There are many pharmacy technicians who have developed their role into that of an oncology specialist pharmacy technician. Most often whilst working at specialist cancer centre hospitals. In this article Judith Chaffey describes the changes that have been put in place to develop the oncology pharmacy technician role within Northumbria Trust, a large district general cancer unit.

NORTHUMBRIA HEALTHCARE is England’s most northerly NHS Trust, and, geographically, one of its largest. Aseptic preparation for the Trust is undertaken at the centralised unit based at Wansbeck General Hospital. The unit provides chemotherapy to three hospital sites 20 to 40 miles apart.

I am the senior technician who manages the unit. The Trust has already skill-mixed successfully in pharmacy; hence all aseptic manipulations are undertaken by a team of specially trained and competency assessed dispensing assistants (ATOs).

The Trust’s oncology pharmacy service is led by a Pharmacist who is a joint appointment with the North of England Cancer Network and is the Trust Chemotherapy Lead Clinician. As part of the vision for the development of pharmacy and in particular oncology pharmacy in the Trust the role of the senior technician was identified as one of great potential.

The development of my role to become an oncology specialist pharmacy technician several aspects.

- Becoming the Medicines management link to each of the three oncology day units within the Trust, visiting them weekly to proactively organise and pre-screen prescriptions prior to sending them to the Aseptic Unit.
- Taking drug histories from chemotherapy patients and performing a medication review.
- Education and Training
- Performing a clinical check and validating chemotherapy prescriptions.

My visits to the oncology day units are always interesting and challenging. I deal with many queries, such as dose queries, treatment dates that do not add up, or queries around whether it is feasible to provide treatment, which generally I can deal with immediately. More involved queries such as problems with administration of chemotherapy or adverse reactions are dealt with in partnership with Steve Williamson, our Lead Pharmacist for Cancer Services, who had encouraged and supported my independence. Dealing with queries such as this has really made me feel part of the multi-disciplinary team, as I can be working as equal with nurse specialists and consultants, and has increased my understanding of their role.

Pharmacy link
The oncology nursing staff have found my visits really helpful, they particularly like having a link with pharmacy as they feel that “it ensures a much better team approach for cancer services as a whole”. It has also given the nursing staff an insight into what it takes to produce intravenous chemotherapy, and has made them more appreciative of potential problems and possible reasons for delay.

I also tackle supply issues whilst visiting the oncology day units. This mainly involves ensuring that prescriptions are written, signed and validated well in advance of the required date of treatment, so ensuring that the workload in the aseptic unit can be planned, that the centralised service can work to its full potential, and that unnecessary patient waits are kept to a minimum.

Again, this aspect of my role has generated very positive feedback from the oncology nurses and managers. There are fewer errors on the prescriptions - Errors are quickly picked up on and dealt with. The ordering system is checked and chased. There are fewer ‘lost’
THESE ARE interesting times for pharmacists. The registration and regulatory function of the Pharmaceutical Society is to be hived off to a separate body, leaving the Society to search for a role. BOPA is contributing to this debate and must be in a position to be able to participate in any future organisation.

Oncology pharmacy is also facing challenges. The introduction of an increasing range of oral cancer treatments will result in more dispensing moving to the community. This raises the issues of training and accreditation of all pharmacy staff involved in cancer treatment. BOPA has formed an accreditation working group to examine this, and to discuss with other pharmacy groups how this will fit in with a new pharmacy structure. This has been raised in this newsletter and members will be informed in future newsletters of the progress.

We all perform different roles. One article describes the expanding role of technicians in cancer treatment, and another illustrates that geography will present no boundaries for a dedicated professional.

Editorial

Facing the challenges ahead

Jeff Koundakjian
Editor

BOPA NEWSLETTER
June 2007 • Issue 35

For hospital doctors, specialist nurses, oncology pharmacists, radiographers, GPs, other health care professionals & pharmaceutical industry personnel who wish to improve their understanding of the underlying science & clinical management of cancer.

9 – 13 July 2007

Department of Biological Sciences
University of Warwick

The course will introduce the scientific background of cancer development and tumour spread. The second part of the course will provide a clinical perspective of the diagnosis and treatment of cancer. The 4th day will concentrate on the pathology and management of specific cancers.

Course leaders: Dr Mike Khan & Dr Alan Morris (University of Warwick)

Application form/enquiries to:
Dr Stephen Hicks, Dept. of Biological Sciences
The University of Warwick, Coventry CV4 7AL
Email: s.j.hicks@warwick.ac.uk
Telephone: 024 7652 3540
Facsimile 024 7652 3701

Web site for application form download:
http://www2.warwick.ac.uk/fac/sci/bio/shortcourses/calendar/
Huge range of questions to be asked

Opportunity for BOPA to influence future

MAY YOU live in interesting times! - allegedly an ancient Chinese curse, quoted by Robert Kennedy in the sixties has certainly come true. For those of you who haven't noticed, a government white paper entitled 'Trust, Assurance and Safety - Regulating the Professions' was published in March looking at how the health professions are regulated and promoted.

One of the major proposals contained in the white paper is the creation of a General Pharmacy Council and formation of a body 'akin to a royal college'

Whilst some sectors of the pharmacy profession have looked upon this as sounding the death knell for the pharmaceutical society there are enormous opportunities for us all with the proposal for the creation of a Royal College for Pharmacy.

At the many meetings since called to discuss these proposals and to inform Lord Carter's working party, BOPA as an invited stakeholder have been putting forward the view that any college developed should contain faculties to allow the further development of specialisations and the recognition of different levels of practice within specialisations. The royal college could form an umbrella organisation to encourage the sharing of best practice between specialist interest groups and also between different sectors of the profession. The government white paper couldn't have come at a better time; allowing BOPA along with other specialist organisations to push for formal accreditation of the expert skills required by our members.

Whilst there remain a huge range of questions to be asked about the timescale and funding for the formation of a royal college, I believe that as an organization BOPA must grasp this opportunity to influence the shaping of what will become one of the dominant forces in our professional lives.

Briefing Paper: Accreditation for specialist oncology Pharmacists

THE PURPOSE of this paper is to inform interested parties of the intention of the British Oncology Pharmacy Association to seek formal accreditation and revalidation for Oncology Pharmacists

In the light of the government’s response to the Foster and Donaldson reports it is becoming increasingly obvious that pharmacists offering services at advanced levels will require an opportunity to demonstrate their fitness to practice not just generally as all pharmacists but also within their specialist area.

To this end, the British Oncology Pharmacy Association are seeking to develop a system of accreditation for specialist oncology pharmacists. Precedents have already been set by various groups such as the neonatal and paediatric pharmacists, the mental health care pharmacists and medicines information pharmacists.

Any accreditation system has to be broad enough to encompass the activities of pharmacists involved in oncology in all branches of the profession; it should also be at different levels to allow recognition of practice at entry level through to advanced levels. Use of existing accreditation systems such as the Advanced and Consultant level framework and when available, the framework for Pharmacists with a Special Interest will facilitate this. The BOPA competency framework for specialist oncology pharmacists will complement this process. Whilst use of the KSF within the NHS will ensure an individuals professional development, use of a nationally recognised accreditation process will ensure that patients and employers can be assured that oncology pharmacists operate at a consistent high standard wherever they are employed.

Ideally the accrediting body should be based within existing pharmacy structures, for example a faculty of the College of Pharmacy Practice, although the potential development of a Royal College may present other opportunities.

The accreditation process will allow employers to be assured that potential candidates have the requisite skills and knowledge for specialist oncology posts. It will also provide a career route for pharmacists in oncology; use of the ACLF will enable pharmacists to demonstrate that they are suitable candidates for consultant pharmacist posts as they are developed in oncology. Inclusion of the PwSI framework when available will allow community and primary care pharmacists to respond to the inevitable shift away from the traditional care settings for patients with cancer.

It is the intention of the British Oncology Pharmacy Association to develop an accreditation system appropriate to all pharmacists interested in oncology whatever their sector of employment. Interested parties are invited to support this intention and to give any feedback to the BOPA executive committee.
APPARENTLY I have an interesting job. To be honest, I’ve never really thought about it, but since the subject came up at the (wonderful!) BOPA conference in Bournemouth last October, I have to concede that I probably do.

My official job title is Clinical Pharmacy Manager at Lorn & Islands District General Hospital, Oban. In theory 50% of my time is spent in the clinical pharmacist role and 50% as an oncology pharmacist. In reality it depends which way the wind blows (quite literally, sometimes, but more of that later).

A Day in the Life goes something like this:

8.30am:
Enter hospital through main entrance to be greeted in foyer by one of our breast cancer patients.

“Hi Sandra. Just wanted to check if I should come up to-morrow and get my bloods done, or wait till Thursday?”

(What? Who are you again? Please let me get my coat off!)

“Hi Mrs X.” (Got the name, just in time)

“How are you?”

“Hi, I’m fine, thanks – just a little tired. Would I be as well to get my bloods done to-morrow, when I’m here anyway?”

Now this is a small DGH, and we do pride ourselves in giving a more personal service than is possible in the bigger centres, but I don’t actually carry round everyone’s schedule in my head. It does start coming to me, however, that this lady is due her next cycle (of AC) on Thursday. I’m pretty sure it’ll be her 3rd cycle, but all this information is carefully documented in her care plan in pharmacy.

I sort out Mrs X, and head for the pharmacy, hoping to get the kettle on and answer a few emails before the rest of the staff come in and the onslaught starts. No chance. “Just thought I’d catch you early” seems to be the theme of the day from the wards.

9.30am:
Staff all here and working to plan. (One other pharmacist and two technicians). Time for ward rounds. Go upstairs expecting the usual exacerbation of COPD, MIs, DVTs and “off legs”, probably due to UTI. No surprises here then, but also an unusual case of Neuroleptic Malignant Syndrome – a rare side effect of atypical antipsychotics. Symptoms are pyrexia, muscle rigidity, coma and death. Our patient has the first three. Responds well to IV Dantrolene.

Called away to emergency meeting called by the Infection Control Nurse to discuss the action plan for the newly discovered case of Norwegian Scabies. This isn’t just your ordinary scabies – oh no – this is much more contagious.
Need to organise a truck-load of Lyclear from our supplier (Who's 90 miles away, and delivers three times a week. Yes, a week.) and what about the staff who are pregnant?

11.30am

Check email. New colorectal patient on the horizon. Would be candidate for weekly 5FU, but lives on Colonsay - an island approximately 20 miles south-west of Oban. There is a direct ferry route from Colonsay to Oban, but it only runs three days a week. Each weekly trip to receive chemo would take 3 days. Patient keen to avoid this, if possible. Will discuss this with the team at Thursday's Oncology meeting. A possible solution might be Capecitabine, depending on patient suitability and taking island remoteness into account. Would need to rely on telephone assessments and cooperation of local GP. (There is a GP on Colonsay, but no district nurse).

It’s probably worth explaining that the oncology service here is delivered on a daily basis by the Macmillan Clinical Nurse Specialist and the Oncology Pharmacist (Yours Truly, ably supported by my colleague, Pam McGuire.) This is supported by a twice-monthly visiting oncologist, from the Beatson Oncology Centre, some 100 miles away, in Glasgow with the additional back-up of 24/7 consultant physician on-site cover. In the eight years that we have provided this model of care it has worked very well. The logistical challenges of having a visiting oncologist who is only on-site two days per month provided the impetus for me to undertake supplementary prescribing training – an opportunity that the whole team recognises as being potentially beneficial to our situation. I have been practising as a supplementary prescriber since July 2005 and it certainly seems to be working well.

So how has this affected my job? Well, instead of hunting down a junior doctor to prescribe Loperamide for 5FU induced diarrhoea, or to add Granisetron to a prescription I can do it myself. Better continuity of care and prescribing by the most appropriate healthcare professional. Ideal.

As I said earlier, half my time is spent delivering a clinical pharmacy service to the hospital. My own hands-on contribution to this in input to the acute medical wards. (Pam covers Care of the Elderly, Surgical and the Dispensary)

3pm:

Go up to medical ward to counsel a patient who has been started on Warfarin. Notice that one of our breast cancer patients has been admitted to the High Dependency Unit. Not sure what the medical term for this is, but I think “Eekkk!!” probably covers it. Instant panic. I had prescribed her first cycle of CMF last week. I’ve obviously miscalculated! Oh no! Now she has neutropenia, might die and it’s all my fault!! Scurry down to pharmacy and re-check (my doubly checked) calculations. No, I haven’t poisoned her. I work up the courage to go back to the ward and find out why she’s been admitted. She has an infection in her central line and is getting appropriate IV antibiotics. A complication of therapy, not anybody’s fault. Brings it home, though, which is no bad thing. It’s all very well basking in the glory of being a prescriber (and let’s face it, the responsibility that goes with it too. It’s probably worth explaining that the oncology service here is delivered on a daily basis by the Macmillan Clinical Nurse Specialist and the Oncology Pharmacist (Yours Truly, ably supported by my colleague, Pam McGuire.) This is supported by a twice-monthly visiting oncologist, from the Beatson Oncology Centre, some 100 miles away, in Glasgow with the additional back-up of 24/7 consultant physician on-site cover. In the eight years that we have provided this model of care it has worked very well. The logistical challenges of having a visiting oncologist who is only on-site two days per month provided the impetus for me to undertake supplementary prescribing training – an opportunity that the whole team recognises as being potentially beneficial to our situation. I have been practising as a supplementary prescriber since July 2005 and it certainly seems to be working well.

So how has this affected my job? Well, instead of hunting down a junior doctor to prescribe Loperamide for 5FU induced diarrhoea, or to add Granisetron to a prescription I can do it myself. Better continuity of care and prescribing by the most appropriate healthcare professional. Ideal.

As I said earlier, half my time is spent delivering a clinical pharmacy service to the hospital. My own hands-on contribution to this in input to the acute medical wards. (Pam covers Care of the Elderly, Surgical and the Dispensary)

3pm:

Go up to medical ward to counsel a patient who has been started on Warfarin. Notice that one of our breast cancer patients has been admitted to the High Dependency Unit. Not sure what the medical term for this is, but I think “Eekkk!!” probably covers it. Instant panic. I had prescribed her first cycle of CMF last week. I’ve obviously miscalculated! Oh no! Now she has neutropenia, might die and it’s all my fault!! Scurry down to pharmacy and re-check (my doubly checked) calculations. No, I haven’t poisoned her. I work up the courage to go back to the ward and find out why she’s been admitted. She has an infection in her central line and is getting appropriate IV antibiotics. A complication of therapy, not anybody’s fault. Brings it home, though, which is no bad thing. It’s all very well basking in the glory of being a prescriber (and let’s face it, the Pharmaceutical Care Awards gave ample opportunity for that) – but there’s a huge responsibility that goes with it too.

4.30pm

Catherine, one of our wonderful technicians notices that there is no Filgastrim in the pharmacy order which has arrived this afternoon form the Vale of Leven. Next delivery is due on Friday at 5pm. We need it for a patient who’s coming in to-morrow for her chemotherapy. No problem I say. We always keep a couple in stock, so we’ll be able to start her off and I’m sure someone will be able to pop in for the balance on Friday. Where does she stay? The Isle of Mull. Of course she does! OK, plan B...

And speaking of Mull, part of my remit is to visit the small community hospital on that island, periodically, check their Controlled Drugs and deal with any pharmacy “issues”. This normally involves a trip on the Cal-Mac ferry, picking up the “hospital” car, doing the pharmacy bit then waiting for the next ferry back to Oban. Enter my ingenious plan to save the NHS the £6.50 ferry fare:

Cut out the drive from home to Oban and the wait for the ferry. Instead take own sailing boat directly from home (Easdale Island) to ferry terminal on Mull. Take crew and camera (to video porpoises frolicking in the sea) and arrive on Mull 10 minutes before the ferry. Inflate dinghy and row ashore, (whilst crew minds the boat) carry out pharmacy checks as usual and sail to Oban. Carry out a few tasks there and set sail back to Easdale. Great plan, got the job done and saved the said ferry fare. Unfortunately the weather blows up and the return leg proves more challenging, beating into the wind, tide and rain, as darkness falls. As we finally enter Easdale Sound on a particularly treacherous piece of coastline I say to Jan (the more experienced sailor, I have to admit) “I’m glad I know this part of the coast well, I can hardly see a thing!”

“No,” she says. “I’m glad you do too!” No pressure then.

We arrive safely, if a little late (10pm) and as I enter the house, doing a good impersonation of a drowned rat, my husband (who’s a little relieved to see me) tells me the hospital has been on the phone. I check this out (I’m not on call) and discover that there has been a discrepancy with a controlled drug order. “Of course, it can wait till the morning” says the senior nurse, “but I thought you’d rather know to-night!” Ah, the joy of small hospitals!
prescriptions. There seems to be less chemotherapy prepared and then not used. Perhaps the most gratifying point for everyone has been that nursing time has been saved - this time can be better used on direct patient care. Nursing staff felt that there were no negative points about the links with pharmacy, and they all felt very strongly that the service should continue.

Medication Histories
Currently, I or an oncology trained pharmacist visit each of the three oncology day units within the Trust on a ‘when required’ basis to take a medicine history and review for patients identified by one of the oncology nurses. The review is of potential contra-indications or interactions between the chemotherapy regime and any regularly taken medications, including herbal remedies. The review is a further opportunity for side effects or problems with chemotherapy to be identified. This direct patient contact has really increased my job satisfaction. The patients are appreciative and we have demonstrated the value of the service.

Referral to Pharmacy
Whilst we would love to be able to undertake a medication history and pharmaceutical care assessment of all chemotherapy patients, audit has shown that it is just not practical and indeed not needed for everyone. We have adopted a ‘targeting tool’ for referral to pharmacy for review. All patients are screened for referral to pharmacy on chemotherapy pre-assessment by the nursing staff against the following criteria:

- Patient regularly taking 4 or more medications
- Patient taking any complementary or alternative medicines (CAMs)
- Nurse is concerned in some way about the patient & their medications
- Patient has an individual drug-related query

Referrals are made using a system that is appointment based. The nursing staff inform pharmacy that a referral has been made. The patient is seen by a member of the pharmacy team whilst having their first or second course of chemotherapy, which gives pharmacy the ability to plan reviews with a degree of flexibility. If the nurse feels that the query or referral is more urgent than this, then telephone queries can be made to pharmacy. Medicine histories/reviews are not conducted by telephone.

Queries received during these medication reviews have mainly been of the type:

- ‘Can this patient take less regular medications?’
- ‘Can I still use fake tan whilst having chemotherapy & can I use it on my radiotherapy site?’

I use various literature sources as well as the internet when looking for information to answer such queries. I always discuss my findings with an oncology trained pharmacist before passing on any information to the patient. During the course of the medication review, I deal directly with the patient’s G.P. surgery to check details of regular medications, dosages, frequency and timings of last issue of a prescription, so ensuring that the review is as complete as possible. I document all of the information gleaned from my searches and from the telephone calls to G.P. surgeries in the appropriate section of the patient’s nursing notes. I also document any advice given and/or potential interactions. At a later date, this medication review is countersigned by an oncology pharmacist.

Technician Clinical Screening
A service development was recently proposed in the Trust to allow a suitably experienced technician such as myself to validate
chemotherapy prescriptions after undergoing an extensive training scheme. A documented record of training is required, with the head of pharmacy accepting responsibility. Under such a scheme a specially trained technician could:

- Check surface area calculations
- Check the patient’s treatment against the chemotherapy protocol
- Check that the dose is calculated properly
- Check that prescription details are completed appropriately
- Adjust doses according to dose banding protocol
- Check maximum doses according to protocol

The scheme does have certain limitations. The first course of chemotherapy must always be validated by a pharmacist. Referral to a pharmacist is required when:

- There are dose modifications or variances from protocols.
- Critical tests need interpretation e.g. impaired renal function, clotting disorders; liver function tests (as appropriate for drug).
- To double check cumulative doses where limits are approached (i.e. anthracyclines).
- To check new/unrecognised chemotherapy protocols.
- To check handwritten prescription and alterations to pre-printed prescriptions.
- To check any dose banded products where the banding has changed for any reason.

To achieve validation accreditation, I needed to have a suitable level of experience, which was assessed by the Lead Pharmacist for Cancer services. I also completed the validation training scheme, to include a log of at least 100 prescriptions checked. Approval for this role extension has also been sought from our Pharmacy Operational Board, who took into consideration the guidance given in aseptic standards and peer review.

Developing Underpinning Knowledge

In order to have the necessary underpinning knowledge to allow me to develop my role, I have undertaken an educational programme devised by Steve Williamson. This has been a combination of attending lectures from Steve to pharmacists within the trust, shadowing Steve, background reading, compiling a portfolio of evidence on chemotherapy regimes for common cancers and haematology, and finally sitting an open book exam on chemotherapy and regimes. I have also attended CPPE workshops relevant to my role and completed a CPPE open learning pack on complementary and alternative medicines. This education has been really fascinating and enjoyable, despite all the extra work. I really feel that, as a result of this programme, I have a much more comprehensive knowledge of oncology and so can deal more confidently with nursing staff and patients. However, it has also reminded me how much I actually do not know – I am still very aware of what my limitations are and when to refer to a more senior colleague. Steve has expressed the opinion that the level of oncology pharmacy knowledge I have obtained is equivalent to the junior Band 6/7 pharmacists who rotate through the oncology pharmacy service.

There have been many benefits from my role extension, not just for my own personal development, but also for the department, for oncology nurses and, perhaps most importantly, for patients. Not only have I developed personally, but I really feel part of the cancer services team. Pharmacy has benefited because I have been able to ensure that the work in the aseptic unit can be more easily planned and so the unit can run more efficiently. I have carried out several audits which can provide evidence of this. My visits to the oncology units have also helped to save some pharmacist time, which has then been used on other clinical duties. By chasing prescriptions and sorting out problems and queries, I have saved nursing time; time which can be better spent on direct patient care.

The scheme does have certain limitations.
THE CNPF has got off to a relatively slow start in 2007 partly due to the fact that the last meeting of the group was in September 06 and partly due to the fact that we await the development of the new BOPA website as a tool to help us communicate and manage work-streams more efficiently.

We have agreed to meet three times a year as part of the Network Development Programme (NDP) and I will summarise the discussions at our March 07 meeting in order to give an overall sense of the work we are doing.

**Terms of Reference Membership Review**

We discussed the value of Chief Pharmacist input into the group given the need to tie many of the work streams of the CNPF back to the provider Trust pharmacy department strategies. Whilst it was acknowledged that there is no national network of Chief Pharmacists to engage and that no two Trusts are identical across England, it was agreed that interested Chief Pharmacists might be co-opted to enrich and ground the discussions of the group.

Using this article as an opportunity I would like to ask any Chief Pharmacists reading this, to discuss with their Network Pharmacist whether current arrangements permit sufficient feedback of CNPF issues to you as Chief Pharmacists and also to the Cancer Network about challenges faced by each of the pharmacy departments? If not, how can these arrangements best be strengthened?

**BOPA/CNPF discussion document**

A proposal paper has been circulated to all members of CNPF & BOPA outlining the relative strengths of the 2 groups and how they might work to complement each other. CNPF members have been broadly supportive of the proposals. It was noted that as Networks merge and are restructured in the future the CNPF may need to engage BOPA members increasingly in its various workstreams.
Oral Chemotherapy

Steve Williamson (North of England) circulated a proposal for an MSc research project to look at the role of pharmacists in oral chemotherapy clinics. There was a lively discussion regarding extended roles of pharmacists and suggestion that these largely reflected local need and individual pharmacist interest rather than patient need. It was decided to support Steve’s proposal to design a questionnaire which could be disseminated via the CNPF to ascertain what is currently happening around the country. You may well have completed this survey by the time you read this article.

Related to this, work is being done nationally by Skills for Health to define competencies for involvement in chemotherapy (multidisciplinary). Also, fitting with work being undertaken by the National Chemotherapy Advisory Group (NCAG) there is a need for definition of the future and how services may be redesigned over the next 5 - 10 years in line with the Cancer Reform Strategy.

It was felt that clinical pharmacy services need to take the lead in the development of locality based treatment to ensure that patients continue to benefit from their involvement. It was also agreed that a much wider piece of work should be undertaken by BOPA on the future role of clinical pharmacy services in the cancer care pathway, looking at where our skills can be best utilised for improved patient care as services develop as part of the Cancer Reform Strategy (Cancer Plan 2) to be published in the autumn.

Education and Training, Workforce and Leadership

Geoff Saunders (Greater Manchester and Cheshire) reported that the National Cancer Advisory Group (NCAG) have requested a report on the oncology pharmacy workforce. Geoff has put together a simple questionnaire which, the group agreed, will be sent via Network Pharmacists for completion by all staff involved in cancer pharmacy. This will be an update of the BOPA toolkit – now 5 years old but will only be in paper format. There would be one questionnaire for each member of staff and it is being refined for clarity and to try to determine the amount of staff time actually used for cancer care recognising the mosaic nature of pharmacy working. It was also suggested that the questionnaire should also request some selected workload data in an attempt to make a link between staffing and workload around the country.

Chemotherapy HRGs

Anne Hines (Merseyside and Cheshire) noted that the new coding document including chemotherapy (version 4.4) has now been produced. The CNPF has not been involved in the production thus far but may now be responsible for maintenance of the list. To ensure the list is as complete as possible it was later suggested that networks should review the list of regimens against their network list to highlight omissions. It is also worth hospitals reviewing their drug costs for each regimen to ensure that it fits into the appropriate band. It is suggested that Trusts consider discussing this with coding departments who may start using this in April to check how trust income will change when fully implemented.

Capacity Planning

At present 6 networks are using the CPORT software and are involved in its ongoing development. There have been a number of delays due to NHS IT firewalls and data collection is taking longer than anticipated. Helen Taylor (North London Cancer Network) has been seconded to help develop the software further. Concerns were raised by members that there has been a lack of communication of the delays which has resulted in frustration about lack of wider access to the software. It is hoped that further Networks will gain access to CPORT in April 2007.

NICE

It was noted that members of CNPF have submitted feedback into a number of NICE Technology Appraisal Guidance (examples available on NICE website). The RPSGB has approached the CNPF as a NICE stakeholder seeking collaboration, having identified that to date the RPSGB have been poor at responding to consultation documents. The group agreed that the CNPF is happy to share the toolkit used by its members to encourage joined up working. The CNPF will continue to be the named NICE stakeholder as to add a third party would make the tight timescales very difficult to achieve.

Dose Banding

Andrew Gillian (North East London) noted that following circulation of a scoping questionnaire 103 responses have been received, with 43 sites undertaking some form(s) of “dose banding”. It was noted that the Purchasing and Supply Agency (PASA) is interested in this area as part of the purchasing for safety initiative. This strategy includes the purchasing of medicines and within this “dose banded cytotoxics”.

It was felt that CNPF should lead on the production of a model of best practice for dose-banding but that it would need to engage purchasing pharmacists, QA pharmacists (owing to the unlicensed nature of the products) and the technical services group of BOPA.

Service Framework for Delivery of Chemotherapy

There are six workstreams for the National Chemotherapy Advisory Group. These are at different stages of their work plans and with the recently announced Cancer Reform Strategy due to be published in the Autumn there is now a clear need to develop this work further to inform the strategy.

The lead pharmacist advisor for each project is specified below:

1. Workforce – Geoff Saunders (Greater Manchester and Cheshire)
2. Out of Hours Management – Andrew Stanley (Pan Birmingham)
3. Neutropenic Sepsis – David Thomson (Yorkshire) /Brendan Sullivan (West Anglia)
5. Models of Care – Libby Hardy (Peninsula)

I would just like to add my thanks to the group members who have given their time to be involved in the work outlined above. In my view this a crucial time for secondary care based oncology pharmacy services. The Cancer Reform Strategy, when it is published, is likely to re-enforce the view that where possible services (including chemotherapy) should be provided in the community. Our challenge as a profession and through the CNPF and BOPA is to ensure that where this happens services are as safe and to the same standards as those in a secondary care based setting.

The involvement of both the CNPF and BOPA in a number of the groups that will be informing the Cancer Reform Strategy should mean that ultimately we have a voice and can use it to ensure that this happens. It is the responsibility of you, as BOPA members, and through engagement with both community based colleagues and the private sector to inform the development of a strategic vision of oncology pharmacy services for the future that will support and enhance these newly developed community based chemotherapy services.

The Cancer Reform Strategy will attempt to ensure that cancer services will be fit for purpose in 2010 and beyond and I would suggest that this is a responsibility that oncology pharmacy should share.

David Thomson, CNPF Chair, April 07
NZW 15. North German Cytotoxic Workshop

Norddeutscher Zytostatika-Workshop 15.
Onkologisch-pharmazeutischer Fachkongress

THE NORTH German Cytotoxic Workshop (NZW) is the main meeting of the German Society of Oncology Pharmacists (DGOP). This was the fifteenth annual meeting and was held, as always, in Harburg/Hamburg in January.

The meeting attracts about 300 delegates with pharmacists both hospitals and the community represented. There are parallel sessions and workshops, with the ‘ESOP’ stream, consisting of TWO half day sessions in English (one with simultaneous English translation) and one workshop session. Presenters in the ‘ESOP’ stream included speakers from Canada, the US, Croatia, Austria, Sweden, The Czech Republic, Germany with Geoff Saunders representing the UK. For obvious reasons, I only attended the ‘ESOP’ presentations.

Although presentations varied, the standard was good and all contained interesting and useful points. Geoff explained the structure, purpose and role of the cancer networks and the importance of the pharmacist within the network. This generated quite a bit of discussion which carried onto the coffee break, and also during drinks in the evening. Robert Terkola’s run through the types, advantages and pitfalls of bar codes also created some discussion despite, what sounded, like an off-putting subject.

Other presentations included the preliminary results of a study using Uridine 10% ointment in the treatment of Palmar-Plantar Syndrome. Ten patients have been treated so far with the grade of P-P Syndrome reduces by one to two grades. An aseptic pharmacist from Croatia described the instillation of the first centralised cytotoxic unit in a hospital in Croatia. Whilst it was encouraging to see that the government investing a lot of money in health and safety, it was frustrating to see a lack of advice present in many of the details, e.g. wooden doors, lino tiles etc. Training for the staff, both for handling and in clinical pharmacy was very comprehensive.

Professor Clairbourne E. Reeder from North Carolina discussed four of the most commonly used pharmaco-economic methods. He was very good in getting the audience to participate in identifying the major elements of a pharmaco-economic evaluation which included clinical outcomes, economic costs and consequences, data sources and types of analyses (not easy when, for most of the audience, English was not the first language). Whilst he was critical of using ‘cost per QUALY’ for determining whether a treatment will be used or not, he admitted that this method was being increasingly used in the U.S. to ration health care (only the value varied).

Professor Per Hartvig (Sweden) presented a literature survey from 1980-2006 examining the adverse health effects recorded in handling antineoplastic drugs. He made the point that, due to widespread protection, it was virtually impossible to quantify the level of exposure which presented a risk, and that it is advisable to assume that minimum to no exposure necessary and politically wise.

A most interesting presentation was from a Dutch Community Pharmacist, Dr Foppe van Mille. In the Netherlands, an increasing number and variety of medicines, both for treatment and palliative care are being dispended in the community. This requires additional training and educational needs for pharmacists. The Dutch Scientific Institute for Pharmacy is currently developing a special cancer care protocol for community pharmacists.

The social side of the meeting was very enjoyable, with lots of food, German beer and Australian wine.
European Society of Oncology Pharmacy (ESOP) Delegates Meeting

THIS MEETING was held in Hamburg over 27/27 January 2007 with representatives from 20 countries of the European Union plus Switzerland and Croatia. The acting President of the International Society of Oncology Pharmacy Practice (ISOPP), Carole Chambers from Alberta, Canada, was present as observer.

Elections for the Secretariat were held. Klaus Meier from Germany (who is also president of the German Association of Oncology Pharmacy, DGOP) will continue to be president, and Camille Groos will remain as treasurer. Professor Per Hartvig, Sweden was appointed secretary, Professor Alain Astier, France and Monica Sonc, Slovenia are joint vice presidents and Vesna Pavlica, Croatia, is to be member responsible for South East Europe.

Klaus Meier presented the report from the president and Camille Groos the treasurer’s report. ESOP currently has in the region of 1300 members with France and Germany representing over half the membership. With the affiliation of the United Kingdom into ESOP, BOPA will be the largest national group. Membership fees remain at one Euro per member.

Jeff Koundakjian

UK Delegate

Lasia Tang, editor of the European Journal of Hospital Pharmacy (EJHP) presented the first issue of the ESOP journal, the European Journal of Oncology Pharmacy (EJOP). Copies of this journal will be sent, free of charge, to all members of ESOP twice yearly. The editorial board includes Professors Alain Astier, Per Hartvig and Gunther Weidemann (Germany), Dr Robert Tercola (Austria) and Klaus Meier. Laisa requested contributions from all members.

Details of a Master Class in Oncology were presented by Per Hartvig and Eva Honoré (Denmark). This will take the form of a five day course in two parts. Three days will be devoted to oncology pharmacy services and safe handling of cytotoxic agents and other treatment agents. Three days will be spent on cancer treatment and, in particular, clinical oncology pharmacy. The two halves will overlap on Wednesday.

Participants may attend either part one, part two or both, and the first Master Class will be held in Denmark in October. It is planned to hold this event, initially, on an annual basis in different countries.

ESOP is affiliated with the Federation of European Cancer Societies (FECS) and will be represented at ECCO 14 in Barcelona in September with a special session slot and a stand.

12th Congress of the European Association of Hospital Pharmacy

Bordeaux, March 2007

THIS CONGRESS was devoted to new therapies in the 21st century (and the incentive to study fine wines and rich food in the evenings).

The proceeding started with a keynote lecture about the effects of genome therapy in hospital pharmacy practice and ended with a discussion on the future of non-profit drug development, with symposiums, oral presentations and satellite symposia, most of which were concerned with biological treatments, in between.

A first for this congress, was that all the seminars were repeated on the following day, so if you were organised, you could catch six of the twelve seminars. Of course, you would miss six of the nine satellite seminars and both of the oral presentation sessions, but not the three keynote presentations, the welcome reception or the lunch break (being France, the wines and the food were excellent).

The common theme throughout was about biopharmaceuticals encompassing biotequivalents, gene therapy, tyrosine kinase inhibitors and other targeted (tailor-made) therapies. How they differed or were similar to traditional drugs and the impact in hospital practice. One session was centred on the mode of action, followed by a discussion of the way forward, the toxicities and other events to be expected.

Philippa Brice, from the Public Health Genetics Unit in the UK and V’Iain Fenton-May, a QC pharmacist presented at a seminar on the effect of genetic information on hospital pharmacy practice. Dr Brice presented a review of the current understanding of the role of genetics in human disease susceptibility and treatment, focusing of pharmacogenetics and discussed the trends and possible directions of future developments.

Of a more practical nature, V’Iain Fenton-May discussed the handling of genetic and viral material. Although there is little knowledge and published information, he suggested that we should assume that there is no safe level of exposure to these products. He also suggested that, as the decontamination process may not remove all viral matter, i.e. that matter i.e. that may occur on the outside of the syringe, or the container leaving the pharmacy, separate facilities should be used. V’Iain advised that, when planning future a-septic units, separate facilities for the handling of genetic material be incorporated into the design.

One of the larger stands in the Industrial Exhibition has a display of dispensing robots, each one in an isolator reconstituting ‘cytotoxics’. The concept was very interesting, unfortunately the representatives ignored delegated to talk among themselves, so no information was available.

My attendance to this congress was made possible by an educational grant from Medac UK
SEVERAL HUNDRED delegates from 38 countries attended ISOPP X, the first time the conference was hosted in Asia, making it both a professional and cultural experience not to be missed.

Not only due to the extensive and well balanced programme, but also the “not to be missed” Eurovision style evening where all participants were invited to go native with a song, dance or poem that epitomised their country. Unfortunately (or perhaps fortuitously) despite the United Kingdom being well represented, with more than a few of the usual suspects in attendance, we did what we do best at these functions. Stay put and comment on everyone else in a tribute to Terry Wogan. Long may he reign supreme!

**Rasburicase**

With over 50 posters and 40 presentations taking place over four days it promised to be a stimulating and varied event. And indeed the organisers did not disappoint. Lectures were mixed with discussion sessions that encompassed both educational updates and the latest research. Topics ranging from pharmacogenomics, to pharmacoeconomics, from error management to delivering aseptic services. Of course there was more than the odd clinical session covering such diverse subjects as mucositis, monitoring patients and recent advances in gynaecological cancer. More than sufficient to encompass an entire year of CPD in a mere 96 hours.

Of the best papers presented at the symposium one seemed of particular significance, the use of single dose rasburicase for prevention of tumour lysis syndrome. This topic was also discussed during a series of short presentations on current controversies in oncology. There is emerging evidence, that a single dose of rasburicase may be just as effective as multiple day dosing. The amounts administered start as low as 3mg. The introduction of such an approach, although unlicensed, has the potential to improve patient care whilst minimising cost.

There were two interesting sessions on the global issues surrounding funding of new cancer therapies. The first dealt with the ethics of resource allocation applying the principles of distributive justice. The second noted that despite considerable differences in the financial framework supporting health care systems worldwide all were struggling with the introduction of new technologies. It is perhaps reassuring that the NHS is not the only organisation with limited resources and that this is becoming a truly international issue. Perhaps less comforting is the fact that as yet no one country has developed a universally acceptable solution.

**Funding**

Funding of new cancer therapies is not the only issue uniting oncology pharmacy. The recruitment, training and certification of specialist personnel was also noted to be problematic. This is confounded by the lack of formally recognised training programmes for junior and senior staff with many individuals learning on the job. Again this was noted to be an issue facing many countries. A lively discussion followed on the role organisations such as ISOPP could play in this arena.

No new antiemetic guidelines but rather a fresh approach examining the point at which research into areas such as the treatment of chemotherapy induced emesis should be incorporated into guidelines. This was followed by a session looking at the role that the novel agents, olanzapine and gabapentin play in the treatment of resistant nausea and vomiting. The session was concluded with a brief overview of the known drug interactions between aprepitant and chemotherapy, most notably docetaxel, an important area in which pharmacists play a key role.

**Rasburicase**

April 3rd – 6th 2006

**Debbie Wright**

Cancer Care Directorate Pharmacist
Southampton Oncology Centre

The areas discussed represent a minority of the topics covered by the conference programme. Just as valuable was the opportunity to network with colleagues from around the world who often provided an alternative approach to common problems. This was only my second time at the ISOPP congress, the first being Hamburg in 1995 as a very youthful pharmacist. Perhaps my lasting impression of this symposia was the participation of the audience in all the sessions. No speaker left the auditorium without at least several questions from the floor. This certainly sets us all a challenge for BOPA conference. If we are to continue to be seen as worldwide leaders in the field of oncology pharmacy we must follow this example and continue to be aware of practices elsewhere. ISOPP provides an excellent means to achieve the latter.

Just as valuable was the opportunity to network with colleagues from around the world who often provided an alternative approach to common problems. This was only my second time at the ISOPP congress, the first being Hamburg in 1995 as a very youthful pharmacist. Perhaps my lasting impression of this symposia was the participation of the audience in all the sessions. No speaker left the auditorium without at least several questions from the floor. This certainly sets us all a challenge for BOPA conference. If we are to continue to be seen as worldwide leaders in the field of oncology pharmacy we must follow this example and continue to be aware of practices elsewhere. ISOPP provides an excellent means to achieve the latter.
AT THE successful ISOPP X Symposium in Kuala Lumpur, Malaysia, the venue for ISOPP XI in 2008 was announced as San Diego, USA. However, a clash with the PGA golf tournament at the same venue has sent hotel prices soaring and, as a result, it was decided to move the Symposium to Anaheim, California.

The conference will still be a joint symposium with HOPA (Haematology and Oncology Pharmacy Association) of the USA, and will cater for a wide variety of interests and levels of practice. The important points for your diary: Venue will be the Anaheim Marriot, California (close to Disneyland, so I am told), and the dates are Wednesday June 18 – Sunday June 22, 2008. Current room rates at the Marriot are a reasonable $172/night (about £88), and there are also a selection of less expensive hotels nearby. This promises to be an excellent meeting!

**Standards of Practice**

With Saad Othman being unable to take up his duties, Carole Chambers (President-Elect, Canada) continues to act as ISOPP President. Other ISOPP personnel news of note is the appointment of Felice Musicco (Italy) to the ISOPP Publications Chair. Felice has responsibility for the ISOPP website and also other major publications from ISOPP. One of his first tasks will be to oversee the imminent publication of the ISOPP Standards of Practice. This document has been through its consultation period, and is in the final stages of editing. Compiling this international guidance has been a huge task, particularly for the three editors: Tom Connor (USA), Johan Vanderbroucke (Belgium) and Robbie McLauchlan (Australia).

The ISOPP journal, The Journal of Oncology Pharmacy Practice, has experienced a change of publisher, from Arnold-Hodder to Sage. The journal, known as JOPP, is now fully indexed by Medline. This development has dramatically improved the quality of manuscripts submitted by authors who are keen to publish their work in an international, indexed, peer-reviewed journal that specialises in oncology pharmacy practice. I would strongly encourage BOPA members to read JOPP and submit material for publication. The journal is available as hard copy (free to ISOPP members) and is also published online. If you have any questions about JOPP, or are thinking of submitting a manuscript for publication, please contact me in my capacity as Associate Editor for Europe, Scandinavia and Africa: G.J.Sewell@kingston.ac.uk

For more information on the ISOPP Symposium, ISOPP membership, publications and activities, JOPP and other educational material, regular visits to the ISOPP website at www.isopp.org are strongly recommended!

Graham Sewell
(Immediate Past President, ISOPP)

---

**The 10th Annual Symposium of The British Oncology Pharmacy Association**

**BOPA 2007 GLASGOW**

**10TH ANNIVERSARY**

12 - 14 October 2007
The Scottish Exhibition and Conference Centre
Glasgow

For further details and a programme and registration form, please contact Tracey Reed at Succinct Healthcare Communications on 01494 549100 or email bopa2007@succinctcomms.com. Alternatively, log onto www.bopa-web.org
Participants are invited to present results of their clinical and technical work as a poster. The author/s should submit to Succinct Communications by 5pm on Friday June 29th 2007, an abstract of the work to be presented. The abstract serves at least two purposes. One is to inform participants at the conference of the content of the contribution; this helps understanding of the material presented and facilitates its discussion. Another is to allow its inclusion in the conference programme and the proceeding of the meeting. Abstracts will be assessed for acceptability against the following criteria:

1. Posters should consist primarily of the work of the authors and it is a condition of acceptance that at least one of the authors intends to attend the meeting as a registered delegate.

2. The contribution should relate to original work in oncology pharmacy and normally will be a report of: a) A completed piece of work, or b) Work in progress with completion planned in time to allow outcomes to be reported in the poster itself.

3. If the work has been presented or submitted for prior presentation elsewhere, this should be made clear in the submission and the BOPA Committee reserves the right to reject any such submission.

Please note the following guidelines:

Size of abstract
1. The abstract should contain 200-300 words and should be carefully proof-read before submission.

Format of abstract
1. Type with single spacing beginning with abstract title, followed by authors on a new line followed by a new paragraph to begin the start of the abstract.
2. Title should be in upper case
3. Include all authors with full first name and surname, department, hospital and town
4. An abstract should start with an introduction to the background of the investigation and, where appropriate, a statement of the aims of the work. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support. A statement of any methods used should follow including, for example, numbers of subjects in the study, drug dosages and regimen, means of collection of data. Results should be clearly stated with, if appropriate, statistical support.

Further Information
1. On a separate page include the following:
   1. Abstract title
   2. Authors (please underline the name of the presenting author)
   3. Name
   4. Full postal address
   5. Telephone
   6. Fax
   7. Email address

2. Abstracts which do not meet the above requirements, are unfinished or are deemed not to be of an acceptable overall standard will not be accepted.

3. Completed abstracts should be submitted electronically on disk or as a Word attachment, by email, by the stated deadline, to: Succinct Communications Ltd Burton House, Repton Place, White Lion Road, Amersham, Bucks HP7 9LP Tel: 01494 549100 • Email: bopa2007@succinctcomms.com

4. The deadline for receipt by Succinct Communications of completed abstracts is 17.00 on Friday June 29th 2007. Only in exceptional cases and with prior agreement from the Chair will late submissions be accepted.

5. Authors who successfully submit abstracts describing “work in progress” are reminded of the need to submit, in time for publication in the proceedings of the meeting, a revision describing the completed work. The deadline for receipt of the revised abstract will be notified in the letter of acceptance.

6. The Committee reserves the right to restrict acceptance of posters describing work carried out primarily in, or by members working in, the pharmaceutical industry.

7. The Committee reserves the right to reject any submission which is deemed not to meet the specified criteria or to be in any way incompatible with the overall objectives of BOPA and/or the meeting itself.

Judging of best abstracts
There will be three judges, each with one vote. At least one judge will be a BOPA Committee member and one a member of the BOPA Education & Training Working Group. Judges must declare conflicts of interest for each judged presentation. Judges declaring a conflict of interest may not vote on the presentation identified. Judges comments and scores must be recorded in writing. The Chairman of BOPA will ensure adherence to these guidelines before prizes are awarded. These will be judged by the following criteria:

● Scientific validity or implications for oncology pharmacy practice
● Relevance to and potential impact on practice
● Originality
● Clarity of writing
● Clarity of presentation
● Overall impression

The judges will select five abstracts to be presented as oral presentations on the Friday of the BOPA annual symposium. The BOPA chairman will inform the winning Author/s by the 31st July. The five winning submissions will each receive one complimentary registration for the BOPA 2008 symposium per winning poster. The award of 1st place will be made at the Annual Symposium based on the posters and oral presentations. All five presentations will also be judged and additional prize of £100 will be awarded to the outright winner.