NHS England: Midlands & East (East) — Medical Directorate

Controlled Drugs Newsletter

Shipman more than 10 years later, lest we forget

Harold Shipman was able to divert large quantities of controlled drugs for over 27 years without detection. He was also an addict himself using 600-700mg of pethidine a day for 18 months before being convicted in 1976. He is thought to have murdered between 218 and 263 people, most of whom were reasonably healthy at the time of their death and the youngest of whom was only 49.

How he was able to continue obtaining drugs that were monitored and recorded for so long? The answer is he used methods that were lawful and inconspicuous, obtaining supplies from a pharmacist who had confidence in him as a clinician.

The report finds that the same methods of obtaining drugs could have been used for self-administration or to sell to others.

As pharmacists or dispensing technicians our best defense to prevent another Shipman is to maintain our professional objectivity. If you are unsure about a situation then consult an independent colleague or contact us for advice.

The Fourth Report of the **Shipman Inquiry** - The Regulation of Controlled Drugs in the Community was published on 14 July 2004.

Controlled Drugs Team Contact Details

It is important that the controlled drugs team are made aware of any incidents or concerns regarding controlled drugs as soon as possible so that action can be taken if necessary.

The preferred point of contact is the generic inbox: england.ea-cdao@nhs.net

Dr Melanie Clements (Controlled Drug Accountable Officer): Can be contacted via the email above, or through another member of the team.

Elizabeth Bennett (Controlled Drugs Programme Manager): elizabethbennett@nhs.net

Jane Newman (Controlled Drugs Senior Pharmacist): jane.newman@nhs.net

Jackie Campbell (Programme Manager): jackie.campbell4@nhs.net

Katy Elliott (Administrative Support): katrina.elliott@nhs.net

Issue 4
January 2016

Welcome to the January 2016 issue of NHS England: Midlands & East (East) controlled drugs newsletter.

This newsletter has been produced to provide a platform for the Area Team, CCGs, Police and other regulatory bodies to share good practice guidance and incidents involving CDs with healthcare professionals in all sectors across the region.

The previous East Anglia and Essex area teams have merged to create one East team covering Cambridgeshire, Norfolk, Suffolk and Essex.

Inside this issue:

Incident reporting update:

We have created a standard form for incident reporting which can be downloaded from the following address:
www.england.nhs.uk/mids-east/our-work/controlled-drugs/

The form contains a number of free text boxes, as well as drop down boxes. When you click on a drop down box, you will see a series of choices which you should then select from accordingly.

It is important to complete the form as fully as possible, because this provides us with all the necessary information for recording to a standard which meets our statutory requirements. It also means our investigations will be completed faster, as we will not have to contact you to clarify information.

If you have any trouble downloading or completing the form, do not hesitate to contact the generic inbox at the address listed on page 1 of this newsletter.

Useful Websites

Home Office
https://www.gov.uk/government/organisations/home-office

Department of Health
https://www.gov.uk/government/organisations/department-of-health

General Pharmaceutical Council
www.pharmacyregulation.org

Care Quality Commission
http://www.cqc.org.uk/

National Prescribing Centre (Legacy site)
www.npc.nhs.uk

"No glue, screws or Velcro" - but what is the question?

The question is: How must the CD cabinet be fixed to the wall or floor?
It hasn't changed since the 1973 Misuse of Drugs (Safe Custody) Regulations which states it shall be:

Securely fixed by at least two rag-bolts each passing through an internal steel anchor plate at least 3mm thickness.

Yet we still have reports of CD cabinets being screwed on to wooden batten, or worse… **please check yours today.**

Learning from recent experiences in Essex

A practice in Essex had a very polite and personable patient who claimed to be experiencing significant pain. The GP believed this to be true. Over time this patient started over using opiate medication to an extraordinary level obtaining extra supplies by reducing the interval between prescriptions to as little as daily in some instances.

For a pharmacy or dispensary to consider:

The local pharmacy continued dispensing despite frequent queries to the practice. Every locum or new pharmacist who re-iterated their concern was told by the prescriber it was 'OK to dispense'. There are parallels with how Harold Shipman was able to repeatedly obtain controlled drugs, he had a close working relationship with the local pharmacist who didn't question what had become a regular occurrence.

If you feel uncomfortable dispensing a prescription for controlled drugs and are unsatisfied with the response you have from the prescriber then contact us for advice and help, particularly where excessive quantities or over frequent repeats are concerned.

As a health professional consider: At what point would you refuse to dispense? Would you be able to justify your action in continuing to dispense if the patient subsequently suffered adversely?

To think about if you are a prescriber or pharmacist:

If you are allowing a patient to obtain more frequent supplies of a drug (determined by prescribed dose/ expected duration) how can you be assured you are discharging your duty of care to that patient? (preventing them from taking an accidental overdose by taking a higher dosage than you have directed).

The patient may try to abuse the system but it is **you** as a prescribers (or pharmacists) who are responsible and accountable for the safety of every patient.

Think: Are you satisfied the patient really needs the quantities prescribed or are the drugs being diverted? It is not always the person for whom the drugs were prescribed who is harmed.

Many thanks to the prescriber and pharmacy for agreeing to let us share this information in the interest of learning.

Opioids Aware

The increase in opioid prescribing in recent years has led to concerns that England may be on the way to the "epidemic proportions seen in the USA" according to Opioids Aware – A new online resource developed in the UK through collaboration between a number of organisations including several medical Royal colleges, NICE, CQC, the British pain Society and the Royal Pharmaceutical Society to support the safe and rational use of opioids for pain.

Headlines

1. Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain.
2. A small proportion of people may obtain good pain relief with opioids in the long-term if the dose can be kept low and especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation).
3. The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit.
4. If a patient is using opioids but is still in pain, the opioids are not effective and should be discontinued, even if no other treatment is available.
5. Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

It is available at www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware

The resource is aimed at both clinicians and the public. It is exceptionally comprehensive and fully referenced to the original evidence. Much of it is online only but there are a few documents available to download and print such as:

- A checklist for prescribers (available at https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware/structured-approach-to-prescribing/checklist-for-prescribers)
- Identification and treatment of prescription opioid dependent patients (available at https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware/clinical-use-of-opioids/dependence-and-addiction)

Best Professional Practice

Opioids and the law, writing opioid prescriptions, patient safety, reporting harms, record keeping, prescribing

The Condition, The Patient, The Context

Assessment and challenges of long-term pain, the role of medicines, a stepped approach to opioid prescribing

Clinical Use of Opioids

Opioids for different types of pain, their effectiveness and harms, dependence and addiction

A Structured Approach to Opioid Prescribing

Patient assessment, the opioid trial, long-term prescribing, stopping opioids, equivalents, the addicted patient

Information for Patients

Types of pain, thinking about starting opioid medication and frequently asked questions about taking opioids

Facts and figures:

- Rises in opioid prescribing have been accompanied by increases in harms such as unintentional overdose, addiction and death.
- 4% of our population are prescribed opioids.
- In the last year over 5% of our adult population have used opioid medicines not prescribed for them.

Controlled Drug Liaison Officers (CDLO)

The CDLO is a member of the police force. Their role is to provide a link between the police and partner agencies such as health (e.g. hospital, primary care and community) and local authorities to prevent or prosecute offences involving controlled drugs. This includes prescribed medicines and illicit substances.

The CDLO's remit only includes offences that involve pharmaceutical controlled drugs and their safer management. Therefore it does not include offences such as bogus doctors, the sales of non-controlled drugs, theft of miscellaneous items from health service providers' premises and fraud. These types of incidents will be dealt with by Local Police Officers, however the CDLO should still be informed for information sharing reasons.

When the police have been called to deal with an incident on your premises involving prescription drugs, forged prescriptions or stolen prescriptions please ensure that the CDLO is also informed as the CDLO will be able to assist the officers with their enquires. Ensure that once you have reported an incident to the Police that you obtain the incident number, which should be similar to the following example: EP-20141111-0123.

The CDLO contact details are:

Cambridgeshire and Peterborough:
Harvey Nutton
harvey.nutton@cambs.pnn.police.uk
101 Ext 3791
07736 084567

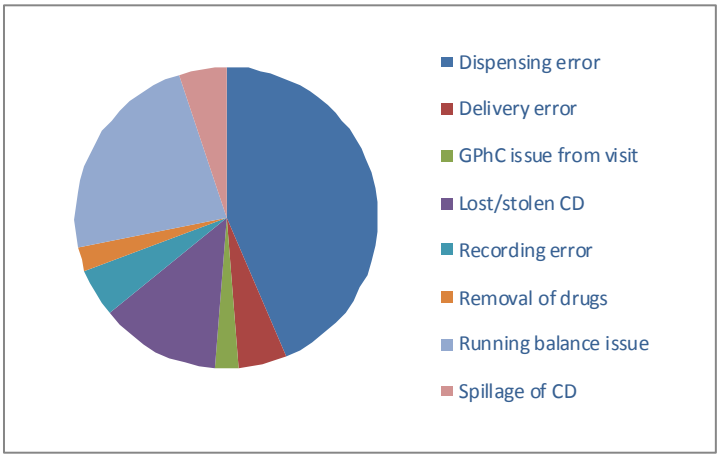
Suffolk:
Robin Pivett
robin.pivett@suffolk.pnn.police.uk
01473 613888 Ext 2869
07979 178664

Essex (controlled drugs contact):
Martin Larner
martin.larner@essex.pnn.police.uk
0300 333 4444 Ext 489074

Incident Reports Breakdown : July-September 2015

A total of **39** incidents were reported to us during this period. The highest number of incidents were reported from health providers in the Cambridgeshire and Peterborough area.

This pie chart shows the breakdown of reported incidents according to their type. As can be seen from the chart, dispensing errors were the most common type of incident reported, making up 44% of the total. Within this, the most frequently reported errors were dispensing the incorrect amount of medication and dispensing the incorrect strength of medication.



Everyone involved in the management or use of controlled drugs has a legal duty to report any incidents or complaints involving controlled drugs (all Schedules) to their Controlled Drug Accountable Officer (CDAO). In Essex and Anglia Dr Melanie Clements, NHSE (East) is the CDAO for community pharmacies, GP practices and other organisations who do not have their own CDAO.

Please make sure you notify us of incidents promptly using our standard template form downloaded from **www.england.nhs.uk/mids-east/our-work/controlled-drugs/**

We welcome all feedback and suggestions for this newsletter.
Email your suggestions to england.ea-cdao@nhs.net