

# Variation has reduced in use of NICE-approved cancer drugs

Variations in the use of cancer drugs approved by the National Institute for Health and Clinical Excellence are reducing, according to a review carried out by the national cancer director, Mike Richards, published by the Department of Health recently.

As its baseline, the review used a study conducted between July and December 2003, which showed that, although overall use of cancer drugs generally increased after a positive NICE appraisal, considerable variation in the use of drugs remained between the 34 cancer networks in England.

The latest study, carried out between January and June 2005, showed that variation had reduced by a minimum of 9 per cent (for capecitabine) and a maximum of 62 per cent (for vinorelbine). The median percentage increase in the uptake of cancer drugs following positive NICE guidance between the two review periods ranged from 11 per cent for vinorelbine and

fludarabine to 120 per cent for temozolomide.

The reviewer states that he would like to see variations further reduced, but makes it clear that differences in uptake will remain. For example, some patients are referred to another network for more specialist treatment.

In the report, cancer networks are advised to use a web-based capacity planning tool that has been developed by the Pharmaceutical Oncology Initiative Partnership, a joint venture between the Association of the British Pharmaceutical Industry, the DoH's Cancer Action Team and the NHS Cancer Services Collaborative. According to Marie Palmer, from the NHS CSC, the roll out process for the tool has started, with expert trainers from Scotland and from six cancer networks in England recently being briefed on its application.

Planning ahead and being aware of drugs under development is another of the main recommendations the

report makes to cancer networks. This is because the NICE appraisal process has been speeded up, so new cancer drugs could potentially be approved within weeks of becoming licensed.

Other recommendations include the use of more local interim solutions for oncology e-prescribing, before the national strategic e-prescribing solutions are deployed (between 2008 and 2010).

Libby Hardy, lead pharmacist for Peninsula Cancer Network, said that the report shows that the "action plans provided by those networks [previously] showing under-use have been successful". However, she added that there are some limitations in the accuracy of the data collected. For example, it does not confirm that the drugs were used for their NICE indication only, and use by home care providers potentially causes distortions. Once e-prescribing is in place, more accurate data on the use of all chemotherapy drugs should be available, she added.

## brief

■ On 1 October, the supply chain services to hospitals previously managed by NHS Logistics were transferred to DHL. These include the supply of items such as food, bedding and medical equipment.

■ Hundreds of lives may be lost waiting for the results of randomised trials of public health interventions, especially in developing countries, according to research in the *BMJ* (2006;333:701-3). The authors suggest that decision makers should assess risks and benefits in local conditions, rather than those in an ideal situation.

■ A new MPharm course is under way at the University of Wolverhampton. This brings the total number of institutions offering undergraduate pharmacy education to 23.

■ A guide to NHS reforms in England, written by the health editor of *The Times* newspaper, has been published in the *BMJ* (2006;333:645-8).

■ Patients and their carers think it is essential that they receive easy-to-understand information about treatments so they can make properly informed decisions. This is according to a survey carried out in 12 countries by the International Alliance of Patients' Organizations.

■ Reports from the British Pharmaceutical Conference 2006 were published in a supplement with the 30 September edition of *The Pharmaceutical Journal*. They are also available online at [www.pjonline.com/bpc](http://www.pjonline.com/bpc)

### Correction

Krishna Patel was lead author in "Acromegaly — treatment options and management" (*Hospital Pharmacist* 2006; 13:281-8) and not as listed.

# New guidance on antibiotics from BNF



New guidance on selecting antibiotics to manage methicillin-resistant *Staphylococcus aureus* infections is contained in the latest edition of the British National Formulary, published

last month. Other new information includes a warning about the potential confusion between "absolute glomerular filtration rate" (creatinine clearance) and "estimated GFR"

when calculating drug dose adjustments for patients with kidney disease. Further information about this topic is contained in an article in the 30 September issue of *The Pharmaceutical Journal*, with a full version of this work set to appear in *Hospital Pharmacist* later this year.

The new BNF edition also contains an updated childhood immunisation schedule, in line with the Department of Health's recommendation for routine immunisation against pneumococcal disease and new timings for other vaccines. Revisions to anticoagulation targets, asthma management and hypertension management, following recent research and evidence, also feature.

# Less than half of registered supplementary prescribers are using skills, research says

Less than half of hospital pharmacists who have registered as supplementary prescribers are carrying out prescribing activities, according to a recent study published in the *The Annals of Pharmacotherapy* (2006;40:1843–50).

Researchers from The Robert Gordon University, the University of Aberdeen and NHS Education for Scotland sent surveys to all (518) pharmacists who were registered as prescribers as of June 2005. Of the 160 hospital pharmacists who responded, 46.3 per cent had practised as a supplementary prescriber since qualifying. For all pharmacists (ie, regardless of employment sector), the corresponding figures were 40.1 and 48.6 per cent.

Further analysis by employment sector was not

presented in the paper but Derek Stewart, senior lecturer in pharmacy at The Robert Gordon University and one of the paper's authors, told *Hospital Pharmacist* that the main reasons given by hospital pharmacists who were qualified as prescribers for not practising prescribing were that his or her organisation did not recognise supplementary prescribing (26 respondents), staff shortages (12 respondents) and lack of time to devote to supplementary prescribing (11 respondents). Other reasons cited included recently changing jobs, supplementary prescribing not being applicable to his or her (sometimes new) role, difficulties with clinical management plans, being on maternity leave and waiting for the rest of the team to finish their training.

The biggest perceived benefit of prescribing was better patient management, with job satisfaction, better recognition and greater independence also being cited. Hospital pharmacists' median confidence score when writing their first prescription was "4" (in a range of 1 to 5), the same as for pharmacists as a whole. Cytotoxic agents, antiretroviral drugs, antiemetics and anticoagulants were the most commonly prescribed items on a first prescription.

Dr Stewart added that he does not think that the percentage of pharmacists registered as prescribers who are practising this activity will have changed much since June 2005. "Independent prescribing may assist some . . .", he said, "as this will reduce some of the paperwork associated with a

clinical management plan for every patient."

□ In a separate development, researchers from Mid Cheshire NHS Trust and Keele University analysed attitudes towards supplementary prescribing among pharmacists, nurses and doctors. The main resistance to pharmacist prescribing cited by doctors and nurses was that pharmacists do not have sufficient knowledge of individual patients. The authors (Buckley *et al*) conclude that their results "suggest divergence between the image of pharmacists in the eyes of medical and nursing clinicians, and pharmacists' own self image and aspirations for practice development". The study is published in *The Pharmaceutical Journal* (2006;277:394–8) and is available at [www.pjonline.com/links/hp](http://www.pjonline.com/links/hp)

## Barcodes reduce errors, study shows

Implementing barcode technology reduces dispensing errors and adverse drug events, according to research carried out at a large teaching hospital in the US. The study, published in the *Annals of Internal Medicine* (2006;145:427–34), measured the occurrence of the type of dispensing errors and potential ADEs that barcode technology would be expected to address (including "wrong medicine", "wrong strength" or dispensing a medicine past its expiry date), before its introduction and after three different systems were implemented.

Barcodes were added to each dose of medicine (ie, individual tablet or ampoule) if not already added by the manufacturer. For the first system, the barcode of each batch of medicines was scanned as they were stocked into a unit-dose retrieval system. Retrieval was machine-directed and only one dose per batch was scanned after retrieval, before administration to the patient.



Use of barcode technology can reduce dispensing errors

For the second system, there was manual stocking and retrieval, but each individual dose was scanned before administration. The third system also involved manual stocking and retrieval, but with only one dose per batch being scanned before administration.

The dispensing error rate reduced by 93 and 96 per cent, respectively, for the first two

systems, and the potential ADE rate reduced by 86 and 97 per cent, respectively. For the third system, the dispensing error rate reduced by 60 per cent but the potential ADE rate increased (2.4-fold). The authors conclude that barcoding technology can increase patient safety, but only if configured in certain ways. They warn against implementation of unevaluated technology.

## Pharmacists identify drug-related problems

A recent Norwegian study has added to the body of evidence showing that pharmacist-led interviews provide a means to identify more drug-related problems (DRPs). The study, reported in *Pharmacoepidemiology and Drug Safety* (2006;15:667–74) found that when hospital inpatients were interviewed by a pharmacist, a mean of 4.4 DRPs per patient was found, compared with a mean of 2.4 that was elicited by the normal care process, which involved doctors taking drug histories. Issues such as the need for an additional medicine, drug chart errors and the need for patient education were the most common DRPs found in the interview group. The authors conclude that their study has highlighted limitations in the usual care process, which pharmacists can address.