NICE National Institute for Health and Care Excellence

NICE quality standard

Diabetes in pregnancy

Quality standard
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www.nice.org.uk/guidance/qs109

Contents

This standard is based on NG3.

This standard should be read in conjunction with QS105, QS37, QS22, QS15, QS6, QS125, QS135, QS180, QS69, QS192 and QS32.

Quality statements

Statement 1 Women with diabetes who are of childbearing potential are offered preconception planning advice at diabetes care reviews. **[new 2023]**

Statement 2 Women with pre-existing diabetes are seen by members of the joint diabetes and antenatal care team as soon as possible after informing their healthcare professional that they are pregnant. **[2016, updated 2023]**

Statement 3 Pregnant women with type 1 diabetes are offered continuous glucose monitoring. **[new 2023]**

Statement 4 Women diagnosed with gestational diabetes are offered postnatal testing of blood glucose levels and referred to the National Diabetes Prevention Programme if eligible. **[new 2023]**

Statement 5 Women diagnosed with gestational diabetes who have negative postnatal testing for diabetes after the birth are offered annual HbA1c testing. **[2016, updated 2023]**

In 2023, this quality standard was updated, and statements prioritised in 2016 were updated (2016, updated 2023) or replaced (new 2023). For more information, see update information.

The previous version of the quality standard for diabetes in pregnancy is available as a pdf.

Quality statement 1: Preconception planning

Quality statement

Women with diabetes who are of childbearing potential are offered preconception planning advice at diabetes care reviews. **[new 2023]**

Rationale

Preconception planning advice for women with diabetes is important because it helps to ensure that they are prepared for pregnancy, which can reduce the risk of adverse outcomes. This advice includes discussing optimal HbA1c levels for pregnancy, taking high-dose folic acid, and advice on medication safety and smoking cessation. 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 preconception planning.

Numerator – the number in the denominator who are offered advice about preconception planning.

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

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. 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 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 who had early pregnancy HbA1c less than 48 mmol/mol.

Data source: The National Pregnancy in Diabetes Audit measures this as under 20 weeks' gestation. 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 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 preconception 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 preconception planning. This includes the importance of smoking cessation, medication safety, trying to ensure their HbA1c levels are below 48 mmol/mol before pregnancy and taking high-dose folic acid before and for the first 12 weeks of pregnancy.

Commissioners (integrated care systems) ensure that they commission services in which diabetes care reviews include the importance of preconception 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 stopping smoking, having a review of their medication to ensure it is safe during pregnancy, trying to reduce their HbA1c to below 48 mmol/mol and taking a high dose of folic acid before they become pregnant. High-dose folic acid can be prescribed for them by their healthcare professional.

Source guidance

Diabetes in pregnancy: management from preconception to the postnatal period. NICE guideline NG3 (2015, updated 2020), recommendations 1.1.2, 1.1.4, 1.1.11, 1.1.18, and expert opinion

Definitions of terms used in this quality statement

Women 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, definition section, National Pregnancy in Diabetes Audit and expert opinion]

Equality and diversity considerations

Self-reported levels of preparation for pregnancy among women with diabetes are lowest in the most deprived communities. Healthcare professionals should actively encourage these women to attend regular diabetes care reviews, where the importance of pregnancy planning can be emphasised.

Women with diabetes should be given information about preconception planning that they can easily read and understand themselves, or with support, so they can communicate effectively with health 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 women with diabetes 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 or the equivalent standards for the devolved nations.

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 as soon as possible after informing their healthcare professional that they are pregnant. **[2016, updated 2023]**

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. Being seen by the joint diabetes and antenatal care team as soon as possible, ideally by 10 weeks' gestation, can help to ensure that a woman's diabetes is controlled during early pregnancy. It will also help to ensure that the woman's care is planned appropriately throughout her pregnancy. The woman can be seen 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

a) Proportion of women with pre-existing diabetes who are seen by members of the joint diabetes and antenatal care team by 10 weeks' gestation.

Numerator – the number in the denominator who are seen by members of the joint diabetes and antenatal care team by 10 weeks' gestation.

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 records and satisfaction surveys.

b) Average wait time for pregnant women with pre-existing diabetes to be seen by members of the joint diabetes and antenatal care team following referral.

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 satisfaction surveys.

Outcome

a) Proportion of women with pre-existing diabetes who have had a review of their medication to ensure it is pregnancy appropriate by 10 weeks' gestation.

Numerator – the number in the denominator who have had a review of their medication to ensure it is pregnancy appropriate by 10 weeks' gestation.

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 records.

b) Optimal diabetes care in pregnancy.

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 patient satisfaction surveys.

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 as soon as possible after informing their healthcare professional they are pregnant, and ideally by 10 weeks' gestation.

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, as soon as possible after the pregnancy is confirmed to a healthcare professional, ideally by 10 weeks' gestation.

Commissioners (integrated care systems) ensure that they commission joint diabetes and antenatal care teams that see pregnant women with pre-existing diabetes, in person or virtually where appropriate, as soon as possible after the pregnancy is confirmed to a healthcare professional, ideally by 10 weeks' gestation.

Women with diabetes who become pregnant are seen by members of the joint diabetes and antenatal care team, in person or virtually where appropriate, as soon as possible after telling their healthcare professional, for example, their GP or diabetes specialist nurse, that they are pregnant. Ideally, they will be seen by the time they are 10 weeks' 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 (2015, updated 2020), recommendation 1.3.37 and table 1

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 a dietician. [Expert opinion]

Quality statement 3: Continuous glucose monitoring

Quality statement

Pregnant women with type 1 diabetes are offered continuous glucose monitoring. **[new 2023]**

Rationale

Continuous glucose monitoring (CGM) allows women with type 1 diabetes to monitor their glucose levels during pregnancy to ensure they can maintain or work towards the level agreed with their healthcare professional. This can help to reduce 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. Women should be offered real-time CGM (rtCGM) but, if they are unable to use rtCGM or would prefer to use intermittently scanned CGM (isCGM, commonly referred to as 'flash'), this should be offered instead.

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.

Services may want to use these measures to focus on dimensions of health inequality, for example, by reporting data grouped by ethnicity or indices of deprivation.

Process

Proportion of pregnant women with type 1 diabetes who use CGM.

Numerator – the number in the denominator who use CGM.

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

Data source: The National Pregnancy in Diabetes Audit began collecting data on the use of CGM in 2021. Data can also be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

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 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) Time in range during pregnancy for 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 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.

c) 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 offered rtCGM (or isCGM if they prefer it or are unable to use rtCGM). Service providers also ensure that they are supported to confidently use the type of CGM they have selected.

Healthcare professionals (GPs, community midwives and healthcare professionals in joint diabetes and antenatal care teams) ensure that they offer pregnant women with type 1 diabetes rtCGM (or isCGM if they prefer it or are unable to use rtCGM). They support the woman to confidently use the type of CGM she has selected.

Commissioners (integrated care systems and NHS England) ensure that they commission services that provide rtCGM or isCGM where appropriate, to pregnant women with type 1 diabetes.

Pregnant women with type 1 diabetes are offered an rtCGM, or an isCGM (commonly referred to as 'flash') if they prefer it or are unable to use rtCGM. They are also supported to confidently use the CGM with which they have chosen to monitor their glucose levels during their pregnancy.

Source guidance

Diabetes in pregnancy: management from preconception to the postnatal period. NICE guideline NG3 (2015, updated 2020), recommendations 1.3.17 and 1.3.18

Definitions of terms used in this quality statement

Continuous glucose monitoring

This covers both rtCGM and isCGM.

A CGM is a device that measures blood glucose levels and sends the readings to a display device or smartphone. [NICE's guideline on type 1 diabetes in adults: diagnosis and management, terms used in this guideline]

Equality and diversity considerations

Pregnant women with type 1 diabetes living in deprived areas are less likely to use CGM. 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 CGM and that they can access it and any additional equipment if they want to use it.

Pregnant women with a physical, mental health related or learning disability may need additional support to use their CGM device.

Commissioners, providers and healthcare professionals should address inequalities in CGM access and uptake by:

- monitoring who is using CGM
- identifying groups who are eligible but who have a lower uptake
- making plans to engage with these groups to encourage them to consider CGM.

[NICE's guideline on type 1 diabetes in adults: diagnosis and management, recommendation 1.6.18]

Pregnant women with type 1 diabetes should be given information about CGM that they can easily read and understand themselves, or with support, so they can communicate effectively with health 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 pregnant women with type 1 diabetes 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 or the equivalent standards for the devolved nations.

Quality statement 4: Postnatal testing and referral

Quality statement

Women diagnosed with gestational diabetes are offered postnatal testing of blood glucose levels and referred to the National Diabetes Prevention Programme if eligible. **[new 2023]**

Rationale

Postnatal blood glucose testing can identify if women have previously undiagnosed type 1 or type 2 diabetes. If women are identified as having diabetes, they will be able to begin treatment. If they do not have diabetes, they can be referred to the National Diabetes Prevention Programme, because women who have gestational diabetes are at significant risk of developing type 2 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 blood test to exclude persisting hyperglycaemia after the birth, before they were transferred to community care.

Numerator – the number in the denominator who had a blood test to exclude persisting hyperglycaemia after the birth, before they were transferred to community care.

Denominator – the number of 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) Proportion of women who were diagnosed with gestational diabetes and whose blood glucose levels returned to normal after the birth 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 whose blood glucose levels returned to normal after the birth.

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. For practical reasons, this test might take place at the 6- to 8-week GP postnatal check.

c) Proportion of women with gestational diabetes who gave birth in the previous 12 months and whose blood glucose levels returned to normal after the birth who were referred into the National Diabetes Prevention Programme.

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

Denominator – the number of women who had gestational diabetes who gave birth in the previous 12 months and whose blood glucose levels returned to normal after the birth.

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 referrals.

Outcome

a) Early 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 blood glucose test to exclude persisting hyperglycaemia after the birth, before they are transferred to community care. For women who were diagnosed with gestational diabetes and whose blood glucose levels returned to normal after the birth, they should have systems in place to ensure women 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 National Diabetes Prevention Programme.

Healthcare professionals (such as GPs, practice nurses, midwives and diabetes nurse specialists) offer women diagnosed with gestational diabetes a blood glucose test to exclude persisting hyperglycaemia after the birth, before they are transferred to community care. For women who were diagnosed with gestational diabetes and whose blood glucose levels returned to normal after the birth, they should also offer:

- 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 National Diabetes Prevention Programme.

Commissioners (integrated care systems) ensure that they commission services in which women diagnosed with gestational diabetes have postnatal testing to exclude the possibility of pre-existing type 1 or type 2 diabetes. They also ensure the services refer women diagnosed with gestational diabetes whose blood glucose levels returned to normal after the birth to the National Diabetes Prevention Programme.

Women diagnosed with gestational diabetes are offered a test of their blood glucose to check whether they have persisting hyperglycaemia (high glucose levels) after they have given birth, before they are transferred to community care. If they do, they will receive treatment for this. If they do not, they are offered another test of their blood glucose 6 to 13 weeks after their baby is born to check again whether they have type 1 or type 2 diabetes. If they do not have this test by 13 weeks following their baby's birth, they are offered testing afterwards. They are also offered referral to the National Diabetes Prevention Programme to help to reduce their risk of developing type 2 diabetes.

Source guidance

Diabetes in pregnancy: management from preconception to the postnatal period. NICE guideline NG3 (2015, updated 2020), recommendations 1.6.8 and 1.6.11

Quality statement 5: Annual HbA1c tests

Quality statement

Women diagnosed with gestational diabetes who have negative postnatal testing for diabetes after the birth are offered annual HbA1c testing. **[2016, updated 2023]**

Rationale

Annual glucose testing for women who previously had gestational diabetes and whose blood glucose levels returned to normal after the birth, can identify changes in glucose levels. This will identify whether the woman is at increased risk of developing or has developed type 2 diabetes. It can also 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

Proportion of women with a record of gestational diabetes and no subsequent diagnosis of diabetes who had a HbA1c test in the previous 12 months.

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

Denominator – the number of women who gave birth more than 12 months ago with a record of gestational diabetes and no subsequent diagnosis of 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, whose blood glucose levels returned to normal after the birth, to have an annual HbA1c test.

Healthcare professionals (such as GPs, practice nurses, midwives and diabetes nurse specialists) ensure that women diagnosed with gestational diabetes, whose blood glucose levels returned to normal after the birth, have an annual HbA1c test.

Commissioners (integrated care systems) ensure that they commission services in which women diagnosed with gestational diabetes, whose blood glucose levels returned to normal after the birth, have an annual HbA1c test.

Women diagnosed with gestational diabetes whose blood glucose levels return to normal after the birth have an annual HbA1c test to check whether they have diabetes.

Source guidance

Diabetes in pregnancy: management from preconception to the postnatal period. NICE guideline NG3 (2015, updated 2020), recommendation 1.6.14

Update information

January 2023: 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 2023]** if the statement covers a new area for quality improvement
- **[2016, updated 2023]** if the statement covers an area for quality improvement included in the 2016 quality standard that has been updated.

The previous version of the quality standard for diabetes in pregnancy is available as a pdf.

Minor changes since publication

March 2022, July 2021 and December 2020: All previous updates are no longer relevant to the statements updated in 2023.

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 is available from the NICE website.

See our webpage on quality standards advisory committees 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.

NICE has produced a quality standard service improvement template 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 statement for the NICE guideline on diabetes in pregnancy: management from preconception to the postnatal period to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard 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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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Diabetes UK
- Royal College of Paediatrics and Child Health
- Royal College of Physicians (RCP)
- Gestational Diabetes UK