Controlled Drugs Newsletter- Summer Edition 2026

Introduction

Welcome to our Summer 2026 edition of the London Region's Controlled Drugs Newsletter. We hope you find it full of useful information and have also found previous editions of the newsletter helpful.

For information, we are now saving the newsletters in the resources section of the Controlled Drugs Reporting website www.cdreporting.co.uk so that they are all in one place for future reference.

Please cascade the newsletter to relevant colleagues within your organisation and continue to give us your feedback and suggestions.

With our best wishes,

The London CDAO Team

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Please note, we have moved offices from Wellington House and are now based at 10 South Colonnade Canary Wharf

Risks of diversion through unchallenged access to the controlled drugs cupboard

We have recently been made aware of an incident whereby a registered healthcare professional was able to access controlled drugs without authorisation. They gained access to a ward and obtained controlled drug cupboard keys from hospital staff in a Trust in which they had previously worked as they were well known and respected by the staff who worked on the ward.

We would like to remind all hospital staff of the need to be vigilant regarding access to staff only areas and controlled drug and medicines cupboard keys. Before handing over controlled drug or medicine cupboard keys, you must consider whether the individual requesting access has a legitimate need to access the cupboards and their contents.

Please consider:

- The reason for their request
- Their ID - you may check their ID badge or check with their department head to verify their identity and any further information
- Is the person a current member of staff / bank staff / locum staff, and are they on their correct assigned shift

Where there is any doubt, please escalate to a senior staff member

Reduction in recommended oral morphine equivalent (OME) threshold from 120mg to 90mg/day

The Faculty of Pain Medicine (FPM) has undertaken a comprehensive update to the Opioids Aware resource reflecting the latest clinical evidence and international guidance. The current version was published for professional and public consultation and revised based on received suggestions. Here are the key changes and highlights:

Dose Guidance Revised

- The recommended oral morphine equivalent (OME) threshold has been reduced from 120mg to 90mg/day, with an ideal target of 50mg/day. These are more clearly designated as guidance and exceptions may be clinically appropriate
- This change is based on new evidence highlighting increased harm at higher doses without proportional benefit

Updated Literature and Reference

- All references and external links have been reviewed and updated

Safeguarding

- A new section addresses safeguarding considerations when prescribing strong opioids, especially in vulnerable populations.

Opioid Statistics

- Outdated statistics, particularly those not relevant to prescribed opioids, have been removed to improve clarity and relevance.

Terminology

- Clarity on the use of terminologies when describing opioids

Updated patient information section

- Updates to content, language and format
- Updated patient information leaflets

Opioids Aware is a living resource with ongoing updates as new evidence arises. It will be a part of the Professional Standards Committee workstream: Opioids Aware | Faculty of Pain Medicine

MedSIP update on safer opioid use for chronic pain

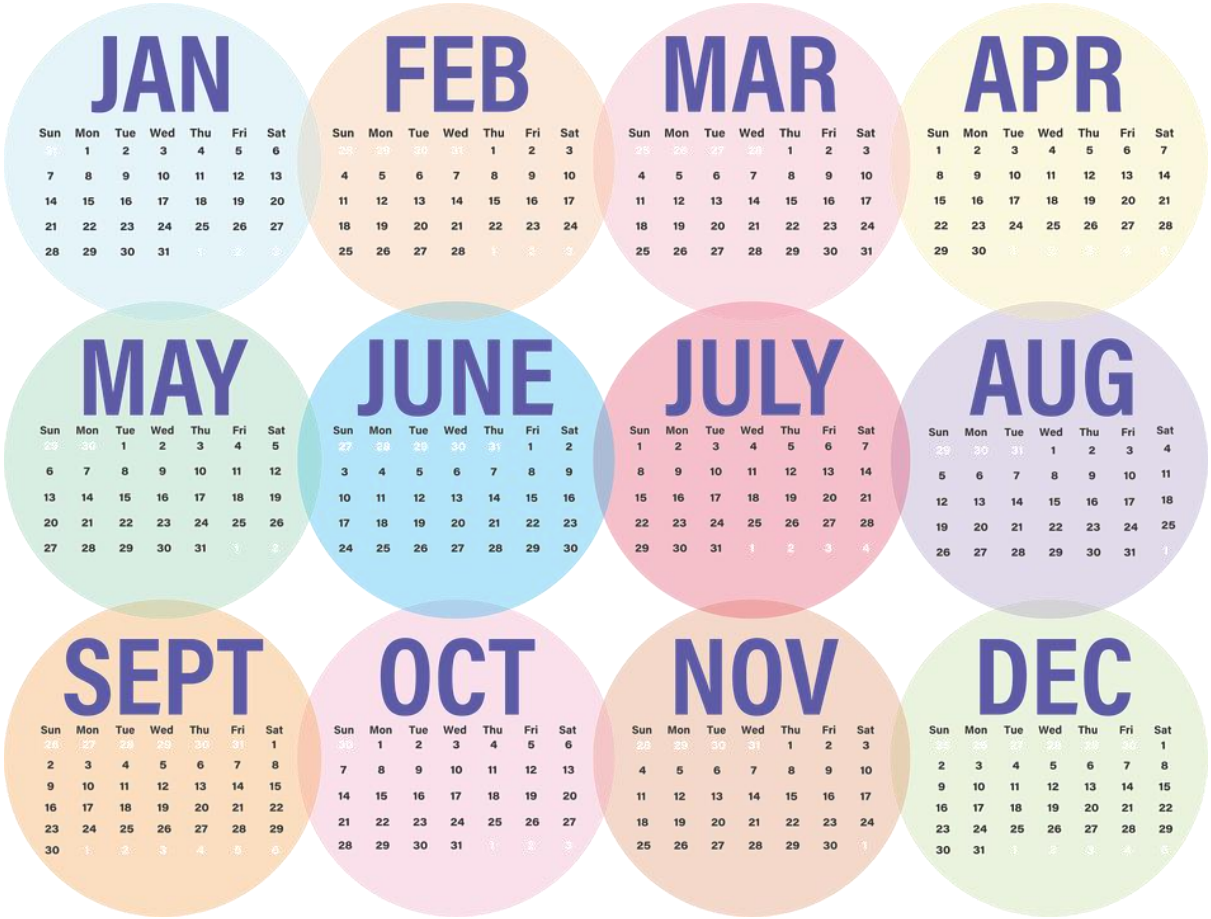
The work of the National Medicines Safety Improvement programme to support safer chronic pain management and reduce high-risk opioid prescribing across England has been published.

The study describes the national improvement initiative across England that used a “7-phase whole system approach” to improve chronic pain management and reduce high-risk opioid prescribing across integrated care systems (ICSs). The approach brought together stakeholders across primary care, secondary care and community services to coordinate system-wide change, supported by data, shared learning and improvement coaching. The initiative achieved measurable outcomes, including a 5.1% reduction in chronic opioid prescribing and a 20.3% reduction in high-dose opioid prescribing, alongside increased access to biopsychosocial support and self-management for patients. Successful ICSs showed more sustained improvement, highlighting the importance of system leadership, collaboration, and continuous improvement processes. The study concludes that a structured whole-system framework can deliver meaningful and sustained reductions in medication-related harm for complex issues such as opioid use. The programme formed part of the improvement aim of the National Patient Safety Strategy delivered in partnership with the Patient Safety Collaboratives within the Health Innovation Network and demonstrates how national coordination can enable locally led change at scale.

Resources:

- The UCLPartners opioid resources can be found here: National Medicines Safety Improvement Programme - UCLPartners
- The ICHP opioid resources can be found here: opioids programme resources
- The South London opioid resources can be found here: opioids - Health Innovation Network

Bank Holiday resources to support community pharmacy teams with Opioid Treatment Programmes



The Community Pharmacy Patient Safety Group (CPPSG) has released two resources aimed at supporting community pharmacy teams with Opioid Treatment Programmes:

- "Focus on Methadone", video resource: designed for community pharmacy professionals, the video provides practical hints and tips to support the safe supply of methadone through an opioid treatment programme, reinforcing best practice standards across the sector

- Bank Holiday checklist, to aid pharmacy teams delivering opioid treatment programmes before, during and after Bank Holidays

The checklist and video are now available, along with CPPSG's other patient safety resources **via the CPPSG Resource Hub.**

Controlled drugs - some commonly occurring errors

Pregabalin/Gabapentin LASA Error

One incident commonly reported to us is the Pregabalin/Gabapentin Look Alike Sound Alike (LASA) error where gabapentin is supplied instead of pregabalin or vice versa. These errors have the potential to cause patient harm as there is a significant difference in the potency between the two medications. The Community Pharmacy Patient Safety Group has issued some guidance around Look Alike Sound Alike Drugs which may be useful: Look-Alike Sound-Alike medicines – Community Pharmacy Patient Safety Group

A further commonly reported incident relates to the incorrect strength of pregabalin being dispensed. We are aware of some reported cases where a patient has inadvertently taken a higher strength than prescribed for a prolonged period, resulting in patient harm due to increased CNS side effects. Please be vigilant to mitigate against mis-selection.

Buprenorphine / Espranor mix up

We have also been made aware of reports of the incorrect selection of buprenorphine preparations between the oral lyophilisate (Espranor) and the sublingual tablet. The two formulations are different; Espranor is a freeze-dried wafer (oral lyophilisate) and has been formulated to disintegrate quickly when placed on the tongue whereas the generic sublingual tablet is intended to be placed under the tongue. Please note that the two preparations are not interchangeable - the initial dissolution of Espranor is higher than that for the generic sublingual tablet and it is therefore absorbed more quickly.

Oral syringes

We would like to remind pharmacy colleagues about the need to supply appropriate measuring devices when dispensing liquid medicines to support patient care. We are aware of controlled drug incidents involving accidental overdoses of oxycodone hydrochloride liquid where the dosing instructions on the pharmacy labels of the medication were misinterpreted by the patient or their carer. In addition, patients had not been supplied with the correct sized syringe for the prescribed dosage by the supplying pharmacy. These incidents have raised awareness that manufacturers will often supply measuring cups within their packaging which may be inappropriate for the dose being prescribed for some prescriptions e.g. some manufacturers supply medicine measuring cups with a starting dose of 5ml with 5ml graduations which are not suitable for measuring prescribed doses of less than 5ml. Please ensure that patients/carers are counselled on the dose and frequency and provided with an appropriate measuring device/oral syringe for the dose being prescribed.

Improving information supplied with gabapentinoids (Pregabalin/Gabapentin), benzodiazepines and z-drugs

The MHRA has reviewed the warnings regarding addiction, dependence, withdrawal, and tolerance for gabapentin, pregabalin, benzodiazepines, and z-drugs. Improving Information Supplied with Gabapentinoids (Pregabalin/Gabapentin), Benzodiazepines and Z-Drugs - GOV.UK

The findings (detailed in the Public Assessment Report) were that it was necessary to strengthen these warnings in the product information and on packaging to better inform healthcare professionals and patients of these known risks.

Advice for Healthcare Professionals:

- gabapentinoids (pregabalin and gabapentin), benzodiazepines and z-drugs are three classes of medicines used to treat a variety of conditions such as neuropathic pain, anxiety and insomnia. Specialist use of these medications for conditions such as epilepsy, or sedation during medical procedures are not included in this review
- all three classes of medications are known to pose risks of addiction, dependency, withdrawal and tolerance
- the Summary of Product Characteristics, Patient Information Leaflets and Outer Packaging of these medicines will have strengthened warnings to better communicate the risks of addiction, dependency, withdrawal and tolerance to healthcare professionals and patients. Updates are in progress and will be rolled out over the coming months
- prior to starting treatment with these medicines, a discussion should be held with patients to put in place a strategy for reducing or ending treatment. By doing this the risk of addiction, dependence, and drug withdrawal syndrome is reduced. NICE guideline, NG215, has resources that include visual summaries which are available to support these discussions. The Agency has also developed additional patient resources for benzodiazepines, gabapentinoids and z-drugs which highlight key messages concerning these risks and should be made available to patients when these medications are prescribed
- addiction and dependence are related but have distinct presentations. Healthcare professionals are reminded of the importance of using non-judgmental language when discussing these terms
- patients may find that treatment is less effective with chronic use and express a need to increase the dose to obtain the same level of symptom control as initially experienced. This could be a sign that the patient is developing tolerance. The risks of developing tolerance should be explained to the patient

- drug withdrawal syndrome may occur upon abrupt cessation of therapy or dose reduction. When a patient no longer requires therapy, it is advisable to taper the dose gradually to reduce symptoms of withdrawal. Tapering from a high dose may take weeks or months. Patients should be informed of this when the medication is first prescribed and should be encouraged to speak to their healthcare professional or prescriber before stopping their medicine. See NICE guideline NG 215 for identifying and managing withdrawal symptoms
- provide regular support especially to individuals at increased risk of drug withdrawal syndrome, such as those with current or past history of substance use disorder (including alcohol misuse) or mental health disorder
- addiction, dependence, withdrawal or tolerance in response to these medications can be reported via the Yellow Card scheme

Advice for Healthcare Professionals to provide to patients:

- as these medicines carry risks of addiction, dependence and withdrawal reactions, before starting treatment with these medicines, you should explain to your patient how long they might need to take them for, and how to stop safely. This helps reduce the risk of addiction, dependence, and drug withdrawal syndrome
- you should explain that anyone can become physically dependent on these medicines, meaning that their body gets used to it, and this can cause them to have withdrawal symptoms if the medicine is suddenly stopped, or the dose is reduced
- drug addiction can feel like a strong desire to take the medicine, and difficulties in controlling medicine use (for example feeling like they want to take more or use the medicine when they shouldn't)
- addiction and dependence are related but they are not the same, being physically dependent on a medicine does not necessarily mean they are addicted to it
- drug tolerance can mean no longer feeling like the medicine is working well, or feeling that a higher dose is required to achieve the same symptom relief as before
- if they want to stop taking their medicine there are additional resources to help them.They should be advised to not stop taking their medication without asking a healthcare professional first
- if they are taking this medicine for epilepsy, they should keep taking it for as long as their doctor says it's needed
- if they find that their treatment is not working as well, they should speak to their healthcare professional about possible alternative treatment options, and they should never take more of their medicine than has been prescribed for them

- when it is time to stop their medication, you should explain how they will gradually reduce the amount of medicine they are taking over time (known as dose tapering). This is very important to reduce the risk of drug withdrawal syndrome. Dose tapering can sometimes take weeks or months. Mild symptoms may still occur, but they should contact their healthcare professional if the withdrawal symptoms become intolerable

Labelling of paediatric medicines

Please note Medicines, Ethics and Practice (MEP) now has the pharmacy labelling of liquid meds in **MLS** only. This follows on from a position statement from the Neonatal and Paediatrics Pharmacy Group (NPPG), Labelling of Dispensed Oral Medicines for Children position statement - NPPG

Labelling of Dispensed Oral Medicines for Children position statement:

The NPPG Executive Committee are pleased to publish Version 2 of our position statement *Labelling of Dispensed Oral Medicines for Children,* which supersedes Version 1 published in June 2025. The publication of Version 1 generated considerable discussion on this important topic, and NPPG are grateful for feedback received from stakeholders across primary and secondary care.

The updates can be summarised as follows:

- The recommendation to express the dose for oral liquid medicines in terms of millilitres (mL) only is unchanged. However, a note has been added to state that the dose can be expressed in terms of “spoonfuls”, provided that the volume of the spoonful is also specified on the label e.g. “....5mL spoonful”.
- A statement has been added to confirm that expressing the dose to be given as a number of drops is acceptable where the product is designed to be used in this way.

- In light of implementation challenges, the specific recommendations on labelling oral solid dosage forms (tablets/capsules) have been withdrawn. Standardisation of solid dosage forms remains a patient-safety priority given the variation observed across hospital and community practice 1,2**.** While the available evidence indicates a user preference for numerical formats, revised guidance will be developed through a collective, consultative process involving all relevant stakeholders.

NPPG's recommendations on labelling oral liquid medicines are now included in RPS *Medicines Ethics and Practice*.

References

- Latheef F, Rashed A, Wignell A, et al – SP3 An exploratory study to characterise dosing instructions on dispensed paediatric medicines labels: BMJ Paediatrics Open 2024;8. https://doi.org/10.1136/bmjpo-2024-NPPG.3 .
- Rashed AN, Ang I, Wignell A, et al. Dosage instructions on community-dispensed paediatric medicine labels: a cross-sectional study. Drugs Ther Perspect (2025). https://doi.org/10.1007/s40267-025-01163-3

Fraudulent prescriptions and how to report a crime

We continue to receive incident reports of fraudulent prescriptions being presented at community pharmacies across London and we are grateful for your continued vigilance.

Our Controlled Drug Liaison officers have asked us to remind you that any encounters where an individual provides false details in order to obtain CDs should be reported to the borough police via 101 or on-line as fraud and a crime reference number obtained.

They have advised that when filing your report to the police, information should be provided by the reporter in as much detail as possible. This should include any evidence that has been obtained that supports the allegation and any context or relevant background information they are aware of. This might include awareness of what the individual does, how they do it and any aliases.

Key information to include in the report includes:

- Date, Time and Place

- Individual's name if known
- Description of individual
- Is the individual still on site
- How was the individual identified
- Is there CCTV available of the individual or incident
- The controlled drug(s) concerned and whether or not it has been supplied
- Witnesses details

Prescriber Identification Numbers (PINs)

In order to prescribe (or requisition) Schedule 2 and/or 3 controlled drugs privately, a prescriber (or requisitioner) must first obtain a Prescriber Identification Number (PIN).

The application process to obtain a PIN in the London region has recently been updated, and prescribers (or requisitioners) are now required to apply using the link below:

Application for a Controlled Drugs (CD) Prescriber Identification Number (PIN) – Fill in form

Please note that previous versions of the application form or applications sent via email attachments will NOT be accepted, you must complete the form in the link above in order for your application to be reviewed and processed.

Please allow 20 working days from the date of submitting a correctly completed application for your application to be processed. Please ensure you read the online form in its entirety, including the notes, before you complete it.

Applications that have not been completed fully or correctly will not be processed and you will be advised on next steps.

A new national mailbox is now in use: Please direct any further queries to england.cdpins@nhs.net

CQC CDAO Register notifications - a reminder!

A reminder to all controlled drug designated bodies to please ensure that you notify CQC when your Controlled Drug Accountable Officer (CDAO) changes or is away for a period of six weeks or more and a temporary replacement is appointed Controlled drug accountable officers - Care Quality Commission

To add, we update our circulation lists based on the CQC CDAO Register updates so if you do not notify CQC of changes to your CDAO, you may also miss communications from the NHSE London CDAO team.

Useful links

Using transdermal patches safely in healthcare settings

This series of three web pages provides practical guidance for safe application, monitoring, removal, disposal, documentation and storage of transdermal patches to reduce risk of medication errors.

Further Information

Source: Specialist Pharmacy Service

Revised SPCs: Lyrica (pregabalin) preparations

SPC updated to note a discussion should be held with the patient prior to starting treatment, to put in place a strategy for ending treatment, to minimise the risk of dependence, addiction and drug withdrawal syndrome. Treatment should be given for the shorted possible duration.

Further Information

Safety and effectiveness of strategies to deprescribe chronic benzodiazepine receptor agonist use in older adults: a systematic review

Review (30 studies; n~11,000) found benzodiazepine deprescribing strategies were generally safe, with generally mild and transient withdrawal symptoms. Structured gradual tapering strategies achieved highest discontinuation rates; other approaches had more variable success.

UK Border operation seizes illicit medicines with an estimated value of £4.6 million

Over 2 million doses of illicit medicines have been seized in a 14-day operation in the UK as part of the world's largest coordinated initiative aimed at tackling the illegal medicines trade; over half of the medicines were controlled drugs, with the remainder classified as POMs.

Source: Medicines and Healthcare products Regulatory Agency

Gabapentinoids found to increase risk of drug toxicity

Researchers found that patients taking gabapentinoids with benzodiazepines were at double the risk of being hospitalised with drug poisoning, while combining the drug with opioids has a 30% increase in risk.

Source: The Pharmaceutical Journal

Ketamine: an updated review of use and harms - GOV.UK

Following a 2025 government commission, the Advisory Council on the Misuse of Drugs (ACMD) has carried out a review of the use and harms of ketamine.

Use of injectable medicines for multiple doses

This web page looks at the use of injectable medicines for multiple doses, discusses how this can increase the risk of contamination, error, patient harm and identifies the governance processes that should be in place to minimise this risk where multiple use is unavoidable

Source: Specialist Pharmacy Service

Updated guidance: Warning statements for labels and leaflets of certain medicines

This guidance sets out the warning statements which should appear on the label and/or in the leaflet of certain medicines, updated to include additional warning statements for inclusion on the label and/or in the leaflet of certain medicines.

Source: Medicines and Healthcare products Regulatory Agency

Wishing you a lovely summer!

The London CDAO Team