

ETP is viable but consent is a problem

ELECTRONIC transmission of prescriptions (ETP) is viable, an independent review of the three pilot schemes in England has concluded, but the need to gain written consent from each patient was a time-consuming exercise that contributed to the pilots' slow starts.

A summary report on the pilots, published by the Department of Health last week, says that although each of the pilots achieved its aim of sending prescriptions electronically, a single common model of ETP is needed for national implementation. Changes to legislation will be needed to remove the current requirements for handwritten signatures from both prescribers and patients or their representatives. Electronic ways of identifying patients' exemption status will also be needed for a national scheme to be successful.

Reviewers from the Sowerby Centre for Health Informatics at Newcastle, the Manchester school of pharmacy, the Industrial Statistics Research Unit at the University of Newcastle and scientific research company QinetiQ examined the first six months' work of the pilots, coinciding mainly with

the second half of 2002. The pilots continued for another six months after this and most of the significant volume of prescription transfer occurred after the review period.

The biggest initial problems were technical difficulties and patient recruitment. Although the pilots were, in their own terms, successful, they did not demonstrate any of the potential benefits expected of ETP. These could have included convenience and choice for patients, greater time for pharmacists to spend discussing medication with patients and reduced workloads for general practitioners and the Prescription Pricing Authority.

The report says no major fraud and security concerns were seen. Some types of fraud might be eliminated but others may become easier, it concludes, without giving details of what these might be.

Both the Pharmacy2u and TransScript consortia told *The Journal* that while the review was fair it would have been better if it had been delayed to take account of the pilots' initial problems. ETP is now to form part of the national integrated care records



Requirements for handwritten signatures will need to be removed if ETP is to work nationally

system (ICRS) for the NHS. The consortia said that they hope to take part in further ETP work if they are invited to do so by companies involved in developing the ICRS.

Ballot in October to approve new contract framework

PHARMACY contractors in England and Wales are to be asked in a ballot next month whether they approve of the framework for the proposed new community pharmacy contract, the Pharmaceutical Services Negotiating Committee has decided.

Sue Sharp, chief executive of the PSNC, speaking at a briefing after the committee's September meeting, said: "We are keen for contractors to send a strong signal to the Department of Health that, if the money and the environment are right, they are prepared to take on the new roles in the contract."

The wording and date of the ballot have yet to be finalised. At this stage, contractors will only be asked to approve the framework that has been agreed by the DoH, the PSNC and the NHS Confederation, which represents primary care trusts (p7, 19 July, p77 and 26 July, p112). A second ballot on funding for the new contract will be held later. In this respect, the arrangements are similar to those for the new general practitioners' contract. GPs approved the framework in a first ballot but concern about losing a second ballot over funding forced concessions from the DoH.

The Government's consultation document on changes to the control of entry regulations was the other main subject of discussion at the PSNC meeting.

The committee has deep concerns about the four proposed exemptions (one-stop primary care centres, shopping developments over 15,000 sq m, pharmacies open more than 100 hours a week, and internet or mail order pharmacies) and their impact on existing contractors. The PSNC is to work

with the National Pharmaceutical Association to commission an expert analysis of the potential impact of the exemptions. This will support its case for the tightest possible definitions of the exemptions so as to prevent abuse of them. Specific concerns about the exemptions are:

- **Primary care centre consortia** It is not yet clear whether a pharmacy contractor or company needs to be listed specifically as the pharmacy partner in any consortium intending to open a one-stop primary care centre, or whether any other partner company can add a pharmacy into the proposal. The definition of what will count as a one-stop centre also needs clarification.
- **Shopping developments** The definitive list of shopping developments over 15,000 sq m has not yet been issued. Once it is available, the PSNC intends to use local pharmaceutical committees to evaluate the impact that might be seen in their areas.

"One of our biggest concerns is that the result of the Government's decision will be the clustering of pharmacies around GP surgeries at a time when the Government should be encouraging the opposite," Mrs Sharpe said. She added that evidence presented by the Office of Fair Trading during its action on resale price maintenance had shown that the control of entry regulations had reduced clustering.

The PSNC also believes that 2006 will be far too early a date to review the impact

of changes to control of entry, given that new regulations would only have been in place for two years.

Mrs Sharpe and Steven Williams, chairman of the PSNC's contract planning and rural subcommittees, have been appointed members of the Department of Health's advisory group on implementing the reform of the regulations. This group will also examine the issue of dispensing contracts in rural areas. The PSNC, the General Practitioners Committee and the Dispensing Doctors Association are reviewing proposed amendments to the regulations that were agreed in principle in 2001 but shelved after the OFT announced its review of the pharmacy market.

ROYAL PHARMACEUTICAL SOCIETY NEWS

Modernisation discussion paper

A new discussion paper from the Society seeks views on how its professional leadership and development responsibilities and its regulatory work can be properly informed and effectively discharged in the future (p431).

Aspirin label change

A Law and Ethics Bulletin item gives guidance on new labelling and package leaflet requirements for aspirin products arising from a possible link between aspirin use in children and Reye's syndrome (p432).

Patients taking warfarin should avoid drinking cranberry juice, CSM warns

PATIENTS treated with the anticoagulant warfarin should avoid drinking cranberry juice, the Committee on Safety of Medicines has warned.

The CSM and the Medicines and Healthcare products Regulatory Agency highlight a possible interaction between warfarin and cranberry juice in the September issue of *Current Problems in Pharmacovigilance*. "The interaction is biologically plausible since cranberry juice contains various antioxidants including flavonoids, which are known to inhibit cytochrome P450 activity," it states.

The CSM also warns that constituents of different brands of cranberry juice may vary, and that such variation might affect the potential for drug interactions.

Dr Joanne Barnes, of the centre for pharmacognosy and phytotherapy, School of Pharmacy, University of London, told *The Journal* that the suspected interaction was a new signal of a herbal safety concern.

"Until further information is available, pharmacists should enquire about use of

cranberry juice in patients taking warfarin who experience changes in their INR [international normalised ratio] values."

She pointed out that the MHRA is recommending that patients taking warfarin should be advised to avoid drinking or limit their intake of cranberry juice. "Along these lines, it would seem prudent to advise patients taking warfarin and who consume large quantities of cranberry juice to reduce their intake gradually, since the possible effect of concurrent use of cranberry juice and warfarin on the INR, ie, an increase or decrease, is not entirely clear."

Since 1999, there have been five reports suggesting a possible interaction between cranberry juice and warfarin, says the CSM. One case was fatal and involved a man whose INR increased dramatically six weeks after starting to drink cranberry juice.

Current Problems in Pharmacovigilance also includes information about HRT and the risk of breast cancer, topical vaginal oestrogens and endometrial safety, selective serotonin reuptake inhibitors and venlafax-

ine use in children (see also p395), salmeterol and formoterol use in asthma management, kava and hepatotoxicity, and the safety of thiomersal-containing vaccines.

The latest issue can be accessed via the *PJ* Online links page (www.pjonline.com/links/pj).

Regulatory agency comes under fire from Consumers' Association

THE Consumers' Association has criticised the Medicines and Healthcare products Regulatory Agency saying it should be more vigilant in policing the pharmaceutical industry. The criticism comes after an advertisement for Cerazette (desogestrel), a new progestogen-only oral contraceptive pill, was withdrawn by its manufacturer Organon Laboratories.

The September issue of the *Drug and Therapeutics Bulletin*, which is published by the Consumers' Association, last week called for the withdrawal of the Cerazette advertisement. The advertisement claimed the pill had the "efficacy of a combined pill with the reassurance of an oestrogen free pill". The *DTB* said this claim had no rigorous scientific basis. "Given the absence of published trials directly comparing Cerazette with a combined oral contraceptive, we believe the company's claim . . . is unsubstantiated and should be withdrawn."

Dr Robert Kaper, medical director of Organon, told *The Journal* that the advertisement had been withdrawn in mid-August at the request of the MHRA and not in response to the *DTB* article. However, a spokesman for the Consumers' Association pointed out that draft copies of the *DTB* article had been sent to the MHRA and Organon in July.

In a statement issued earlier this week, the Consumers' Association says that the advertisement is the third in a year to be withdrawn following *DTB* investigations. Wendy Garlick, principal policy adviser at

the Consumers' Association, said: "The CA has long warned of the dangers of allowing the pharmaceutical industry to be a direct source of information to the public. The fact that yet another advert has had to be withdrawn not only calls into question the ability of the MHRA to do its job, but highlights the fact that drug companies are incapable of communicating honestly with health care professionals, let alone the public."

"It should not fall to the likes of the Consumers' Association to catch drug companies trying to circumvent the rules. The MHRA must be more robust and vigilant in taking charge of policing the industry."

In response to the criticism, a spokesman for the MHRA said: "By the time the article in the *Drugs and Therapeutics Bulletin* on Cerazette was published, the MHRA had already taken action . . . following a complaint from a health care professional. As a result of the Agency's action, not only was the material withdrawn by the company, a corrective statement is being issued to address the concerns raised."

□ **MHRA remit on policing advertising**
The control of medicines advertising in the United Kingdom is based on a system of self-regulation underpinned by statutory powers administered by the MHRA. Given the volume of medicines advertising material, the MHRA in part relies on concerns being drawn to its attention in order that regulatory action can be taken. In addition, the MHRA pre-vets advertising in cases where a particular risk has been identified.

Repeat dispensing to move into second wave by February

A SECOND wave of 40 repeat dispensing pathfinder sites for England has been announced by the Department of Health.

Primary care trusts that want to be in the second wave have until 12 November to complete their applications. Those that are successful will be notified by 5 December, with implementation planned for 2 February 2004.

The first wave of pathfinder sites was restricted to repeat prescriptions generated by general practitioners. This time, independent nurse prescribers and nurse and pharmacist supplementary prescribers are to be included in the arrangements provided they produce computer-generated prescriptions.

Practices and pharmacies that are involved with other initiatives, such as local pharmaceutical services schemes and fourth-wave medicines management services will also be allowed to take part in the second wave of repeat dispensing schemes.

It has taken nearly a year to get the first wave of pathfinder sites started. The sites were announced in October 2002 (*PJ*, 12 October 2002, p513), but National Health Service Regulations to allow repeat dispensing were not introduced until May 2003 (*PJ*, 3 May, p606). The first repeat prescriptions were only issued last month (*PJ*, 23 August, p225).

The introduction of repeat dispensing at community pharmacies throughout England remains a target for 2004.

Suicide risk warning for children now extended by CSM to cover venlafaxine

VENLAFAXINE (Efexor, Efexor XL) should not be used in children and adolescents under the age of 18 years, the Committee on Safety of Medicines has warned. The advice comes after new safety concerns surfaced linking use of the drug with suicidal behaviour in this age group of patients.

Data from two clinical trials comparing venlafaxine, a serotonin and noradrenaline reuptake inhibitor, with placebo reveal that venlafaxine is not effective for the treatment of depression in children and that it is associated with an increase in harmful outcomes including hostility, suicidal thoughts and self-harm. Although there were no successful suicides during the trials, there were three suicide attempts among the children and adolescents treated with venlafaxine but none in the group given placebo (the trials involved 361 patients).

Professor Gordon Duff, CSM chairman, said: "Efexor is already contraindicated in those under 18 years, but we do know that it is used in this age group outside its licensed indications. Young people under 18 years currently taking Efexor should consult their doctor for advice."

Wyeth, manufacturer of Efexor estimates that 3,000 patients under 18 years have been treated with venlafaxine in the past year.

The CSM has reminded prescribers that venlafaxine should not be stopped suddenly. The dose should be reduced gradually over at least two weeks and the patient monitored to minimise risk of withdrawal reactions. A letter detailing the new advice has been sent to health professionals.

Similar advice was issued by the CSM in June about the use of paroxetine (Seroxat) in young patients (*Pf*, 14 June, p813).

Tamiflu endorsed for influenza prophylaxis by NICE

THIS week the National Institute for Clinical Excellence has approved oseltamivir (Tamiflu) for the prophylaxis of influenza in "at risk" patients.

NICE recommends that when the influenza A or influenza B virus is circulating in the community, oseltamivir, a neuraminidase inhibitor, should be used for post-exposure prophylaxis in "at risk" patients aged 13 years or older, who are not protected by vaccination and who can begin prophylaxis within 48 hours.

At risk patients are defined as people who have chronic respiratory disease, significant cardiovascular disease, chronic renal disease, diabetes, or are immunocompromised or who are aged 65 years or over.

The guidance also recommends that the drug should be made available to those living in residential care establishments whether or not they have been vaccinated. The guidance advises use of oseltamivir in hospitals at the discretion of the clinical staff in charge of wards where at risk patients may be exposed to the influenza virus.

NICE advises that oseltamivir should not be used for the prevention of 'flu in otherwise healthy people under 65 years of age, even if they have been in contact with people with 'flu-like symptoms. The guidance points out that vaccination is the most effective way of preventing illness from influenza, and says oseltamivir is not a substitute for vaccination. Amantidine (Lysovir) is not recommended for either post-exposure or seasonal prophylaxis of influenza (*Pf*, 1 March, p291).

The full NICE guidance can be accessed via the internet (www.nice.org.uk).

News feature p400

NICE endorses mania treatments as data suggest prevention role

PATIENTS in England and Wales who have acute mania associated with bipolar I disorder should be offered the option of treatment with olanzapine (Zyprexa) or valproate semisodium (Depakote), says the National Institute for Clinical Excellence in guidance issued this week.

NICE stresses the importance of discussing all treatment options with patients before deciding on which drug to prescribe in acute mania. The full guidance is available on the NICE website (www.nice.org.uk).

Meanwhile, data presented at the annual congress of the European College of Neuropsychopharmacology in Prague this week indicate that olanzapine is at least as effective as lithium in the long-term maintenance treatment of manic depression.

In a randomised double blind trial, patients diagnosed with bipolar I disorder and who had experienced at least two manic episodes within the past six years were randomised to take either olanzapine (5–20mg daily, n=217) or lithium (titrated to a serum level of 0.6–1.2mEq/L, n=214).

Patients taking olanzapine had a lower incidence of relapse into episodes of mania compared with those taking lithium (14.3 per cent versus 28.0 per cent) and both groups had similar incidence of relapse into depressive episodes (16.1 per cent vs 15.4 per cent). The incidence of admission to hospital was also lower in patients treated with olanzapine.

A licence application for olanzapine as a preventive agent is currently being reviewed.

Suicide risk in bipolar disorder lower with lithium than valproate

THE risk of suicide among patients treated for bipolar disorder is lower during treatment with lithium than with valproate semisodium (valproic acid, Depakote), say researchers from the United States.

Dr Frederick Goodwin, George Washington University medical centre, Washington DC, and colleagues point out that lithium use in bipolar disorder has declined in the US over the past decade and that use of anticonvulsants, such as valproic acid, has increased. And while there is evidence to support the anti-suicide effects of lithium, few studies have addressed the effects of anticonvulsants on suicide risk, they say.

They therefore compared the risk of

suicide attempt and suicide death among 20,638 patients with bipolar disorder. Patients were 1.5 to three times more likely to attempt suicide or to die from a suicide attempt during periods of treatment with valproic acid (known as divalproex in the US) than during periods of treatment with lithium.

The researchers say their findings are consistent with previous data suggesting lithium reduces suicide attempts and suicide mortality. "If lithium does have an anti-suicide effect not matched by currently available alternatives, then current prescribing patterns should be re-evaluated," they conclude (*JAMA* 2003;290:1467).

NPC launches new support service

ADDITIONAL support for primary care trusts and other National Health Service bodies is being offered by the National Prescribing Centre through a new service, NPC Plus, from 29 September.

Based in Manchester, NPC Plus is designed to spread good prescribing practices, and offers assistance with drug budgets and other management issues, by providing packages and training to ensure that the NPC approach reaches many more people in the NHS than its existing service can. NHS organisations can commission, for example, packages that will enhance health care professionals' understanding of evidence-based prescribing in different therapeutic areas. NPC Plus trainers will be on hand to ensure the packages are implemented effectively through all levels in the commissioning organisation.

Heidi Wright, assistant director NPC Plus, said: "These packages are designed to provide solutions to some of the most pressing issues around prescribing and medicines management in primary and secondary care."

She also explained that any revenue generated by the development and use of the packages will be reinvested to enhance the NPC core services and to develop further NPC Plus packages.

In addition to primary care trusts and other trusts showing interest in the packages the NPC has also had expressions of interest from a number of workforce development confederations and prisons, and is working with the Prescribing Support Unit.

For further information contact Heidi Wright on 0161 611 3264, e-mail heidi.wright@npc.nhs.uk.

Different therapy packages available from NPC Plus

Available now:

Management of common infections in primary care
Use of NSAIDs
Hypertension
Dyspepsia

Available soon:

Asthma
Depression
Type 2 diabetes and obesity
Lipids

Nurses and others to prescribe CDs from next month

NURSE prescribers are to be allowed to prescribe or supply many Controlled Drugs from 15 October.

Specialist nurses will be allowed to prescribe or supply diazepam, lorazepam and midazolam for use in palliative care. They will also be allowed to prescribe or supply codeine phosphate, dihydrocodeine tartrate and co-phenotrope generally.

Schedule 4 CDs, except anabolic steroids, and all Schedule 5 CDs will also be made available under patient group directions for use by paramedics, health visitors, midwives, ophthalmic opticians, chiropodists, orthoptists, physiotherapists and radiographers. PGDs will also be allowed for the supply of diamorphine for the treatment of cardiac pain by specialist nurses in hospital accident and emergency and coronary care units.

The changes were proposed in a consultation paper in February (*PJ*, 15 March, p356). Pharmacists are already authorised to supply Schedule 4 CDs under PGDs.

Pharmacy restaurant and bar closes



Pharmacy was forced by the Royal Pharmaceutical Society to change its name

THE restaurant called Pharmacy which opened five years ago in west London has closed.

The restaurant, designed by Damien Hirst, was forced to change its name to "Pharmacy restaurant and bar" because the word pharmacy in connection with retail businesses is a restricted title under the Medicines Act 1968 and may only be used by pharmacy businesses registered by the

Royal Pharmaceutical Society. Although the change did not satisfy the Society, counsel's advice was that it satisfied the law and the Society's threat of prosecution was dropped.

Around the same time, the Society also threatened two public houses with prosecution for misusing the pharmacy title.

More recently, an internet sex-shop dropped the word pharmacy from part of its website after being warned by the Society.

BRIEFLY

Cataract risk with inhaled steroids

The increased risk of cataract associated with systemic corticosteroid use is also seen with inhaled therapy. A study of more than 30,000 people found that those with cataracts were more likely to have been treated with inhaled steroids than those who did not have cataracts. For people prescribed corticosteroids at daily doses of 1,600mg or more, 41 per cent of their cataract risk was calculated to be due to their inhaled steroids (*British Journal of Ophthalmology* 2003;87:1247).

PJ Online

PJ Online contains the editorial contents of *PJ* publications.

Electronic prescription transmission

The Department of Health's website contains the current position, background information and contact e-mail addresses. www.pjonline.com/links/doh

Reclassification of medicines

A list of medicines reclassification applications (POM to P and P to GSL) since April 2002. www.pjonline.com/reclassification

Guide to the Society

Articles on the organisation and activities of the Royal Pharmaceutical Society. These include what the Society does for its members, the branch structure, and promoting the role of pharmacists. www.pjonline.com/noticeboard/society/guide

Focus on technicians

A series in *Hospital Pharmacist*. Although "Focus on technicians" examines technicians issues, the series is not designed exclusively for them. www.pjonline.com/noticeboard/series

Patients with aggressive non-Hodgkin's lymphoma should be offered rituximab, NICE recommends

RITUXIMAB (MabThera) in combination with cyclophosphamide, doxorubicin, vincristine and prednisolone (CHOP) should be used first-line for the treatment of aggressive non-Hodgkin's lymphoma, according to the National Institute for Clinical Excellence.

In guidance issued this week, NICE recommends that patients with CD20-positive diffuse large-B-cell lymphoma that is at stage 2, 3 or 4 and who are candidates for CHOP therapy should also be offered rituximab. Patients who cannot have CHOP

therapy should not receive rituximab and patients with stage 1 disease should only receive rituximab as part of a clinical trial. NICE also recommends that a lymphoma specialist supervises patients' treatment with rituximab.

NICE estimates that the guidance will increase National Health Service treatment costs by between £9.1m and £17.2m. "However, because the number of cases of diffuse large-B-cell lymphoma is increasing, this annual cost increase could rise to an upper estimate of £27.3m by 2007," NICE says.

Rituximab is a monoclonal antibody that targets the CD20 surface marker, which is expressed on almost all B-cell lymphomas. The NICE guidance says that rituximab probably induces the death of CD20-positive cells by antibody-directed cytotoxicity, complement-dependent cytotoxicity and the induction of apoptosis. It also appears to sensitise cells to the action of conventional cytotoxic drugs.

The guidance, which is available in full via the NICE website (www.nice.org.uk), will be reviewed in August 2006.

BRIEFLY

Cancer cachexia helped by ProSure

A nutritional supplement enriched with n-3 fatty acids (ProSure) may reverse weight loss in patients with cancer. Compared with a high-protein formula with the same calories, both supplements stopped weight loss in 200 patients with pancreatic cancer but the enriched supplement showed a positive correlation between intake and increases in body weight and lean body mass (*Gut* 2003;52:1479).

Doctor sentenced over vincristine death

A DOCTOR who caused the death of a cancer patient in 2001 after wrongly instructing a senior house officer of only four weeks' standing to inject vincristine into the patient's spine has been given an 18 month prison sentence after pleading guilty to manslaughter.

Dr Feda Mulhem, who had been in his post as a specialist registrar in haematology at the Queen's Medical Centre, Nottingham, for two days, failed to note what was written on the patient's haematology chart, failed to see which drug should have been administered and did not check a syringe which was

clearly labelled with an instruction that its contents should not be injected intrathecally. The SHO twice checked that Dr Mulhem wanted the drug to be injected into the patient's spine before following his instructions. The patient died four weeks later.

Dr Mulhem was sentenced to eight months imprisonment for manslaughter and 10 months for unrelated assaults. He has already been in prison on remand for 11 months and so has been released.

Compulsory guidelines to try to prevent further such deaths were introduced later in 2001 (*PJ*, 17 November 2001, p707).

Advertisement

Award winners improve prescribing and communication at care interface

THE possibility of community pharmacists advising on secondary care prescribing was examined by the winners of the 2002 joint National Pharmaceutical Association and Guild of Healthcare Pharmacists award.

Reporting the results at the British Pharmaceutical Conference last week, Ros McLoughlin, community services pharmacist, Royal Cornwall Hospital NHS Trust, explained that the aims of the project had been to improve communication across the primary/secondary care interface and to find out more about outpatient prescribing. Information was collected from 17 community pharmacies that regularly dispensed hospital outpatient prescriptions.

Michael Wilcock, pharmaceutical adviser, Central Cornwall Primary Care Trust, reported that over the nine months of the project, 5,315 outpatient prescription forms and 7,217 items were processed by the community pharmacists. Few opportunities for cost savings were found with generic switches identified in only 0.9 per cent of the prescriptions and strength optimisations in none.

"There was little evidence of off-formulary prescribing, although general practitioners had the perception that there was lots of it," he explained. However, in terms of the quality of prescribing, 4.8 per

cent of prescriptions were classified as "difficult to dispense". This was for a number of reasons, the most common ones included lack of clarity about the quantity, lack of clarity about the dose or strength, lack of clarity about the medicine itself, incorrect patient name and illegible doctor's name.

One of the outcomes of the project is that community pharmacists have been sent a list of contact details for all the doctors that work in the outpatient departments at the hospital, said Mr Wilcock. He pointed out that if the NHSnet was available in community pharmacies then this would allow pharmacies access to local hospital telephone directories. Another outcome is that hospital doctors have been issued with a simple guidance sheet about writing prescriptions.

□ **2003 award** The winner of the 2003 joint National Pharmaceutical Association and Guild of Healthcare Pharmacists award is a team from Guy's and St Thomas' NHS



Alice Osborne (right) is presented with the 2003 National Pharmaceutical Association/Guild of Healthcare Pharmacists award by Alison Ewing (left), the Society's Vice-President, watched by Dr Gill Haworth (centre), the Society's President

Trust and Lambeth Primary Care Trust. Alice Osborne, Chima Olughu, Lucy Oakley and Duncan McRobbie will develop a smoking cessation referral system from secondary to primary care with the aim of making care continuous between the two settings. They will report the results of their work at next year's BPC.

The award is sponsored by MSD.

Dispensing robot flown to UK

A FULLY automated, multiple monitored-dose dispensing robot was displayed in the United Kingdom for the first time at BPC.

"We believe it is the first machine in the world to offer multi-dose dispensing in blister packs to this level of automation," said Todd Siegel, president of MTS Packaging Systems, the American company that brought the robot to the Conference.

The robot, called "OnDemand", holds 400 drugs. Barcodes from stock pots are scanned in, and then each drug is placed loose into a cassette. Prescription information is fed into a computer operating the robot and, once it is told to dispense the items for a particular patient, the robot fills the dosage system. It uses a standard disposable monitored dose pack with four blisters for each day. The robot is able to fill multiple drugs into each blister at once.

Once the pack has been filled it comes out of the machine open so that a physical inspection can be made before it is sealed. Finally the labels are printed and stuck on to the pack in one movement using the prescription data fed into the computer at the start of the dispensing process.

Peter Williams, general manager of MTS Packaging Systems International, the UK subsidiary of the company, said: "It takes less than a minute from the prescrip-



Part of the MTS Packaging Systems machine is shown to Conference participants

tion data to the end product, irrespective of the complexity of the drug regimen."

The new robots cost £190,000 each and the company expects them to be used in hospitals or in centralised dispensaries for a number of community pharmacies.

BPC BRIEFS

BPC 2004

Next year's British Pharmaceutical Conference will be held on 27-29 September 2004 at the Manchester International Convention Centre. The theme of the conference will be "Medicines: from cell to society" which will explore the transfer of innovation into effective medicines.

ADR reporting

Hospital doctors need to be encouraged to report suspected adverse drug reactions in children, according to a study reported at the BPC by researchers from Wales. Of 43 hospital doctors questioned, only 30 per cent believed that all ADRs in children should be reported and 75 per cent would not report a known complication of a medicine. Reporting rates could be improved by training, reminders and involvement of other staff.

Warning over mixing medicines

Researchers from King's College London reported at the BPC that one in 20 people are taking potentially dangerous combinations of prescription and complementary medicines (Media interest, see photograph p409). The most common interaction was between St John's Wort and SSRIs.

London pharmacists secure training funds for supplementary prescribing

THIRTY-TWO pharmacists working in London have secured funding from their local Workforce Development Confederation for supplementary prescribing courses which start this month, according to the London pharmacist supplementary prescribing support team.

They include cardiology pharmacists who work in heart failure, transplantation and hypertension clinics, and HIV pharmacists who wish to prescribe antiretroviral and supportive therapy. Other specialist areas of pharmacists doing the training include cancer, mental health, renal medicine, nutrition, anticoagulation and adult intensive care.

This first cohort includes people working in community pharmacy, as well as in hospitals, primary care trusts and the prison service. A further 10 pharmacists are ready to start the next wave of courses in January 2004.

Speaking at the British Pharmaceutical Conference in Harrogate last week, Jane Nicholls, leader of the project team, explained that pharmacist supplementary prescribing should allow patients to have quicker and more efficient access to medicines. Reducing the workload of doctors, making the best use of pharmacists' skills and meeting National Health Service access



Jane Nicholls



Jatinder Harchawal

targets are other benefits that could be highlighted when making a business case for pharmacist supplementary prescribing. Hospitals that use pharmacist prescribers should see a reduction in wasted medicines and greater financial control of drug expenditure. Patients who have access to pharmacist prescribers will have a greater choice of health care provider with higher levels of safety and a better quality of care.

Jatinder Harchawal, secondary care lead for the project team, explained that some trusts are developing non-medical prescribing committees to manage the introduction of supplementary prescribing. They are responsible for advising the trusts on changes in legislation and developing

trust-wide frameworks to support and co-ordinate development.

Mr Harchawal outlined some of the remaining challenges to successful implementation of pharmacist prescribing. Relationships would need to be developed between supplementary and independent prescribers. Both the supplementary and independent prescribers will also have to learn to use clinical management plans successfully. It is important that clinical management plans are kept simple, he added. The London pharmacist prescribing team have made examples of clinical management plans which they have written available on Druginfozone (www.druginfozone.nhs.uk).

Ashok Soni, a community pharmacist and professional executive committee member for Lambeth Primary Care Trust, said: "I will be training as a supplementary prescriber because I believe it will improve the patient experience."

Grainne Goldsmith, a senior pharmacist working in outpatient clinics at Barts and the London NHS Trust, said: "The course will allow me to take responsibility for the treatment decisions I make with patients and it is encouraging for me to have the support of patients, nursing and medical staff in this venture."

Community pharmacy now higher priority for PCTs than in the past

COMMUNITY pharmacy is developing a higher profile for primary care trusts, and it is now on directors' agendas, according to Sally Greensmith, a member of the Royal Pharmaceutical Society's Council, who was speaking at a Conference session on current issues and attitudes involving primary care pharmacists (see p413).

But, although the working relationship between community pharmacists and primary care organisations in some areas has become closer, community pharmacists are still not sufficiently integrated into the primary care team, Ms Greensmith said.

Primary care trusts need to recognise that community pharmacists are primary care pharmacists as much as those directly employed by the PCTs and it is up to pharmacists working in PCTs to help manage this change, she added.

This is to be achieved through two-way communication. Community pharmacists need to recognise the pressures that PCTs are under but, at the same time, it is important that advisers who have not come from a community pharmacy background understand the history of community pharmacy and the service it has delivered for the

National Health Service, Ms Greensmith told the session. In addition, Ms Greensmith acknowledged that the Society has a role to help all community pharmacists and primary care pharmacists to be fit for the purpose that PCTs need. In order to perform this function the Society is planning a series of roadshows to improve information links between itself and primary care pharmacists. Venues in Scotland, Wales and England are being looked at, Ms Greensmith announced.

BPC BRIEFS

Ideas for error research wanted

Suggestions that pharmacists want to make about potential topics for research into medication errors have been requested by the director of the Patient Safety Research Programme (PSRP). Professor Richard Lilford of the University of Birmingham made his request during a hospital pharmacy session at the BPC (see p416).

Start thinking now about independent prescribing issues

PHARMACY needs a wake up call to start thinking about independent prescribing fairly quickly, Clive Jackson, chief executive, National Prescribing Centre, told a practice session on primary care at the BPC.

Independent prescribing presents two key issues for the profession, Mr Jackson said. First, pharmacy needs to look at its diagnostic skills and second, it needs to look at the range of medicines that pharmacists are likely to be allowed to prescribe independently. All the indications are that the development of the independent prescribing policy will begin in the new year but, bearing in mind all the consultation and other things that development requires, we are unlikely to see even "a fair wind" given to pharmacists prescribers until mid or late 2005. Mr Jackson said. However, the profession needs to be proactive in policy development, especially in "looking at what the options are for pharmacists and where it could make a positive impact, rather than just waiting for the Committee on Safety of Medicines, and a range of others, to decide what options there are in terms of medicines that can be prescribed," he warned.