Early lessons from a local intelligence network on managing Controlled Drugs

Legislation was introduced last year to improve the management of Controlled Drugs. In this article David Harris, Alison Tennant and Duncan Jenkins describe problems encountered and progress made by Dudley Primary Care Trust in setting up a local intelligence network.

The Shipman inquiry exposed gaps in the governance arrangements for Controlled Drugs. The Government responded by enacting legislation that required primary care trusts in England and health boards in Scotland to set up local intelligence networks (LINs) to share information and intelligence about the use and potential misuse of CDs and to share good practice.

The Health Act 2006 and the Controlled Drugs (Supervision and Management of Use) Regulations 2006 defined the priorities of the LIN and the role of the accountable officer (AO), which is summarised in Panels 1 and 2. How these are achieved is determined by the individual network. The Dudley LIN was established at the end of 2006 and this article describes the early experience in identifying resources required, deciding membership and establishing the role of the LIN.

Resources
Early in 2006, the Dudley Primary Care Trust pharmacy team identified two priority areas that would require resources to meet the obligations proposed in the Health Bill. These were monitoring, audit and inspection within Dudley PCT, and support for establishing and maintaining a Dudley LIN. No specific central funding was allocated so the resource had to be found from within the PCT’s current funds. It was estimated that the network would need support with administration and a Controlled Drugs clinical lead (CDCL) for two days a week for the first six months, and two days a month thereafter, to maintain the network functions. The PCT allocated funding for a grade 8(c) pharmacist for two days a week for six months to develop and establish the network.

The Dudley local intelligence network
All agencies listed in Panel 3 were contacted to find out who would represent their organisation on a LIN. Some had not yet decided and the exercise was useful in alerting agencies to their responsibilities under the legislation. At the inaugural meeting a number of additional partners who were not present were identified. An action plan was agreed, which included preliminary tasks, such as agreeing terms of reference. One early difficulty was the lack of a regular attendee from the local police force. The police were keen to be involved, but took time to nominate an individual. However, they have become an invaluable part of the network, bringing expertise into intelligence gathering and experience in investigation. One requirement of the regulations is the submission of a quarterly occurrence report to the PCT AO by the AOs of partner organisations. A standard format based on that produced by the Healthcare Commission (see www.healthcarecommission.org.uk) has been agreed.

Mapping exercise
One of the first tasks of the LIN was to map the remit of each agency with respect to the monitoring and management of CDs and how staff are involved with CDs in their working environments. This process helped LIN members to understand each other’s roles and responsibilities and to identify gaps in membership of the LIN. The local NHS counter-fraud officer was recruited after the exercise as an additional member. Another gap identified related to the monitoring of residential educational establishments for children by OFSTED and how assurances of these systems could be obtained. This has been formally logged as a gap.

Intelligence sharing
The benefits of sharing information and concerns across the LIN were quickly demonstrated. At the first meeting several members described circumstances that led to information-sharing and a more robust approach to governance. At the outset it was not clear how the network would share information routinely. Participants were concerned about confidentiality and it was clear that organisations wanted to deal with incidents in-house before sharing details with others. Members also said they would like to share information on an informal basis in some circumstances. For example, they have concerns about individuals, but lack evidence. The sharing of intelligence and concerns was seen as useful to confirm or allay suspicions. It was suggested that the group learn from the process for information sharing used in child protection, as there are a number of similarities in terms of information often being received informally and in the number and type of agencies involved.

One incident discussed at the first meeting involved an individual working locally with CDs. There have been no serious incidents to date, but the discussion has helped participants learn about handling incidents and what core data they need to gather. The model being developed consists of a central database maintained by the PCT that can be accessed and populated by LIN members. It is essential that information recorded on the central database is an accurate summary of information received, when it was communicated and by whom. This should be consistent with records held by contributing organisations. It is important to log information received and any ensuing action. A secure
Co-operate and disclose information with each other in relation to Controlled Drugs
Take appropriate action in respect of matters arising in relation to the management or use of CDs
Keep a detailed record of any decision or request to disclose information
Map the local arrangements in place for monitoring and investigating concerns
Accountable officers in designated bodies to provide a quarterly occurrence report to the primary care trust
AO to summarise all incidents relating to CDs
Map the local use and management of CDs
Keep up to date with any local issues of CD diversion and substance misuse
Establish robust protocols for the sharing of information and intelligence between agencies
Establish arrangements for calling the incident panel to investigate urgent serious concerns

One early goal was to educate LIN members and representatives such as the police force to help develop expertise in handling CDs. The template form produced by the RCP has also developed a database for monitoring controlled drugs dispensed monthly by month, according to class of CD. This enables unusual patterns, including excessive prescribing, to be identified quickly.

All PCT AOs are required to sign an annual self-assessment and declaration covering all premises in the PCT, including GP practices, acting, using, prescribing, or administering CDs. The template form produced by the RCP is available on the website www.pjonline.com.

Monitoring, audit and inspection
The prescription pricing division has produced a set of electronic reports for PCTs in electronic prescription analysis and cost data for monitoring of CDs. The RCP has also produced a set of electronic reports for PCTs in electronic prescription analysis and cost data for monitoring of CDs. The RCP has also produced a set of electronic reports for PCTs in electronic prescription analysis and cost data for monitoring of CDs.