The safer management of controlled drugs: Annual update 2024

Introduction

CQC is responsible for making sure that health and care service providers, and other regulators, maintain a safe environment for the management and use of controlled drugs in England.

We do this under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

The responsibilities under these regulations include reporting every year about what we find through our oversight. This information, together with our regulatory activities under the Health and Social Care Act 2008, helps us to make recommendations to ensure the arrangements for managing controlled drugs safely in England continue to be effective.

The information in this report is important for:

- organisations that manage controlled drugs
- all senior and executive officers and board members of organisations that handle or have an interest or remit in controlled drugs

- all controlled drugs accountable officers (CDAOs) in England and their support teams
- other health and care professionals with an interest or remit in controlled drugs
- commissioners of health and care services
- professional healthcare and regulatory bodies
- police controlled drugs liaison officers.

Data in this annual update relates to the calendar year 2024, but we also include relevant information for the first part of 2025.

Our oversight activity in 2024

Register of controlled drugs accountable officers

Where relevant, the 2013 Regulations (as amended) require organisations that are registered with us to have a controlled drugs accountable officer (CDAO). These organisations are defined as 'designated bodies' under the regulations and are required to notify CQC of their CDAO appointment. We publish an online register of controlled drugs accountable officers (CDAOs) across England, which we update monthly.

At the end of 2024, there were approximately 1,000 CDAOs listed. We approved 16 requests to be exempt from the requirement during the year.

We remind all designated bodies that it is a legal requirement to tell us about any changes to the contact details for your CDAO so they are up-to-date on our published register. Designated bodies also need to notify us where a temporary CDAO is going to be in post for longer than 6 weeks. See more information for CDAOs

NHS England regional teams and controlled drug local intelligence networks

Under the 2013 controlled drugs regulations, NHS England controlled drugs accountable officers (CDAOs) are the assigned lead for establishing local intelligence networks (LINs) in their geographical areas in England.

NHS England's National Medical Director is the Senior Responsible Officer for the CDAO function. In 2024, NHS England CDAOs worked effectively and collaboratively. They held regular national and local meetings for members of local intelligence networks.

Led by NHS England CDAOs, each network held at least 2 online meetings in the year. Several regions also held in-person or hybrid meetings. As well as sharing details about controlled drugs incidents, most LIN meetings also discuss how the learning can help to improve local management of controlled drugs.

NHS England CDAOs provide a regular reminder to attendees at local intelligence network meetings about the importance of sharing information of concern. This enables members to connect key pieces of intelligence to identify issues at the earliest stage. They explain what information can be shared appropriately, and within data protection legislation, where it relates to concerns over individual people or services.

Other initiatives from NHS England CDAOs included 2 national learning events for all local intelligence network members across the country. Regional CDAO teams also produced newsletters to share information and maintain contact with LIN members between the network meetings.

Key issues discussed at local intelligence network meetings

- Lack of governance processes, although more organisations reported that they are now carrying out regular audit and monitoring checks.

- Increasingly complex commissioning of services, and the need to ensure that all organisations involved consider controlled drugs appropriately.
- The challenge of ensuring adequate controlled drugs governance in relation to paramedics and independent ambulance services.
- Home Office controlled drugs licences, including those that have lapsed, or need to be progressed.
- Prescribing of cannabis-based products for medicinal use (CBPMs), support for people who have been prescribed CBPMs, and the governance arrangements needed.
- Diversion of controlled drugs:
    - by health and care professionals and support staff
    - in the lower schedules
    - through using electronic systems to conceal the theft.
- Ongoing fraud with private prescriptions, and as in previous years, often for controlled drugs in lower schedules.
- The increasing use of electronic controlled drugs registers and electronic medicines storage, and the benefits and issues associated with implementing electronic systems.

Artificial intelligence and online LIN meetings

Artificial intelligence (AI) is rapidly becoming part of everyday life, offering many benefits. We're aware that some companies subscribe to AI programmes that are able to record and take minutes in meetings, even when the participant is not attending.

We remind all LIN participants that this software is not suitable for use at LIN meetings. This is because LINs must remain a safe space for participants to speak freely about concerns, incidents and learning from their practice. All NHS England CDAOs provide minutes for each of their LIN meetings for those who cannot attend, or who wish to use the information for future reference.

Controlled drugs reporting tool

The NHS England Controlled drug reporting tool provides a standard platform for regional CDAOs to receive reports of incidents and concerns, and carry out other related functions. It was updated to include a suite of short learning videos on controlled drug governance topics.

Controlled Drugs National Group

CQC leads the Controlled Drugs National Group, which met in March, June and November 2024. Membership comprises government departments, key regulators and agencies with a controlled drugs remit in England, Scotland, Wales, Northern Ireland, Ireland, Isle of Man and the Channel Islands.

A separate summary of activity from the past year shows how member organisations contributed to the overall safer management of controlled drugs. If you would like a copy of this summary, email medicines.enquiries@cqc.org.uk.

Operational sub-group

The operational sub-group to the National Group also met twice in 2024. Membership comprised:

- NHS England lead CDAOs
- specialist pharmacists and medication safety officers
- NHS Business Services Authority

- chief pharmacists
- integrated care system (ICS) prescribing leads
- other government bodies.

Going forward, this group will be re-structured and future meetings based around themed issues and concerns in relation to controlled drugs. We are also keen to include a wider range of organisations from across the NHS and independent sectors, dental and online providers, as well as social care.

If you wish to be involved in this group, or have concerns to propose for discussions, please get in touch at medicines.enquiries@cqc.org.uk

Key issues in 2024

Post Implementation Review of the 2013 Regulations

The Department of Health and Social Care and the Scottish Government conducted a Post-Implementation Review of the 2013 Regulations. A report with the findings of the review will be published on www.legislation.gov.uk. The review reflects on the original policy objectives and whether the regulations are still achieving their intended objectives. The department engaged a range of stakeholders across different sectors to inform the review.

Impact of changes to NHS England

In March 2025, the government announced that NHS England would be re-integrated into the Department of Health and Social Care. This will have an impact on delivering the national controlled drugs accountable officer (CDAO) function and therefore the oversight of governance and safety of controlled drugs across the health and social care landscape.

Currently, each NHS England region has its own CDAO, assisted by a support team. This dedicated role was set out in the 2013 regulations and includes an element of contributing to medication safety more widely than just controlled drugs. There is no similar role elsewhere in the health and care system. Although CDAOs in designated bodies have clear roles and accountabilities in relation to controlled drugs, NHS England regional CDAOs have a crucial role in monitoring, promoting and ensuring their safe use across organisational boundaries, and in sharing learning and intelligence that would not otherwise be available to those with a remit in controlled drugs.

We recognise the value of the role of NHS England CDAOs. We have found they deliver the function and fulfil their duties effectively within the current structure, which comprises both dedicated national co-ordination and regional CDAO leadership. Importantly, this means they support local intelligence networks to function effectively, which is crucial to reducing the risks around the use and management of controlled drugs.

Where CDAO roles are split or shared with other roles, such as in designated bodies, we often see that the lack of time and workload pressures mean that controlled drugs do not always get the appropriate focus needed. This is because in designated bodies, roles such as a chief pharmacist, medical director or chief nurse are often also given the role of CDAO.

In 2006, when the first iteration of the Safer Management and Use regulations were introduced, the national controlled drugs function was spread across primary care trusts. In practical terms this meant that the function was diluted, and it was not as effective in identifying, sharing or acting on incidents or concerns, nor was it as consistent as the current function.

With the impending changes to NHS England, it is important to include the learning from how this crucial function was delivered previously. It is also an opportunity to ensure that teams with the CDAO oversight function have appropriate and consistent resource and capabilities to carry out their statutory functions.

National datasets on controlled drugs prescribing

Controlled drugs prescriptions that are written or produced by prescribers in England may be dispensed in other countries, such as Scotland, Wales and Northern Ireland. This includes private prescriptions. Currently, there is no UK-wide picture of prescribing and dispensing occurring 'across borders'. This gap in data means that it can be difficult to gather a wider view of risk.

It's important that the relevant organisations and bodies work together to enable a better understanding of:

- the different processes for managing prescriptions
- what information is available and can be shared
- how this could help to build a better picture of risk across the UK.

'Corridor care'

We have heard about concerns resulting from a lack of capacity in hospital settings in relation to managing controlled drugs, and people's medicines more generally, when care is being provided in areas outside wards or emergency departments.

Some services have proactively considered how to support staff and patients to manage their medicines in these settings. This is both to ensure they get essential medicines on time, and to minimise any risks around theft and diversion.

Home Office licences

If your service handles stocks of controlled drugs, you might need to have a Home Office controlled drugs licence. The Home Office Drugs and Firearms Licensing Unit (DFLU) issues these licences.

We receive questions from services in relation to controlled drugs licences and have worked with the Home Office Controlled Drugs Licensing Team to produce an information guide on how to apply for a licence.

Important: If you need a licence, you need to apply for one as early as possible. It can take longer than 6 months from the point of application to obtain a licence. Current waiting times can be up to 12 months.

In exceptional circumstances only, you can request your application to be expedited. If you are registered with CQC and you need to use this service, you must ensure you complete this form fully and include any supporting evidence requested, and only submit it once you have applied for a licence.

Legislation update

The Human Medicines Regulations 2012 were amended in December 2024 to improve access to naloxone (a prescription only medicine) for use in life saving emergencies. Naloxone is used in diagnosing and treating acute overdose or intoxication from both natural and synthetic opioids.

Previously, only drug and alcohol services were able to supply naloxone without a prescription. Now the regulations have been expanded to allow more services and healthcare professionals to supply naloxone to take away without prescription.

Services that intend to supply naloxone must ensure that the staff are trained and competent to store and supply it.

The changes to the law mean that people in the following roles and types of services can supply naloxone to someone without a prescription if they have been sufficiently trained in storing and supplying naloxone products:

- anyone employed or engaged in providing drug treatment services
- pharmacists, pharmacy technicians, nurses, midwives, paramedics
- anyone employed or engaged in providing medical services for the armed forces
- police forces in England, Wales, Scotland, and Northern Ireland
- people working in prison services, probation services and youth justice services

More detailed guidance is available on this, including who can supply naloxone and examples of circumstances in which it may be appropriate to do so.

Designated bodies: Board-level oversight of controlled drugs

Last year, we highlighted the importance of having board-level oversight of controlled drugs in designated bodies. To support this, we worked with NHS England Controlled Drugs Accountable Officers to deliver a webinar on considerations and good practice for boards.

Controlled drug self-assessment tool for care homes

We now provide a self-assessment tool for care homes to support staff to safely manage controlled drugs. Staff can download this from our website and use it anonymously, as we do not have access to details of users. We welcome your feedback to help develop and improve the tool. You can email medicines.enquiries@cqc.org.uk with any questions or feedback about the tool.

- Download self-assement tools from our Controlled drug accountable officers page

Destruction of controlled drugs

We are receiving more enquiries about who can be authorised to destroy controlled drugs in services defined as designated bodies under the 2013 Regulations. Specifically, services that also have a Home Office controlled drugs licence have asked whether their CDAO can appoint an authorised witness who is not named on their licence.

Our understanding of the law is that the CDAO can do this. Preventing services from doing this would lead to an accumulation of stocks of controlled drugs awaiting destruction and the associated risks. We have heard specific examples of this issue leading to increased risks of patient harm and diversion in the last year. Any person authorised to witness destruction should have appropriate training and follow appropriate governance arrangements.

Controlled drugs outside the remit of human healthcare

Over the last few years, we have consistently highlighted the importance of ensuring appropriate support for health and care staff. We continue to hear about cases where staff who are under pressure and emotional distress have inappropriate access to controlled drugs. Although our regulatory remit concerns healthcare for people, we have heard about tragic cases where veterinary staff have procured controlled drugs intended for animal use, with fatal consequences.

It is important to highlight that veterinary staff may also require support and may well need this from the health and care system. We highlight this issue in the Controlled Drugs National Group, of which the Veterinary Medicines Directorate is a member.

Prevention of Future Death Reports

In 2022, we highlighted learning about controlled drugs safety in Prevention of Future Death Reports, sometimes called a 'Regulation 28 Report', issued by Coroners. This year, we looked at alcohol, drug and medicines-related reports from January 2023 to December 2024.

The following describes a range of themes that we found, which we are sharing to highlight the risks associated with controlled drugs.

Communication

A recurrent theme is the lack of effective communication between healthcare providers and patients – both within care settings and across boundaries of care. Several deaths have been attributed to not sharing or adequately communicating information in a timely way, such as:

- changes in medicines
- patient histories
- risks associated with specific drugs.

The failure to update and share critical medicines information across care settings is a significant risk to patient safety. Health and care systems need to ensure seamless communication and accurate record-keeping, particularly when managing controlled drugs.

Assuming drug seeking behaviour

Prescribing controlled drugs carries the risk of misuse, which puts healthcare professionals in the difficult position of determining whether a patient's request is genuine. Assuming drug-seeking behaviour without thoroughly reviewing a patient's history has resulted in serious consequences, including:

- inadequate disease management
- delayed treatment
- unnecessary suffering.

We have seen cases where dismissing legitimate medical needs can worsen physical and mental health, potentially leading to self-harm or suicide.

Poor pain management

In some cases, people have died after taking extreme measures to manage their pain, such as doubling their prescribed doses without guidance from a clinician. It is important that people's care is well-structured, regularly reviewed, and includes a pain management plan to prevent unsafe self-medication and reduce the risk of overdose or other severe complications.

Lack of fail-safes in prescribing and dispensing

Numerous cases in Regulation 28 reports involved issues with prescribing and dispensing controlled drugs. For example, duplicate prescriptions or oversupply of medicines went undetected. One patient with a history of opioid misuse was prescribed a controlled drug by their GP. The patient regularly sought additional emergency supplies from various pharmacies and GP surgeries, exploiting the lack of real-time communication and flagging mechanisms.

This allowed the patient to acquire excessive quantities of opioids, contributing to their accidental overdose.

Polypharmacy and inappropriate drug combinations

Prescribing multiple medicines has contributed to several deaths, particularly central nervous system (CNS) depressants for people who were already on opioids.

In one case, a patient was prescribed a combination of benzodiazepines, opioids, and other CNS depressants, leading to respiratory depression and overdose. Despite this combination posing a significant risk, there was no consideration of the potential for dangerous drug interactions, no formal review of the patient's medicines, and the risks of polypharmacy were not communicated to the patient. This lack of proactive monitoring and review contributed to the patient's death.

It is vital to implement regular reviews of medication regimens, particularly for patients on long-term prescriptions or those receiving medicines that are more likely to be misused.

Providers need to establish clear guidelines to manage polypharmacy-related risks.

Deviations from policy and procedure

Many deaths resulted from a failure to adhere to established clinical guidelines and policies that are designed to prevent errors. The improper administration of drugs and the failure to follow proper protocols for monitoring vital signs were contributing factors in several cases. Similarly, there were instances where we identified a lack of clear treatment plans or medicines reviews for vulnerable patients, particularly those with a known history of substance use.

Providers should reinforce the importance of adhering to clinical guidelines, policies, and safety protocols, particularly in the administration of controlled drugs and in the care of groups of people in more vulnerable situations.

Controlled drugs governance and management in non-designated bodies

Designated bodies are required under the 2013 regulations to have a CDAO. However, a wide range of organisations still prescribe and/or handle controlled drugs in their day-to-day work but do not meet the definition of a designated body.

These organisations should ensure they have a nominated person as a lead for controlled drugs, to enable relevant focus on governance and oversight, ultimately helping to ensure safe care for people.

Controlled drugs liaison officers

Last year, we reported concerns on resourcing for the Controlled Drug Liaison Officer Role (CDLO) across the 43 police forces. This situation remains stable with a number of forces having now filled vacancies or having plans to do so, but it needs to be monitored. We are aware that consistency and function of the CDLO role across the country is being examined and discussed nationally.

CDLOs remained concerned regarding the use and endorsement of 'cards', which can suggest that patients are in lawful possession of cannabis-based products for medicinal use (CBPMs) even though they do not have a prescription issued by a specialist doctor. The Association of Police Controlled Drug Liaison Officers (APCDLO) is developing guidance on CBPMs to support police officers and staff, which will hopefully be endorsed by the National Police Chiefs Council.

The APCDLO is also committed to raising its profile within the Police Service and welcomes the support of healthcare partners.

Currently, there is no published cost, or estimation of cost, attributed to the annual diversion of controlled drugs in the UK. In 2013, government statistics showed that organised crime cost the UK £24 billion each year; having better data on controlled drugs diversion would help to ensure national resources are appropriate to the risk.

Statutory notifications

Registered providers must tell CQC about certain safety incidents. The registered person should record the action taken on the relevant notification form. There is no requirement to notify CQC about medicines errors, but you must tell us if a medicines error has caused:

- a death
- an injury
- abuse, or an allegation of abuse
- an incident reported to or investigated by the police.

This includes where any of these have been caused by a controlled drug. We know that these incidents are not always reported to us, and we encourage services to report any instances associated with controlled drugs that meet these thresholds to us as soon as possible.

Cannabis-based products for medicinal use

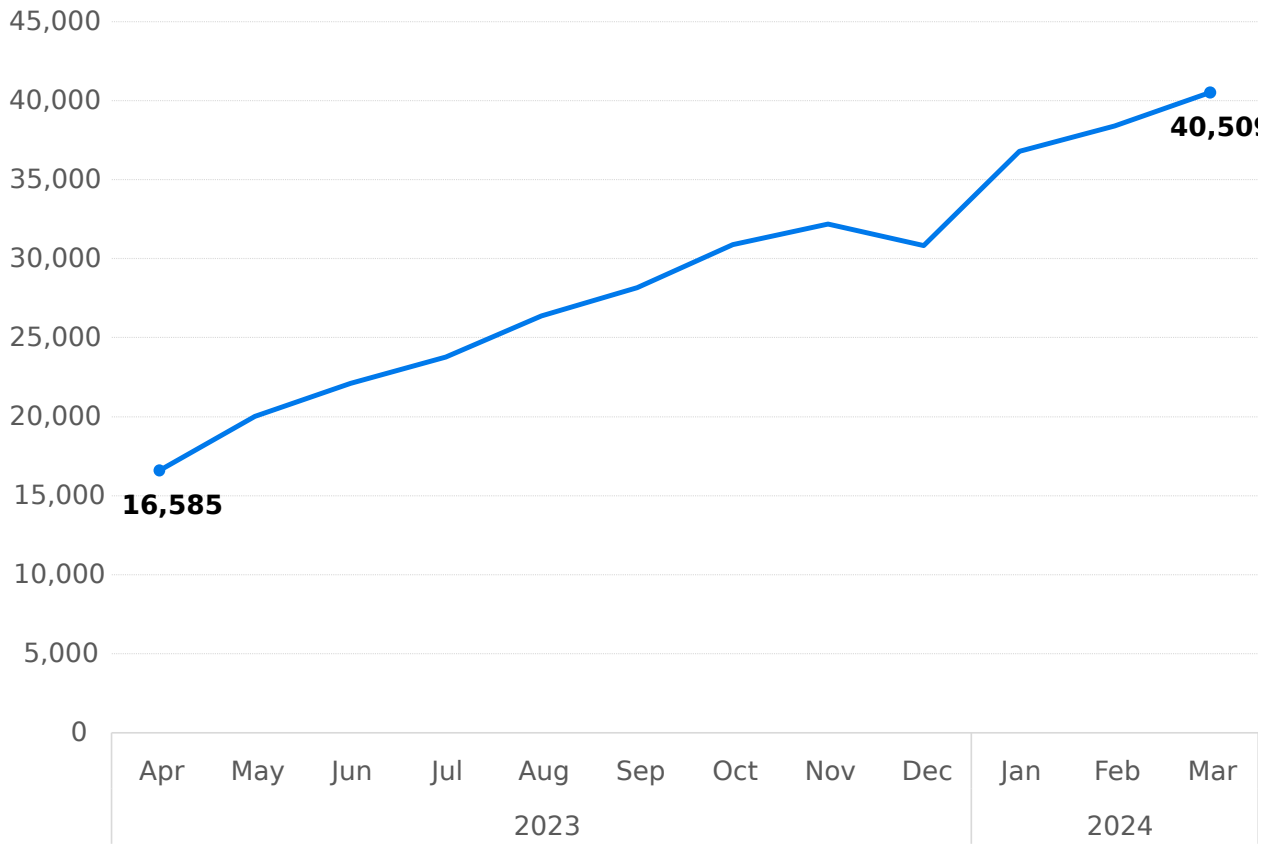
Cannabis-based products for medicinal use (CBPMs) are Schedule 2 controlled drugs under the Misuse of Drugs Regulations 2001. They can be prescribed by, or under the direction of, a doctor who is on the specialist register of the General Medical Council to treat patients on a case-by-case basis for an unmet clinical need.

During 2024, we continued to register clinics in the independent sector that provide treatment with CBPMs. At the time of publishing, 35 providers that prescribe unlicensed CBPMs were registered with CQC.

Over the last year, we have seen instances where providers have not always communicated treatment plans and information on prescribed CBPMs in a timely way with other healthcare professionals involved in a person's care. It is vitally important to share information effectively with people's regular prescribers (normally their GP) to keep them safe. In some cases, this may also include liaising with secondary care and other independent services.

As in previous years, almost all prescribing of CBPMs continues to be in the independent sector (figure 1).

Figure 1: Number of private unlicensed CBPM items prescribed in England, April 2023 to March 2024

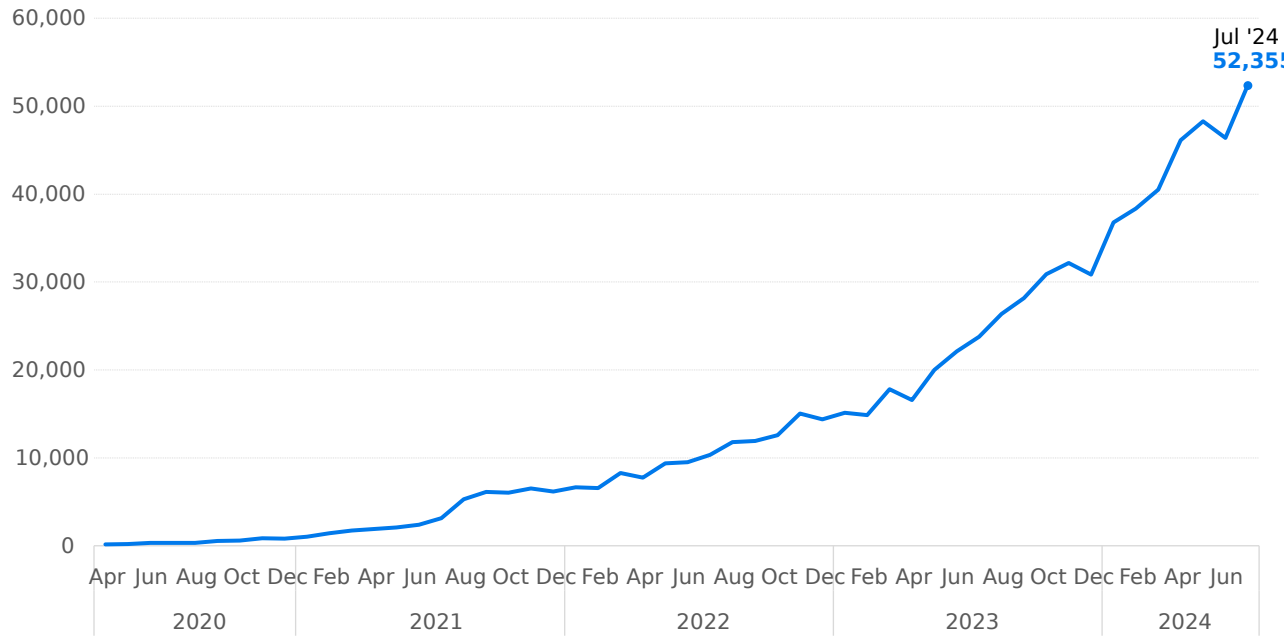


Prescriptions for CBPMs are processed manually because CBPMs are not included in the Dictionary of medicines and devices. This means there is a time lag in the prescribing data available. The most current available prescribing data for unlicensed CBPMs in independent services has shown an increase of 130% between 31 March 2023 and 31 March 2024:

- 1 April 2022 to 31 March 2023: 150,527 items dispensed
- 1 April 2023 to 31 March 2024: 346,600 items dispensed.

Figure 2 also shows the 5-year trend of prescribing, with a steeper increase in the last 3 years.

Figure 2: Number of private unlicensed CBPM items prescribed in England, April 2020 to July 2024



This data relates specifically to prescriptions dispensed in a community setting.

As in previous years, we are not able to publish the data for NHS prescribing of unlicensed CBPMs. This is because the number of items prescribed in the NHS is so small that this could potentially breach patient confidentiality.

Concerns relating to CBPMs

Scope of practice and oversight

The majority of non-medical prescribing for CBPMs is undertaken by pharmacist prescribers. It is important that pharmacists work within their scope of practice, as highlighted in guidance issued by their professional regulator, the General Pharmaceutical Council.

By law, medical specialists must retain oversight of the care of the patient, including prescribing. It is crucial for services that prescribe CBPMs to assure themselves that medical specialists have this oversight in practice and have the time to undertake all duties associated with this.

We remind all providers to advise the relevant NHS England CDAO of any incident or concern that occurs, through the Controlled drug reporting tool.

Unmet clinical need

We continue to hear that services are prescribing for a very wide range of medical conditions – for some of these, there is poor evidence to justify the use of CBPMs. CBPMs must only be prescribed for unmet clinical need. This must be clearly demonstrated before prescribing and recorded in clinical notes.

We note that some services state that to make a patient eligible for CBPMs, they need to have tried 2 previous treatments. It is essential that providers demonstrate unmet clinical need in each person before making the decision to prescribe CBPMs for them. For some people, this may well involve significantly more than 2 previous treatment options.

Peer review of prescribing

During 2024, more smaller providers were interested in prescribing CBPMs. But in some cases, we found that the multi-disciplinary team of GMC registered specialists did not have an appropriate range of specialisms to do this. The general purpose of the multi-disciplinary team is to peer-review and ratify prescribing decisions. It is essential that the team comprises the right specialists to ensure that prescribing decisions are effectively peer-reviewed. For example, if reviewing a patient case involving complex epilepsy, it would not be appropriate for a gastroenterologist with no experience in this clinical area to carry out the peer review.

Providers must notify CQC of certain medicines errors. However, through our inspection activity, we found several examples where this had not happened in cases involving CBPMs.

Advertising

CBPMs prescribed by clinics are unlicensed, prescription-only medicines. This means that providers must operate within the law in any advertising activities. Advertise your medicines guidance from The Medicines and Healthcare Products Regulatory Agency (MHRA) offers useful guidance on this.

If you think a service is inappropriately advertising prescription-only medicines, you can also report this to the appropriate organisation.

Provision of patient information

CDLO colleagues have told us about concerns when clinics do not give patients relevant information about how to prove they are in legal possession of a CBPM. Clinics should offer patients guidance on this when they are prescribed CBPMs. The NHS has published information on this.

Nitazenes and xylazine

Nitazenes

We have previously highlighted the dangers associated with nitazenes, which are synthetic opioids. They remain illicit substances with no clinical value, but colleagues across different sectors report that they are becoming more prevalent, sometimes with tragic consequences for those involved. We are also aware that nitazenes have been detected in some counterfeit medicines.

We therefore reiterate the need to make staff aware of this through the National Patient Safety Alert from the Office for Health Improvement and Disparities. This alert relates to synthetic opioids and the treatment of overdose. It is relevant for organisations whose staff may encounter people who use drugs and those who provide emergency care for opioid overdose, including in health and justice settings.

Xylazine

An amendment to The Misuse of Drugs Act 1971 has classified xylazine as a class C drug. Xylazine is a high-strength sedative used for veterinary purposes. It is increasingly being used illicitly in combination with opioids such as heroin and has also been found in some cannabis vapes.

Drug testing of employees

Drug testing of employees is widely implemented in industries such as transportation and construction due to the significant safety risks involved, aligning with the Transport and Works Act 1992. In contrast, routine drug testing is relatively rare in the healthcare sector in England, as healthcare professionals are not legally mandated to undergo such testing. Typically, healthcare providers do not require routine drug testing for their employees, as they prioritise professionalism, self-regulation, and support and rehabilitation.

Implementing drug testing within health and care settings poses financial and logistical challenges, considering the scale of the workforce. However, individual NHS and private health and care organisations may decide to develop their own policies regarding drug testing as part of employment contracts and workplace regulations.

The approach to drug testing in health and care sectors in England aims to balance patient safety, professional standards, and employment rights. In 2024, there were examples of positive outcomes from drug testing schemes in healthcare settings. These resulted in healthcare staff being able to access support earlier than they otherwise would have, as diversion and addiction was detected sooner. This has also undoubtedly contributed to ensuring that patients have been kept safe.

Individual organisations need to decide whether it is useful and appropriate to introduce drug testing schemes – this is not something that CQC requires. Employers should already ensure they have clear policies on drug and alcohol use in the workplace and provide clear information for staff on how to ask for support or report concerns in relation to these issues.

Further research may be helpful in assessing the potential value of more standardised drug testing policies and the impact on both patient safety and the wellbeing and performance of the healthcare workforce.

Recording medicines in patients' own homes

The use of controlled drugs in patients' own homes presents a unique governance challenge. Care providers need to carry out a risk assessment and give advice on how to store them safely in the home. This is especially important where there may be family members who are more vulnerable, such as children or those with a history of substance misuse. Patients are able to return unused medicines directly to community pharmacies.

There have been instances over the last year of healthcare professionals visiting patients in their own homes but not recording the administration of controlled drugs. This is not limited to one profession and has included GPs, paramedics and nurses. Ensuring that patients' records are accurate is not just crucial for safe and effective care, but it also helps guard against inadvertent losses or intentional diversion of controlled drugs.

Any visiting healthcare professional who administers medicines to a person must record this information in the right place, in a timely way.

Self-prescribing of controlled drugs

Prescribing controlled drugs for personal use or to people who are known personally to the prescriber should not happen apart from in the most exceptional of circumstances.

We therefore remind services and healthcare professionals of the standards and guidance from professional regulators, which make clear that this should not happen.

- General Medical Council

- General Pharmaceutical Council
- Nursing and Midwifery Council
- Health and Care Professions Council

Access to prescribing data for independent services

Data relating to prescribing in the NHS is already available to individuals working in NHS organisations. Independent services have told us that they would like access to prescribing data that relates to activity in their organisation, where it exists. This would allow them to further monitor controlled drugs prescribing in their organisation.

We believe there is a need to review how private prescribing data is captured and shared. Wider access to this data should also be explored to promote greater scrutiny of prescribing in the independent sector.

Fraudulent activity and diversion of controlled drugs

Impersonating healthcare professionals

In 2024, there have been cases of people impersonating a range of healthcare professionals, including pharmacists and doctors. When recruiting, it is imperative that employers are vigilant and check all relevant information to be assured of its legitimacy. Among other areas, this includes a person's professional registration, previous employers and identification documentation. People sometimes use publicly available registers of professionals' names and registration numbers to claim to be legitimate and gain employment.

Equally, employing organisations must have a process to enable staff to report concerns.

Similarly, when employees leave an organisation, it is important to have a robust process to return any security badges, keys and uniforms to minimise the risk of inappropriate access to controlled drugs.

Switched medication

In some examples of attempted diversion, tablet blisters of controlled drugs have been emptied and replaced with another tablet of similar size and shape containing a completely different medicine, which fits back into the blister pack. Liquid medicine preparations have been diverted and been 'topped up' with other liquids so that the volume appears unaltered to avoid detection.

This has helped to conceal the theft of controlled drugs but also puts people at risk of not getting essential medicines that have been prescribed for them, potentially leading to harm. In addition, they could receive a medicine that has not been prescribed, which again could cause harm.

Diversion and electronic systems

Fraudulently producing prescriptions within electronic systems in primary care is still happening. For example, producing a prescription then deleting it, and requesting to 're-print' copies. It is important to ensure controlled and authorised access to electronic systems, as fraudulent activity has not been limited to healthcare professionals, but has extended to support staff, such a prescription clerks working in GP surgeries.

When carrying out audits on electronic systems, staff should be aware of gaps or areas that are more difficult to audit to help identify anomalies or potentially fraudulent activity. This can include paper prescriptions that have been generated and then deleted from a patient's record or inappropriate access to records of deceased patients.

Sharps bins and diversion

We have heard of instances where used sharps bins have been stolen in order to extract any part-used controlled drugs that may have been disposed of in the bin. In some instances, stolen sharps bins were sealed, and others were unsealed, having been partially used.

Organisations that use sharps bins need to make sure they are managed and secured in a timely way.

Repeat prescribing toolkit

NHS England commissioned a repeat prescribing toolkit to be developed to address recommendation 7 of the National Overprescribing Review. This involved collaborative work between the Royal Pharmaceutical Society and Royal College of General Practitioners. The toolkit aims to help GP practices improve the consistency of repeat prescribing processes supported by training resources.

Millions of patients in England receive their medicines through the repeat prescription process. The National Overprescribing Review, combined with patient feedback, indicated that regular reviews for people who take long-term medicines don't always happen in a timely way. We know from our inspection activity and reviewing coroners' reports that this causes harm.

This toolkit is a significant resource as it is the first national good practice guidance on repeat prescribing to be made available in 20 years – and can benefit both patients and services who use it.

Impact of older legislation on patient care and efficient use of resources

Wet signatures

Service providers tell us about the challenges from outdated legislation. For example, there is currently still a requirement for a wet signature when supplying controlled drugs in schedules 2 and 3 for hospitals and for prison services for people being discharged.

In 2023 the Advisory Council on the Misuse of Drugs (ACMD) has recommended that electronic prescribing should be allowed in these settings. However, this has not yet happened. This causes logistical issues, especially for services that operate over large geographical areas. It also leads to instances of delays in supply, and therefore delays to discharge, because of the time and resource required to meet the legislative requirement. Many services have the capability to use secure, auditable systems, with improved safety measures, but are unable to due to legislation. This issue should be prioritised to ensure services are able to operate as safely and effectively as possible, with improved convenience for both patients and staff supporting them.

Good end of life care

In our 2022 report, we talked about the need to ensure good access to medicines at the end of life, and the barriers associated with this. We're still hearing from the care home sector in relation to the drawbacks of not being able to hold a very small stock of controlled drugs for end of life care, without a Home Office licence. This has also been highlighted by the Royal College of Nursing as an issue that needs to be addressed. Requirements in relation to controlled drugs licences are driven by the Misuse of Drugs Regulations 2001.

Some care homes are not aware that they may be exempt from the need for a Home Office licence if their funding comes from at least 50% charity or public fundings. Others are concerned that it can be difficult to assure themselves that they meet this requirement. Where providers don't meet this exemption, they can be concerned about the cost of a licence, especially for holding a very small quantity of stock.

In practice, this means that services may often use other processes and supply routes to help provide access to controlled drugs. These are not failsafe and people aren't always able to access the right medicines on time. They can also represent both an inefficient use of time for health and care professionals and an increased cost, particularly where each person has their own named supply of anticipatory medicines. This may also increase opportunities for diversion.

As we have previously highlighted, good symptom management is a crucial part of end of life care and we know that health and care teams provide excellent work in relation to anticipatory prescribing. Going forward, it is crucial that appropriate government bodies and other national organisations work together to review the impact of current practice on people receiving care, as well as on those supporting them, and how these link to the current requirements of the Misuse of Drugs Regulations 2001.

Good practice and learning

Over the last year, we have heard of a range of good practice initiatives and learning across a range of different settings. The following are some examples.

NHS trust: Controlled drugs oversight group

An NHS trust has taken a comprehensive approach to improving its oversight of controlled drugs and implementing good practice. The pharmacy team established a controlled drugs oversight group, which enabled greater focus on a range of controlled drugs priorities. Key to the success of this initiative was a multi-disciplinary team approach, ensuring that senior leaders from nursing and pharmacy teams collaborated effectively.

This has resulted in:

- more efficient investigation and resolution of controlled drug stock discrepancies
- fewer controlled drug balance discrepancies
- more reporting on incidents, demonstrating increased awareness and vigilance
- improved communication and understanding of controlled drugs across all levels of nursing and pharmacy
- improved physical storage and management of controlled drugs
- increased engagement from all staff on the importance of safe and secure storage of controlled drugs, largely because of the multi-disciplinary team approach.

Other examples of learning and improved practice in services

- Developing 'bite-size training' on controlled drugs to deliver at clinical safety huddles.
- Configuring patient body maps within Electronic Prescribing and Administration (EPMA) systems to enable nurses to record the assessment and administration of transdermal patches. This is especially important as we often hear about errors with controlled drug patches. This service has since seen a significant reduction in patch related errors.
- Organising multi-disciplinary meetings between GP, care home, pharmacy and integrated care board (ICB) medicines teams to streamline processes around requesting and supplying controlled drugs.
- Raising awareness among patients around the dangers of obtaining controlled drugs and other medicines from inappropriate sources.

- Changing how documentation is stored in response to an administration error of controlled drugs for end of life care in a care home. This ensures that staff have everything they need in one place – such as ReSPECT forms, syringe driver prescriptions, syringe driver check lists and the drug balance charts. This is in addition to offering further training for staff on dose calculations.
- Work to avoid unaccounted-for losses in dispensing GP practices when making up multi-compartment compliance aids.

National trends in the prescribing of controlled drugs

Notes on data: Data on prescribing is collected by ePACT2 – an online application that provides authorised users with access to prescription data held by NHS Business Services Authority. For prescribing in the NHS, including hospitals and dental services, we have extracted data from this application for the years 2022, 2023 and 2024 to provide overall figures and trend analysis. For non-medical prescribing, the NHS Community Pharmacist Consultation Service, and requisitions and prescribing in independent primary care, the data for 2024 was supplied directly by NHS Business Services Authority.

In this report, we compare current data for 2024 with the data published in our report for 2023. There may be changes to overall figures for 2023, as ePACT2 may be updated over time.

Prescribing trends in primary care

In this section, we highlight trends of the most prescribed controlled drugs.

Overall prescribing of controlled drugs in 2024 - Schedules 2 to 5

Total controlled drug items prescribed by NHS primary care services increased slightly by 0.4%:

- **74,160,671 items in 2024**
- 73,851,955 items in 2023

The cost of this was £585,671,333 in 2024 compared with £572,621,516 in 2023 (an increase in cost of 2%).

Overall prescribing levels across the different schedules remain stable and prescribing trends in NHS primary care in 2024 are very similar to previous years (figure 3):

- There were increases in prescribing volumes of medicines that are licensed to treat attention deficit hyperactivity disorder (ADHD), such as dexamfetamine, lisdexamfetamine and methylphenidate (figure 7).
- Prescribing of testosterone continued to increase.
- There was also an increase in non-medical prescribing, as prescribing by pharmacists continues to grow and again accounts for over half of non-medical prescribing.
- There was a reduction in prescribing of pholcodine, pethidine, co-proxamol, oxazepam, nitrazepam, fentanyl, diamorphine, zopiclone and zolpidem.

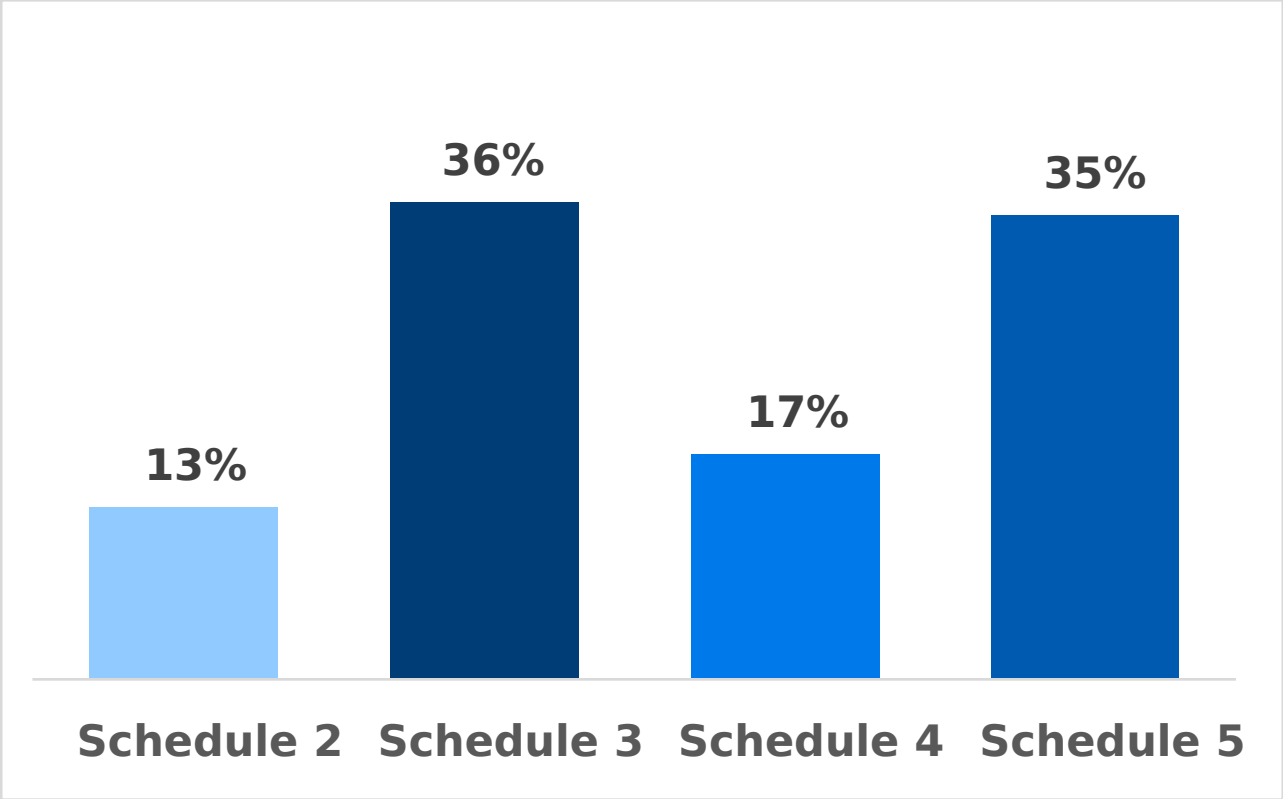
Figure 3: Prescribing of controlled drugs by schedule in 2024

Schedule	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Schedule 2	up by 2%	9,514,472	9,359,728
Schedule 3	up by 2%	26,551,610	26,114,783
Schedule 4	down by 3%	12,450,327	12,845,310
Schedule 5	up by less tha n 0.5%	25,644,262	25,532,134

Of all prescribing of controlled drugs in primary care in 2024:

- **Schedule 2** accounted for 13%
- **Schedule 3** accounted for 36%
- **Schedule 4** accounted for 17%
- **Schedule 5** accounted for 35%

Figure 4: Prescribing of all controlled drugs in primary care, by schedule, 2024



(Totals add up to more than 100% due to rounding)

Patterns of prescribing in NHS primary care

Of the most prescribed controlled drugs in 2024, there was a **reduction in prescribing** for some compared with 2023 (figure 5).

Figure 5: Reductions in prescribing of controlled drugs in 2024

Controlled drug	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Pholcodine (Schedule 5)	down by 9 8%	113	5,744

Controlled drug	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Pethidine (Schedule 2)	down by 25%	1,522	2,035
Diamorphine (Schedule 2)	down by 21%	6,559	8,279
Co-proxamol (Schedule 5)	down by 18%	4,177	5,078
Oxazepam (Schedule 4)	down by 10%	44,042	48,850
Fentanyl (Schedule 2)	down by 9%	681,555	746,034
Zolpidem (Schedule 4)	Down by 7%	579,437	625,656
Co-dydramol (Schedule 5)	down by 6%	1,246,920	1,324,448
Methadone (Schedule 2)	down by 5%	1,629,110	1,711,427
Phenobarbital (Schedule 3)	down by 5%	145,102	153,148

Controlled drug	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Diazepam (Schedule 4)	down by 5%	3,962,912	4,189,217
Zopiclone (Schedule 4)	down by 4%	4,311,158	4,486,295
Dihydrocodeine (Schedule 5)	down by 2%	1,366,965	1,390,035
Temazepam (Schedule 3)	down by 1%	332,834	335,123

Prescribing of pholcodine has continued to reduce following the 2023 safety alert recommending that it should not be used.

At the same time, of the most prescribed controlled drugs in 2024, there was an increase in prescribing for some, compared with 2023 (figure 6).

Figure 6: Increases in prescribing of controlled drugs in 2024

Controlled drug	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Dexamfetamine (Schedule 2)	up by 50%	169,467	113,308
Lisdexamfetamine (Schedule 2)	up by 27%	630,949	498,620
Testosterone (all forms) (Schedule 4)	up by 13%	683,678	606,002
Methylphenidate (Schedule 2)	up by 7%	1,643,120	1,529,638
Pregabalin (Schedule 3)	up by 5%	9,507,036	9,053,894
Buprenorphine (Schedule 3)	up by 4%	3,485,411	3,349,558
Midazolam (Schedule 3)	up by 1%	370,147	365,586

Looking at the proportions of controlled drugs in different schedules prescribed in 2024:

- pregabalin and gabapentin accounted for 64% of all Schedule 3 prescribing

- diazepam and zopiclone accounted for 66% of all Schedule 4 prescribing
- co-codamol accounted for 59% of all Schedule 5 prescribing
- methylphenidate, lisdexamfetamine and dexamfetamine accounted for 26% of all Schedule 2 prescribing
- morphine sulfate accounted for 29%, and oxycodone 20% of all Schedule 2 prescribing

These general trends are similar to previous years.

Figure 7: Total number of items of methylphenidate, lisdexamfetamine and dexamfetamine prescribed in NHS primary care in England, 2020 to 2024

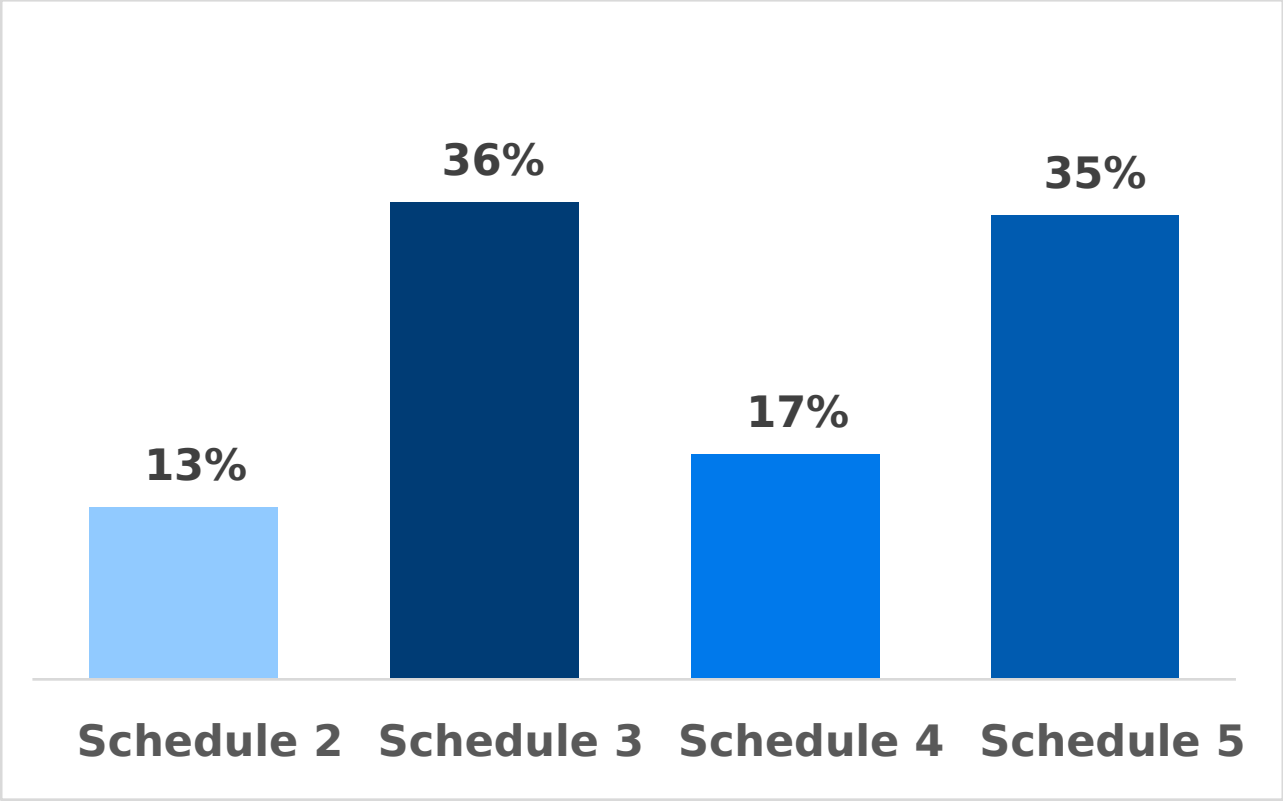


Figure 7 shows the sustained increase in prescribing, which has become more pronounced since 2020. All 3 medicines continue to show relatively sharp upward trends in prescribing compared with many other controlled drugs. We continue to monitor the trends of these in particular because of concerns around capacity in NHS settings, increases in the number and activity of independent clinics (including online clinics) and concerns around shared care, all of which we have highlighted in previous reports.

Adult and child prescribing of medicines for ADHD

This year, we also looked at the trends for prescribing of medicines for ADHD, for both adults and children, since 2015. This includes both prescribing in NHS hospitals and primary care. In general, prescribing for adults has risen steeply since 2019, especially for dexamfetamine and lisdexamfetamine (figures 8 and 9).

Figure 8: Prescribing of medicines for ADHD in adults in NHS hospitals and primary care by number of items, 2015 to 2024

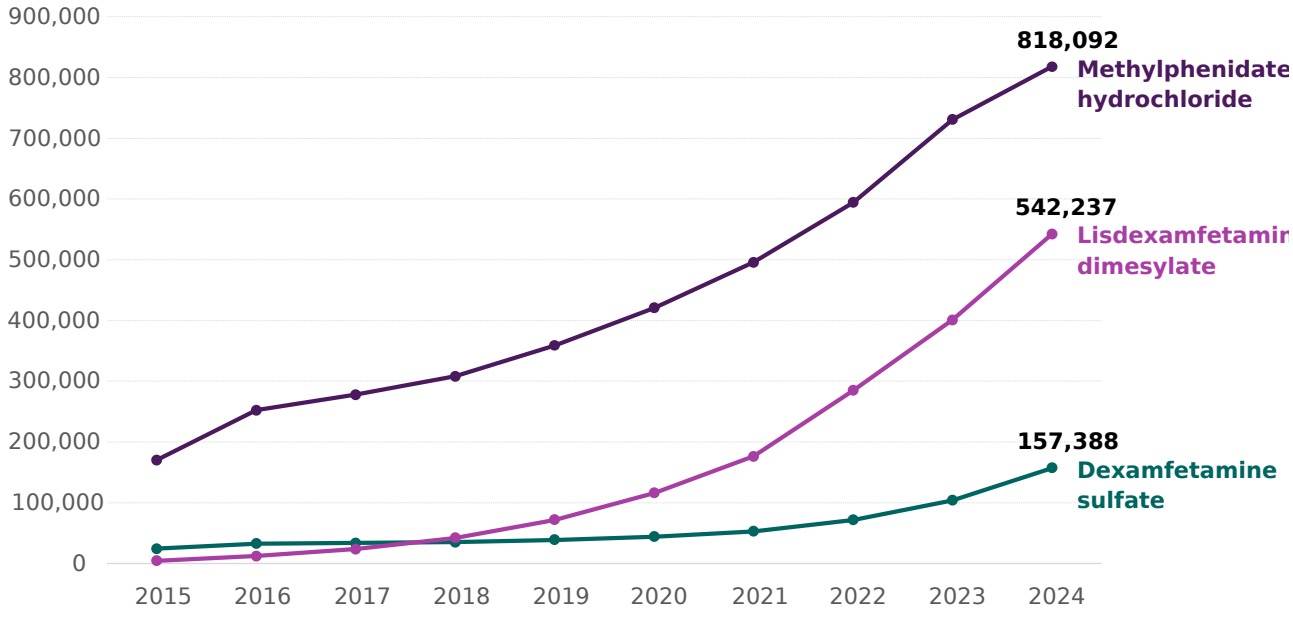
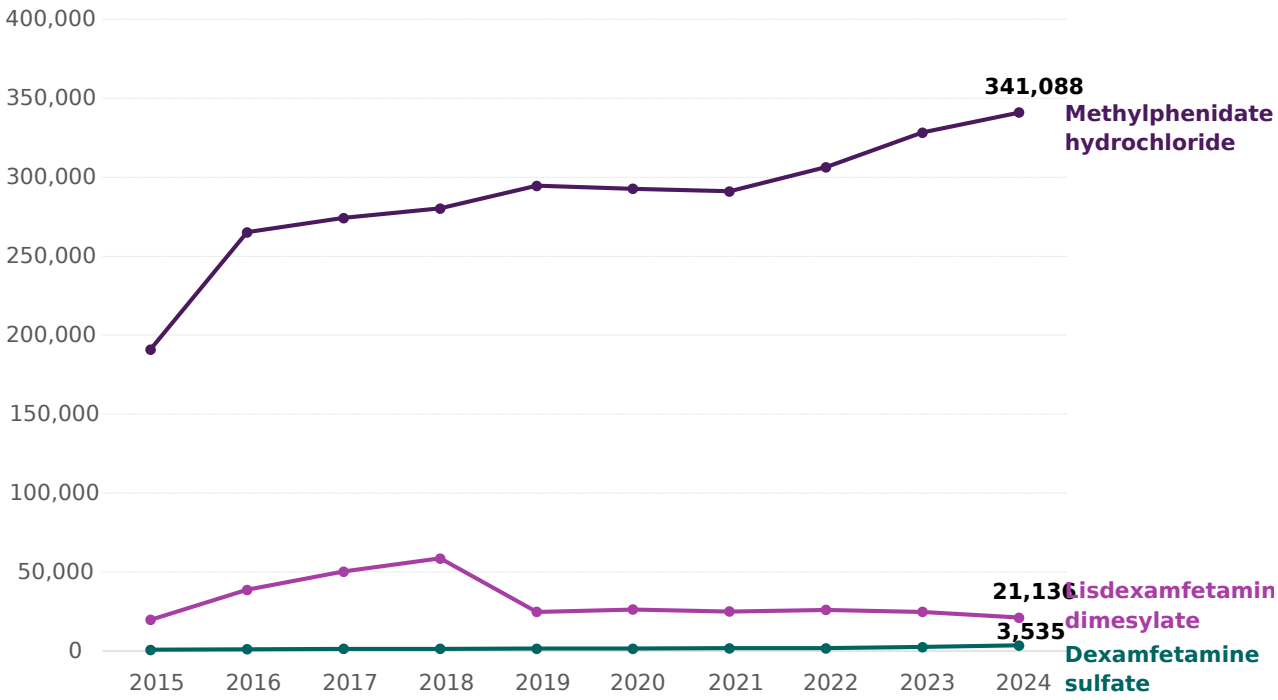


Figure 9: Prescribing of medicines for ADHD in children in NHS hospitals and primary care by number of items, 2015 to 2024



Note: Age data was missing for a number of prescriptions, therefore these have been excluded from figures 8 and 9.

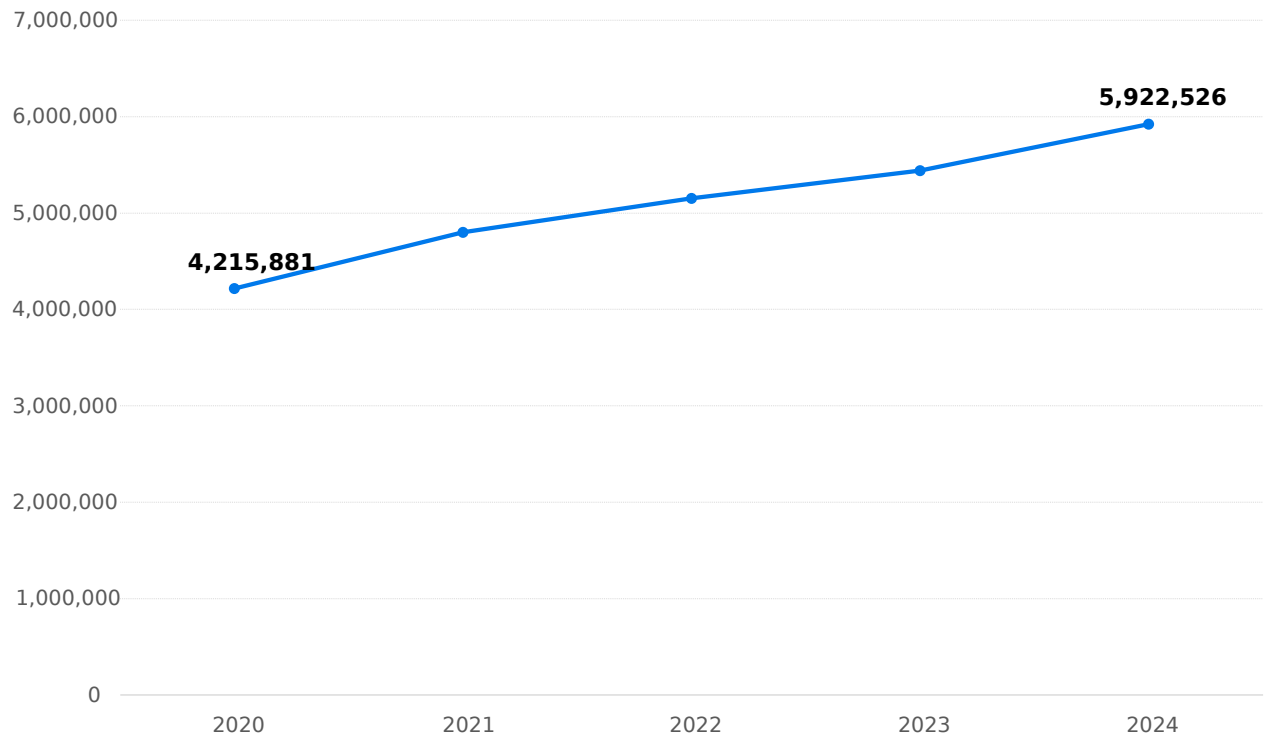
NHS non-medical prescribing

Overall prescribing of controlled drugs by non-medical prescribers (healthcare professionals other than a doctor or dentist) increased by 9% during 2024:

- **5,922,526 items prescribed in 2024**
- 5,440,585 items prescribed in 2023

Figure 10 shows the continued trend for increases in non-medical prescribing since 2020. We expect this to continue, particularly as pharmacists who graduate in 2025 and register with the General Pharmaceutical Council in 2026 will all be prescribers.

Figure 10: Non-medical prescribing of controlled drugs by number of items, 2020 to 2024



Pharmacists undertook 56% of all non-medical prescribing of controlled drugs in 2024 (3,332,074 items) compared with 53% in 2023. There has also been a sharp increase in the number of items prescribed by paramedics.

Figure 11: Non-medical prescribing of controlled drugs in 2024 by professional group

Non-medical prescriber	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Pharmacist	up by 15%	3,332,074	2,908,340
Nurse	up by 1%	2,545,702	2,524,854
Paramedic	Up by 704%	41,154	5,116
Physiotherapist	up by 62%	3,395	2,098
Radiographer	down by 2 0%	89	111
Podiatrist	Up by 38%	87	63

Figures 12 to 15 show increases in prescribing by pharmacists, nurses and paramedics since 2020.

Figure 12: Pharmacist prescribing of controlled drugs by number of items, 2020 to 2024

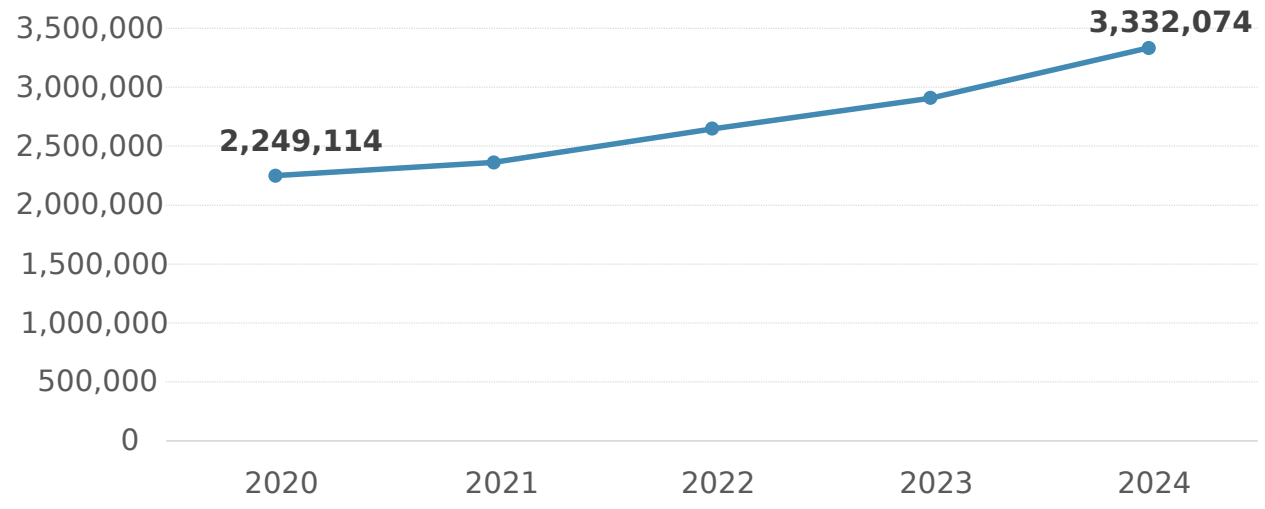


Figure 13: Nurse prescribing of controlled drugs by number of items, 2020 to 2024

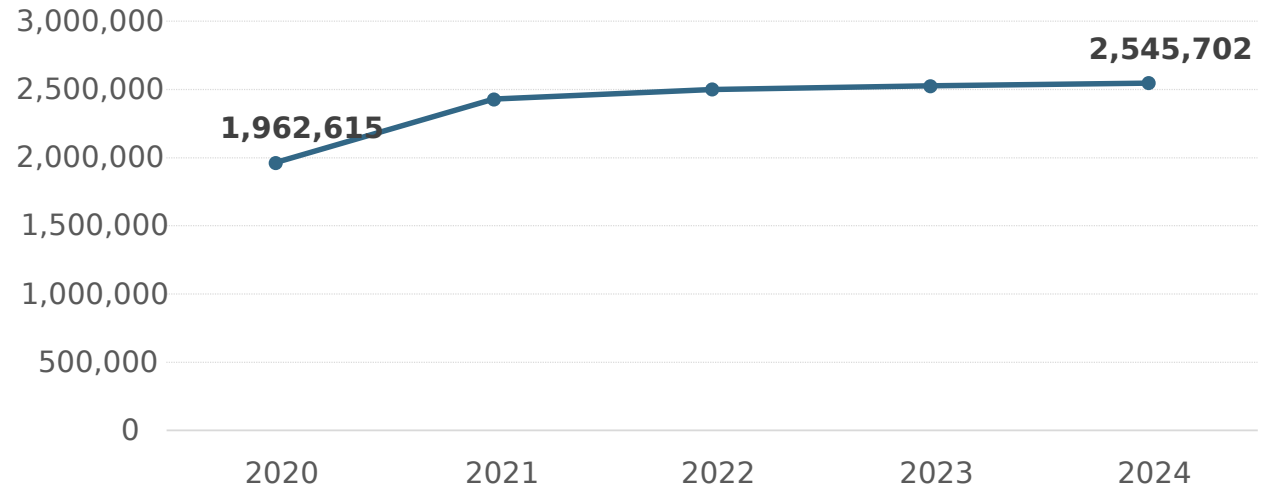
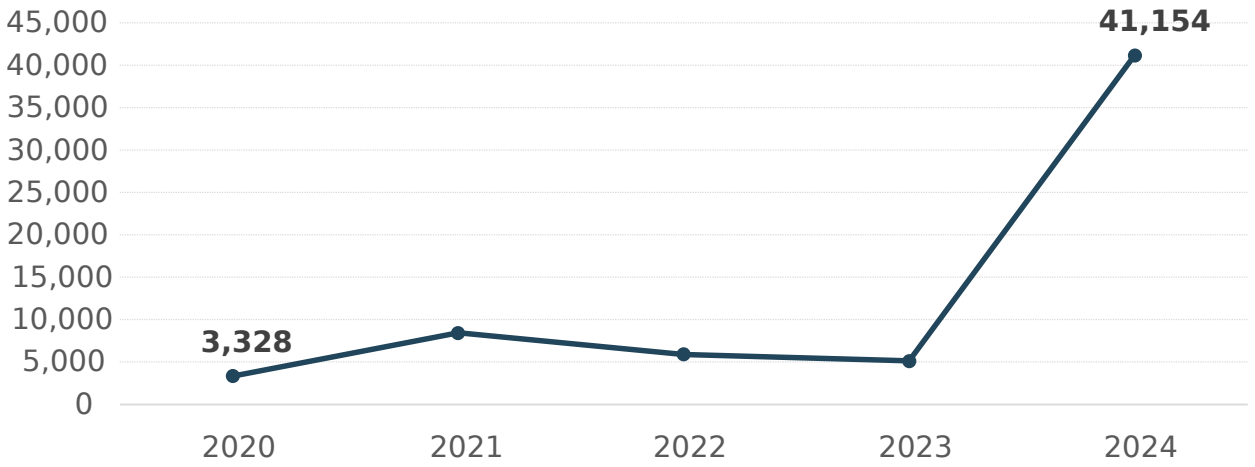


Figure 14: Paramedic prescribing of controlled drugs by number of items, 2020 to 2024



Overall, nurse prescribing accounts for 3% of all controlled drug prescriptions in NHS primary care, with pharmacist prescribing accounting for 5%.

Pharmacist prescribing

Figure 15 shows the controlled drugs prescribed by pharmacists at volumes in excess of 10,000 items during 2024. As a professional group, prescribing volume increases are higher than those for nurses, especially for co-codamol, pregabalin and gabapentin.

Pharmacist prescribing of medicines for ADHD also increased in 2024:

- lisdexamfetamine (schedule 2) increased by 42% from 25,625 to 36,389 items.
- methylphenidate (schedule 2) also increased by 42% from 57,770 to 82,181 items.
- dexamfetamine (schedule 2) prescribing increased by 65% from 6,026 to 9,947 items.

Figure 15: Pharmacist prescribing of controlled drugs in 2024

Controlled drug & Schedule	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Co-codamol (Schedule 5)	up by 15%	648,599	563,232
Pregabalin (Schedule 3)	up by 22%	490,330	401,398
Gabapentin (Schedule 3)	up by 14%	341,202	299,679
Tramadol (Schedule 3)	up by 12%	237,120	212,149
Codeine (Schedule 5)	up by 16%	225,456	195,183
Zopiclone (Schedule 4)	up by 8%	174,167	160,604
Diazepam (Sch 4)	up by 7%	168,907	157,141
Buprenorphine (Schedule 3)	up by 12%	138,758	124,265
Morphine sulfate (Schedule 2)	up by 11%	125,288	112,692

Controlled drug & Schedule	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Morphine sulfate (Schedule 5)	up by 13%	103,592	91,361
Oxycodone (Schedule 2)	up by 13%	96,560	85,593
Methylphenidate (Schedule 2)	up by 42%	82,181	57,770
Dihydrocodeine (Schedule 5)	up by 14%	64,876	56,920
Methadone (Schedule 2)	down by 1 3%	61,086	70,092
Co-dydramol (Schedule 5)	up by 16%	59,614	51,554
Clonazepam (Schedule 4)	up by 18%	54,232	46,095
Lorazepam (Schedule 4)	up by 14%	45,806	40,195
Lisdexamfetamine (Schedule 2)	up by 42%	36,389	25,625

Controlled drug & Schedule	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Fentanyl (Schedule 2)	down by 1%	28,488	28,689
Zolpidem (Schedule 4)	up by 13%	25,322	22,356
Clobazam (Schedule 4)	up by 23%	23,021	18,781
Testosterone (all forms) (Schedule 4)	up by 20%	27,824	23,102
Temazepam (Schedule 3)	up by 15%	14,170	12,337
Nitrazepam (Schedule 4)	up by less t han 0.5%	13,305	13,266
Tapentadol (Schedule 2)	up by 29%	10,170	7,910

Nurse prescribing

Figure 16 shows controlled drugs that were prescribed by nurses at volumes in excess of 10,000 items during 2024.

Figure 16: Nurse prescribing of controlled drugs in 2024

Controlled drug & Schedule	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Methadone hydrochloride (Schedule 2)	down by 5%	508,781	536,072
Co-codamol (Schedule 5)	up by 1%	394,003	391,431
Buprenorphine (Schedule 3)	up by 4%	342,751	328,009
Pregabalin (Schedule 3)	up by 6%	192,358	181,212
Codeine (Schedule 5)	up by 3%	164,389	159,539
Gabapentin (Schedule 3)	up by 4%	157,757	151,814
Tramadol (Schedule 3)	down by 2%	111,575	113,710
Diazepam (Schedule 4)	down by 6%	97,447	103,938
Zopiclone (Schedule 4)	down by 3%	88,489	91,282

Controlled drug & Schedule	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Morphine sulfate (Schedule 2)	up by 3%	80,265	77,796
Morphine sulfate (Schedule 5)	up by 3%	62,568	60,545
Methylphenidate (Schedule 2)	up by 8%	62,087	57,536
Oxycodone (Schedule 2)	up by 10%	51,323	46,708
Dihydrocodeine (Schedule 5)	down by 1%	29,647	29,986
Lorazepam (Schedule 4)	down by 2%	27,757	28,182
Midazolam (Schedule 3)	up by 8%	27,352	25,210
Co-dydramol (Schedule 5)	down by less than 0.5%	25,309	25,404
Lisdexamfetamine (Schedule 2)	up by 18%	22,697	19,201

Controlled drug & Schedule	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Clonazepam (Schedule 4)	up by 3%	18,519	17,929
Testosterone all forms (Schedule 4)	up by 15%	17,348	15,054
Fentanyl (Schedule 2)	down by 8%	15,604	17,011
Zolpidem (Schedule 4)	down by 7%	10,691	11,468

Paramedic prescribing

Paramedic prescribing increased by 704% in 2024 compared with the previous year. Changes to the law at the end of 2023 permitted paramedic independent prescribers to prescribe a range of controlled drugs. These are:

- morphine sulfate by oral administration or by injection
- diazepam by oral administration or by injection
- midazolam by oromucosal administration or by injection
- lorazepam by injection
- codeine phosphate by oral administration.

Increases in prescribing are likely linked to this change in prescribing permissions. As in previous years, paramedics continue to prescribe a wider range of controlled drugs than they are legally entitled to. For example, prescribing data shows that 1,176 prescriptions for zopiclone (Schedule 4) were issued and dispensed in 2024.

This serves as a reminder that all prescribers should be working within their scope of practice, and within the legal boundaries of their prescribing rights. Professional regulators also have guidance on this for their registrants.

When we inspect services, we check how providers assure themselves that prescribers are working within their scope of practice, and that the service offered is safe and effective.

Non-medical prescribing in different settings

This year, to gain a better understanding behind the increase in non-medical prescribing, we also looked at the different types of services where prescriptions from non-medical prescribers originate. Figure 17 shows the number of items prescribed in a range of settings. Although most prescribing happens in GP settings, it is also encouraging to see prescribing in other areas, such as in care homes and services in the health and justice sector.

Figure 17: Examples of non-medical prescribing of controlled drug items by profession and setting, 2024

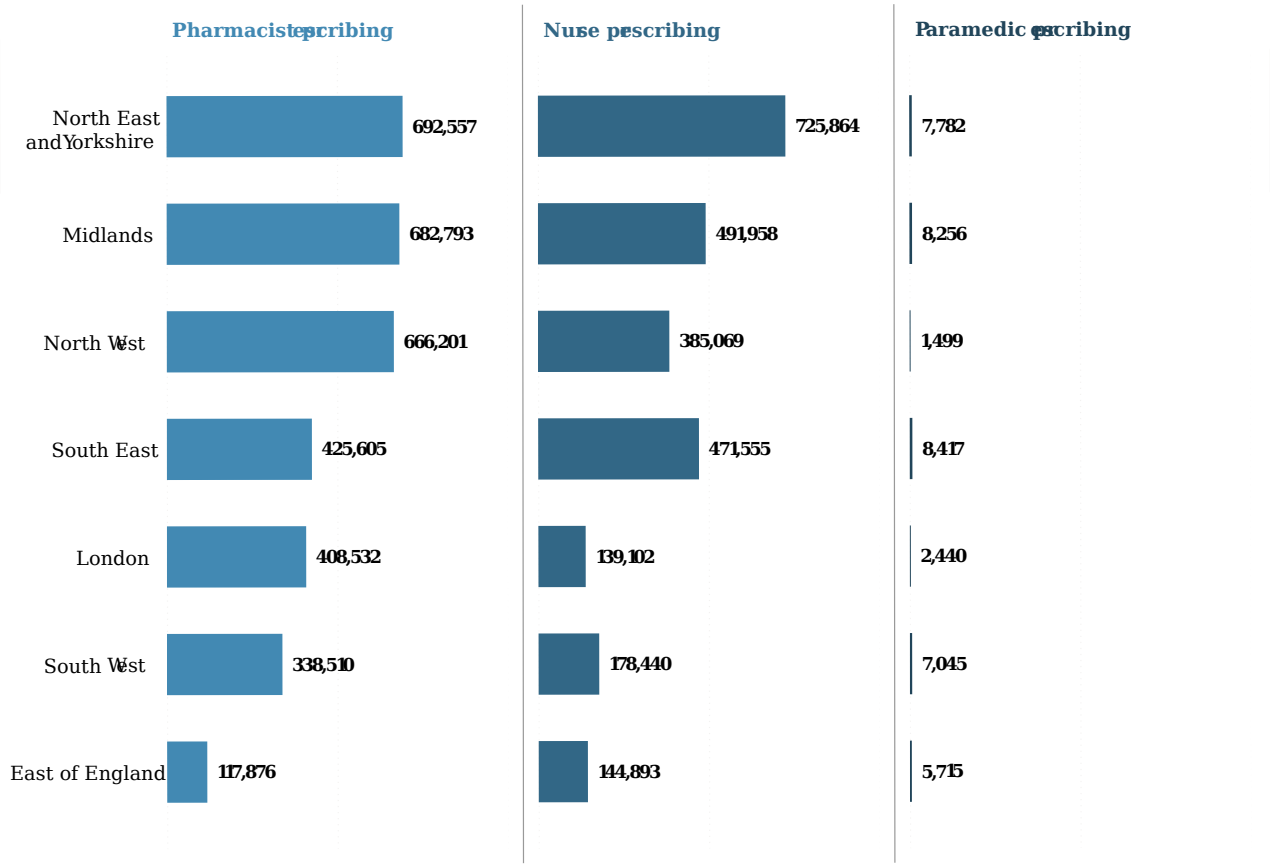
Location	Nurse prescribers	Paramedic prescribers	Pharmacist prescribers
GP practice	1,572,661	38,727	3,238,228

Location	Nurse prescribers	Paramedic prescribers	Pharmacist prescribers
Community health service	235,168	486	42,498
Hospital service	54,868	151	10,026
Hospice	19,825	4	206
Out-of-hours service	12,514	410	4,283
Urgent & emergency care	5,301	727	172
Walk-in-centre	3,507	108	-
Primary care network	1,751	131	240
Walk-in centre and out-of-hours service	1,688	-	-
Care home/care home with nursing	1,329	-	304
Health & justice services	219	-	3
Other	265,021	410	6,856

Non-medical prescribing in geographical locations

We also looked at the geographical split of pharmacist, nurse and paramedic prescribing. This is highest in the North East and Yorkshire and lowest in the East of England.

Figure 18: Geographical prescribing of controlled drug items by non-medical prescribers in England, 2024



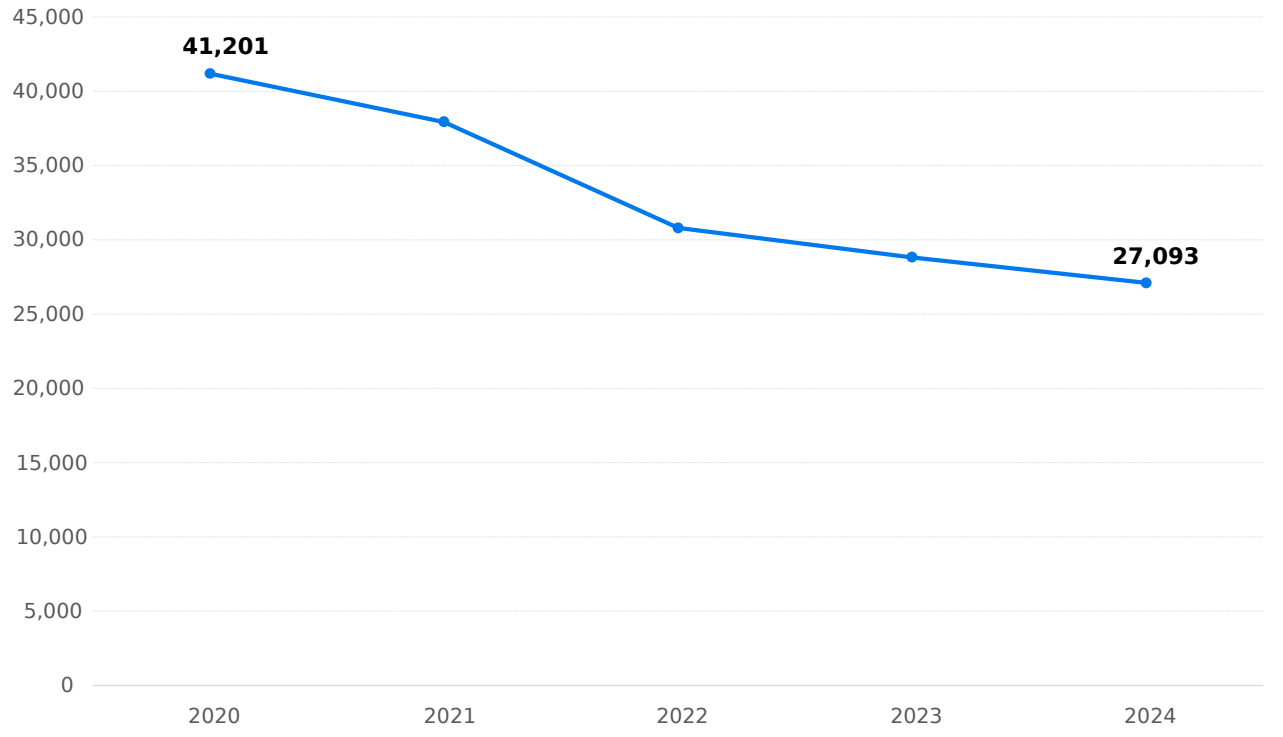
NHS dental prescriptions for controlled drugs

Total controlled drug items prescribed by NHS dentists decreased by 6%:

- 27,093 items in 2024
- 28,819 items in 2023

Since 2021 there has been a gradual reduction in controlled drugs prescribing by NHS dentists (figure 19). This has largely been driven by reduced dihydrocodeine prescribing.

Figure 19: Total controlled drug items prescribed by NHS dentists in England, 2020 to 2024



Dentists working in the NHS can prescribe 3 controlled drugs on NHS dental prescription forms to patients.

Dihydrocodeine: as in previous years, this was the most prescribed medicine, accounting for 80% of total dental prescribing in 2024, although prescribing decreased by 8%:

- 21,783 items prescribed in 2024
- 23,714 items prescribed in 2023

Diazepam: Between 2023 and 2024 prescribing increased by 3% (4,497 total items prescribed in 2024).

Temazepam: Between 2023 and 2024, prescribing increased by 11% (813 total items prescribed in 2024).

Our most recent State of Care report highlighted that NHS dental care is facing a crisis, as the proportion of adults who have seen an NHS dentist in the last 24 months and children who have seen an NHS dentist in the last 12 months is lower than in 2019/20.

As in previous years, the patterns of decreased prescribing may be an ongoing consequence of this.

ePACT2 Opioid comparators dashboard

Last year, we looked at prescribing of opioids in a specific geographical area. This pattern remained similar for 2025, with prescribing highest in the North of England.

We also looked at prescribing of 'high oral morphine equivalent' volume of opioid prescribing, in combination with other medicines, such as gabapentinoids, antidepressants and z-drugs (figure 20). The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit. Risk can be increased further when this is prescribed alongside these other medicines.

Figure 20: High oral morphine equivalent prescribing with other medicines, 22 January to 18 February 2025 compared with 29 February to 27 March 2024

Medicines prescribed in combination with high oral morphine equivalent	Prescribed for 1 to 84 days	Prescribed for 85 to 168 days	Prescribed for 169 days or more
Gabapentinoids	237 in 2025 263 in 2024	402 in 2025 440 in 2024	24,919 in 2025 26,525 in 2024
Antidepressants	259 in 2025 272 in 2024	445 in 2025 463 in 2024	34,954 in 2025 37,332 in 2024
Benzodiazepines	79 in 2025 109 in 2024	137 in 2025 131 in 2024	6,973 in 2025 7,559 in 2024
Z-drugs	43 in 2025 63 in 2024	69 in 2025 83 in 2024	5,129 in 2025 5,576 in 2024

We have seen a reduction in the co-prescribing of high oral morphine equivalent with other medicines, particularly in patients who have been taking them for a longer period (169 days or more). This could be because some health and care teams place more emphasis on reducing higher risk prescribing.

Prescribing in NHS hospitals for community pharmacy dispensing

In 2024, hospital prescribing (on FP10HP prescription forms that can be dispensed in a community pharmacy) was also broadly in line with 2023.

Total controlled drug items across Schedules 2 to 5 prescribed in hospital using an FP10(HNC) or FP10SS form increased by 5%:

- **1,022,291 items in 2024**
- 978,223 items in 2023

The cost of this was £18,176,281 in 2024 compared with £16,420,790 in 2023 (an increase of 11%).

Of all prescribing of controlled drugs in hospitals for dispensing in a community pharmacy:

- **Schedule 2** accounted for 51%
- **Schedule 3** accounted for 15%
- **Schedule 4** accounted for 20%
- **Schedule 5** accounted for 14%

Figure 21: Prescribing of all controlled drugs in hospitals for dispensing in a community pharmacy, 2024

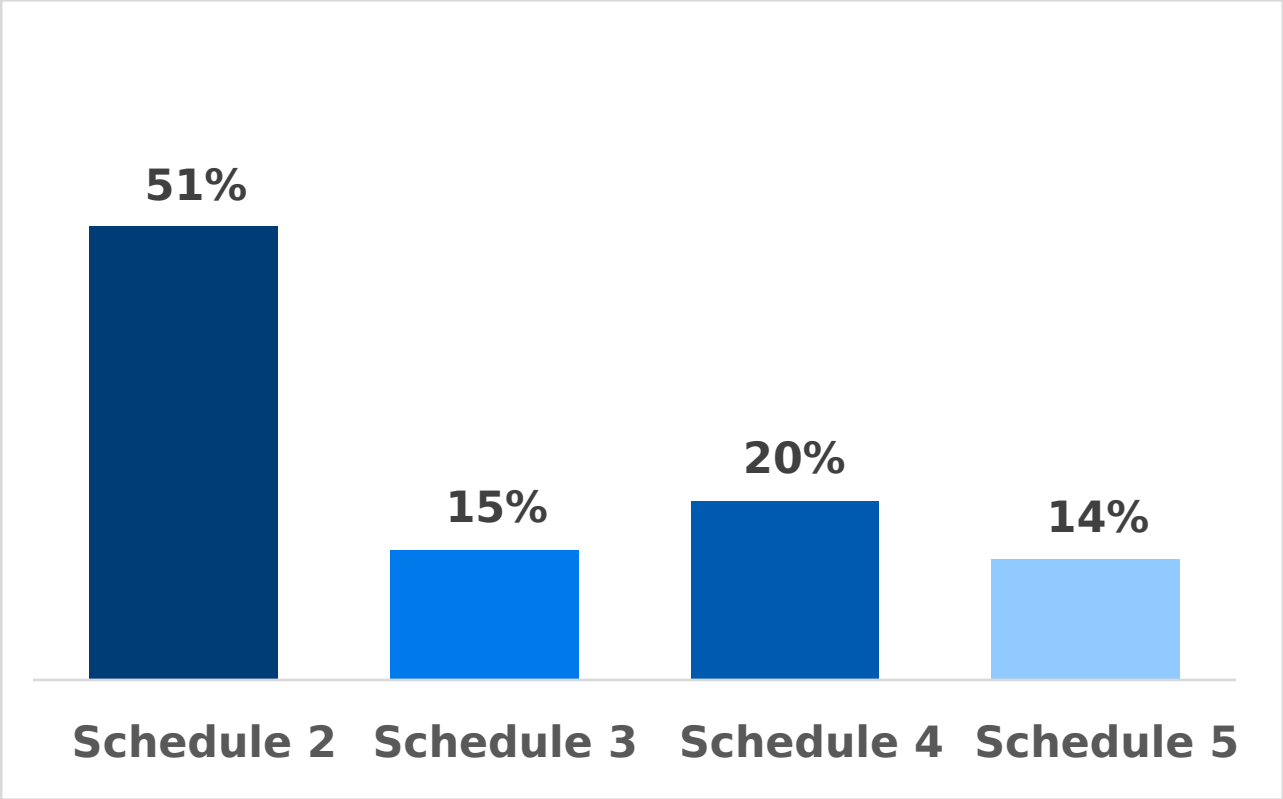


Figure 22: Key reductions in hospital prescribing of controlled drugs for community pharmacy dispensing in 2024

Controlled drug & Schedule	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Methadone (Schedule 2)	down by 6%	235,472	249,631
Buprenorphine (Schedule 3)	down by 6%	107,679	114,887
Temazepam (Schedule 3)	down by 6%	1,651	1,752

Figure 23: Key increases in hospital prescribing of controlled drugs for community pharmacy dispensing in 2024

Controlled drug & Schedule	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Dihydrocodeine (Schedule 5)	up by 29%	6,951	5,393
Oxycodone (Schedule 2)	up by 27%	5,120	4,040
Morphine (Schedule 5)	up by 21%	24,720	20,362
Codeine (Schedule 5)	up by 20%	52,175	43,324
Lisdexamfetamine (Schedule 2)	up by 18%	59,905	50,635
Dexamfetamine (Schedule 2)	up by 14%	10,547	9,228
Methylphenidate (Schedule 2)	up by 12%	204,395	182,071
Co-codamol (Schedule 5)	up by 11%	52,454	47,219

Controlled drug & Schedule	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Gabapentin (Schedule 3)	up by 7%	6,398	5,956
Lorazepam (Schedule 4)	up by 6%	29,566	27,793
Co-dydramol (Schedule 5)	up by 6%	3,408	3,207
Tramadol (Schedule 3)	up by 5%	7,934	7,571
Zolpidem (Schedule 4)	up by 1%	5,409	5,371

NHS Pharmacy First service

The national NHS Pharmacy First service aims to reduce pressure on primary and urgent care services, including emergency departments and out-of-hours GP services. It does this by referring people to community pharmacies for advice, treatment, and urgent repeat prescriptions, and may supply certain controlled drugs in specific circumstances for a limited period.

Of all controlled drugs supplied in 2024, the majority supplied by Pharmacy First were in Schedule 5. We continue to see increases in the number of controlled drugs supplied through the service. We also see that pharmacists are supplying quantities of controlled drugs that exceed what would be needed for 5 days. This is also something that has been highlighted at many Controlled drug local area networks during the year.

The controlled drugs most commonly supplied by the service in 2024 were:

- **co-codamol** (in a range of forms, including tablets and capsules) 30/500mg, 15/500mg and 8/500mg
- **codeine** 15mg and 30mg tablets
- **co-dydramol** 10/500mg tablets
- **clobazam** 5mg and 10mg tablets
- **clonazepam** 500mcg tablets
- **diazepam** 2mg tablets
- **dihydrocodeine** 30mg tablets
- **morphine sulfate** oral solution 10mg/5ml
- **testosterone** all forms
- **zopiclone** 7.5mg tablets

Private controlled drug prescribing in independent primary care

The total number of controlled drug items prescribed privately across independent primary care services in 2024 increased by 38%:

- **540,227 items in 2024**
- 390,788 items in 2023

Although this is a smaller percentage increase from 2023, (73% increase), it still represents an increase of nearly 150,000 items, which is similar to the increase in number of items in 2023.

As in both 2022 and 2023, this trend is primarily driven by prescribing of Schedule 2 controlled drugs licensed to treat ADHD and could be linked to lack of access to NHS mental health services.

Of all private prescribing of controlled drugs in independent primary care:

- **Schedule 2** accounted for 97%
- **Schedule 3** accounted for 3%

Private prescribing of Schedule 2 controlled drugs

Prescribing of Schedule 2 controlled drugs alone in 2024 increased by 39%:

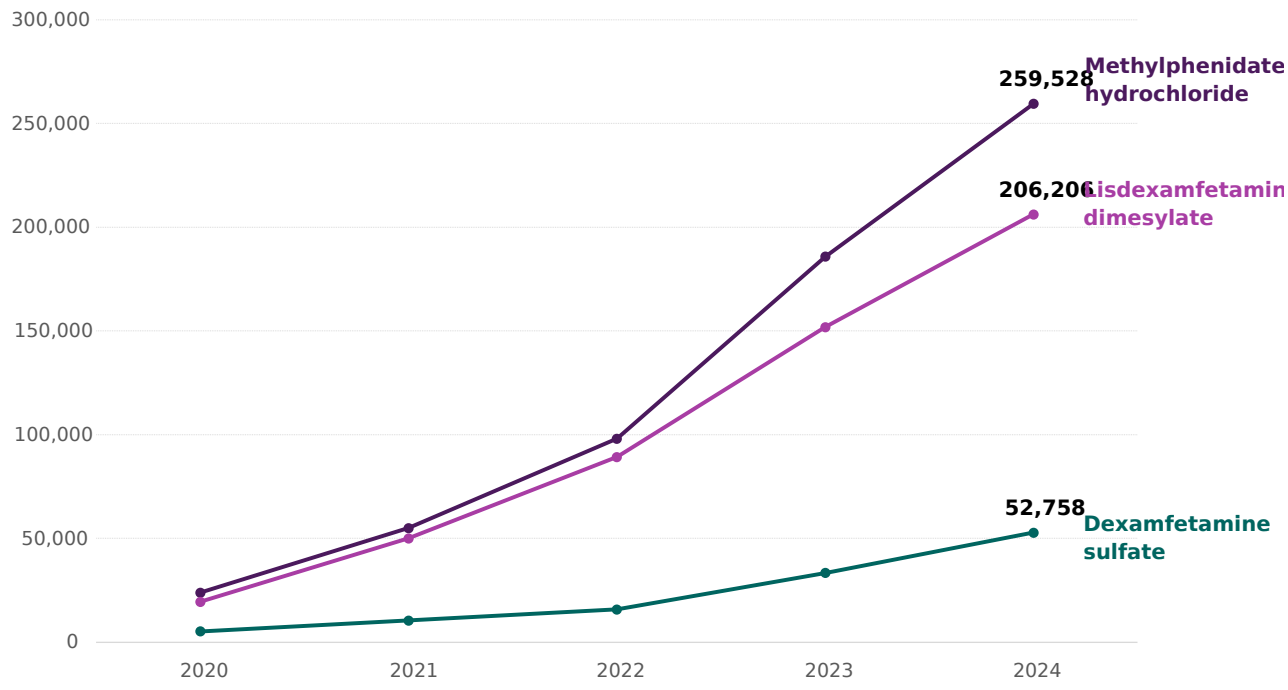
- **525,873 total Schedule 2 items in 2024**
- 378,049 total Schedule 2 items in 2023

This figure does not include unlicensed cannabis-based products for medicinal use and, as in previous years, has largely been driven by the increase in prescribing for medicines licensed for ADHD (figure 25).

Figure 24: Schedule 2 controlled drugs prescribed in independent primary care in 2024

Controlled drug	Percentage change	Total items prescribed in 2024	Total items prescribed in 2023
Methylphenidate	up by 40%	259,528	185,819
Lisdexamfetamine	up by 36%	206,206	151,827
Dexamfetamine	up by 58%	52,758	33,384

Figure 25: Number of items of methylphenidate, lisdexamfetamine and dexamfetamine prescribed annually in independent primary care in England, 2020 to 2024



Private prescribing of Schedule 3 controlled drugs

Prescribing of Schedule 3 controlled drugs in 2024 increased by 14%:

- **14,125 total items prescribed in 2024**
- 12,411 total items prescribed in 2023

Pregabalin: this is the most prescribed drug in Schedule 3, accounting for 53% of all Schedule 3 prescribed items in 2024, with prescribing increasing by 8%:

- **7,510 total items in 2024**
- 6,922 total items in 2023

Across the most commonly prescribed schedule 3 controlled drugs, we have seen increases in:

- **tramadol** (up by 33%, 1,642 total items in 2024)
- **gabapentin** (up by 29%, 1,119 total items in 2024)
- **buprenorphine** (up by 31%, 2,606 total items in 2024)
- **temazepam** (up by 18%, 636 total items in 2024)

At the same time, we have also seen a reduction in the prescribing of midazolam hydrochloride (down by 30%, 560 total items in 2024).

Requisitions

Requisitions are documents that allow the appropriate people to order medicines for use in their professional practice, such as ordering a stock of controlled drugs that are later administered to patients.

The volume of requisitions decreased by 18% in 2024:

- **12,896 total items requisitioned in 2024**

- 15,739 total items requisitioned in 2023

Looking at where these requisitions came from in 2024:

- 73% of all requisitions were from NHS providers (compared with 74% in 2023)
- 27% were from independent organisations (compared with 26% in 2023)

In 2024, the top 10 controlled drugs on requisition remained similar to the previous year, with methadone replacing tramadol in the list (Figure 26).

Figure 26: Most commonly requisitioned Schedule 2 and 3 controlled drugs in 2024

Controlled drug	Percentage of all requisitions	Total items in 2024
Methylphenidate	20%	2,554
Pregabalin	18%	2,355
Morphine sulfate (Schedule 2 and 5)	10%	1,235
Oxycodone	8%	1,074
Buprenorphine	8%	994
Midazolam	8%	983
Gabapentin	6%	773

Controlled drug	Percentage of all requisitions	Total items in 2024
Fentanyl	5%	681
Lisdexamfetamine	5%	642
Methadone hydrochloride	4%	475

Recommendations

For national bodies and government

Ensure that the national and regional oversight of controlled drugs is assured through any future structural changes

There are still risks from controlled drugs in the health and care system. The current function operates effectively, offers good oversight of risks and shares learning well. It is crucial to retain these outcomes in future structures and to ensure effective and consistent resource for them.

This will minimise any unwarranted variation in the ability of local lead controlled drug accountable officers to monitor and manage risk in their area.

Address the available evidence on the cost of diversion and inappropriate use of controlled drugs

There are significant gaps in the evidence relating to the costs associated with the diversion and inappropriate use of controlled drugs. Although this is a complex area with a large number of variables, it would be helpful to work towards a better understanding of the cost to the health and care system, and wider economy.

This could help to ensure that the resources to address concerns about controlled drugs are proportionate to the issue.

Work together to understand cross-border prescribing data for controlled drugs

Prescriptions produced in England for controlled drugs may be dispensed in Scotland, Wales and Northern Ireland. This includes private prescriptions. However, there is no UK view of prescribing and dispensing that occurs across borders.

National organisations should collaborate to gain a better understanding of each other's processes and available datasets, and how these can feed into a UK-wide picture of controlled drugs risks.

Enable appropriate access to controlled drugs in care homes

It's important that people can access the right medicines, at the right time, especially at the end of their lives. It's also crucial that staff supporting them are able to meet this need in the most timely and efficient way.

Relevant government departments and other national organisations should work together to review the impact of current practice around access to controlled drugs on people receiving care, as well as on those supporting them.

For health and care services

Designated bodies: ensure you provide effective resource for your controlled drugs accountable officer.

Non-designated bodies: ensure there is a lead for controlled drugs in your organisation.

We often hear that CDAOs are not resourced effectively. Effective resourcing is a requirement under the 2013 Regulations. Many services don't fit the definition of a designated body. Although these services won't have a CDAO, many will handle, prescribe and administer significant volumes of controlled drugs.

It's therefore vital that they have a controlled drugs lead, to ensure proper oversight and management.

For healthcare professionals

Work within your scope of practice

Our findings from both inspections and prescribing data indicate that healthcare professionals are working outside their scope of practice, and in some cases, outside of the law. To ensure people receive safe care, all healthcare professionals must work within their scope of practice. All professional regulators have guidance on this.

Services should ensure they support this and do not encourage professionals to work outside of their scope of practice.