REPORTING CONTROLLED DRUG INCIDENTS

- All organisations who **prescribe, dispense, supply, hold or administer controlled drugs (CDs)** must report CD related incidents, including lost prescriptions and lost controlled stationery to the NHS England CDAO. This should be done via online CD reporting tool: **www.cdreporting.co.uk** and/or via **Datix**.(see flow chart)
- Organisations must register with the online tool at www.cdreporting.co.uk or by emailing england.cmcd@nhs.net. This **web-based system will also be used for annual declarations for CDs and can also be used to request an authorised witness for destruction of stock CDs.**
- If **criminality** is suspected contact **Police Controlled Drug Liaison Officer** for advice or report to **101 and get a crime number.**
- **Serious incidents should also be reported to National Reporting and Learning System (NRLS) and Strategic Executive Information System (STEIS). Refer to CQCs guide https://www.cqc.org.uk/sites/default/files/20160229_briefguide-interpreting_reporting_incident_data.pdf**

REPORTING LOST/ STOLEN/ MISSING PRESCRIPTION FORMS

- Lost/stolen controlled drug prescriptions should be reported to the **NHS England Primary Care** team using the Missing Prescriptions Forms proforma found on the Medicines management Website.
- Completed form should be emailed to **england.cwwalerts@nhs.net** within 24 hours.
- Contact NHS England CD team on telephone: **011382 48208 or 011382 52355** or email england.cmcd@nhs.net for advice.
- Lost/stolen prescriptions of controlled drugs (CD) should also be reported to the **police** telephone **101** and get **a crime number**.
- Record the loss on patient's records.
- If a replacement prescription is needed, the practice should NOT delete the previous issue but should reprint it and record reason. On EMIS Web system, a pop up text box will appear which allows the reason for the reprint to be recorded. This record will remain in the drug history.
- **'Duplicate'** should be printed automatically in capital above the signature box. If unclear, write it on the script in indelible ink where it can be clearly seen.
- If the original prescription is later found, ask for it to be returned to the practice; report to the police and area team; record in patients' notes and destroy the prescription as per practice protocol.
- Practice to report the incident on DATIX. CCG to report incident to NHSE via Quarterly Occurrence Report.
- For incidents within practice, record and review as a Significant Event.
- Review practice protocol for security and audit trail for blank and completed prescriptions. Aide memoire, guidance and templates available from NHS Protect and CQC.

MIDLANDS AND LANCASHIRE COMMISSIONING SUPPORT UNIT

NHS England

CD Concerns - Reporting, analysis and sharing learning for CCGs in Cheshire and Merseyside

CCG CD LEAD
(Cheshire and Merseyside)

Share learning through organisation (CCG, GP practices, and commissioned services)

CD concerns identified in **GP practices#**
(e.g. missing or forged FP10s, self-prescribing of CDs Sch 2-5, prescribing anomalies through monitoring)

CD concerns identified in **CCG Commissioned services**

RAG rated for risk to patients and to wider NHS
Report via online CD reporting tool **www.cdreporting.co.uk**
and/or via **Datix**
(see Appendix for NHSE National CD Risk Assessment Tool)

GREEN (low risk)

- Do not report to NHSE as CD incident
- May need to report elsewhere according to CCG/national policy (e.g. NRLS, Datix)
- Include in Quarterly CD occurrence report Part B (i.e. no details required)

AMBER (moderate risk)

- Do not report to NHSE as CD incident
- May need to report elsewhere according to CCG/national policy (e.g. NRLS, Datix)
- Include in Quarterly CD occurrence report Parts B + C (i.e. details required)

RED (high/extreme risk)

- DO report to NHSE as CD incident*
- May need to report elsewhere according to CCG/national policy (e.g. NRLS, Datix)
- Include in Quarterly CD occurrence report Parts B + C (i.e. details required)

NHSE

- ANALYSE trends and lessons
- SHARE with CCG CD leads and rest of CDLINs

GPs and practice staff should be encouraged to identify and report CD concerns to NHSE CDAO.
CDAO NSHE: **Devina Halsall**
Email: england.cmcd@nhs.net
If criminality suspected, contact police at Paul.Storey@merseyside.pnn.police.uk or paul.corteen@cheshire.pnn.police.uk for advice, or report to 101 and get crime number.

Appendix NHSE National Controlled Drug Risk Assessment Tool (v1.0)

Risk rating	Examples: Type of incident	Category
Low	Manufacture error	Unaccounted for losses
Low	Whistle blowing	Professional individuals of concern
Low	CD cupboard unlocked	Governance
Low	CD licence issue	Governance
Low	Discharge procedure error not affecting patient	Governance
Low	GPhC issue	Governance
Low	Out of hours process not affecting patient	Governance
Low	Policy deviation not affecting patient	Governance
Low	Recording errors	Record keeping
Low	Running balance issue <5% discrepancy;	Unaccounted for losses
Low	Running balance issue >5% and less than 10%,	Unaccounted for losses
Low	SOP failure	Governance
Low	Spillages / breakages / damaged CDs	Accounted for losses
Low	Stock error	Unaccounted for losses
Low	Storage error	Governance
Low	Dispensing error - before reaching patient	Patient related
Low	Prescribing error - before reaching patient	Patient related
Low	Administration error - before reaching patient	Patient related
Low	Out of hours process failure - before reaching patient	Patient related
Low	Transcription error - before reaching patient	Patient related
Moderate	Destruction error	Unaccounted for losses
Moderate		Unaccounted for losses

	Delivery error	
Moderate	Lost / stolen / missing CD keys	Unaccounted for losses
Moderate	Lost / stolen / missing CD prescriptions	Unaccounted for losses
Moderate	Lost / stolen / missing CD Requisitions	Unaccounted for losses
Moderate	Lost / Stolen / Missing CDs	Unaccounted for losses
Moderate	Removal of CDs by a third party, e.g. Police	Unaccounted for losses
Moderate	Running balance; >10% discrepancy	Unaccounted for losses
Moderate	Allegation professional selling controlled drugs	Professional individuals of concern
Moderate	Allegation professional receiving controlled drugs	Professional individuals of concern
Moderate	Patient / public known to be selling CDs	Patient / Public
Moderate	Fraudulent attempt to obtain CDs by patient	Patient / Public
Moderate	Fraudulent attempt to obtain CDs by professional	Professional individuals of concern
Moderate	Fraudulent Claims	Professional individuals of concern
Moderate	Theft or potential theft of CDs, prescriptions, etc. by professional	Professional individuals of concern
Moderate	Theft or potential theft of CDs, prescriptions, etc. by patient	Patient / Public
Moderate	Prescribing error patient received but not taken	Patient related
Moderate	Prescribing systems of concern Prescribing outliers and anomalies	Patient-related
Moderate	Dispensing error - patient received but not taken	Patient related
Moderate	Administration error - patient received but not taken	Patient related
Moderate	Out of hours process failure - patient received but not taken	Patient related
Moderate	Administration error - patient received but not taken	Patient related
Moderate	Transcription error - patient received but not taken	Patient related
High	Illicit use by patient	Patient related
High	Policy deviation affecting patient	Patient related

High	Police investigation	Patient related
High	Wrong prescription given out	Patient related
High	Discharge procedure error where patient takes drug	Patient related
High	Administration error – patient taken	Patient related
High	Dispensing error – patient taken	Patient related
High	Prescribing error – patient taken	Patient related
High	Transcription error – patient taken	Patient related
High	Out of hours process failure – patient taken	Patient related
High	Deliberate Overdose – no harm	Patient related
High	Abuse by the patient	Patient related
High	Never event	Patient related
High	Poor Governing body/Board oversight of CD risks Contracts/service level agreements do not include relevant statutory duties for safe management and use of CDs Commissioner has poor/no systems in place for providers to report CD risks Commissioner has weak/no systems in place to share learning from CD risks	Governance
Extreme	Patient death	Death