NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Paediatric Continuous Glucose Monitoring Therapy Policy

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CONSULTATION SCHEDULE		

APPROVALS & RATIFICATION SCHEDULE	
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Governing Bodies meets in common	
Integrated Care Board	1st July 2022

VERSION CONTROL			
V	**Version/Description of amendments**	**Date**	**Author/amended by**
1.0	1 June 2019	Draft	
1.1	1 February 2020	Final	
2.0	Adapted for ICB	01.07.20	Jane Chapman

Impact Assessments – available on request			
	Stage	Complete	Comments
Equality Impact Assessment			
Quality Impact Assessment			
Privacy Impact Assessment			

1. Treatment	**Continuous Glucose Monitoring (CGM) Device**
2. For the Treatment of	Type 1 diabetes mellitus.
3. Background	**Definition** Continuous glucose monitoring is a way to measure glucose levels in real-time. The glucose sensor is inserted under the skin, which measures blood glucose levels throughout the day and night, enabling patients with variable and unpredictable glucose levels to achieve safer and more stable overall control.
4. Scope	The scope of this policy is to outline eligibility criteria for continuous glucose monitoring and insulin pump therapy for patients diagnosed with type 1 diabetes mellitus. Diabetes specialist teams will determine with the patient the monitoring and treatment options. This could include: • Continuous Glucose Monitoring with pump therapy • Continuous Glucose Monitoring • Pump therapy
5. Commissioning Position	**Commissioned Services** Providers of CGM are required to seek prior approval from the commissioner for new patients that they consider suitable for a CGM device. **Requests should be made by a consultant Diabetologist.** CGM should be provided by a centre with expertise in its use, as part of strategies to optimise a person's HbA1c levels and reduce the frequency of hypoglycaemic episodes. Requests for long term funding for continuous monitoring should be made based on the results of a short term (six months) trial. A referral proforma should be completed by the provider and submitted to the commissioner, post assessment, to confirm eligibility for treatment. **Eligibility Criteria** The commissioner will consider the request for ongoing real-time continuous glucose monitoring with alarms to children and young people with type 1 diabetes who have: • Frequent severe hypoglycaemia or • Impaired awareness of hypoglycaemia associated with adverse consequences (for example, seizures or anxiety) or • Inability to recognise, or communicate about, symptoms of hypoglycaemia (for example, because of cognitive or neurological disabilities) The commissioner will consider the request for ongoing real-time continuous glucose monitoring for: • Neonates, infants and pre-school children • Children and young people who undertake high levels of physical activity (for example, sport at a regional, national or international level)

	• Children and young people who have comorbidities (for example anorexia nervosa) or who are receiving treatments (for example corticosteroids) that can make blood glucose control difficult The commissioner will consider intermittent (real-time or retrospective) continuous glucose monitoring to help improve blood glucose control in children and young people who continue to have hyperglycaemia despite insulin adjustment and additional support. Following a six month trial (funded by the ICBs) CGM will only be continued if the patient has continued benefits such as a sustained decrease in the number of hypoglycaemia episodes, if that was the reason for initiation. Such targets for reductions in the number of episodes of hypoglycaemia should be set individually for each patient. **Responsibilities of the family using CGM** • Main carers and family to show commitment to the successful use of CGM and to engage fully with the medical advice and recommendations of the diabetes team • To attend at least 4 clinic appointments/year, as per NICE guidance for review, HbA1C and blood checks. • Commit to using CGM at least 70% of the time and to calibrate it as needed. Also to act on high and low readings appropriately. • To attend all education sessions organised by the team • Always perform a finger prick check for rapidly changing blood glucose levels or sensor readings <4mmol, for driving (if applicable) or if symptoms do not match the system reading. • The CGM sensor and transmitters remain the property of the acute trust and should be returned promptly if no longer required or if assessed that CGM is no longer the best option for diabetes management. **Responsibilities of the Paediatric Diabetes Team** • Assess the suitability of the patient for CGM against ICB policy • Provide CGM education and assessment for child, family and nursery/school before CGM start, as per team CGM education and on an on-going basis • Provide ongoing CGM education • Arrange for a minimum of 4 follow up clinic visits in a year along with HbA1c measurements and ensuring family has 8 other contact with team/ year e.g. telephone contacts, school or education sessions • If the CGM is found to meet the criteria for continuation at 6 months, review on-going suitability of CGM annually to ensure sustained improvement, safety of use to achieve goals and ongoing eligibility according to CCG policy criteria. Report back to the commissioner at 6 months and then annually for on-going funding.

	• Ensure that the family know how to order supplies of sensors and consumables **Criteria to withdraw CGM** Withdraw continuous CGM if: • CGM has not been used 70% of the time – every day. • Family have not attended all recommended education sessions unless extenuating circumstances • No improvement in glycaemic control – e.g. HbA1c did not improve by >0.5% if it was >7.5% at start of CGM therapy • No improvement in scores on fear of hypoglycaemia scales where CGM was introduced for anxiety • No improvement in hypoglycaemia unawareness if introduced for hypoglycaemia unawareness (Gold score) • No reduction in frequency of hypoglycaemia – particularly nocturnal hypoglycaemia Benefit from CGM should be clearly evidenced and documented in the notes. CGM does not need to be reviewed for withdrawal if it was introduced following hypoglycaemic seizures and provided it is being used 70% of the time each day or in younger children providing it is in regular use. **Transition from Paediatric Care** For patients already using CGM and having demonstrated significant clinical benefit, funding will continue where this is maintained and where on-going provision is justified.
6. Indicative numbers	It is expected that CGM will largely be used as an 'add on' therapy for those already using insulin pumps and may often be provided through a sub-specialty insulin pump service. It is not envisaged that the therapy will be offered to more than 30% of children and young people with type 1 diabetes attending a specialist service (under current guidelines and with current technologies).
7. Effective from	1 February 2020
8. Summary of evidence/rationale	NICE Diabetes (type 1 and type 2) in children and young people: diagnosis and management – August 2015 – NG18 NICE Type 1 diabetes in adults: diagnosis and management – August 2015 – NG17 Association of Children's Diabetes Clinicians. A Practical Approach to the Management of Continuous Glucose Monitoring (CGM) / Real-Time Flash

	Glucose Scanning (FGS) in Type 1 Diabetes Mellitus in Children and Young People Under 18 years. April 2017