NHS
Herefordshire and Worcestershire
Clinical Commissioning Group

Flash Glucose Monitoring in Adults

(managed within Adult Diabetes Services)

August 2021

Commissioning Summary

NHS Herefordshire and Worcestershire CCG (also termed "the Commissioner" in this document) will fund the provision of sensors for Flash Glucose Monitoring (FlashGM), if clinically appropriate and within the recommendations of this policy, for patients* with type 1 diabetes (unless otherwise stated) who have:

1. established diabetes and
2. completed the local requirements for structured education and
3. had their insulin regime optimised and
4. engaged with active self-management and
5. the ability to engage with education on flash glucose monitoring and commit, via a patient/carer contract, to the requirements for use of FlashGM

and who meet one of the following clinical criteria:

- Monitoring > 8 times a day (also insulin-dependent type 2 on haemodialysis)
- Diabetes associated with cystic fibrosis
- People with diabetes (type 1 and 2) and a learning disability who use insulin to treat their diabetes
- Unable to routinely self-monitor blood glucose due to disability requiring carer support or monitoring and insulin management
- Occupational or psychosocial circumstances warranting use
- Recurrent severe hypoglycaemia
- Impaired awareness of hypoglycaemia
- Diabetes associated with total pancreatectomy or labile diabetes associated with chronic pancreatitis where a national criterion is met (as defined)

*and/or carer as appropriate for the requirement

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Please contact the Communications Team: 01905 681956

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Author(s)	Fiona Bates - Specialist Medicines and Clinical Policy Adviser Helen Bryant – Head of Acute Contracts
Directorate Responsible	Contracting
Directorate Lead	Ruth Lemiech – Director of Strategy
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1.0	Creation of policy for Worcestershire CCGs	New Policy	Fiona Bates	March 2019
2.0	Alignment of policies from NHS Herefordshire Clinical Commissioning Group and NHS Worcestershire Clinical Commissioning Groups to create new policies across the new CCG.	Updated Policy	Fiona Bates	25th March 2020
3.0	Incorporation of NHSE&I recommendation to include people with diabetes and a learning disability who use insulin to treat their diabetes in to the FlashGM criteria.	Updated Policy	Ruth Prince	December 2020
3.1	Minor	Change of Executive Lead Addition of EBI information	Jennie Hammond	August 2021
3.2	Minor updates to acknowledge that NHSE reimbursement has ended, removal of Blueteq requirement.	Updated Policy	Ruth Prince	3rd August 2021

Key individuals involved in developing the document:

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Circulated to the following individuals/groups for comments:

Name	Date	Version Reviewed
Worcestershire Area Prescribing Committee	March 2019	V1.0
Worcestershire Clinical Commissioning Policy Collaborative (CCPC)	March 2019	V1.0
Worcestershire Clinical Innovation Group	March 2019	V1.0
Herefordshire & Worcestershire Policy Alignment Task & Finish Group	Various	V2.0
Herefordshire & Worcestershire Clinical Commissioning Groups - Joint Commissioning Committee	25th March 2020	V2.0
Herefordshire & Worcestershire Clinical Commissioning Policy Collaborative (CCPC)	Various 2020	V2.0 and V3.0
Herefordshire and Worcestershire Medicines and Prescribing Committee	August 2021	V3.2

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1. Definitions

1.1 **Exceptional** - refers to a person who demonstrates characteristics, which are highly unusual, uncommon or rare.

1.2 **Exceptional clinical circumstances** are clinical circumstances pertaining to a particular patient, which can properly be described as exceptional, when compared to the clinical circumstances of other patients with the same clinical condition and at the same stage of development of that condition (i.e. similar patients). A patient with **exceptional clinical circumstances** will have clinical features or characteristics which differentiate that patient from other patients in that cohort and result in that patient being likely to obtain significantly greater clinical benefit (than those other patients) from the intervention for which funding is sought.

1.3 A **Similar Patient** is a patient who is likely to be in the same or similar clinical circumstances as the requesting patient and who could reasonably be expected to benefit from the requested treatment to the same or a similar degree. The existence of more than one similar patient indicates that a decision regarding the commissioning of a **service development** or commissioning policy is required of the Commissioner.

1.4 An **individual funding request (IFR)** is a request received from a provider or a patient with explicit support from a clinician, which seeks exceptional funding for a single identified patient for a specific treatment.

1.5 An **in-year service development** is any aspect of healthcare, other than one which is the subject of a successful individual funding request, which the Commissioner agrees to fund outside of the annual commissioning round. Such unplanned investment decisions should only be made in exceptional circumstances because, unless they can be funded through disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.

1.6 The term "**where appropriate"** within this document means that clinical judgement is exercised in determining which aspects of the policy guidance can be applied to individual patients depending on their condition; ability to tolerate the listed treatment; and whether they have already undergone that treatment.

1.7 **Diabetes mellitus** (DM) is a chronic disease caused by inherited and/or acquired deficiency in production of insulin by the pancreas, or by the ineffectiveness of the insulin produced. Such a deficiency results in increased concentrations of glucose (sugar) in the blood, which in turn damages many of the body's systems, in particular the blood vessels and nerves. There are two different forms of diabetes:

a. **Type 1 diabetes** in which the pancreas fails to produce the insulin which is essential for survival. This form develops most frequently in children and adolescents but is being increasingly noted later in life.
b. **Type 2 diabetes** which results from the body's inability to respond properly to the action of insulin produced by the pancreas. Type 2 diabetes is much more common and accounts for around 90% of all diabetes cases worldwide. It occurs most frequently in adults but is being noted increasingly in adolescents as well.

1.8 **Continuous Glucose Monitoring** (CGM) is used in people who rely on insulin to control their diabetes. It involves use of a small device worn just under the skin; this measures interstitial glucose (sugar) levels continuously throughout the day and night, identifying

trends in glucose levels. Some devices provide alerts for highs and lows to facilitate glucose control. There are different types of CGM available:

a. **Real-time CGM** (rtCGM) uniformly tracks glucose concentrations in the body's interstitial fluid, providing near real-time glucose data. There are different types of rtCGM, those that can be used independently (standalone) and those that are used with an insulin pump (insulin pump compatible – CGM sensor augmented pump therapy).
b. **Intermittent CGM** (iCGM) uses similar methodology to show continuous glucose measurements retrospectively at the time of checking. This is also known as **Flash Glucose Monitoring** (FlashGM).

1.9 **Self-monitoring blood glucose** (SMBG) involves a skin prick to draw blood and the application of a chemically active test-strip to the blood. The test-strip is inserted into a meter which provides a reading for the concentration of glucose in the blood at that time. This is the standard method of measuring and monitoring blood glucose in patients with diabetes, particularly those who use insulin to manage their disease.

1.10 **Insulin pumps** are small electronic devices that deliver regular insulin to the body throughout the day and night; also termed **Continuous Subcutaneous Insulin Infusion (CSII)**. There are 2 types of insulin pump – a tethered pump and a patch pump. Both are attached to the body by a tiny tube called a cannula which sits just under the skin. Insulin pumps may be used with or without CGM.

1.11 **Hypoglycaemia** is where the level of glucose (sugar) in the blood drops to less than 4mmol/l; it mainly affects people with diabetes, especially those using insulin.

1.12 **Hyperglycaemia** is where the level of glucose (sugar) in the blood is excessively high; it mainly affects people with diabetes and if it persists can cause damage to the body's internal organs.

1.13 **Nocturnal hypoglycaemia** is an episode of abnormally low blood glucose (sugar) occurring at night-time during sleep.

1.14 **HbA1c** is a measurement in the blood that represents the average blood glucose (sugar) levels for the last two to three months. A high HbA1c means there is too much glucose (sugar) in the blood indicating that diabetes control is suboptimal.

2. Scope of Policy

2.1 This policy is part of a suite of locally endorsed Commissioning Policies. Copies of these Commissioning Policies are available on the following website address: www.herefordshireandworcestershireccg.nhs.uk

2.2 This policy applies to all patients for whom Herefordshire & Worcestershire CCG has responsibility including:

- People provided with primary medical services by GP practices which are members of the CCG and
- People usually resident in the area covered by the CCG and not provided with primary medical services by any CCG.

2.3 The clinical responsibility for applying this policy to a presenting patient rests with the clinician who is responsible for the patient at that point in the treatment pathway and should be done in consideration of the patient's individual clinical circumstances, their place on the management pathway and following discussion with the patient.

2.4 Where a patient's clinical presentation does not clearly meet the requirements for secondary care referral within the context of this policy, and where a GP is uncertain or concerned about the appropriate treatment/management pathway, referral for Advice & Guidance should be considered as an alternative to a referral for clinical assessment.

2.5 There may be occasions when a primary care referral is made for specialist assessment which appears to meet the policy requirements, but which on specialist clinical examination either does not meet the clinical criteria for the intervention or is not considered clinically suitable for the intervention. Such patients should be discharged without the intervention.

2.6 For patients who do not fall within the eligibility criteria set out in the policy but where there is demonstrable evidence that the patient has exceptional clinical circumstances, an Individual Funding Request may be submitted for consideration. The referring clinician should consult the Commissioner's "Operational Policy for Individual Funding Requests" document for further guidance on this process.

For a definition of the term "exceptional clinical circumstances", please refer to the Definitions section of this document.

2.7 This policy applies to adults under the care of adult diabetes services with a diagnosis of diabetes mellitus and who require medical treatment involving use of insulin.

2.8 The purpose of this policy is to define when FlashGM is appropriate for use in adults under the care of adult diabetes services.

2.9 Patient groups not within the scope of this policy include pregnant people with type 1 diabetes mellitus, people managed within the paediatric diabetes service or those with a diagnosis of DM who do not require insulin to manage their disease.

2.10 The following policies are also available for people with a diagnosis of diabetes who use insulin to manage their disease:

i. CGM (including rtCGM and FlashGM) in children and young people managed by paediatric diabetes services
ii. Continuous (real-time) Glucose Monitoring in adults managed by adult diabetes services – in development

iii. Continuous Subcutaneous Insulin Infusion (CSII) in children and young people – in development
iv. Continuous Subcutaneous Insulin Infusion (CSII) in adults
v. Real time and intermittent Continuous Glucose Monitoring during Pregnancy for people with type 1 diabetes mellitus – updated December 2020

3. Background

3.1 The NHS Constitution, which details the principles and values that guide the NHS, has been applied in the agreement of this policy.

3.2 NHS Herefordshire & Worcestershire Clinical Commissioning Group consider all lives of all patients whom they serve to be of equal value and, in making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability except where a difference in the treatment options made available to patients is directly related to a particular patient's clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment.

3.3 NHS England/Improvement launched their Evidenced Based Interventions (EBI) programme in 2018 which aims to ensure that interventions routinely available on the NHS are evidence-based and appropriate. Adoption of published EBI guidance is mandated in the NHS standard contract; commissioners have the freedom to implement criteria with local variations, provided that the decision to adopt varying criteria reflects the requirement to have regard to the national guidance. Where EBI guidance is available, this has been accommodated within the policy criteria.

3.4 Type 1 diabetes most commonly occurs in childhood, the disease can also develop in adults, and always requires insulin therapy for treatment. Type 2 diabetes most commonly occurs in adults and is usually managed by diet or oral medication; in some situations, insulin is required to manage the disease.

3.5 NICE guidelines advise routine self-monitoring of blood glucose levels for all adults with type 1 diabetes, and recommend testing at least 4 times a day, including before each meal and before bed. NICE recommends testing up to 10 times a day if the following apply: to optimise HbA1c, increased frequency of hypoglycaemic episodes, as per DVLA requirements before driving, during periods of illness, before and after sport, when planning and during pregnancy, breastfeeding, impaired awareness of hypoglycaemia. Additional blood glucose testing (more than 10 times a day) is recommended for adults with type 1 diabetes if this is necessary because of the person's lifestyle (for example, driving for a long period of time, undertaking high-risk activity or occupation, travel) or if the person has impaired awareness of hypoglycaemia.

3.6 All patients with type 1 disease require access to a multidisciplinary diabetes team who can provide ongoing support and education to help them manage their condition. Patients are either managed entirely within general practice or jointly with diabetes specialist teams. Adults whose diabetes is not well controlled or who are experiencing problems (for example, hypoglycaemia requiring third party assistance) will require additional support for management of diabetes. When problems persist, consideration may be given to use of either CSII therapy or CGM.

3.7 Insulin pump therapy has been routinely available on the NHS since 2008, with a variety of different rtCGM becoming available some years later, most recently those that are insulin pump compatible.

3.8 FlashGM became available in 2016 but was not routinely available on the NHS. NHS reimbursement of sensors for FlashGM was permitted from October 2017, however, this was dependant on the local commissioning arrangement. Herefordshire and Worcestershire commissioners did not support early use due to concerns with the evidence base to inform appropriate and beneficial use.

3.9 There is currently only one type of FlashGM readily available on the NHS; this product is licensed for people age 4 years and over. Other products are in development.

4. Relevant National Guidance and Facts

4.1 Type 1 diabetes accounts for 8% of all people with diabetes mellitus but almost 100% of children and young people with diabetes. The prevalence of diabetes mellitus in adults is 6% of the UK population or **1 in every 16** people having diabetes (diagnosed and undiagnosed). It is known that there are around 2,696 adults (aged 18 and over) with type 1 diabetes in Worcestershire and around 775 in Herefordshire.

4.2 The following guidelines have been used to inform development of this policy:

Type 1 diabetes in adults: diagnosis and management
National Institute for Health and Care Excellence (NICE) guideline [NG17]. Published date: August 2015, last updated 16 December 2020.

A variety of other NICE guidance has been published but these primarily relate to insulin pump therapy and are not directly relevant to this policy.

4.3 The NICE guideline provides recommendations for use of CGM but was written before intermittent CGM (FlashGM) became available and so does not provide any recommendations for this

4.4 In November 2018, NHS England announced that FlashGM would be available for patients with insulin-dependent diabetes who meet agreed national clinical criteria. On 7th March 2019 the clinical criteria were published for reimbursement of FlashGM on the NHS from 1st April 2019; these allow consideration for use in the following patient cohorts:

1. **Type 1 diabetes requiring intensive monitoring >8 times daily**, as demonstrated on a meter download/review over the past 3 months
2. **Type 1 or 2 diabetes on haemodialysis requiring intensive monitoring >8 times daily**, as demonstrated on a meter download/review over the past 3 months
3. **Diabetes associated with cystic fibrosis**
4. **Type 1 diabetes during pregnancy** (12 months total including post-delivery period)
5. **Type 1 diabetes with disability and carer support** who are unable to routinely self-monitor blood glucose
6. **Type 1 diabetes with occupational or psychosocial circumstances** (e.g. working in insufficiently hygienic conditions to safely facilitate finger-prick testing) that warrant a 6-month trial with appropriate adjunct support.
7. **Type 1 diabetes experiencing recurrent severe hypoglycaemia**
8. **Type 1 diabetes with impaired awareness of hypoglycaemia**

4.5 The national guidance also sets other requirements for use of FlashGM, notably:

- Education on FlashGM has been provided (online or in person)
- Agree to scan glucose levels no less than 8 times per day and use the sensor >70% of the time
- Agree to regular reviews with the local clinical team
- Previous attendance, or due consideration given to future attendance, at a type 1 diabetes structured education programme (DAFNE or equivalent if available locally)
- Continuing prescription for long-term use of FlashGM post initial 6 months is contingent upon evidence of agreeing with the above conditions and that on-going use of FlashGM is demonstrably improving an individual's diabetes self-

management- for example improvement of HbA1c or Time In Range; improvement in symptoms such as diabetic ketoacidosis (DKA) or hypoglycaemia; or improvement in psycho-social wellbeing

4.6 Finally, the national guidance recognises that there is a cohort of patients who have self-funded FlashGM in advance of the device being available on the NHS. For these patients:

- those with clinical responsibility for their diabetes care must be satisfied that the patient's clinical history suggests that they would have satisfied one or more of these criteria (as above) prior to commencing use of FlashGM had these criteria been in place prior to April 2019 AND
- they have shown improvement in HbA1c since self-funding commenced

4.7 In November 2020 NHSE&I made an announcement that:

The original roll out of Flash only applied to select patients with Type 1 diabetes. Many people with diabetes and a learning disability have Type 2 diabetes. The NHS is now offering all patients with a learning disability and diabetes, who use insulin to manage their condition, a Flash Glucose Monitor (or Flash for short).

All people with Type 1 diabetes or insulin treated Type 2 diabetes who are living with a learning disability and recorded on their GP Learning Disability register are eligible for Flash.

4.8 The NHSE&I reimbursement of FlashGM for patients who met the agreed national clinical criteria ended on the 31st March 2021, with funding reverting back to CCGs.

5. Patient Eligibility

5.1. Local pathways specific to service providers are available for the management arrangements for patients being considered for FlashGM.

5.2. Consideration of whether a person may be appropriate for FlashGM will be undertaken at the patient's next annual clinical review or at an earlier review that takes place as a result of changes in diabetic needs; this review could be either in general practice or secondary care depending on how the patient is managed. An earlier review might only be indicated for patients who are planning a pregnancy, become pregnant, are experiencing recurrent severe hypoglycaemia or those with hypoglycaemia unawareness.

5.3. At the annual clinical review (or earlier as above), appropriateness of clinical referral for consideration of FlashGM will be determined by the health professional. The review should include an assessment of blood glucose monitoring (from a meter download) over the last few months to inform eligibility for referral.

5.4. Patients being considered for FlashGM will need to demonstrate that they (or their carer as appropriate) meet all the following requirements:

1. Established type 1 diabetes mellitus (and other forms as listed in 5.5)

2. Completion of the local requirements for structured education (unless considered inappropriate eg. pregnancy, housebound, residential/nursing home, carer administration). Usually involving an educational programme or refresher session within the last 2 years.

3. Optimised insulin regime

4. Engaged with active self-management, evidenced by regular attendance at review appointments by patient or carer

5. Ability to engage with education on flash glucose monitoring and willing to commit, via a patient/carer contract, to the requirements for use of FlashGM (including use > 70% of the time and scanning ≥ 8 times a day

5.5. Patients being considered for FlashGM will also need to demonstrate that they meet one of the clinical indications for use of FlashGM:

1. **Type 1 diabetes requiring intensive monitoring >8 times daily**, as demonstrated on a meter download/review over the past 3 months

2. **Type 1 or 2 diabetes on haemodialysis and on insulin treatment requiring intensive monitoring >8 times daily**, as demonstrated on a meter download/review over the past 3 months

3. **Diabetes associated with cystic fibrosis** on insulin treatment

4. **People with insulin treated diabetes (type 1 or 2) and a learning disability** recorded on their GP Learning Disability register.

5. **Type 1 diabetes with disability and carer support** who are unable to routinely self-monitor blood glucose

6. **Type 1 diabetes with occupational or psychosocial* circumstances** (e.g. working in insufficiently hygienic conditions to safely facilitate finger-prick testing) that warrant a 6-month trial with appropriate adjunct support.
   * Psychosocial circumstances will be assessed by diabetes service teams using a validated scoring tool

7. **Type 1 diabetes experiencing recurrent severe hypoglycaemia****
   ** Recurrent severe hypoglycaemia - defined as more than 1 episode of hypoglycaemia, within a 6 month period, that:
   i. has required third party assistance due to a reduced conscious level needing treatment with oral glucose gel or intra-muscular (IM) glucagon and
   ii. is a diabetic emergency

8. **Type 1 diabetes with impaired awareness*** of hypoglycaemia**
   *** Impaired awareness of hypoglycaemia will be assessed by diabetes service teams using a validated scoring tool eg. the Clarke Hypoglycaemic Index or Gold Score necessitating a score of >4 and ≥ 4 respectively

9. **Diabetes associated with total pancreatectomy or labile diabetes associated with chronic pancreatitis**, as agreed by the specialist diabetes MDT, where one of the national criteria is met:
   - intensive monitoring > 8 times daily
   - pregnancy
   - disability and carer support
   - occupational or psychosocial circumstances
   - recurrent severe hypoglycaemia
   - impaired awareness of hypoglycaemia

   The full definition for these national criteria, as previously stated, applies.

5.6. A referral should be completed for patients who meet the above requirements and submitted to the diabetes service team for consideration of eligibility.

5.7. Diabetes service teams are responsible for triaging referrals and determining eligibility for a 4-6 month trial of FlashGM. It may be determined that some patients require alternative management or clinical review prior to commencing a trial of FlashGM; it may also be determined that a patient referred does not meet the requirements of this policy. Some patients will be returned to general practice management.

5.8. Where a patient meets the requirements for a trial of FlashGM they will be invited to complete device specific online training. The patient may also be asked to complete other assessment tools to help guide diabetes service triage and agree a baseline value for monitoring purposes eg. psychosocial circumstances or impaired awareness of hypoglycaemia.

5.9. In accordance with local pathways, upon completion of online training and any other screening tools, patients who remain eligible for a trial of FlashGM will be invited to attend a group education session. At this session patients will receive training regarding use of the device, provision of a reader and at least 1 sensor and will need to agree the patient contract.

5.10. Further support for use of Flash GM will be provided at regular defined intervals:

a. Clinical review at 2-3 weeks
b. Group review at 4-6 weeks
c. Clinical review to assess eligibility for continuation at 4-6 months.

Additional diabetes service team support will be provided during the initiation stage and as the need arises; appointments will involve either face-to-face or non-face-to-face depending on the patient's requirements.

5.11. Following initiation of FlashGM in eligible people, baseline parameters will be recorded in relation to the monitoring parameters necessary to determine eligibility for ongoing use. These parameters will be taken from information prior to commencement of FlashGM and information gathered during use of the first FlashGM sensor (2-3 week review).

5.12. Eligibility for ongoing use of FlashGM will be assessed initially at 4-6 months and annually thereafter and will require demonstration of compliance with the patient contract and:

a. Wearing the sensor for more than 70% of the time and scanning at least 8 times a day
b. Reduced number of SMBG tests
c. Ongoing engagement with diabetes management and attendance at clinical reviews and educational events as required by diabetes specialist team
d. improved self-management evidenced by one or more of the following parameters and depending on the reason for commencement:

i. Improved HbA1c (as per target agreed at initiation)
ii. Improved time in defined patient range
iii. Reduced time in hypoglycaemia (< 4mmol/l)
iv. Reduced time in hyperglycaemia (>10mmol/l)
v. Reduced diabetes related admissions/A&E attendance for DKA/hyperglycaemia in last 12 months
vi. Reduced diabetes related admissions/A&E attendance for hypoglycaemia in last 12 months
vii. Improved hypoglycaemic awareness - necessitating an improvement from baseline (pre-FlashGM) in one or more of the following assessment tools: Clarke Hypoglycaemic Index or Gold Score
viii. Improvement in psycho-social well-being

5.13. Specialist diabetes teams at provider trusts are responsible for determining eligibility for FlashGM, initiating use of the device (including education) and arranging supply of sensors during the initiation period (4-6 months). When ongoing eligibility is demonstrated (beyond 4-6 months), general practitioners will be asked to maintain ongoing supply of sensors together with any other established diabetes medication requirements.

5.14. Specialist diabetes teams are required to provide evidence of eligibility for:

i. initiation of FlashGM
ii. ongoing use at 4-6 months and annually thereafter

5.15. People who self-funded FlashGM prior to availability on the NHS will be assessed for NHS eligibility in accordance with the above arrangements, including:

1. Demonstrating that they met one of the clinical criteria (section 5.5 above) prior to commencing use of FlashGM; **AND**
2. Demonstrating:
   a. completion of the requirements in section 5.4
   b. completion of online training for FlashGM and any other necessary assessment tools
   c. evidence of benefit from FlashGM since commencement in accordance with section 5.12

Where diabetes service teams are assured that eligible patients meet the parameters below, the patient may not need to complete all elements of the pathway, this will need to be individualised to the patient's circumstances:

a. FlashGM use has been optimised and patient is both competent and confident with use
b. the sensor is worn for more than 70% of the time with scanning at least 8 times a day
c. evidence of reduced number of SMBG tests since self-funding commenced
d. ongoing engagement with diabetes management and attendance at clinical reviews and educational events as required by diabetes service team
e. improvement in HbA1c since self-funding commenced

Where a patient is not able to immediately demonstrate the above parameters further support and education will be offered with re-assessment at 4-6 months in accordance with the pathway arrangements.

6. Supporting Documents

- NHS Herefordshire & Worcestershire: Individual Funding Request Operating Procedure
- NHS Herefordshire & Worcestershire: Prioritisation Framework for the Commissioning of Healthcare Services
- WM01 – Ethical Framework
- WM02 – Orphan Drugs
- WM03 – Patients Leaving Industry Sponsored Trials
- WM05 – NICE Guidance
- WM07 – Choice
- WM08 – In Year Service Developments
- WM09 – Individual Funding Requests (to be read with local process document)
- WM10 – Patients Leaving Non Commercially Funded Trials
- WM11 – Patients Leaving a CCG Funded Trial
- WM12 – Patients Changing Responsible Commissioner
- WM13 – NHS Private Interface
- WM14 – Experimental Treatments
- WM15 – Trial of Treatment
- NHS Constitution, updated 27th July 2015
- NICE Guideline NG17: Type 1 diabetes in adults: diagnosis and management. National Institute for Health and Care Excellence (NICE) guideline [NG17]. Published date: August 2015, last updated December 2020
- NHS England - Flash Glucose Monitoring: National Arrangements for Funding of Relevant Diabetes Patients. March 2019
- NHS England and Information - Comms Pack: Flash Glucose Monitors for people living with diabetes and a learning disability. November 2020

7. Equality Impact Assessment

Equality Statement

7.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on race equality. This obligation has been increased to include equality and human rights with regard to disability, age, gender, sexual orientation, gender reassignment and religion.

7.2. HWCCG endeavours to challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

7.3. All staff are expected to deliver services and provide care in a manner which respects the individuality of patients and their Carer's and as such treat them and members of the workforce respectfully, regardless of age, gender, race, ethnicity, religion/belief, disability and sexual orientation.

7.4. Providers are expected to use the appropriate interpreting, translating or preferred method of communication for those who have language and/or other communication needs. CCG staff and Providers will need to assess that the policy is applied fairly and equitably for all groups covered under the Equality Act 2010 and that they are implementing the Accessible Information Standard and have considered health inequalities.

7.5. HWCCG must meet its statutory duty to reduce inequalities of access and outcomes, as set out in the NHS Act 2006 (as amended). As a result, the CCG aims to design and implement policy documents that seek to reduce any inequalities that already arise or may arise from any new policy. Therefore, the CCG will consciously consider the extent to which any policy reduces inequalities of access and outcomes.

7.6. Any change to this policy will require a conscious effort from the HWCCG to actively consider the impact that this will have on any Protected group(s) and act due diligently. Where an impact on any of the Equality groups is realised after the implementation of this policy, HWCCG and the Providers, will seek to minimise such an impact and simultaneously carry out a full review.

7.7. HWCCG aims to design and implement policy documents that meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. This document has been designed to ensure that no-one

receives less favourable treatment due to their personal circumstances, i.e. the protected characteristics of their age, disability, sex, gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration has also been given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

Organisation	NHS Herefordshire & Worcestershire Clinical Commissioning Group		
Department	Medicines Commissioning	Name of lead person	Fiona Bates
Name of Policy being assessed	Flash Glucose Monitoring (FlashGM) in Adults		
Aims of this Policy	To define the arrangements for accessing FlashGM in Herefordshire and Worcestershire including eligibility criteria, continuation criteria and management responsibilities		
Date of EIA	4th March 2020 Reviewed December 2020 and updated with additional equality groups	Other partners/stakeholders involved	Area Prescribing Committee, Clinical Commissioning Policy Collaborative (2019), Policy Alignment Task and Finish group (2020)
Who will be affected by this Policy?	Adult Patients, GPs, Secondary Care clinicians		
Did the Policy require Engagement or Consultation?	No		

Equality Group	**Potential Positive Impact**	**Potential Neutral Impact**	**Potential Negative Impact**	**Baseline data and research on the population that this piece of work will affect.** What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**
Age			Y	There is a significant difference regarding the type of diabetes developed depending on age: - adults are more likely to develop type 2 disease

Equality Group	Potential Positive Impact	Potential Neutral Impact	Potential Negative Impact	Baseline data and research on the population that this piece of work will affect. What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**
				- children are more likely to develop type 1 disease The criteria within this policy are primarily focussed on type 1 disease and this will have a differential impact.
Disability		Y		There is no available evidence regarding the breakdown of the UK population with diabetes who have a disability and whether this creates a differential impact.
Gender Reassignment		Y		There is no published information that indicates that gender reassignment affects the development of diabetes.
Marriage & Civil Partnerships		Y		There is no published information that indicates that being married or in a civil partnership affects the development of diabetes.
Pregnancy & Maternity		Y		The CCG has published a separate commissioning policy document to provide guidance on the use of CGM and CSII treatment options for patients who are pregnant, so this patient group is not part of this specific policy document.
Race including Travelling Communities		Y		There is limited information in relation to those with type 1 disease. Type 2 diabetes (predominantly adults) is: - up to six times more common in people of South Asian descent - up to three times more common among people of African and African-Caribbean origin. - almost four times as prevalent in Bangladeshi men, and almost three times as prevalent in Pakistani and Indian men compared with men in the general population. - more than five times as likely among Pakistani women, at least three times as likely in Bangladeshi and Black Caribbean women, and two-and-a-half times as likely in Indian women, compared with women in the general population.
Religion & Belief		Y		There is limited evidence regarding the direct impact of religion on the likely development of diabetes however this is strongly linked to ethnicity.
Sex		Y		Currently, the number of people diagnosed with diabetes in the UK is estimated to be 3.5 million

Equality Group	Potential Positive Impact	Potential Neutral Impact	Potential Negative Impact	Baseline data and research on the population that this piece of work will affect. What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**
				Slightly more men than women have been diagnosed with diabetes. Audits suggest that about 56% of all adults with diabetes in the UK are men and 44% are women
Sexual Orientation		Y		There is no published information that indicates that sexual orientation affects the development of diabetes.
Carers		Y		There is no published information that indicates that being a carer affects the development of diabetes.
Care Leavers		Y		There is no published information that indicates that being a carer leaver affects the development of diabetes.
Homeless		Y		The rate of diabetes among people who are homeless is nearly impossible to track, but researchers estimate that it is higher than among the general population. And life expectancy for a person without a home is just 45-49 years, according to a study done by the National Health Care for the Homeless Council. The NHCHC also reports that the number one cause of death among the homeless population is complications related to chronic conditions like diabetes. Things like nutrition and testing blood glucose levels take a back seat when a person is worrying about where they are going to get their next meal or whether someone is going to steal their meager belongings. Treating diabetes is a challenging task for any healthcare professionals but treating patients who are also without a home is double-challenging.
Socio/Economic Deprivation			Y	Deprivation is strongly associated with higher levels of obesity, physical inactivity, unhealthy diet, smoking and poor blood pressure control. All these factors are inextricably linked to the risk of diabetes or the risk of serious complications for those already diagnosed. This is more likely to be associated with type 2 disease and therefore there is a differential impact in adults.
Other Vulnerable and Disadvantaged Groups		Y		In producing the policy, the commissioner's intention was to provide clear clinical information to patients and their responsible clinician, therefore improving the option for equitable access to treatment for clinically eligible patients.

Equality Group	Potential Positive Impact	Potential Neutral Impact	Potential Negative Impact	Baseline data and research on the population that this piece of work will affect. What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**
Health Inequalities	Y			In producing the policy, the commissioner's intention was to provide clear clinical information to patients and their responsible clinician, therefore improving the option for equitable access to treatment for clinically eligible patients.
Does this policy impact on an individual's Human Rights?		Y		The local commissioning policy would not seek to affect a patient's human rights.

Equality Impact Assessment Action Plan

Equality Group	Risk Identified	Action required to reduce/eliminate negative impact	How will you measure the outcome/impact	Timescale	Lead
Age	There is a significant difference regarding the type of diabetes developed depending on age: - adults are more likely to develop type 2 disease - children are more likely to develop type 1 disease The criteria within this policy are primarily focussed on type 1 disease and this will have a differential impact.	The guidance informing this policy has been agreed nationally and is therefore outside of the control of local commissioners.	NA	NA	NA
Social deprivation	Deprivation is strongly associated with higher levels of obesity, physical inactivity, unhealthy diet, smoking and poor blood pressure control. All these factors are inextricably linked to the risk of diabetes or the risk of serious complications for those already diagnosed. This is more likely to be associated with type 2 disease and therefore there is a differential impact in adults as the criteria within this policy are primarily focussed on type 1 disease.	The guidance informing this policy has been agreed nationally and is therefore outside of the control of local commissioners.	NA	NA	NA