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I N S I G H T S

— INSIGHT • ANALYSIS • INTELLIGENCE —

System-wide Strategies
for Better Diabetes Care
Chapter 2: *Ensuring
Equitable Access to Glucose
Sensing Technology for
Type 2 Insulin Users*

CHAired BY PROFESSOR PARTHA KAR

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Foreword



PROFESSOR PARTHA KAR, NATIONAL SPECIALTY ADVISOR, DIABETES, NHS ENGLAND

There are now people being born in the NHS or diagnosed with type 1 diabetes (T1D) who will not know what it is like to prick their fingers regularly to test blood glucose levels. The advent of continuous glucose monitoring (CGM) technology allows people to check glucose levels by wearing a sensor that links to a phone to display the real time glucose data. This is a paradigm shift for those with type 1 diabetes and soon, injecting will be a thing of the past for this group as hybrid closed loop technology (an artificial pancreas responds to CGM by delivering insulin in a closed loop system) is being implemented following the latest NICE recommendation.¹ We have the evidence to demonstrate the benefits of CGM to those with diabetes, both in terms of quality of life from a reduction in finger pricking but also, importantly from an economic standpoint of better diabetes management and a reduction in long-term complications and associated comorbidities.

Given the NHS expenditure on diabetes care, this technology cannot come soon enough. For those with type 1 diabetes, implementation of CGM technology has been widely achieved; now 97 per cent of those with type 1 diabetes have CGM technology. However, despite NICE guidelines recommending CGM for insulin users with type 2 diabetes (T2D), access to this technology is still limited. The picture across the country shows geographical inequalities in access with just over half of all integrated care boards having a policy in place for CGM implementation.

System-wide strategies for better diabetes care is a PPP policy series that identifies gaps and inefficiencies and improves outcomes for patients. The second roundtable in the series focused on: *Ensuring equitable access to glucose sensing technologies for type 2 insulin users*. The roundtable brought together key stakeholders from across the diabetes treatment pathway; primary, secondary and ICB level delegates to better understand the challenges and potential solutions to adopt CGM technology. This report is the summary of that important and timely conversation.

ABOUT PUBLIC POLICY PROJECTS

Public Policy Projects (PPP) is an organisation operating at the heart of health and life sciences policy delivery. We bring together senior leaders and practitioners in the public and private health and life sciences sectors to find realistic solutions to the most pressing issues relating to health and care delivery. We facilitate effective collaboration between

public and private sector organisations. We help businesses to grow their profile within the NHS and wider public sector. In turn, we support public sector leaders and organisations with practical recommendations on implementing policy to improve health and wellbeing outcomes for local populations.

Key Information

ACKNOWLEDGEMENTS

System-wide Strategies for Better Diabetes Care is a Public Policy Projects (PPP) programme designed to identify opportunities for improvements and transformation in diabetes care. The programme convenes key stakeholders from primary and secondary care, pharmacy, and integrated care boards (ICBs) and other key stakeholders for key discussions across a series of roundtables and events. In March 2024, PPP hosted the second of four roundtables, which was chaired by Professor Partha Kar, National Specialty Advisor for Diabetes, NHS England.

The session was attended by more than 30 sector leaders and key stakeholders, including: integrated care system (ICS) leadership, primary care diabetes leads, secondary care consultants, researchers, pharmacists, charities, patient representatives, and key industry representatives. The findings of this paper are

based on these discussions, which have been supplemented with additional research by PPP. As such, it is not an exhaustive account of the Ensuring equitable access to glucose sensing technology for T2D insulin users roundtable, but rather a succinct reflection from a key group of stakeholders.

We are extremely grateful to all of those who have given up their time to contribute to this series. We would like to thank Professor Partha Kar, whose insight and leadership has provided vital steer in this complex landscape. We would also like to thank the speakers; Professor Sam Seidu, Ritesh Dua and Helen O'Neil and the delegates who gave their time to contribute to the discussions. Finally, we thank Abbott for being our industry partner on this roundtable as well as Diabetes UK for their support across the series.

NEXT STEPS

This is the second in a series of four roundtable insights report in the *System-wide Strategies for Better Diabetes Care* programme, which will be followed by webinars, a conference and a final report will synthesise the recommendations from the series.

This is an evolving programme, and PPP has planned a host of events and engagement activities across 2024. We plan to use the platform provided by this report and delve into the intricacies of population health

management strategy, of training and supporting the workforce to drive transformation and harnessing vital innovation to connect the sector together in a time of unprecedented pressure.

We invite all stakeholders who wish to facilitate a diabetes-led transformation of health and care services or those likeminded industry partners who wish to contribute to this debate please write to: Ameneh Saatchi, Director of Market Access and Policy for Diabetes and Wound Care: Ameneh.Saatchi@publicpolicyprojects.com

Key Insights

- CGM is hugely beneficial to people with T2D who use insulin. This is evidenced by NICE guidelines, as well as examples from clinicians where people have made behavioural changes following seeing real-time data and had better management and outcomes.
- There are other groups of people with T2D who might stand to benefit from CGM in the shorter-term (as an educational tool that promotes behaviour change). These groups include people who are newly diagnosed, undergoing pharmaceutical intensification, people awaiting surgery (pre-operative preparation) and the elderly.
- CGM could be used in the short-term as a preventative measure for those at risk of developing T2D.
- CGM provides clinicians with a rich dataset, providing the level of detail needed to make robust, timely and more personalised treatment plans.
- There is considerable variation across the country in ICB adoption of the NICE guidelines recommending CGM for T2D insulin users. Where ICBs have not adopted these guidelines (and therefore there is no implementation policy in place), this may result in widening inequalities as only the most health literate will be able to access CGM technology. There is considerable evidence to support the cost saving of CGM technology in both the short and long-term, but acquisition costs are still an issue due to the financial climate that ICBs face.
- Research shows that having diabetes still holds significant stigma and wearing a sensor potentially identifies an individual as having diabetes. This is a barrier impacting uptake of CGM technology, particularly among those with T2D. It is crucial to address stigma in order to promote uptake of this technology and better self care.
- The impact of CGM technology is limited by a lack of trust, particularly among marginalised groups, in sharing data with healthcare professionals and organisations. As CGM relies on data sharing to maximise health gains, this lack of trust impacts uptake, particularly among marginalised groups. Failure to address this lack of trust risks exacerbating health inequalities.
- For good continuation of care, data needs to be shared effectively and efficiently between primary and secondary care as well as with clinicians in multi-disciplinary teams who are part of the management and treatment plan.
- Primary care staff are under-resourced to cope with the number of new guidelines published and this is influencing willingness to uptake and push this technology.
- Industry support is crucial to promote the roll out of CGM. Industry understands the product design, capabilities, and limitations, so can support effective use of the devices by health and care professionals (HCPs) and people with diabetes through training and educational support. This can reduce the time burden on HCPs.
- Partnerships between industry and the NHS need to continue and grow for successful uptake of CGM more widely.

Recommendations

For integrated care boards

- 1) Develop a policy to facilitate implementation of CGM technology for T2D insulin users. Look to ICBs that do have such policies in place to understand how best to implement given the up-front costs (for instance, phased implementation aligned to NICE guideline NG28).
- 2) Create system-level strategic partnerships with industry to ensure that primary care staff across localities receive the support and training needed to understand CGM technology and that people offered the technology have a clear understanding of the benefits. Such training partnerships should be embedded in ICS policies for CGM implementation.
- 3) Optimise use of CGM technology and streamline existing pathways so patients can get support with CGM, closer to home. This could be done through working with clinical pharmacists who dispense repeat prescriptions of the technology and could help support users in their understanding of CGM.

For primary care leadership

- 4) Proactively encourage primary care teams to understand CGM technology; work with industry to understand CGM technology and upskill to advocate for it for their patients. Develop an understanding of which aspects of the technology are intuitive in order to start building understanding from that entry point.
- 5) Provide training and materials to all HCPs on the value of data sharing for patients and the data protection processes in place such that they can promote this to patients in order to build trust and confidence in data sharing.

- 6) Have peer-to-peer training and share best practice to promote the adoption of CGM as well as other technology innovations that come in via primary care.
- 7) Mobilise all primary care staff to help reduce the stigma surrounding T2D by promoting the patient voice and having positive conversations around management and treatment of diabetes.

For NHS England and central government

- 8) Review how NICE guidelines can be better implemented at system level. Consider pairing new NICE guidelines with resources to ensure they are possible to implement, for instance, staff resource and funding.
- 9) Review the evidence for short-term use of CGM in particular cohorts. For instance, pre-operative preparation or for educational purposes in people who are at risk of diabetes (pre-diabetic) or intensifying treatment.
- 10) When updating guidelines or issuing new NICE guidelines, consider primary care clinicians' time and provide additional resource to ensure effective implementation. Training needs to be extended to every aspect of primary care including those working in the community (such as district nurses) to prevent people who are housebound or have additional needs being left behind. Ensure additional funding and resources are available and that the longer-term cost savings are highlighted so that the health economic argument as well as the patient experience is understood by HCPs. Provide case studies of where it has been done successfully.

Introduction

In 2023, NICE released guidelines (NG28) recommending CGM technology for T2D diabetes insulin users.² The technology allows users to check glucose levels without having to prick fingers by wearing a sensor that links to a mobile smartphone or other device to display the real time glucose data. Users can use it to set an alarm if interstitial glucose levels drop too low. People can also see how food, exercise and other factors affect blood glucose levels.³ The data can be shared with HCPs and provides a rich and robust view of a patient's diabetes management which can be used to support strong clinical decision-making.⁴

This technology was first approved for everyone with T1D in 2022 and the roll out has been a success with high uptake across the T1D population. However, despite the NICE guidelines recommending CGM technology for T2D insulin users, nearly half of ICBs in the UK have not yet implemented the guidelines and so have yet to put a policy in place to support the implementation of CGM technology for those eligible.⁵ As a result, there are many people living with T2D who would benefit from the technology that do not have access. This report captures the conversation of a multidisciplinary group (MDT) of experts brought together to discuss how equitable access to glucose sensing technology could be achieved for people with T2D who use insulin.

THE BENEFITS OF CONTINUOUS GLUCOSE MONITORING

Over four million people have T2D in the UK and that number is growing, in part driven by rising obesity rates.⁶ NICE guidelines published in 2022 approved the use of CGM technology for the approximately 50,000 T2D insulin users in the UK.^{7,8} For these people with diabetes, NICE has determined that the evidence for improved management and outcomes warrants the upfront cost of the technology acquisition. Many roundtable contributors highlighted enthusiasm for benefits of this technology for patients; one delegate, a Clinical Diabetes Lead, said, “I cannot tell you how it’s revolutionised my practice in primary care, and we can’t go back.”

“With this technology, you have real-time data, an alert system that can be shared remotely, the ability of the healthcare provider to remotely monitor the patient’s data and provide timely support and adjustments to their treatment plans – Senior Diabetes Researcher

Primary care staff contributing to the roundtable pointed to positive changes they had seen in patient behaviour, highlighting that “as soon as they (T2D insulin users) had that instant feedback from the CGM, they went away and changed their lifestyle”. Roundtable attendees affirmed a sense of renewed motivation and engagement from patients with their diabetes treatment plan following feedback provided by the CGM. There was also the suggestion that patients are empowered by the data that can help users inform their decisions about their care, and not be so reliant on the healthcare professional. Additionally, the use of CGM can be reviewed in users and as one primary care professional pointed out, “just like any other medication, CGM should be reviewed and if not having desired effect then its usage should be re-considered”.

Overall, it was felt that CGM holds huge potential benefits for the T2D insulin-using community. The richer data set provides comprehensive insights and allows clinicians

to give more personalised care with timely support in treatment. “CGM makes it much safer for clinicians to make decisions around insulin management. How many times does someone come to see you with only very few glucose levels documented?” posed a senior primary HCP. It also allows for more remote management from clinicians for instance using telehealth consultations more regularly. Given the success of using peer-to-peer telehealth consultations in trials, the side effects of CGM could also prove beneficial.⁹

While NICE guidelines are currently limited to T2D insulin users, there was discussion about other groups that may stand to benefit from CGM use - delegates felt that short-term use of CGM could be beneficial as an educational tool. One delegate, a senior primary care professional, argued that “patients don’t need CGM technology forever. I think access for 1-2 weeks would have a legacy effect. And then maybe every so often, every six months. I don’t think CGM needs to be something that’s there constantly.” Meanwhile, another primary care delegate stated a rationale for short term use; “you create that bio-feedback mechanism for the patient too and they can continue the behaviour change after the sensor is removed.” As well as supporting people to make behavioural changes to improve their diabetes management, it was felt that CGM could be used preventatively. For instance, for people who are at risk of developing diabetes (such as those with pre-diabetes or using population health management to identify people at risk of T2D), seeing real time data could help promote behavioural changes that would mitigate their risk of developing T2D.

Another key cohort discussed was for patients awaiting surgery. It is well established that surgical outcomes are affected by unregulated or poorly regulated blood glucose.¹⁰ Short term use of CGM could help patients manage their blood glucose pre-operation to give the best chance of surgical outcomes.

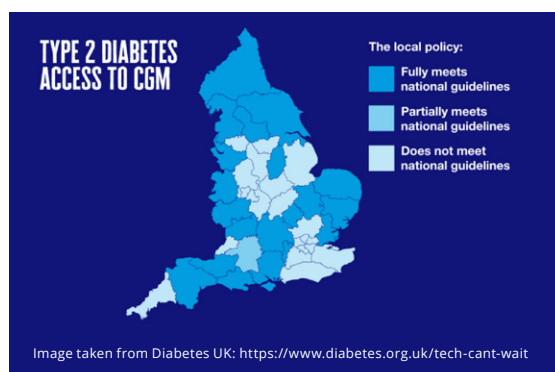
“It’s the acute glucose excursions around surgery, which make a difference to people’s outcomes as opposed to more chronic glucose levels. So, with CGM you’ve got the potential to improve preoperative preparation, and to improve outcomes” – Clinical Consultant

Similarly, further groups of people were identified that might stand to benefit from CGM; those with a new diagnosis of T2D or whose treatment is being intensified and the elderly. One commissioner mentioned a project looking at using CGM technology more widely in care homes and therefore reducing emergency admissions from hyperglycaemias in this population.

BARRIERS TO ACCESS AND INEQUALITIES IN ACCESS

Despite the benefits discussed and the NICE guidelines in place, there are currently significant barriers to accessing CGM technology. These barriers have the potential to widen health inequalities if not addressed. A patient representative also pointed out the toll differential access can have for patients who may be frustrated by the lack of clarity on who is eligible and who isn’t, the representative argued that: *“There needs to be a clear implementation strategy that makes sense to the patient population.”*

MAP SHOWING THE ICB VARIATION IN ACCESS TO CGM ACROSS THE UK



A key barrier discussed was the geographical differences across ICBs in adopting the guidelines and creating a policy to support implementation. Despite the NICE guidelines, there has been resistance to the implementation of the recommended technology from nearly half the ICBs in England.

Roundtable contributors from Welsh health systems pointed to similar issues in rolling out CGM, despite having guidelines recommending CGM predating NICE. The challenges are largely financial and delegates from a commissioning background pointed out the desire of most ICBs to get this technology to patients, but high acquisition costs pose a challenge to commissioners in the current financial climate. Delegates raised concerns about increased inequalities where there is no ICB policy in place as only those teams that are very health literate and follow NICE guidelines will be able to advocate for this technology to their care teams. This is in spite of a clear directive in the guidelines regarding inequalities. One senior academic highlighted that: *“There is a clear statement (in NG28) that commissioners have got to make the effort to identify patients who would otherwise be left behind and come up with comprehensive strategic plans that they can implement across their area to ensure that nobody is left behind.”*

While there was an appreciation of the difficult financial position faced by ICBs, delegates argued that greater access of CGM could reduce hypoglycaemia related hospital admissions - which each costs the NHS £1000.¹¹ Also, data from France where CGM has been implemented shows that over a set time period, there is a 50 per cent reduction in emergency admissions associated with diabetes.¹² Therefore, CGM promises a short-term cost saving for the NHS as well as the longer-term benefit from reduced complications.

Another barrier discussed was stigma. There is significant stigma around diabetes, and evidence has shown it can even impact an

individual's chance of getting married.¹³ The visibility of the CGM technology is therefore a barrier to some who do not wish to be identified as having T2D. A paediatric diabetologist pointed out that this is also true for young people. Many young people also don't want to be identified as having diabetes and as the sensor is permanently attached to the skin, for some this is too identifying. Furthermore, the colouration of sensor covers has previously been limited and designed for Caucasian skin tones, therefore presenting another barrier to people with diabetes from ethnic minorities. This is something that industry are assessing, with industry stakeholders present at the roundtable stating: *"we are always looking at how we can best meet the needs of people with diabetes and that includes product design. Feedback is useful for our R&D team for consideration as they work on future product updates."* Delegates felt that addressing stigma is important for the T2D community and some delegates felt positive about the future stating that as more people with T2D share experiences, this will grow empathy and understanding of people living with T2D. This has been seen in the T1D community and undoubtedly influenced uptake of CGM.

While some people are able to learn independently and access educational resources online, those with additional needs and those that are housebound and dependent on carers will require additional support. These people are at risk of being left behind as delegates stressed that there is reluctance in implementing CGM for these groups due to the increased workload. To ensure that these groups get equitable access to this technology requires primary care resources and quality leadership to both allow HCPs the capacity to take on this technology as well as inspiring them to feel positive and confident in CGM.

The issue of data sharing and trust was also discussed. For CGM to be most effective, the data from the sensor needs to be shared

with HCPs.^{14, 15} This aids clinical decision-making and can pick up trends early as well as allowing for timely escalation and de-escalation of medication. However, broader issues concerning public trust in sharing their health data could hamper the progress and uptake of CGM.^{16, 17}

PRIMARY CARE AND CGM IMPLEMENTATION

Primary care support is essential for engaging communities at a neighbourhood level and therefore essential for CGM technology uptake.

"People always talk about the successful rollout of CGM to the type one population. Do you think that's happened due to secondary care? No. It's happened because it went on the FP10 prescription and our primary care colleagues helped us with practice nurses and everybody else. That's how we rolled it out. That's how we beat the whole system of years of technology being only being available to a few."

– Senior Diabetes Lead

Those with T2D are almost exclusively managed by primary care teams with NICE publishing 34 guidelines that are relevant to primary care staff last year. Delegates pointed out this is an overwhelming number of guidelines to 'get to grips with' with times already stretched and resources limited. Yet, primary care is crucial to the adoption of new health technology as it is the main point of contact for people with T2D. Furthermore, one delegate said that in their experience, uptake, particularly among marginalised groups, is influenced by several factors:

- The patient's relationship with the HCP.
- What the HCP's view of the technology is and the knowledge that the HCP has of the technology.

- Whether the HCP has the time required to make the technology work for that patient through both explanation and personalised follow up and support.

Enthusiastic and well-trained staff are crucial to adoption of new technology particularly for marginalised groups (often the people that stand to benefit most from this technology). For the most health literate, this is less impactful as these people have the time and resource to research and understand the technology directly.

Primary care is already an overstretched workforce and delegates recognised the challenge in training and supporting primary care staff to roll out CGM. *"You can throw as much money as you want at it but if you don't have the GP's and the nurses and the pharmacist to do the work, it's not going to be done,"* said a senior expert in primary care. There was also a suggestion that *"guidelines should consider clinicians' time needed to treat. And to further promote the attractiveness of guidelines for primary care, the design of the*

guidelines should be oriented more towards that application" said a primary care HCP.

Delegates discussed the fragmented nature of diabetes care and some suggested that creating diabetes hubs providing a 'one stop shop' for all aspects of diabetes care would help support CGM rollout. Experts by Experience were also mentioned again as having huge workforce potential as well as being able to engage with patients where HCPs haven't managed to.

Roundtable delegates felt that industry collaboration is key to supporting primary care, one senior primary care professional argued that: *"If we can collaborate with industry properly, we can do searches for the right patients, industry can run group initiations. Industry can come and do a group teach. When you try to implement yourself in your busy clinics, with everything else in primary care, it's just not going to work."* Other delegates pointed to successful examples of industry support, with one delegate highlighting how *"industry have been very helpful going into practices doing more of a supervision role to give people confidence to start this technology"*.

CASE STUDY: EFFECTIVE IMPLEMENTATION OF CGM IN HEREFORDSHIRE

Abbott is a global healthcare leader that helps people live more fully at all stages of life. We believe people with diabetes should enjoy active lives, so we're focused on making breakthrough technology accessible and approachable for all. Our groundbreaking sensing technology is revolutionising how people monitor glucose and providing healthcare professionals with more data to make better informed treatment decisions.

Herefordshire and Worcestershire Integrated Care Board (ICB) serves a population of over 50,000 people living with diabetes. In October 2022, the ICB was one of the first in the country to align with NICE guideline NG28 regarding the management of diabetes in adults. The policy outlined the use of continuous glucose monitors and recommended they be considered for eligible patients, including adults living with type 2 diabetes who used multiple daily insulin injections. This was an opportunity for system-wide roll out of this technology, working with ICB colleagues supported by clinical leaders and front-line healthcare professionals, to enable eligible people living with diabetes to better understand and self-manage their condition.

Hereford Medical Group, located within the Herefordshire and Worcestershire ICB, led the implementation of the NICE guidelines across the practice and Primary Care Network (PCN). At the time, a total of 2,814 patients lived with diabetes. Abbott supported healthcare professionals (HCP) by providing local webinars and in-person training events for HCPs and practice staff to help improve their understanding of Abbott's FreeStyle Libre 2 system, and how it could benefit patients and HCPs in the long term.

To address inequality of access, the Business Intelligence & Long-Term Conditions Manager worked closely with the Abbott local team using an EMIS search template, available via the ICS TeamNet diabetes page, to run searches and proactively identify patients who were eligible to be offered the FreeStyle Libre system. The diabetes team then reviewed the patient list to ensure people met the eligibility criteria and that no one was missed. The final list included 142 people who were invited to enroll for online training. Alternatively, patients who needed face-to-face support were booked onto a group training clinic delivered by Abbott reps. Dedicated care coordinators managed the process, making the patient journey as smooth as possible. This consistent management meant care coordinators could update patient records appropriately so that GPs could confidently prescribe the technology.

This model of implementation in primary care can be replicated in other areas of the country. With clinicians working closely with ICBs on rolling out this technology in primary care settings, supported by industry, patients can be easily identified and trained in an efficient way that does not create additional workload and brings added benefit to practices and patients.

The use of the FreeStyle Libre 2 system has helped patients to change their behaviour, delaying intensification of pharmacological treatment. The team had very positive feedback from patients, who say the technology has been life changing. It improves their safety, while also giving clinicians more information to offer better informed treatment choices.

For clinicians, working collaboratively with Abbott to train practice staff on how to implement the use of the technology to eligible patients has enabled them to support people living with diabetes. Improved understanding of the technology has played a pivotal role in how diabetes care is delivered for their patients.

Conclusion

The NHS has been proactive in creating guidelines to improve the lives of those with diabetes across the UK. These guidelines create significant potential for long-term health and wellbeing benefits for those eligible. However, across the devolved nations, there are considerable challenges in the implementation of these guidelines, demonstrating that guidelines alone are not enough in promoting new treatments across the NHS.

To enable ICBs and HCPs across the country to give everyone access to the best treatments available, guidelines cannot be issued in isolation. A system that considers resources, including staff capacity and funding when updating guidelines or approving new treatments is essential to ensure patient access. Without this, there is a risk of widening the health inequalities gap as only those that are very health literate and can advocate for themselves in line with new NICE guidelines will access new treatment.

As NHS resources and workforce challenges remain huge issues impacting patient care, it is increasingly important to develop effective partnerships with industry. Industry colleagues are best placed to support with training on their technologies for healthcare professionals and people with diabetes and have the incentive to enable users.

The UK has an outstanding track record in developing new treatments and NICE is the gold standard on evaluating treatments globally. These incredible resources have great potential to ensure that the best possible patient outcomes are achieved, taking into account health economic analysis. The next step is to make best use of NICE by ensuring guidelines are implemented across the country with equality and this is done fairly ensuring everyone eligible stands to gain from treatment innovations.

Attendees

The insights and recommendations of this report have been informed by a roundtable event which took place on the 21st February 2024. Thank you to all the participants of the roundtable, and those who supported and gave comments to the report.

Professor Partha Kar

National Specialty Advisor, Diabetes, NHS England

Helen O'Neil

Senior Medicines Optimisation Pharmacist, NECS

Ritesh Dua

GP Partner, The Weobley & Staunton-on-Wye surgeries

Samuel Seidu

Professor of Primary Care Diabetes and Cardiometabolic Medicine, University of Leicester

Emma Dobbie

Patient Advocate

Nusrat Kausar

Clinical Director / Dietitian, Primary Care Dietitians

Pooja Sachdev

Clinical Associate Professor in Paediatric Endocrinology, Nottingham University Hospitals NHS Trust

Vicki Alabraba

Diabetes Specialist Nurse, University Hospitals Leicester NHS Trust

Ibi Erekosima

Consultant, Northern Care Alliance NHS Foundation Trust

Jenny Foster

Network Manager, CYP NENC Diabetes Network

Balraj Mavi

GP, Wordsley Green Surgery

Nadra Ahmed

Executive Chairman, National Care Association

Amelia Cook

Clinical Lead Diabetes Black Country, Black Country ICS

Bernadette Adeyileka-Tracz

Executive Director, Diabetes Africa

Dalvinder Ratra

GP, NHS

Efa Mortty

Head of Medicine's Management, NCL ICB

Alistair Lumb

Consultant Diabetologist, Chair DTN-UK, Diabetes Technology Network-UK/Oxford University Hospital

Stephane Roze

CEO Expert Health Economist, Vyoo Agency

Rani Khatib

Consultant cardiology pharmacist & Associate Professor, Leeds Teaching Hospitals & University of Leeds

Sarah Davies

GP and Wales lead for diabetes in primary care, Woodlands Medical Centre

Michelle Turner

District Specialist Nurse, Shropscom

Samantha Howard

Market Access Director, Abbott Diabetes Care

Shay Speakman-Brown

Head of Market Access, Dexcom

Lynne Reedman

Founder & Service Lead, DUET diabetes Ltd

Laura Wetherly

Public Affairs Lead, Sanofi UK

Mike Houghton

Government Affairs Manager, Novo Nordisk

John Gray

Market Access Manager, Dexcom

Slade Cartner

Senior Government Affairs Manager,
Boehringer Ingelheim

Anthony Walker

Senior Policy Officer, Diabetes UK

Natasha Jacques

Lead Medicines Optimisation Pharmacist,
Coventry & Warwickshire Integrated Care Board

Judith Reid

Paediatric Associate Specialist, Gateshead
Health NHS FT

Komal George

Holistic Pharmacist and Type 2 Diabetes Coach,
Otway House Consulting Ltd

Jason Cheung

Consultant Diabetologist, Norfolk and
Norwich University Hospitals NHS
Foundation Trust

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