

TO: London Diabetes care providers (NHS Trust, and primary care)

Cc: London ICB Executive colleagues

Urgent London-wide action required: Levemir® discontinuation

Every remaining patient must be identified, clinically reviewed and have a safe transition plan by end of November 2026.

KEY MESSAGES

The majority of patients still prescribed insulin detemir (Levemir®) are likely to have type 1 diabetes. There will be a significant risk of harmful hyperglycaemic emergencies/diabetic ketoacidosis in the majority of these patients if they are not safely transitioned to an alternative basal insulin.

GP practices and specialist diabetes providers are responsible and accountable for ensuring that every patient still prescribed Levemir is identified, clinically reviewed and safely transitioned to an alternative basal insulin before the end of November.

Given the risk of patient harm, we must work together to ensure that capacity constraints or organisational boundaries do not leave any patient without an alternative treatment plan.

Dear colleagues,

We are writing to GP practices, Community Pharmacists, acute and community trusts, and specialist diabetes services across London about an urgent patient safety issue. Insulin detemir (Levemir®) is being discontinued with immediate effect, and a [National Patient Safety Alert](#) was issued on 1 October 2026 due to the number of people who still require review and transition to an alternative basal insulin.

The London region has historically been a high user of Levemir. Although substantial progress has been made, London-wide prescribing data to September 2026 and current estimated patient numbers (approximately 3,500 patients – see appendix 1) confirms that significant use remains. Local intelligence also indicates that most of the remaining cohort are people living with type 1 diabetes. The precise number requiring action will continue to change as switches are completed and prescribing data catches up, but the overall position is clear: every remaining patient needs to be safely transitioned before the end of November 2026.

Clinical and organisational responsibility

A prescriber has a core professional responsibility to support the safe and clinically appropriate ongoing treatment of a patient for whom they prescribe. Where the continued supply of a medicine becomes uncertain, the patient must be reviewed and an appropriate alternative arranged. A patient should not remain on Levemir® without action because of uncertainty or differing views about where responsibility for the review sits across the system.

For some patients, a suitably competent primary care prescriber may be able to review and complete the switch. Others, particularly people with type 1 diabetes or more complex needs, will require specialist diabetes input. The route may differ, but the required outcome does not: **the patient must be reviewed and safely transitioned by the end of November 2026.**

Responsibilities of GP practices and diabetes providers

1. Identify the remaining cohort

- GP practices must identify all patients currently prescribed Levemir using an appropriate clinical system search and local prescribing intelligence.

- Each practice must nominate a senior clinician to oversee its response and ensure that every identified patient is either reviewed by a competent prescriber or referred urgently to an appropriate diabetes service.

2. Review, switch or refer without delay

- Where the prescriber has the necessary competence, the practice should complete the clinical review and switch in accordance with the National Patient Safety Alert and appropriate [clinical guidance](#).
- Where specialist input is required, the practice must make an urgent referral or use the locally agreed advice and guidance route. Diabetes services must provide a responsive offer that supports rapid review and safe transition.
- The outcome and ongoing prescribing plan must be clearly documented and communicated to the patient and relevant care teams.

3. Resolve capacity constraints and blockages

- Diabetes providers that cannot accommodate the required activity must escalate this immediately through their senior clinical leadership and to their commissioner. A lack of current capacity does not remove the provider's accountability for securing a safe route for the patient.
- Providers should work with commissioners to reprioritise activity where necessary and to resolve operational or contractual blockages.
- Systems should work as one. Where the usual diabetes provider cannot undertake the review within the required timeframe, an alternative competent provider should be identified to complete the review and switch on its behalf.

Responsibilities of commissioners

- Commissioners will work with providers to resolve capacity constraints and other blockages, including supporting reprioritisation or mutual aid where required.
- Commissioners will support lawful and proportionate approaches to data sharing, where appropriate, to help identify affected patients in line with information governance and data protection requirements.

Actions required now

GP practices:

1. Nominate a senior clinician to oversee the response
2. Identify all patients currently prescribed Levemir and ensure that each is reviewed and switched by a competent prescriber or referred urgently for specialist diabetes input.
3. Document and communicate the outcome and ongoing prescribing plan to the patient and relevant care teams. End current repeat prescriptions for Levemir so that it cannot be re-ordered.

Diabetes providers:

1. Nominate a senior clinician to oversee the response
2. Liaise with primary care colleagues to ensure they have the support needed
3. Confirm a responsive route for urgent advice, review and switching, and act promptly on referrals received.
4. Identify and escalate any capacity gap or blockage immediately, working with commissioners to secure reprioritisation or an alternative provider.
5. Document and communicate the outcome and ongoing prescribing plan to the patient and relevant care teams. Ensure that no further prescriptions for Levemir are issued.

This is an urgent London-wide patient safety priority. GP practices and specialist diabetes providers are jointly responsible and accountable for ensuring that every affected patient has a safe and timely transition plan. We ask providers to act collectively and at pace so that no patient experiences an interruption in insulin supply or avoidable harm because responsibility or capacity was unclear.

Yours sincerely,

Dr Chris Streater	Chief Medical Officer, NHS England - London
Dr Stephen Thomas	London Diabetes Clinical Network Director, NHS England - London
Professor Nick Oliver	London Diabetes Clinical Network Type 1 Diabetes Lead, NHS England - London
Jon Hayhurst	Regional Chief Pharmacist, NHS England - London
Dr Jo Sauvage Dr Paul Gilluley Dr Toby Garrood Dr Nicola Jones	Chief Medical Officers of London Integrated Care Boards
Louise Coughlan Raliat Onatade Vanessa Burgess Helen Porter	Chief Pharmacists of London Integrated Care Boards
Sarah Mcilwaine Charlotte Pomery Ed Waller	Chief Commissioning Officers of London Integrated Care Boards

Appendix 1: Approximate number of patients prescribed Levemir

The numbers below have been extracted from population health systems.

Table 1: Approximate number of patients prescribed Levemir across London

	WNL	NEL	SEL	SWL
September 2026	890	1398	1020	1083
October 2026	625	1243 [^]	729	948
November 2026	388 [*]	1101 [*]	403 [*]	888 [*]
December 2026	335 [*]	729 [*]	77 [*]	828 [*]

[^]data 30.9.26, ^{*}predictions based on average reduction in past 2-3 months

Appendix 2: Approximate numbers of primary care prescriptions issued for Levemir

	WNL	NEL	SEL	SWL
April 2026	1002	1388	1031	749
May 2026	947	1342	870	677
June 2026	928	1282	774	612
July 2026	859	1253	683	630
August 2026	639	997	478	455
September 2026	571	899	361	432

Data source: unverified EPS items dataset from NHSBSA.