Safer Management of Controlled Drugs: Annual Report 2017/18

NHS England South West

BNSSG, Cornwall & the Isles of Scilly, Devon, and Somerset

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Annual Report 2017/18

Version number: 2.0

First published: August 2018

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Classification: OFFICIAL

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1.1.3 All incidents involving Controlled Drugs should be reported to the relevant Accountable Officer. This provides assurance that any risks have been mitigated, and prompts any action to be taken if they are not. Reporting also allows for the identification of themes in reported incidents from which learning can take place.

1.1.4 In 2017/18 we noted that we receive more incident reports about the prescribing and dispensing of methadone than we do about any other drug and we shared the learning from these in a newsletter that was published in the spring of 2018.

1.1.5 We continue to hear regular reports of medicines containing Controlled Drugs being diverted by healthcare professionals, most commonly in hospital and hospice settings.

1.1.6 We have successfully supported a large number of healthcare professionals to investigate, to reflect, to learn, and to prevent recurrence of those incidents that they reported to us - every one of the 684 reported incidents this year received a bespoke response from a member of the team.

1.1.7 We have also been successful in holding a number of healthcare professionals to account for their actions, where risky and criminal behaviour led to a significant risk of harm to themselves or others. We have ensured that we have assisted the police to secure a conviction where appropriate.

1.1.8 A number of key operational improvements were implemented in 2017/18:

- The introduction of a new incident database and reporting system
- The introduction of a new method of authorising witnesses for Controlled Drug destructions
- A new method of monitoring NHS prescribing activity to ensure that all Controlled Drug prescriptions are screened
- Improvements to our approach to reviewing applications for prescriber codes for the private prescribing of Schedule 2 and 3 Controlled Drugs

1.1.9 The South West team routinely receive requests to send alert notifications to providers of healthcare in the South West. These alerts usually involve warnings about lost or stolen prescriptions that may be used fraudulently, or advice about people who are believed to be fraudulently seeking medication in order to misuse or divert them. In 2017/18 we circulated 117 such alerts.

1.1.10 We published a patient story via newsletter in the summer of 2017 – *Faye's Story*. Faye was a patient who was prescribed many medicines, including opioids at high doses, who passed away following a significant deterioration in her quality of life. It has subsequently been published on the NHS Improvement website, and circulated to every Clinical Commissioning Group in England via the *CCG Bulletin.* We have received positive feedback from a wide range of healthcare professionals to say how useful it has been.

1.1.11 Our objectives for 2018/19 include:

- Review the report of the Gosport Independent Panel and share the learning from this as widely as we can
- We also intend to support the likely changes to the scheduling of Cannabis derivatives, and also gabapentin and pregabalin
- A number of significant shifts in the NHS, and the regulatory landscape are expected, that will need to be planned for and managed well
- We will continue our work to support safer prescribing of opioids and continue to use patient stories – we hope to be able to produce a number of short films to support GPs in reviewing prescribing

2 Introduction

2.1 Context

2.1.1 The NHS has embarked on a journey to become one of the safest healthcare systems in the world as part of the next steps on the NHS Five Year Forward View.

2.1.2 The World Health Organisation has announced its Third Global Safety Challenge – *Medication Without Harm*. The NHS in England has responded by establishing the Medicines Safety Programme with objectives across four 'domains'.

2.1.3 NHS England has a statutory duty to ensure that safe systems are in place for the management and use of Controlled Drugs. This is to prevent harm to patients and staff from misuse.

2.1.4 The work of the South West Controlled Drugs Team aims to ensure that medicines use is both safe and effective.

2.2 Regulation

2.2.1 Controlled Drugs are essential to modern clinical care and are also drugs that are especially addictive and harmful. They include strong painkillers, stimulants, tranquilisers, and anabolic steroids, and are subject to high levels of regulation as a result of government policy.

2.2.2 The aim of the Misuse of Drugs Act 1971 is to control 'dangerous or otherwise harmful substances'. The drugs subject to control are listed in Schedule 2 to the Act and are divided into parts or classes largely on the basis of decreasing order of harmfulness: class A, class B, and class C. This division into classes is solely for the purpose of determining penalties for offences under the Act.

2.2.3 The classification of Controlled Drugs for purposes of control when these drugs are used for lawful purposes appears in the Schedules to the Misuse of

Drugs Regulations 2001. The drugs controlled under the Act are classified in the 2001 Regulations into five schedules in descending order of control, the most stringent controls applying to drugs in Schedule 1 (which may not be used for medicinal purposes), whereas drugs in schedule 5 have the least control (on the basis that these have the lowest risk of abuse).

2.2.4 The Controlled Drugs (Supervision of Management and Use) Regulations 2006 were introduced as part of the then Government's response to the Shipman Inquiry's Fourth Report in 2004. The Shipman Inquiry reported on the activities of the former GP and serial killer, Harold Shipman, who used Controlled Drugs to kill many of his patients.

2.2.5 The aim of the 2006 Regulations (which were amended in 2013 as a result of the Health and Social Care Act 2012) is to strengthen the governance arrangements for the use and management of Controlled Drugs. It is essential that NHS England enforces robust arrangements for the management and use of Controlled Drugs to minimise patient harm, misuse, and criminality.

2.2.6 The 2013 Regulations expire in 2020, and the Department of Health & Social Care is currently in the process of reviewing and renewing them.

2.3 The Appointment of Accountable Officers

2.3.1 The 2013 regulations require NHS England and other 'designated bodies' such as NHS trusts and independent hospitals to appoint Accountable Officers for Controlled Drugs, and requires those Accountable Officers to ensure safe systems are in place for the management and use of Controlled Drugs. Accountable Officers appointed by NHS England have additional responsibilities in the regulations as 'Lead Accountable Officers'.

2.3.2 A national register of Accountable Officers is maintained by the Care Quality Commission and published online. There are 48 such Accountable Officers in the South West, appointed by the designated bodies.

2.3.3 The Accountable Officer for NHS England with responsibility for Bristol, North Somerset, and South Gloucestershire, Cornwall and the Isles of Scilly, Devon, and Somerset was Sue Mulvenna until her retirement in June 2017. The current Accountable Officer (Jon Hayhurst) was appointed in July 2017.

2.4 The Controlled Drugs team in the South West

2.4.1 In the South West the Accountable Officer is supported by a pharmacist who deputises (Darren Barnett) and two Project Officers from the performance team (Vicky Bawn and Elizabeth Audsley). The Accountable Officer reports to the Medical Director (Dr Caroline Gamlin).

2.4.2 The team cover an area with a population of roughly 3.3 million patients, and with 278 medical practices employing over 3,300 GPs. These GPs issue over 67 million prescriptions per year, dispensed at 565 pharmacies in the region.

2.4.3 The team manages the operational day to day work that falls within the NHS England Controlled Drugs Accountable Officer's remit. This includes:

- Responding to incident reports by seeking assurance
- Drafting alert messages and authorising their dissemination
- Investigations for complex cases
- Monitoring of Controlled Drugs prescribing
- Collation and review of Occurrence Reports
- Sharing learning and intelligence with stakeholders
- Arranging for authorised witnesses to facilitate Controlled Drugs destruction
- Processing applications for unique prescriber identification numbers for the private prescribing of Controlled Drugs

3 Local Intelligence Network

3.1 Overview

3.1.1 The regulations require NHS England Accountable Officers to facilitate 'Local Intelligence Networks' to share information and intelligence about unsafe use of Controlled Drugs.

3.1.2 The South West Local Intelligence Network (LIN) is compliant with the regulations. We have an established system to develop co-operation between members to capture information and disseminate lessons learnt.

3.1.3 The network meets twice a year, in five locations due to the large geography it covers (i.e. there are ten meetings per year). In 2017/18 meetings of the network were held in Bristol, Bodmin, Exeter, Saltash, and Taunton. These five meetings took place across five days in October, and then again across five days in March.

3.2 Membership

3.2.1 The membership is comprised of

- Accountable Officers of designated bodies
- Police Constables working as Controlled Drugs Liaison Officers
- Local Counter Fraud Specialists
- Inspectors from the Care Quality Commission
- Inspectors from the General Pharmaceutical Council
- Accountable Officers or their representatives from the armed forces

3.2.2 Others are in attendance

- Controlled Drugs Leads from Clinical Commissioning Groups
- Patient Safety Leads from Local Pharmaceutical Committees
- Substance Misuse Service commissioners from Local Authorities
- Controlled Drugs Leads from other organisations (such as social enterprises or bodies corporate) that provide healthcare

3.3 Effectiveness of the network

3.3.1 Communication with the network is achieved through e-mail correspondence, telephone calls, and also routine and *ad-hoc* meetings.

3.3.2 In 2017/18 the Controlled Drugs team invited feedback from all members of the Local Intelligence Network by requesting that they fill in a short online questionnaire.

3.3.3 Non-responders were reminded and at the time of publication roughly one quarter of the group (n=20) had completed this survey.

3.3.4 The key points from the survey confirm that:

- Responders unanimously stated that they felt comfortable sharing intelligence
- Meetings of the network were deemed by the majority to have the correct attendance, the appropriate frequency, the appropriate duration, and the appropriate level of formality
- The meetings were deemed to be held at suitable venues for members to attend

3.4 Agenda style and content for meetings of the network

3.4.1 Meetings of the Local Intelligence Network are held in two parts (‘part A’ and ‘part B’).

3.4.2 Part A is a plenary session in which the majority of presentations, discussion and learning takes place. This may include general concerns raised, information coming to light from monitoring prescribing, or specific incidents involving Controlled Drugs. In addition to sharing information, these meetings are used to discuss local and national issues. Attendees are invited to present incidents or scenarios from their own organisations from which learning can be shared.

3.4.3 Part B is a session reserved for the members, and other attendees normally leave before this session commences. It allows for the sharing of the names of individuals where there are concerns regarding their use or management of Controlled Drugs.

3.4.4 The minutes from Part B of meetings of the Local Intelligence are exempted from disclosure under Section 31 (Law Enforcement) of the Freedom of Information Act 2000. Details of minutes should not ordinarily be disclosed upon request under the Freedom of Information legislation.

3.5 Attendance at meetings of the network

3.5.1 Attendance at the meetings has generally been very good, with Accountable Officers from the designated bodies and the leads from other organisations listed above regularly attending.

3.5.2 In the event that an Accountable Officer does not participate in the Local Intelligence Network, the Care Quality Commission can be notified, who may then follow up with the Accountable Officer concerned.

4 Incident reporting

4.1 Overview

4.1.1 All incidents involving Controlled Drugs should be reported to the relevant Accountable Officer. This provides assurance that any risks have been mitigated, and prompts any action to be taken if they are not. Reporting also allows for the identification of themes in reported incidents from which learning can take place.

4.1.2 The South West Controlled Drugs team strongly advocate a 'Just Culture' in which healthcare staff are supported to be open about mistakes to allow valuable lessons to be learnt so the same errors can be prevented from being repeated. We help people to investigate, to reflect, to learn and to take action to prevent a recurrence.

4.1.3 Staff in organisations that do not have their own Accountable Officer report their incidents to the Accountable Officer at NHS England. They do this online at www.cdreporting.co.uk. This website and database is maintained by colleagues at NHS England in Manchester, at a cost to regional teams. This method was introduced into the South West by us in October 2017, prior to which we received incident reports by secure e-mail.

4.2 Activity

4.2.1 In the period April 2017 to March 2018, the team received 684 reports of incidents involving Controlled Drugs from organisations that do not have their own Accountable Officer – these mostly came from community pharmacies. Each report was reviewed by the team to seek assurance that any risks had been mitigated. Further information was requested when necessary to provide the appropriate level of assurance. Some incidents reports led to complex cases that we investigated ourselves due to their complexity.

4.2.2 We share the learning from the themes in incidents reported to us and update on relevant topics via our Local Intelligence Network and to wider stakeholders via our website and newsletters.

4.2.3 In a newsletter article circulated in 2017/18 we advised reporters on 'best practice' regarding the detail to be included when submitting incident reports (see below):

What a good incident report looks like

- *Report the incident promptly - has anyone been harmed?*
- *State the facts - what happened? Be open and honest.*
- *Have you explained what has happened to any patients involved and apologised if appropriate?*
- *Tell us why you think it happened.*
- *Tell us what you have done to try to prevent it from happening again.*
- *What have you learnt as a result by reflecting on what happened? Have you shared this with your team?*
- *How will you check that the change in your practice is working?*

Our priority is to ensure that the incident is investigated fully and that a recurrence of the incident is less likely as a result of the learning that has taken place, which we aim to share

From our April 2018 Controlled Drugs newsletter (see appendix)

4.3 Classification of incidents by type

4.3.1 A summary of those incidents reported to us in 2017/18 is provided in table one (below):

Incident type	Frequency (number)	Frequency (percentage)
Dispensing errors	265	39%
Balance discrepancies	160	23%
Administration errors	60	9%
Theft/fraud	48	7%
Smash/spillage	31	5%
Lost prescriptions	26	4%
Prescribing incidents	20	3%
Other	74	11%
Total	**684**	**100%**

4.3.2 This shows that dispensing errors (in which the product supplied to the patient is not what was ordered on prescription) were the most common error.

4.3.3 Balance discrepancies were another very common type of incident reported. This is when an organisation has less medication in stock than records show it should have (and stock is therefore missing), or when an organisation has more medication in stock than records show it should have (and stock therefore may not have been supplied when it should have been).

4.4 Source of incident reports

4.4.1 The source of those incidents reported to us in 2017/18 is provided in table two (below):

Type of organisation	Frequency (number)	Frequency (percentage)
Community Pharmacy	544	80%
Care Home	50	7%
GP Practice	35	5%
Prison healthcare	24	4%
Other	31	5%
Total	**684**	**100%**

4.4.2 It can be seen from this information that four in every five incidents reported to us originate from a community pharmacy. A high frequency of reports from this setting is to be expected considering that Controlled Drugs are held as stock in significant quantities, and are regularly obtained and supplied; however it does suggest that reporting from other organisations might be improved.

4.4.3 The themes and learning from these are summarised in section six of this report.

5 Occurrence Reporting

5.1.1 Incidents involving Controlled Drugs that have been reported to the Accountable Officer in organisations other than NHS England are recorded locally by that organisation. It is for that Accountable Officer to seek assurance that risks have been mitigated and to prompt for any action to be taken if they have not.

5.1.2 The 2013 Regulations require these Accountable Officers to submit a summary of those incidents reported to them to the Accountable Officer at NHS England on a quarterly basis. This is provided in what is known as an 'Occurrence Report'. This reporting allows for the identification of themes in reported incidents from which learning can take place.

5.1.3 There are currently 48 such organisations that are required to send us their Occurrence Reports every three months - a list of these can be seen in the appendix.

5.1.4 A new template for Occurrence Reports was developed nationally and implemented in the South West in 2017/18. The template had more emphasis on categorising incidents and required a risk rating on individual incidents and so captured more detailed data. Using a standardised template in this way aims to enable the compiling of a national report that will help to illustrate the amount of risk being managed by Accountable Officers.

5.1.5 The updated template was more onerous to complete - a number of Accountable Officers expressed concern about this, and their feedback was useful.

5.1.6 The Accountable Officers from other designated bodies would be expected to submit four Occurrence Reports over the course of the year (one each quarter). In 2017/18 we requested 209 such reports, and received 179. We therefore received 86% of the reports that we should have. When

organisations persistently omit to send us Occurrence Reports we can notify the Care Quality Commission who may then follow up with the Accountable Officer concerned.

5.1.7 We also request occurrence reports from organisations that are not required to do so where these are add significant value (one example is substance misuse service providers).

5.1.8 From the 179 Occurrence Reports that we received in 2017/18, we noted 2,391 incidents had occurred within the period April 2017 to March 2018. The breakdown of these is displayed below in table three (below):

Category / Type of incident		Number of occurrences
Patient safety incidents	Prescribing	187
	Dispensing	102
	Administration	474
	Other	180
Unaccounted for losses such as theft and fraud (from the organisation), unexplained stock discrepancies, lost prescriptions / requisitions		345
Accounted for losses such as spillages, breakages		267
Patient / public such as fraud and theft (by patients / public), misrepresentation by patients		18
Professional individuals of concern These are relevant individuals i.e. people who work in health or social care		13
Governance issues such as CD safe custody, staff competence, audit, statutory requirements, SOPs		361
Record keeping		444
Totals		**2,391**

5.1.9 Some of the themes and learning from these are summarised in section six of this report.

6 Shared Learning

6.1 National issues

6.1.1 We received significant feedback from a number of stakeholders, and via the Local Intelligence Network that healthcare professionals working in the South West were not as informed about the misuse and diversion of two drugs, gabapentin and pregabalin, as we would hope them to be. These are not Controlled Drugs, but the Home Office recently consulted with the public about whether they should be. We issued a newsletter in the December 2017 to raise awareness of this issue, and to encourage people to respond to the consultation.

6.2 Themes from reported incidents

6.2.1 In 2017/18 we noted that we receive more incident reports about the prescribing and dispensing of methadone than we do about any other drug and we shared the learning from these in a newsletter that was published in the spring of 2018 (see appendix).

6.2.2 The theme that caused us the most concern was the number of incidents reported to us in which one patient's medication was supplied to another in error. The risk of harm is significant with this type of error, and the recurrence rate of this type of error is also high. The most common examples involve a patient prescribed methadone receiving a dose of methadone intended for another patient; resulting in some patients receiving too small a dose, and some too large a dose. Our newsletter article advised of best practice in terms of how to attempt to prevent this type of error, as well as how to safeguard the welfare of the patient in the case of an overdose when it does happen.

6.2.3 Another related theme concerned the supply of methadone to patients that had missed their dose for three or more days. The risk of harm from overdose is significant here as the patient's tolerance to the medication may have declined and so it is important to contact the prescriber before making a

supply. Our newsletter article advised of best practice and how to manage the situation well.

6.2.4 A large number of incidents reported to us concern balance discrepancies with liquid medication containing Schedule 2 Controlled Drugs in which a differing quantity of medication was found to be in stock than records indicated there should be. Our newsletter article advised of best practice in terms of how to both measure and to investigate such discrepancies, and how to deal with accidental spillages of such medication.

6.3 Themes from occurrence reporting

6.3.1 We continue to hear regular reports of medicines containing Controlled Drugs being diverted by healthcare professionals, most commonly in hospital and hospice settings. Accountable Officers usually become aware of excessive use of a medicine in a particular clinical area, which leads to an investigation in which a member of staff has been found to be stealing the medication concerned.

6.3.2 Such incident themes are discussed in our Local Intelligence Network. Our Police Controlled Drugs Liaison Officer colleagues are experts in advising how best to conduct investigations, and respond to their findings. This might include the installation of covert recording equipment if the correct procedures are followed. Incidents such as this most commonly involved codeine phosphate tablets, and as such, many organisations have reviewed the number of clinical settings that stock this medication, and the quantities they hold.

6.4 Complex cases

6.4.1 Some of the incidents or intelligence reported to us leads to investigations that uncover significantly unsafe practice.

6.4.2 In one case a GP working for an Out-of-Hours medical provider was committing fraud by writing prescriptions for patients that had not consulted

him, and obtaining supplies of morphine and tramadol by presenting at pharmacies in another county to get the prescriptions dispensed. The reporting of a concern about the unusual prescribing from a pharmacist led to an investigation that established the GP was the person committing fraud. He was sentenced to 24 weeks in prison suspended for 18 months and is now receiving support with his addiction. Learning in this case focussed on vigilance with security of prescription forms in the out-of-hours setting.

6.4.3 In another similar case, a medical practice in the South West became aware that a nurse working there was committing fraud by writing prescriptions for patients that had not consulted her, and obtaining supplies of diazepam by presenting at pharmacies to get the prescriptions dispensed. The nurse herself was not qualified as a prescriber. The Controlled Drugs team were able to provide evidence for this case via their work on prescribing monitoring.

6.4.4 One case involved a nurse prescriber informing us as a whistle-blower of unsafe prescribing by a GP in her practice. Thus, we were able to challenge that GP about their prescribing of benzodiazepines. The GP has since changed role and works in another setting.

6.4.5 The theft of a number of prescription forms from a practice led to many forged prescriptions being presented for dispensing over a period of several weeks in Torquay. The theft was not reported, but the presentation of fraudulent prescriptions was reported by pharmacy staff and the sharing of this information prevented many forged prescriptions that were subsequently presented from being dispensed.

6.4.6 We were made aware of the death of a young woman in Exeter as a result of a Coroner's Regulation 28 letter. The case involved inappropriate long-term prescribing of short-acting benzodiazepines and this was discussed within our Local Intelligence Network, with the learning shared with medical practices via the *GP Bulletin*. This Regulation 28 letter resulted in a national communication from Professor Tim Kendall and Peter Pratt about benzodiazepines and suicide.

7 Issue of Prescriber Identification Numbers

7.1.1 The regulations require that medicines containing schedule 2 and 3 Controlled Drugs in England are only prescribed privately by individual practitioners that have been issued with a unique private prescriber identification number by an NHS England Accountable Officer. This is also required when medicines containing schedule 2 and 3 Controlled Drugs are obtained on an ad hoc basis with a requisition.

7.1.2 The South West team routinely receive requests for the issuing of such a private prescriber identification number from doctors and dentists. We also regularly receive requests from paramedics who are notable in that they cannot currently prescribe Controlled Drugs, although they can obtain morphine and diazepam by requisition. We occasionally also receive requests from nurses, pharmacists, and physiotherapists who have qualified as independent prescribers.

7.1.3 Those practitioners requesting the issuing of a unique private prescriber identification number are required to complete standardised application forms that seek assurance that the practitioner is aware of their responsibilities and the requirements of the regulations.

7.1.4 In 2017/18 we improved our process by requiring a copy of photographic identification such as a passport or driver's license from all applicants.

7.1.5 Applications are reviewed by the Accountable Officer or deputy and if satisfactory, a prescriber identification number is requested from the NHS Business Services Authority.

7.1.6 In 2017/18 the South West team received and approved 24 applications. A further small number of applications did not progress and result in a unique private prescriber identification number being issued.

8 Monitoring of prescribing and supply

8.1 Overview

8.1.1 In order to provide assurance that the medical services directly commissioned by NHS England are using Controlled Drugs safely, the South West team routinely monitoring their prescribing.

8.1.2 In order to provide assurance that prescribers to whom we have issued a unique private prescriber identification number to prescribe and obtain schedule 2 and 3 Controlled Drugs privately are using Controlled Drugs safely, the South West team routinely monitor their prescribing, and their requisitions for supplies.

8.2 Prescribing in the course of providing NHS services

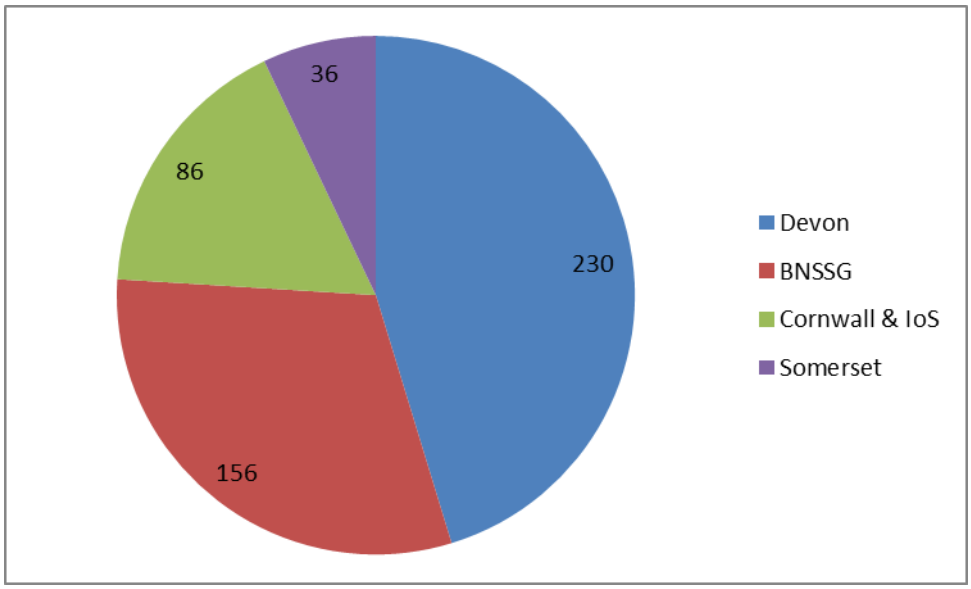
8.2.1 All NHS prescribing in primary care services in England takes place using prescriptions written on controlled stationery known as FP10 forms. NHS England makes provision for supply of this stationery to medical and dental practices providing NHS services as a matter of course. These prescriptions are dispensed by both pharmacies and dispensing doctors and the forms are then submitted to the NHS Business Services Authority for payment. This organisation then provides detailed data on the prescribing to both NHS England and Clinical Commissioning Groups.

8.2.2 The South West team routinely monitor this prescribing data to identify Controlled Drugs prescribing that may be unsafe. Any such prescribing is followed up, either directly with the relevant practice to seek assurance of its safety, or with the relevant Clinical Commissioning Group where agreements are in place for them to seek assurance on our behalf.

8.2.3 In 2017/18 the South West team implemented a new framework for their monitoring of NHS Controlled Drugs prescribing. For the first time we reviewed the prescribing of all five schedules of Controlled Drug, rather than just those in schedules 2 or 3. This meant that we reviewed a much larger dataset, but

effective use of the resources already available to us meant that this was not significantly more onerous than it has been.

8.2.4 Following the introduction of this new framework, data for one 3-month period (December 2017 to February 2018) was extracted from the NHSBSA database (ePACT2), with over 604,000 lines of initial prescribing data filtered to highlight a total of 508 potentially unsafe prescriptions to be queried in the South West. The breakdown of these queries by CCG is shown in figure one (below):



8.2.5 Our work to contact prescribers via the practice they work for has been well received. The majority of prescribers respond to us in a very timely fashion, and are grateful for the opportunity to discuss a challenging patient, or to correct an inadvertent prescribing error. It is common for prescribers to tell us that it is helpful for them to be able to explain to patients that their Controlled Drugs prescribing is monitored by the NHS when faced with inappropriate requests.

8.3 Private prescribing of schedule 2 and 3 Controlled Drugs

8.3.1 The regulations require that private prescribing of schedule 2 and 3 Controlled Drugs in England also takes place using prescriptions written on specific controlled stationery known as FP10PCD forms. NHS England makes provision for supply of this stationery to individual practitioners that have been issued with a unique private prescriber code by an NHS England Accountable Officer. These prescriptions are dispensed by both pharmacies and dispensing doctors, and then the forms are submitted to the NHS Business Services Authority for audit purposes only. This organisation then provides detailed data on the prescribing to NHS England.

8.3.2 The South West team routinely monitor this data to identify Controlled Drugs prescribing that may be unsafe. Any such prescribing is followed up with the individual practitioner to seek assurance of its safety.

8.3.3 In 2017/18 we reviewed data from 717 private prescriptions, and for 9 of those prescriptions the team sought assurance of its safety and clinical appropriateness from the prescriber.

8.4 Supplies of schedule 2 and 3 Controlled Drugs by requisition

8.4.1 Similarly the regulations also require that *ad hoc* supplies of schedule 2 and 3 Controlled Drugs in England also take place using a standardised FP10CDF requisition form. These forms can be obtained online and printed by practitioners, but can only be fulfilled by a supplier where they bear a unique private prescriber code issued by an Accountable Officer.

8.4.2 The South West team routinely monitor this data to identify Controlled Drugs supplies that may indicate unsafe practice. Any such ordering and supply is followed up with the individual practitioner practice to seek assurance of its safety.

8.4.3 In 2017/18 we reviewed data from 886 private requisitions, and for 18 of those requisitions the team sought assurance of its safety and clinical appropriateness from the practitioner.

8.4.4 Requisition data had highlighted the potential inappropriate ordering of Controlled Drugs by a named paramedic. This was thoroughly investigated by the South West team and we were assured that this was in fact due to a processing error in which a medical practitioner's requisition had been inappropriately attributed to a paramedic.

9 Lawful destruction of Controlled Drugs

9.1.1 The Environmental Protection Act 1990 requires that pharmaceutical waste is disposed of safely. Such waste is placed into appropriate disposal containers and eventually incinerated by specialist providers of clinical waste disposal services.

9.1.2 The 2001 Regulations additionally require that medicines containing Controlled Drugs in schedules 2, 3, and 4 (part 1) be denatured (destroyed) before they are disposed of. This denaturing process renders the Controlled Drugs irretrievable so that they cannot be misused or diverted. The denaturing process takes place by the use of a special kit designed for this purpose.

9.1.3 Any such denaturing is classed as treatment of clinical waste by the Environment Agency and as such this requires a specific permit. Healthcare settings such as pharmacies can however apply for an exemption (known as a T28 exemption) to this requirement that allows them to denature Controlled Drugs on the premises. This is outlined in the Environmental Permitting (England and Wales) Regulations 2010.

9.1.4 The regulations require that in the case of stock of schedule 2 Controlled Drugs, that denaturing only takes place in the presence of a witness authorised by an Accountable Officer, or a person authorised by the Home Office by virtue of their role (i.e. Police Constables and General Pharmaceutical Council Inspectors). No such requirement exists for medicines returned by patients for disposal, nor for stock in other schedules. It is however good practice to always have any denaturing of Controlled Drug witnessed by a colleague.

9.1.5 The South West team routinely receive requests for an authorised witness for the destruction of stock of schedule 2 Controlled Drugs from organisations that do not have their own Accountable Officer. The regulations require that we ensure there are a sufficient number of authorised witnesses to perform this task. We must ensure that denaturing and disposal take place in a timely

fashion as obsolete stock is a risk in that it might be dispensed in error, or diverted.

9.1.6 We have existing arrangements with NHS Kernow CCG, NHS NEW Devon CCG and NHS South Devon & Torbay CCG for certain members of their staff to be authorised by the NHS England Accountable Officer to witness the denaturing of stocks of medicines containing schedule 2 Controlled Drugs on those premises used by our commissioned medical practices and community pharmacies. We have a similar arrangement with NHS Somerset CCG for premises used by our commissioned medical practices. We are very grateful to those organisations for providing the resource to do this.

9.1.7 In 2017/18 a new approach was implemented to facilitate the denaturing of stock of medicines containing schedule 2 Controlled Drugs within premises used by our commissioned medical practices and community pharmacies in Bristol, North Somerset, and South Gloucestershire, and premises used by our commissioned community pharmacies in Somerset. This process, adopted from colleagues in London and now common across England allows registered healthcare professionals employed by the provider to be authorised as a witness on a temporary basis (e.g. 14 days) with the agreement of the NHS England Accountable Officer on a case by case basis. The approach is supported by the Police, the General Pharmaceutical Council and by the Care Quality Commission.

9.1.8 The use of this new approach is very efficient on resource and ensures that denaturing takes place in a very timely fashion. Before any authorisation is granted, checks on the applicant's professional registration are undertaken, with reference to any fitness to practise concerns, and confirmation is sought from both the NHS England contracting and performance teams that we are not aware of any concerns with the practice, or the individual. If there are any concerns we provide our own staff as an authorised witness.

9.1.9 In 2017/18 we provided authorised witnesses for destruction at 177 different premises. This is consistent with 2016/17 when we provided authorised

witnesses for destruction at 170 premises. A log of all premises which have requested witnesses is maintained, and any pharmacies that have not requested a witness are contacted periodically to ensure that they understand the process to request a witness and that obsolete stock of medicines containing schedule 2 Controlled Drugs should not be allowed to accumulate.

9.1.10 The range of premises that authorised witnesses were provided for, and the relevant locality, is outlined in table four (below):

Locale	Method	Medical	Pharmacy	Other	Total
Bristol, North Somerset, and South Gloucestershire	New system	15	21	4	40
Somerset	Hybrid	21	10	2	33
Devon, Cornwall, and Isles of Scilly	Historic arrangement	62	38	4	104
Total		**98**	**69**	**10**	**177**

10 Alert notifications

10.1.1 The South West team routinely receive requests to send alert notifications to providers of healthcare in the South West. These alerts usually involve warnings about lost or stolen prescriptions that may be used fraudulently, or advice about people who are believed to be fraudulently seeking medication from healthcare professionals in order to misuse or divert them.

10.1.2 These alerts have been useful in preventing risky behaviour liable to cause harm to patients and the public, and help us to provide evidence for police investigations into illegal activities involving Controlled Drugs.

10.1.3 NHS England commissions a service from the South, Central, and West Commissioning Support Unit to maintain a distribution list of contact e-mail addresses for all providers of primary care services in the South of England. The main reason for this is in order to fulfil our obligation to cascade national alerts to our commissioned providers as part of what is known as the Central Alerting System (CAS).

10.1.4 The Commissioning Support Unit will also circulate bespoke alerts using this system too as part of their contract. In the South West, the Controlled Drugs team are responsible for approving the circulation of such alerts.

10.1.5 The alerts are written in liaison with local Counter Fraud and Security Management Services, or Police Constables working as Controlled Drugs Liaison Officers. It should be noted that these often involved the sharing of patient information, and as such Information Governance are adhered to, as are the Caldicott principles.

10.1.6 In 2017/18 we circulated 117 such bespoke alerts. Of these, 84 concerned lost stolen, or fraudulent prescriptions, and 33 related to patients seeking medicines inappropriately. This is comparable with the previous year (2016/17) when 121 alerts were circulated.

10.1.7 One example of an alert that we circulated was in relation to a member of the public well known nationally as someone that inappropriately seeks pethidine by calling 999 and presenting as having fallen from his wheelchair and dislocating his shoulder. This patient presented at Musgrove Park Hospital in the summer of 2017 and was successful in receiving pethidine. Staff then realised that they were being deceived. We re-circulated the alert to all trusts in the South West following this event.

10.1.8 Another example of an alert that we circulated was in relation to a member of the public resident in the South West who is well known nationally who impersonates healthcare professionals as a way of obtaining medicines or medical equipment, or tampering with patient records. This patient impersonated a healthcare professional at an equestrian event at Blenheim Palace in the autumn of 2017 and was involved in injecting a patient despite her having no medical qualifications. The perpetrator has since been sentenced to four years in prison.

11 Declarations

11.1.1 In order to be assured that those services directly commissioned by NHS England are aware of their obligations and the requirements of legislation, the lead Accountable Officer at NHS England periodically requests that the providers of those services provide assurance of this in writing by way of a declaration.

11.1.2 The South West team currently only requests these declarations from medical practices. This were last requested in 2016/17 and will be requested again in 2018/19.

11.1.3 The South West team have worked with our counterparts across England to develop standardised declarations. To make the work less onerous for providers, it is intended that the declaration will be more concise and simply provide assurance that the requirements of the regulations are being adhered to. This will be performed online via www.cdreporting.co.uk in 2018/19 and we intend to request declarations from dental practices as well as medical practices if resource allows.

12 Inspections

12.1.1 The regulations give Accountable Officers the power to enter and inspect relevant premises where this may be relevant to the purpose of securing the safe, appropriate and effective management and use of Controlled Drugs.

12.1.2 In the case of the NHS England lead Accountable Officer, the premises in scope are those in that area that are not already subject to inspection by:

- The Care Quality Commission
- The General Pharmaceutical Council
- An Accountable Officer of a regular or reserve force

12.1.3 The responsibility for inspection of Community Pharmacies with respect to their management and use of Controlled Drugs is the responsibility of the General Pharmaceutical Council. Three such Inspectors work in the South West, and all are members of our Local Intelligence Network.

12.1.4 The responsibility for inspection of Medical and Dental practices with respect to their management and use of Controlled Drugs is the responsibility of the Care Quality Commission. A number of their Inspectors work in the South West, and those with expertise in medicines are members of our Local Intelligence Network.

12.1.5 Good local relationships with these CQC and GPhC inspectors through the Local Intelligence Network allows for information and intelligence sharing.

12.1.6 The South West Controlled Drugs team did not undertake any inspections in 2017/18 for the purposes of discharging our duties under the 2013 regulations.

13 Challenges, Successes and Priorities

13.1 Progress on objectives set in 2016/17

13.1.1 The *Report on the Safer Management of Controlled Drugs* by NHS England South (South West) in 2016/17 set three objectives for the South West Controlled Drugs team in 2017/18.

13.1.2 The first - Implementation of the national Controlled Drugs Incident Reporting tool (www.cdreporting.co.uk) in the South West of England as the preferred method of receiving incident reports has been implemented fully. The team rolled this out in the autumn and over 99% of incidents reported to us are received by this method. Feedback from users has been positive. Although the use of this website has a cost, we have achieved a significant productivity gain within the team as a result.

13.1.3 The second - to increase and extend support for GPs to manage prescribing patients with chronic pain more safely is in progress, with a great deal achieved so far. The team has worked hard to raise awareness of the over-prescribing of high dose opioids in chronic pain, and the helpful resources from the Royal College of Anaesthetists – '*Opioids Aware'.* We have also championed the work of Dr Jim Huddy and colleagues at NHS Kernow CCG; they have published a range of resources including videos and leaflets on the internet. We also have plans to record a short video in which a consultant anaesthetist from North Bristol NHS Trust will talk about this subject, with GPs being her intended audience.

13.1.4 *Faye's story*, the patient story that we published via newsletter in the summer of 2017 was circulated widely across England and subsequently we have received positive feedback from a wide range of healthcare professionals to say how useful it has been to them and their patients. Faye was a patient who was prescribed many medicines, including opioids at high doses, who passed away following a subsequent significant deterioration in her quality of life. Her parents Linda and Steve continue to campaign to ensure learning takes place as a result of her experience, and also for a change in the law to regulate the

prescribing of high dose opioids in primary care. Liam Fox MP wrote to NHS Improvement about *Faye's story* in 2017 and it has subsequently been published on the NHS Improvement website, and circulated to every Clinical Commissioning Group in England via the *CCG Bulletin.* Colleagues at NHS Improvement have also made contact with the Editors of the *British National Formulary* to ask for a specific review of opioid prescribing guidance as a result. Some of the feedback received is displayed below:

"I received [Faye's Story] via our local CCG newsletter, it's a very powerful moving piece and brings home hard the risks of CDs, especially when we consider escalating analgesia rather than looking at emotional issues. Salutary lesson no less. Please convey my thanks, and condolences, to the aggrieved family that it's reminded me, a front line doctor, of the importance of doing no harm and caring for our patient."
GP, Wandsworth

"Sometimes there is a patient tragedy and guidance that comes from it that every doctor in every practice should learn from. This is one of those. It is relevant to every GP in our current daily prescribing. Reading this could save lives and make your practice safer."
GP Chair, NHS Solihull CCG

"Thank you for sharing Faye's story (please pass on my thanks also to Faye's parents for sharing the story and condolences for their loss). This is very tragic and must be so difficult for them. It is exactly stories like this that highlight the importance of [our research], and we are hoping we can make a difference, at least in the first instance by bringing attention to the problem we have with prescribing of strong opioids for long term pain.
Associate Professor in Health Psychology, Warwick Medical School

"This is very powerful – I endorse it and encourage every GP to read this and include and reflect upon it as Quality Improvement Activity in their current appraisal."
GP Lead for Medicines & Prescribing, NHS Solihull CCG

"We had the presentation earlier this week and the GPs responded really well to Faye's story – there were tears in the audience! I circulated your bulletin to all of the GPs'.
Deputy CCG Lead Medicines Optimisation Pharmacist, NHS Medway CCG

"What a sad case study and one that absolutely needs sharing and learning from. Her parents are very brave and gracious to allow us to use this learning."
Head of Workforce and Education, Hampshire CCG Partnership

Feedback received on *Faye's Story during 2017/18*

13.1.5 We have also worked with colleagues at NHS NEW Devon CCG to facilitate the recording of another patient story (*Sean's story*). This is similar to Faye's story, but with a positive outcome for the patient. Sean successfully withdrew from his prescribed high dose opioids and has much better quality of life as a result. We hope to share the learning from this in 2018/19.

13.1.6 The third objective from the 2016/17 Annual report was to support safer use of Controlled Drugs in care homes, including end of life care ('just in case' medicines), and the use of analgesic patches for patients with dementia. There has been less progress on this objective as the incoming Accountable Officer prioritised other work. We continue to encourage the reporting of incidents from care home settings and have been pleased to see an increase in 2017/18.

13.2 Further Progress on objectives set in 2015/16

13.2.1 The *Report on the Safer Management of Controlled Drugs* by NHS England South (South West) in 2015/16 set a number of objectives for the South West Controlled Drugs team in 2016/17.

13.2.2 One was to work more closely with Medicines Safety Officers in non-acute settings. In 2017/18 the incoming Accountable Officer performed stakeholder mapping of Medicines Safety Officers in the South West of England and surveyed non-acute colleagues to canvass opinion on the establishment of a network, which continues to progress. We have also forged links with the already established acute Medicines Safety Officer network in the South West and have agreed to work more closely together.

13.2.3 Another objective from the 2015/16 report was to find an effective and efficient way to monitor prescribing. We believe that we have made a significant advance completing this objective in 2017/18 in our work to monitor the NHS prescribing of medicines in all Controlled Drugs Schedules (see section 8).

13.3 Successes in 2016/17

13.3.1 The South West team have ensured that *Faye's Story* has had a significant impact nationally by distributing this widely so that as many people as possible can share in the learning from this tragic case. In addition to the feedback that we have received from stakeholders in the English NHS, we have also heard similar reports from colleagues in Scotland, and at the Ministry of Defence.

13.3.2 We have been successful in supporting a large number of healthcare professionals to investigate, to reflect, to learn, and to prevent recurrence of those incidents that they reported to us - every one of the 684 reported incidents received a bespoke response from a member of the team.

13.3.3 We have also been successful in holding a number of healthcare professionals to account for their actions, where risky and criminal behaviour led to a significant risk of harm to themselves or others. We have ensured that we have assisted the police to secure a conviction where appropriate.

13.3.4 We have worked with the NHS England Communications team to publish a new page on the NHS England South West website that explains the work of the team in language that would be understood by patients, and also includes an archive of all of the newsletters that the team have published from 2013 onwards. This publication of this archive is something that has been requested by a number of stakeholders to support Continuing Professional Development, and to support newly qualified pharmacists.

13.3.5 A number of key operational improvements were implemented in 2017/18 – these included:

- The introduction of a new database and reporting system for all of our incidents
- The introduction of a new method of authorising witnesses for Controlled Drugs Destructions
- A new method of monitoring NHS prescribing activity to ensure that all Controlled Drugs prescriptions are screened

- Improvements to our approach to reviewing applications for unique prescriber codes for the private prescribing of Schedule 2 and 3 Controlled Drugs

13.3.6 Our team have invited feedback from the membership of our Local Intelligence Network on its effectiveness, shared this feedback with the membership, and now are implementing some of the recommendations from that feedback. As part of this work, members of our team joined meetings of other Local Intelligence Networks in 2017/18 to seek ideas for improvement. The networks visited were London, South Central, and Wessex.

13.3.7 Members of the South West team continue to be members of the Care Quality Commission's Controlled Drugs sub-group on prescribing, and furthermore, we are now also represented on the vigilance sub-group. Through participation in these sub-groups we have been able to share learning from incident themes reported to in the South West Newsletter nationally by feeding into the Care Quality Commission's national communications.

13.4 Objectives for 2018/19

13.4.1 Our plans for 2018/19 are outlined below:

13.4.2 We will review the report of the Gosport Independent Panel and share the learning from this as widely as we can, guided by the response to the report from the Department of Health and Social Care and work led by the NHS England central team.

13.4.3 We will continue our work to support safer prescribing of opioids and continue to use patient stories – we will complete the publication of the video of *Faye's story*, and an interview with a consultant anaesthetist to support GPs in reviewing prescribing. We will also do what we can to raise the profile of *Sean's story*; paying tribute to the work of NHS NEW Devon CCG.

13.4.4 A number of significant shifts in both the NHS and the regulatory landscape are anticipated that will need to be planned for and managed well. The organisational change within NHS England and NHS Improvement has necessitated that our Accountable Officer become accountable for Dorset in 2018, and that our team assume responsibility for operation work too. We will also need to feed into the Department of Health and Social Care's review of the 2013 regulations that underpin our work and the longer term plan for the NHS England Controlled Drugs Functions following the reorganisation. We will need to be vigilant through these times of change to ensure that we continue to discharge our duties effectively.

13.4.5 We anticipate that the drugs gabapentin and pregabalin will become controlled in 2018/19 and we will need to support this change, noting the increase in work this will bring (i.e. a likely increase in requests for the issuing of private prescriber codes, and prescribing monitoring).

13.4.6 We await updates to the Misuse of Drugs (Safe Custody) Regulations 1973, that will likely cause all organisations to review the way they store the

medicines containing Controlled Drugs in their possession. We will need to support the introduction of the new regulations.

13.4.7 We also await expected amendments to the regulations with respect to Cannabis derivatives such as cannabidiol (CBD), which have proved to be useful in treating long-term conditions in a small number of high profile cases. There has been significant discussion about this within our Local Intelligence Network and we will need to support this change.

13.4.8 We intend to further utilise the website www.cdreporting.co.uk to receive occurrence reports from Accountable Officers in the South West, and also to receive requests for authorised witnesses for Controlled Drugs destructions.

13.4.9 We will continue to review our process for sharing patient information by approving the distribution of alert notifications to provide assurance that we are compliant with the latest data protection legislation, whilst continuing to prevent harm and criminal activity.

13.4.10 We intend to provide training resources for pharmacy staff in the summer of 2018 by recording a presentation and training session that can be used free of charge by our commissioned services. This follows requests from staff trainers in the South West for us to provide training.

14 Conclusions

14.1.1 NHS England has fulfilled its legal obligations in the South West related to the Controlled Drugs (Supervision of Management and Use) Regulations 2013, in the context of the Misuse of Drugs Regulations 2001, and the Misuse of Drugs Act 1971.

14.1.2 We have had many successes in 2017/18, with the team's work being shared nationally, raising the profile of both the wider function and our team. The key successes in broad terms are our work to share learning and prevent harm, and also to hold individuals to account where they have been deliberately breaking the law and engaging in risky behaviour that might cause harm to themselves or others.

14.1.3 Our work has contributed to our relationships with stakeholders across the region to ensure that Controlled Drugs are used safely, and that opportunities for misuse and diversion are minimised. Patient and public safety are paramount in this work, and it provides opportunities to support best practice in appropriate clinical use of Controlled Drugs.

14.1.4 We have made significant improvements in a number of the operational aspects of our work, standardising and improving our processes, and using innovative new ways of working that have facilitated administrative and technical efficiencies.

15 Appendices

15.1 Appendix A - Designated Bodies

15.1.1 This list, drawn from the register maintained by the Care Quality Commission shows those organisations classed as designated bodies under the 2013 regulations that provide services in the South West. Each is required to appoint an Accountable Officer and submit Occurrence reports to the NHS England Accountable Officer.

Organisation Name	Location
Avon and Wiltshire Mental Health Partnership NHS Trust	Bath
Bosence Farm	Hayle
BPAS Taunton Central	Taunton
Bristol Plastic Surgery	Bristol
Charlton Farm	Bristol
Cornwall Partnership NHS Foundation Trust	Bodmin
Cygnet Hospital Kewstoke	Weston Super Mare
Cygnet Hospital Taunton	Taunton
Devon Partnership NHS Trust	Exeter
Duchy Hospital	Truro
Emersons Green NHS Treatment Centre	Bristol
Frenchay Brain Injury Rehabilitation Centre	Bristol
Hospiscare	Exeter
Little Bridge House	Barnstaple
Little Harbour	St Austell
Marie Stopes International Bristol Centre	Bristol
Meadow Lodge	Newton Abbot
Mount Edgcumbe Hospice	St Austell
Mount Stuart Hospital	Torquay
North Bristol NHS Trust	Bristol
North Devon Hospice	Barnstaple
North Somerset Community Partnership	Clevedon
Northern Devon Healthcare NHS Trust	Barnstaple
Nuffield Health Bristol Hospital	Bristol
Nuffield Health Exeter Hospital	Exeter
Nuffield Health Plymouth Hospital	Plymouth
Nuffield Health Taunton Hospital	Taunton
Peninsula NHS Treatment Centre	Plymouth
Rowcroft Hospice	Torquay
Royal Cornwall Hospitals NHS Trust	Truro

Organisation Name	Location
Royal Devon and Exeter NHS Foundation Trust	Exeter
Sherwood Lodge Independent Healthcare	Weston Super Mare
Sirona Health and Care	Bristol
Somerset Partnership NHS Foundation Trust	Bridgwater
South Western Ambulance Service NHS Foundation Trust	Exeter
Spire Bristol Hospital	Bristol
St Julia's Hospice	Hayle
St Luke's Hospice - Turnchapel	Plymouth
St Margaret's Somerset Hospice - Taunton	Taunton
St Margaret's Somerset Hospice -Yeovil	Yeovil
St Peter's Hospice	Bristol
Taunton and Somerset NHS Foundation Trust	Taunton
The Copse	Weston Super Mare
The Priory Hospital Bristol	Bristol
Thornbury Hospital	Bristol
Torbay and South Devon NHS Foundation Trust	Torquay
University Hospitals Bristol NHS Foundation Trust	Bristol
University Hospitals Plymouth NHS Trust	Plymouth
Wellesley Hospital	Wellington
Weston Area Health NHS Trust	Weston Super Mare
Weston Hospicecare	Weston Super Mare
Yeovil District Hospital NHS Foundation Trust	Yeovil

15.2 Appendix B – Newsletters

15.2.1 The newsletters published by the South West team in 2017/18 are available online:

- April 2017 – Special Edition: *Faye's Story*
- June 2017 – Regular Edition with various articles
- December 2017 – Special Edition: gabapentin and pregabalin
- March/April 2018 - Regular Edition with various article

15.3 Appendix C – Further reading

Care Quality Commission. Controlled Drugs (2018):
https://www.cqc.org.uk/guidance-providers/controlled-drugs/controlled-drugs

Care Quality Commission. The safer management of Controlled Drugs: Annual Report 2017 (2018):
https://www.cqc.org.uk/publications/major-report/safer-management-controlled-drugs

Department for Environment, Food & Rural Affairs. Environmental Protection Act 1990:
https://www.legislation.gov.uk/ukpga/1990/43/contents

Department for Environment, Food & Rural Affairs. The Environmental Permitting (England and Wales) Regulations 2010
https://www.legislation.gov.uk/uksi/2010/675/contents/made

Department of Health & Social Care. The Controlled Drugs (Supervision of Management and Use) Regulations 2013:
https://www.legislation.gov.uk/uksi/2013/373/contents/made

Home Office. Misuse of Drugs Act 1971:
https://www.legislation.gov.uk/ukpga/1971/38/contents

Home Office. Misuse of Drugs Regulations 2001:
http://www.legislation.gov.uk/uksi/2001/3998/contents/made

NHS England. Next steps on the Five Year Forward View (2017):
https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/

NHS England. NHS England (South West) - Safe Use of Controlled Drugs (2018):
https://www.england.nhs.uk/south/info-professional/safe-use-of-controlled-drugs/

NHS Improvement. A Just Culture Guide (2018):
https://improvement.nhs.uk/resources/just-culture-guide/

NHS Improvement. Faye's story: good practice when prescribing opioids for chronic pain (2017):
https://improvement.nhs.uk/resources/fayes-story-good-practice-when-prescribing-opioids-chronic-pain/

NHS England. Specialist Pharmacy Service - About the WHO Medication Without Harm Global Patient Safety Challenge
https://www.sps.nhs.uk/articles/about-the-who-medication-without-harm-global-patient-safety-challenge/

World Health Organisation. Medication Without Harm: WHO's Third Global Patient Safety Challenge (2017):
http://www.who.int/patientsafety/medication-safety/en/