Newbury and District Clinical Commissioning Group
North and West Reading Clinical Commissioning Group
South Reading Clinical Commissioning Group
Wokingham Clinical Commissioning Group

Procedure that requires prior approval

Thames Valley Priorities Committee Commissioning Policy Statement

Policy No. TVPC64 **Real-time continuous glucose monitors for adults with type 1 diabetes**

Recommendation made by the Priorities Committee: July 2017

Date of issue: **April 2018**

The Thames Valley Priorities Committee has considered the evidence of clinical and cost effectiveness and NICE guidance for the use of real-time continuous glucose monitors (CGM) for adults with type 1 diabetes. The Committee supports the use of CGM as per NICE Clinical Guidelines as outlined below.

NICE Clinical Guideline NG17, Type 1 diabetes in adults, makes the following recommendations on CGM:

Do not offer real‑time continuous glucose monitoring routinely to adults with type 1 diabetes.

Consider real‑time continuous glucose monitoring for adults with type 1 diabetes who are willing to commit to using it at least 70% of the time and to calibrate it as needed, and who have any of the following despite at least 1 year of optimised use of insulin therapy and conventional blood glucose monitoring:

- More than 1 episode a year of severe hypoglycaemia with no obviously preventable precipitating cause.
- Complete loss of awareness of hypoglycaemia.
- Frequent (more than 2 episodes a week) asymptomatic hypoglycaemia that is causing problems with daily activities.
- Hyperglycaemia (HbA1c level of 75 mmol/mol [9%] or higher) that persists despite testing at least 10 times a day. Continue real‑time continuous glucose monitoring only 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.

CGM therapy should only be continued if it results in a documented sustained improvement in glycaemic control, evidenced by a fall in HbA1c levels, or a documented sustained decrease in the rate of hypoglycaemic episodes. For patients for whom loss of hypoglycaemia awareness is restored, and other criteria do not apply, a trial off CGM after 6 to 12 months is an appropriate consideration. Appropriate targets for such improvements should be set by the responsible physician, in discussion with the person receiving the treatment or their carer. CGM therapy will be discontinued after a period of 12 months if the agreed targets are not met.

NICE Clinical Guideline NG3, Diabetes in pregnancy, makes the following recommendations on CGM:

Do not offer continuous glucose monitoring routinely to pregnant women with diabetes.

Consider continuous glucose monitoring for pregnant women on insulin therapy:

- who have problematic severe hypoglycaemia (with or without impaired awareness of hypoglycaemia) or
- who have unstable blood glucose levels (to minimise variability) or
- to gain information about variability in blood glucose levels.

Ensure that support is available for pregnant women who are using continuous glucose monitoring from a member of the joint diabetes and antenatal care team with expertise in its use.

CGM therapy should only be initiated if the patient is willing to commit to using it at least 70% of the time and to calibrate it as needed. CGM should only be continued if it results in a documented sustained improvement in glycaemic control, evidenced by a fall in HbA1c levels, or a documented sustained decrease in the rate of hypoglycaemic episodes. Appropriate targets for such improvements should be set by the responsible physician, in discussion with the person receiving the treatment or their carer. CGM therapy will be discontinued after a period of 12 months if the agreed targets are not met.

CGM should be initiated and supported following assessment by a NHS specialist and multidisciplinary team, which provides structured education programmes and advice on diet, lifestyle and exercise. Appropriate goals should be agreed by the team in discussion with the person or their carer. The patient is required to understand how to use the CGM system and be committed and able to be compliant.

The most appropriate CGM device with the lowest acquisition cost should be considered.

Funding is not available for replacement devices within the original warranty period. NHS funding is not available for consumables or replacements following initial private provision or purchase of a CGM device.

Sensor augmented pump (SAP) systems, with integrated continuous glucose monitoring (CGM), will only be considered in line with NICE DG21 criteria for patients with IHA (Gold score ≥ 4). SAP therapy should only be continued until hypoglycaemic awareness has been restored (Gold < 4) and there is a documented sustained decrease in the rate of hypoglycaemic episodes. Appropriate targets for such improvements should be set by the responsible physician, in discussion with the person receiving the treatment or their carer. SAP therapy will be discontinued after a period of 12 months if the agreed targets are not met.

This policy applies to adults with type 1 diabetes, including pregnant women. CGM is not funded for people with type 2 diabetes.

For the purpose of this policy:

- severe hypoglycaemia is defined as having low blood glucose levels that requires assistance from another person to treat.
- 'problems with daily activities' is defined as potential / actual loss of driving licence , potential or actual loss of employment, inability to care for dependents safely, significant disruption to ability to live independently

NOTES:

- Potentially exceptional circumstances may be considered by a patient's CCG where there is evidence of significant health status impairment (e.g. inability to perform activities of daily living) and there is evidence that the intervention sought would improve the individual's health status.
- This policy will be reviewed in the light of new evidence or new national guidance, e.g., from NICE.
- Thames Valley clinical policies can be viewed at http://www.fundingrequests.cscsu.nhs.uk/