. **[2015, updated 2022]**

[Statement 3](#_Quality_statement_X) Women with diabetes are supported to self-monitor their blood glucose levels during pregnancy. **[2015, updated 2022]**

[Statement](#_Quality_statement_[X]) 4 Women diagnosed with gestational diabetes are offered postnatal and annual testing of blood glucose levels and referred to the NHS Diabetes Prevention Programme if eligible. **[new 2022]**

In 2022 this quality standard was updated and statements prioritised in 2015 were updated (2015, updated 2022) or replaced (new 2022). For more information, see [update information](#_Update_information_2).

The [previous version of the quality standard for](http://www.nice.org.uk/guidance/QS109/documents) diabetes in pregnancy is available as a pdf.

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| Questions for consultation Questions about the quality standard**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?**Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?**Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.Questions about the individual quality statements **Question 4** For draft quality statement 1: For measurement purposes, an age range of 15 to 50 years has been suggested to identify women and girls of childbearing potential. Is this age range reasonable and, if you do not feel it is, please suggest the age range that should be used? Local practice case studies**Question 5** Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form. |

# Quality statement 1: Pre‑conception planning

## Quality statement

Women with diabetes who are of childbearing potential are offered pre‑conception planning advice at diabetes care reviews. **[new 2022]**

## Rationale

It is important that women with diabetes are prepared for pregnancy, to reduce the risk of adverse outcomes. Having an HbA1c level below 48 mmol/mol can reduce the risk of miscarriage, stillbirth and neonatal death. Taking high dose (5 mg per day) folic acid can reduce the risk of women with diabetes having a baby with a neural tube defect, such as spina bifida (when the spine and the spinal cord do not develop completely). If women with diabetes are planning a pregnancy, they can inform their healthcare professional and folic acid can be prescribed.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of women with diabetes who are of childbearing potential and attend a diabetes care review who are offered advice about pre‑conception planning.

Numerator – the number in the denominator who are offered advice about pre‑conception planning.

Denominator – the number of women with diabetes who are of childbearing potential and attend a diabetes care review.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. While childbearing potential depends on the individual, for measurement purposes an age range of 15 to 50 years could be used.

### Outcome

a) Percentage of pregnancies in women with diabetes where 5 mg folic acid was taken at the time of the last menstrual period.

**Data source:** The [National Pregnancy in Diabetes Audit](https://digital.nhs.uk/data-and-information/publications/statistical/national-pregnancy-in-diabetes-audit/2019-and-2020)measures this. Data can also be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Percentage of pregnancies in women with diabetes with early HbA1c less than 48 mmol/mol. **Data source:** The [National Pregnancy in Diabetes Audit](https://digital.nhs.uk/data-and-information/publications/statistical/national-pregnancy-in-diabetes-audit/2019-and-2020)measures this. Data can also be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

c) Percentage of women with diabetes who were well prepared for pregnancy.

**Data source:** The [National Pregnancy in Diabetes Audit](https://digital.nhs.uk/data-and-information/publications/statistical/national-pregnancy-in-diabetes-audit/2019-and-2020)measures this. Data can also be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

## What the quality statement means for different audiences

**Service providers** (such as GP practices and community and secondary care diabetes services) ensure that during diabetes care reviews, women of childbearing potential are informed of the importance of pre‑conception planning and the steps they should take before becoming pregnant and when their pregnancy is confirmed.

**Healthcare professionals** (such as GPs, practice nurses and diabetes nurse specialists) inform women of childbearing potential during diabetes care reviews of the importance of pre‑conception planning. This includes the importance of ensuring their HbA1c levels are below 48 mmol/mol before pregnancy and taking folic acid before and for the first 12 weeks of pregnancy.

**Commissioners** (such as integrated care systems and NHS England) ensure that they commission services in which diabetes care reviews include the importance of pre‑conception planning for women of childbearing potential.

**Women with diabetes who could become pregnant** are offered advice about planning a pregnancy at their diabetes care reviews. This advice includes keeping their HbA1c below 48 mmol/mol and taking a high dose of folic acid before they become pregnant. This can be prescribed for them by their healthcare professional.

## Source guidance

[Diabetes in pregnancy: management from preconception to the postnatal period. NICE guideline NG3](https://www.nice.org.uk/guidance/ng3) (2015, updated 2020), recommendations 1.1.2, 1.1.4, 1.1.11 and 1.1.18, and expert opinion

## Definitions of terms used in this quality statement

### Women and girls of childbearing potential

Childbearing potential should be determined on an individual basis. It should not be determined solely by age because childbearing potential can be dependent on factors other than age. However, for measurement purposes, the age range of 15 to 50 years could be used.

[Adapted from [NICE’s guideline on antenatal and postnatal mental health](https://www.nice.org.uk/guidance/cg192) and [National Pregnancy in Diabetes Audit](https://digital.nhs.uk/data-and-information/publications/statistical/national-pregnancy-in-diabetes-audit/2019-and-2020)]

## Equality and diversity considerations

Women from ethnic minority groups are more likely to have unplanned pregnancies and less likely to have a measure of long-term glycaemic control in the 6 months before pregnancy. Healthcare professionals should actively encourage these women to attend regular diabetes care reviews, where the importance of pregnancy planning can be emphasised.

## Question for consultation

For measurement purposes, an age range of 15 to 50 years has been suggested to identify women and girls of childbearing potential. Is this age range reasonable and, if you do not feel it is, please suggest the age range that should be used?

# Quality statement 2: Joint diabetes and antenatal team care

## Quality statement

Women with pre-existing diabetes are seen by members of the joint diabetes and antenatal care team within 1 week of informing their healthcare professional they are pregnant. **[2015, updated 2022]**

## Rationale

Women with diabetes who become pregnant need extra care in addition to routine antenatal care. Members of the joint diabetes and antenatal care team can ensure that specialist care is provided to minimise adverse pregnancy outcomes. Immediate access to the joint diabetes and antenatal care team can help to ensure that a woman's diabetes is controlled during early pregnancy. This is the period when there is an increased risk of foetal loss and anomalies. It will also help to ensure that the woman's care is planned appropriately throughout her pregnancy. Immediate access means within 1 week of the woman informing her healthcare professional that she is pregnant and can be in person or virtually, as appropriate.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of women with pre-existing diabetes who are seen by members of the joint diabetes and antenatal care team within 1 week of informing their healthcare professional that they are pregnant.

Numerator – the number in the denominator who are seen by members of the joint diabetes and antenatal care team within 1 week of informing their healthcare professional that they are pregnant.

Denominator – the number of pregnant women with pre-existing diabetes.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient satisfaction surveys.

### Outcome

Perinatal mortality.

**Data source:** The [National Pregnancy in Diabetes Audit](https://digital.nhs.uk/data-and-information/publications/statistical/national-pregnancy-in-diabetes-audit/2019-and-2020)measures this. Data can also be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

## What the quality statement means for different audiences

**Service providers** (such as GP practices and community and secondary care diabetes services) ensure that referral pathways are in place so that pregnant women with pre-existing diabetes are seen, in-person or virtually where appropriate, by members of the joint diabetes and antenatal care team. Women are seen within 1 week of informing their healthcare professional they are pregnant.

**Healthcare professionals** (such as GPs, midwives and members of the joint diabetes and antenatal care teams) ensure that women with pre-existing diabetes are referred immediately to the joint diabetes and antenatal care team when they inform their healthcare professional that they are pregnant. The joint diabetes and antenatal care team see pregnant women with pre-existing diabetes, in-person or virtually where appropriate, within 1 week of the pregnancy being confirmed to a healthcare professional.

**Commissioners** (such as integrated care systems and NHS England) ensure that they commission joint diabetes and antenatal care teams that see pregnant women with pre-existing diabetes, in-person or virtually where appropriate, within 1 week of the pregnancy being confirmed to a healthcare professional.

**Women with diabetes who become pregnant** are seen by members of the joint diabetes and antenatal care team, in-person or virtually where appropriate, within 1 week of telling their healthcare professional, for example their GP or diabetes specialist nurse, that they are pregnant. The joint team will work together throughout the woman’s pregnancy to make sure that her care is planned appropriately.

## Source guidance

[Diabetes in pregnancy: management from preconception to the postnatal period. NICE guideline NG3](https://www.nice.org.uk/guidance/ng3) (2015, updated 2020), recommendation 1.3.37

The 1‑week timeframe is derived from expert consensus to support measurability for achieving 'immediate contact', which is the wording within the source recommendation in the [NICE guideline on diabetes in pregnancy](https://www.nice.org.uk/guidance/ng3). It is considered a practical timeframe to enable stakeholders to measure performance.

## Definitions of terms used in this quality statement

**Joint diabetes and antenatal care team**

A clinic with a multidisciplinary team consisting of an obstetrician, endocrinologist or diabetologist, diabetes specialist midwife, diabetes specialist nurse and dietician. [Expert opinion]

# Quality statement 3: Self-monitoring of blood glucose levels during pregnancy

## Quality statement

Women with diabetes are supported to self-monitor their blood glucose levels during pregnancy. **[2015, updated 2022]**

## Rationale

Women with diabetes need to be able to self-monitor their blood glucose during pregnancy. Frequent monitoring helps all women with diabetes to maintain good blood glucose control throughout pregnancy. This reduces the risk of adverse outcomes, such as a baby that is large for gestational age, trauma during birth, neonatal hypoglycaemia and perinatal death. The likelihood of caesarean section and neonatal intensive care unit admissions should also be lower.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

a) Proportion of pregnant women with type 1 diabetes who use rtCGM.

Numerator – the number in the denominator who use rtCGM.

Denominator – the number of pregnant women with type 1 diabetes.

**Data source:** No routinely collected national data for this measure has been identified. The [National Pregnancy in Diabetes Audit](https://digital.nhs.uk/data-and-information/publications/statistical/national-pregnancy-in-diabetes-audit/2019-and-2020)began collecting data on which women use isCGM and rtCGM in 2021.

b) Proportion of pregnant women with gestational or pre-existing diabetes who have access to equipment to regularly test their blood glucose levels.

Numerator – the number in the denominator who have access to equipment to regularly test their blood glucose levels.

Denominator – the number of pregnant women with gestational or pre-existing diabetes who are not using rtCGM or isCGM.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records and in patient satisfaction surveys.

c) Proportion of pregnant women with type 1 diabetes who are unable to use rtCGM or express a clear preference for isCGM, who use isCGM.

Numerator – the number in the denominator who use isCGM.

Denominator – the number of pregnant women with type 1 diabetes who are unable to use rtCGM or express a clear preference for isCGM.

**Data source:** No routinely collected national data for this measure has been identified. The [National Pregnancy in Diabetes Audit](https://digital.nhs.uk/data-and-information/publications/statistical/national-pregnancy-in-diabetes-audit/2019-and-2020)began collecting data on which women use isCGM and rtCGM in 2021

d) Proportion of pregnant women who are on insulin therapy but do not have type 1 diabetes and have problematic severe hypoglycaemia or have unstable blood glucose levels causing concern, who use rtCGM.

Numerator – the number in the denominator who use rtCGM.

Denominator – the number of pregnant women who are on insulin therapy but do not have type 1 diabetes and have problematic severe hypoglycaemia or have unstable blood glucose levels causing concern.

**Data source:** No routinely collected national data for this measure has been identified. The [National Pregnancy in Diabetes Audit](https://digital.nhs.uk/data-and-information/publications/statistical/national-pregnancy-in-diabetes-audit/2019-and-2020)began collecting data on which women use isCGM and rtCGM in 2021.

### Outcome

a) Adverse foetal and neonatal outcomes for babies of women with diabetes.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. The [National Pregnancy in Diabetes Audit](https://digital.nhs.uk/data-and-information/publications/statistical/national-pregnancy-in-diabetes-audit/2019-and-2020) collects data on congenital anomalies and serious adverse outcomes and their association with HbA1c levels in early pregnancy. It also collects data on the relationship between HbA1c levels in late pregnancy and the percentages of babies admitted to neonatal care, preterm live births before 37 weeks, perinatal deaths and babies who are large for gestational age.

b) Maternal diabetic complications.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

## What the quality statement means for different audiences

**Service providers** (such as GP practices and community and secondary care diabetes services) ensure that pregnant women with type 1 diabetes are given a real-time continuous glucose monitor (or an intermittently scanned continuous glucose monitor if they are unable to use real-time or prefer intermittently scanned). A real-time continuous glucose monitor can also be considered for pregnant women who are on insulin therapy but do not have type 1 diabetes. Women with type 2 diabetes or gestational diabetes are given a blood glucose monitor that suits them and are prescribed enough testing strips for their needs. Service providers also ensure that, whichever type of blood glucose monitoring a woman is using during pregnancy, she is supported to use it confidently to self-monitor her blood glucose levels.

**Healthcare professionals** (GPs, community midwives and healthcare professionals in joint diabetes and antenatal care teams) ensure that they give pregnant women with diabetes the most appropriate type of blood glucose monitor and, if needed, testing strips. They support the woman to use whichever type of blood glucose monitor she prefers, to ensure she can use it confidently to self-monitor her blood glucose levels.

**Commissioners** (such as integrated care systems and NHS England) ensure that they commission services that provide blood glucose monitoring equipment, including rtCGM or isCGM where appropriate, to pregnant women with diabetes. For pregnant women with diabetes for whom rtCGM or isCGM is not suitable, commissioners ensure that the services provide them with enough testing strips for their needs.

**Pregnant women with diabetes** are supported to monitor their blood glucose. Pregnant women with type 1 diabetes can use rtCGM, or isCGM if they are unable to use rtCGM or prefer isGCM. rtCGM can also be considered for pregnant women who are on insulin therapy but do not have type 1 diabetes. Women with type 2 diabetes or gestational diabetes have a blood glucose monitor that suits them and are prescribed enough testing strips for their needs.

## Source guidance

[Diabetes in pregnancy: management from preconception to the postnatal period. NICE guideline NG3](https://www.nice.org.uk/guidance/ng3) (2015, updated 2020), recommendations 1.1.13, 1.2.11, 1.3.17 and 1.3.18.

## Equality and diversity considerations

Pregnant women with type 1 diabetes, or those who don’t have type 1 diabetes but are on insulin therapy, living in deprived areas are less likely to use rtCGM. This is also the case for pregnant women with Black or Asian family backgrounds. It is therefore important for services to work closely with these groups to ensure that they are aware of the benefits of rtCGM and that they can access it and any additional equipment if they want to use it.

Pregnant women with diabetes should be given information about blood glucose monitoring that they can easily read and understand themselves, or with support, so they can communicate effectively with health and social care services. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally and age appropriate. People should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

# Quality statement 4: Care following gestational diabetes

## Quality statement

Women diagnosed with gestational diabetes are offered postnatal and annual testing of blood glucose levels and referred to the NHS Diabetes Prevention Programme if eligible. **[new 2022]**

## Rationale

Women who have been diagnosed with gestational diabetes are at significant risk of developing type 2 diabetes within 5 to 10 years. Type 2 diabetes can be prevented if women are referred to the NHS Diabetes Prevention Programme. Those who would benefit from being referred can be identified through postnatal and annual glucose checks.

In addition, postnatal and annual testing of blood glucose levels can identify the small number of women who have previously undiagnosed type 1 diabetes.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

a) Proportion of women who were diagnosed with gestational diabetes who had a fasting plasma glucose test at 6 to 13 weeks after the birth.

Numerator –the number in the denominator who had a fasting plasma glucose test 6 to 13 weeks after the birth.

Denominator – the number of women who were diagnosed with gestational diabetes.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. For practical reasons this test might take place at the 6 to 8 weeks GP postnatal check.

b) Proportion of women with previous gestational diabetes who have an annual HbA1c test.

Numerator – the number in the denominator who had a HbA1c test in the previous 12 months.

Denominator – the number of women who had gestational diabetes and gave birth more than 12 months ago.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

c) Proportion of women with gestational diabetes and raised blood glucose levels 6 – 13 weeks after birth who are referred into the NHS Diabetes Prevention Programme.

Numerator – the number in the denominator who were referred into the NHS Diabetes Prevention Programme.

Denominator – the number of women, in the previous 12 months, who had gestational diabetes and raised blood glucose levels 6 to 13 weeks after birth.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records and referrals.

d) Proportion of women with previous gestational diabetes and raised blood glucose levels at an annual HbA1c test who are referred into the NHS Diabetes Prevention Programme.

Numerator – the number in the denominator who were referred into the NHS Diabetes Prevention Programme.

Denominator – the number of women who had gestational diabetes and gave birth more than 12 months ago whose blood glucose levels were raised at an HbA1c test in the previous 12 months.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records and referrals.

### Outcome

a) Identification of pre-existing type 1 diabetes in women who were diagnosed with gestational diabetes.

**Data source:**No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Rates of type 2 diabetes in women diagnosed with gestational diabetes.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

## What the quality statement means for different audiences

**Service providers** (such as GP practices and community and secondary care diabetes services) ensure that systems and pathways are in place for women diagnosed with gestational diabetes to have:

* a fasting plasma glucose test 6 to 13 weeks after the birth to exclude diabetes
* a fasting plasma glucose test after 13 weeks if this has not been done earlier, or an HbA1c test if a fasting plasma glucose test is not possible
* a referral into the NHS Diabetes Prevention Programme if eligible based on the results of the fasting plasma glucose test or HbA1c test
* an annual HbA1c test.

**Healthcare professionals** (such as GPs, practice nurses and diabetes nurse specialists) offer women diagnosed with gestational diabetes:

* a fasting plasma glucose test 6 to 13 weeks after the birth to exclude diabetes
* a fasting plasma glucose test after 13 weeks if this has not been done earlier, or an HbA1c test if a fasting plasma glucose test is not possible
* a referral into the NHS Diabetes Prevention Programme if eligible based on the results of the fasting plasma glucose test or HbA1c test
* an annual HbA1c test.

**Commissioners** (such as integrated care systems and NHS England) ensure that they commission services in which women diagnosed with gestational diabetes have postnatal testing to exclude the possibility of pre-existing type 1 diabetes and assess the need for referral to the National Diabetes Prevention Programme. They ensure the services they commission make referrals to the National Diabetes Prevention Programme where test results indicate that it is necessary. The services also ensure that annual HbA1c testing is carried out.

**Women diagnosed with gestational diabetes** are offered a test of their blood glucose 6 to 13 weeks after their baby is born to check whether they have pre-existing type 1 diabetes or would benefit from referral to the National Diabetes Prevention Programme. If they don’t have this test by 13 weeks following their baby’s birth, they are offered testing afterwards. If it is needed, they are offered referral to the National Diabetes Prevention Programme to help to reduce their risk of developing type 2 diabetes. They are also offered a test of the blood glucose levels every year.

## Source guidance

[Diabetes in pregnancy: management from preconception to the postnatal period. NICE guideline NG3](https://www.nice.org.uk/guidance/ng3) (2015, updated 2020), recommendations 1.6.11 and 1.6.14

# Update information

**June 2022:** This quality standard was updated, and statements prioritised in 2016 were replaced. The topic was identified for update following a review of quality standards. The review identified:

* changes in the priority areas for improvement
* updated guidance on diabetes in pregnancy.

Statements are marked as:

* **[new 2022]** if the statement covers a new area for quality improvement
* **[2016, updated 2022]** if the statement covers an area for quality improvement included in the 2016 quality standard that has been updated.

# About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards) is available from the NICE website.

See our [webpage on quality standards advisory committees](http://www.nice.org.uk/Get-Involved/Meetings-in-public/Quality-Standards-Advisory-Committee) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10157/documents).

NICE has produced a [quality standard service improvement template](https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact products for the [NICE guideline on diabetes in pregnancy: management from preconception to the postnatal period](https://www.nice.org.uk/guidance/ng3) to help estimate local costs.

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10157/documents) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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