

Consultation seeks views on skill mix in pharmacy

A consultation document on making better use of a range of skills in pharmacy was launched this week by health minister Rosie Winterton.

"We need to look at a more flexible approach in how services are delivered, allowing pharmacists to make full use of their expertise in medicines with the support of all staff working in pharmacies," Ms Winterton said.

In essence, "Making the best use of the pharmacy workforce", looks at two issues: personal control and supervision in pharmacy. The principles underpinning the document have been agreed across the UK, but separate consultations on the details will follow in Wales, Scotland and Northern Ireland.

The document begins by stating that the pharmacist should retain overall responsibility for ensuring that proper procedures are in place in each pharmacy for both dispensing and sales of medicines.

However, it suggests that a fresh look should be taken at personal control. "To support the pharmacist in offering professional services off pharmacy premises, the law will make clear that the responsible pharmacist does not have to be physically present in the pharmacy at all times," it states. Rather than making specific proposals on how this should happen, it lists some issues on which it would like views. These include restricting the circumstances in which pharmacists may be away from the pharmacy, setting time limits

on a pharmacist's absence from the pharmacy, and requiring the pharmacist to be at the premises at certain hours of opening. Another issue is whether a pharmacist can be responsible for more than one pharmacy at any one time. It also discusses changes to supervision requirements (see Panel).

The National Pharmaceutical Association stated that, when considering skill mix, a balance has to be struck between enabling pharmacists to get involved in cognitive aspects of the job while preserving safety assurances and the value of the availability of a pharmacist at all times on the pharmacy premises.

David Pruce, director of practice and quality improvement at the Royal Pharmaceutical

Society, commented: "Pharmacists already make a significant contribution to improving health and preventing illness. As part of its commitment to lead and support the development of the pharmacy profession, the Society has an ongoing programme of work to look at how pharmacy staff expertise can be best utilised."

He added that a Pharmacy Practice Research Trust's report into skill mix is expected early next year.

The document concludes by listing a series of questions on which it is seeking responses. Comments should be submitted by 11 March 2005. A link to the document can be found on *PJ Online* (www.pjonline.com/links/pj).

Options for supervision requirements

The document outlines a number of options for relaxing the current supervision requirements relating to the sale and supply of pharmacy and prescription-only medicines. One possibility is that a registered and suitably qualified pharmacy technician could supervise medicines sales and supply under a standard operating procedure approved by the pharmacist responsible for the pharmacy. Another option is for other registered and suitably accredited pharmacy staff, including technicians, nurses or NHS-accredited health care assistants, to take over supervision. The document suggests that this might offer greater potential for flexible use of staff, such as a nurse and pharmacist providing a range of services from the pharmacy.

A further option is to introduce remote supervision using new IT, something that is supported by the document. "The pharmacist does not need to be always physically present to exercise his/her responsibility for the safe conduct of business. Changes in the supervision requirements will support remote supervision by the pharmacist," it states. However, remote supervision by a non-pharmacist will not be allowed.

NHS logos for community pharmacies in England launched at Essex pharmacy



NHS branding for community pharmacies in England was officially launched this week at Barry Shooter pharmacy in Ilford, Essex. Guidance on how pharmacies can adopt the NHS identity by using the NHS logo and the pharmacy green cross was published earlier this year (*PJ*, 10 July, p41).

The photograph shows five pharmacists (left to right): Gary Boorman, Jayanti Dattani, Brian Conn, Dipak Doshi and Barry Shooter with health minister Rosie Winterton MP and local MP Linda Perham (right) at the launch on 15 December.

PPRS price cut delayed to ensure supplies

Community pharmacies in England, Scotland and Wales have been granted one month's grace before an agreed 7 per cent cut in medicine prices is implemented for NHS reimbursement purposes.

The price cut, agreed under the new Pharmaceutical Price Regulation Scheme which comes into effect on 1 January 2005, will not apply to dispensed NHS prescriptions until 1 February.

Both the Department of Health, which manages the Drug Tariff for England and Wales, and the Scottish Executive Health Department have agreed to the delay to fend off the risk of patients being unable to obtain adequate supplies of medicines over the Christmas and New Year period.

A Pharmaceutical Services Negotiating Committee statement said: "This agreement ensures that contractors should not be financially disadvantaged by being reimbursed at lower prices for stock bought at higher prices, and removes the need to minimise stock holdings. Contractors are encouraged to ensure that they have adequate stocks over the Christmas and New Year holiday season."

The Society

Non-practising members' retention fee

The Council is considering amending its policy on the retention fee for non-practising members in the light of concerns expressed by members (p887).

Code of Ethics updated

The Council has updated the Code of Ethics to reflect the introduction of continuing professional development and to tighten the code's requirements for the control of online pharmacy services (p889).

Latest Shipman report may affect Society's roles

Criticisms of the General Medical Council made in the latest Shipman Inquiry report could have implications for the Royal Pharmaceutical Society.

The inquiry's fifth report, which was published last week, examines the monitoring and disciplinary systems for doctors. The GMC, doctors' regulatory body, is criticised for acting in the interests of registrants rather than putting patient protection first.

According to the report, one of the GMC's fundamental problems is a conflict between representative and regulatory roles. The report notes that a perception of a representative role has arisen despite the fact that the GMC is solely a regulatory body. It suggests that the GMC cannot rid itself of this perception because of its constitution, which means that it is effectively controlled by elected members.

"It is not appropriate that the GMC should be dominated by elected members. It should certainly be dominated by medical members; I am not suggesting that there should be any increase in the proportion of lay members. But I do suggest that there should be more appointed medical members, people who are not beholden to an electorate and who do not see themselves in the position of representatives of the profession," Dame Janet Smith, chairman of the inquiry, recommends.

"To do their work properly as members of a regulatory body, they have to put the public interest first," she added.

The report also highlights another structural issue for the GMC. It states that it is inappropriate for the GMC to carry out both the investigation of a case and then the adjudication on it. In other words, the GMC cannot be both the prosecutor and the judge. The GMC had taken steps to separate these functions, but these do not go far enough for the Shipman Inquiry. "I have recommended that responsibility for the adjudication stage should be transferred to an independent organisation," says Dame Janet.

Commenting on the report, Mandie Lavin, the Society's director of fitness to practise and legal affairs, said: "It is useful to have such a complete examination of the fitness to practise process."

The Society recognises that some of the report's recommendations could have implications for its functions. "It is conceivable that the dual role of the Society as a regulator and as a representative body for registrants will be subject to increased scrutiny in the future," said Ms Lavin. "There are strengths in the combined function but the Society will need to put in additional safeguards to provide both the membership and the public with an assurance that the regulatory and representative functions are separate." Ms Lavin also pointed out that the Society will need to consider its position on the issue of whether a separate adjudicating body to hear cases from all regulators should be set up.

Other recommendations made by the inquiry are that all health care professionals



Mandie Lavin: dual role under scrutiny

should have a duty to view the actions of fellow professionals with independence and objectivity, and that doctors' disciplinary records should be made publicly available on the GMC website. These are issues that Ms Lavin said that the Society would consider for pharmacists. The report also highlights the introduction of revalidation for doctors planned for 2005. It says that revalidation could make a major contribution to identifying incompetent doctors and improving patient safety but that the present proposals are unsatisfactory.

The report highlights the work of the Council for Healthcare Regulatory Excellence and states that a future review of its powers should be undertaken to see if they should be extended.

CD registers are to be centralised at Prescription Pricing Authority

Central records of all community pharmacy Controlled Drug registers are to be kept by the Prescription Pricing Authority once electronic CD registers are in common use.

In addition, transactions are to be monitored through the supply chain from manufacturer to individual pharmacies so that pharmacy registers can be reconciled with supplies they have received and prescriptions

they have dispensed. Pharmacists will be expected to try to verify the identity of anyone collecting dispensed CDs and to record this information.

These are some of the ways in which the Government proposes to implement recommendations from the fourth report of the Shipman Inquiry.

A recommendation that patients prescribed Schedule 2 injectable CDs, such as diamorphine, should keep their own records of use so that unused supplies can be reconciled for destruction is to be piloted first to assess the likely costs and benefits.

The Government has rejected the inquiry recommendation of a nationally co-ordinated CD inspectorate. Instead, all health care organisations will have to nominate a senior person to be responsible for managing the use of CDs. Health care organisations, police forces, social services and relevant inspection bodies will be given a statutory duty to share information about potential CD offences.

The Royal Pharmaceutical Society, the Healthcare Commission and the Commission for Social Care Inspection will be asked to assess the management of CDs in

all inspections or assessments they carry out. GP practices that hold CDs will be subject to random inspection by primary care trusts.

This response is a joint response from the Department of Health and the Home Office. It makes it clear that all proposed changes that are to be made by amending Controlled Drugs or medicines legislation will apply across the UK. But other changes, such as those involving the Healthcare Commission and PCTs, are for England only. It will be for the devolved administrations to decide what to do in Wales, Scotland and Northern Ireland about other administrative matters.

Mandie Lavin, director of fitness to practise and legal affairs at the Royal Pharmaceutical Society, said that the Society had worked with the DoH to help it find solutions to problems identified by the Shipman Inquiry. "In particular, through our working party chaired by Elizabeth Filkin, we have considered the key issues raised, such as inspection arrangements, CD registers and the destruction of unused CDs," she said. "We support the Government's response and will work collaboratively with them to put in place effective safeguards."

Other recommendations

- NHS prescription forms to be redesigned so that they can be marked as CD prescriptions and include patient identifiers
- Private prescribers to use serial numbered forms obtained from the PPA
- Copies of all dispensed CD prescriptions to be sent to the PPA for reconciliation against central records
- Pharmacists to have some freedom to dispense CD prescriptions that have technical irregularities
- Records to be kept for 11 years, rather than the current two years

Scotland moves away from volume-based contract

Community pharmacists in Scotland look likely to have a new contract that moves away from payment by prescription volume for the first time. Instead, subject to the agreement of contractors, the contract will be based on a capitation payment for two of the four core services, a fixed practice payment for one and a volume-based payment for the remaining service.

In preparation for the new contract, which will be implemented in April 2006, transitional arrangements were announced this week (see news item below). This will allow contractors to have a period of stability in which to prepare for the new contract, and will also put them in a more informed position before they are asked to agree the contract, which is still being negotiated.

By moving from a volume-based contract to a service-based contract, contractors would receive capitation fees for the minor ailments service and the chronic medication service

(which involves serial dispensing and incorporates the pharmaceutical care model schemes). Prescriptions dispensed through the acute medication service will be funded by a dispensing fee, the only aspect of the core contract to remain volume-based. Funding for the fourth core service, public health, will be a fixed payment.

Frank Owens, chairman of the Scottish Pharmaceutical General Council, said: "Moving away from a purely volume-based contract to one which rewards the quality of the pharmaceutical care we provide our patients will secure pharmacists not only the long-term security we all desire but, more importantly, a future which is both exciting and rewarding."

Bill Scott, chief pharmaceutical officer at the Scottish Executive commented: "Removing the perceived barriers will enable community pharmacists in Scotland to participate fully as members of the NHS

family and deliver pharmaceutical care in its widest sense to the population of Scotland."

Mr Owens added: "This deal lays down the foundations from which to develop and integrate Scottish community pharmacy as a principal member of the primary care prescribing team." In future, this will be through supplementary prescribing within the chronic medication service. Further ahead, there is potential for independent prescribing to fit into this part of the contract.

Mr Owens explained that this is why a non-volume-based contract is so important. "If contractors are to be given these prescribing rights we need to remove any perverse incentive to prescribe, ie, you cannot receive remuneration based on the number of prescriptions you write. It is also important that pharmaceutical care activity, which is core within the chronic medication service, is measured and assessed by the clinical needs and outcomes of patients," he said.

Transitional funding agreed in Scotland

Transitional funding arrangements, to cover the 15 months until the new community pharmacy contract in Scotland is implemented in April 2006, were announced this week.

The aim of the transitional phase is to provide a period of stability so that contractors can prepare for the move away from a

volume-based contract to a service-based model. It will also give contractors a period of consolidation so that they can make any necessary changes, such as to premises or computer systems and to train staff, before the new contract is implemented.

The financial package was unanimously agreed by the Scottish Pharmaceutical General Council's standing committee on 10 December.

Funding to support the transitional arrangements is an increased global sum of £99.171m in 2004-05, up 6.36 per cent from the previously agreed figure of £93.235m. The global sum for 2005-06 will be increased by a further 3.9 per cent to £103.039m. On top of this, the 2.5 per cent overspend on the global sum in 2003-04 has been written off rather than clawed back. Any additional spending on stock order on cost, direct supply pilots and model schemes above the previous spend on the schemes of £2.899m will be met by the Scottish Executive Health Department in addition to the global sum.

The funding for the new contract is still being negotiated. In addition, discussions are ongoing on further funding outside the global sum to support community pharmacists in meeting increased demand resulting from GPs' new out of hours arrangements and to allow community pharmacists to implement supplementary prescribing.

The transitional arrangements will apply to payments from December 2004 until March 2006. Details of category allocation will be sent to contractors before 14 January 2005. Further information will be provided in the SPGC's December "Vision" newsletter to be posted to contractors next week.

First cohort of supplementary prescribers qualify in Wales



Pharmacist Marc Donovan receives his certificate from David Grant

An awards ceremony was held at Cardiff University earlier this month for the 47 pharmacists and nurses who have just qualified as supplementary prescribers from the University's Welsh School of Pharmacy and School of Nursing and Midwifery Studies.

Pictured is Marc Donovan (right), prescribing support pharmacist at Vale of Glamorgan Local Health Board, receiving his practice certificate from David Grant, vice-chancellor at Cardiff University.

Transitional funding

Under the transitional arrangements, the majority of contractors will receive a fixed monthly payment based on what they were paid in 2003-04. Individual contractors' payments will be determined according to which of seven categories they fall into. Most will be contractors who have held a contract since April 2003. For these contractors, each monthly payment will be:

- One-12th of the sum of dispensing fees and professional allowances paid during 2003-04
- Less 2.5 per cent to avoid a repeat of last year's overspend on the global sum
- Plus growth money: 5.34 per cent from December 2004 and a further 3.9 per cent from 1 April 2005

Contractors will also continue to receive payments on stock orders and for model schemes, minor ailments service pilots, compliance assessment fees, out-of-pocket expenses and other locally negotiated payments. Adjustments to the transitional payments will be made if a contractor's activity level changes significantly. Special arrangements will be put in place for new contractors who do not have a history of 2003-04 payments and for essential small pharmacies.

Barcodes may be best way in short term to identify patients, says NPSA

Technologies such as barcodes, radio frequency identification and biometrics could help improve patient safety in the NHS by ensuring that patients are correctly identified, according to studies commissioned by the National Patient Safety Agency.

Barcodes may be the best option for most applications in the short term but, in the longer term, radio frequency identification (using radio-frequency transfer of data between a reader and a tag) may provide a better solution if costs are reduced sufficiently and the technology gains wider public acceptance. However, in areas such as outpatients, biometric measures (eg, finger printing and iris scans) could provide unique benefits.

In a report entitled "Right patient — right care", the NPSA pulls together the findings of two studies commissioned in 2003 to look at the use of manual checking processes and technologies to match patients with their care, including ensuring the correct medicine is given to the correct patient. It concludes that there is considerable scope in the NHS for improving patient safety through the development of fail-safe methods of manual identification and checking alongside the use of new technologies.



Barcodes could improve patient safety

The NPSA identifies a range of technologies used for identification and describes cases of hospitals and surgeries using barcodes, finger-print technology and active radio frequency identification for a variety of identification tasks. However, it concludes that, at present, none would meet all the requirements for patient and sample identification in the NHS, although barcodes may offer the best fit for most applications.

NPA appoints new managers to help its members

Two new managers to help community pharmacists develop their businesses have been appointed by the National Pharmaceutical Association.

Neal Patel, the new NHS liaison manager, will work at national level to gather information about NHS policy that will impact on community pharmacy and develop networks within the Department of Health. By identifying significant areas of emerging policy at an early stage, the NPA will be able to work with the NHS for the benefit of community pharmacy and keep NPA members

informed. Mr Patel is a former group pharmacy manager for Boots The Chemists.

Raj Nutan, who was until recently a Moss Pharmacy regional professional development manager, has been appointed to the post of NPA pharmacy business manager. He will seek to develop and promote business opportunities for NPA members, both within the NHS and more generally. These may include opportunities for lowering business costs, for maximising profits or for streamlining operations.

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Lloyds offers £10k for long service

Preregistration trainees working for Lloydspharmacy are being offered an incentive to stay with the company. Trainees who complete the preregistration year and who go on to complete three more years of service will be offered £10,000.

PGD website

A website, run by the London and South East Medicines Information Service and providing resources for patient group directions, was launched this week (*PJ*, 6 November, p672). The new website, launched via the National Electronic Library for Medicines, is accessible via *PJ Online* (www.pjonline.com/links/pj).

Parasitic worms benefit Crohn's disease patients

Parasitic worms may be a safe and effective treatment for Crohn's disease, new research suggests.

In an open label study 29 patients with active Crohn's disease ingested a drink containing 2,500 eggs of the helminth *Trichuris suis* every three weeks for 24 weeks. The eggs had been treated so that they would not transfer any bacteria or viruses to the study participants. Patients continued to take their regular medicines at the dose they had been stabilised on and their symptoms were recorded using a disease activity score. After 24 weeks, nearly 80 per cent of patients (23) experienced an improvement in their condition and over 72 per cent (21) went into remission.

Crohn's disease is less common in less developed areas of the world where most people carry worms, and worms have previously been shown to reduce inflammation in mouse models of colitis. The researchers describe how Crohn's disease is associated with over reactive type 1 T-helper cell pathways and say that helminths inhibit these immune responses.

They add that although a high placebo effect cannot be excluded, no side effects or complications were reported from the treatment and helminths may therefore offer an alternative or supplement to current treatments. They say that these results justify further research (*Gut* 2005;54:87).

***Trichuris* species offers treatment hope**

BP trial is halted early

A trial comparing blood-pressure-lowering treatments has been stopped early after one of the treatment arms was found to offer significant advantages to patients.

The Anglo-Scandinavian cardiac outcomes trial (ASCOT) compared a treatment strategy based on the beta-blocker atenolol and the thiazide diuretic bendroflumethiazide with one based on the calcium channel blocker amlodipine and the angiotensin converting enzyme inhibitor perindopril.

The newer strategy of using a combination of amlodipine and perindopril resulted in greater benefits for patients.

The ASCOT study co-chairmen commented: "Although at the moment we are unable to provide any definite figures on the effectiveness of the new treatments compared with the old, we have seen important significant differences."

Poor technique a problem with new inhalers

Newer dry powder inhalers are ineptly used as often as older pressurised metered dose inhalers, a new study suggests (*Annals of Allergy, Asthma and Immunology* 2004;93:439).

Researchers found that 22.8 per cent of patients using dry powder inhalers (DPIs) and 23.9 per cent of patients using pressurised metered dose inhalers (pMDIs) failed to perform at least one step judged to be critical for reliable drug delivery to the lungs.

DPIs were developed in response to the problems that many patients have in achieving a good inhalation technique with pMDIs and, in controlled clinical trials under strict conditions, poor inhalation technique has not been found to be a major problem with DPIs.

However, it is not clear whether, in clinical practice, patients use DPIs any better than they do pMDIs. The researchers therefore

studied inhalation technique in 1,404 patients aged 15 to 88 years who were experienced inhaler users. Trained observers recorded patients' inhalation techniques using a standardised check-list.

Judith Green, senior respiratory pharmacist at Wirral Hospital NHS Trust, commented: "Pharmacists can play a pivotal role in asthma and chronic obstructive pulmonary disorder management. We are ideally placed to assess patients' ability to use inhaler devices and to ensure therapy is optimised."

She added: "Patient preference and ability to use the device are crucial to successful management. Dry powder inhalers are good inhaler devices if used appropriately. The patients' inspiratory flow rate and manual dexterity must be considered before prescribing such devices."

Antiemetic also provides pain relief in migraine

Metoclopramide, an antiemetic, effectively reduces headache pain associated with acute migraine and should be considered a primary treatment option in accident and emergency departments, say researchers (*BMJ* 2004;329:1369).

They examined data from 13 randomised controlled trials, observing that as few as four patients need to be treated with the drug to enable one patient to achieve significant pain reduction. The researchers explain that metoclopramide has long been used to treat nausea associated with migraine and that anecdotal reports have indicated it may also have analgesic properties.

They report that five studies confirmed that metoclopramide is more effective than placebo for relief of pain and nausea and relapse of headache. Metoclopramide compared favourably with ibuprofen and sumatriptan in two trials but three studies suggested it may provide less relief from pain and nausea than

other phenothiazine antiemetics. Several studies showed metoclopramide combinations were as, or more, effective for pain relief than comparison regimens (eg, hydroxyzine-meperidine, dihydroergotamine, valproate, ibuprofen, ketorolac, promethazine-meperidine).

□ **Stroke risk** People with a history of migraine appear to be twice as likely to suffer a stroke than people without migraine. Those who also use oral contraceptives are at even greater risk. Researchers looked at data from 11 case-control studies and three cohort studies and found that the relative risk for ischaemic stroke among patients with migraine headache was 2.16 (95 per cent confidence interval 1.89 to 2.48). Migraine sufferers who also use oral contraceptives had an approximately eight-fold increase in risk of stroke compared with those not using these agents (published on *BMJ Online First*, www.bmj.com, 13 December).

Rivastigmine reduces dementia in Parkinson's

Rivastigmine (Exelon) treatment is associated with moderate reductions in dementia associated with Parkinson's disease, a new study has shown (*New England Journal of Medicine* 2004; 351:24).

Since cholinergic deficits are the most consistent neurochemical findings associated with the cognitive and neuropsychiatric symptoms of Parkinson's disease, Murat Emre, of Istanbul University, and colleagues investigated the effects of the dual cholinesterase inhibitor rivastigmine on dementia in Parkinson's disease. They found that, when compared with placebo, rivastigmine produced moderate but significant improvements in global ratings of dementia, cognition, and behavioural symptoms.

However, worsening of parkinsonian symptoms, mainly tremor, occurred more frequently in the rivastigmine-treated patients than those given placebo.

Treatment duration of action is important in ED

Duration of action of erectile dysfunction treatment appears to be the most important factor when patients are able to choose which product to use, data from three patient preference studies suggest.

The three studies were presented at last week's European Society for Sexual Medicine congress in London and their results show a broad consensus that after trying three phosphodiesterase inhibitors most men will choose to continue with tadalafil.

The first study asked 120 men with previously untreated erectile dysfunction (ED) to use sildenafil (Viagra), tadalafil (Cialis) and vardenafil (Levitra) for six weeks each. The order of the treatments was randomised.

At the end of the study the most important factor in deciding which treatment to continue with was duration of action — 15 per cent wanted to carry on taking vardenafil, 19 per cent sildenafil and 62 per cent tadalafil.

The second study looked at 418 treatment-naïve men with ED who were asked to use each phosphodiesterase inhibitor at least four times. The data suggest that men with milder erectile dysfunction prefer to take tadalafil but that the popularity of sildenafil and vardenafil increases with severity of the problem.

The final study was carried out in 107 men with diabetes and ED. Around two thirds had used sildenafil before. The results show

that 15 per cent preferred taking sildenafil, 28 per cent vardenafil and 36 per cent tadalafil. Of those who preferred taking tadalafil, 82 per cent said they liked the longer duration of action.

Author of the first study, Benny Verheyden, consultant urologist at the University of Antwerp, commented: "We also saw a clear trend towards a preference for tadalafil for those in long-term, stable relationships.

"Sildenafil and vardenafil tended to be chosen by men in relationships with short and well planned sexual encounters."

No pharmaceutical industry funding was declared for the three studies.

Workshop examines new process analytical technology guidance for manufacturers



Pictured (left to right): David Radspinner (Aventis), John Clements, Ken Leiper (Benson Associates), Chris Watts (FDA), Keith Pugh (MHRA), Vibhakar Shah (FDA), Ingrid Maes (Siemens) and Ali Afnan (FDA)

Representatives from UK and US regulatory agencies met pharmaceutical industry professionals earlier this week to discuss new US Food and Drug Administration guidance on process analytical technology (PAT).

The workshop was hosted by the Royal Pharmaceutical Society in London. John Clements, the Society's science secretary, explained that the current practice of testing small samples of medicines at the end of the manufacturing process is no longer regarded as a satisfactory measure of quality. Regulators and manufacturers increasingly recognise the

benefits of monitoring the quality of materials throughout the manufacturing process. Using process analytical technology, any problems can be picked up as they arise and the information can be fed back into the manufacturing process.

The workshop was held in collaboration with the FDA and provided an opportunity for delegates to learn about the implications for the industry of the new PAT guidance, and to discuss these with speakers from the FDA and the Medicines and Healthcare products Regulatory Agency.

Pharmacists should distance themselves from industry

Nofreelunch, an international organisation that wants to break the hospitality and patronage-based relationship between health professionals and the pharmaceutical industry, is asking pharmacists to distance themselves from the industry.

Pharmacists, and other health professionals, are being asked to sign and display a pledge that they will not accept company gifts or hospitality and will not rely on medical information disseminated by drug companies.

A spokesman for the Association of the British Pharmaceutical Industry, commented: "Working in partnership benefits everyone — health care professionals, industry and most of all patients. Of course that relationship must not cross certain boundaries but we have a code of practice that is vigorously enforced."

The Nofreelunch website can be accessed via *PJ Online* (www.pjonline.com/links/pj).

Lilly's trial registry launched

Lilly has launched its online registry of clinical trials of its products (*PJ*, 28 August, p281).

Available at www.lillytrials.com, the registry at present contains nearly half the data the company has committed to making publicly available. The company aims to make the remaining data available by July 2005.

For phase I-IV clinical trials of marketed products, the company will post the predefined primary and secondary outcome measure results, safety and efficacy results and any results that do not support the hypothesis or are contrary to the expected outcome. The results will be posted when a drug's indication is approved and the drug is commercially available.

Lilly will also make available details of all initiated phase II-IV trials that it sponsors, including information on the status of the trial and its projected end date.

Novartis corrects misleading Clozaril statement

Novartis Pharmaceuticals has issued a corrective statement at the request of the Medicines and Healthcare products Regulatory Agency following the voluntary withdrawal earlier this year of two promotional booklets for Clozaril (clozapine). Novartis has accepted that the overall message of the booklets — that

replacing Clozaril with generic clozapine would increase treatment costs and place patients at risk — was misleading. The company accepts that there was insufficient evidence to support the claims.

Details of the correction are available via *PJ Online* (www.pjonline.com/links/pj).