

DERBYSHIRE LINCOLNSHIRE & NOTTINGHAMSHIRE AREA PRESCRIBING COMMITTEE (DLN APC) DECISION AND JUSTIFICATION LOG

Meeting Date: 13th August 2026

Updated by: DDICB Policy Team

Ethical Framework

Chair to ensure that all decisions made are in line with the [ICBs Ethical Framework](#), following examples of evidence of clinical and cost effectiveness, health care need and capacity to benefit, policy driver/strategic fit.

Declarations of Interest

Committee members are reminded of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the ICB. Declarations declared by members of the DLN APC are listed in the Register of Interests and included with the meeting papers. The ICB's Registers of Interests are also available via the ICB's Corporate Governance Manager.

Agenda Item number	Agenda Item Title	Owner	Summary of Discussion	Decision & Justification	Action(s)
	Attendance/Quoracy	Chair	Reid Baker, Sue Bamford, Hazel Baxter, Naomi Burden, Mark Clymer, Richard Coates, Slak Dhadli, Eve Evans, Lesley Gant, Ruth Gooch, Grace Gough, Nicola Graham, Steve Haigh, Claire Haynes, Kiran Hewitt, Helen Hill, Tim Hills, Steve Hulme, Nicola Jay, Paul Jenks, Steve Jones, David Kellock, Gladys Maponese, Dominic Moore, Ben Milton, Andy Mott, Vimbayi Mushayi, Kerrie Nearn, Kate Needham, Vivek Patil, Simon Robinson, Alun Roebuck, Kate Sanderson, Irina Varlan, Helen Walker, Sandya Wellwood, Ann Whitfield, Kim Willett, Rob Wise		
1	Apologies	Chair	Mark Clymer, Ruth Dils, Jo Flemming, Helen Halling, Lynne Kennell, Emily Khatib, Fatima Malik, Glenn Spencer, Jacqui Toner Woods		

2	Conflict of interest declarations	Chair	Alun Roebuck declared a specific interest in relation to the Wegovy agenda item, having previously delivered Novo Nordisk-sponsored talks that included Wegovy for cardiovascular disease prevention.		
	a. Register of interests		Unified register still in development Minor update required to Ben Milton employment details		
3	Declarations of any other business	Chair	None		
4	Matters arising				
	a. DLN Process to Review NICE Technology Appraisals (TAs)	Lesley Gant	APC members support the development of a joint approach to managing NICE TA implementation across the DLN cluster which will enable timely review of clinical and implementation implications of a TA, consideration of financial impact, escalation of high-cost decisions and subsequent approval of formulary classifications. It was agreed that the interim process requires further consideration before being implemented. Feedback from members will be reviewed and the process updated as appropriate.	Further development required	
	b. Derbyshire classification of fezolinetant		The Derbyshire classification for fezolinetant for treating moderate to severe vasomotor symptoms associated with menopause was clarified as GREEN after specialist recommendation. An accompanying guideline is in development which will support appropriate patient selection, safe prescribing and provide clarity on the proposed positioning of treatments.	GREEN after specialist recommendation in Derbyshire No change for Lincolnshire and Nottinghamshire	
	c. Semaglutide for CVD (TA1152)		Prescribing budget approval has been granted for use of semaglutide (Wegovy) for reducing the risk of major adverse cardiovascular events in people with cardiovascular disease and overweight or obesity. However, work is ongoing to resolve implementation	Derbyshire: GREEN Lincolnshire: GREEN with guideline	

			challenges, including service delivery arrangements and workforce implications. The traffic light classifications recommended at the July APC meeting were confirmed.	Nottinghamshire: Amber 3	
5	DLN APC Decision and Justification Log July 2026	Lesley Gant	For ratification	Ratified	Publish
6	Formulary additions and amendments				
	a. Pylera® and Derbyshire Dyspepsia and GORD guideline	Eve Evans	Pylera is a combination product containing Bismuth, Metronidazole and tetracycline. It has recently been approved by the UHDB Drug & Therapeutics Committee for the eradication of Helicobacter Pylori (H. Pylori). NICE CKS 'Dyspepsia with unidentified cause' supports the use of bismuth as a part of the second line regimen for patients allergic to penicillin. Having bismuth as part of the eradication regime for H.Pylori has been shown to have improved patient outcomes (even in the presence of resistant infections). Pylera reduces tablet burden for patients, provides a simpler dosing regime and doesn't carry the allergy risks associated with bismuth salicylate containing compounds such as Pepto-Bismol. Bismuth availability is uncertain as it has previously been out of stock. Bismuth alone is only available as an unlicensed special as a standalone treatment. This is significantly more expensive than Pylera. The Derbyshire Dyspepsia and GORD guideline has been updated to place Pylera as second line treatment in patients with a penicillin allergy with a treatment duration of 10 days. The previous second line regimen for penicillin allergic patients contained levofloxacin, which is associated with significant side effects.	Derbyshire: GREY - 2nd line for <i>H. pylori</i> eradication in penicillin allergic patients GREY specialist recommendation - 3rd line for <i>H. pylori</i> eradication in non-penicillin allergic patients No change for Lincolnshire or Nottinghamshire	Update Derbyshire formulary and publish updated guideline

			In patients with no penicillin allergy, it is placed as third line treatment with 14-day duration, only recommended on specialist advice. Pylera is licensed for 10 days but local specialists advised that for non-penicillin allergic patients who have had 2 other treatments previously, evidence shows that 14 days of treatment is more successful. Pylera is licensed for use in combination with omeprazole. Omeprazole replaces lansoprazole as the preferred PPI in all H.Pylori treatment regimens. The clinical content of the updated guidance was reviewed and agreed at the Derbyshire Guideline Group meeting in July.		
7	Clinical Guidelines				
	a. Update on DLN Type II Diabetes guideline	Hazel Baxter	The review of the updated NICE guideline NG28 (published February 2026) has required detailed consideration of a complex and recently revised set of recommendations; interpreting the distinction between NICE recommendations to offer or consider specific interventions; and recognising that NG28 is a clinical guideline rather than a NICE Technology Appraisal and therefore does not carry the same statutory funding requirements. Development of DLN wide guidance aims to support an equitable, consistent and sustainable approach to the management of type 2 diabetes that is feasible within the available financial envelope. The recommendations in NICE NG28 that represent a change to current practice were discussed and agreed for DLN as follows.	See each individual recommendation for each APC decision.	For escalation to ICB Executive Directors due to significant financial and other resource implications

			1. <u>Offer</u> initial modified-release metformin for people with type 2 diabetes and: - o no relevant comorbidity - o heart failure (with any ejection fraction, unless specified) - o atherosclerotic cardiovascular disease (ASCVD) - o early onset type 2 diabetes - o obesity - o chronic kidney disease. Previously modified-release metformin was generally reserved for people with gastrointestinal intolerance to immediate-release metformin. The NICE Resource Impact Template assumes no change in the overall number of people receiving metformin following implementation of the updated recommendation, therefore it is considered there is no additional finance cost of this recommendation. APC Recommendation: Adopt GREEN TLC for modified-release metformin across DLN without restriction for initiation of therapy. To be implemented prospectively for new treatment initiations.	APC decision to recommend this element of the guideline be implemented	
			2. <u>Offer</u> initial SGLT-2 inhibitor with metformin, or as monotherapy if metformin is unsuitable, to adults with type 2 diabetes, including those with: - o no relevant comorbidity - o heart failure (with any ejection fraction, unless specified)	APC decision to recommend this element of the guideline be implemented – subject to	

			- o atherosclerotic cardiovascular disease (ASCVD) - o early onset type 2 diabetes - o obesity - o chronic kidney disease. Implementation of this recommendation represents an expansion of the eligible population for SGLT2 inhibitor treatment across all three ICBs, with the potential for increased prescribing of SGLT2 inhibitors in people who are not currently receiving treatment. There is potential to mitigate some of the additional expenditure through optimisation of existing SGLT2 inhibitor prescribing. The current use of empagliflozin 10 mg and 25 mg across DLN represents a potential opportunity for clinically appropriate switching to dapagliflozin 10 mg. NICE impact modelling indicates significant savings to the system from the resulting reduction in cardiovascular and renal events. Members recognised that further planning on implementation is required, including service delivery and associated costs, robust patient education, monitoring and reporting mechanisms and discussion with commissioners and contracting colleagues regarding funding flow and system-wide benefits. APC Recommendation: Adopt TLCs as below (for type 2 diabetes) and prioritise generic dapagliflozin 10 mg for new initiations where clinically	executive approval.	
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		appropriate. (*Indicates change from current classification) <table><tr><th>DDICB</th><th>LICB</th><th>NNICB</th></tr><tr><td>Dapagliflozin GREEN 1st line</td><td>Dapagliflozin *AMBER 3</td><td>Dapagliflozin AMBER 3</td></tr><tr><td>Empagliflozin GREEN 2nd line</td><td>Empagliflozin *AMBER3</td><td>Empagliflozin AMBER 3</td></tr><tr><td>Canagliflozin GREY</td><td>Canagliflozin *Non-formulary</td><td>Canagliflozin *Non-formulary</td></tr><tr><td>Ertugliflozin GREY</td><td>Ertugliflozin *Non-formulary</td><td>Ertugliflozin *Non-formulary</td></tr></table>	DDICB	LICB	NNICB	Dapagliflozin GREEN 1 st line	Dapagliflozin *AMBER 3	Dapagliflozin AMBER 3	Empagliflozin GREEN 2 nd line	Empagliflozin *AMBER3	Empagliflozin AMBER 3	Canagliflozin GREY	Canagliflozin *Non-formulary	Canagliflozin *Non-formulary	Ertugliflozin GREY	Ertugliflozin *Non-formulary	Ertugliflozin *Non-formulary		
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		3. <u>Offer</u> as initial treatment subcutaneous semaglutide (Ozempic) up to 1 mg once a week with metformin and an SGLT-2 inhibitor, or with an SGLT-2 inhibitor if metformin is not suitable, for people with type 2 diabetes and atherosclerotic cardiovascular disease (ASCVD). Implementation of this recommendation is expected to increase the number of people eligible for semaglutide compared with the current local position. However, there is overlap with the population already eligible for semaglutide (Wegovy) under NICE TA1152, which was considered by DLN in July 2026. The extent of this overlap cannot currently be quantified, and the financial modelling represents an estimate of the potential additional prescribing expenditure associated with implementation of NG28. NICE impact modelling indicates significant savings to the system from the resulting reduction in cardiovascular and	APC decision to recommend this element of the guideline be implemented – subject to executive approval.																

		renal events, though this saving does not mitigate the total cost implication of increasing prescribing of semaglutide (Ozempic) to eligible patients. APC Recommendation: Adopt TLCs as below for semaglutide (Ozempic) for this indication. <table><tr><td>DDICB</td><td>LICB</td><td>NNICB</td></tr><tr><td>GREEN</td><td>GREEN</td><td>Amber 2/GREEN</td></tr></table> 4. Offer prescribable evidence based CGM to adults with type 2 diabetes on multiple daily insulin injections if any of the following apply: • they have recurrent hypoglycaemia or severe hypoglycaemia • they have impaired hypoglycaemia awareness • they have a condition or disability (including a learning disability or cognitive impairment) that means they cannot self-monitor their blood glucose by capillary blood glucose monitoring but could use a CGM device (or have it scanned for them) • they would otherwise be advised to self-measure at least 8 times a day Nottinghamshire and Lincolnshire ICBs have previously adopted these recommendations and have prescribing guidance in place to support eligible use of CGM. Adoption across Derbyshire would provide a consistent approach across the DLN footprint and align local practice with current NICE recommendations. Existing implementation within	DDICB	LICB	NNICB	GREEN	GREEN	Amber 2/GREEN	APC decision to recommend this element of the guideline be implemented – subject to executive approval.	
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			Nottinghamshire and Lincolnshire means that the principal financial impact of adoption is expected to fall within DDICB. The estimated gross annual cost of CGM for the identified eligible Derbyshire population is approximately £1.08 million. Implementing updated NICE NG28 recommendations will increase CGM expenditure, but improved glycaemic control may reduce longer-term diabetes complications and healthcare use. Detailed referral and implementation guidance is currently being developed by the DLN diabetes specialist group to support consistent application of the NICE eligibility criteria and appropriate use of CGM across the three ICBs APC Recommendation: Approve the proposed DLN formulary position for CGM, with Green or Grey (specialist recommendation) classification proposed for DDICB, and to note that there will be no change to the existing formulary position in NNICB and LICB. 5. <u>Consider</u> initial GLP-1 receptor agonist or tirzepatide treatment for people with <u>early onset type 2</u> diabetes (diagnosed before the age of 40). NICE recommends considering a GLP-1 receptor agonist as initial treatment alongside metformin and an SGLT-2 inhibitor, for its cardiovascular, renal and glycaemic benefits, or tirzepatide for its glycaemic benefits. Decision. For further review There is greater uncertainty regarding the balance of benefits, risks and cost effectiveness of this recommendation compared with the stronger	APC to escalate and discuss with executive directors regarding implementation	
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			recommendations within NG28. NICE modelling indicates no significant cost saving or reduction in events over a 3-year period by implementing this change. 6. <u>Consider</u> earlier use of GLP-1 therapies for those with diabetes and obesity; previous guidance restricted use for those with BMI $\geq 35\text{mg/m}^2$ in whom further intensification was required following the use of 3 oral agents. New guidance advises that GLP-1 therapies are considered following use of 2 oral agents and BMI criteria are implied to be $\geq 30\text{mg/m}^2$. Decision. For further review	APC to escalate and discuss with executive directors regarding implementation	
	b. Tirzepatide (Mounjaro™)	Vimbayi Mushayi	The APC approved the Prescribing Tirzepatide (Mounjaro) for the Management of Overweight and Obesity in Primary Care guidance as a unified DLN guideline. This guidance was developed using the Derbyshire Tirzepatide for the Management of Overweight and Obesity in Primary Care guideline. This was first developed in September 2025 in response to the NHS England interim commissioning guidance and updated in May 2026 to reflect the introduction of the 2026/27 QOF arrangements and associated implementation requirements for tirzepatide. The guidance has been reviewed by members of the DLN Weight Management Group and amendments made to reflect stakeholder feedback and to support a harmonised approach to the prescribing, monitoring and governance of tirzepatide across Derbyshire, Lincolnshire and Nottinghamshire.		

			Amendments to the guideline include: • Inclusion of wording that the initial assessment for tirzepatide prescribing in primary care should be undertaken by an appropriately trained healthcare professional, as per NHSE interim commissioning guidance • Removed the exclusion criterion for patients prescribed tirzepatide primarily for the glycaemic management of type 2 diabetes. • Clarified that for patients prescribed tirzepatide for type 2 diabetes, any further dose escalation undertaken primarily to achieve additional weight loss after glycaemic targets have been met should be managed in accordance with this weight management guideline rather than type 2 diabetes management guidance • Additional information regarding retinopathy and diabetic retinal screening, including checking the most recent screening results before initiation and considering liaison with ophthalmology where appropriate. • Clarification of the baseline monitoring requirements • Added clarification that waist circumference should be measured in people with a BMI below 35 kg/m² to enable calculation of the waist-to-height ratio • Removed timeframe on face-to-face appointments • Inclusion of links and references relating to FSRH guidance and BMS guidance on HRT • Addition of counselling information relating to the risk of metabolic acidosis associated with benzyl alcohol accumulation in patients with hepatic or renal impairment • Updated references with NHSE interim commissioning guidance		
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			The APC acknowledged that significant funding, service delivery and implementation concerns remain. These issues should be escalated through commissioning and governance routes for resolution outside of the APC.		
8	Subgroups				
	a. Derbyshire Guideline Group Key Messages July 2026		Updates and decisions from the July Guideline Group meeting were shared for information	Noted	
	b. Lincolnshire PACEF Minutes July 2026		Updates and decisions from the July PACEF (Prescribing and Clinical Effectiveness Forum) meeting were shared for information	Noted	
10	Any other business		None		