Medicines Safety Newsletter

Issue 1 – November 2025

NHS West Yorkshire
Integrated Care Board

Welcome to the latest edition of our Medicines Safety Newsletter; a newsletter produced by West Yorkshire ICB Medicines Safety & Quality Team. Our aim is to highlight key safety information to promote and support safer practice across WY.

Medication Safety Incident involving insulin

A patient was admitted to SDEC (Same Day Emergency Care) at Leeds Teaching Hospitals Trust and was prescribed insulin, with a dose matching the Summary Care Record (SCR). The dose should have been confirmed with the patient / family but that didn't happen, and the patient received several incorrect doses during their stay. As the patients' medical condition began to improve it became apparent that the insulin dose was too high. Further investigation found that the dose on the SCR was incorrect, it had been amended during District Nurse care and recorded in a separate part of SystmOne.

Reminder/Action: Insulin doses should not be recorded in the dosage direction box on repeat template as they can frequently change. Dosage frequency can be added e.g. 'inject subcutaneously once or twice a day as directed'.

Learning From Patient Safety Events (LFPSE)

- All healthcare staff in England are encouraged to use this to record PSE's, to share good practice, highlight actual or potential safety risks, and share learning. Watch a short video here
- Staff and organisations input information directly via an online account and can easily record incidents arising in other organisations
- Patients can still use the patient eForm
- Following Changes to 2025/26 GP contract practices will be required to have regard to the patient safety strategy and also register for an administrator account
- Practices will be expected to use their own data from LFPSE, to support local response and patent safety governance

Prescribers to be aware of new/strengthened advice on Carbimazole (Rosemont Pharmaceuticals): Risk of acute pancreatitis and contraception guidance

Acute pancreatitis
If acute pancreatitis occurs during treatment with carbimazole, immediately and permanently stop treatment. Re-exposure to carbimazole may result in life-threatening acute pancreatitis with a decreased time to onset. Carbimazole must not be restarted.

Pregnancy
A new review of available evidence from studies and case reports strengthens the evidence that carbimazole is associated with an increased risk of congenital malformations, especially when administrated in the first trimester of pregnancy and at high doses. Women of childbearing potential should use effective contraception during treatment with carbimazole. Carbimazole should only be considered in pregnancy after a thorough individual assessment of benefits and risks of treatment, and only at the lowest effective dose without additional administration of thyroid hormones; close maternal, foetal, and neonatal monitoring is recommended

Contact your Medicines Optimisation Team for associated patient safety searches.

DHPC_Letter_for_Carbimazole_August_2025.pdf
Carbimazole: increased risk of congenital malformations; strengthened advice on contraception - GOV.UK
Drug Safety Update: Carbimazole: risk of acute pancreatitis

Rybelsus® (oral semaglutide): risk of medication error due to introduction of a new formulation with increased bioavailability

Novo Nordisk announced in August 2025 that Rybelsus® (oral semaglutide) 3mg, 7mg, 14mg tablets, will be replaced by a new formulation, which have an increased bioavailability, resulting in lower doses to attain the same drug exposure. The strength of the new tablets differs (1.5mg, 4mg, 9mg), and their bioequivalence is listed in the table below:

Initial formulation	bioequivalent	New formulation
[one oval tablet]		[one round tablet]
3mg (starting dose)	=	1.5mg (starting dose)
7mg (maintenance dose)	=	4mg (maintenance dose)
14mg (maintenance dose)	=	9mg (maintenance dose)

The two formulations will temporarily co-exist on the market, which may lead to prescribing and dispensing errors, resulting in overdosing, and an increased risk of adverse events. The new formulation tablets will be available in the UK from the **15th of September**, and there may be a short delay as they are added to GP clinical systems.

We have made the decision at the West Yorkshire ICB, to categorise the new formulation as '**Do not prescribe – not yet classified',** which will give us more time to explore how to safely transition across, whilst minimising workload to GP practices. For now, please do not prescribe the new formulation, and local formularies will be updated accordingly.

Further information can be found at:
https://www.medicines.org.uk/emc/dhpc/105215/Document#gref

Information for people living with diabetes can be found:
https://www.medicines.org.uk/emc/rmm/105214/Document

Medicine Supply Issues and Discontinuations

Create an account with the Specialist Pharmacy Service to access the Medicines Supply Tool which has the latest information on supply issues, actions to take, alternatives to use, and expected resolution dates. Content provided by DHSC and MVA team, NHS England.

MHRA Safety Roundup – October 2025

A summary of all safety alerts (including Drug Safety Updates) published during the month. The bulletin also includes a new 'News Roundup' section which will include updates to product information as well as key safety-related information which may be of interest to you.

You can subscribe to the Safety Roundup bulletin here.

This newsletter has been produced by the West Yorkshire ICB Medicines Safety & Quality Team.
If you have any queries or feedback relating to the newsletter, we can be contacted by emailing: wyicb-kirk.wymsaq@nhs.net.

We also welcome any suggestions or ideas you may have for future editions.