Board of Directors

SUMMARY REPORT	Meeting Date:	26 July 2023
	Agenda Item:	18

Report Title:	**Controlled Drugs Accountable Officer (CDAO) Report**	
Author(s):	**Abiola A-M Allinson, Chief Pharmacist and CD Accountable Officer**	
Accountable Director:	**Dr Mike Hunter, Executive Medical Director**	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	N/A
	Date:	N/A
Key points/ recommendations from those meetings	N/A	

Summary of key points in report

The Controlled Drugs (CD) incidents trajectory indicates that there has been continued progress in reducing incidents noting the 19% reduction in reported CD incidents from 232 in 2021/22 to 189 in 2022/23. This is indicative of an improvement in processes and culture though we need to continue our due diligence and monitoring to ensure this reduction is maintained and is sustained. This report provides assurance that we are aware of the main issues namely unaccounted for CD discrepancies; second signatory checks and have a clear line of sight on the remedial actions required to improve the quality and safety of care for our service users.

Our key areas of concern remains the CD stock discrepancies which are unaccounted for and missing second signatory checks to administrations.

81 (108 in 21/22) out of a total on 189 incidents were attributed to discrepancies. Of the 81 discrepancies reported; 31 (38%) were unresolved in 2022/23 compared to 46 (43%) unresolved in 2021/22. This indicates a steady maintenance in the resolution of CD discrepancies. The work continues with the teams to improve the percentage resolution of discrepancies and impact positively on the administration and recording processes. 81 incidents reported relating to missing second signatures to administration- On going work with ward teams to reduce these occurrences. From a context perspectice- In the year from 01/04/2022 to 31/03/2023 there were a total of 53,401 ward-based administrations of schedule 2, 3 and 4 controlled drugs. This equates to an average of 146 per day. This is inclusive of PRN (when required) and regular administrations.

In 2022/23, there were no critical CD incidents reported at SHSC. 7 moderate incidents reported;(2 non SHSC). No adverse impact on service users with reported SHSC incidents.

As part of the overarching work to improve medicines safety and processes on the wards, the Medicines Safety Group and Medicines Optimisation Committee lead a review of medicines safety on the wards, with nursing leads on the training and competency framework for staff who work with medication. Yearly competencies to improve medicines safety have now been established as part of ongoing training – this

includes a compulsory yearly calculation assessment and revamped medicines optimisation training. This quality improvement informed project which will be supported by data to show improvement. This should impact positively on management of controlled drugs in those areas.

In conclusion, this report demonstrates assurance that there are effective processes in place and remedial actions are taken to address any concerns raised in relation to the handling/management of Controlled Drugs in SHSC.

Recommendation for the Board/Committee to consider:

Consider for Action		**Approval**		**Assurance**	**X**	**Information**	

The Board of Directors is asked to accept the assurance provided by this report that the key risks and concerns relating to the management of controlled drugs evidenced in the report are being suitably addressed and mitigated.

Please identify which strategic priorities will be impacted by this report:				
Recover services and improve efficiency	*Yes*		*No*	***X***
Continuous quality improvement	*Yes*	***X***	*No*	
Transformation – Changing things that will make a difference	*Yes*		*No*	***x***
Partnerships – working together to make a bigger impact	*Yes*	***x***	*No*	

Is this report relevant to compliance with any key standards ?	**State specific standard**				
Care Quality Commission Fundamental Standards	*Yes*	***x***	*No*		
Data Security and Protection Toolkit	*Yes*		*No*	***x***	
Any other specific standard?					

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety, Engagement and Experience	*Yes*	***x***	*No*		***Safer management of CDs improves patients safety and therefore experience***
Financial (revenue &capital)	*Yes*		*No*	***x***	***There are no directly related revenue or capital issues***
Organisational Development /Workforce	*Yes*	***x***	*No*		***An appropriately trained workforce is essential for the safe management of all drugs***
Equality, Diversity & Inclusion	*Yes*		*No*	***x***	*Please complete section 4.3 in the content of your report*
Legal	*Yes*	***x***	*No*		***The Misuse of Drugs Act 1971; The Misuse of Drugs Regulations 2001; The Controlled Drugs Regulations 2013***
Environmental sustainability	*Yes*		*No*	***X***	

Controlled Drugs Accountable Officer (CDAO) Report

Section 1: Analysis and supporting detail

Background

1.1 To ensure that "safe management of controlled drugs" is maintained as an organisational priority.

To provide assurance on the systems and processes within SHSC that lead to the safe management of controlled drugs.

To update the BoD on the concerns raised in last year's (2022) report.

To highlight the recommendations from the Care Quality Commission (CQC) annual report on controlled drugs (published July 2023).

1.2 In January 2000, Doctor Harold Shipman was convicted of the murder of 15 of his patients using the drugs diamorphine (heroin) and morphine. Reports also suggest that he may have used these drugs to kill many more of his patients, possibly around 250.

Between 2002 and 2005 six reports were published under the chairmanship of Dame Janet Smith. These led to the legislative changes which were introduced in the 2007 Health Act to strengthen the governance arrangements surrounding the use of controlled drugs by "relevant people".

As part of the statutory requirements contained within the 2007 Health Act organisations such as NHS trusts were required to appoint a Controlled Drugs Accountable Officer (CDAO), who was responsible for the assurance of safe use of controlled drugs throughout the organisation. Other requirements included the sharing of information (or intelligence) across organisational boundaries and a duty to collaborate. Where there are strong grounds for concern a CDAO must share intelligence with other bodies such as the police, the NHS counter fraud service, the CQC or registering bodies such as the General Medical Council, the Nursing and Midwifery Council, and the General Pharmaceutical Council.

In 2013 new legislation was introduced (The Controlled Drugs [Supervision of Management and Use] Regulations 2013) which brought the previous medicines and CD legislation in line with the NHS organisational changes. This legislation was put in place to ensure that the overriding aim of the CDAO continued to be to protect the public from harm in relation to controlled drug use by relevant people.

The NHS England– (NE and Yorkshire) team CDAO is responsible for coordinating the sharing of information through Local Intelligence Networks (LINs). To support the CDAO in this task the Sheffield place ICB team has a designated lead who co-ordinates the functions of the Sheffield LIN.

Information concerning all incidents relating to controlled drugs is reported by the SHSC CDAO to the North-East and Yorkshire CD LIN on a quarterly basis.

1.3 **Controlled Drugs**

In August 2012, the legislation covering medicines for human use was revised and consolidated into a new act – The HUMAN MEDICINES REGULATIONS 2012. This legislation updated the 1968 Medicines Act and incorporated various changes introduced by EU legislation together with all the updates and variations to the original act.

There is a degree of complexity surrounding the laws relating to medicines and CDs but in general terms the main legislative points to note are:

1.4 **The Misuse of Drugs Act 1971 (MDA 1971)**

This act primarily covers the illegal use of drugs and provides a schedule system for classification of these drugs. This system of classification provides the courts with guidance on the maximum sentences to be imposed if this law is broken (Schedules A, B & C).

1.5 **The Misuse of Drugs Regulations 2001 (MDR 2001) (and subsequent amendments)**

Covers the medical use of those drugs listed within the MDA 1971. Within the context of MDR 2001 the classification system for the medical use of these drugs defines the drugs by a different system of schedules (1, 2, 3, 4 & 5). Within this context these drugs are classified according to their likelihood of harm vs therapeutic benefit. With Schedule 1 drugs being the most tightly controlled in terms of prescribing, dispensing, storage & transportation, and Schedule 5 having the least control. Schedule 4 also includes anabolic steroids.

The British National Formulary (BNF) gives details of the legal status of most of the medicines used in the UK. The Chief Pharmacist/CDAO would be expected to intervene in all cases where there may be a concern about the use of these drugs by relevant people. Further details can be found on the home office website http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-licences/controlled-drugs-list .

1.6 **Management of Controlled Drugs (CD's)**

Following the activities of Dr Harold Shipman in the 1990's, it became clear that the systems and process of control that were in place at the time to govern the use of CDs were inadequate. Following the fourth report of the Shipman enquiry in 2004, the chairman Dame Janet Smith concluded that the governance arrangements for these drugs needed to be strengthened.

Many of her recommendations from the enquiry were incorporated into part three of the 2007 Health Act and statutory instrument No. 3148 The Controlled Drugs (Supervision of Management and Use) Regulations.

http://www.legislation.gov.uk/ukpga/2006/28/pdfs/ukpga_20060028_en.pdf

http://www.legislation.gov.uk/uksi/2006/3148/pdfs/uksi_20063148_en.pdf

One of the key changes introduced by the 2007 Health Act was the statutory requirement for NHS trusts (and other relevant bodies) to appoint an Accountable Officer for Controlled Drugs (CDAO).

1.7 **Statutory role of the Controlled Drugs Accountable Officer (CDAO)**

The requirement for designated bodies to appoint a CDAO was made in the 2007 Health Act and has been reiterated in subsequent legislation. The CDAO must ensure that their designated body has adequate arrangements for the safe and legal management and use

of controlled drugs throughout the organisation.

The overriding concern of the CDAO is to protect the patients and public from harm due to controlled drugs by relevant people. There are a number of specific duties of the CDAO. Full details of the duties of the CDAO are laid down in Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (http://www.legislation.gov.uk/uksi/2013/373/part/2/made).

The CQC are required to hold a record of all CD accountable officers (and ensure all relevant organisations are registered with them. See http://www.cqc.org.uk/content/controlled-drugs-accountable-officers).

Duties of the CDAO include ensuring that:

- The organisation is following "adequate and up to date" Standard Operating Procedures (SOPs).
- Appropriate arrangements for monitoring and auditing the management and use of controlled drugs.
- Systems exist to alert the accountable officer of any complaints or concerns involving the management or use of controlled drugs.
- The incident reporting system captures untoward incidents involving the management or use of controlled drugs.
- Appropriate arrangements in place for analysing and responding to untoward incidents involving the management or use of controlled drugs.
- Relevant individuals receive appropriate training in relation to controlled drugs.
- Arrangements are appropriate for monitoring and auditing the management and use of controlled drugs by relevant individuals and assessing their performance.
- The recording of any concerns raised in relation to the management or use of controlled drugs by a relevant individual.
- The assessment and investigating of any concerns raised regarding the management or use of controlled drugs by a relevant individual. The CDAO must determine whether these concerns should be shared with a responsible body.
- Appropriate action is taken to protect patients or members of the public in cases where concerns in relation to the management or use of controlled drugs by a relevant person appear to be well-founded.
- Appropriate arrangements for ensuring the proper sharing of information.

The designated body (Board of Directors) has a responsibility to ensure that they notify the CQC of the name of the CDAO and that they are a "fit, proper and suitably experienced person" who does not 'routinely supply, administer, or dispose of controlled drugs as part of their duties'.

The BoD can be assured that the CQC hold details as of July 2023 of the CDAO for SHSC as follows:

TAH	Sheffield Health and Social Care NHS Foundation Trust	Abiola	Allinson	Abiola.allinson@shsc.nhs.uk	0114 2718630	Sheffield	S10 3TH

Designated bodies are required to ensure that the CDAO is provided with the necessary funds and resources to carry out their responsibilities.

1.8 **CD Recommendations from the Care Quality Commission (CQC)**

The CQC scrutinise and report on how well NHS trusts and other agencies work together to ensure the sharing of intelligence/information on the safe management and use of controlled drugs by relevant people.

In July 2023, the CQC published their latest annual report.

The safer management of controlled drugs: Annual update 2022 - Care Quality Commission (cqc.org.uk)

The BoD are advised the following recommendations relate to SHSC.

Recommendations

1) **Make sure your governance processes are up-to-date and fit for purpose.** In the last 2 years we have made recommendations around the importance of governance in the context of controlled drugs. We continue to monitor the progress, but still find areas that need to improve across health and social care. This is particularly the case where there are complex commissioning arrangements for services.

2) **Make sure prescribing at transfer of care is completed safely**. Clinicians must have the relevant medical and medication history before prescribing controlled drugs to patients. Private prescribing services should request these details from a person's NHS GP before issuing prescriptions, and NHS GP services should supply these details in an appropriate way when asked. See prescribing guidance from the General Medical Council.

3) **Know the identity of your local controlled drugs accountable officer (CDAO) and police-controlled drug liaison officer CLDO.** Any organisation with a responsibility around controlled drugs must have these details and know how to report controlled drugs incidents. CDAOs and CDLOs are important partners and can provide help, support, and advice on a wide range of controlled drugs issues, as well as for reporting incidents.

4) **Work collaboratively to improve the prescribing, managing and monitoring of controlled drugs.** We have already seen examples of how better collaboration and partnership working as part of a local system can result in improved safety and better outcomes for people.

1.9 **SHSC Assurance Statements**

1) Any serious concerns relating to controlled drugs are investigated and actions taken to prevent recurrence.
2) All reported losses/discrepancies are reviewed, investigated, and followed robustly with teams and managers.
3) The CDAO will share any serious concerns relating to controlled drugs and relevant

people with NHS England, Yorkshire, and Humber LIN and CDAO

4) The CDAO attends the Regional CD LIN meetings which are currently take place on-line.

Update on issues reported to the BoD in the previous annual CDAO reports (2016-2023)

1.10 Update 2016 The timeliness of reporting of incidents has improved – but the overall increase in the number of incidents has led to delays in fully investigating incidents. *The interim Chief Pharmacist.*

(In agreement with the CDAO) has agreed to update the SOP relating to the investigation of small discrepancies of schedule 3,4 & 5 controlled drugs in an attempt to create the capacity for timely investigation of incidents.

Update 2018 The improvements in the timeliness of reporting and investigation of incident not considered serious, have not been maintained. Systems for tracking low level discrepancies have not been introduced. It is expected the support systems will be strengthened by the appointment of the new Trust chief pharmacist and medication safety officer in July 2018.

Update 2019 – Close scrutiny of the reported low-level incidents has led to a review of Standard operating procedures of management of Controlled drugs on the wards. These updates and implementation plan should improve the management of CDs in those areas.

Update 2020 – Updated SOPs implemented in September 2019. This has led to a decrease in unresolved medication losses and closer scrutiny of the CD processes.

Update 2021- The number of incidents reported have increased and this shows transparency and needs to be encouraged. There has conversely been an increase percentage wise in the resolution of CD discrepancies.

Update 2022 - The trust MSO continues to work with the risk department and the teams to improve the quality of reporting and learning from CD incidents.

There has been a noticeable decrease in number of CD incidents reported overall. The unresolved discrepancies though account for 43% of reported discrepancies and 18% of all reported CD incidents. To note there has been a significant downtrend in the proportion of unaccounted for CD discrepancies compared to previous years this is a real positive improvement in our management.

Update 2023 – There is a relative plateau in the number of unresolved CD incidents 38% (43% in 2012/22). This represents 16% of all reported CD incidents SHSC. The processes put in place with the wards supporting investigations, education, and training for nurses and second signatories has had an effect. Following the critical incident in 2022, the clinic room design has been updated to include a vestibule to reduce the risk of inadvertent service user medication appropriation.

	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-23
Total CD incidents reported to CDAO	253	279	305	419	232	189

1.11 **Incidents reported to the CDAO (October 2012 to September 2017)**

(Note" year" relates to period ending September i.e., reporting period (Oct to September)

	2017	2016	2015	2014	2013	2012
Total CD incidents reported to CDAO	266	242	220	143	96	115

Incidents reported to CDAO October 2017 to March 2022

1.12 **The annual trend in reported incidents involving all controlled drugs is shown below (Oct 2012 to Mar 2022)**

Graph 1

Graph 1 shows the trend in the reported incidents – noting the change in process in September 2019 for second signatories required for administration of benzodiazepines, z-drugs (hypnotics) and amalgamation to only have one record book. The increase in incidents in 2020-21 could be attributable to change in process. Noting that with the embedding of the process there has been a gradual reduction in incidents. This continue to be monitored as to improvements.

1.13 Review and investigation of incidents

Incidents were reported to the CDAO through the trust electronic incident reporting and management system – “Ulysses”.

In cases of known or suspected serious or major concern, the CDAO will immediately inform the Chief Executive and Medical Director and will put systems in place to prevent further harm. If the CDAO believes that there are strong grounds for major concern they will share information with other relevant bodies e.g., Local Intelligence Network (LIN), professional bodies, Police, Care Quality Commission (CQC), etc.

All reported CD incidents are subject to a brief initial assessment by the Medicines Safety Officer (MSO) and team/ward pharmacist as a triaging process for the CDAO. A prioritised investigation is triggered if the CDAO or others suspect that the incident may be a major concern.

In cases where the management investigation of a reported incident is considered insufficient, the MSO will oversee a more granular investigation and interview the staff involved, their manager and any other relevant people to triangulate and verify the information received. Details of individuals’ behaviour in relation to relevant SOP’s, their medicines related training and their involvement with other CD or medicines related incidents are all considered and recorded as part of the investigation process.

There are cases where there is insufficient information, or it is impractical to gather more details. Rather than leaving these as open, or on-going, but where there is little prospect of gathering more detailed information e.g., staff leaving, then these incidents will be classed as “technically closed” but would be re-opened if further

information comes to light through other incidents. Details of all incidents and subsequent investigation are held by the CDAO in electronic format. The trust incident recording system also contains details of the incident, but it is not currently possible for this system to capture any associated information (e.g., copies of paper records).

April 2022 to March 2023

1.14 **Issues of serious or major concern (April 2022 to March 2023)**

There was no issue reported of major concern.

1.15 **Other issues (April 2022 to March 2023)**

Moderate incidents (7 reported; 2 non-SHSC)

1 START patient prescribed methadone 80mls rather than 30mls. Patient received 6 days of the higher dose of 80mls by the chemist.

Actions taken:

a) Review process of medication changes and how it is communicated. SOPs reviewed.

b) Scriptor identified who 'wrote/ typed' the prescription.

c) Prescriber who signed prescription -identify and request for their line manager to do a reflection piece and supervision.

Mitigating circumstance: e-prescribing order form in process of being switched to Share point -temporarily using email instead.

Follow up:

Service-user was fine with no ill effect, phone and face to face consultation following incident.

Scriptor has left the Trust, however all other scriptors have been given support and guidance to avoid this recurring. SOP reviewed and communicated.

The prescription was not flagged as a change - the original request was "no changes". Therefore, it would not have been flagged. The doctor would have routinely signed that prescription, without additional checks /queries when there is a change to the prescription—either dose change or pick-ups.

2 A START service user was given another service users methadone medication from a chemist. The service user was given 2 days supply to cover the weekend – they were issued 2 x 50mls bottles of methadone rather than 2 x 60mls of methadone. (*This is a non-SHSC incident)*

Service user was fine about the reduced amount and suffered no ill effect from the reduced amount. They were supported by the NMP.

Actions:

Service user assured not their fault (concerned another user may have missed their methadone due to them)

Pharmacist apologised to service user. Chemist to review handing out- system.

3 **Incident**: Patient at Woodland View required lorazepam oral. The last dose was given the previous day.

Underlying cause: Delay in ordering by team, delay in receiving lorazepam by Boots.

4 **Incident**: Service user administered Lorazepam IM when not prescribed on EPMA

Actions:

I. Doctor contacted; physical health Incident discussed in handover/safety huddle.

II. Staff to ensure that medication plans/prescription changes are communicated properly.

III. Nursing staff to ensure two staff members are present when administering controlled drugs, this will be circulated to the wider team.

5 **Incident**: START patient was dispensed methadone 70ml rather than 25ml and issued 3 doses for the next few days. Patient administered the wrong dose of methadone. *This incident was a non-SHSC dispensing incident.*

Immediate Action: Patient was contacted and made aware of error. Was euphoric and over sedated. Concern of overdose and advised to contact 999 if overdose symptoms shown. Monitored by Day centre staff, methadone retrieved and returned to pharmacy and correct doses issued.

Pharmacy actions: Pharmacy was contacted regards the incident. Locum pharmacist involved. Reported via pharmacy internal system. Pharmacy was making changes to the dispensing of methadone process and moving to a larger site with more room for consultations with patients.

6 **Incident**: Missing diazepam 5mg x 14 tablets. Delivery of medication for CRHTT arrived on lunch time run. Signed by nurse as received medication. Medication was not logged in by any staff member. Two days later staff went to retrieve the medication ordered and noted diazepam not in bag.

Actions: 48-hour report completed. Medication was not accounted for following the investigation. Police were contacted for advice. Ordering and recording processes tightened in CRHTT.

7 **Incident:** Woodland view during the monthly audit noted that they had several CD discrepancies, for several patients. None could be accounted having reviewed the EMAR system and medical notes.

Investigation: After investigation, and emails from the GP -concerns were raised that Woodland view and Birch Avenue are not following the Trust CD policy

Actions:

- Staff made aware of the policy.
- CD checks put into place per shift.
- Controlled drug books contain all CDs in it.
- Staff made aware of the training videos on JARVIS and asked to watch these.
- Annual Competency Framework for staff and the 3 yearly training to be reviewed by Head of Nursing and MSO -working alongside the staff to see the staff training needs and putting in place systems to address this.

1.16 **CD Discrepancies**

Finding the root cause for some of the CD discrepancies often remains difficult; it is usually related to poor documentation; 76 (108 in 21/22) out of a total of 232 (419 in 20/21) incidents reported were attributed to discrepancies. Of the 81 discrepancies reported; 31 (41%) were unresolved in 2022/23 compared to 46 (43%) unresolved in 2021/22 (*See Table 2; Chart 2*)

	Q1 22/23; 21/22); (20/21),	Q2 22/23; (21/22); (20/21),	Q3 22/23; (21/22); (20/21),	Q4 22/23; (21/22); (20/21),	Total 22/23; (21/22); (20/21),
Accounted for	8; (15); (16)	11; (12); (20)	21; (18); (14)	10; (17); (13)	50; (62); (63)
Unaccounted for	9; (14); (25)	5; (10); (8)	8; (12); (20)	9; (10); (17)	31; (46) (70)
Total	17; (29); (41)	16; (22); (28)	29; (30); (34)	19; (27); (30)	81; (108) (133)

Table 2

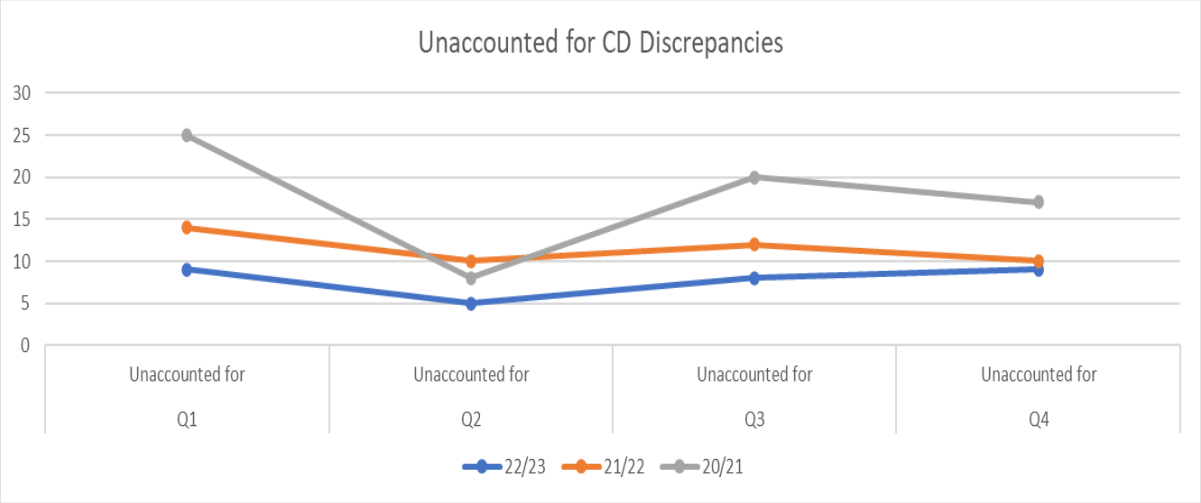
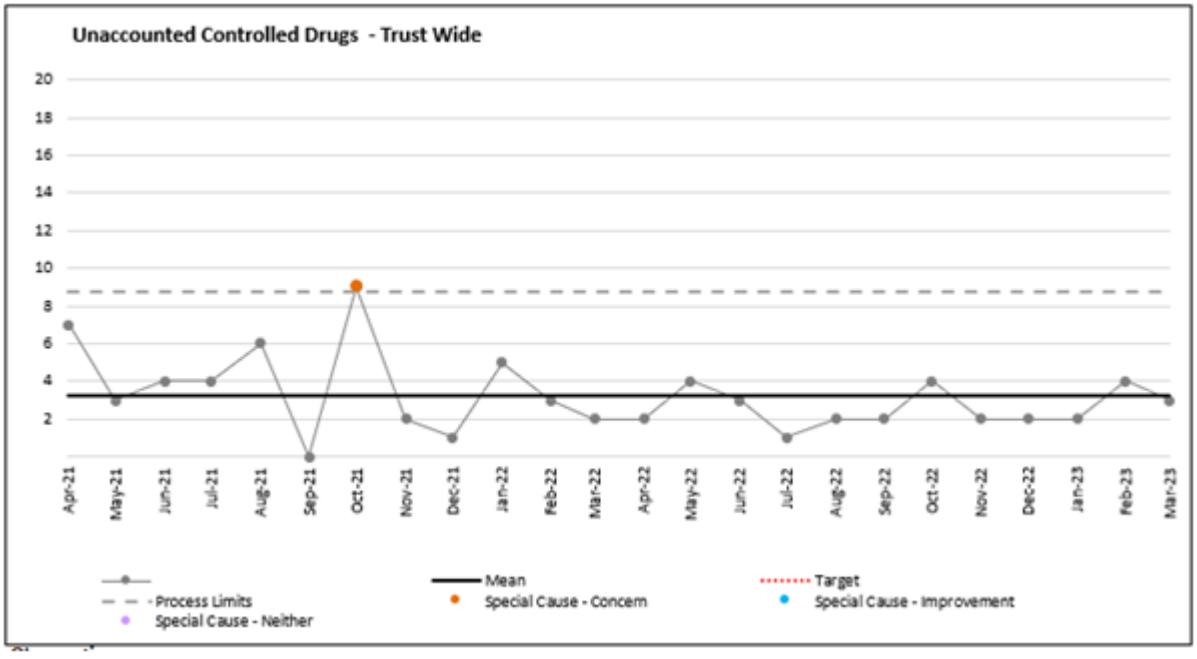


Chart 2

Chart 2 shows the trajectory of unaccounted for CD discrepancies from 20/21 to 22/23; this appears to show a reduction in the number of unaccounted for CD discrepancies. There is still ongoing work with the teams to address the work processes/administration recording that would impact positively on the reports.



Graph 2

Graph 2 indicates the accounting of unaccounted for CD discrepancies. The numbers have reduced slowly and culture change is slowly happening. The change though not significant stastitically, it is positive and gives us assurance that we are heading in the right direction. A reminder on a regular basis that each unaccountable medication should be thoroughly investigated and ward areas need regular CD training to keep the culture change progressing to the ward areas. See Appendix 1 for details of unaccounted for losses.

1.16a **Missing Second signatures**

Total of 81 incidents reported with second signatures missing. Some of the incidents reported state multiple numbers of missing signatures. A large proprotion of thesewere identified following the 3 monthly CD audits undetaken by pharmacy. This indicates that wards are not reporting the incidents and continuing to administer without second signatures.

From a context perspectice- In the year from 01/04/2022 to 31/03/2023 there were a **total of 53,401 ward-based administrations** of schedule 2, 3 and 4 controlled drugs. This equates to an average of **146 per day**. This is inclusive of PRN (when required) and regular administrations.

Some staff have been highlighted as regularly not obtaining second signatures. These individuals are having this discussed in supervision with the management team on the ward. Some of the feedback from the supervision has been – staff raising concerns of staff shortages.

Ongoing Actions

Ongoing monthly training by pharmacists and MMTs on CD's to all ward staff -rolled out in August 2022.

Encouraging more staff to get second signature competent. Pharmacists are supporting the wards to get an increased number of staff trained.

1.17 **Ongoing Actions Trust wide for assurance:**

1. Ward pharmacists & Ward managers have updated the staff CD training check list for countersignatories. Ward managers will continue to ensure that all RMNs have had the CD training.The online training and documentation of competency will be completed and shared with the MSO & ward pharmacist. Face to face training on the wards has been reinstated to support better CD management.

2. A daily task checklist is available in the clinic room as a visual reminder of tasks including when CD stock checks have taken place.

3. Pharmacy technicians continue to visit wards for 2 weekly CD audits and ward pharmacists doing 3 monthly CD audits and inform the MSO as part of monitoring to triangulate progress and provide assurance that the action plan is working.

   There has been a noted a 38% reduction in the total number of CD incidents reported; 189 in (2022/23) compared with 232 (2021/22). This is good news as to practice and accounting for losses which would be indicative of better scrutiny and checking processes. This improvement is supported by the checks at shift changes (to narrow down the time frame of discrepancy occurrences -this supports quicker resolutions) and training at ward level on CD management by pharmacy staff.

1.18 <u>The NHS England and NHS Improvement – (NE and Yorkshire) CD LIN</u>
This body continues to function and is well attended by CDAO's. Meetings are held 6 monthly and reports requested quarterly.

1.19 **Conclusion**

The overall pattern of incidents involving CD's and relevant people within the Trust indicate that:

1) Safeguarding and information sharing relating to serious concerns across the NHS England and NHS Improvement – (NE and Yorkshire) CD LIN is continuing to work well.

2) CD incidents reports have decreased in 22/23. This could be indicative of better processes related to education and working practices. We continue to support an open and honest reporting culture to learn from incidents and improve. We will also continue to monitor to ensure this is sustained.

3) Assurance that the CDAO is aware of and addressed any concerns about controlled drugs.

4) A higher proportion of CD discrepancy incidents reported are now resolved to a satisfactory conclusion.

Section 2: Risks

2.1 There is a risk that the Trust is unable to improve controlled drugs processes resulting in a failure to comply with CQC requirements and achieve necessary improvements.

Section 3: Assurance

Benchmarking

3.1 Benchmarking regarding the number of controlled drugs incidents can be challenging to interpret and a decrease in reports of incidents may be considered a positive development. This will be monitored ongoing. Graph 2 shows the reduction in unaccounted for discrepancies over a 2-year period which is encouraging and points to a change in culture.

3.2 Data is regularly provided to QAC regarding controlled drugs incidents through the bi-annual Medicine Safety Report.

3.3 Evidence of how well the education, training and improvements instigated into practice will be borne out by the CD incidents reported and themes and discussed/addressed through the Medicines Safety Group

Triangulation

3.4 Data and actions reflected in this report triangulates information and experience relating to Patient Safety, Medicines Optimisation, Medicines Safety and Learning from Incidents.

Engagement

3.5 Working consistently with the Medicines Safety Officer, ward pharmacists and ward managers to address issues and these are reported to the Medicines Safety Group and the Medicines Optimisation Committee which are multidisciplinary.

Section 4: Implications

Strategic Priorities and Board Assurance Framework

4.1 Recommendations within this report clearly support the mitigation of the following risks linked to the Board Assurance Framework:

BAF Risk 0020: Risk of failure to move our culture sufficiently to address any closed subcultures, behavioural issues and not reflecting and respecting diversity and inclusion, resulting in poor engagement, ineffective leadership and poor staff experience in turn impacting on quality of service user experience.

BAF Risk 0024: Risk of failing to meet fundamental standards of care with the regulatory body resulting in avoidable harm and negative impact on service user outcomes and experience staff wellbeing, reputation, future sustainability of particular services *which could result in* regulatory action.

Equalities, diversity and inclusion

4.2 SHSC's strategic aims and ambition regarding equality, diversity and inclusion are considered when developing and implementing improvement actions.

It is not anticipated that this work has any equality-related impacts or associated risks at the time of this report.

Culture and People

4.3 There has been a culture of acceptance of medication errors.

4.4 There is ongoing training on CD processes on wards because of the improvement work undertaken. This is reflected in this report.

4.5 Work identified by the Medicines Management Task & Finish Group and further driven by the Medicines Safety Group will support the cultural transformation agenda by focusing on personal and professional responsibility in relation to medicines optimisation. It will lead to an improved and more competent and able workforce.

Integration and system thinking

4.6 The output of this work will ensure that patient safety is optimised through accurate administration and recording of controlled drug medications prescribed or initiated in both primary and secondary care.

Financial

4.6 It is not anticipated that this work has any financial impacts or associated risks at the time of this report.

Compliance - Legal/Regulatory

4.7 There could be legal or regulatory risks if these controlled drugs issues are not addressed..

Environmental sustainability

N/A

Conclusion

In conclusion, this report demonstrates assurance that there are effective processes in place and remedial actions are taken to address any concerns raised in relation to the handling/management of Controlled Drugs in SHSC.

Chief Pharmacist and CD Accountable Officer