Cheshire and Merseyside
Strategic Clinical Networks

Diabetes and Pregnancy

Developed through collaboration between the CVD Strategic Clinical Network and the Maternity, Children and Young People Strategic Clinical Network.

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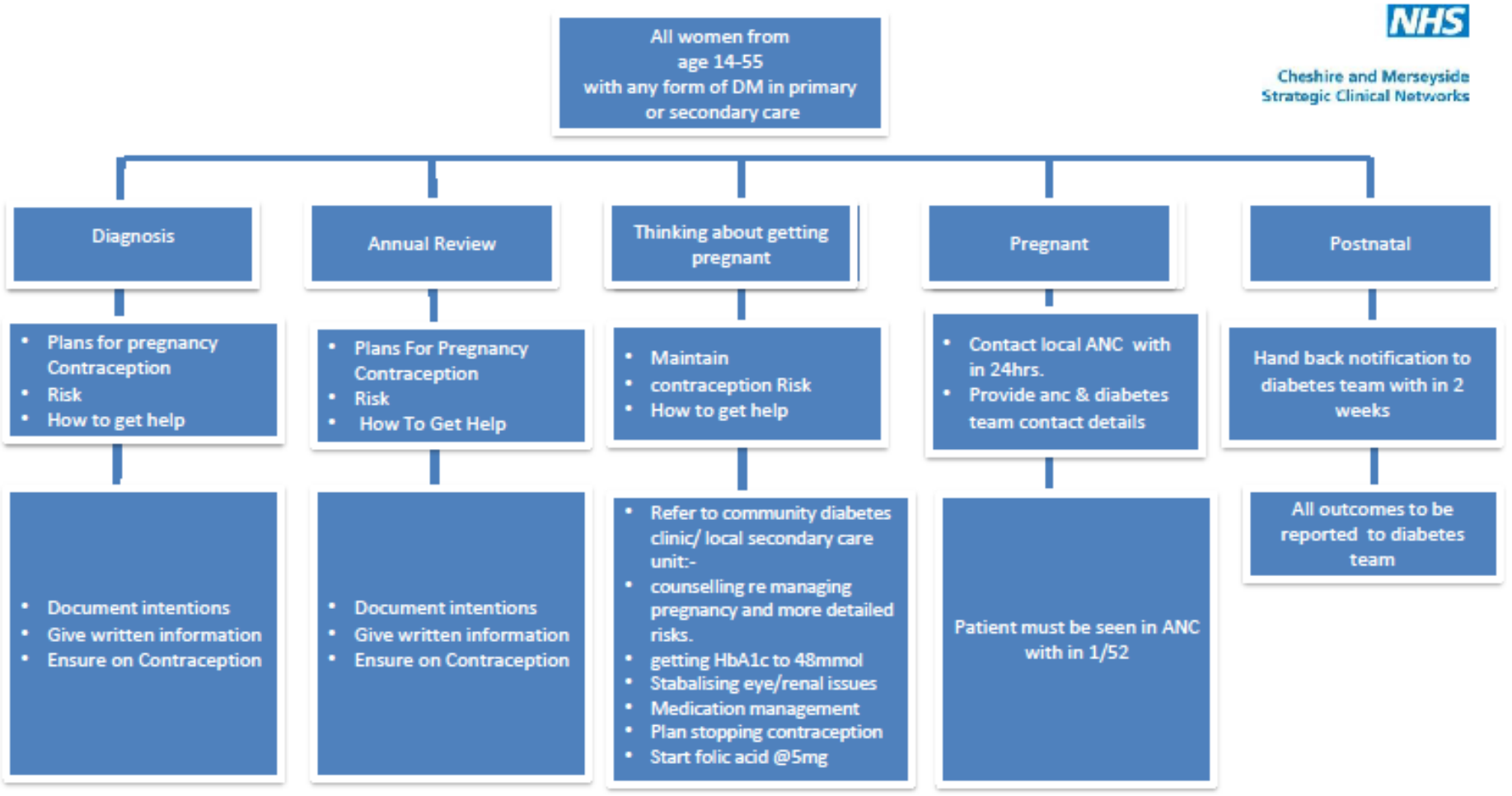
Introduction

Although it is well known that conception with high blood glucose can lead to poor outcomes for women with Diabetes, the ways in which this can be tackled are not clear. A multidisciplinary approach educating women and health care professionals as well as rapid access to optimisation and antenatal clinics is the focus of this document.

There are 4 main themes

1. Pre-Pregnancy education for patients
2. Education and guidance for Healthcare Professionals
3. Optimisation services
4. Caring for Pregnant Women with Diabetes

Diabetes and Pregnancy



The above model should be apply to all women with DM in both primary and secondary care

Pre-Pregnancy education for patients

Pre-Pregnancy Education

- Patients-Group Sessions in Community; On-going Education For Established Patients;
- Newly Diagnosed Patients (Types 1& 2).
- Target Age Range: 14 to 55 years old
- At Annual review
    - Enquire about Contraception; Future Plans
    - Part of GP Template as prompt
- Intermediate Reviews-Pill Checks

Primary Health Care Teams
-GP
-Practice Nurse
-Health Visitors
-Practice Receptionists
-Lead Midwife in Diabetes and Midwifery Team
-Call Centre
-Community-Sexual and Reproductive Healthcare Team
-Obstetricians
-Fertility Services

Signposting

Internet Access/Choose and Book Links

Definite No:	Maybe:	Thinking:	Pregnant:
LARC; Contraceptive Advice at reviews	Contraception; Community/Hospital Optimisation Clinic-Contact Phone Number/Single Point of Contact phone number	Contraception- Local Secondary Care Optimisation Clinic Contact Number/Single Point of Contact phone number	Booking Clinic Phone Number; Diabetes Antenatal Clinic Number(Fast Track); Single Point of Contact Number

Standardised Leaflets for Primary Care for advice-Pregnancy and Diabetes/ Tele health; Websites; DUK; Apps (Diabetes in Pregnancy)

Pre-Pregnancy Education

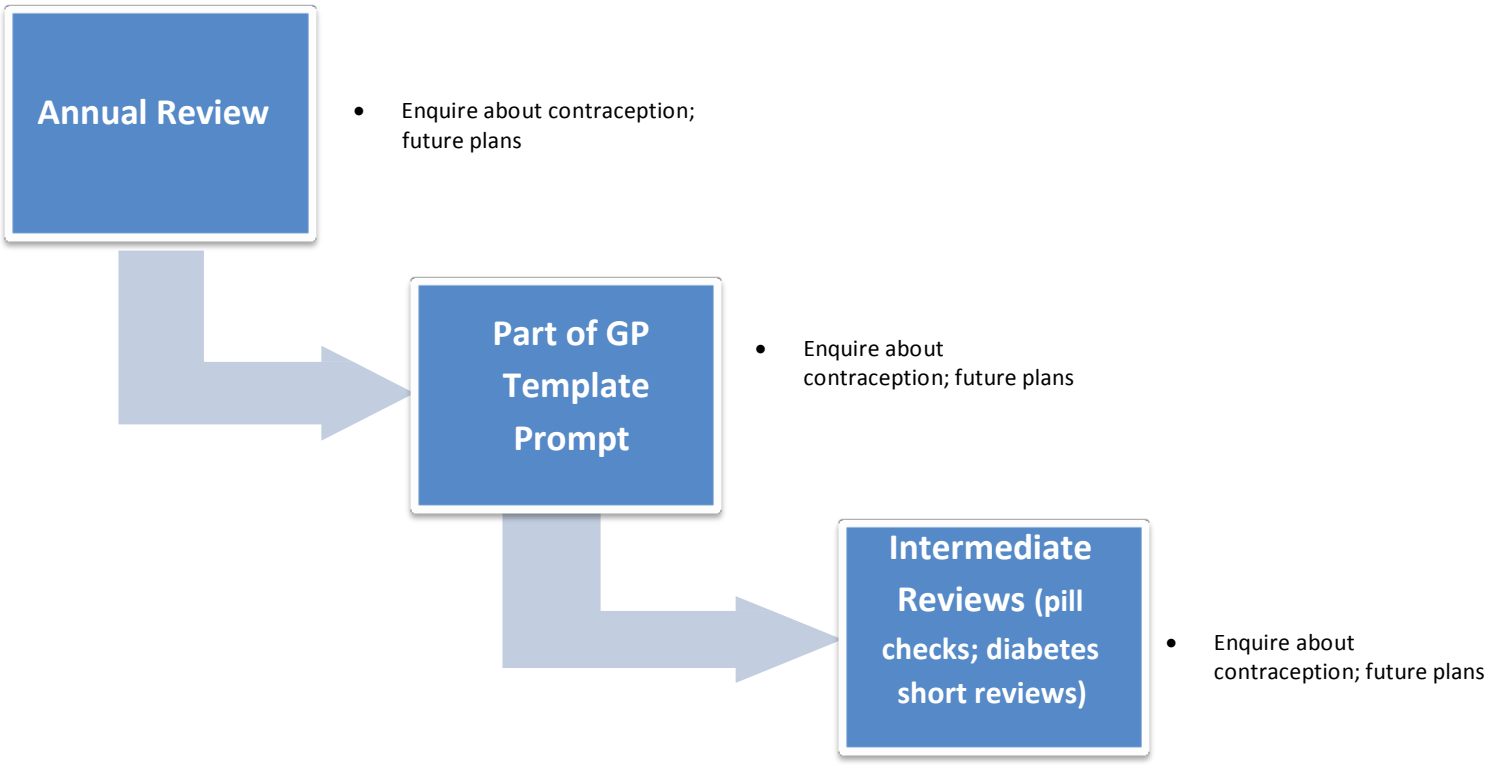
Newly Diagnosed

Target Range: 14 - 55
Community on going education
in practice annual review
By Hospital or community diabetes service

Established Diagnosis

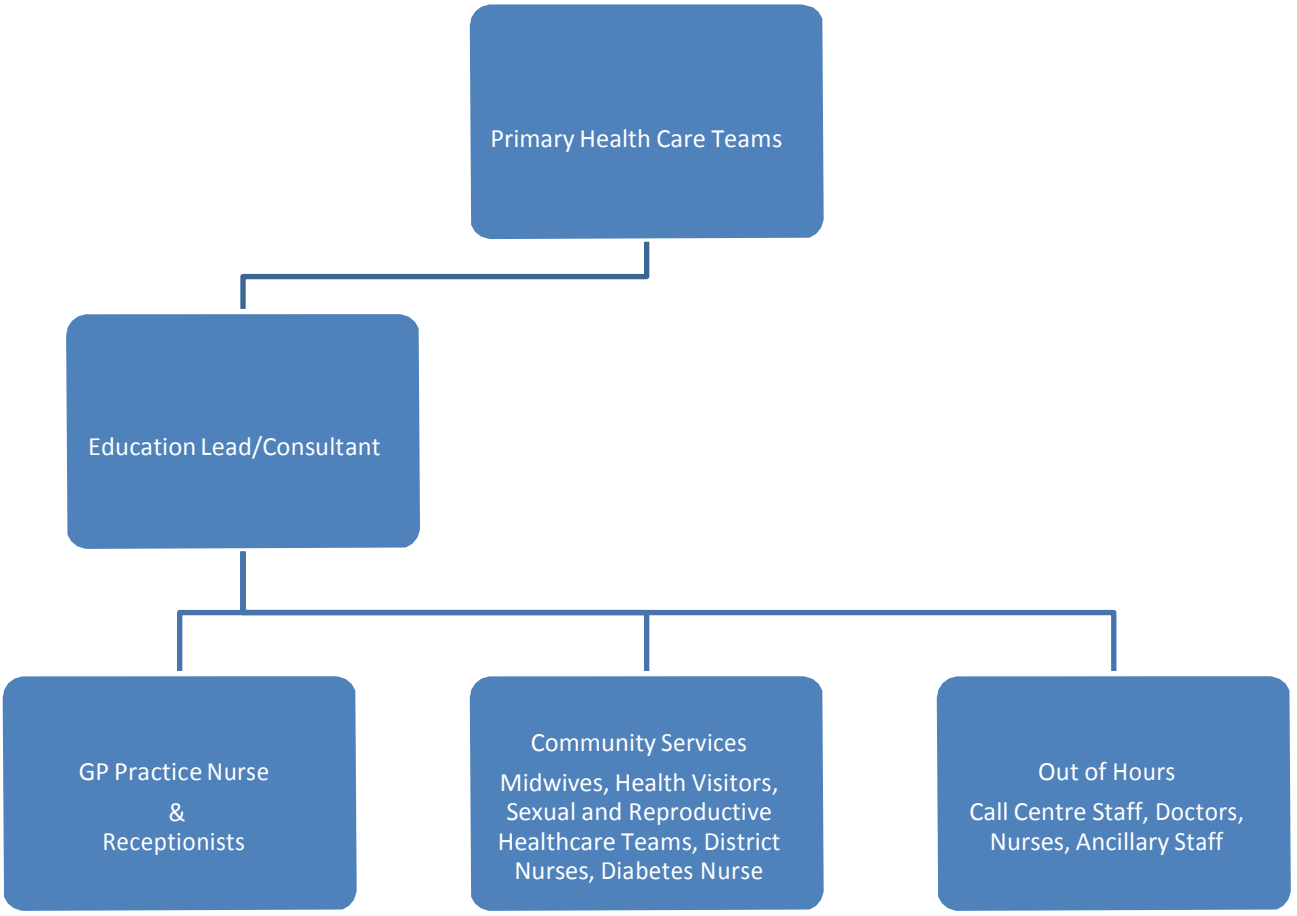
Target range: 14 - 55
Community ongoing education
In practice at annual review
By hospital or community diabetes service

Patient education needs to be delivered by an appropriately trained team or health care professional depending on the setting.

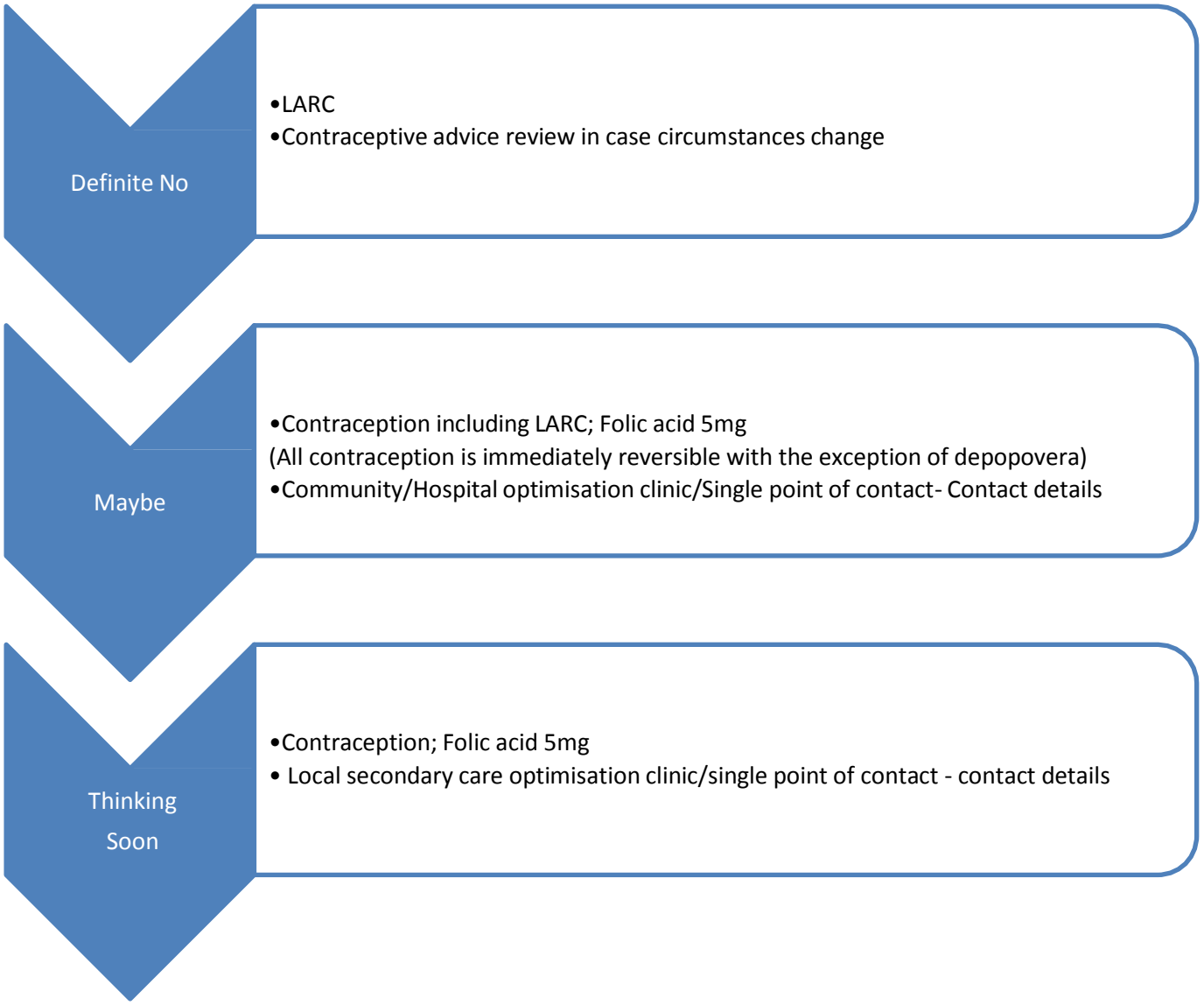


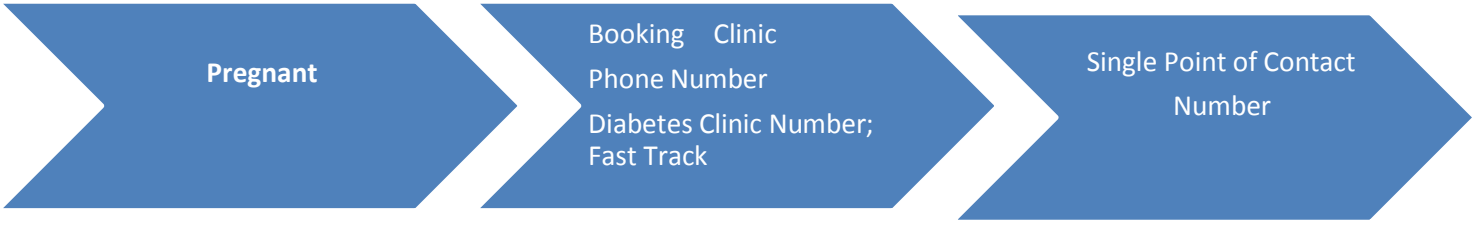
Wider Primary Health Care Team

Education would need to be delivered by a secondary care based educational team (consultant led) at least in the first instance. Appropriate support information will be required for staff at different levels in the chain.



Signposting





In the future there may be internet access/choose and book links for all of the Clinics.

Education for Health Care Professionals

An essential part of this work is to ensure that all Health Care professionals coming into contact with women with diabetes have enough information to educate women about pregnancy and also direct them towards help for optimisation or management if they are planning pregnancy or become pregnant.

Most women with diabetes will meet a number of different healthcare professionals several times a year. Empowering the health care professional to raise the question of pregnancy whilst giving them a good pathway for directing the women to more information or medical help may be a good model to adopt.

Important Healthcare professional groups

- GPs
- Primary care diabetes nurses
- Sexual and Reproductive Healthcare Teams
- Pharmacists
- Secondary care doctors, nurses and podiatrists

Possible approaches to Education for Health care professionals

- Annual region wide teaching events
- Web-based learning modules
- Website for reminding HCPs about what to tell women and how to get them into the correct local service
    - Possible pre-existing information on DUK & NICE Websites. Scope for Map of Medicine

- Reading materials – leaflets, education packs
- Enabling community based practitioners to attend ANC and Optimisation clinics
- Consider basic training for front line HCPs about how to raise the question

Resources

- Information from across region about
    - Optimisation services
    - ANC
    - Help for contraception
- For each of the above – named clinical leads, contact details, frequency of clinics etc.
- Ways in which to communicate this information to HCPs.

Optimisation services

It is known that HbA1c levels as close to 48mmol/mmol as possible before pregnancy will give a woman with diabetes the best outcome both for her own and her baby's health. From discussion within the network it was felt that extra help for these women in terms of education about risk, education about antenatal care and additional input to optimise control could improve outcomes. The two main issues raised in this discussion were that it was not clear when these referrals should occur or to whom the patients should be referred. It became apparent that many parts of the region do have an available optimisation service (either in the community or in secondary care) but the key for all healthcare professional was getting women into them in a timely fashion.

Another key issue is that women will start thinking about pregnancy at a time convenient for them, which is unlikely to coincide with planned health care episodes. Enabling self-referral for optimisation, for example using apps, websites or leaflets about what to do if they want to get pregnant or want more information about pregnancy and diabetes may improve outcomes

For each GP, nurse, secondary care doctor, the following 2 questions should be easily answered

1. What is available in my local area to optimise this patient's care prior to pregnancy?
2. How do I get my patient into this service as soon as possible?

It may be helpful if all the optimisation services work along a similar framework

Possible framework

- Access – patients should be seen within a month of referral
- Patients should be given information about how to Self-refer
- Each patient should receive clear written information about targets and risks, as well as verbal information
- The optimisation service should aim to improve control over 3-6 months
- Structure

Each optimisation service should have access to:-

  - Doctors, DSNs and dieticians and possibly Obstetric team

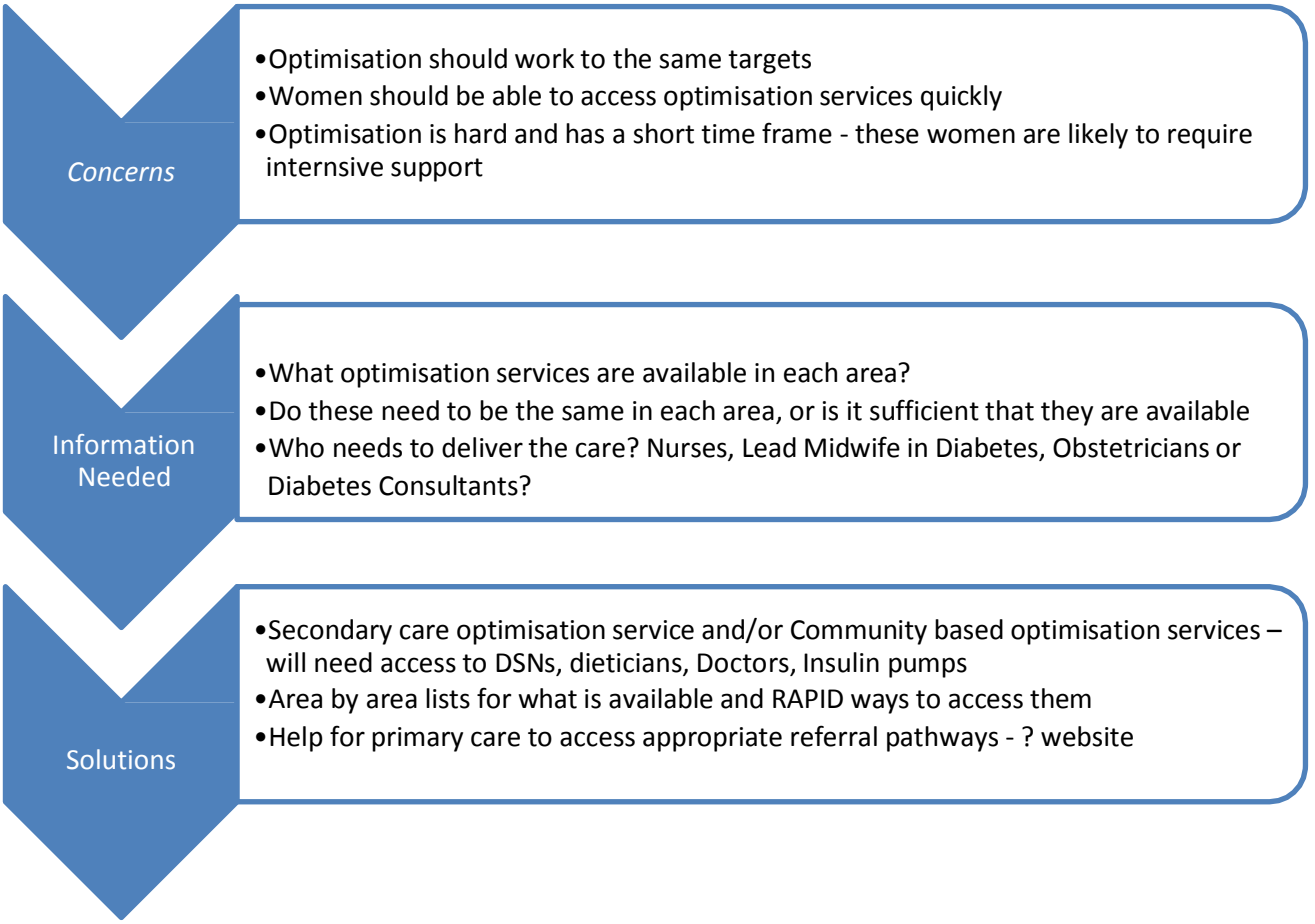
Services

Each optimisation service should be able to offer

- Advice about contraception
- Carbohydrate counting
- Insulin pumps
- Conversion to basal bolus regime
- Management of medication
- Management of BP
- Rapid referral to ophthalmology and renal services
- Initiation of folic acid 5mg

Pre-pregnancy Services

Women need help to optimise their diabetes as well as knowing the facts. Where can they be appropriately optimised?



Pregnant Women with Diabetes

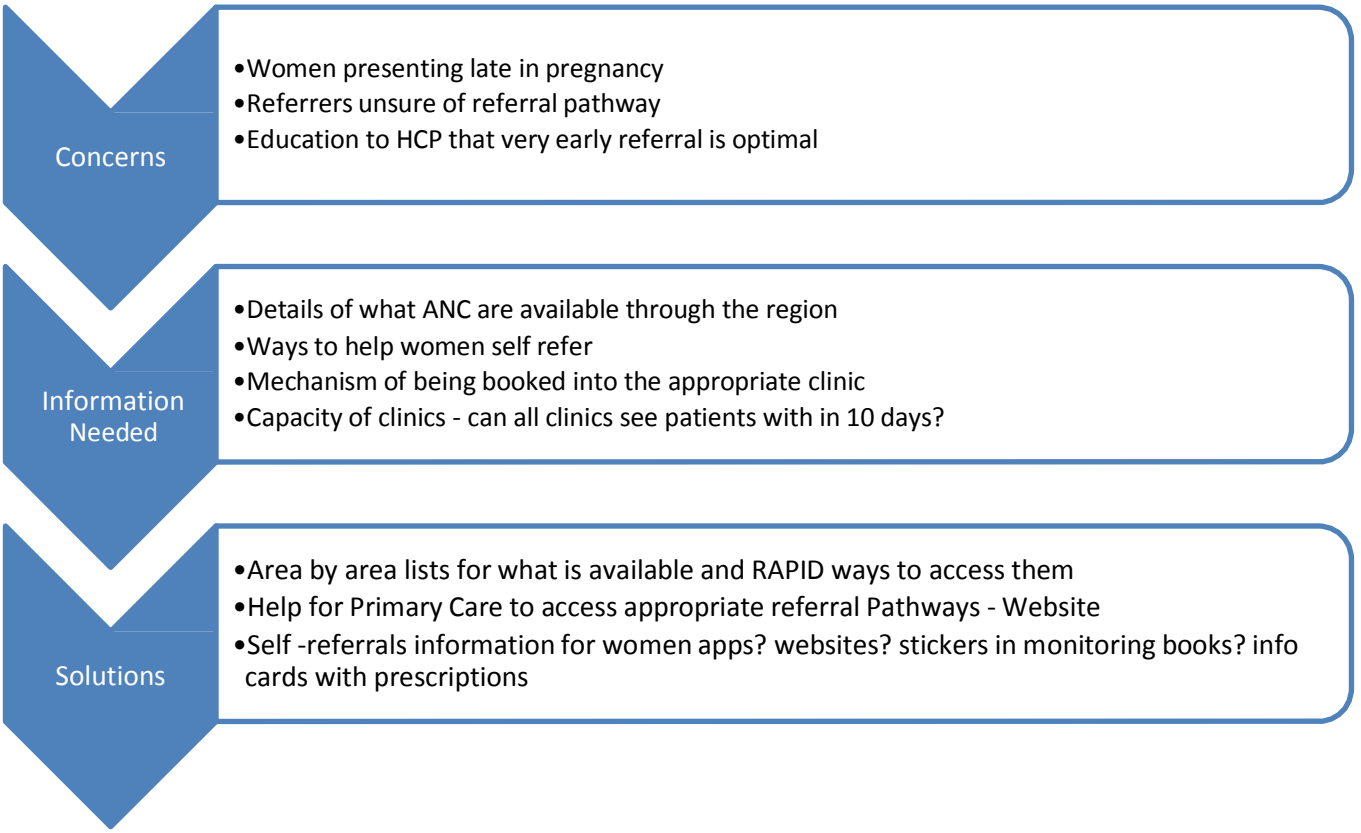
The main concern for both primary and secondary care is rapidity of review in ANC once a patient with diabetes is pregnant. All parts of the region have specialist joint diabetes clinics, so enabling rapid referral is the key.

Concerns that need to be addressed

1. Education for primary care, midwives and patients so it is known that women are seen in clinic as soon as possible (before booking)
2. Women should be seen within a week of their pregnancy being suspected or confirmed
3. Enabling women to self-refer
4. Clear referral pathways for primary and secondary care to ensure speedy referral to ANC. The various services across region need to provide details about how to refer quickly with accurate fax and phone numbers. It may be useful to have a centralised place – e.g. website to keep this information so the information is readily available.
5. Prompt handover back to normal diabetes care with opportunity for post pregnancy support where needed
6. Signpost to support groups or peer support as appropriate

Pregnant

Most areas have joint ANC clinics. They do not all run in the same way – but that is not the scope of this work. Timely access needs to be improved.



Structure

It may be useful to organise the structure according to the local available diabetes ante natal clinic.
I.e. for each geographic area covered by an antenatal clinic, the primary care teams responsible for the patient are made aware of where the patients need to be referred once pregnant, but also the local optimisation options could be linked to the ANC.
This would ideally give the GP and or the patient 2 phone numbers, or e-mail contacts – one for optimisation and one for pregnancy.
Important things for the network to know are therefore:

- Which ANC have a diabetes service, and how are patients referred to it?
- What is available locally for optimisation – is it a secondary care clinic? Is it a clinic attached to Ante natal services? Is there a community specialist clinic? What is the existing referral pathway for optimisation clinics?