

# Charter petition to lead to court action

THE Save Our Society campaign said this week that it will go to the High Court in an attempt to prevent the granting of the new Charter in its final draft form.

The Council of the Royal Pharmaceutical Society petitioned the Privy Council for a new Royal Charter this month (*PJ*, 13 December, p801). The SOS campaign has already confirmed that it will submit a counter-petition.

This week, the SOS campaign said that, acting on legal advice, it will also be taking its case to the High Court on the basis that the Society's Council has abused its powers. "This will entail commencing proceedings against individual Council members who voted for the resolution at the 2 December meeting," the group said in a statement.

"Our legal counsel has advised that although there can be no guarantee of success in such matters, the members have a strong case. He has also advised that it would not be sensible simply to rely on a counter-petition and that to have the appropriate effect, legal proceedings must be commenced as soon as possible," the statement added.

Ann Lewis, the Society's Secretary and Registrar, said: "It is quite wrong to suggest that, in the matter of the new Charter, the Council has acted outside its authority, in bad faith or without taking the members' views into account. The Council has acted entirely properly, within its authority, using robust processes, to a known timetable and, particularly, with emphasis on ensuring that decisions have been fully informed by the views of the membership." All decisions of

Council were binding on the Council as a whole, she said.

"It is the right of any member of the Society or of the public to agree, disagree or make no comment on any decision that affects them and all citizens have recourse to the law should they wish to test their view," she commented.

Miss Lewis added that the process had been transparent, with all decisions taken in open Council business and that the Council had consulted the membership widely. "The Council was determined to provide opportunities for all members to express their views and not to limit feedback to those who might attend a special general meeting."

Miss Lewis explained that the Council had undertaken an eight-month consultation which had included regional roadshows, branch meetings, and discussion at a number of other meetings such as the annual general meeting and the British Pharmaceutical Conference. "As a result of this, over 1,000 pharmacists have had the opportunity to debate the draft Charter proposals with Council members and senior staff: 430 written responses were received to the consultation on the first draft and 245 responses received on the second draft. Through their responses, the Society's members have played a real part in the development of the new Charter," she said.



The SOS campaign plans to take its case to the High Court

However, the SOS campaign said that massive disquiet had been expressed during these meetings. "The concerns expressed by the members at the SGM have been virtually ignored in the final draft of the Charter," the group said.

An official notice stating that the Privy Council has been presented with a petition for a new Charter appeared in the *London Gazette* ([www.gazettes-online.co.uk](http://www.gazettes-online.co.uk)) on 15 December (notice code 1106). The notice states: "All petitions for or against such a grant should be delivered to the Privy Council Office, 2 Carlton Gardens, London SW1Y 5AA, on or before 23 January."

## PSNC asks NE London contractors to pay levy direct

PHARMACY contractors in the North-East London Local Pharmaceutical Committee area are being asked to pay their levies direct to the Pharmaceutical Services Negotiating Committee if they want to continue to receive support services from it.

The PSNC and the LPC have been locked in a row over payment of the LPC levy for the past two years. The levy is collected by LPCs from Prescription Pricing Authority payments. It is based on dispensing volumes and supports PSNC work for contractors and in national negotiations.

The row has its roots in motions passed at the local pharmaceutical committees' conference in 2001 (*PJ*, 17 March 2001, pp345-7) and subsequent criticism of the PSNC regarding progress on these at the LPCs' conference in 2002 (*PJ*, 9 March 2002, p311). The motions related to developing a public health strategy for community pharmacy and schemes to support patients after discharge from hospital.

The PSNC said that it became aware in October 2002 that the LPC was linking withholding of its levy to these issues. It sent a solicitor's letter in February 2003 demanding payment after hearing that LPCs in the

London area were considering breaking away from the PSNC. The PSNC later withdrew the letter and PSNC executives met the LPC in September this year. Now the PSNC says that the LPC is trying to impose further preconditions on payment of its outstanding levies.

Barry Andrews, chairman of the PSNC, has written to contractors in north east London direct saying that it can no longer

defend to other contractors continued provision of support to an LPC that is not making a financial contribution. He says the move is disappointing at a time when pharmacy needs to pull together to work on developing the new contract.

Sue Sharpe, chief executive of the PSNC, told *The Journal* that the issues raised by the LPC, particularly around public health, are being addressed as part of the new contract framework.

Alan Castell, vice-chairman of North East London LPC, confirmed that the LPC has been withholding its levy for some time "in dispute over the manner in which the PSNC has been discharging its duties to the contractors that we represent". This was done because "democratic processes were not yielding progress", he added.

He said that at no time had the LPC discussed or even considered divorcing itself from the PSNC. Its action was aimed entirely at persuading the PSNC to pursue policies that it believed would promote the future security and professional development of contractors. He stressed that the dispute was with the PSNC as a body and not its executives.

### ROYAL PHARMACEUTICAL SOCIETY NEWS

#### Regulation of assistants

The Society has finalised the arrangements for exempting existing dispensing and pharmacy assistants from needing a new qualification when the regulation of such assistants begins in 2005 (p847).

#### Draft new Charter

An article explains how membership feedback has changed the Society's draft new Charter (p848).

# Drug industry has neglected needs of children and elderly, says think-tank

RESEARCH into conditions that affect children, women and older people has been neglected by the British pharmaceutical industry, according to a think-tank report.

The King's Fund says that the pharmaceutical industry has focused too much on profitable drugs rather than investing in research to protect and promote health. In addition, the Government has tended to purchase medicines passively rather than to drive the research agenda. "We want to see a relationship develop between Government and the pharmaceutical industry that is geared towards the promotion of health, not just the promotion of wealth," says report author Anthony Harrison, a senior fellow at the King's Fund.

He suggests that the narrow focus on new, profitable drugs has been allowed to happen because the Government has failed to specify its health-related research and development objectives. This has been made worse by the fact that patients and the public play almost no part in deciding research priorities.

The King's Fund describes the relationship between the Government and the industry as an implicit public-private partnership (PPP) and suggests that it should be made more explicit.

It calls for a health research and development task force to be set up. "This task force could set about systematically identifying all the areas poorly served by the current implicit PPP and identify the appro-

priate response on behalf of the Government, the rest of the public sector and the private sector." Such a task force should also be able to commission research into the priorities of citizens and service users.

In a statement, the Association of the British Pharmaceutical Industry pointed out that its members spend nearly £9m every day in Britain on research. It also collaborates with researchers working for other organisations, including academia, medical charities, the National Health Service and the Medical Research Council.

Dr Trevor Jones, director general of the ABPI, added: "While such collaboration is extremely valuable, it would be quite wrong to suggest that our research endeavour should be determined by the Government. The UK-based industry is extremely innov-

ative as well as competitive, with a large and varied pipeline of products, including many for children, women, older people and developing world nations."

The comments by the King's Fund report echo those made last month at the launch of the Centre for Paediatric Pharmacy Research. Dr Ian Wong, director of the centre, said: "Paediatric medicine is a small market, the research is expensive and in some cases difficult to carry out. There are no regulations specifically requiring companies to carry out the research and it's not a funding priority for the Government."

The new centre — a collaboration between Great Ormond Street Hospital, the Institute of Child Health and the School of Pharmacy, University of London — is designed to support research into this area.

However, Gregory Kearns, professor of paediatrics and pharmacology, University of Missouri, speaking at the launch, pointed out that a ruling in the United States (allowing companies to obtain six-month patent extensions to products, provided safety, dosage and efficacy research is carried out on children) has resulted in some products, such as angiotensin converting enzyme inhibitors, that had huge market value but little application in children, being studied.

"*Getting the right medicines? Putting public interests at the heart of health-related research*" is available from the King's Fund (tel 020 7307 2591, [www.kingsfund.org.uk/publications](http://www.kingsfund.org.uk/publications)), price £8.

## Health inequalities will determine NHS spending

STRONG social gradients are seen in health status, deaths from major diseases and poor lifestyle factors, Derek Wanless has found in a review of population health trends in the United Kingdom. Addressing these health inequalities will form part of his recommendations to the Government about how public health activities should be funded in the future.

Before the Government's spending review in 2002, Mr Wanless, a former chief executive of NatWest, was asked to examine future health trends and suggest how much funding the National Health Service would need in future. His work paved the way for large increases in the NHS budget (*P7*, 20 April 2002, p522). In particular, Mr Wanless recommended that the public be encouraged to take a much greater responsibility for their own health, potentially saving billions of pounds over a 20-year period.

Mr Wanless is currently preparing a second report on securing good health for the whole population which is to be published in February 2004. As part of this, a background document on current population health trends in the UK and eight comparable developed countries was published

by the Department of Health and the Treasury last week.

"The UK (and England) perform poorly compared with other countries on some key measures of health outcomes and chronic disease such as coronary heart disease, cancer and particularly on respiratory diseases," the document notes. "Chronic diseases, such as CHD and cancer, are also strongly related to lifestyle factors such as smoking, poor diet, physical inactivity and alcohol consumption. There is a strong social gradient to the prevalence of many of these risk factors; for example, it is estimated that half the difference in survival to 70 years of age between social class I and V is due to higher smoking prevalence in class V."

In England in 2001, life expectancy at birth for women was lower than in all but one of eight comparator countries. For men, life expectancy was lower than for women but on average was relatively better, ranking fifth out of nine.

□ **British health spending tops £80bn** Spending on health in the United Kingdom in 2002 was £80.6bn or 7.7 per cent of gross domestic product, according to figures from the Office of National Statistics. Public

spending on the NHS rose by 8 per cent over 2001 to £67.2bn while private spending, including non-prescription medicines, private medical care and funds from charities, rose by 5 per cent to £13.4bn.

### BRIEFLY

#### Investment needed for global health

Health care systems world-wide need to be stronger if global health goals are to be met, according to the World Health Organization. In a new report, "The World Health Report 2003 — Shaping the Future" (available at [www.who.int/whr](http://www.who.int/whr)), WHO calls for urgent investment and international support for health care services in developing countries. "Today's global health situation raises urgent questions about justice. In some parts of the world there is a continued expectation of longer and more comfortable life, while in many others there is despair over the failure to control disease although the means to do so exist," it adds.

# High-dose GLA fails to improve eczema

BORAGE oil, sold as starflower oil and which has a high content of gamma linolenic acid (GLA), does not provide benefit in atopic dermatitis, new research shows (*BMJ* 2003;327:1385).

Previous studies investigating the effects of GLA have failed to produce convincing evidence of any benefit in eczema. One suggested reason for this has been that the GLA preparations used — usually extracts of evening primrose oil — were not of high enough strength.

Researchers therefore randomised 151 patients with atopic dermatitis to receive either borage oil capsules (920mg GLA per day for adults, half dose for children) or placebo for 12 weeks. Symptoms were

assessed in 140 patients at two, four, eight and 12 weeks. The symptoms and signs of atopic dermatitis improved to a similar degree in both groups, with a marginally greater improvement in the placebo group. In addition, subset analysis did not reveal any difference between placebo and GLA for either adults or children.

In an accompanying editorial (*ibid*, p1358), Professor Hywel Williams, Centre for Evidence-based Dermatology, Queen's Medical Centre, Nottingham, writes: "This most recent study, along with the UK's Medicines Control Agency's decision to withdraw the product licence, suggests that GLA supplementation for atopic dermatitis has had its day."

## Three-drug regimen most effective in HIV

A SPECIFIC combination of three anti-HIV drugs appears to be a more effective initial regimen than other drug combinations tested in a large international study.

Two reports published in *The New England Journal of Medicine* last week show that while all of the regimens tested were effective, patients who started therapy with a combination of zidovudine, lamivudine and efavirenz were successfully treated for longer.

The first part of the trial compared several triple therapy regimens to determine their optimal sequencing in 620 patients who had not previously been treated. They received either zidovudine and lamivudine or stavudine and didanosine. The third drug in the triple therapy regimens was either efavirenz or nelfinavir. After treatment failure, patients in each of the four groups were switched to a second three-drug regimen.

The researchers found that failure of subsequent regimens was delayed for longest in the patients who started treatment with a combination of zidovudine, lamivudine and efavirenz. "Even among the subjects who had high viral loads at screening the combination of zidovudine, lamivudine and efavirenz was more effective than the other regimens," they comment (2003;349:2293).

The second part of the trial compared the use of four-drug regimens with the use of two consecutive three-drug regimens in 980 patients (*ibid*, p2304).

After an average of 2.3 years, the four-drug regimens were no more effective than any of the sequential three-drug regimens. The researchers point out that there were relatively few first regimen failures among patients who began therapy with zidovudine, lamivudine and efavirenz. This regimen also led to faster viral load suppression than the four-drug regimens.

Another important finding that emerged from the two studies was that the combination of stavudine and didanosine should not be used for the initial treatment of HIV infection because of unacceptably high rates of adverse effects.

## Switching to anastrozole reduces recurrence of breast cancer

SWITCHING postmenopausal women with breast cancer to the aromatase inhibitor anastrozole (Arimidex) after two years' treatment with tamoxifen more than halves the risk of recurrence compared with continuing tamoxifen, according to new research.

An Italian study randomised 448 women who had been on adjuvant tamoxifen (20mg/day) for at least two years to continue tamoxifen or to switch to anastrozole (1mg/day) for up to five years in total.

After a median follow-up of 36 months patients changed from tamoxifen to anastrozole had experienced 17 events (12 disease recurrences, five second primaries) compared with 45 events (32 disease recurrences, 10 second primaries) in those who continued with tamoxifen ( $P=0.0002$ ).

Results also showed a trend to fewer deaths with anastrozole (4 vs 10 with tamoxifen,  $P=0.1$ ).

Gynaecological changes were more common in patients who continued tamoxifen (7.1 per cent vs 0.9 per cent,  $P=0.001$ ). Gastrointestinal symptoms were more common with anastrozole (6.3 per cent vs 1.3 per cent,  $P=0.006$ ), as was raised cholesterol (8.1 per cent vs 2.7 per cent,  $P=0.01$ ).

Commenting on the clinical significance of the Italian study, Professor Jeffrey Tobias, professor of cancer medicine at University College London Medical School, said: "The results show that in women who have been taking tamoxifen for two to three years but then have to stop due to side effects or reduced efficacy, we can confidently consider treatment with anastrozole as an alternative that is at least as effective and better tolerated."

The data were reported at the San Antonio breast cancer symposium held in Texas earlier this month.

## Top dose of Symbicort increased

THE maximum adult dose of Symbicort Turbohaler (budesonide and formoterol) for asthma has been increased. Patients using 100/6 and 200/6 inhalers will now be able to adjust their dose according to symptoms up to a maximum of four inhalations twice daily.

Anna Murphy, consultant respiratory pharmacist at Glenfield Hospital, Leicester, told *The Journal* that a more flexible approach to asthma management has been shown to have positive outcomes.

She referred to a study, published in *The Lancet* last year, which showed that the dose of inhaled corticosteroid could be adjusted according to the level of inflammation in the airways, measured by eosinophil counts in patient's sputum. This improved symptom control and reduced the overall steroid load. Ms Murphy said: "Patients can be educated to adjust their medication according to vari-

ation in asthma using physician- or nurse-guided self management plans."

Another study, presented in September at the International Congress for Allergology and Clinical Immunology, held in Vancouver, had showed a reduction in exacerbation rate for Symbicort adjustable dosing compared with Symbicort or Sereotide fixed dosing.

She noted that the extended dosing range is potentially more cost effective since the dose can be stepped up or stepped down by changing the number of inhalations, but the patient can keep the same inhaler.

The recommended dose for adolescents (12–17 years) for Symbicort Turbohaler 100/6 and 200/6 is still one to two inhalations twice daily. For Symbicort Turbohaler 400/12 the maximum adult dose is now two inhalations twice daily, and the adolescent dose remains at one inhalation twice daily.

# US pharmacists to be paid for reviews

PHARMACISTS in the United States are to be reimbursed for providing patient medication reviews under new Medicare legislation that became law in the US on 8 December. It will result in pharmacists in the US receiving payment for a non-supply related function for the first time.

Under the new scheme, pharmacists will be able to provide medication reviews for selected patients when this is recommended by a patient's doctor. Patients eligible will include those with chronic conditions such as diabetes, asthma, hypertension, hyperlipidaemia and heart failure.

Pharmacists will compete with other health care professionals to provide these services. Kathleen Cantwell, director of federal affairs for the American Society of Health-System Pharmacists (ASHP) said that the next goal was to achieve federal "provider" status for clinical services, which would indicate that pharmacists provide a unique service other professionals cannot deliver.

Dr Dan Ashby, president of ASHP, said: "For the first time, pharmacists — who are medication use experts — will be paid to manage drug therapies. This is an incredibly



Older Americans will get help paying for drugs

important step in ensuring that [people over the age of 65 years] who take multiple medications do so safely."

In the future, ASHP also hopes to see pharmacists being reimbursed for disease

detection and screening for diabetes and cardiovascular problems.

Medicare is the federal health service for people over the age of 65 years (seniors) in the US. One of the main changes of the new legislation will be to reduce and cap the amount patients have to pay for prescription medicines. A prescription drug scheme will be established from 2006. Under this, patients would pay around \$250 (£147) for an annual medicines policy.

The government would cover up to 75 per cent of the cost of medicines up to an annual limit of around \$3,600, beyond which it would cover 95 per cent of the cost. Low-income seniors would pay only a small fee for each item. This scheme could cost the government up to \$400bn over 10 years.

Pressure from the pharmaceutical industry has prevented the federal government from negotiating lower prices. Increasing parallel importation of cheaper products from Canada, however, has raised awareness among Americans that they pay more for their drugs than most other people in the world. — *Gareth Jones, editor, Hospital Pharmacist.*

## Kidney transplant patients need second phase of less toxic therapy

TRANSPLANTED kidneys may fail in the long term because of the effects of the drugs used to prevent acute rejection, a new study confirms. A two-stage treatment strategy should be adopted, suggest the authors of the study — first using powerful anti-rejection drugs to minimise immunologic injury and then switching to an alternative immunosuppressant that is not nephrotoxic.

The researchers, from the University of Sydney in Australia, regularly examined biopsies of transplanted kidneys over 15 years to find out why kidneys eventually succumb to chronic allograft nephropathy. They found two distinct phases of injury: an initial phase caused by ischaemic injury and, beyond one

year, a phase characterised by microvascular and glomerular injury. They report that nephrotoxicity was almost universal at 10 years. This finding suggests that drugs used to prevent early rejection of kidney transplants — such as ciclosporin and tacrolimus — are not suitable as long-term immunosuppressants. "A two-stage treatment may be preferable, optimising therapy according to the individual risks during each period after transplantation," they suggest (*New England Journal of Medicine* 2003;349:2326).

The National Institute for Clinical Excellence is expected to produce guidance on the use of immunosuppressant regimens in kidney transplantation in March 2004.

## Combination therapy best for BPH

LONG-TERM combination therapy with the alpha-adrenoceptor blocking drug doxazosin and the 5 $\alpha$ -reductase inhibitor finasteride (Proscar) reduces the progression of benign prostatic hyperplasia (BPH) more than treatment with either drug alone.

In a double-blind trial 3,047 men aged 50 years or over with symptoms of BPH were randomly assigned to receive placebo, finasteride 5mg daily, doxazosin 1mg daily or combination therapy. The doxazosin dose was doubled weekly up to 8mg daily.

Over a mean follow up of 4.5 years, the risk of overall clinical progression of BPH compared with placebo was reduced by 39 per cent with doxazosin treatment

( $P<0.001$ ), 34 per cent with finasteride treatment ( $P=0.002$ ), and 66 per cent with the two drugs combined ( $P<0.001$ ). Progression was defined as worsening of symptoms, acute urinary retention, incontinence, urinary tract infection, or renal insufficiency. Compared with placebo, the risks of acute urinary retention and the need for invasive therapy were reduced by combination therapy and finasteride monotherapy, but not by doxazosin monotherapy.

The researchers conclude that long-term combination treatment is appropriate in men with increased risk of disease progression (*New England Journal of Medicine* 2003;349:2387).

### BRIEFLY

#### Rituximab boosts standard therapy

Adding rituximab (MabThera) to conventional chemotherapy can improve outcomes for patients with non-Hodgkin's lymphoma, results from two studies suggest. MabThera is licensed for use as a single agent in chemotherapy-resistant non-Hodgkin's lymphoma but the new data show that a combination of rituximab plus conventional therapy prolongs time to treatment failure. Data from the studies were presented at the American Society of Hematology meeting in San Diego earlier this month.

#### Sore throat persists with penicillin

Most children with a sore throat do not need to be treated with penicillin, say researchers. Treatment failed to shorten the duration of sore throat, reduce non-attendance at school or reduce recurrence of sore throat compared with placebo, irrespective of the presence of group A streptococci. The researchers suggest that only children who are severely ill (with imminent quinsy) or at high risk should receive penicillin for sore throat (*BMJ* 2003;327:1324).

#### Guidelines for glaucoma

The European Glaucoma Society has published new treatment guidelines for glaucoma. The updated guidelines say that, in many cases, prostaglandin derivatives have superseded beta-blockers as first-line therapy. The guidelines are available via the European Glaucoma Society website ([www.eugs.org](http://www.eugs.org)).

# Testing time in Wakefield when Minister visits Moss



Ms Winterton has her blood pressure measured at Moss pharmacy in Wakefield

MINISTER of State for Health Rosie Winterton visited a Moss Pharmacy in Wakefield, West Yorkshire, last week. During the visit she had her blood pressure measured.

The branch at 82 Upper Warrengate has been part of the Moss chain since August 2000 and is managed by Irene Gummerson, a pharmacist with a special interest

in diabetes. During her visit, Ms Winterton was told about the diabetes care service run by the pharmacy and its smoking cessation clinics.

The visit was also attended by the President of the Royal Pharmaceutical Society, Dr Gill Hawksworth, and Moss superintendent pharmacist Tricia Kennerley.

## Local pharmacies still under threat

THE decline of local shops, including community pharmacies, is continuing, according to a report published this week. The report criticises the Government's response to the Office of Fair Trading proposals on deregulation of community pharmacy, describing it as profoundly disappointing.

The report, "Ghost town Britain II: death on the high street", was written by the think-tank the New Economics Foundation and provides an update to the original "Ghost town Britain" report which was published last year (*Pfj*, 21/28 December, p877).

The new report warns that if the Government's proposals on control of entry to pharmacy contracts are followed then the aims of the Department of Health's "Vision for pharmacy" will be blocked. "The Government should follow its own agenda of 'joined-up thinking' by further enhancing the role of community pharmacists; they should be allowed to take on a broader public health role and some of the doctors' pre-

scribing powers," it recommends. In particular, the report makes the following criticisms of the "balanced package of measures" for control of entry:

- The proposal that primary care trusts should consider consumer choice in applications for new contracts ignores the possibility that PCTs might have vested interests in the decisions.
- Questions remain over the criteria that will be used to determine consumer choice and whether this will lead to a postcode lottery in services.
- Making it easier for pharmacists to locate in large shopping developments is deregulation by stealth and measures are needed to ensure this has no adverse effects on local community provision.

"Ghost town Britain II: death on the high street" is available on the foundation's website ([www.neweconomics.org](http://www.neweconomics.org)).

### PJ Online

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

#### Prescribing and Medicines Management

The November/December issue is now online. All pages are available in both HTML and PDF formats. The next issue will be available in March 2004. [www.pjonline.com/pmm](http://www.pjonline.com/pmm)

#### Wants, resources, warnings

As part of the news page redesign, three pages have been added.

**Resources** General information regarding leaflets, resource packs and contact details. **Wants** Miscellaneous requests on a variety of subjects.

**Warnings** Of current concern are an anonymous telephone caller and bogus e-mails. [www.pjonline.com/news](http://www.pjonline.com/news)

## CHI praises Hull for scheme to accredit pharmacies

ACCREDITATION of community pharmacies in Hull has been praised by the Commission for Health Improvement as something the rest of the National Health Service can learn from.

CHI recently issued reports on Eastern Hull and West Hull primary care trusts. Both PCTs, and two others, take part in a locally developed accreditation scheme which covers 96 of the 116 pharmacies in the area. Pharmacies are assessed against core areas of clinical governance and action plans are produced following this. There are opportunities to progress to higher levels of accreditation.

The Eastern Hull review found that the PCT had invested considerable resources in developing community pharmacist support for general practitioners. This support is valued by GPs, the report says. Pharmacist involvement in a primary care specialist diabetes service is also highlighted.

In West Hull, CHI singled out for praise the involvement of community pharmacies in schemes to support GPs, in providing nicotine replacement therapy against vouchers, in supplying emergency hormonal contraception under a patient group direction and in a minor ailments scheme.

### BRIEFLY

#### TransScript closes down

TransScript, which ran one of the three pilot trials of electronic transmission of prescriptions (ETP), is to close down at the end of the year. PharMed, a sister organisation to TransScript that was involved in previous ETP trials, is also closing on 31 December.

#### LPS pilots provide repeats

Local Pharmaceutical Services pilots are to be allowed to provide repeat dispensing services if primary care trusts agree. Directions amending the relevant regulations came into force on 4 December. They allow pharmacies taking part in the first wave of LPS pilot contracts to provide repeat dispensing in the same way as pharmacies in the repeat pathfinder sites. They also allow LPS pharmacies to dispense prescriptions that have been written by supplementary prescribers and independent nurse prescribers.

#### January Drug Tariff delay

The January 2004 edition of the Drug Tariff has been delayed because of a printing problem. The Prescription Pricing Authority says that copies should be delivered to contractors by 8 January. The preface to the edition will be available at [www.ppa.org.uk](http://www.ppa.org.uk).