Royal Cornwall Hospitals
NHS Trust

Hypoglycaemia
Neonatal Clinical Guideline

V4.2

October 2025

1. Aim/Purpose of this Guideline

1.1. Definition:

Blood glucose < 2.6mmol/l for ≤36+6 weeks.

Blood glucose ≤3.5mmol/l for infants with suspected hyperinsulinism or other metabolic disorder with raised Glucose Infusion Rate (GIR).

1.1.1. These guidelines are based on the BAPM (British Association of Perinatal Medicine) guidance released May 2017.

1.1.2. Blood gas machine measurement of blood glucose is superior to handheld glucometer measurements at low levels (<2.0mmol/l) and is the recommended gold standard method for bedside evaluation. Any result <3.4mmol/L in babies ≤ 36^{+6} or <2.8mmol/L in babies ≥ 37^{+0} on a handheld device **MUST be checked with a blood gas blood glucose IMMEDIATELY due to inaccuracies associated with this device**.

1.1.3. Samples should be taken from a warm heel or free-flowing sample.

1.1.4. No equivalent external evidence-based guideline exists for preterm infants at the time of writing.

1.1.5. We recommend the use of flowcharts A or B (as applicable) for preterm infants below 37 weeks, but with a treatment threshold of **<2.6mmol/l.**

1.1.6. For all babies <2.5Kg refer to RCHT Care of the Newborn Clinical Guideline and RCHT Birth Weight Less Than 2.5kg (Neonates) Standard Operating Procedure .

1.2. **Background**

- Prolonged exposure to hypoglycaemia can cause brain damage.
- Neonates are known to have a physiological fall in their blood glucose levels shortly after birth and for this reason blood glucose levels are not recommended until pre-second feed (4 hours of age) if the baby is well.
- For the majority of babies physiological fall in blood glucose is not a problem if their brains have the normal substrate stores to utilise, but if they don't, they will become neurologically symptomatic and require blood glucose management sooner.
- 40% glucose gel has been found in multiple trials to be effective and safe in managing hypoglycaemia with or without a subsequent feed. **N.B., oral 40% glucose gel does not need to be prescribed as it is not classified as a drug product.**
- This means that 40% glucose gel can now be administered and is not an indication for admission to the NNU (Neonatal Unit).

1.3. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Routine Management to Prevent Hypoglycaemia in all Healthy Babies

- Dry and place skin-to-skin with hat on.
- Maintain warm ambient room temperature and ensure free from draughts.
- Provide skin to skin and ensure this is not interrupted unless there is a medical indication to do so.
- Provide the mother with:
    1. Breastfeeding support.
    2. Information about recognition of early feeding cues (rapid eye movements under the eye lids, mouth and tongue movements, body movements and sounds, sucking on a fist).
    3. Information about signs of effective attachment.
- Assess and document feeding cues and feeding effectiveness with each feed.
- Offer the breast (or formula feed if this is mothers' choice) in response to feeding cues as often as possible.
- Continue feeding support until mother and midwife are satisfied that effective feeding is established.
- If the baby is not showing signs of effective feeding encourage continuous skin-to-skin contact.

2.2. Identifying Babies at Risk of Hypoglycaemia

2.2.1. The babies detailed in section 2.2.2 are at risk of impaired metabolic adaptation and recognition of clinical signs and are at risk of neurological sequelae of neonatal hypoglycaemia, and measures should be in place to identify them at birth for early milk /energy

provision and monitoring of blood glucose. Measure blood glucose before the second feed at 4 hours of age.

They should be placed on **flowchart A in section 2.4 "management of infants at risk of hypoglycaemia".**

2.2.2. Risk Factors

- IUGR (intrauterine growth restriction) (birth weight 2nd centile, Table 1), clinically wasted.
- Premature infants.
- Infants of diabetic mothers (gestational, IDDM or type 2).
- Maternal beta-blockers e.g., labetalol in the third trimester or at time of delivery.
- Perinatal acidosis (cord arterial or infant blood gas **pH <7.1 and /or base deficit ≥ -12mmol/l**).

Table 1.

Birth weight on 2nd centile/kg		
Gestational age/weeks	**Boys**	**Girls**
34	1.5 NNU admission	1.4 NNU admission
35	1.70 NNU admission	<1.80 NNU admission
36	1.90	≤1.80 NNU admission
37	2.10	2.00
38	2.30	2.20
39	2.50	2.45
40	2.65	2.60
41	2.80	2.75
42	2.90	2.85

Please note: All babies born less than 2.5kg should have 12 hrs of NEWS (newborn early warning score) observations completed and documented. A plan for discharge or ongoing admission should be discussed with the Neonatal Registrar after 12 hours of NEWS observations **and** a minimum 24 hour stay are complete. Any concerns prior to completion of 12 hours of observations should be escalated to the Neonatal Team.

All infants with risk factors for impaired metabolic adaptation and hypoglycaemia must not be discharged from hospital until they are at least 24 hours old.

2.3. **Identifying symptomatic babies regardless of risk factors (measure Blood glucose immediately as part of assessment)**

2.3.1. Measurements of blood gas glucose concentration should be performed for any infant who has one or more of the following diagnoses or clinical signs:

- Hypothermia (less than 36.5°C) not attributed to environmental factors.
- Suspected /confirmed early onset sepsis.
- Cyanosis.
- Apnoea.
- Altered level of consciousness.
- Seizures.
- Hypotonia.
- Lethargy.
- High pitched cry.

2.3.2. Jitteriness is not considered a sign suggestive of hypoglycaemia and not by itself an indication to measure blood glucose.

2.3.3. Abnormal feeding behaviour (not waking for feeds, not sucking effectively, appearing unsettled and demanding very frequent feeds), especially after a period of feeding may be indicative of hypoglycaemia.

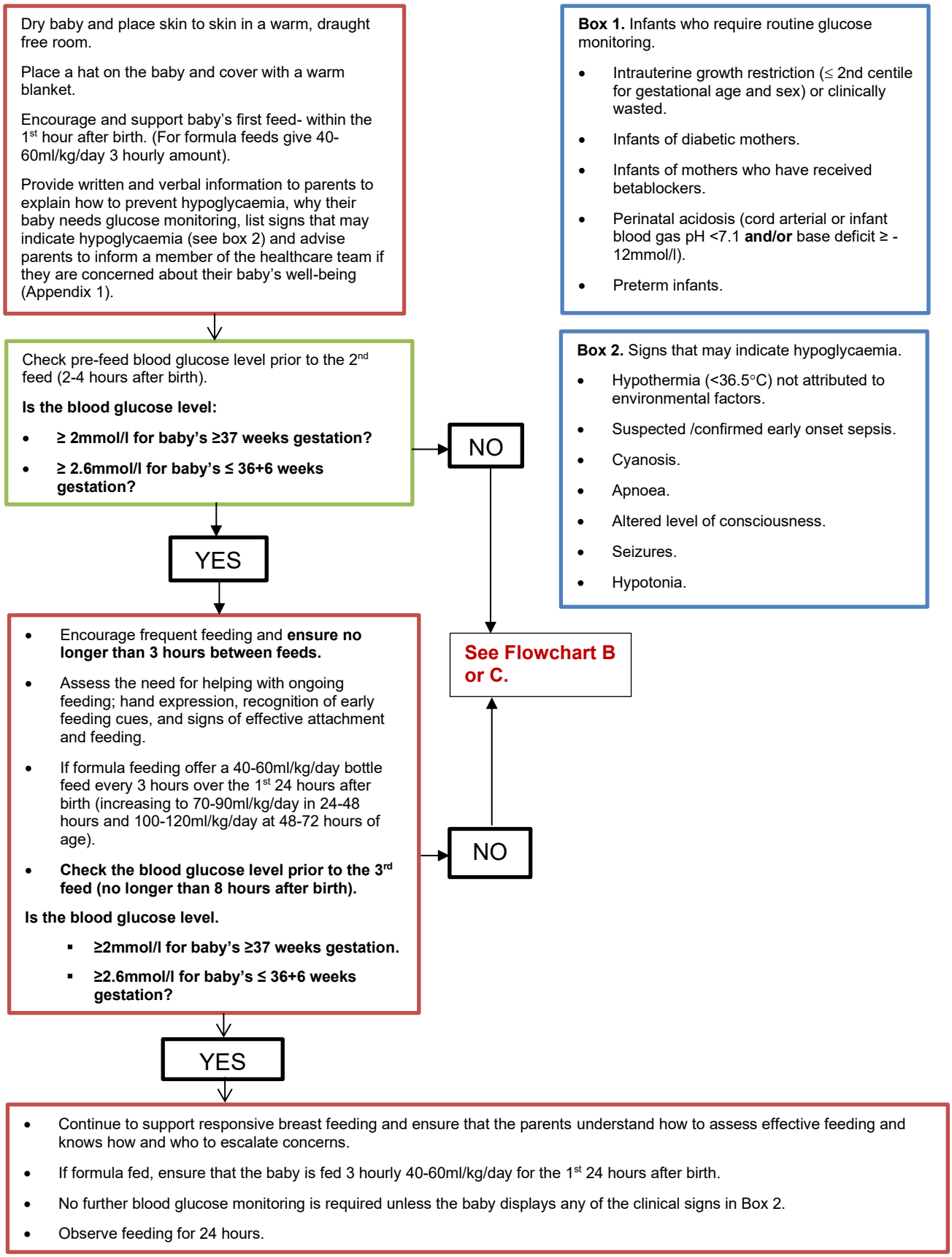
2.3.4. If a baby has abnormal clinical signs suggestive of hypoglycaemia, **blood gas glucose should be measured immediately and urgent review by a Neonatal Doctor or Advanced Neonatal Nurse Practitioner (ANNP) should be sought**. Use flowchart A (2.4.).

2.3.5. Large for gestational age (LGA) Infants should only be monitored if concerns about Beckwith Wiederman, Soto's, Prader-Willi, Turners, or Costello syndrome.

2.4. Flowchart A. Management of infants at risk of hypoglycaemia (Box 1.)

Please see next page.

Flowchart A. Management of infants at risk of hypoglycaemia (Box 1.)



2.5. Additional best practice for babies at risk of hypoglycaemia

In addition to all points in the first green box above, routine management to prevent hypoglycaemia in all healthy babies:

- Do not allow more than 3 hours to pass between feeds, until Blood glucose measurements have been **≥ 2mmol/l for baby's ≥ 37 weeks gestation and ≥ 2.6mmol/l for baby's ≤ 36+6 weeks gestation** on two consecutive occasions.
- Continue feeding support until mother and midwife are satisfied that effective feeding is established.
- If the baby is not showing signs of effective feeding encourage continuous skin-to-skin contact and teach the mother to hand express. Any colostrum expressed should be fed immediately to the baby, using a method that is best suited to the infant's capabilities and parent's preferences and consistent with local policy.

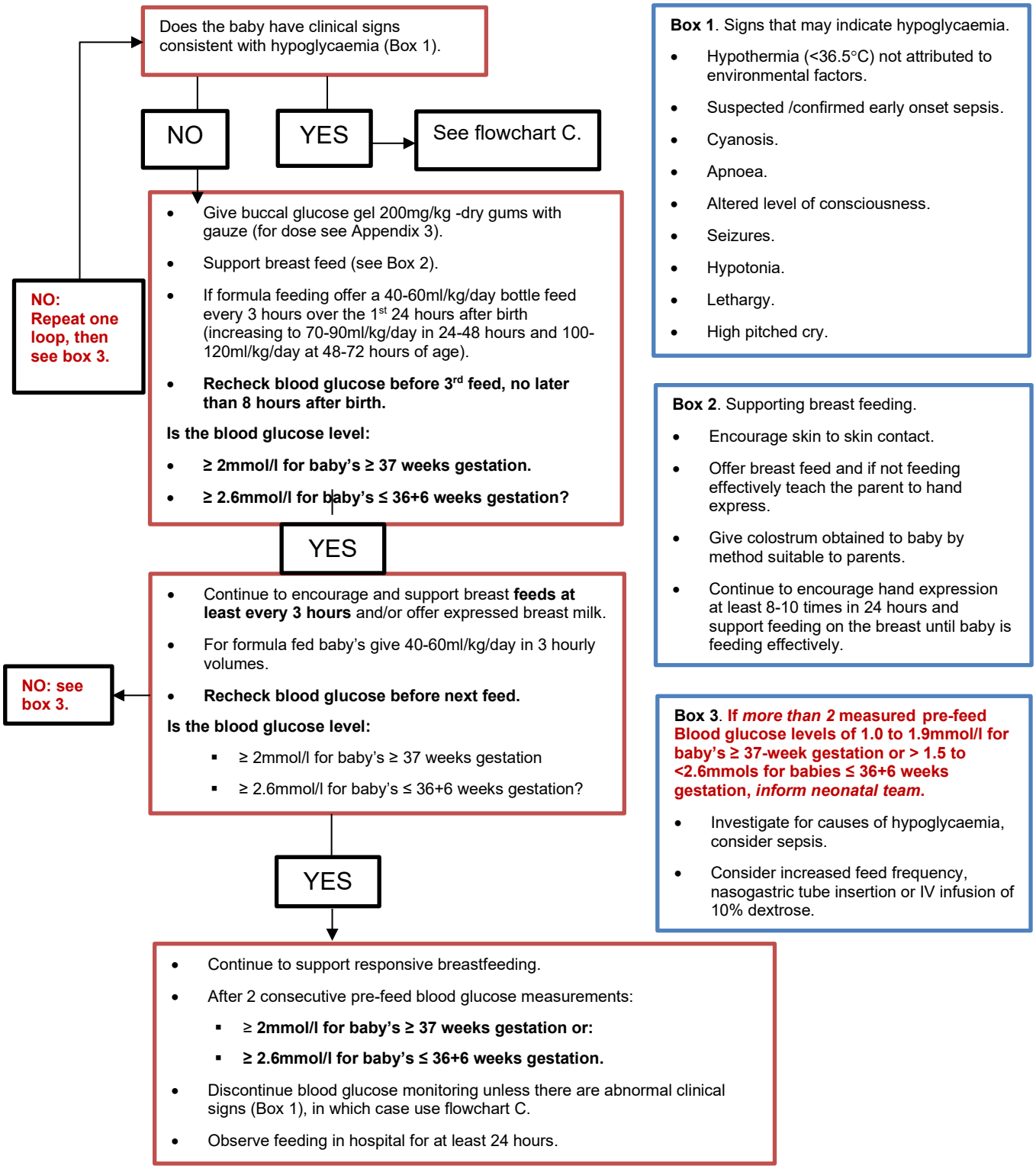
2.6. Management of confirmed hypoglycaemia

When Blood glucose measurements are obtained the baby should be placed onto the appropriate flow chart. **N.B., oral 40% glucose gel does not need to be prescribed as it is not classified as a drug product.**

- **Flowchart B (2.5.1.):** First pre-feed Blood glucose:
  - ≥ 37 weeks gestation and no abnormal signs = 1.0 to 1.9mmol/l.
  - ≤ 36+6 weeks gestation and no abnormal signs = 1.5 to 2.6mmol/l.
- **Flowchart C (2.5.2.):** First pre-feed Blood glucose:
  - Blood gas glucose <1.0mmol/l and /or clinical signs consistent with hypoglycaemia in babies ≥ 37 weeks gestation.
  - Blood gas glucose <1.5 mmol/l and /or clinical signs consistent with hypoglycaemia in babies ≤ 36+6 weeks gestation.

See next page for flowchart B (2.5.1).

2.6.1. Flowchart B. Pre-feed Blood glucose 1.0 to 1.9mmol/l for baby's ≥ 37-week gestation, > 1.5 to <2.6mmols for babies ≤ 36+6 weeks gestation and no abnormal clinical signs, on NNU, Delivery Suite or Postnatal Ward (birth to 72 hours).

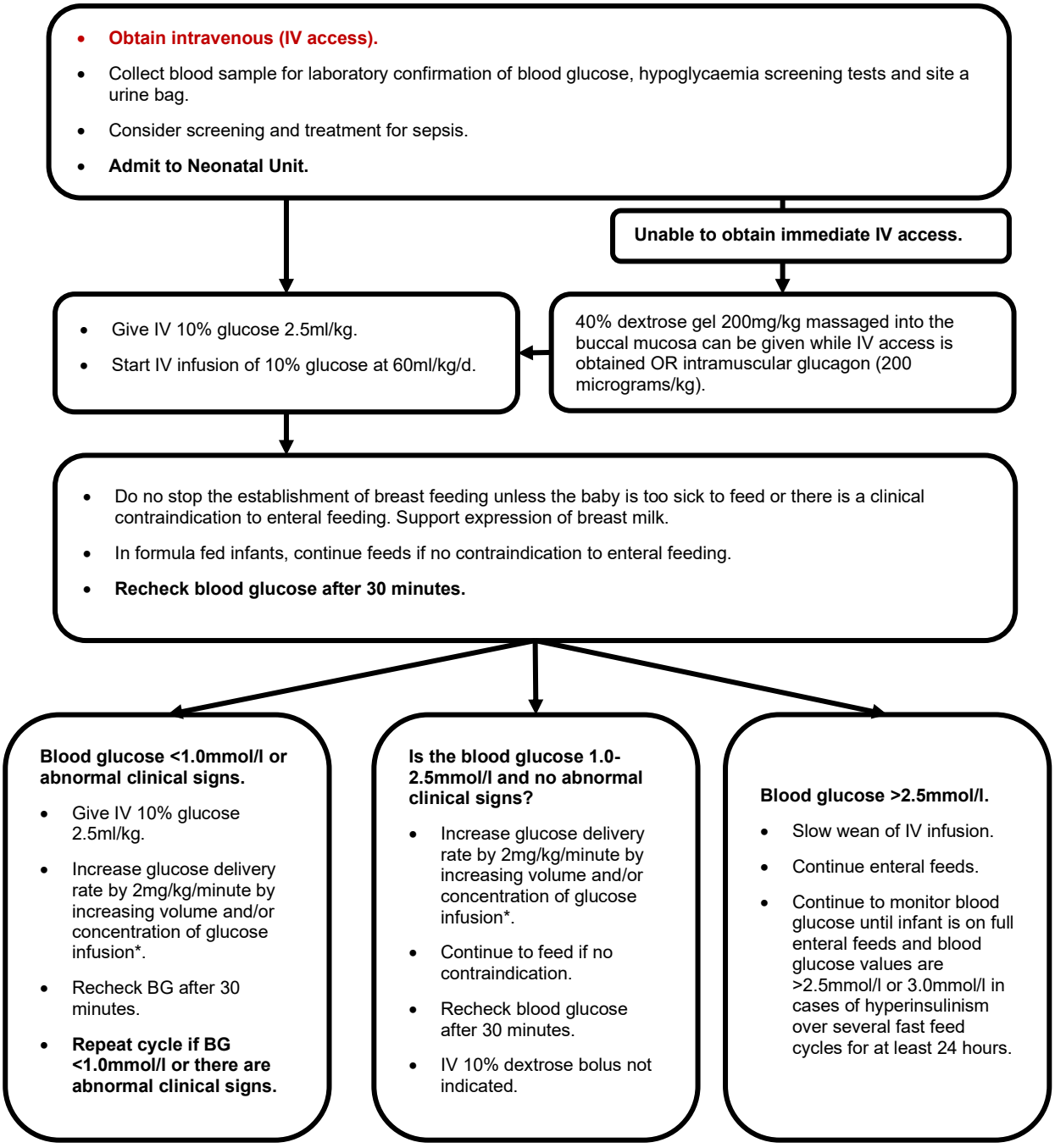


N.B., oral 40% glucose gel does not need to be prescribed as it is not classified as a drug product.

2.6.2. Flowchart C

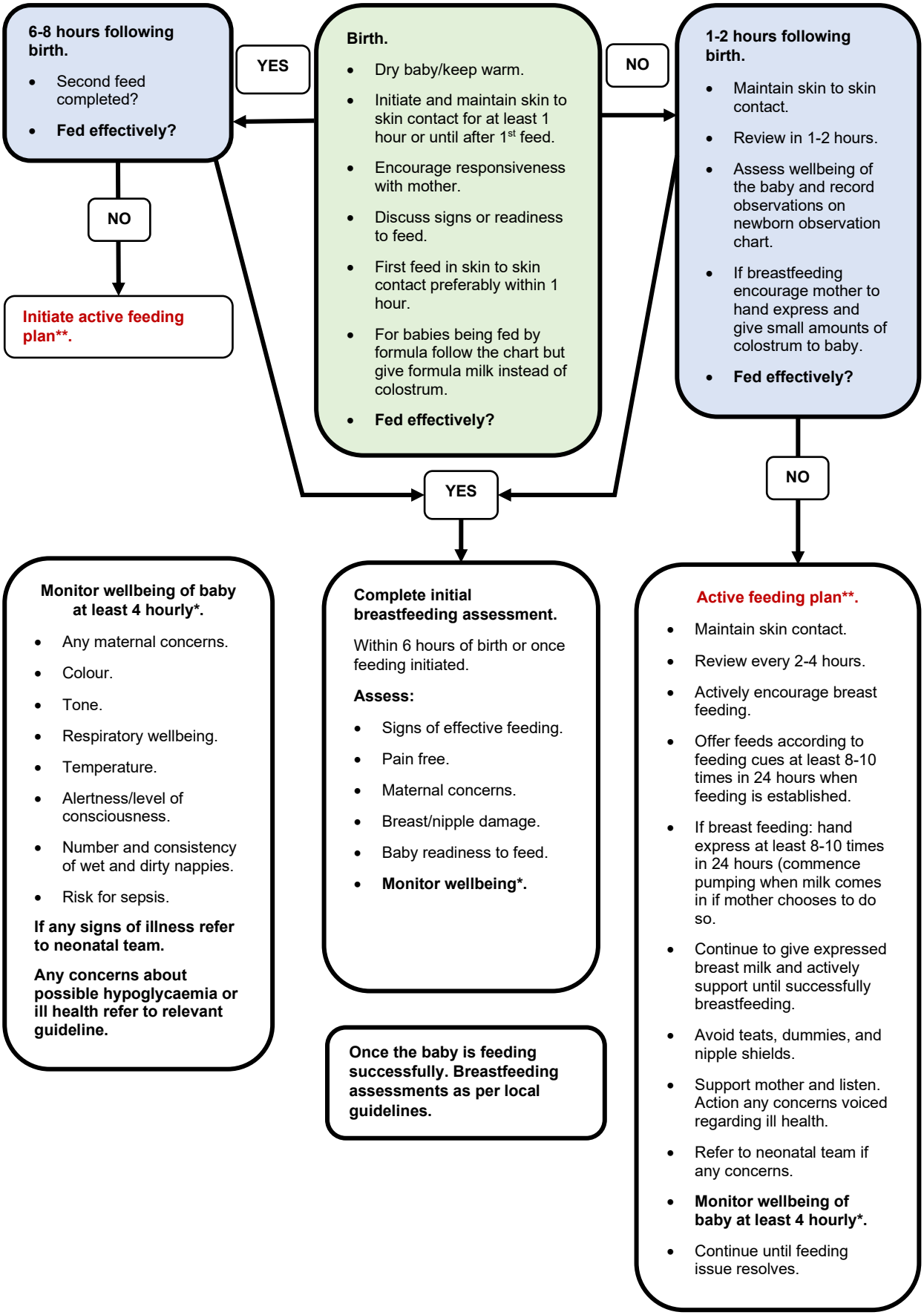
- Blood gas glucose <1.0mmol/l and /or clinical signs consistent with hypoglycaemia in babies ≥ 37 weeks gestation.
- Blood gas glucose <1.5 mmol/l and /or clinical signs consistent with hypoglycaemia in babies ≤ 36+6 weeks gestation.
- Please note: IV 10% dextrose bolus is **not indicated** for babies with blood glucose 1.0-2.5mmol/L.
- **ADMIT TO THE NNU.**

Flowchart C. Blood glucose <1.0mmol/l and/or clinical signs consistent with hypoglycaemia.



***If glucose infusion rate >8mg/kg/min, test for hyperinsulinism, contact specialist team and increase the glucose threshold to 3.0 mmol/L or 3.5mmol/L if > 48 hours of age.**

2.6.3. Flowchart D. Management of reluctant feeding in healthy term infants ≥ 37 weeks.



2.7. Treating with 40% Oral Glucose gel

2.7.1. Consideration

Infants being managed using the pathway in flowchart A are fed within the first 60 minutes and must have a blood glucose level measured prior to the 2nd feed (2- 4 hours after birth).

- ≥ 37-week gestation babies:

  If the first blood gas glucose is 1.0-1.9mmol/l or there is a subsequent Blood glucose measurement < 2.0mmol/l, 40% buccal Glucose gel (200mg/kg) should be given alongside a feeding support plan.

- ≤ 36+6-week gestation:

  If the first blood gas glucose is < 2.6mmol/l but > 1.5 mmol/l or there is a subsequent Blood glucose measurement < 2.6mmol/l, 40% buccal glucose gel (200mg/kg) should be given alongside a feeding support plan to provide an effective feed. **Neonatal Doctor/ANNP must be informed.**

  Please note, post-feed blood glucose measurement is not routinely indicated, however the neonatal team may request one to be taken depending on the individual circumstances.

2.7.2. Indications

Blood gas glucose 1.0-1.9mmol/l with no abnormal clinical signs for babies ≥ 37-week gestation and < 2.6mmol/l but > 1.5 mmol/l in babies ≤ 36+6 week gestation.

2.7.3. Notes

- Must be used in conjunction with a feeding plan.

- For babies with severe hypoglycaemia (blood gas glucose <1.0mmol/l) use 40% oral glucose gel only as an interim measure while arranging for urgent medical review and treatment with intravenous glucose.

- **N.B. Oral 40% glucose gel does not need to be prescribed as it is not classified as a drug product.**

2.7.4. Dose

Use approximately 200mg/kg glucose gel (0.5 ml/kg of 40% Glucose gel) as outlined in the below table, up to two doses given 30 minutes apart per episode of hypoglycaemia and a maximum of six doses of buccal glucose gel in 48 hours.

Please note, Glucogel is not recommended for babies less than 34 weeks. IV access should be obtained, and IV 10% dextrose commenced. If IV access difficult, glucogel can be given in small

quantities, (rubbed into the gums, see 2.7.5.) and care must be taken for baby's ability to tolerate the gel.

Table 2.

Weight of baby (kg)	Volume of glucose 40% oral gel (ml)	Dose of glucose
<1.5	Not indicated	
1.5-1.99	1	400mg
2.0-2.99	1.5	600mg
3.0-3.99	2.0	800mg
4.0-4.99	2.5	1000mg
5.0-5.99	3.0	1200mg
6.0-6.99	3.5	1400mg

2.7.5. Method of Administration

- Draw up correct volume of 40% Glucose gel using an oral/enteral syringe.
- Dry oral mucosa with gauze, gently squeeze in gel with syringe onto the inner cheek and massage gel into the mucosa using latex-free gloves.
- For pre-term infants- dry oral mucosa with gauze, squeeze small amounts of gel onto an appropriately sized-gloved finger and massage the gel into the mucosa of the inner cheek and gums, ensuring that the baby is tolerating the gel. Always monitoring their breathing and colour and ensuring the baby is swallowing normally. If the baby is noted to be struggling with the administration of gel at any time, stop immediately and call ANNP/Doctor for advice.
- Offer a feed (preferably breast milk), immediately after administering 40% dextrose gel.
- Repeat Blood gas glucose measurement if requested – normally 1 hour post completion of the feed.
- Repeat 40% Glucose gel if baby remains hypoglycaemic according to flow chart.
- Up to 6 doses can be given over a 48-hour period **but any more than one dose should be discussed with the neonatal team, and**

it is advisable for the baby to be examined before the 3rd dose is administered.

2.8. Once admitted to the NNU

Further investigations for hypoglycaemia should be considered:

- In the case of suspected sepsis.
- If there has been ≥ 2 episodes Blood gas glucose < 2.0mmol/l in ≥ 37-week gestation or < 2.6mmol/l in ≤ 36+6 week gestation in 72 hrs.
- If blood gas glucose less than 1.0mmol/l.
- If blood gas glucose less than 2.5mmol/l in ≥ 37 week gestation or less than 3.0mmol/l in ≤ 36+6 week gestation and the baby had altered neurology.
- If baby is requiring more than 8.0mg/kg/min dextrose to maintain blood glucose, consider hyperinsulinism.
- If diagnosed with hyperinsulinism aim for blood gas glucose equal or more than 3.5mmol/l.
- Babies with proven Hypoxic Ischemic Encephalopathy aim for Blood glucose ≥ 3.5mmol/l.

2.8.1. Hypoglycaemia screening bloods should only be taken if the blood gas glucose < 2.0mmol/l as results not valid if normoglycaemic.

Hypoglycaemia screening bloods and urine **(Use Hypo Pack).**

N.B. Take samples before correcting blood sugar.

AIM for 2 yellow, 2 green, 1 clear and 2 lilacs (one of the lilac on ice (frozen water, not the requesting system), a blood spot (Guthrie) card and a gas (fill the bottles).

Lithium heparin (green).	U and E's (urine and electrolytes), LFT (liver function test), cortisol, plasma amino acids.
Paediatric yellow.	Glucose, FFA (free fatty acids), beta hydroxybutyrate (and lactate if not on gas).
Plain clear top.	Growth hormone.
Lilac EDTA.	Ammonia ON ICE, insulin, c peptides.
Guthrie.	Acylcarnitines.
Blood gas.	

2.8.2. If difficult to obtain blood:

- Minimum 1 yellow, 1 green, 1 lilac and a gas.
- **Priority** samples whilst hypoglycaemic: Glucose, insulin, FFA, beta hydroxybutyrate, gas for lactate.
- Can take other samples when the hypoglycaemia has been corrected.

Do not delay in correcting the hypoglycaemia if the blood samples are very difficult to obtain.

2.8.3. Urine (first sample)

- Organic acids.
- Urine dipstick for ketones.
- Consider sugar chromatography.

2.8.4. Ongoing care once blood glucose levels normalise.

Infants at risk of hypoglycaemia must not be transferred to the community until they are at least 24 hours old.

Babies with risk factors for impaired metabolic adaptation and hypoglycaemia must remain in hospital, and therefore not transferred into community care, for at least 24 hours to ensure that they are feeding well and have completed the blood glucose monitoring as per this guideline.

Infants who have been hypoglycaemic requiring treatment in the first 24 hours must be discussed with neonatal registrar or ANNP prior to arranging discharge.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Key changes to practice.
Lead	Advanced Neonatal Nurse Practitioner.
Tool	Audit using a Word or Excel template.
Frequency	As dictated by audit findings.
Reporting arrangements	Child Health Directorate Audit and Neonatal Clinical Guidelines.

Information Category	Detail of process and methodology for monitoring compliance
Acting on recommendations and Lead(s)	Dr. C. Lea, Consultant Paediatrician and Neonatologist.
Change in practice and lessons to be shared	Required Changes in Practice will be identified and actioned within 3 months.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment.

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Hypoglycaemia Neonatal Clinical Guideline V4.2.
This document replaces (exact title of previous version):	Hypoglycaemia Neonatal Clinical Guideline V4.1.
Date Issued/Approved:	October 2025.
Date Valid From:	October 2025.
Date Valid To:	August 2027.
Directorate /Department responsible (author/owner):	Lel George; Advanced Neonatal Nurse Practitioner.
Contact details:	01872 252667.
Brief summary of contents:	Definition, identification, and management of neonatal hypoglycaemia.
Suggested Keywords:	Neonatal. Hypoglycaemia. Low blood sugar. Glucose gel. Reluctant feeder.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer.
Approval route for consultation and ratification:	Neonatal Audit and Guidelines Meeting.
General Manager confirming approval processes:	Caroline Chappell.
Name of Governance Lead confirming approval by specialty and care group management meetings:	Tamara Thirlby.
Links to key external standards:	Identification and Management of Neonatal Hypoglycaemia in the Full Term Infant (2017) |

Information Category	Detailed Information
	British Association of Perinatal Medicine (bapm.org).
Related Documents:	Infant feeding Policy, Enteral Feeding of Preterm Infants. RCHT Immediate Care of the Newborn Infant guideline. RCHT Standard Operating Procedure for Infants over 37 weeks born at less than 2.5Kg.
Training Need Identified?	Neonatal medical and nursing staff, midwifery staff.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet.
Document Library Folder/Sub Folder:	Clinical/Newborn Care.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
July 2014.	V1.0.	Original Guideline.	Dr Paul Munyard.
November 2017.	V2.0.	New National BAPM Guidance incorporated.	Dr Paul Munyard and Lel George (ANNP).
June 2021.	V3.0.	Separation of blood glucose threshold levels for term, preterm and symptomatic preterm infants. Recommendation that babies monitored for hypoglycaemia should remain in hospital for 24 hours from birth even if x2 blood sugars are satisfactory. Changes to hypoglycaemia screen bloods. Changes to flow diagrams to incorporate changes in blood glucose thresholds Changes to table for 2nd centile weights – 36 week and 35 week gestation infants added. Sign posting to other relevant documents – Added to sections 1.1 and 2.2 For all	Lel George (ANNP) and Caroline Rose (SSR).

Date	Version Number	Summary of Changes	Changes Made by
		babies < 2.5Kg refer to RCHT Immediate Care of the Newborn Infant guideline and RCHT Standard Operating Procedure for Infants over 37 weeks born at less than 2.5Kg. Babies with risk factors for impaired metabolic adaptation and hypoglycaemia must remain in hospital, and therefore not transferred into community care, for at least 24 hours to ensure that they are feeding well and have completed the blood glucose monitoring as per this guideline. Infants who have been hypoglycaemic requiring treatment in the first 24 hours must be discussed with neonatal registrar or ANNP prior to arranging discharge.	
March 2023.	V3.1.	1. Wording adjusted throughout the guideline from pH <7.1 and base deficit ≥ -12mmol/l to **pH <7.1 and /or base deficit ≥ -12mmol/l.** 2. Flowchart A Box 1 preterm infant < 36 weeks changed to preterm infants. 3. Section 2.4 wording in green box adjusted to: Do not allow more than 3 hours to pass between feeds, until Blood glucose measurements have been **≥ 2mmol/l for baby's ≥ 37 weeks gestation and ≥ 2.6mmol/l for baby's ≤ 36+6 weeks gestation** on two consecutive occasions. 4. Section 2.5.2 wording in title changed to be the same as in Flowchart C : Blood gas glucose <1.0mmol/l and /or clinical signs consistent with hypoglycaemia in babies ≥ 37 weeks gestation. Blood gas glucose <1.5 mmol/l and /or clinical signs consistent with	Lel George (ANNP).

Date	Version Number	Summary of Changes	Changes Made by
		hypoglycaemia in babies ≤ 36+6 weeks gestation. Section 2.7 wording altered to - If baby is requiring more than 8.0mg/kg/min dextrose to maintain Blood glucose consider hyperinsulinism and If diagnosed with hyperinsulinism aim for Blood gas glucose equal or more than 3.5mmol/l.	
August 2024.	V4.0.	N.B. Oral 40% glucose gel does not need to be prescribed as it is not classified as a drug product added to sections 1.2, 2.5, 2.5.1 and 2.6.3. 1.1.6 referenced guideline and protocol titles updated. 2.2.2. 34-week weights added to Table 1, note added 'Infants with risk factors for impaired metabolic adaptation and hypoglycaemia must not be discharged from hospital until they are at least 24 hours old (BAPM Jan 2024). 2.6.1 Flow diagram wording changed to bold text 'ensure no longer than 3 hours between feeds'. 2.6.2 Please note, IV 10% dextrose bolus is not indicated for babies with blood glucose 1.0-2.5mmol/L. 2.7.1 Please note, post-feed blood glucose measurement is not routinely indicated, however the neonatal team may request one to be taken depending on the individual circumstance. 2.7.4 Table 2 updated - Dose of glucose added to the glucose 40% oral gel table and note added, Glucogel is not recommended for babies less than 34 weeks (Bristol guidance). 2.8 If there has been ≥ 2 episodes Blood gas glucose < 2.0mmol/l in ≥ 37-week gestation or < 2.6mmol/l in ≤ 36+6 week gestation in 72 hrs (changed from 48 hrs – BAPM Jan 2024).	Lel George (ANNP).

Date	Version Number	Summary of Changes	Changes Made by
		Flowcharts A, B and C updated according to BAPM Jan 2024.	
January 2025.	V4.1.	2.7.4 Please note, Glucogel is not recommended for babies less than 34 weeks. IV access should be obtained, and IV 10% dextrose commenced. If IV access difficult, glucogel can be given in small quantities, (rubbed into the gums, see 2.7.5.) and care must be taken for baby's ability to tolerate the gel. 2.7.5. For pre-term infants- dry oral mucosa with gauze, squeeze small amounts of gel onto an appropriately sized-gloved finger and massage the gel into the mucosa of the inner cheek and gums, ensuring that the baby is tolerating the gel. Always monitoring their breathing and colour and ensuring the baby is swallowing normally. If the baby is noted to be struggling with the administration of gel at any time, stop immediately and call ANNP /Doctor for advice.	Lel George (ANNP).
October 2025	V4.2	Update to flow chart A regarding formula amounts.	Neonatal Audit and Guidelines Group.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy /policy /proposal /service function to be assessed:	Hypoglycaemia Neonatal Clinical Guideline V4.2
Directorate and service area:	Neonatal
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Neonatal Audit and Guidelines Group
Contact details:	01872 252667

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Aimed at clinical staff who manage newborns, (midwifery and neonatal staff). Diagnosis and management addressed.
2. Policy Objectives	Prompt identification and management of neonatal hypoglycaemia.
3. Policy Intended Outcomes	As above.
4. How will you measure each outcome?	Audit.
5. Who is intended to benefit from the policy?	Neonatal patients.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/visitors: No • Local groups/system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/groups:** Neonatal Audit and Guidelines Group.
6c. What was the outcome of the consultation?	Approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	Any information provided should be in an accessible format for the parent/carer needs- i.e., available in different languages if required/access to an interpreter if required.

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those parent/carer with any identified additional needs will be referred for additional support as appropriate- i.e., to the Liaison Team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g., easy read, audio etc.
Religion or belief	No	All staff should be aware of any beliefs that may impact on the decision to treat.
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Neonatal Audit and Guidelines Group

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis