Introduction

From the Medicines Safety Team, London Region, NHS England and our London Medication Safety Officer Network Chair

Welcome to our Autumn 2025 London Region Medication Safety Newsletter which we have produced to coincide with MedSafetyWeek 2025. Whilst you can access the newsletter using the link, we have also sent you the pdf version so that you can save it / upload it as required.

We hope you find it useful and informative, and we also hope you have enjoyed the previous editions. This issue contains updates on the new Medicines Safety Improvement Programme priorities, the work we are doing with London Ambulance Service to improve the transfer of medicines between LAS and acute trust emergency departments, a spotlight on Emily Wighton, our Regional Senior Pharmacy Integration Lead, and some further updates which we hope will be of interest.

The aim is for you to take away some of the suggested actions for your organisations for implementation, and to share these with others.

As always, we welcome your feedback and any contributions.

With best wishes, Sarah, NHSE London Region Controlled Drug Accountable Office & Medication Safety Officer and Amandeep, London MSO Network Chair.

Please feedback your comments or send any contributions via Amandeep Setra, London MSO Network Chair (amandeep.setra@nhs.net)

#MedSafetyWeek 2025

#MedSafetyWeek is a social media campaign that takes place annually in November each year, with a different focus or theme to encourage the reporting of suspected side effects.

This year is the tenth annual #MedSafetyWeek campaign and will take place 3rd - 9th November 2025. The theme will be **'we can all help make medicines safer'**.

In the UK the MHRA will focus on the importance of reporting suspected adverse reactions to medicines and vaccines, but are also encouraging the reporting of suspected problems with medical devices or other healthcare products to the Yellow Card scheme.

Patients and healthcare professionals can also show their support by sharing the MHRA messages and materials which can be found here.

MedSIP: Psychotropics workstream update

The National Medicines Safety Improvement Programme (MedSIP) is advancing work to reduce harm from psychotropic prescribing for behaviour that challenges in people with learning disability. The programme is progressing through Phases 2–4 of the Whole System Approach (WSA7).

Key Achievements

National Action Learning Sets (NALS) 2 & 3 delivered: Supported shared understanding, surfaced lived experience, and built a compelling case for change.

ICS mapping underway: Identifying prescribing and non-pharmacological approaches across London.

Metric co-design initiated: Aligning local measures with national reporting and ICS priorities.

Stakeholder engagement: Active collaboration with Clinical Reference Groups and Steering Group across the London footprint.

Challenges

Barriers to deprescribing include system fragmentation, limited alternatives, and concerns about destabilisation.

Need for stronger integration of lived experience and family/carer voices.

Next Steps

NALS 4 (Jan 2026): Focused on co-developing and coordinating solutions.

Continued mapping and metric development to support safe, person-centred care.

To get involved please contact your local HIN MedSIP Lead

UCLP: Jessica.Catone@uclpartners.com

South London HIN: Kristina.Leonnet@nhs.net

ICHP: Catherine.Caldwell@imperialcollegehealthpartners.com

LAS transfer of medicines project progress update

A working group was established earlier this year comprising of a Trust from each ICB which had an emergency department, and London Ambulance Service, to look at how medicines are handed over from LAS to acute Trust emergency departments. A baseline audit was conducted on each site in April 2025 focussing on patients admitted to the emergency departments from home, looking at how many medicines they brought in with them, and assessing how many of these were time critical medicines.

A total of 115 forms were completed, and results were broken down for each site. Results showed an expected variation in operational practices, with some similarities also noted across the region, including concerns around insulin storage and a perception that medicines may not be required if a patient is not being admitted into hospital.

Members of the working group are currently reviewing arrangements in their own Trusts for time critical medicines and looking to see how time critical medicines can be better managed within their organisations, whilst LAS continue to work with the group to see what can be co-designed. Trusts have also been asked to look at their results in conjunction with the HSSIB report that was published in December 2024 – Medication not given: administration of time critical medication in the emergency department.

Work is continuing around this aspect of care and further communication will be issued to colleagues in the new year, with information on how they can support this improvement work. Further updates will be provided in the Spring newsletter.

Special Feature: Pharmacy Integration Across London

In this edition, Emily Wighton, Regional Senior Pharmacy Integration Lead **– NHS London,** shares with us the role of the Regional Senior Pharmacy Integration Lead, NHS England, current workstreams and priorities:

As Regional Senior Pharmacy Integration Lead for London, my role is all about **connecting the dots** - ensuring that pharmacy services are fully integrated across our health and care system. I work closely with Integrated Care Boards (ICBs), provider organisations in both primary and secondary care, and NHS England colleagues to make sure pharmacy plays its vital part in delivering safer, more efficient, and patient-centred care.

A big part of my work involves supporting community pharmacy to delivery quality clinical services across London. MSOs in ICBs and provider organisations are the driving force behind medicines safety, identifying risks, learning from incidents, and sharing best practice. By linking these local insights at a regional level, we can spot wider trends, strengthen governance, and turn learning into real improvements across the system. My role helps to create those connections, making sure that good practice and safety learning flow across boundaries.

What's Hot in Pharmacy Right Now

There's a lot happening across the pharmacy world this autumn. Here are some of the big topics on our radar:

- Think Pharmacy First – This national campaign is shining a spotlight on community pharmacy as the first port of call for many common conditions. A current focus is on ensuring robust processes for urgent medicines supply, particularly around Schedule 4 and 5 Controlled Drugs, to support safe and timely access for patients.
- Learning from Patient Safety Events (LFPSE) – Community pharmacies are moving towards the new national LFPSE system for reporting and learning from safety events. We're hearing about challenges with flow of information between primary

and secondary care (i.e. Discharge Medicines Service), between community pharmacy and General Practices (i.e. post-consultation event reporting and issues with pregnancy coding in Pharmacy IT) and we are working with system partners to address these.

- Ask Your Pharmacist Week (3–9 November) – This annual campaign is a great opportunity to showcase the expertise and accessibility of pharmacy teams. It's a reminder of how pharmacy continues to evolve as an essential part of integrated neighbourhood care.

Looking Ahead

Pharmacy integration is key to delivering the ambitions of the NHS 10 Year Plan in London, and specifically the neighbourhood health target operating model **for London** - where different professionals work together around patients and communities. By strengthening links between regional leadership, MSOs, and front-line teams, we can keep building safer, smarter, and more connected pharmacy services across London.

Explore more on the NHS 10 Year Plan NHS London microsite and how Pharmacy is contributing to the 'three shifts'

Never event summary

When data was extracted on 27 August 2025, 142 patient safety incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between April 2025 and July 2025. Of these 142 incidents:

- 139 patient safety incidents appeared to meet the definition of a Never Event in the Never Events list 2018 (published 28 February 2018). This number is subject to change as local investigations are completed
- 3 patient safety incidents did not appear to meet the definition of a Never Event

More detail can be found here: NHS England » Provisional publication of Never Events reported as occurring between April 2025 and July 2025

PSIRF / LFPSE

The Patient Safety Incident Response Framework (PSIRF) is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers. This includes maternity and all specialised services. Primary care providers may also wish to adopt PSIRF, but it is not a requirement at this stage. Further exploration is required to ensure successful implementation of the PSIRF approaches within primary care.

Further information and resources can be accessed here: NHS England » Patient Safety Incident Response Framework

The Learn from Patient Safety Events (LFPSE) service is a national NHS system for the recording and analysis of patient safety events that occur in healthcare. The service introduces a range of innovations to support the NHS to improve learning from the over 2.5 million patient safety events recorded each year, to help make care safer (see 'How LFPSE will improve patient safety learning').

LFPSE is now in use across the NHS, and organisations have switched to recording patient safety events onto the new LFPSE service using LFPSE-compliant local systems, rather than the National Reporting and Learning System (NRLS), which was decommissioned on 30 June 2024. The Strategic Executive Information System (StEIS) is still in use while the next version of LFPSE is rolled out to replace it

Organisations without a Local Risk Management System (LRMS), (typically private primary care providers, such as GP, dental and optometry practices and community pharmacies) are asked to record patient safety events directly onto LFPSE by registering for an account and using the online Learn From Patient Safety Events service. To support local safety governance, response and improvement, this online service offers users the ability to assign relevant individuals access to data on all safety events recorded within their organisation, and to complete statutory and national policy requirements as necessary. Relevant staff within Integrated Care Boards (ICBs) and Regional teams can request read-only access to data submitted by providers within their areas, to enable their remit for patient safety oversight and offer support to provider organisations.

This web page provides information on the different types of LFPSE accounts, and who should use them.

Controlled Drugs

Discharge Medicines Service (DMS) - Controlled Drugs and High-Risk Medicines

The NHS Discharge Medicines Service (DMS) is an essential community pharmacy service which enhances medication safety during patient transitions from hospital to primary care. It involves structured referral, pharmacist review, and follow-up consultation to ensure safe continuation of medication use. DMS directly supports the NHS's Three Strategic Shifts by enabling safer community-based care, using digital referrals, and promoting preventive action through early intervention on high-risk medicines. DMS plays a vital role in reducing hospital readmissions, with data showing a readmission rate of 5.8% for patients who received DMS compared to 16% for those who did not.

It prioritises controlled drugs and other high-risk medicines due to their potential for harm, misuse, and complex dosing requirements. By ensuring accurate medication reconciliation and clear communication during care transitions, DMS significantly lowers adverse events, dependency risks, and readmissions. The service supports safe prescribing, enhances patient understanding and adherence, and strengthens collaboration between hospital and community care providers—ultimately improving patient safety and outcomes. For more information, see B0366-discharge-medicines-toolkit.pdf
(Article courtesy of Gawain Young, Pharmacy Advisor, NHS England - London)

Prolonged release opioids no longer indicated for post-operative pain

MHRA has advised that the indication for the treatment of post-operative pain has been removed from the licences of all prolonged release opioids. These opioids should not be used post-operatively due to the increased risk of persistent post-operative opioid use (PPOU) and opioid-induced ventilatory impairment (OIVI). It is not recommended to use transdermal patches for the treatment of post-operative pain. Prolonged-release opioids: Removal of indication for relief of post-operative pain - GOV.UK

Stimulant and non-stimulant agents for ADHD

The Pharmaceutical Journal has published a medication guide that details the different types of treatments for attention deficit hyperactivity disorder, for both adults and children: Stimulant and non-stimulant agents for ADHD - The Pharmaceutical Journal

CQC Controlled Drugs annual report

CQC published their annual update on controlled drugs for the calendar year 2024 in July 2025: Controlled drugs annual update report for 2024 published - Care Quality Commission

Some key issues they highlight from 2024 include:

- impending changes to NHS England and the regional and national controlled drugs oversight function
- the need to improve cross-border prescribing datasets on controlled drugs
- access to controlled drugs in care homes for end-of-life care
- the importance of healthcare professionals working within their scope of practice
- fraudulent activity and diversion of controlled drugs by health and care professionals and support staff, as well as by people impersonating a range of healthcare professionals.
- prescriptions produced fraudulently within electronic systems in primary care to conceal the theft, and ongoing fraud with private prescriptions, often for controlled drugs in lower schedules.

The report also includes a range of themes that they found from a review of Prevention of Future Death Reports, which they share to highlight the risks associated with controlled drugs.

Hub and spoke dispensing – schedules 1 to 3 controlled drugs

Dispensing doctors, community pharmacy contractors and pharmacy commissioners should note that schedules 1 to 3 controlled drugs must not be assembled or dispensed through hub/spoke arrangements between two different legal entity dispensing businesses as this would not comply with the provisions of the Misuse of Drugs Regulations 2001. All types of orders for these schedules of controlled drugs therefore must be assembled and dispensed at the spoke pharmacy/dispensing doctor site. More information on hub and spoke arrangements.

Rybelsus

In September 2025 Novo Nordisk circulated a communication regarding a formulation change to Rybelus - whereby the tablets will be replaced with a new formulation with increased bioavailability and advising that the two formulations would temporarily co-exist on the market, which may cause mix-ups.

Each of our London ICBs medicines teams has been working with diabetes network colleagues in their ICB to ensure there are clear action plans in place to manage this. If you have any queries, please contact your ICB medicines team and they will be able to advise you.

Useful links

Investigating under the Patient Safety Incident Response Framework (PSIRF): sharing HSSIB learning for future development

This report identifies opportunities to develop patient safety incident investigation under the Patient Safety Incident Response Framework. It is intended for national and local organisations to help support staff in system-based investigation across the NHS in England.
Source: Health Services Safety Investigation Body

HSSIB: Medication related harm

The Health Services Safety Investigations Body (HSSIB) have completed 3 local investigations, with a fourth underway, looking at medication related harm.

These investigations explore the safety issues associated with medication not given. HSSIB was told of many instances where patients do not receive the medication they need whilst in hospital, at home or in a nursing home.

The three investigations are:

- Medication not given: administration of time critical medication in the emergency department
- Medication not given: anticoagulation before and after a procedure
- Medication not given: discharge from an acute hospital to the community

  Source: Health Services Safety Investigation Body

Polypharmacy Programme: Getting the Balance Right

Economic analysis estimates that the programme's interventions prevented £20k in hospital admissions and related costs and saved £76k in medicines expenditure over 2022–2025 in the 5 ICB case study regions, equating to over £1.1 million savings, if extrapolated across England.

Further Information

Source: Health Innovation Network

How medicines optimisation would save the NHS billions

Analysis of literature on problematic polypharmacy and medicines safety; medication reviews and deprescribing; staff costs and time; and adherence to medication, has concluded a potential £1.2bn of savings based on expansion of NHS community pharmacy services.

Further Information

Source: National Pharmacy Association

MHRA Safety Roundup: October 2025

The MHRA has published updates to prescribing guidance amending and clarifying previous advice regarding follow up consultations, pregnancy testing and sexual function monitoring. A survey will be conducted of services where isotretinoin is prescribed to support its safe prescribing. Clinical Service leads need to complete the baseline survey for their service by 16th November 2025.

Source: Medicines and Healthcare products Regulatory Agency

MHRA Safety Roundup: September 2025

Summary of the latest safety advice for medicines and medical device users includes a reminder that taking paracetamol during pregnancy remains safe, links to direct healthcare professional communications, medicine recalls and a news roundup.

Source: Medicines and Healthcare products Regulatory Agency

World Pharmacists Day 2025

World Pharmacists Day (25th Sept 2025) is an annual awareness day led by the International Pharmaceutical Federation. This year's theme was, 'Think Health, Think Pharmacist', reflects what community pharmacy delivers for patients and communities through the Pharmacy First service.

Source: Community Pharmacy England

Using transdermal patches safely in healthcare settings

This series of three web pages provides practical guidance for safe application, monitoring, removal, disposal, documentation and storage of transdermal patches to reduce risk of medication errors.

Further Information

Source: Specialist Pharmacy Service

Community pharmacy services expanded

Two community pharmacy clinical services have been expanded as part of the Community Pharmacy Contractual Framework for 2025/26.

Community pharmacies can provide the emergency contraceptive pill (oral emergency contraception) free of charge as part of the NHS Pharmacy Contraception Service. And the NHS New Medicine Service (NMS) has been expanded to include medicines for depression.

General information

Alerts

All alerts can be accessed via the Central Alerting System: **CAS - Home**

How do I get included?

For those of you who are newly into a Medication Safety Officer role: You need to provide your contact details to the MHRA's Central Alerting System (CAS) team and once signed up, you will be invited to a national Medication Safety Officer monthly webinar which is held from 1-2pm on the last Wednesday of the month. Previous webinar resources are kept in an MSO workspace on FutureNHS. You may also find it helpful to access the SPS website where you will find many helpful pieces of guidance and resources. For the London MSO Network, please contact Amandeep Setra, amandeep.setra@nhs.net

Learning and development

You may not be aware, but HSSIB run courses which are currently available free of charge to NHS staff in England, with a focus on those with patient safety and investigation roles. Their flagship programme, the CPD accredited 'A systems approach to investigating and learning from patient safety incidents', is on-demand learning and they can accommodate large numbers of leaners in each cohort. They also provide other courses which are delivered online to small groups. They release new dates for NHS courses on a regular basis. Please subscribe to their mailing list to be notified of new dates.

Dates for your diary

London MSO Network next meeting date: Monday 26th January 2026 **(2-3.30pm)**