London Guidance: Recommended Commissioning Arrangements for Continuous Glucose Monitoring (CGM) in Adults with Type 1 Diabetes

Version number: 1.0

First published: 20 September 2018

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Summary

This guidance, developed by the London Diabetes Clinical Network and NHS London Procurement Partnership, provides recommended arrangements for the commissioning and provision of continuous glucose monitoring (CGM) in adults with type 1 diabetes.

The guidance has two main parts:

- Suggested initiation and continuation criteria for the use of CGM and
- Expected costs and benefits associated with reimbursement for these devices (when initiated/continued as per the guidance below).

We encourage commissioners to review and adopt this guidance to support the appropriate and equitable commissioning of CGM in adults across London.

The request for funding for this device via commissioners is based on the expected improvement in outcomes, and subsequent health economy savings, following its use in eligible patients.

1. Background

In 2016, NHS London Procurement Partnership (LPP) formed a specialist stakeholder group to support the clinical aspects of a pan London procurement framework agreement for insulin pump and continuous glucose monitoring (CGM) devices. Prior framework agreements from across the country were focused solely on insulin pumps, and did not include the multiple CGM devices which are now widely available. LPP's work – along with other national events, such as changes to paediatric insulin pump commissioning in 2017 – has prompted London organisations to consider the availability of continuous glucose monitoring (CGM) devices and their local arrangements.

An initial scoping exercise by LPP in 2017 found variations in commissioning processes and access across the region. Currently, routine commissioning arrangements are only available in North West London STP, where these have been in place for a year.

Whilst the South East Coast and London Paediatric Diabetes Network drafted guidance in conjunction with local commissioners for the use of insulin pumps and CGM in paediatrics (yet to be published), a regional equivalent for adults did not exist.

Thus, the Type 1 Diabetes Network within the London Diabetes Clinical Network and the NHS LPP Responsible Diabetes Prescribing Group has produced the following guidance, reflecting the North West London arrangements, in a format suitable to aid uniform implementation across the region.

2. Current situation in London

In the scoping of this guidance, North West London STP has developed guidance and a formal commissioning arrangement in place for CGM. The others confirmed that they had no formal arrangement and did not routinely commission CGM, though there were varying rates of individual funding requests (IFR).

Many patients with type 1 diabetes routinely access specialist services outside of their area and in some cases patients have intentionally moved to clinics further from their home in order to access this technology from larger sites (e.g. Kings College and Guy's and St Thomas').

2.1. Barriers

Existing barriers in London prior to the development of this guidance include:

- Inconsistency – There has been no regional guidance previously in place to consider use of CGM devices across London.
- Lack of clarity – Where funding arrangements did exist for CGM devices, they may be unclear or not formalised. (For example, one trust had a funding arrangement for a defined amount of money, but not specific criteria, resulting in confusion.)
- Tariff payments – There may be disagreement regarding funding arrangements for CGM devices (not excluded from tariff, but general acknowledgement that tariff payments are not sufficient to cover associated costs of using this technology).

3. What is continuous glucose monitoring (CGM)?

Continuous glucose monitoring devices measure glucose in the interstitial fluid – as opposed to in the blood – via a sensor inserted under the skin. This is connected to a transmitter that sends continuous glucose results to a receiver device and these results are then presented as continuous values and trends over time. These can be read as and when required by the user, and will also alarm/alert the user when glucose levels are high or low (regardless of whether they are being actively downloaded by the user).

The full NICE guideline NG17, *Type 1 diabetes in adults: diagnosis and management*, states:

> "Self-monitoring of blood glucose (SMBG) is the cornerstone of diabetes self-management. There is evidence that increased frequency of blood glucose monitoring improves overall blood glucose control, as assessed by glycosylated haemoglobin (HbA1c) (see Section 10). However, the utility of blood glucose monitoring is limited by the fact that the measurement represents a single point in time, and cannot inform the user as to the trend in blood glucose levels. Continuous glucose monitoring addresses these limitations, but is significantly more expensive and has its own limitations."[1]

Flash monitoring is a form of intermittent glucose monitoring. There are many similarities to CGM in regard to how glucose levels are read, but this information is not transmitted to a receiver continuously, and is reliant on the user scanning their sensor device at appropriate intervals. This will then provide a retrospective reading of values and trends over a set time period. It is unable to alert the user if glucose levels are out of range, which is seen as a key benefit of CGM for the majority of patients indicated for these devices under this guidance.

4. Evidence for the use of CGM

CGM has the potential to improve glucose control (measured by HbA1c), reduce exposure to hypoglycaemia, and positively impact on hypoglycaemia fear. A landmark JDRF study in 2008 demonstrated that CGM, when used for six days out of seven, reduces HbA1c in children, young adults, and adults with type 1 diabetes as compared to self-monitoring of blood glucose (SMBG)[2]. A meta-analysis of this and other randomised controlled trials of CGM against SMBG in 2011 reinforced this finding and showed that the HbA1c reduction is both dose-dependent and is proportional to the baseline HbA1c[3]. A reduction in median exposure to hypoglycaemia of 23% for continuous glucose monitoring compared with self-monitoring of blood glucose was also shown. The studies included recruited mixed participants using both insulin pump therapy and multiple dose injection (MDI) regimens.

More recently, studies have assessed the impact of CGM in more representative populations with higher baseline HbA1c values and using MDI regimens only. These studies have reproducibly shown a mean reduction in HbA1c of around 0.6% (6mmol/mol) and clinically, and statistically, significant reductions in exposure to hypoglycaemia at all thresholds compared with SMBG[4,5]. High risk populations have also been studied and demonstrated reductions in hypoglycaemia and severe hypoglycaemia (requiring the assistance of a third party) in people with type 1 diabetes and an impaired awareness of hypoglycaemia or a recent history of severe hypoglycaemia (in comparison to SMBG)[6]. Similar findings have been reported for CGM compared with flash glucose monitoring suggesting that CGM is the preferred monitoring modality for people at high risk of hypoglycaemia[7]. In studies of people at highest risk of hypoglycaemia, hypoglycaemia fear is also reduced with CGM compared to SMBG and flash monitoring.

Overall, available trial evidence shows that CGM can reduce HbA1c proportionally to use, address hypoglycaemia exposure independently of insulin delivery modality compared to SMBG, and can also improve hypoglycaemia exposure and reduce hypoglycaemic fear (as measured with validated fear scores) in people at highest risk, when compared to SMBG and flash glucose monitoring.

In addition, real-world data collected in a reimbursed health system suggests that CGM in people with type 1 diabetes managed in specialist centres improves HbA1c, and quality of life and reduces fear of hypoglycaemia (as per validated fear scores), while work absenteeism and admissions for acute diabetes complications, including severe hypoglycaemia, decreased.[8]

Within the London region, the NWL STP recently implemented commissioning of CGM as per the guidance outlined in this document. An analysis of the audit data for this cohort is provided in appendix 1.

5. CGM devices

There are currently a number of CGM devices on the market that may or may not be used in conjunction with an insulin pump. All of the items below are available for procurement via the NHS LPP insulin pumps and CGM procurement framework agreement.

Supplier	Lot 2 – Insulin Pumps with integrated CGM and associated consumables	Lot 3 – Standalone CGM devices and associated consumables
Dexcom		G4 G5 G6
Medtronic	Minimed 640G Paradigm Veo	Guardian Connect
Medtrum	A6 System	S6 System
Roche		Eversense *****This CGM uses a sensor that is surgically inserted and an additional level of training is required prior to provision by specialist services. Associated payments for appointments may differ, compared to other devices. Implantation and removal require a minor procedure carried out under local anaesthetic.

6. When should CGM devices be used?

CGM devices should not be routinely offered to all adults with type 1 diabetes. Real time CGM may be considered where patients have any of the following, despite optimised use of insulin and conventional blood glucose monitoring:

- More than one episode a year of severe hypoglycaemia with no obvious preventable cause. Severe hypoglycaemia is defined as having low blood glucose levels that requires assistance from another person to treat.
- Complete loss of awareness of hypoglycaemia (as defined by Clark or Gold score).
- Frequent (more than two episodes a week) asymptomatic hypoglycaemia that is causing problems with daily living or performance impairment. When considering this indication:
    - Precipitating causes must be excluded
    - Assessment must be made using a blinded diagnostic CGM
    - Hypoglycaemia is defined as <4mmol/L
- Extreme fear of hypoglycaemia (as per the Hypoglycaemia Fear Survey and after failure of psychological therapy).
- Hyperglycaemia (HbA1c level of 75mmol/mol or higher) that persists despite testing at least 10 times a day over a three month period. Continuation criteria for this indication that HbA1c must be sustained at or below 53mmol/mol and/or there has been a fall in HbA1c of 27mmol/mol or more.

An initial review of mutually agreed outcomes should take place at six months and then annually thereafter.

The following additional requirements must be met before and during use:

- The use of a CGM device must be supported by a multidisciplinary specialist diabetes team.
- All patients should have followed the clinical pathway of usual interventions such as dietetic care, structured education and, where necessary, specialist psychological support to manage their diabetes.
- Patients must be willing to commit to use their CGM device at least 70% of the time and to calibrate it as needed.
- Real-time continuous glucose monitoring 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.
- For adults with type 1 diabetes who are having real time continuous glucose monitoring, use the principles of flexible insulin therapy with either a multiple daily injection (MDI) insulin regimen or continuous subcutaneous insulin infusion (CSII or insulin pump) therapy.

These recommendations align with those in the NICE guidance (NG17). However, we have included additional criteria to ensure standardisation of CGM use for London, plus appropriate identification of patients who would most benefit according to NICE.

7. Alignment with other diabetes technology guidance

Glucose monitoring is an essential part of type 1 diabetes treatment and the self-monitoring of blood glucose – via meter devices and disposable strips – should be available to all patients first-line.

FreeStyle Libre® (flash glucose monitoring) is a form of intermittent glucose monitoring that measures glucose levels in the interstitial fluid. It has a number of indications outlined in the London implementation guidance and indication two most closely matches scenarios where CGM is also considered: "Recommended implementation of FreeStyle Libre® prescribing for patients with type 1 diabetes with HbA1c >8.5% (69.4mmol/mol) or disabling hypoglycaemia who would be eligible for insulin pump therapy as per TA151". The London implementation guidance advises that flash monitoring may be considered as an option if traditional CGM devices are deemed not to be suitable or practical (including for patients already on an insulin pump). Particular caution is advised for prescribing of flash where there is impaired awareness of hypoglycaemia, a history of severe hypoglycaemia (defined as requiring the assistance of another person), or frequent asymptomatic episodes; in these cases the use of a device with warnings or alarms (real time continuous glucose monitoring) is strongly advised.[9]

7.1. Best practice for clinics and real time CGM

NG17 states that "Real time continuous glucose monitoring 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."[1]

These centres should be led by an appropriately staffed hub with a multidisciplinary diabetes team and an identified Type 1 diabetes lead. These centres should:

- Provide appropriate structured education,
- Provide access to clinical psychology,
- Have the ability to download and review glucose monitoring data and trends.

Another technology used in the treatment of problematic glycaemia in type 1 diabetes is insulin pump therapy. Indications for the use of these are clearly stated in NICE TA151[10] and initiation and continuation should only be carried out by specialist centres that can adequately support patients with these. Some of these devices are "sensor-augmented", meaning the technology is presented in conjunction with the ability to continuously monitor interstitial glucose levels. This guidance refers to the use of CGM both in patients with type 1 diabetes using MDI and patients with type 1 diabetes who use an insulin pump.

While the indications for each of these appear comparable, each technology has its own merits and limitations and the best choice for an individual should be decided by the clinician and the patient in a face to face review of current diabetes care and treatment options. These devices are therefore not necessarily interchangeable and direct comparisons are not appropriate.

7.2. Notes on transition from paediatrics to adults

The ongoing use of CGM in people with type 1 diabetes aged 16 to 19 should be reviewed by the transition clinic multidisciplinary team at regular reviews, with a focus on outcomes including HbA1c, frequency and severity of hypoglycaemia, and quality of life.

8. Why is access to CGM devices important?

In some patients, the self-monitoring of blood glucose does not provide sufficient warning if their levels are falling dangerously low, meaning there is a greater risk of severe hypoglycaemia. The alarms and warnings that accompany CGM are particularly important for use where there is impaired awareness of hypoglycaemia (IAH). Overall, 10% of deaths of people with type 1 diabetes are directly attributable to hypoglycaemia[11] and the risk of severe hypoglycaemia increases six-fold with impaired awareness[12]. Those who self-reported severe hypoglycaemia in the preceding five years were noted to have 3.4-fold higher mortality than those who reported mild or no hypoglycaemia[13]. Where other interventions have not resulted in optimal glycaemic control, access to these devices, where appropriate, may enable significant improvements in management for individuals with type 1 diabetes.

9. Predictions for London

9.1. Number of adult patients eligible under this guidance

By using figures from North West London STP (Appendix 1) for the number of people starting CGM per member of the population in accordance with the criteria outlined above (1.4 per 100,000 total population), an estimated 123 people per year would be eligible for starting CGM in London (assuming total population 8.788m as per 2016 census).[14] This is likely to result in increasing costs for the initial few years until usage reaches a plateau.

This is a best guess estimate based on NWL data but it is recommended localities consider local intelligence and amend as needed.

9.2. Associated direct costs

There are now multiple suppliers of CGM available in London and these devices and prices are captured on the NHS LPP framework agreement for members (includes all Trusts in London). Review of these presents the average cost of CGM (with or without a pump) as around £3,000 per device per patient per year. Please note that the framework contains a number of devices and also associated “innovative offers” and volume related discounts/free items from individual suppliers; the relative value of these locally should be considered by trusts and commissioners and used to aid determination of local costs.

In some scenarios, patients on insulin pumps may benefit from the addition of CGM. In such cases, sensor augmented pumps are gold standard, as opposed to using standalone pumps with CGM devices. The cost of CGM consumables with a sensor augmented pump is comparable to a standalone CGM device and consumables and therefore costs have not been considered separately. The estimated number of patients above includes those who may be using CGM with a pump.

The total approximate cost of these devices for the estimated 123 patients over London for year 1 is **£369,000**. This figure may vary depending on uptake, supplier choice and the volume purchased by organisations. Other associated costs - such as initiation sessions run by the Trust - are expected to fall under existing Tariff payments, with no additional cost to the commissioner.

This equates to **£4,200 per 100,000** population. This is approximately £10-20,000 per year per CCG (depending on total population).

9.3. Associated benefits

Patients featured in the NWL data set showed a clear and significant reduction in episodes of severe hypoglycaemia, with the vast majority reducing to zero episodes in the year of initiation.

Whilst data on healthcare service use was not collected by NWL, there are a number of known direct health economy costs related to episodes of severe hypoglycaemia, which can be considered when predicting benefits from CGM use in the selected population. Severe hypoglycaemia is noted as a common indication for ambulance call-outs, with audited trusts highlighted in the admissions avoidance guidance from JBDS - IP reporting 23 – 28 callouts per 1000 people with diabetes per year. London Ambulance Service (LAS) data shows that ambulances were alerted to incidences of hypoglycaemia on over 10,000 occasions in 2017/18. Nearly two-thirds (6166) were taken to A&E. The estimated cost to receive an ambulance and be treated at home is £155.30 and for those taken to hospital is £254.57 (LAS 2016). This document also states that about 30% of diabetic ketoacidosis (DKA) and severe hypoglycaemia admissions are in people who have been re-admitted or who are frequent attenders. It is noted that intensive support of these individuals reduces admission risk but in those where specialist follow-up has not helped improve the frequency or intensity of these episodes, CGM may be an important adjunctive therapy.[15]

It is unclear how many of the patients highlighted by LAS with incidences of hypoglycaemia were subsequently admitted for inpatient care but it is well documented that the cost to the healthcare system for hypoglycaemia related admissions is significant. A recent cohort study in England identified the cost for an inpatient stay for acute hypoglycaemia as around £1034, with a length of stay of around 5 days.[16] A previous study in Scotland had identified similar cost implications per day. In 2011, with the estimated cost of a single episode of severe hypoglycaemia requiring healthcare professional support of £377–1,306.[17]

Hypoglycaemia call-outs will have a variety of precipitating causes and it is clear that not all call-outs (or potential subsequent admissions) will be for patients who are eligible for CGM under this guidance. However, based on the assumption that the criteria above represents the most at risk portion of the population - in whom other alternative interventions have failed to improve outcomes and quality of life – it is likely that subsequent improvements facilitated by CGM, where appropriate - will translate to reductions in both direct and indirect costs to the health economy.

Whilst only one patient was initiated for CGM for sustained hyperglycaemia, the benefits of optimal glycaemic management are well known and understood and a key aspect of all diabetes management plans.[18]

As highlighted above, the place of CGM in broad treatment pathways for adults with type 1 diabetes in NG17 was deemed as not sufficiently cost-effective for routine use. However, for a highly selected cohort of patients with problematic hypoglycaemia, the NWL real-world data shows clear clinical outcome benefits, which are likely to translate to economic benefits to the wider health economy when considering other real world evidence. It is noted that the sample available is small but this is reflective of the small number likely to be eligible and there is firm clinical consensus that if these restrictive criteria are followed - in order to highlight those most at need - then there is a strong likelihood that benefits will be seen.

10. Forms for reimbursement

It is suggested that electronic forms are used for approval and reimbursement. These will also facilitate ongoing data collection. Please find an initiation and continuation form below, with thanks to North West London Collaboration of Clinical Commissioning Groups:


34. CGM initial request v4.1_New.d


35. CGM continuation reques

It is recognised that not all areas implement such forms for CGM initiation and continuation. The use of these – or similar – is recommended in order to provide clear communication between providers and commissioners, with sufficient information to confirm compliance with this guidance for appropriate reimbursement (as locally agreed).

10.1. On-going data collection

Clinical details from the forms above can be used to facilitate ongoing usage and outcome reviews at population level. It is suggested the following parameters are collected and reviewed:

- HbA1c level
- Number of severe hypoglycaemic episodes each year
- % of device usage by the patient
- HYPO/CLARK/GOLD scores.

Appendix 1 | Lessons from North West London

i) Results from the first year of commissioning

North West London is a group of eight CCGs, covering a population of around 2 million people. Access to CGM for adults with type 1 diabetes who meet the NICE criteria has been implemented following collaboration between specialists, commissioners, and primary care to support people with challenging glycaemia to access appropriate technologies, enabling effective self-management of type 1 diabetes. Following a stakeholder meeting between commissioners, specialists, primary care physicians and business managers, a business case was prepared that included an evidence review, and defined access criteria, duration of use and monitoring processes. The business case included emergency response data for hypoglycaemia in North West London, provided by the London Ambulance Service. The final business case was presented to the Collaboration Board of CCGs where it was approved, along with a short application form for initial funding and a renewal form including monitoring data to be completed at 6 month intervals.[19]

In 2016, the NWL proposal for commissioning noted that 30 requests from each provider (4) had been submitted for CGM in NWL over 5 years. This equates to approximately 24 per year for the STP.

During the first year of this policy there were upwards of 20 initiations on CGM across the STP. The original prediction was 50 new starts; initial slow uptake may be due to this being a new policy and this may increase in the future.

Data was collected from 20 of these new starts over the year, though not all entries were complete for the information requested. Results are presented below with reference to completed entries only. Data was collected on rate and severity of hypoglycaemia episodes, GOLD score, Hypoglycaemia Fear Survey score, HbA1c values and episodes of diabetic ketoacidosis. Data was not collected on subsequent outcomes, such as use of healthcare services.

*Indications for initiating CGM (>1 may apply to individual patients)**

Indication		Number of patients
Hypo.	Hypoglycaemia unawareness	11
Hypo.	Severe hypoglycaemia	9
Hypo.	Asymptomatic hypoglycaemia	18
Hypo.	Extreme fear of hypoglycaemia	9
HbA1c	High HbA1c	1

The majority of indications for initiation were related to hypoglycaemia. Therefore key outcomes to observe in the data were those related to improvements in the frequency and management of hypoglycaemia. Please note that use of the recently approved FreeStyle Libre® (also defined as intermittent CGM) would not necessarily be first line for the majority of these patients, as the technology may not be best suited to those with asymptomatic or complete loss of awareness of hypoglycaemia.

Awareness of hypoglycaemia was captured by the reported Gold score. Pre-CGM, the majority of patients had a score of 7, with some with a score of 5 or 6 (total n = 15). Impaired awareness is classified as a Gold score of 4 or more and therefore all patients in the data set were at a higher risk of severe hypoglycaemia. The Gold score improved for some patients, but not all – however, this should not be a definitive measure of effectiveness as awareness can be difficult to regain and the data only covers one year (or less). The use of a CGM device with alarms and warnings should enable users to act promptly when hypoglycaemia is pending. A reduction in severe hypoglycaemic episodes was noted in all 8 patients where before and after data was provided. All bar one patient reduced to 0 episodes; in the case of this patient their initial number of recorded episodes was the highest in the group and the use of CGM facilitated a significant reduction.

*Reduction in severe hypoglycaemic episodes (individual patients)**

Gold score pre-CGM (where noted)	Severe hypoglycaemic episodes pre-CGM initiation	Severe hypoglycaemic episodes post-CGM initiation
7	>1	0
7	>1	1
7	3	1
7 (or 5)	>2	0
	>2	0
7	2	0
7	>2	0
7	>2	0

The number of episodes of asymptomatic hypoglycaemia across the population ranged between 2 and 21 pre-CGM initiation and reduced to between 0 and 4 post-CGM initiation.

Hypoglycaemia fear scores also significantly reduced across the cohort and for individuals; nine patients were noted as having extreme fear, with before and after scores available for four of these:

*Extreme fear of hypoglycaemia**

Hypoglycaemia Fear Survey score pre-CGM initiation	Hypoglycaemia Fear Survey score post-CGM initiation
44	21
38	17
31	25
46	21

**Information governance review was carried out by NHS England (London Region) for publication of small numbers*

ii) Summary of results from NWL with consideration of NICE review

Evidence available at the time of the NICE review had a number of limitations and was not best placed to demonstrate improvements for people with high baseline rates of hypoglycaemia. The full NICE guideline (NG17) for type 1 diabetes management in adults, states: “It was clear to the GDG that current data do not support the routine use of CGM. There is some evidence of clinical benefit but this is not compelling, and it is not currently a cost-effective intervention. However, there are some clinical situations in which routine management fails to control episodes of hypoglycaemia despite efforts to optimise both monitoring and treatment. The GDG did not want their recommendations to remove the possibility of using CGM in such cases, and therefore agreed by consensus a recommendation which set out the situations in which a trial of CGM might be warranted.”[1] The results from NWL – whilst a small sample – demonstrate clear and unequivocal improvements in hypoglycaemia management and/or fear of, for all patients who were initiated on CGM under the recommended guidance.

The NICE review found evidence (with some limitations) of clinically and statistically significant improvements in HbA1c. HbA1c did not significantly reduce across the NWL cohort, but it must be considered that the majority of patients began this study with an HbA1c below 75mmol/mol (initiated for hypoglycaemia related indications and not for sustained hyperglycaemia). The one patient initiated for hyperglycaemia had a 23% reduction in their HbA1c after using CGM. None of the NWL cohort experienced diabetic ketoacidosis but it is unclear what the baseline for this group was; this may be an additional benefit in these and other patients.

Appendix 2 | Process for production and review

- Raised as a potential workstream from NHS LPP at the NHSE London Type 1 Diabetes Steering Group Meeting on the 6th of October 2017 - supported by members.
- Proposal for London wide guidance approved by NHS LPP Medicines Optimisation & Pharmacy Procurement Primary Care Sub-group on 2nd November 2017.
- Scoping exercise undertaken by LPP and results discussed at NHS LPP Responsible Diabetes Prescribing Group in January 2018 – agreement to move forward with this work.
- NWL work presented at meeting of Chief Pharmacists of provider Trusts, CCGs and CSUs in London in March 2018 – agreement to support regional work based on NWL arrangements. Feedback received on useful supporting information.
- Workstream discussed and supported at NHSE type 1 diabetes network and diabetes clinical leadership group, respectively (April 2018).
- Proposal accepted by NHSE London Diabetes Transformation Board on the 3rd of May 2018.
- This document has been produced by members of NHS LPP Responsible Diabetes Prescribing Group and the NHSE Type 1 Diabetes Network, with reference to the NWL commissioning proposal for CGM, NICE guidance[1,20,21] and the London diabetes commissioning pack.[22]
- This document has been presented to the following groups for comment before publication:
  - NHS LPP Responsible Diabetes Prescribing Group (representatives from NCL, NEL, SEL, SWL) to liaise with local commissioners
  - NHSE Type 1 Diabetes Network (06.07.18)
  - Via email to London Chief Pharmacists of provider Trusts, CCGs and CSUs
  - NHSE Diabetes Clinical Leadership Group (07.09.2018)
  - NHSE London Diabetes Transformation Board (20.09.18)

Appendix 3 | References

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