

Response to Chemotherapy Services in England, ensuring quality and safety: a report from the National Chemotherapy Advisory Group, draft for consultation

The British Oncology Pharmacy Association (BOPA) and the Cancer Network Pharmacists Forum (CNPF) would like to offer our congratulations and support to the National Chemotherapy Advisory Group (NCAG) on the production of such a positive, constructive and forward looking report. We look forward to continuing our involvement with the implementation of the final report, which will represent one of the most important contributions to, and challenges for chemotherapy services since their inception.

We offer the following points for consideration as part of the consultation process. Where we have been able we have suggested alternative wording and where it should be inserted into the report.

General Comments

As a general comment we feel that the NCAG report should carry sufficient weight, perhaps similar to an NICE Improving Outcomes Guideline (IOG), so as to render it a “must do” document. This would facilitate its uptake and implementation by promoting both acute trust processes and the commissioning cycle. A preface stating this as well as an implementation time frame is needed.

Chapter 2: The Chemotherapy Pathway

Step1: Access and referral to an oncologist

Acute Oncology

The importance of the oncology pharmacist involvement in the ‘acute oncology team’, particularly in terms of safe prescribing, should be included in the report. A lack of this direct involvement was seen to contribute to reported amphotericin fatalities last yearⁱ. These incidents highlighted that when a specialist oncology pharmacist became involved the error was spotted immediately – whilst this was unfortunately too late for those patients it adequately demonstrates the need for the ‘real time’ specialist check.

BOPA is the British Oncology Pharmacy Association. The stated purpose of BOPA, which is a registered charity, is "To promote excellence in the pharmaceutical care of patients with cancer through education, communication, research and innovation by an alliance of hospital, community and academic pharmacists, pharmacy technicians, those in the pharmaceutical industry and other healthcare professionals".

We would suggest the following changes to paragraph 2.5 - replace “pharmacy” with “specialist oncology pharmacist”.

As an integral part of the quality and safety of chemotherapy services we believe the NCAG report should consider mandating a review of chemotherapy related clinical incidents. This should be carried out in a similar way to the current measures for use of non-approved Network regimens which require trust Chemotherapy Groups to monitor this at every meeting and Network Chemotherapy Groups on an annual basis. These reviews should include “near misses” which may not have led to an actual IR1 incident report.

Step 2: Assessment and decision to treat

A requirement for all chemotherapy patients to have a treatment plan for each line of chemotherapy they undergo, similar to those used by the clinical oncologist for radiotherapy would be of positive benefit to patient care and a practical document for the consultant to initiate and sign.

Suggested wording in section 2.15

All patients should have a treatment plan for each line of chemotherapy they undergo. This treatment plan must be authorised and signed by a consultant oncologist or haematologist.

This treatment plan should include the following information as a minimum:

- *Diagnosis*
- *Treatment intent*
- *Tests required pre-chemotherapy*
- *How often response will be assessed (e.g. CT scan after cycle 3)*
- *Criteria to stop/review decision to continue therapy*

These care plans should be supported by the production, and maintenance of a core nationally approved web based chemotherapy protocols, which should be linked to the Office of Population Censuses and Surveys Classification of Surgical Operations and Procedures (OPCS) chemotherapy regimen list. The CNPF is involved in the development of the OPCS chemotherapy regimen list and would be keen to be involved in the development of nationally approved web based chemotherapy protocols.

Steps 3, 4 and 8: Prescribing and dispensing

There are two distinct but complementary components to the oncology pharmacy service. The *clinical pharmacy* services role includes chemotherapy

prescription verification i.e. ensuring that the prescription details are complete, clear and unambiguous and clinically appropriate for the patient at the time. The *aseptic compounding* role includes responsibility for dose preparation and ensuring that the final product is exactly as prescribed. Although one pharmacist may have both roles, it's more usual that they are split between two individuals and are physically separated in time and place. In these circumstances, and particularly as outsourcing of aseptic compounding services becomes more common, it is critical that these respective responsibilities are explicit. Where the compounding service is outsourced, responsibilities and accountabilities must be clearly defined in the service level agreement between trust and third party provider(s).

In addition we would like the wording "appropriately trained pharmacist" strengthened and suggest a variation of the wording used in the NCEPOD report:

Section 2.25 replace bullet point 6 with

- All chemotherapy prescriptions should be checked by a pharmacist who has undergone specialist training demonstrated their competence and are locally authorised/accredited for the task. This applies to oral as well as parenteral treatments.*
- Oncology Pharmacist should sign the chemotherapy prescription to indicate that it has been verified and validated for the intended patient and that all safety checks have been undertaken.*
- The pharmacist clinical pharmacy check signature must be visible on any paper based prescription that is used for chemotherapy delivery or administration. This includes prescriptions for oral chemotherapy.*
- Trusts using electronic prescribing systems should ensure that these systems are fully validated, and that as for paper based prescribing a clinical pharmacy check is required to authorise the prescription. This needs to be auditable.*

We would like NCAG to be aware that BOPA and the CNPF are currently commencing work on the development of a number of standards that will support the recommendations in this report. We propose to:

- Set standards for assessment of chemotherapy prescriptions.
- Set standards for the quality of oncology clinical pharmacy service provision e.g. Prescription monitoring, patient monitoring parameters, discharge planning, patient counselling.
- Set standards for the minimum level of clinical pharmacy services to oncology wards in relation to time allocation, band of staff and level of expertise.

We would suggest, however, that there should also be a recommendation stating that local procedures must be in place to ensure the roles of

responsibilities of the multidisciplinary team members are clear with regard to checking responsibilities.

The report should specifically require multidisciplinary training and competencies for tasks such as the prescribing and administration of chemotherapy.

Action point for section 2.25

Each chemotherapy service should require multidisciplinary training and agreed competencies for the prescribing, dispensing, checking and administering of chemotherapy.

Chapter 3: Models of Chemotherapy Service Delivery

Suggested wording for pharmacy specific service level descriptors:

Level 3

Oncology clinical pharmacist(s): always based on site

Compounding chemotherapy: based on or off site

Oral chemotherapy dispensing: available on site

Level 2

Oncology clinical pharmacist(s): usually on site

Compounding chemotherapy: on or off site

Oral chemotherapy dispensing: usually available on site

Level 1

Oncology clinical pharmacy: advice accessible but not necessarily on site

Compounding chemotherapy: may be off site

Oral chemotherapy dispensing: may be off site

The importance of oncology pharmacy technicians many of whom undergo considerable additional specialist training should be acknowledged as should the need for additional trained staff to facilitate the extensive portfolio of clinical trials.

Workforce and training

We acknowledge the difficulties in defining and counting the oncology pharmacy workforce and support more research in this area. With the suggested increased roles of oncology pharmacists we suggest the following wording for paragraph 4.16:

In order for oncology pharmacists to provide the levels of service required by the report, trusts should ensure that they have job plans which adequately reflect the time they will need.

Leadership

The report should specifically acknowledge that the leadership of chemotherapy services for a trust could be carried out by a consultant pharmacist.

Suggested insertion in para 4.17

....who can provide both professional and chemotherapy service leadership.....

We recognise the effort that the Cancer Action Team (CAT) have put in to developing the network pharmacist post. Recent audit suggests that most networks do have a named person in the post, however many of these posts are still not substantive or are “borrowed” from clinical pharmacy time. For this reason we would ask that the following be added to strengthen the recommendations for a substantive funded network pharmacist post.

Suggested additional paragraph under section 4.4

Historically pharmacists have not always been substantive members of the network team. Given the extent of current guidance in the funding, delivery and commissioning of chemotherapy services a network pharmacist should be considered essential.

If you require any clarification of any points raised in this reply please do not hesitate to contact either Anne Hines, Chair, CNPF or David Thomson, Chair, BOPA. We look forward to being in the forefront of the changes in chemotherapy services that this report will undoubtedly bring.

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References

ⁱ <http://www.npsa.nhs.uk/nrls/alerts-and-directives/rapidrr/injectableamphotericin/>