NHS England - Midlands Controlled Drugs Newsletter

Winter Edition 2024

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

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In this newsletter:

Midlands Controlled Drugs Accountable Officers

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IMPORTANT INFORMATION

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

england.midlandscd@nhs.net

News around Controlled Drugs

1. Temporary Authorised Witness Certificate Module

A new Temporary Authorisation module has been launched on the CD Reporting Portal **(**www.cdreporting.co.uk**)**. Temporary authorisation to **witness** the destruction of Controlled Drugs is an authority for a specified period of time in which a registered healthcare professional can **witness** the destruction of Controlled Drugs by another person.

The module is for requests to be a **witness** to destroy controlled drugs (schedule 2) only if your organisation does not have a Controlled Drugs Accountable Officer.

If you are a multiple pharmacy (5 or more) then please refer to your Standard Operating Procedures and your Superintendent before completing the application form or contact your Regional Controlled Drugs team to discuss further.

The application can be completed on behalf of the Temporary Authorised Witness Applicant. In this situation, please ensure that you have consent from the Temporary Authorised Witness Applicant to complete the form on their behalf and that the details are correct and can be validated.

When the form has been completed, and submitted, it will then be sent to the team who cover your region. A member of staff will review your form, checking all the required information is correct and that the named person has entered the correct professional details. When all checks are complete, the CDAO (Samantha Travis in the East Midlands or Amit Dawda in the West Midlands) will issue you a temporary authorisation certificate, valid for a suitable time period – this could be between one week and a month.

2. Providing Accurate Measuring Equipment with CD Prescriptions

We have recently had an incident share with us, whereby a patient who had been prescribed 2.5mls of Morphine Sulphate 10mg/5ml oral solution four times daily, sadly and mistakenly, took 20mls in their first dose. The patient had measured the liquid in a measuring cup, as no oral syringe had been provided with their prescription. The patient was also house bound, and we assume no counselling had been provided with the delivery of medications.

Where controlled drugs, and especially liquid formulations, are initiated and dispensed by community pharmacy, please consider whether any adjustments are needed for patients that are housebound, receiving their medication via delivery or elderly, e.g. larger print labels with a clear dose, telephone counselling, and most certainly ensure the provision of an oral syringe if a small or difficult to measure dose has been prescribed.

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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. Espranor (Buprenorphine) Bioavailability

We have recently seen an increased number of cases where other brands of Buprenorphine have been dispensed to patients when the Espranor prescribed has not been available. Espranor

is not interchangeable with other buprenorphine products, as the bioavailability of products differ. Please see further details below around the bioavailability of Espranor as well as information around use and dosage:

Espranor (Buprenorphine)

- Oral lyophilisates sugar free 2mg, 8mg

Indications

- Substitution treatment for opioid drug dependence
- **Not to be used for the treatment of pain**

Dose

- By oromucosal administration, adults and adolescents aged 15 years or over: Initially 2 mg daily, followed by 2–4 mg if required on day one, adjusted in steps of 2–6 mg daily if required, for adjustment of dosing interval following stabilisation, consult product literature; maximum 18 mg per day.

Notes

1. **Espranor must be prescribed by brand**
2. **Espranor is not interchangeable with other buprenorphine products, as the bioavailability of products differ.** Espranor has a higher bioavailability (25-30%) compared to Subutex.
3. Once the appropriate dose has been identified for a patient with a certain product (brand), the product cannot readily be exchanged with another product.
4. Oral lyophilisates should be placed **on the tongue** and allowed to dissolve which usually occurs within 15 seconds. Patients should be advised not to swallow for 2 minutes and not to consume food or drink for at least 5 minutes after administration.

Should Espranor not be available, the prescriber should be contacted for advice and agreement over any substitute medications. This allows for discussion around appropriate dosing and consideration of alternative options.

5. Educational Resources for Clinicians and Healthcare Professionals

There are a series of video resources available to healthcare professionals and clinicians wanting to improve the management of chronic non-cancer pain for their patients and to reduce harm from opioids. These videos have been developed by Professor Roger Knaggs who is a Professor in Pain Management.

Please access here - **https://vimeo.com/showcase/11133214 .**

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6. Repeat Prescribing and Opioids

Having a robust and effective process for repeat prescribing of opioids helps to ensure that these high-risk medicines are managed safely.

A toolkit is now available to help improve the consistency, safety, and efficiency of repeat prescribing. The toolkit provides a framework for GP practices, community pharmacies and patients to collaboratively work together to improve patient care and safety. This resource was commissioned by NHS England to address recommendation 7 of **the National Overprescribing Review.**

The toolkit can be accessed here: **Repeat Prescribing Toolkit** .

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7. Anthony Nixon: Prevention of Future Deaths Report

Investigation into the death of Anthony Nixon took place from 4th September 2023. It was concluded that the death was drug related and that the actions of the Pharmacy contributed more than minimally in supplying additional methadone on multiple occasions, not in accordance with the prescription for such.

The MATTERS OF CONCERN are as follows. The Pharmacist in this case gave evidence that he believed that he had discretion to provide CNS depressing drugs in advance, and not in accordance with the prescription for supervised provision of X drug on specific days and maintained this was a “standard practice” when the Pharmacy was open for half a day on Saturdays.

He interpreted the wording on the prescription namely “please dispense instalments due on a Pharmacy closed days on a prior suitable date” to include Saturdays when the Pharmacy was open for half a day, despite the prescriptions stipulating the specific days that the drug was to be provided, including specification of the dose each Saturday.

This led to a situation where the deceased was in possession of multiple doses of a controlled drug, on a regular basis in the period leading up to his death, which was not in accordance with the prescription, which had been carefully considered to attempt to manage the obvious risks of such. The Pharmacy had been specifically chosen by the deceased's drug treatment provider because it was able to provide supervised administration on a 6 day per week basis and because in their assessment this was required to attempt to manage the risks inherent in the deceased having access to multiple doses.

The report can be accessed here: **Anthony Nixon: Prevention of Future Deaths Report - Courts and Tribunals Judiciary**

Our records indicate majority of community pharmacy incident reports do involve FP10MDA scripts. We would like to encourage all key stakeholders take time to share with their team members, read, understand, and discuss this report.

Useful resource: **Drug misuse and dependence: UK guidelines on clinical management - GOV.UK** - How clinicians should treat people with drug misuse and drug dependence problems.

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8. Controlled Stationery in Dental Practices

Our team and the Police Controlled Drug Liaison Officers (CDLOs) have been dealing with prescription theft from dental practices. Unfortunately, the dental practices involved were victims of burglary. We always recommend that you have a process in place to manage your controlled stationery. Ensure all prescriptions are always secure and a robust audit trail is in place. There is a helpful guide produced by the NHS Counter Fraud Authority which outlines best practice solutions around prescription management. Please refer to this guide for support.

The guide can be accessed here: **Management and control of prescription forms**

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9. Handing Out of Dispensed Items

We have recently received a number of CD incidents where the identity of the person collecting medication was not adequately checked and medication was given to an incorrect patient i.e. pharmacy staff just called out a name. Please can all staff be reminded that the person collecting medication should be asked to give the full name and address of the patient and this confirmed against the prescription.

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

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