# Board of Directors

| SUMMARY REPORT | Meeting Date: | 24th July 2024 |
|---|---|---|
| | Agenda Item: | 15 |

| | | |
|---|---|---|
| **Report Title:** | **Controlled Drugs Accountable Officer (CDAO) Report** | |
| **Author(s):** | **Abiola A-M Allinson, Chief Pharmacist and CD Accountable Officer** | |
| **Accountable Director:** | **Dr Helen Crimlisk, 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 a 24% increase in reported CD incidents from 189 in 2022/23 to 249 in 2023/24.

This is indicative of increased reporting culture and transparency but there is still a concern of non-reporting of certain types of incidents and concerns about some practices in clinical areas regarding controlled drugs. There is a monitored action plan on improvement with the wards. In addition, engagement with senior nursing colleagues on culture change on wards, introduction of Eldorado Medicines Error Tool (EdMET) to identify patterns of practice and standardise medication error reviewing across the Trust.

This report provides assurance that we are aware of the main issues namely unaccounted for CD discrepancies; second signatures and we have a clear line of sight on the remedial actions required to improve the quality and safety of care for our service users. Key is engagement, embedding and continuous improvement.

There has been an overall increase (107- 249) in medication incidents reported over the last year and an increase in CD stock discrepancies (81-107). CD Stock discrepancies therefore make up a smaller proportion of overall medication incidents. Over the last year a higher number (50) and proportion (47%) of CD stock discrepancies remained unresolved following investigation compared to last years figures (31 and 38%)

This should be placed in context of there being circa 52,000 administrations of controlled drugs or 143 administrations per day on wards in SHSC during this year.

In 2023/24, there were no critical CD incidents reported at SHSC. Three moderate incidents were reported and adverse impact on service users was not directly attributed to the reported SHSC incidents.

A significant proportion of incidents (96/249) relate to reported missing second signatures on administration, however this is known to be a significant underestimate as the 3 monthly CD audits showed that 1133 second signatures were missing and would have been reported as individual incidents, indicating a

significant issue with under-reporting.

A number of pieces of work are underway reporting into Medicines Safety Group and Medicines Optimisation Committee including:

- Improving medicines safety and processes on the wards
- Nursing leads on training
- Competency framework for staff who administer medication
- A compulsory yearly calculation framework for staff who work with medication
- Revised and Improved Medicines Optimisation Training
- Introduction of EdMET for error monitoring and to standardise review of medicines errors across the Trust. This spotlights trends in individual practice for either improvement or education needs.

In conclusion, there are concerns about the trends identified

a) Under-reporting of incidents,
b) Some nursing practice with respect to controlled drugs

There are further actions being considered

a) A specific nursing action plan to tackle the issues identified in this report.
b) An active review of the system of stock CD supplies to wards

| **Recommendation for the Board/Committee to consider:** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Consider for Action** | | **Approval** | | **Assurance** | **X** | **Information** | |

The Board of Directors (BoD) is asked to accept the assurance provided by this report that the key risks and concerns relating to the management of controlled drugs are understood and there are several plans in place to address the issues of incident reporting, second signatures, closer monitoring of supplies of CDs to wards and nursing practice.

| **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*** | |

# 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 (2023) report.

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 Care Quality Commission (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 2024 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 | S4 7QQ |

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.

The 2023 report on safer management of controlled drugs from the CQC is due to be published in July 2024

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.

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)**

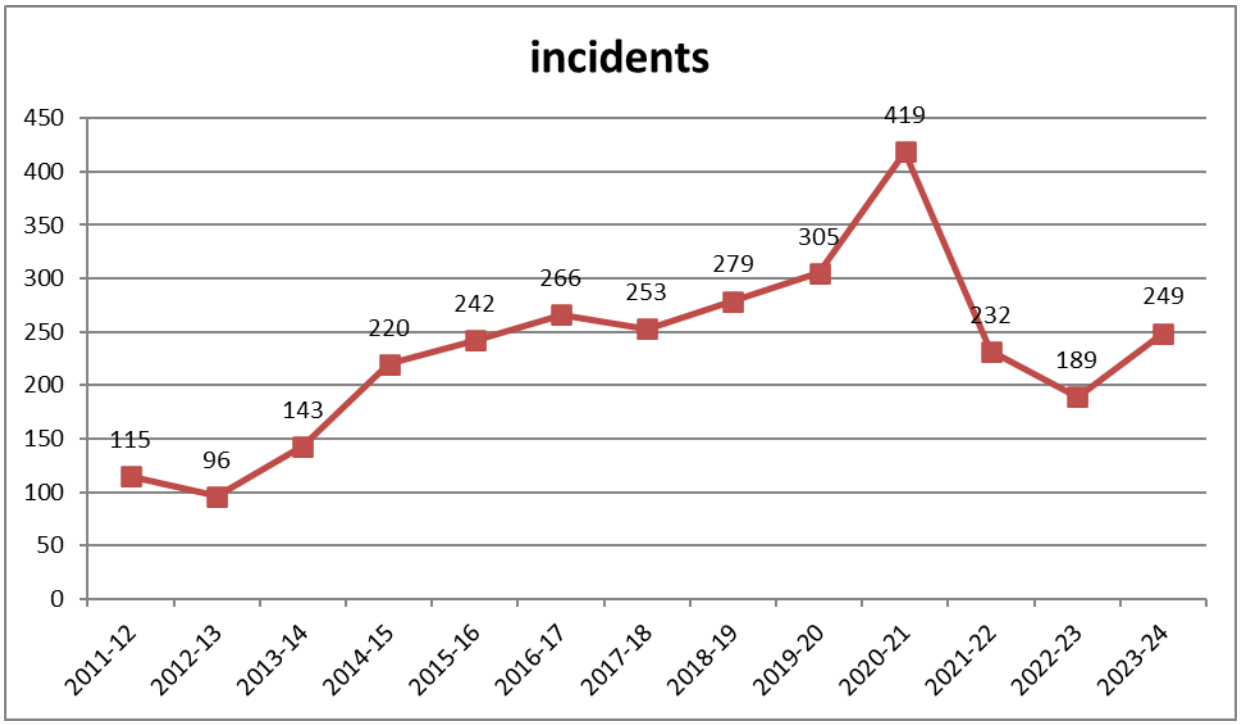
| | 2017 | 2016 | 2015 | 2014 | 2013 | 2012 |
|---|---|---|---|---|---|---|
| Total CD incidents reported to CDAO | 266 | 242 | 220 | 143 | 96 | 115 |

**Incidents reported to CDAO October 2017 to March 2024**

| | 2017-2018 | 2018-2019 | 2019-2020 | 2020-2021 | 2021-2022 | 2022-23 | 2023-24 |
|---|---|---|---|---|---|---|---|
| Total CD incidents reported to CDAO | 253 | 279 | 305 | 419 | 232 | 189 | 249 |

1.12 **The annual trend in reported incidents involving all controlled drugs is shown below (Oct 2012 to Mar 2024)**

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. Increase in number of incidents reported last year could be attributed to closer scrutiny of the ward processes particularly in relation to second signature omissions. Noting this is still under-reported and is included as a specific section in the EdMET tool.

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 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 2023 to March 2024

1.14 **Issues of serious or major concern (April 2023 to March 2024)**

There was no issue reported of major concern.

1.15 **Other issues (April 2023 to March 2024)**

Moderate incidents (3 reported)

1. Patient was given duplicate prescriptions of zopiclone and diazepam from the GP and SHSC. Team had stated to give 1 week’s prescription and then GP to pick up prescription. Overlapped for 6 weeks. Patient died of a mixed dose overdose. Doses of diazepam would have meant he would have not gone above the maximum BNF dose, and the zopiclone would have potential to double dose over this period.

   **Actions**: 48-hour review undertaken

   Templates letters to GPs requested to be reviewed for Rio to ensure information is clear regarding medication.

   Reminder email sent to all prescribers regarding learning from incidents, discussed the responsibility around prescribing and clarifying who is the prescriber and avoiding duplicate prescribing. Contacting GPs to ensure duplication prescribing does not occur.

2. **Incident**: Several errors in the CD register. Staff on a ward had not completed the CD checks on the day. When a CD check was completed, several discrepancies were noted. Buprenorphine patches not documented in book. Received by ward three days prior and not recorded. Clonazepam tablet level incorrect – further investigation found that dose had been administered but not recorded in CD book. Lorazepam tablet count was incorrect, found one patient’s administration not documented in CD book, also noted one was not documented on EPMA. Unable to account for the lorazepam oral medication discrepancy. Lorazepam vials incorrect - after investigation found to have been administered but not documented in CD book. Diazepam 5mg tablets had 4 administrations without any signature, similar with clonazepam 500micrograms. Patients own medications stored in wrong location and not recorded in CD book. Two CD books in use at the same time.

   **Actions**: Investigation into errors -Medicines Management Technician (MMT) reviewed EPMA and CD book to clarify issues. Majority were accounted for; however, some could not be accounted for.

   The CD book was transferred to one CD book.

   The ward manager was contacted to clarify staff who worked on the day of the incident to clarify if regular staff/ preceptorship nurses/locum or bank staff. No response was received regarding the request.

   Ward had been offered on regular occasions CD training from the MMTs and the ward pharmacist. The ward has not taken up this offer. Have stated to ward manager to contact pharmacy as they have been regularly asking when the team is available

with no engagement from the team. This is now included in the ward improvement plan.

3. **Incident**: CD check noted lorazepam 10 tablets down.

Levels were checked day before. Records were checked and compared to administration. Patient named medication. Not second checked the day before. Unable to account for amount missing.
**Actions**: 48-hour review. Police informed. CDAO informed. Names of staff present documented. The Local Counter Fraud Specialist informed and advised of actions. Reported in CD Local Intelligence Network (CD LIN).

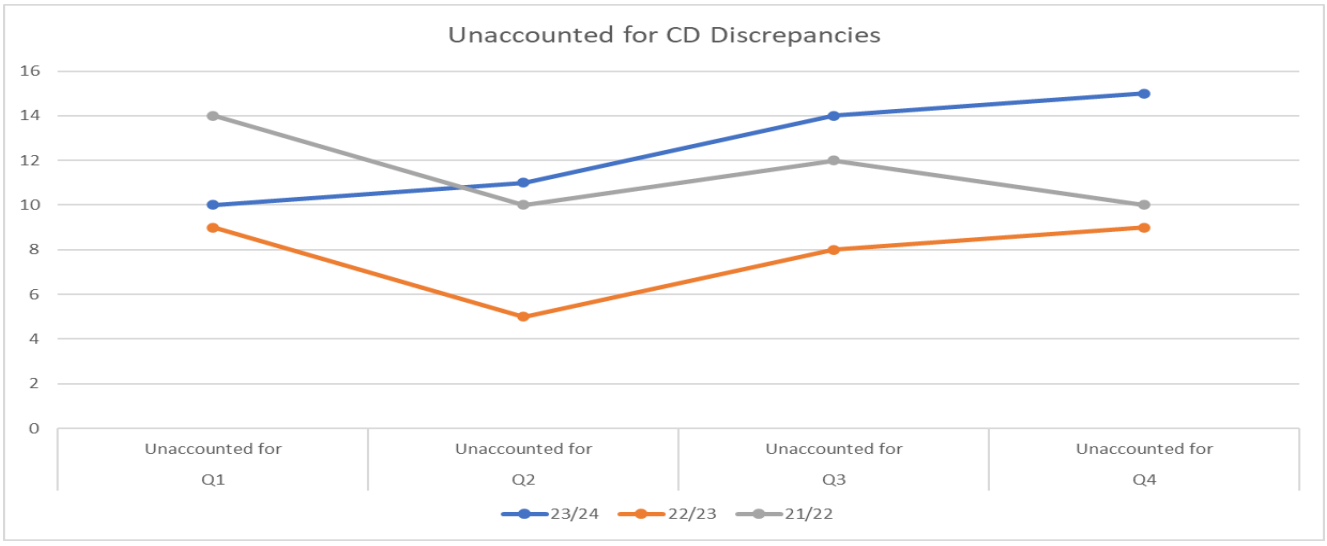
1.16 **CD Discrepancies**

Finding the root cause for some of the CD discrepancies often remains difficult; it is usually related to poor documentation; Of the 107 discrepancies reported, 50 (47%) were unresolved in 23/24 compared to 31 (38%) were unresolved in 2022/23. (*See Table 1; Graph 1*).

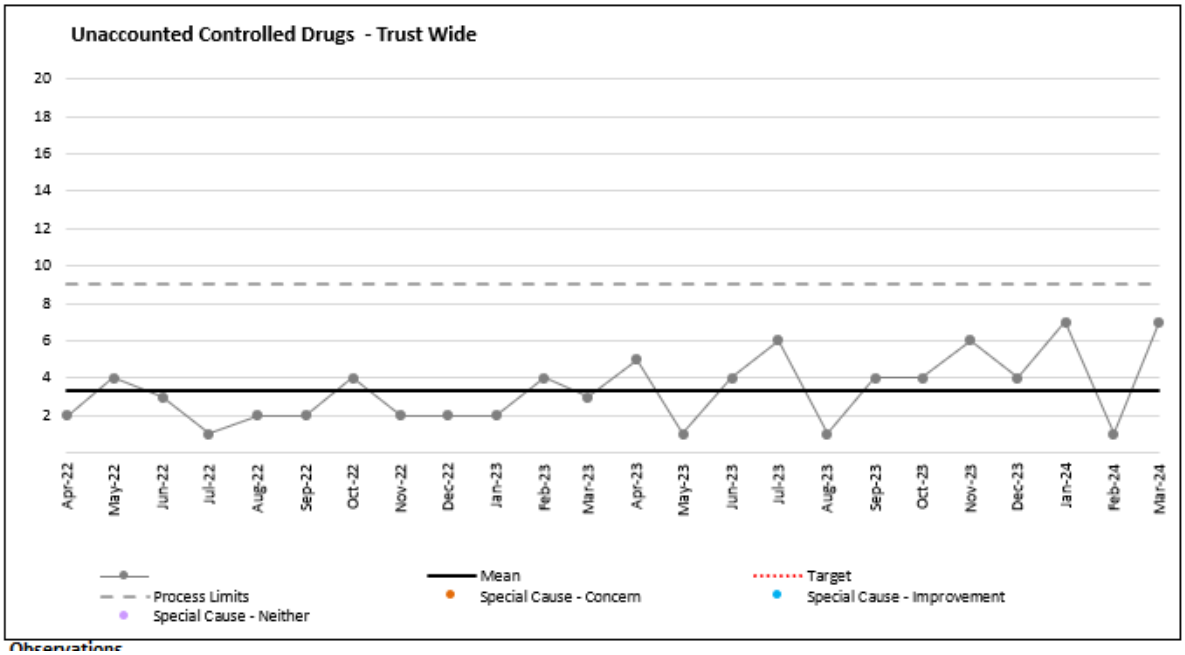
**CD stock discrepancies over last 3 years**

| | Q1 23/24; (22/23); 21/22) | Q2 23/24; (22/23); (21/22) | Q3 23/24; (22/23); (21/22) | Q4 23/24; (22/23); (21/22) | Total 23/24 (22/23); (21/22) |
|---|---|---|---|---|---|
| Accounted for | 12; (8); (15) | 16; (11); (12) | 13; (21); (18) | 16; (10); (17) | 57; (50); (62) |
| Unaccounted for | 10; (9); (14) | 11; (5); (10) | 14; (8); (12); | 15; (9); (10) | 50; (31); (46) |
| Total | 22; (17); (29) | 27; (16); (22) | 27; (29); (30) | 31; (19); (27) | 107; (81); (108) |

Table 1




Graph 1




Graph 2

Graph 2 indicates the unaccounted for CD discrepancies. The numbers have fluctuated but culture change is slowly happening. The graph shows normal variation. 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.

1.16a **Missing Second signatures**

96 incidents were reported with second signatures missing (note this represented circa 210 missing second signatures as some incidents were collated) however this is a significant underestimate. A large proprotion of missing signature incidents were identified following the 3 monthly CD audits undertaken by pharmacy which reported as 1,133 over 2023/24. This indicates that staff on wards are not reporting incidents and continuing to administer without second signatories. There is a correlation between adminstration errors and missing second signature checks

In the year from 01/04/2023 to 31/03/2024 there were a **circa 52,000 ward-based administrations** of schedule 2, 3 and 4 controlled drugs. This equates to an average of **143 per day**. This is inclusive of PRN (when required) and regular administrations.

1.17 **Actions in place and planned :**

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/Assistant Technical Officers continue to visit wards for 2 weekly CD audits and ward pharmacists or Medicines management Technicians doing 3 monthly CD audits and inform the MSO as part of monitoring to triangulate the progress and provide assurance that the action plan is working.

4. CD training support regularly offered, Audits every 3 months. SOP NCD7 updated which includes community teams. Planned roll out of training to community teams, following correct equipment (CD register and CD cabinets) availability.

5. An additional category for CD incidents within the EdMET (El Dorado Medication Error Tool) to ensure that staff not seeking second signatures and discrepancies due to poor paperwork are highlighted. To start when EdMET launched.

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 wards. Some of the feedback from the supervision has been staff raising concerns of staff shortages.

**Actions**

Monthly training by pharmacists and MMTs on CD's to all ward staff -was rolled out in August 2022 -this offer is ongoing

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

Improving medicines safety and processes on the wards,

Nursing leads on training

Competency framework for staff who administer medication.

A compulsory yearly calculation framework for staff who work with medication,

Revised and Improved Medicines Optimisation Training

Introduction of EdMET for error monitoring and to standardise review of medicines errors across the Trust. This spotlight trends in individual practice for either improvement or education needs.

Nursing action plan on medicines management including CD's

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 increased in 23/24. This could be indicative of more open reporting and processes related to education and working practices. The main incidents relate to poor documentation and we are working closely with the nursing leadership to improve this. 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 unaccounted for discrepancies over a 2-year period without significant variation. We need to continue the ongoing work on culture and practice to improve our processes.

3.2 Data is regularly provided to QAC regarding controlled drugs incidents through the bi-annual Medicine Safety Report. Monthly reports are delivered to the Medicines Optimisation Committee

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

1.5 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.0001: If the Trust is not properly prepared there is a risk that patients and staff will not be adequately protected from harm and that service delivery could be adversely impacted.

BAF.0003: There is a risk that the Trust is unable to improve patient safety resulting in a failure to comply with CQC requirements and achieve necessary improvements.

BAF 0004: There is a risk that the Trust is unable to improve the quality of patient care, resulting in a failure to comply with CQC requirements and achieve necessary improvements.

### 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 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 that there is a clear line of sight to issues identified and on going assurance work that there are effective processes in place and remedial actions are being taken to address any concerns raised in relation to the handling/management of Controlled Drugs in SHSC.

**Chief Pharmacist and CD Accountable Officer**