NHS England - Midlands Controlled Drugs Newsletter

Summer Edition 2024

This newsletter contains local and national CD information to support safe use and handling of controlled drugs

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Midlands Controlled Drugs Accountable Officers

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IMPORTANT INFORMATION

NEW SINGLE REGIONAL E-MAIL ADDRESS CONTACT FOR MIDLANDS-WIDE NHSE CONTROLLED DRUGS TEAM

england.midlandscd@nhs.net

With effect from 1st August 2024, the NHS England Midlands Controlled Drugs Team will be using a single group (enquiries) e-mail account. The new account will have the address:

england.midlandscd@nhs.net

The account launches on 1st August 2024, and will effectively replace, the three sub-regional group e-mail accounts below:

- england.westmidlandscd@nhs.net
- england.centralmidlands-cd@nhs.net
- england.northmidlandscd@nhs.net

The three sub-regional group in-boxes, will stay open for a set period, but we encourage all enquirers to utilise the new Midlands Regional e-mail account from the beginning of August. Please could you

amend your records accordingly. Further promotion material advising of the change will be released during July. Thank you for your assistance and co-operation in this matter.

News around Controlled Drugs

1. Methadone dispensing - single dose containers

There were a significant number of incidents reported to the Midlands CDAOs where the doses of methadone prescribed on **FP10MDA** prescriptions were dispensed in one large bottle instead of being dispensed in single daily dose containers. We would like to remind you of the following:

- Daily dose containers may support the individual to take the correct dose, better manage their medication and encourage adherence to treatment. The volume of methadone prescribed may not be easily measured using a medicine spoon, oral syringe or measuring cup. As a result, there have been tragic consequences of daily dose bottles not being used and coroners subsequently issuing prevention of future death notices to support the use of daily dose containers
- Prescriptions for methadone printed with the Home Office approved "Dispense daily doses in separate containers" wording should be dispensed in single daily dose containers
- If a patient requests their methadone to be dispensed in a single large bottle, advice/permission should be obtained from the patient's prescriber/key worker prior to dispensing
- If there is an agreement to supply the methadone in a single large bottle, the pharmacist should provide counselling to the patient to ensure the patient is aware on how to administer their dose and has the appropriate sundry item to measure their dose

Guidance on methadone dispensing (FP10 and FP10MDA) can be found using the following link from the Community Pharmacy England (CPE) - **Methadone dispensing (FP10 and FP10MDA) - Community Pharmacy England (cpe.org.uk)**

CPE have also provided additional guidance to support contractors to correctly claim a packaged dose fee for each individual packaged dose using the PD (packaged dose) endorsement - **Reminder: Packaged dose endorsement on prescriptions for methadone oral liquid - Community Pharmacy England (cpe.org.uk)**

(Some of the information on this article was kindly provided by Turning Point and Community Pharmacy Dudley and reproduced with their permission)

2. Community pharmacy: delivering substance misuse services

This **guidance** is for community pharmacies in England that deliver services to people who use drugs and alcohol. It aims to assist the commissioning and delivery of high-quality, safe and effective care

that can engage more people in drug and alcohol treatment. It also aims to reduce harms associated with the use of drugs and alcohol, including deaths from accidental overdose.

Link: [Community pharmacy: delivering substance misuse services - GOV.UK (www.gov.uk)]

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3. Pharmacy First - Urgent repeat medicine supply (former CPCS Scheme)

The Midlands Controlled Drugs Accountable Officers (CDAOs) at NHS England, periodically review the Pharmacy First - urgent repeat medicine supply (previously commissioned as the CPCS) data to be assured the urgent medicines supplies for Controlled Drugs (CDs) are provided appropriately and to identify pharmacies supplying more than five days of CDs.

In the last few months, we have seen a significant increase in patients using this service in the Midlands, especially requesting codeine preparations. But more concerning, we have seen a substantial increase in pharmacies supplying quantities of codeine preparations above the five days limit. A few pharmacies supplied quantities of 100 or more tablets/capsules of codeine preparations to patients. The highest quantity we observed was 200 tablets.

We would like to remind you that and under this service, patients may be supplied with **up to five days'** treatment of their regular medication, including schedule 4 or 5 controlled drugs but only if it is clinically appropriate, legal to make and after an assessment has been made of the risk that the patient might be using the service to gain additional supplies inappropriately. Schedule 3 CDs - phenobarbitone or phenobarbital sodium used for the treatment of epilepsy can also be supplied.

If necessary, please review your processes and provide training to your pharmacy team including any locum pharmacists.

More information can be found on the Community Pharmacy England (CPE) website - [Pharmacy First service - FAQs - Community Pharmacy England (cpe.org.uk)] under *Urgent Supply of medicines or appliances* then *Further advice on requests for controlled drugs.*

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4. Codeine Linctus reclassified as a POM (prescription-only medicine)

Codeine linctus, an oral solution or syrup licensed to treat dry cough in adults, has been reclassified to a prescription-only medicine due to the risk of abuse, dependency and overdose.

Codeine linctus is an opioid medicine which has previously been available to buy in pharmacies under the supervision of a pharmacist but will now only be available on prescription following an assessment by a healthcare professional.

Since 2019, there have been increasing reports in the media of codeine linctus being misused as an ingredient in a recreational drink, commonly referred to as 'Purple Drank'.

The decision to reclassify the medicine has been made following a consultation with independent experts, healthcare professionals and patients. 992 responses were received.

The consultation was launched by the MHRA after Yellow Card reports indicated instances of the medicine being abused, rather than for its intended use as a cough suppressant.

Responses to the consultation identified the pressure pharmacists were under to provide the medicine to those suffering from addiction.

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5. Morphine sulphate products

MST Continus prolonged release tablets, **MXL prolonged release tablets** and **Sevredol tablets** SPCs include acute generalised exanthematous pustulosis, central sleep apnoea syndrome, pancreatitis and spasm of the sphincter of Oddi as adverse reactions of unknown frequency. Also notes interaction with gabapentin/ pregabalin which increases risk of respiratory depression.

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6. MHRA Drug Safety update - Warfarin and Tramadol

MHRA update can be found at **Warfarin: be alert to the risk of drug interactions with tramadol - GOV.UK (www.gov.uk)**. It includes:

- Advice for healthcare professionals
- Advice for healthcare professionals to provide to patients
- Risk of adverse drug interaction with tramadol
- Report any suspected adverse drug reactions

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7. Prescribing, supply and administering of controlled drugs by certain healthcare professionals

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The Home Office has made changes to the Misuse of Drugs Regulations 2001 to enable the prescribing, supply and administering of controlled drugs by certain healthcare professionals, including paramedic, podiatrist, chiropodist, and radiographer independent prescribers - **Legislative changes to enable the prescribing supply and administering of controlled drugs by certain healthcare professionals**

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8. Pharmacy break-ins - security advice

Following a number of break-ins / burglaries of pharmacies and thefts of pharmacy delivery vehicles across the Midlands, we would like to remind organisations to be extra vigilant and ensure all security measures are considered. You may want to consider reviewing potential vulnerabilities such as locks, shutters, grilles, windows and doors. Below are some suggestions from our Controlled Drug Liaison Officers (CDLOs) and Community Pharmacy colleagues for you to consider:

- Ensure an alarm is in place and that it's fully operational

- Identify areas that may be vulnerable to forced entry and have them made more secure
- Make sure any service doors are locked and secure when not in use
- Make sure you have a monitored alarm and that it's fully operational
- If you have CCTV, make sure it is operational, provides good quality images and covers any vulnerable areas. 24-hour digital CCTV is also highly recommended
- Consider shutters on windows and doors. External shutters, although effective, may require planning approval. Use attack-resistant laminated glass in sturdy frames where possible. Alternatively, film can be applied to glass to make it more resilient
- Anti-ram raider bollards mounted externally can be used to protect frontages but may require planning approval
- Try not to keep cash on the premises and always use a bolted-down safe
- Consider placement of products – for example high value items or medication of abuse nearer the counter or out of sight
- Make sure stockrooms are locked and, where possible, keep stock out of sight
- Smoke-generating devices that activate on unauthorised entry create a smokescreen and foil burglary. They're designed not to damage stock
- Make sure your keys are not left on the premises and that only designated staff have access. In case of emergency, make sure there's a list of keyholders who can be contacted
- Do not leave keys in the ignition when making deliveries
- Ensure the vehicle is secure when unattended
- Call 999 as soon as possible after the event
- Remember if Sch 2-5 CDs are stolen / missing you should report this to your CDAO on the CD Reporting Portal – **www.cdreporting.co.uk**

If you would like further advice on security and crime prevention please **Contact your nearest CDLO (apcdlo.org)** or read this guidance from the National Business Crime Centre **Pharmacy Safety - Crime Prevention Series (Oct 22)**.

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9. Submission of private CD prescriptions and requisitions to the NHS Prescription Services

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Pharmacy contractors in England are required to submit FP10PCD (CD private prescriptions) and FP10CDF (requisitions) forms to the NHS Prescription Services for audit purposes each month using a special submission document, FP34PCD, which is available to download on the NHS Prescription Services website (FP34PCDv6.pdf (nhsbsa.nhs.uk).

For more information please visit the following websites:

- **Private controlled drugs | NHSBSA**
- **Safer management of controlled drugs (CD) | NHSBSA**

- [Dispensing Controlled Drugs - Community Pharmacy England (cpe.org.uk)]

IMPORTANT: Community pharmacies require a private CD account number which should be used when submitting FP10PCD private forms which is a different account to the NHS account number used by contractors to submit NHS prescriptions. In England, suppliers who need to submit private prescription forms but who do not already have a private CD prescription F code must contact their local NHS England CDAO team.

Case Studies

Case study 1 - Death of Service User

A Drug and Alcohol Team notified the NHS England Controlled Drug Accountable Officer (CDAO) of an unexpected death of a service user in treatment for opiate dependency. The Police Controlled Drug Liaison Officers (CDLO) were liaised with as there were concerns over the medication in possession of the service user at the time of their death. The service user was receiving Medically Assisted Treatment (MAT) from the Drug and Alcohol Team in the form of prescribed opiate substitute medication methadone solution (85ml daily) which was being collected from the pharmacy weekly. The service user last collected their medication the day before their death. The Drug and Alcohol Teams records show that the service user was not on any other prescribed medication.

The coroner's report established the cause of death as:

- Fatal respiratory depression
- Methadone and morphine overdose

Following investigation into this service user's treatment it was established

- No safeguarding issues or physical / mental health concerns had been raised or reported for this service user
- A medical review was completed 2 months prior to their death. This review was however completed in the absence of service user as they did not attend appointment
- Actions were set for service user which required them to collect prescriptions directly from the Drug and Alcohol Team. This was believed to have happened on three occasions however, there was no evidence of this on their case notes
- Multiple booked appointments evidenced but no evidence of service users' attendance
- No face-to-face contact in 252 days, no attended medical review in 362 days and no drug screen in 322 days

Learning identified following investigations

- Service users to be audited regularly by team leaders to monitor frequency of medical reviews ensuring overdue reviews and drug screens are chased
- Ensure appropriate information is recorded on services user's case notes to evidence interactions. This may include check ins with key workers and pharmacies
- All medical reviews are completed by either a specialist Doctor, Consultant or a Non-Medical prescriber (NMP). Medical reviews completed in absence are decided case by case
- Oversight of all service users to be strengthened
- Confirm all services users are given harm minimisation advice, including overdose and relapse prevention
- Ensure services users are given overdose prevention medication Naloxone and also issued a safe storage box

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Case study 2 - Dosage calculation error

What happened?

A GP practice reported a CD incident to the NHSE CDAO team, involving diazepam tablets and a child with complex medical needs.

The practice was contacted by the patient's father following the child's hospital admission. The child had been admitted to hospital with drowsiness, dilated pupils, low tone, bradycardia and vomiting.

On admission, it was noted the patient had been receiving 2.5 times of their usual diazepam dose for approximately 3 weeks. The correct dose of diazepam 2m/5ml liquid the patient should be taking **was 5mg (i.e. 12.5ml daily)**.

Due to a supply issue with the liquid preparation, the patient was switched to tablet form and when the dose was converted from liquid to the tablet form, the number of millilitres (mls) was misread as milligrams (mg). Consequently, the patient was issued diazepam 5mg tablets 2 and a half tablets (i.e. 12.5mg) to be taken daily.

The patient was an inpatient for 6 days and was subsequently discharged from hospital on a slow weaning regime of diazepam with a view to stopping the drug

What were the contributory factors?

- **Ongoing drug supply issues:** leading to a need to change formulation
- **Human error:** a misreading of millilitres and milligrams
- **Patient complexity:** The child has ongoing complex medical needs who is under the care of specialists. This patient is known to have medication changed regularly and medicines at unusual doses

Review with the supplying community pharmacist:

- Community pharmacist was made aware of the incident by the hospital pharmacist
- The CDAO team contacted the pharmacy to investigate the incident further
- The family use only one pharmacy, the patient was known to the pharmacy and were fully aware of the medical complexities involved. They have been supporting the family
- The pharmacist completed a BNF check, Checked with Dad if they were aware of the dose error

Preventative actions taken by the practice

- A Significant Event Analysis (SEA) meeting was held with the lead pharmacist, pharmacist who received the initial telephone call from the patient's father, the practice manager and the complaints officer.
- The error was discussed in detail and the possible causes which may have led to this serious event

The following mechanisms have been agreed and will be implemented immediately across the practice:

- All paediatric formulation conversions will need to be second checked by a pharmacist (if the change has been initiated by a pharmacist, this will still need to be double checked by another pharmacist)
- For any other formulation conversions, reducing/increasing dose regimes or any other regimes which requires dose calculations, if the person who is issuing the prescription feels this needs a double check, they can ask a pharmacist to do so.
- For all liquid formulations, the administration label must state the dose (in mg, mcg, g, etc) as well as the number of mls this pertains to in brackets. E.g. Morphine 10mg/5ml solution: Take 15mg **(7.5ml)** FOUR times a day
- Use the incident as a case study for teaching and learning purposes
- The incident will be shared across all PCNs in Herefordshire to highlight the risks and to increase awareness and vigilance

Reminders

Incidents and Concerns

All incidents and concerns raised involving CDs must be reported to the CD Accountable Officers. Concerns may include patients potentially misusing or abusing drugs, prescribing concerns, dispensing concerns etc.

To report all CD incidents, concerns please use the online CD reporting portal

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CD Destructions

It is a legal requirement under the 2001 CD regulations to have stocks of obsolete, expired and unwanted Schedule 2 CDs destroyed in the presence of an Authorised Witness. Please complete the CD Destruction form on the CD reporting portal **CD reporting portal** - www.cdreporting.co.uk

PLEASE REMEMBER:

- Out of date schedule 3 CDs (e.g. temazepam, tramadol, gabapentin, pregabalin, buprenorphine, midazolam) **do not require the presence of an Authorised Witness**. It is recommended for the denaturing to be witnessed by another member of staff, ideally a registered healthcare professional and familiar with controlled drugs
- **Denaturing is required for all schedule 2, 3 and 4 (part 1) -** expired, obsolete or unwanted stock and patient-returned CDs
- **Record Keeping** - patient returned CDs and their destruction should be recorded in a separate Patient Returns Register. Concerning schedule 2 CDs an entry should be made in the appropriate CD register