

Mixed results for NHS trusts in England in latest health check

Poor performing NHS trusts in England have been challenged to close the gap between themselves and top performers by Anna Walker, chief executive of the Healthcare Commission.

The results of the commission's second annual health check were released recently, and show that the NHS is getting better but still has room for improvement. All trusts in England were assessed on their use of resources and quality of services, and given a rating of excellent, good, fair or weak.

The results for acute and specialist hospital trusts show an increase in the number of trusts gaining excellent ratings for quality of care — 33 compared with last year's 12. However the number of trusts achieving fair or weak ratings remained similar (76 compared with 79). Hospital trusts showed a greater improvement in their use of resources — this year 49 per cent of trusts scored good or



Norfolk and Norwich University Hospital NHS Trust was rated excellent for use of resources

excellent compared with 30 per cent last year.

Of the 48 trusts that were rated excellent for use of resources, the only one not to hold foundation status was Norfolk and Norwich University Hospital NHS Trust. Carol Farrow, chief pharmacist at the trust, told *Hospital Pharmacist* that the pharmacy department was keen to seize

opportunities wherever possible to improve patient flow through the hospital. "We are proactive in modifying our service whenever we see an opportunity to expedite discharge," she said. "Even if these measures do not create a direct cost saving, by getting patients out of hospital faster, new patients can be admitted faster and we can make better use of our resources."

New health regulator

Health care providers that fail to provide good quality and safe care for the public could be ordered to close temporarily by the new regulator for health and adult social care. The Department of Health has announced that the new regulator — to be called the Care Quality Commission (CQC) — will bring together the expertise of the Healthcare Commission, Committee for Social Care Inspection and Mental Health Act Commission.

Unlike its predecessors, the CQC will not just bring problems to the attention of the government and public. It will be empowered to take rapid and appropriate action against health care providers that put patients or service users at risk. The CQC is expected to assume its duties in April 2009.

Consultation opens on professional leadership

Hospital pharmacists have been urged to respond to the consultation on the possible options for a new professional leadership body for pharmacy, which began this month.

Speaking at a press conference at the launch the consultation, Nigel Clarke, chairman of the independent inquiry commissioned by the Royal Pharmaceutical Society, said that he was particularly keen to hear from hospital pharmacists and locum pharmacists. "A professional body that is perceived by parts of the profession not to properly represent their interests isn't going to work," he said.

Jean Curtis, professional secretary of the Guild of Healthcare Pharmacists said: "It

is extremely important that everyone puts their views forward, from both hospitals and primary care. It would be helpful if members would also forward their responses to the guild so that we understand how the members feel and what they want from a professional leadership body." She added that members can do this by copying their submissions to their regional guild member.

A draft consultation document was due to be published on the inquiry website (www.theclarkeinquiry.com) as *Hospital Pharmacist* went to press.

The consultation will close on 31 January 2008 and the final report will be presented to the Society in March.

brief

■ A consultation on the regulations relating to the "responsible pharmacist" (replacing "personal control") has been launched by the Department of Health. The proposals can be accessed via *PJ Online* (www.pjonline.com/hp). Closing date 20 January 2008.

■ A new strategy for managing medicines information in the NHS has been launched by UK Medicines Information (UKMi). Building on its 2000 strategy, the new strategy takes into account political, policy and organisational change in the NHS. It details five aims for UKMi, including reflecting a patient-focused NHS and collaborating with other organisations at national level. It can be accessed at www.ukmi.nhs.uk.

■ Updated guidance on good practice regarding Controlled Drugs in secondary care in England has been published by the Department of Health. Advice covers the appointment of destruction witnesses by accountable officers, record keeping requirements and the possession and supply of CDs by operating department practitioners. Interim guidance on future requirements for requisitions and record keeping has also been published. It can be accessed via *PJ Online* (www.pjonline.com/links/hp).

■ Girls aged 12–13 are to be routinely vaccinated against cervical cancer from September 2008, Health Secretary Alan Johnson has announced. There will also be a two-year "catch up" campaign for girls aged up to 18 years, starting in autumn 2009. The decision follows advice from the Joint Committee on Vaccination and Immunisation based on an evidence review.

Non-inferiority trials criticised as unethical

Non-inferiority and equivalence trials for new drugs should be banned because they are unethical, say researchers.

They argue that non-inferiority trial designers can arbitrarily set allowable limits of inferiority, meaning that test drugs could be less safe than current therapy, without this being recognised. For example, the COMPASS study determined the thrombolytic drug saruplase to be non-inferior to streptokinase post-myocardial infarction, despite causing 35 more deaths per 1,000 patients treated.

They conclude that non-inferiority trials answer no useful clinical question, and it is unethical to recruit patients into a trial from which they cannot benefit. Their criticism could extend to equivalence trials, which aim to prove that a new product is not much worse (or much better) than a comparator. The article was published online in *The Lancet* on 23 October (www.thelancet.com).

Flu vaccination in the elderly does not reduce hospital cases

Influenza vaccination should not be the sole tactic for reducing hospital admissions of elderly patients over the winter months, according to a group of UK researchers.

A case-control study examining the effect of flu vaccination on preventing hospital admissions in the elderly between October 2003 and March 2004 found that routine flu vaccination did not reduce hospital admissions.

Cases were defined as patients who presented to their GP with acute respiratory illness and were consequently admitted to hospital. Controls were recruited from the patients who presented to their GP but were treated in the community.

Of the 157 cases, 74.5 per cent had received a flu vaccination at least three weeks before they presented to the GP, compared with 74.2 per cent of the 639 controls. After adjustment for factors such as age, sex and smoking status, this gave an odds ratio of 1.2 (95 per cent



Flu vaccination alone will not reduce pressure on hospital beds over the winter

confidence interval 0.8–1.9). A benefit was observed when analysis was restricted to the weeks of peak virus activity (9 November to 9 December), although it was not statistically significant.

However, the researchers cautioned against interpreting their results to suggest that flu vaccination was futile, because other benefits of vaccination (eg, reducing infection,

morbidity and mortality) had not been assessed.

They say that rather than relying on flu vaccination to reduce winter bed pressures, attention should be given to other factors such as treatment of comorbidities and housing conditions.

The study was published online in *Vaccine* on 21 September and can be accessed at www.sciencedirect.com.

New use for topiramate

Topiramate has shown promise for treating alcohol dependence, according to a US study.

A double-blind, randomised, placebo-controlled trial was conducted on 371 patients, aged 18–65 years, who consumed large amounts of alcohol (more than 35 standard drinks per week for men, 28 for women). After an assessment of drinking habit during the 28 days prior to the trial, each participant was assigned either a titrating dose of topiramate (up to 300mg per day) or placebo.

Participants were asked to report the number of days in which they had drunk heavily over a 14-week period. This was defined as at least five standard (ie, containing 14g absolute alcohol) drinks in a day for men and at least four for women. All patients

who dropped out of the study were assumed to have reverted to their original drinking habits. In the topiramate group, 70 of the 183 participants dropped out, compared with 44 of the 188 given placebo.

The topiramate group displayed an average decrease in heavy drinking days from 81.91 per cent to 43.81 per cent. This compared with 82.97 per cent to 51.76 per cent for the placebo group. The topiramate group were also more likely to complete 28 days without drinking heavily and 28 days of continuous abstinence.

The researchers concluded that topiramate was a safe and consistently efficacious treatment of alcohol dependence, and warrants further research (*JAMA* 2007;298:1641–51).

Hospital drug costs rise

Estimated costs of drugs used in NHS hospitals in England rose by 7.7 per cent last year, compared with a 3.2 per cent increase in the cost of prescribing in primary care, new statistics published in a bulletin from The Information Centre show. Medicines issued in NHS hospitals in 2006 represented nearly 24 per cent of the total cost of medicines, which was £10.3bn.

The strategic health authority with the greatest proportion of drugs supplied by hospitals (excluding items prescribed on FP10HPs) was London SHA, at 38.2 per cent. Reasons for this include the presence of tertiary hospitals in the SHA (which tend to provide more expensive medicines) and local arrangements in which drugs are provided through hospitals rather

than through primary care. The lowest proportion of drugs supplied by hospitals was found in the South East Coast SHA.

Other findings include that the proportion of low-cost statins and low-cost proton pump inhibitors used in hospitals was higher than in primary care. The bulletin says that this may be because more new patients are initiated on these drugs in hospital, whereas patients in primary care may have been started on these drugs when prices were different.

Interferon beta had the highest level of prescribing, by cost, for drugs supplied on FP10HP prescriptions and dispensed in the community.

The bulletin can be accessed via *PJ Online* (www.pjonline.com/links/hp).