NHS England
East of England

Controlled Drugs Newsletter

Month/Year: April 2026
Issue No. 35

Supporting safe use and handling of controlled drugs

INSIDE

NHS England, East of England CD team

Email: england.ea-cdao@nhs.net

Jane Newman
Controlled Drugs Accountable Officer

Update – fake private prescriptions for codeine linctus

In January we circulated an urgent briefing regarding fraudulent prescriptions for codeine linctus that have been presented at pharmacies across England, believed to be the work of an organised crime group (OCG).

We have not received reports of any new forgeries in the past month and would like to thank pharmacies for their vigilance in identifying them.

Please continue to take the following action:

• Remain vigilant and check prescriptions carefully

• If you suspect a prescription is fraudulent, do not dispense and report immediately to your CDLO / local police as per standard procedures

• Report suspected fraudulent prescriptions via the www.cdreporting.co.uk website, including those you may have already dispensed

Updates from other organisations:

Briefing 002/26: **Pharmacy First – Urgent supply of medicines** and appliances

Community Pharmacy England have published a briefing providing information on the Urgent supply of medicines and appliances strand of the Pharmacy First service.

-

Safety concerns reported by coroners following fentanyl patch fatalities in England, Wales and Northern Ireland between 1997 and 2024 - Mshari - British Journal of Clinical Pharmacology - Wiley Online Library

The BJCP have published a study identifying safety concerns reported by coroners following fentanyl patch-related deaths concluding "Safety events, including poor adherence, usage and administration errors of fentanyl patches, were repeatedly identified".

Fentanyl patches – Soya/peanut oil allergies

Our colleagues in the South East regional CDAO team highlighted in their recent CD Local Intelligence Network meetings that some brands of fentanyl patches contained soya / peanut oil therefore making them unsuitable for those patients with allergies.

Please see the following information the South East shared in their newsletter –

Soya oil (arachis oil is peanut oil, a type of groundnut oil, which is related to soya bean oil) is used as an excipient (inactive ingredient) in fentanyl transdermal patches. For patients with a known allergy to peanuts or soy, it is crucial to check the specific product's information leaflet before use. Different brands of fentanyl patches may use different excipients (fillers/inactive ingredients) and are not always interchangeable, which is why they should be prescribed by brand name.

Brands known to contain soya oil:

• Fencino transdermal patches

• Fenylat transdermal patches

• Yemex transdermal patches

Applying to be a Temporary Authorised Witness in community pharmacy

If you have stock schedule 2 CDs which require destruction in a community pharmacy, please visit www.cdreporting.co.uk and complete the form "Apply to be a Temporary Authorised Witness".

We would like to issue a reminder that **if authorised to be a Temporary Authorised Witness (TAW):**

- You must not destroy any CDs yourself
- **You must remain present for the duration of the destruction**

Unfortunately, we are aware of an incident where an individual that was subsequently arrested having been suspected of diverting CDs was left to act as both the TAW AND person destroying the CDs, which would have presented an opportunity for further diversion of CDs.

Ketamine: an updated review of use and harms

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.

For more information, please see Ketamine: an updated review of use and harms - GOV.UK

Useful Websites

CD Reporting
www.cdreporting.co.uk

Home Office
https://www.gov.uk/government/organisations/home-office

Department of Health
https://www.gov.uk/government/organisations/department-of-health

General Pharmaceutical Council
www.pharmacyregulation.org

Care Quality Commission
http://www.cqc.org.uk/

NHS Prescription Services CD section
https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/prescribing-and-dispensing/safer-management

Community Pharmacy England
Dispensing & Supply - Community Pharmacy England (cpe.org.uk)

Case Study

A patient attended a pharmacy to request emergency hormonal contraception (EHC). Instead, the patient received a dose of methadone (30mls) in error due to patient mix-up in the pharmacy; another patient was waiting for their supervised dose of methadone. The lady commented that the medication looked different but was advised by the pharmacist that medicines change all the time and she therefore took the dose.

The error was then identified and the patient informed. She was initially advised to wait for 20 minutes and then, if she felt ok, she could drive home. Another pharmacist colleague intervened and liaised with the patient to ensure she was transferred to hospital for medical assessment. She received treatment, including activated charcoal, to counteract the methadone and was observed until the early hours of the morning before being discharged home.

What went wrong?

- The pharmacist did not follow procedure.
    - The identity of the patient was not confirmed. Even when the patient said the medication did not look the same as usual, the pharmacist did not carry out any further checks despite this extra clue that something was wrong.
        - For all medicines, always confirm the identity of the patient by asking for their name/address/DOB
    - Controlled drugs require additional checks
        - It is a legal requirement for pharmacists to determine whether the person collecting a schedule 2 controlled drug is the patient, their representative or a healthcare professional.
        - If the person collecting is the patient or their representative it is best practice to ask for proof of identity unless that person is known to the pharmacist.
- The initial advice to wait in the pharmacy for 20 minutes observation was inappropriate due to
    - the potential for serious harm
        - The toxic dose of methadone according to TOXBASE is 0.4mg/kg
        - The estimated lethal dose of methadone in opiate naïve adults has been cited as 30-50mg
    - the long half-life of methadone (20-37 hours).
        - Asymptomatic patients who are not daily opioid users should be referred for medical assessment if they have ingested a toxic dose; they require monitoring in hospital for at least 12 hours after ingestion.

What went well?

- Duty of candour was exercised – the patient was informed of the error.
- On recognition of the error, other colleagues intervened to ensure the patient
    - was reviewed in hospital.
    - still received the EHC as requested.

Reminders for good practice

The next in a series of reminders for good practice that we will be sharing – taken from incidents that have been reported to NHS England – focusses on **dispensing and supply:**

- Remain vigilant in undertaking due diligence checks for presentations of potential/suspected fraudulent prescriptions
- CDs have the potential to be diverted to the illicit market. When a patient presents a CD prescription for an acute condition more than two or three weeks after the prescriptions was issued, it would be prudent to check with the patient and/or the prescriber that the supply of the CD is still warranted before dispensing
- When splitting a pack - the original pack should be kept alongside for accuracy checking, enabling cross referencing of the strength, brand and expiry date of the medication
- Part packed boxes should also have the box contents accuracy checked to ensure the correct medication is being supplied
- It is advisable to ensure more than one person is involved in the dispensing and checking of CD prescriptions to help prevent errors
- Be aware of LASA (Look Alike, Sound Alike) medications, e.g., pregabalin and gabapentin, and ensure appropriate mitigations are in place to prevent errors
- Ensure caution when checking; check the item against the prescription and not the label
- Staff should remain vigilant when using scanning technology, particularly when using override functions, as errors can still occur
- With Opioid Substitution Therapy (OST) patients, *"It is also good practice for pharmacists to alert the prescriber whenever there are significant concerns: such as when consecutive daily doses of OST have been missed, following repeated missed pick-up of single days (or even one missed day for certain patients) and when the pharmacist has any concerns regarding the patient's presentation (such as intoxication or apparent significant deterioration in health and wellbeing)".* (Dispensing Controlled Drugs - Community Pharmacy England)
- When handing out medication, remember to check if there are multiple bags e.g., in the CD cupboard or fridge
- Confirm patient details when handing out and offer counselling about the medication to the collector, as appropriate
- For schedule 2 CDs, legislation states that the pharmacist must establish if the person collecting is the patient, the patient's representative or a health care professional acting in his professional capacity on behalf of the patient. This information must be recorded in the CD register
- Confirm proof of identity where appropriate i.e., the person is not known to you and/or if they are a healthcare professional acting in their professional capacity
- It is good practice to obtain a signature on the back of the prescription form or EPS dispensing token for schedule 2 and 3 CDs
- When dispensing always use the PMR and CD register to check the patient, or their representative, is not collecting their CD prescriptions more frequently than they should
- CDs are high risk drugs, always check that the strength and dose is clinically appropriate for the patient

---

How to contact the East of England Controlled Drugs Team

East of England CD team primary contact is **england.ea-cdao@nhs.net**

This inbox is continuously monitored during normal working hours. If you need to speak to someone urgently, please email us requesting a call back with your phone number included.

To report a CD incident or concern, request an Authorised Witness or apply to be an Authorised Witness, please go to: **www.cdreporting.co.uk**