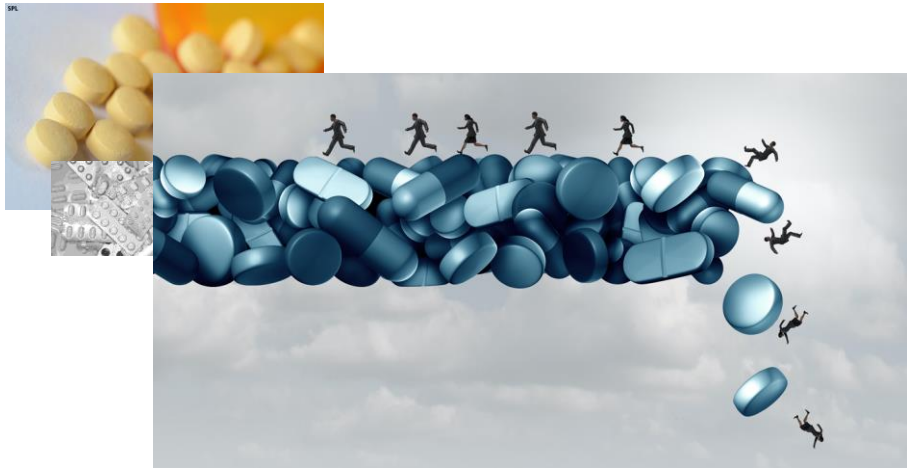
Lancashire & South Cumbria
PRIMARY CARE TRAINING HUB

NMP Lunch & Learn Training Session

Diabetes & GLP1

21st July 2026



Speaker:

- Sanjay Tanna
- Senior Pharmacist
- Morecambe Bay Primary Care Collaborative

Welcome & Housekeeping

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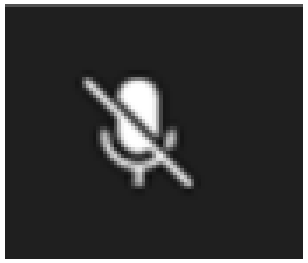
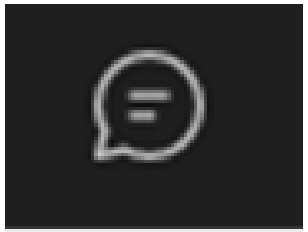
Thank you for joining us today!

- ✓ The session is for 45-minutes (30-minute presentation and 15-minute Q&A session).
- ✓ Please switch off your cameras and put yourselves on mute.
- ✓ Please use the chat function if you want to ask a question or for comments.
- ✓ Please respect others' views and opinions. (We have prescribers from across the system on the call – primary, secondary care and community).
- ✓ Please use the chat function to network with your peers and share ideas.
- ✓ At the end of the session there will be a short online feedback form (live!).





Please note the 30-minute presentation will be recorded, and the slides and the recording will

Disclaimer

- If you do access the slides and recordings to the bitesize sessions using the following link: Independent Prescribing – Lancashire and South Cumbria Training Hub, please be aware that the sessions were intended to support Non-Medical Prescribers in their development and understanding of the subject area, however these sessions should not be considered the sole source of your learning. Please ensure that you also refer to your Trust/Employer guidance, up-to-date national guidance e.g. NICE guidance and professional body standards alongside these bitesize sessions.
- The information in the sessions are current and accurate at the time of creation.

NICE Guidance Update Feb 2026

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Type 2 diabetes in adults: choosing, reviewing and changing medicines

Diet and healthy living advice

At each point, reinforce advice about diet and other aspects of healthy living (also see the NICE guideline on overweight and obesity and the NHS better health website).

Involving people in medicine discussions

Discuss the benefits and risks of each medicine treatment option with adults with type 2 diabetes, and support them to make an informed decision about their treatment. Take into account the:

- effect of each medicine on HbA1c and weight
- effectiveness of each medicine at preventing and managing cardiovascular and renal conditions
- factors that might prevent the person from following a specific treatment option (for example, pioglitazone is contraindicated for people with heart failure)
- cost: when more than 1 medicine from the same drug class are equally suitable for the person, use the least expensive.

If a person has more than one comorbidity (for example, atherosclerotic cardiovascular disease and obesity; see recommendation 1.9.3), make a shared decision with them about which comorbidity to prioritise when choosing medicines. Take into account: medicines required for cardiovascular and renal protection (for example, subcutaneous semaglutide (Ozempic) for people with atherosclerotic cardiovascular disease), medicines that are contraindicated (for example, metformin for people with chronic kidney disease and an eGFR of less than 30 mL/min/1.73 m^2), and any other medicines they are taking and at what dose, particularly if the person has frailty (see recommendations for people with frailty in the initial medicines section).

Give clear sick day rules in each person's individualised treatment plan (also see the guideline section on sick day rules).

Reviewing medicines

When reviewing treatments, make a shared decision about changes with the person with type 2 diabetes. See the recommendations on involving people in medicine discussions. Optimise their current treatment regimen before changing treatments, taking into account factors such as:

- adverse effects
- prescribed doses and formulations
- adherence to, and management of, existing medicines
- the need to revisit advice about diet and healthy living.

If response to medicines suggests that type 2 diabetes might not be the correct diagnosis, see the recommendations on initial diagnosis and revisiting initial diagnosis in NICE's guideline on managing type 1 diabetes.

If the person has reached their individualised glycaemic and weight targets (as defined in NICE's guideline on overweight and obesity), consider continuing any medicines that have contributed to this.

Consider continuing SGLT-2 inhibitors for their cardiovascular or renal benefits, even if they do not help the person reach their individualised glycaemic targets.

Stop GLP-1 receptor agonists or tirzepatide if:

- the person becomes underweight (BMI under 18.5 kg/m^2), or
- they do not help the person reach their individualised glycaemic targets and they are not being taken for their cardiovascular benefits.

Do not offer a GLP-1 receptor agonist or tirzepatide and a DPP-4 inhibitor together to treat type 2 diabetes.

NICE Guidance Feb 2026

- Discuss the benefits and risks of each medicine treatment option with adults with type 2 diabetes and support them to make an informed decision about their treatment. Consider the
  - effect of each medicine on HbA1c and weight
  - effectiveness of each medicine at preventing and managing cardiovascular and renal conditions
  - factors that might prevent the person from following a specific treatment option (for example, pioglitazone is contraindicated for people with heart failure)
  - cost: when more than 1 medicine from the same drug class are equally suitable for the person, use the least expensive.

NICE Guidance Feb 2026
Review of medicines

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- When reviewing treatments, make a shared decision about changes with the person with type 2 diabetes. See the recommendations on involving people in medicine discussions. Optimise their current treatment regimen before changing treatments, taking into account factors such as:
- adverse effects
- prescribed doses and formulations
- adherence to, and management of, existing medicines
- the need to revisit advice about diet and healthy living

NICE Guidance Feb 2026
Review of medicines

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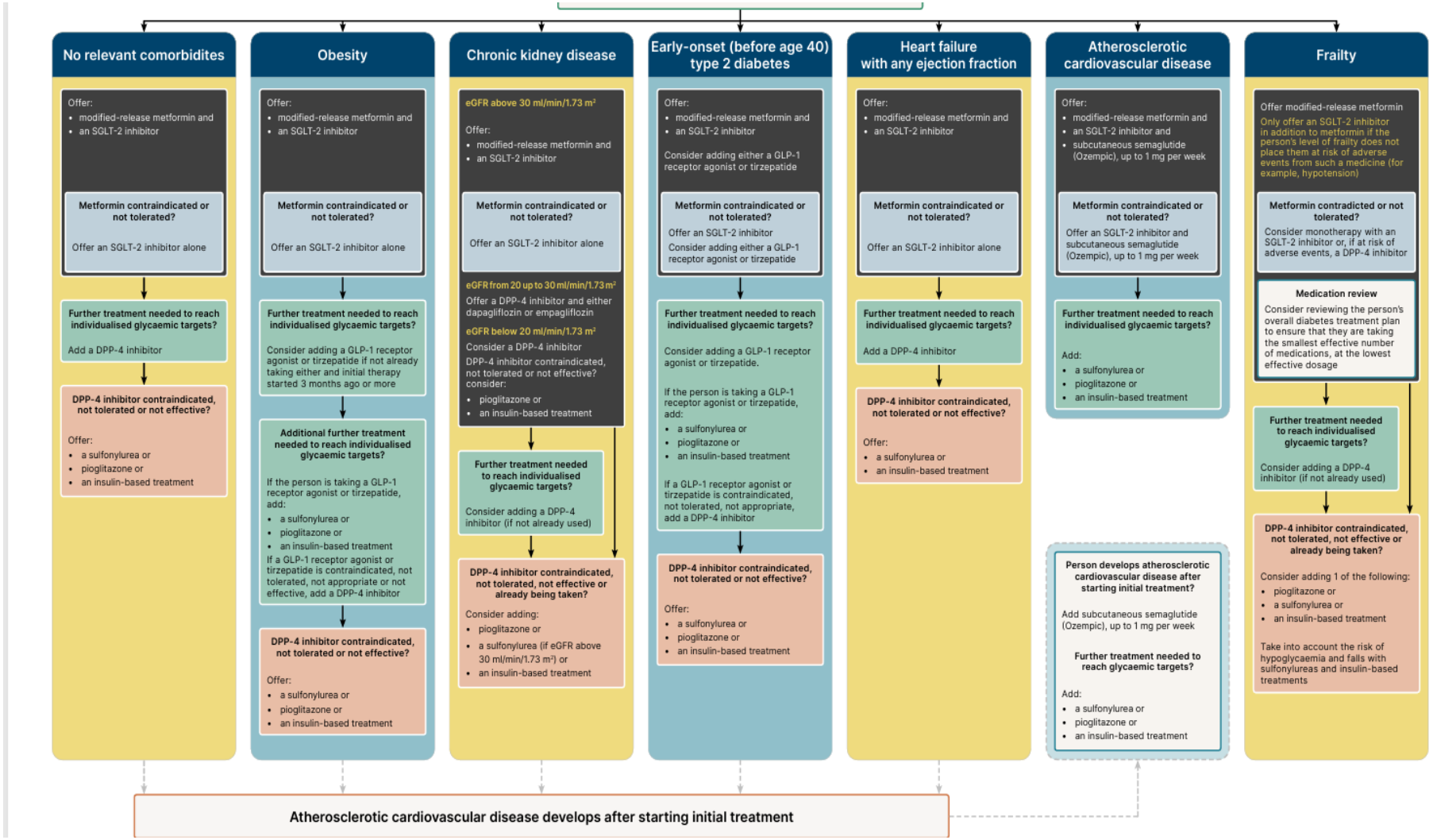
- If the person has reached their individualised glycaemic and weight targets (as defined in NICE's guideline on overweight and obesity), consider continuing any medicines that have contributed to this.
- Consider continuing SGLT-2 inhibitors for their cardiovascular or renal benefits, even if they do not help the person reach their individualised glycaemic targets.
- Stop GLP-1 receptor agonists or tirzepatide if: the person becomes underweight (BMI under 18.5 kg/m2), or they do not help the person reach their individualised glycaemic targets and they are not being taken for their cardiovascular benefits.
- Do not offer a GLP-1 receptor agonist or tirzepatide and a DPP-4 inhibitor together to treat type 2 diabetes.

NICE Guidance Feb 2026



NICE Guidance Feb 2026
When to use GLP-1 Agents?

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- **Indicated**
- Patients who are diabetic and Obese
- Patients with early Onset diabetes (under age 40)

- **Not indicated (can be considered?)**
- Patients with no relevant co-morbidities
- Patients with Chronic Kidney Disease
- Patients with Heart Failure (any ejection fraction)
- Patients with atherosclerotic cardiovascular disease
- Patients with frailty

Indicated Use

- For both categories, the guidance says CONSIDER adding in GLP-1 therapy or tirzepatide in addition to initial therapy

- Local LSCMMG guidance (2025) suggests using GLP-1 class of drugs after second intensification using other agents (as per old NICE guidance)

LSCMMG Guidance for use of GLP-1 mimetics and Tirzepatide

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NICE Criteria for GLP-1 mimetics and Tirzepatide

BMI > 35kg/m^2 and specific psychological or medical problems associated with obesity
OR BMI < 35kg/m^2 and insulin would have significant occupational implications
OR weight loss would benefit other obesity-related comorbidities.
Oral GLP-1 mimetic is recommended for patients who are unable to use subcutaneous formulations or patients who prefer oral administration.
GLP-1 mimetic in combination with insulin only on advice of specialist with ongoing support from a consultant-led multidisciplinary team

Local Criteria for the use of GLP-1 mimetics and Tirzepatide

Preference of agent should be decided based on the clinician's judgement about patient characteristics. **Local specialists have suggested the following**:

1. Semaglutide (or other available GLP-1 RAs) may be preferred in patients with lower BMIs e.g. < BMI 35 kg/m^2 or patients who have established CVD or are at high risk of CV events and require an agent with proven CV benefit.
2. Tirzepatide may be preferred in patients with higher BMIs e.g. > BMI 40 kg/m^2 or who despite optimisation of all other therapies still require further glycaemic control.

Please note: Rybelsus® (semaglutide) tablets are now available in sufficient quantities to support initiation of GLP1 RA treatment in people with type 2 diabetes (T2DM) in whom new initiation of GLP-1 RA therapy would be clinically appropriate.

Review and stopping treatment

- Careful consideration **MUST** be given to stopping GLP-1 mimetics and tirzepatide if ineffective or not tolerated (evidence of poor tolerance as dose escalates). GLP-1 mimetics and tirzepatide should be reviewed after 6 months, and the deprescribing of other agents, e.g. sulfonylureas and gliptins, should be considered where possible.
- As a minimum expectation, it is recommended that GLP-1 mimetics and tirzepatide are only continued if the adult with type 2 diabetes has had a beneficial metabolic response **(a reduction of at least 11 mmol/mol [1.0%] in HbA1c and weight loss of at least 3% of initial body weight in 6 months).**

GLP-1 Patient contract

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Patient agreement form – GLP-1 agonists for Type 2 diabetes

At your appointment today we have agreed to start treatment with one of the following medicines to help manage your type 2 diabetes:

- Liraglutide
- Dulaglutide (Trulicity)
- Semaglutide (Ozempic/Rybelsus)
- Tirzepatide (Mounjaro)

These medicines all work in a very similar way and are sometimes known as GLP-1 agonists. Further information on how to use the device and any side-effects you should be aware of is included in the patient information provided with your medicine supply.

Although these medicines can be given as an injection (except Rybelsus which is taken by mouth as a tablet), they work in a different way to insulin. However, they should help reduce your blood glucose levels and may also help you lose weight, especially if you follow a healthy diet and take regular exercise.

Please ask your diabetes nurse if you would like further information on the use of these medicines to treat type 2 diabetes or help and support with losing weight.

These GLP-1 agonist medicines do not work for everyone and if left unchecked may not be the best use of NHS resources. We therefore need to regularly monitor whether they are being effective.

In order to do this, we follow the guidance from the National Institute for Health and Care Excellence (NICE). This states that treatment with these medicines should only be continued after 6 months ***if a patient sees a reduction in their HbA1c (measurement of long-term blood sugar control) of 11mmol/mol (in the old number system that is about 1% HbA1c) and a reduction in their weight of 3% or more***.

If the GLP-1 agonist medicine we have agreed to start today does not provide these beneficial outcomes after 6 months, **we will need to consider alternative options to**

PATIENT AGREEMENT:

The information overleaf has been explained to me and I understand that treatment with GLP1 agonist will be stopped and alternative options considered if the beneficial effects on my weight and HbA1c are not achieved after 6 months or continued long-term.

	Today	6 month's target
Weight (3% loss needed by 6 months)		
HbA1c (11mmol/mol (1%) reduction needed by 6 months)		
eGFR (To check your kidney function)		To be measured in 6 months

Patient Name: _____ Patient Signature: _____

Clinician Name: _____ Clinician Signature: _____

Date: Date of 6-month review:

If you have any questions or problems with your treatment, please contact:

Name:

Contact number:

Protocol/ monitoring of GLP-1 Agents

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- Generally, patients should be followed up every month (via phone) to check for side effects, tolerability etc when titrating the dose of the agent
- Once at acceptable dose (i.e. 3 months) then patient would need review at 6 Months (3+3) with weight and HBA1c check; If targets met then can continue with treatment . Recheck 6 monthly
- This would apply to both oral and injectable GLP-1s

GLP-1 Options

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Agent	Strengths
Oral Semaglutide (Rybelsus)	1.5mg, 4mg, 9mg
Dulaglutide (Trulicity)	0.75mg, 1.5mg, 3mg, 4.5mg
Semaglutide Inj (Ozempic)	0.25mg, 0.5mg, 1.0mg
Tirzepatide (Mounjaro)	2.5mg, 5mg

Thank you for listening

Please complete our short online poll!

Next session: 15th September 2026

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Question and Answer

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