Controlled Drug Prescribing

Schedule 2	Schedule 3	Schedule 4 pt 1	Schedule 4 pt 2	Schedule 5
Codeine injection Dexamfetamine Diamorphine Fentanyl Ketamine Lisdexamfetamine Methylphenidate Morphine Oxycodone Sodium oxybate	Buprenorphine Gabapentin Midazolam Phenobarbital Pregabalin Temazepam Tramadol	Chlordiazepoxide Clonazepam Diazepam Lorazepam Nitrazepam Sativex® Zaleplon Zolpidem Zopiclone	Somatropin Testosterone	Codeine (oral) Dihydrocodeine (oral) Oramorph 10mg/5ml® Pholcodine

Misuse of Drugs Act (MDA) 1971

The MDA 1971 and its Regulations control the availability of drugs that are considered sufficiently 'dangerous or otherwise harmful', with the potential for diversion and misuse. The drugs that are subject to the control of the MDA 1971, are listed in Schedule 2 of the Act and are termed CDs

Misuse of Drugs Regulations (MDRs) 2001

The use of CDs in medicine is permitted by the MDRs. The MDRs 2001 divide CDs into five Schedules, which dictate the degree to which a CD's use is regulated. The Schedule in which a CD is placed depends upon its medicinal or therapeutic benefit balanced against its harm when misused.

A list of the most commonly encountered drugs currently controlled under the misuse of drugs legislation is available of the Government website
https://www.gov.uk/government/publications/controlled-drugs-list--2

The Controlled Drugs (Supervision of Management and Use) Regulations 2013

The 2013 Regulation require those who provide services to have up to date standard operating procedures in relation to the management and use of controlled drugs, which cover (amongst other matters) best practice relating to—

- the prescribing, supply and administration of controlled drugs, and
- clinical monitoring of patients who have been prescribed controlled drugs.

CCG factsheets on practical management of CDs are available at
https://www.cambridgeshireandpeterboroughccg.nhs.uk/health-professionals/prescribing-information/controlled-drugs/

Who can prescribe CDs?

Prescriber	Permitted to prescribe
Chiropodist / podiatrist independent prescriber	For the treatment of organic disease or injury provided that the CD is prescribed to be administered by the specified method: • Diazepam; • Dihydrocodeine; • Lorazepam; and • Temazepam By oral administration.
Doctors	No restrictions (except Diamorphine, Dipipanone or Cocaine for the treatment of addiction without a licence)
Dentists	CDs included in the Dental Prescribing Formulary (Part XVIIA of the Drug Tariff) on an FP10D prescription.
Community Practitioner Nurse Prescribers	No CD prescribing
Optometrist Independent Prescriber s	No CD prescribing
Nurse Independent Prescribers	Any Schedule 2, 3, 4 or 5 CD (except Diamorphine, Dipipanone or Cocaine for the treatment of addiction).
Physiotherapist Independent Prescribers	For the treatment of organic disease or injury provided that the CD is prescribed to be administered by the specified method: • Diazepam, Dihydrocodeine, Lorazepam, Morphine, Oxycodone, Temazepam, by oral administration; • Morphine for injectable administration; and • Fentanyl for transdermal administration.
Pharmacist Independent Prescribers	Any Schedule 2, 3, 4 or 5 CD (except Diamorphine, Dipipanone or Cocaine for the treatment of addiction).
Supplementary Prescribers	Any Schedule 2, 3, 4 or 5 CD (except diamorphine, cocaine and Dipipanone for the treatment of addiction), providing it is in accordance with the patient's clinical management plan.

Any prescriber wishing to write a private prescription for a Schedule 2 or 3 CD that is intended to be dispensed in the community must do so only on the designated stationary and include their private prescriber number (contact NHS England for further information https://www.england.nhs.uk/mids-east/our-work/controlled-drugs/)

Prescriptions for Schedule 2, 3 and 4 CDs are only valid for 28 days.

It is recommended that prescriptions for Schedule 2, 3 and 4 CDs are limited to a quantity necessary for up to 30 days clinical need. In exceptional circumstances where the prescriber believes a supply of more than 30 days medication is clinically indicated and would not pose an unacceptable threat to patient safety, the prescriber should:

- Make a note of the reasons for this in the patient's notes
- Be ready to justify his/her decision if required

Essential Process	Minimum standards
Prescribing – general processes	
Initiation of CDs	• Schedule 2, 3 and 4 CDs should only be prescribed after careful consideration of the risks and benefits • CDs are preferably only initiated by a doctor that knows the patient well • Locums and registrars are encouraged to discuss acute prescriptions for Schedule 2 or 3 CDs with a senior partner • CDs Locums and registrars never add schedule 2, 3 or 4 CDs to the 'repeat medication list' • The practice aims to prescribe modified release preparations in preference to immediate release formulations • The practice aims to prescribe liquid formulations instead of immediate release solid dose formulations for prn dose. • The practice aims to prescribe only monthly quantities • The practice aims to minimise prescribing of low strength / high volume formulations • The practice follows CCG formulary guidance on choice and formulation of CD
Monitoring of CD prescribing **The Controlled Drugs (Supervision of Management and Use) Regulations 2013 require provision of standard operating procedures for clinical monitoring of patients who have been prescribed controlled drugs**	• The culture of the practice allows open peer review and scrutiny of CD prescribing at clinical meetings; • Usual triggers for this will be anecdotal when someone has spotted 'something odd' in a patient's medical records • The practice does regular audits of CD prescribing to look for unusual products, quantities, dose, formulations and strength
Out of hours requests or prescriptions for CDs are automatically incorporate into the medical records (unless the patient has opted out of sharing data)	• Each OOH CD request / prescription triggers a review of the medical records and the medication record • The reviewing clinician makes an entry in the medical records of this review
Significant Event Analysis	• The practice has SEA processes in place to support review of incidents that involve CDs • The practice routinely liaises with MOT regarding incidents involving CDs • The practice should be aware of how to contact the Cambridgeshire police CD Liaison Officer • Incidents involving CDs must be reported the NHS England CDAO. This should occur within 48 hours.
Prescribing – **Repeat Prescribing** *Current legislation does not allow Schedule 2 and 3 CDs to be prescribed as repeat prescriptions (i.e. to be part of the repeat prescribing or dispensing system, also called 'Batch prescribing').* *It is common practice to allow patients to receive a prescription for Schedule 2, 3 or 4 CDs (hand signed by a practitioner) without a consultation. This is not*	

subject to legislation, but is a clinical decision made on a case by case basis.	
Repeat Prescribing: Allowing patients to receive a prescription for Schedule 2, 3, or 4 CDs (hand signed by a practitioner) without a consultation	• The ability to create computer-generated prescriptions for Controlled Drugs has made the actual process of prescribing opioids much easier and opioids may be entered into opioids onto repeat prescribing systems. However, this practice is discouraged. • In general, opioids should not be added to the repeat prescribing system but should be generated as acute prescriptions. • If an opioid has a demonstrable positive benefit for an individual patient and there is a robust system for monitoring use then consideration may be given for short-term authorisation of repeat prescriptions. • The prescriber and patient together should review the continuing benefit of opioid therapy and potential harms at regular intervals (at least twice each year). • Practices should actively assess whether changes to a patient's prescription should be notified to the dispensing contractor, especially where these changes made are mid cycle or shortly after a script has been issued. • Practices with attached dispensary or pharmacy do not allow patients to collect 'repeat prescriptions' for S2 or 3 CDs without a doctor signature. • Repeat requests for S2, 3 or 4 CDs are subject to a strict Standard Operating Procedure within the practice with clear lines of accountability and responsibility for admin staff and clinical staff • Prescriptions for CDs are signed by the doctor that knows the patient the best: 'the usual doctor'. • Medication review is auditable with clear evidence in the medical records that total quantities issued have been reviewed and found to be clinically appropriate by the doctor that knows the patient best: 'the usual doctor'
Interaction with CCG, MOT, and the NHS England CD Accountable officer	
Dealing with medicine Optimisation updates (e.g. Think! Medicines)	• The updates are circulated in the clinical team and discussed at the clinical meetings and easily available electronically for reference • These updates are incorporated into the practice prescribing policies
Dealing with requests for information from MOT and the NHS England CDAO	• The request is acknowledged and answered promptly • When requested to complete a CD self- assessment, the form filled in by the most appropriate senior clinician, and not delegated without clinician input • Information requests and self-assessment declaration are discussed at the clinical meeting • The practice understands the role of the accountable officer and its own obligations with regard to CDs
Requesting advice from MOT for difficult cases	• The practice is aware of the MOT prescribing partnership contact details • The practice is aware of the MOT governance structure for providing advice and guidance relating to CDs • The practice has active interaction and dialogue with the MOT who attend practice meetings frequently
Prescribing – Palliative Care	
Awareness of local palliative care formularies and	• The practice is aware of local palliative care guidelines and can obtain timely advice • A copy of local palliative care guidelines is in the practice

guidelines	and available to all
Liaison with local palliative care/DN team	• QOF quarterly meetings • The practice follows the Gold Standard Framework principles • Review of all practice deaths (including non-expected, OOH deaths) with dissemination of good practice and lessons learned
Anticipatory prescribing	• The practice closely cooperates with District Nurses • The practice follows either the CCG Just in case Where available within the GP clinical system, the CCG End of Life Care + template is used
Prescribing – Analgesia **Opioid analgesia is not recommended for chronic pain.** **The principles of the WHO analgesic ladder should not be applied to prescribing in chronic pain.**	
The practice has a prescribing policy and formulary which covers analgesia	• The practice follows the most up to date guidance from Public Health England and Faculty of Pain Medicine – Opioids Aware • The practice adheres to the Cambridgeshire and Peterborough formulary • This is to include brand prescribing where indicated • The 'analgesic ladder' should only be applied to requirements of patient's receiving palliative care • Post-operative analgesia should not be continued in primary care. • The practice has an awareness of unintended secondary dependency by excessive / prolonged / in appropriate prescribing
Prescribing - Emergencies *Administering CDs in an emergency is becoming rare in general practice* *Any practice that chooses to have available CDs to be given in emergencies either in the practice or during home visits must have available sufficient quantity of naloxone (as defined in the BNF) both in the practice and during home visits.*	
Administering CDs in emergencies	• Situations that have needed emergency CDs are discussed afterwards at the practice clinical meetings • The practice reviews annually the frequency and indications for which emergency CDs are administered •
Availability of naloxone	• The practice has sufficient quantity of naloxone available (as defined in the BNF) both in the practice and during emergency visits

Prescribing – substance misuse	
Tight control of prescriptions for patients on CDs for substance misuse problems	• The practice has a register of these patients • The practice is aware of local substance misuse services and referral pathways and when to use them • Methadone or buprenorphine prescribed by the substance misuse service should be added to the patient's other medication record. • GPs should refer patients to the local substance misuse service who usually retain prescribing responsibility due to specialist nature of treatment. • GPs prescribing for drug addiction should hold RCGP level 2 certificate. • The concurrent use of methadone with other opioid(s)/opiate(s) and/or respiratory depressants, e.g. alcohol, sedatives, which can result in a cumulative respiratory depressant effect leading to serious patient harm is avoided. • Clinicians should review these medicines and avoid their use if possible; and if prescribed, patients should be made aware of potential interactions. • Any patient on CDs for substance misuse problems have their requests dealt with by a dedicated clinician with support from a dedicated admin team member if appropriate. • There is written Standard Operating Procedure in place describing the above process in detail which includes arrangements to cover absence or leave. • The care of these patients is subject to an annual audit and review, the results of which are shared with the whole clinical team • Some clinical systems allow restrictions so that prescriptions for Schedule 2 or 3 CDs can only be printed only by clinicians, and not by admin team members. • The practice takes part in clinical governance arrangements with the local substance misuse services
Prescribing – mental health	
The practice has a prescribing policy and formulary which covers CDs for mental health conditions e.g. benzodiazepines	• Anxiolytics and hypnotics are used for short term use only, in accordance with product licence. • Non-pharmacological interventions should always be used first line. • They should not be added to repeat lists. • Patients already prescribed long term anxiolytics and hypnotics should be identified and dose reduction discussed and commenced.