Board of Directors - Public

SUMMARY REPORT	Meeting Date:	27 July 2022
	Agenda Item:	13

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, Medical Director**	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	N/A
	Date:	N/A
Key Points recommendations to or previously agreed at:	N/A	

Summary of key points in report

The Controlled Drugs (CD) incidents trajectory currently indicates that there has been progress in reducing incidents noting the 45% reduction in reported CD incidents from 419 in 2020/21 to 232 in 2021/22. This could be indicative of an improvement in processes and culture though we need to continue our due diligence and monitoring to ensure this reduction is not spurious 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 remain the CD stock discrepancies, which are unaccounted for and missing second signatory checks to administrations.

108 (133 in 20/21) out of a total of 232 (419 in 20/21) incidents reported were attributed to discrepancies. Of the 108 discrepancies reported; 46 (43%) were unresolved in 2021/22 compared to 70 (53%) unresolved in 2020/21 (compared to 71% in 2019/20). This indicates a positive improvement in resolution of discrepancies In 2021/22, there was 1 critical incident reported relating to the loss of 20 Nitrazepam 5mg tablets, this was thoroughly investigated, and remedial actions put in place to address medicines management concerns on the ward it occurred on.

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 implemented and will now be part of ongoing 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:				
Covid-19 Recovering effectively	*Yes*	***X***	*No*	
CQC Getting Back to Good	*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	*Yes*	***X***	*No*		***Safer management of controlled Drugs***
IG Governance Toolkit	*Yes*		*No*	***X***	

Have these areas been considered? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Patient Safety 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.***
OD/Workforce	*Yes*	***X***	*No*		***An appropriately trained workforce is essential for the safe management of all drugs.***
Equality, Diversity & Inclusion	*Yes*	***X***	*No*		***Improving patient safety by reducing avoidable harm from controlled drugs has the potential to reduce inequalities as harm from CDs may be variably distributed between groups with different protected characteristics.***
Legal	*Yes*	***X***	*No*		***The Misuse of Drugs Act 1971; The Misuse of Drugs Regulations 2001; The Controlled Drugs Regulations 2013***

Title	Controlled Drugs Accountable Officer (CDAO) Report

Section 1: Analysis and supporting detail

Background

1.1 Purpose of the report

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 (2021) report.

To highlight the recommendations from the Care Quality Commission (CQC) annual report on controlled drugs (published July 2022).

1.2 Background

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 and NHS Improvement – (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 CCG* 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.
*NHS Sheffield Clinical Commissioning Group has been legally dissolved and from 1 July 2022 has been replaced by a new organisation: NHS South Yorkshire Integrated Care Board (SY ICB)

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 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'.

Notification to the CQC should be done through the relevant section of the CQC website

(http://www.cqc.org.uk/content/controlled-drugs-accountable-officer-notifications) -This notification section is password protected.

The BoD can be assured that the CQC hold details as of July 2022 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 2022, the CQC published their latest annual report

https://www.cqc.org.uk/publications/safer-management-controlled-drugs-annual-update-2021

The BoD are advised the following recommendations relate to SHSC;

Recommendations

1) **Providers need to ensure their governance of controlled drugs is up to date and fit for purpose.**

   Good governance of controlled drugs will help services to improve the safety and quality of people's care and the minimise risk of diversion. Good board-level engagement in relevant organisations is an essential element of ensuring the safer management of controlled drugs.

2) **Health and care staff need to make sure they provide shared care in line with best practice guidance.**

   This helps people to receive safe care in a timely way, and that the safety and effectiveness of their medicines is monitored continually. Learning from incidents should be shared across local areas to support this work.

3) **Providers should use the available data sources and tools to better understand prescribing risks and issues with controlled drugs**.

   Once those risks and issues are identified, local collaboration can help to create action plans and interventions to promote safer care.

4) **Designated bodies should fully engage with controlled drugs local intelligence network activities.**

   Local intelligence networks are vital in sharing intelligence and valuable learning. To be effective, networks need the full co-operation and engagement of members. It is also important for designated bodies to ensure that quarterly controlled drug occurrence reports are returned promptly when requested by an NHS England CDAO.

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 in the times of the COVID pandemic have been on-line

1.10 Update on issues reported to the BoD in the previous annual CDAO reports (2016-2021)

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 42% 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.

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

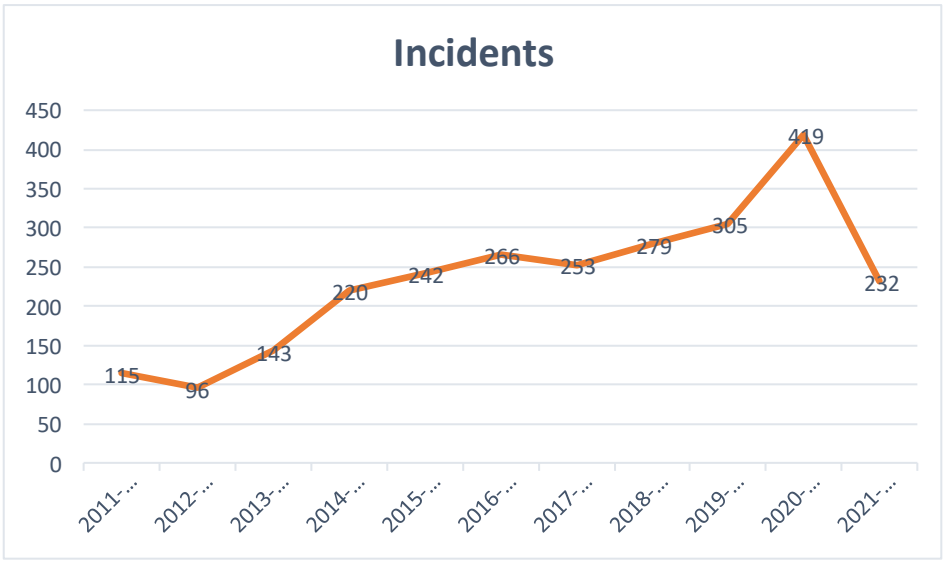
(Note" year" relates to period ending September i.e. reporting period Oct to Sept)

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

1.12 Incidents reported to CDAO October 2017 to March 2022

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

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



Graph 1

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 act immediately and 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 possible for this system to capture any associated information (e.g. copies of paper records).

1.14 **Issues of serious or major concern (April 2021 to March 2022)**

There was one issue reported of major concern. This triggered a 48-hour report and investigation.

1) **Critical Incident**: 20 tablets of Nitrazepam missing in Forest Close 1A:

   Action taken by Forest Close Staff:

   • Two RMN's checked the count and the documentation, x1 box of 28 present x1 box of 20 missing.

   • Thorough search of clinic room undertaken on the night shift and the following day.

   • Statements requested from nurses in charge of medication keys on shifts in question.

   • Room searches completed for those that had been present in the clinic room on the 28th June.

   Outcome and actions

   Service user admitted to taking the medication and self medicating on the ward.

   Change of medication administration process on the ward- No admission of service users into the clinic room -Staff to ensure medication is locked away appropriately. Clinic room design/environment under review by Medicines safety task and finish group to create a patient area.

1.15 Other issues (April 2021 to March 2022)

Moderate incidents

1) Service user was given methadone daily dose 70ml on Maple ward but also attended the community pharmacy and took a second dose of methadone 70ml in afternoon.

   Actions: Process reviewed for MDT liaise with START and community Pharmacy on admission and discharge.

2) On G1, service user was administered 2mg diazepam dose instead of lorazepam. No harm to service user reported

   Actions: The staff involved had an incident debrief with the duty Deputy ward manager and the Ward Manager on the day of the incident. The incident was discussed in the morning Huddle. Staff did medicines with respect refresher training and a supervision with Advanced Clinical Practitioner and line manager.

3) Stanage ward had a significant CD stock discrepancy where 30 x 10mg Chlordiazepoxide capsules were reported missing.

   Actions: After escalation and thorough investigation, the medication was located on the side of one of a patient's own medication container in the medicine's cupboard. Ward manager to monitor controlled drug and incidents to see if further or similar trend arise.

4) Administration with wrong dose given to service user in Endcliffe ward. Zopiclone 7.5mg and promethazine 25mg were administered together to service user as opposed to offer one or the other as per care plan.

   Actions: Service user was monitored for any respiratory concerns through the night.

5) A box of 27.5 Lorazepam 1mg tablets were reported missing and unaccounted for at Woodland view. After a thorough investigation, concluded that staff removed the tablets due to them coming to the end of the expiry date but then realised was the only nurse on duty and that to destroy needs two nurses. Staff wrote the note to say destroy and kept them in the dressing cupboard rather than locking the tablets away.

   Actions: Increased CD checks from monthly to daily will be completed by two nurses of the morning shift and afternoon shift. Spot checks to be done intermittently by the deputy managers in between. Discussion with G.P to review all stock to optimise their repeat prescriptions. Only what is needed will be ordered. Deputy managers will complete a monthly audit.

6) At Birch Avenue, a resident was found with two Buprenorphine patches in-situ applied on 21/02/22 and on 28/02/22.

   Actions: Both patches were removed and a new one applied as per prescription. Staff nurse who discovered made visual checks of well- being throughout the shift for signs of deterioration. Next of Kin informed under Duty of Candour and management informed. Supervision/support of staff member involved took place within 48 hours of incident.

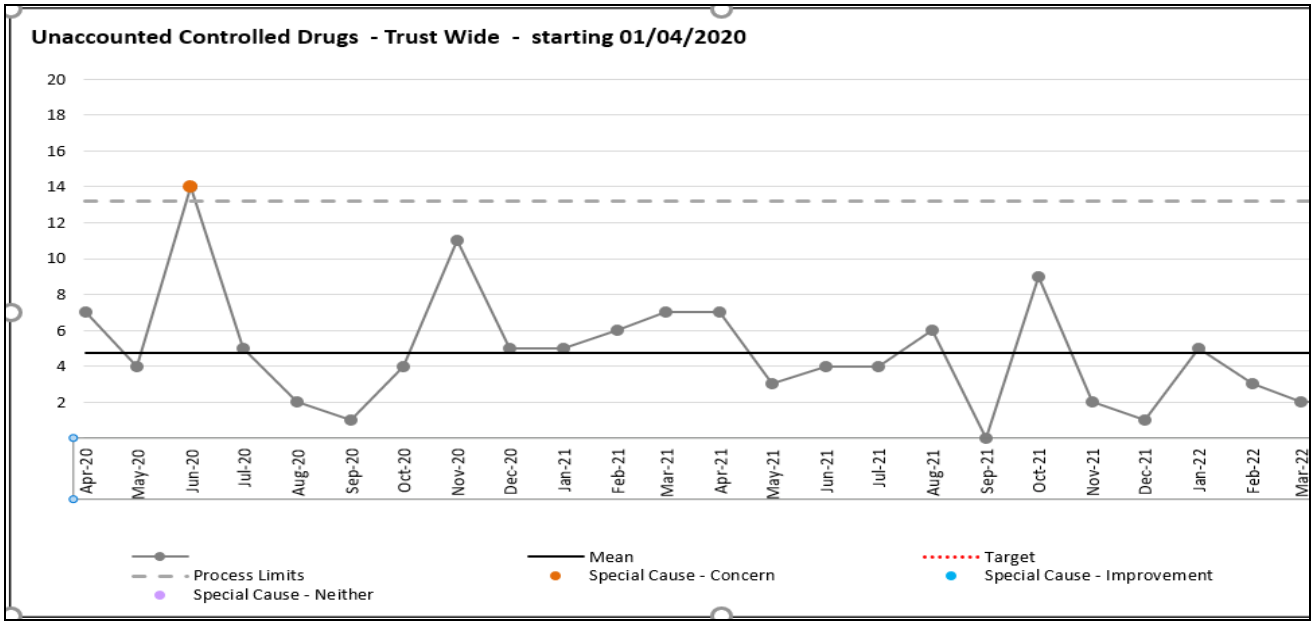
   Email sent out to all staff at Birch Avenue to ensure that body maps are used when using patches.

1.17 CD Discrepancies

Finding the root cause for some of the CD discrepancies often remains elusive; 108 (133 in 20/21) out of a total of 232 (419 in 20/21) incidents reported were attributed to discrepancies. Of the 108 discrepancies reported; 46 (43%) were unresolved in 2021/22 compared to 70 (53%) unresolved in 2020/21 (compared to 71% in 2019/20) (*See table 2 below*)

	Q1 21/22; (20/21), (19/20)	Q2 21/22; (20/21), (19/20)	Q3 21/22; (20/21), (19/20)	Q4 21/22; (20/21), (19/20)	Total 21/22; (20/21), (19/20)
Accounted for	15 (16) (3)	12 (20) (5)	18 (14) (5)	17 (13) (11)	62 (63) (24)
Unaccounted for	14 (25) (12)	10 (8) (10)	12 (20) (25)	10 (17) (10)	46 (70) (57)
Total	29 (41) (15)	22 (28) (15)	30 (34) (30)	27 (30) (21)	108 (133) (81)

Table 2



Graph 2

Graph 2 indicates the accounting of unaccounted for CD discrepancies. The numbers have been reducing slowly and culture change is slowly happening. 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.

1.18 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 has also been reinstated to support good CD management.

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

3. Nurse who discovers a CD stock discrepancy will intitiate CD investigation with the support of their ward pharmacist using CD guidance before reporting as an incident.

4. Pharmacy technicians will continue to visit their 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 45% reduction in the total number of CD incidents reported 232 in (2021/22) compared with 419 (2020/21). This could be good news as to practice and accounting for losses which is 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.

108 (133 in 20/21) out of a total of 232 (419 in 20/21) incidents reported were attributed to discrepancies. Of the 108 (133- 2021/22) discrepancies reported; 46 (43%) were unresolved in 2021/22 compared to 70 (53%) were unresolved in 2020/21 (compared to 71% in 2019/20)

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

1.20 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 even in the COVID environment.

2) CD incidents reports have decreased in 21/22. 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 if this is sustained

3) Assurance that the CDAO is aware of and acted on incidents in relation to any concerns about controlled drugs.

4) A higher proportion of CD discrepancy incidents reported are now able to be 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 and Triangulation

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

3.3 Data is regularly provided to QAC regarding controlled drugs incidents through the Quarterly Medicine Safety Report.

3.4 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

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 Aims and Board Assurance Framework

4.1 Improved CD safety supports our strategic aims of delivering outstanding care and reducing inequalities, as well as the strategic priorities to get back to good and recovering effectively from Covid.

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.

4.3 Improving safety by reducing avoidable harm from controlled drugs has the potential to reduce inequalities as harm from CDs may be variably distributed between groups with different protected characteristics.

Culture and People

4.4 There has been a culture of acceptance of medication errors

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

4.6 Work identified by the Medicines Management Task & Finish 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

4.7 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

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

Compliance - Legal/Regulatory

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