Our Ref: 67621

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southseftonccg.foi@nhs.net

NHS South Sefton CCG
Magdalen House
Trinity Road
Bootle
Merseyside
L20 3NJ

Tel: 0151 317 8456
Email: southsefton.ccg@nhs.net

Re: Freedom of Information Request

Please find below the response to your recent Freedom of Information request regarding Patients with Diabetes within NHS South Sefton CCG.

Request/Response:

1. How many individuals with Type 1 diabetes are recorded across your CCG area? Please can you break this total down into the following groups:
a. Paediatric
b. Pregnancy
c. Adult (excluding pregnancy)

NHS South Sefton CCG does not hold this information.

2. Does your CCG have local guidance in place regarding the use of real-time Continuous Glucose Monitoring (rt-CGM)? If so, please could you provide us with a copy of this guidance (or a link to an online document if easier).

Please see attached appendix 1

3. What measures does your CCG take to enable access and support for individuals with Type 1 diabetes who require rt-CGM in areas where there is high multiple deprivation indices?

No specific measures. Services are usually provided by our local hospitals

4. Does your CCG provide funding for rt-CGM to individuals with Type 1 diabetes?

Yes in line with commissioning policy referenced in question 2

IF YES:

a. How many individuals have rt-CGM support funded across your CCG?

   Requests approved from 2017/18 to 2020/21 (4years) (8)

b. Which funding stream is used to provide rt-CGM support to across your CCG?

Rt-CGM support is funded in line with commissioning policy through commissioning budgets or via individual funding requests. New allocations of national funding for CGM in type 1 pregnant women will be granted directly to maternity provider units

5. Beyond rt-CGM, please list any other diabetes technologies that are funded and available through your CCG to those with Type 1 diabetes in your area?

Pumps in line with commissioning policy, Flash GM in line with national guidance and digital information and support technologies such as My Diabetes, My Way and Digibete are available for our residents.

Appendix 1

NHS Halton Clinical Commissioning Group
NHS Liverpool Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group
NHS South Sefton Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
NHS Warrington Clinical Commissioning Group

Continuous Glucose Monitors (CGM)

You can see your blood glucose level every few minutes with a continuous glucose monitor (CGM). It lets you see patterns in your levels and warns you if your glucose is too high or low.

A CGM is made up of:

- a sensor – a small device you attach to your abdomen – it senses how much glucose is in the fluid under your skin
- a transmitter – attached to the sensor – it sends results to a receiver
- a receiver – a small box that displays your blood glucose level – you can carry this on your belt or in your bag

A sensor usually lasts for 14 days. Some are implanted and worn for 6 months.

The National Institute for Health and Care Excellence (NICE) states there is not enough evidence to show CGMs are cost-effective enough for everyone with type 1 diabetes.

Intervention	Continuous Glucose Monitoring
Policy Statement	**Restricted**
Minimum eligibility criteria	**Adults with type 1 diabetes** CGM is not routinely commissioned. CGM will only be considered for patients when the following criteria are met: • Already established for at least 3 months on a continuous subcutaneous insulin pump of high specification in strict accordance with NICE appraisal TAG 151 and the local insulin pump policy. **OR** • When, in the opinion of the diabetes specialist, a patient is unable to use an insulin pump for genuine clinical reasons, stand-alone CGM may be considered, alongside multiple daily insulin injections, only when all the other criteria for CGM in adults are met. The evidence suggests that whenever possible, the preferred option of combined insulin pump and CGM should be considered. **AND** • Managed by a recognised adult specialist centre of expertise. This will have a multidisciplinary team comprising a trained diabetes nurse specialist, physician and dietician with all patients trained to count carbohydrates. **AND** • Willing to commit to using CGM at least 70% of the time and to calibrate it as needed. **PLUS** • HbA1c ≥75 mmol/mol (9%) that persists despite blood glucose testing at least 10 times a day** **OR** • Experiencing more than one severe hypoglycaemic episode a year with no obviously preventable precipitating cause. (Severe hypoglycaemia is generally recognised as hypoglycaemia involving convulsions/ unconsciousness) **OR** • Experiencing more than 2 episodes of hypoglycaemia per week that the patient has been unable to manage themselves and are causing problems with daily activities. **OR** • Complete loss of awareness of hypoglycaemia **OR** • Inability to recognise or communicate about symptoms of hypoglycaemia e.g. because of cognitive or neurological disabilities where other forms of glucose monitoring are not appropriate. **Pregnancy – funded by NHS England** CGM in pregnancy for women with type 1 diabetes is funded by NHS England. The diabetes service will access this funding from the Head of Midwifery at the trust where the patient is receiving maternity care.

	CGM with alarms should be offered to all pregnant women with type 1 diabetes for a duration of 12 months. If a patient is already using CGM prior to pregnancy, funding will need to be transferred to NHS England funding for the agreed 12 months and then revert to the previous funding arrangement. Add hyperlink to NHSE document **FOR ALL PATIENTS** A CGM system with a low Mean Absolute Relative Difference (MARD) value should be chosen. Where there is a CGM system with alarm function that will integrate and communicate directly with the patient's established insulin pump, then this CGM system should generally be used. However, an appropriate real-time Dexcom CGM system with alarm function may be considered for patients using other insulin pumps, or those individuals where the integrated system is not the most clinically appropriate CGM system. **The device should be withdrawn from patients who fail to achieve a clinically significant response after 6 months*.** There should also be an annual review to assure the clinically significant response is maintained and that CGM is still the most appropriate method of glucose monitoring for the patient. Consideration should be given to switching to an integrated insulin pump/CGM system when seeking to replace the insulin pump at warranty expiry, if appropriate. **Children and young people with type 1 diabetes** CGM is not routinely commissioned. CGM will only be considered for patients when the following criteria are met: • Currently using a continuous subcutaneous insulin pump of high specification, in strict accordance with NICE appraisal TAG 151 and the local insulin pump policy. **OR** • When, in the opinion of the diabetes specialist, a patient is unable to use an insulin pump for genuine clinical reasons, stand-alone CGM may be considered, alongside multiple daily insulin injections, only when all the other criteria for CGM in adults are met. The evidence suggests that whenever possible, the preferred option of combined insulin pump and CGM should be considered. **AND** • When provided by a specialist centre with a multidisciplinary team including an active member who attends at least 67% (2/3) of the North West children and young people's diabetes network meetings. In addition, the specialist centre is

	achieving best practice tariff in paediatric diabetes and is also engaged with the national peer review programme in paediatric diabetes, to monitor the quality of its service. **AND** • Willing to commit to using CGM at least 70% of the time and to calibrate it as needed. **PLUS** • Experiencing more than 2 episodes per week of severe hypoglycaemia. This is defined as having low blood glucose levels that require assistance from another person to treat and that are happening often enough to have a significant impact on school work or quality of life. **OR** • Inability to recognise or communicate about symptoms of hypoglycaemia e.g. because of cognitive or neurological disabilities, or less than 4 years of age. **OR** • Impaired awareness of hypoglycaemia which is associated with significant adverse consequences e.g. seizures or severe anxiety. Prior to transition to adult services, the child should be counselled on the transition process and advised that their CGM will be reviewed as part of the transition and their ongoing adult diabetes care. On transition to adult services there should be a review to assure there is still a clinically significant response* and that CGM is still the most appropriate method of glucose monitoring for the patient. **Ongoing continuation of CGM** * A clinically significant response is considered to be: • When the patient demonstrates wearing the sensor for at least 70% of the time. **PLUS** • A reduction in the frequency and/or severity of hypoglycaemic episodes. **OR** • A reduction in the need for third party intervention during hypoglycaemic episodes. **AND/OR** • Achievement of a clinically significant reduction in HbA1c, that demonstrates the patient is moving towards their individually agreed HbA1c target. **Where CGM is initiated due to hyperglycaemia in adults, it should only be continued longer-term if HbA1c can be sustained at or below 53 mmol/mol (7%) and/or there has been a fall in HbA1c of 27 mmol/mol (2.5%) or more, in accordance with NICE CG17
Evidence for inclusion and threshold	**1**. Benkhadra K, Alahdab F, Tamhane S, Wang Z, Prokop LJ, Hirsch IB, et al. Real-time continuous glucose monitoring in type 1 diabetes: a systematic review and individual patient data meta-analysis. *Clinical endocrinology*. 2017;**86**(3):354-60.

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