Freshmint
The best tasting gum ever from Nicorette is here.

DoH gives PCTs draft guidance on new contract

MPs voice fears over ETP and patient direction

Script charge variations come under spotlight

The rise of the pharmacy robots - are you ready?
Help them enjoy weeks of freedom from recurrent heartburn

Zanprol® Tablets, taken as a short course (2-4 weeks), can offer weeks of remission from recurrent attacks, giving the oesophagus time to heal. So recommend a simple, short course of Zanprol, because that’s the kind of thinking that really makes sense.

Product Information. Presentation: Each Zanprol 10mg Tablet contains 10 mg of omeprazole. Uses: Relief of reflux-like symptoms (eg heartburn). Dosage: Adults over 18 years only - 20 mg once daily before a meal. May be reduced to 10 mg daily, returning to 20 mg if symptoms return. Use lowest effective dose. Contraindications: Hypersensitivity, pregnancy/ lactation. Precautions: Refer to doctor if no relief within 2 weeks, continuous use for 4 or more weeks to control symptoms, aged over 45 with new or recently changed symptoms, unintentional weight loss, anaemia, gastrointestinal bleeding, difficult or painful swallowing, persistent vomiting or vomiting with blood, epigastric mass, previous gastric ulcer or surgery, jaundice, any other significant medical condition (including hepatic or renal impairment), or pre-endoscopy. Interactions: Diazepam, phenytoin, warfarin, ketoconazole, itraconazole, clobazam, voriconazole, digoxin, tacrolium, C-urea breath test. Side effects: Skin rash, urticaria, pruritus, photosensitivity, bullous eruption, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis, alopecia and increased sweating. Arthritic and myalgic symptoms, bronchospasm, diarrhoea, constipation, abdominal pain, nausea/vomiting, flatulence, dry mouth, stomatitis and candidiasis. Increases in liver enzyme levels, encephalopathy in patients with pre-existing severe liver disease, hepatitis with or without jaundice and hepatic failure. Interstitial nephritis resulting in acute renal failure, gynaecomastia, impotence, headache, paraesthesia. Taste disturbances, mental confusion, agitation, depression, aggression, blurred vision, blood disorder, hyponatraemia, vertigo, anaphylactic shock and angioedema, dizziness, light-headedness, feeling faint, somnolence, insomnia, peripheral oedema, malaise and fever. Legal Status: P. Retail Selling Price: 14 Table E9.49. Product Licence Number: PL 14017/006. Licence Holder: Dexcel-Pharma Ltd, 1 Cottesbrooke Park, Heartlands Business Park, Daventry, Northamptonshire, NN11 5YL. Date of Preparation November 2003.

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Bob Gartside considers what can be learnt from sector on dispensing automation.
DoH offers guide to control of entry regs

by Gary Paragpuri

Draft guidance enabling PCTs to assess pharmacy contract applications under the revised control of entry regulations due on April 1 has been published by the Department of Health. It details how PCTs should handle applications, how the new criteria of ‘competition and choice’ is to be applied, and expands on the four proposed exemptions to the control of entry regulations (see panel).

But details of how contract applications will be handled in rural areas have not been revealed. In addition, new requirements for contractors and pharmacists to declare information about their suitability to provide NHS services will be introduced. Details of these ‘fitness to practise’ procedures were unavailable as C+D went to press.

Under the revised rules, PCTs will make five types of decisions: minor relocations (including cross-PCT boundaries), change of ownership, change of services, preliminary consent applications, and other applications.

For minor relocations, the ‘necessary and desirable’ test will not apply but applicants must trade from the new premises for a minimum of 12 months before seeking further minor relocation. For ownership changes, the PCT must be satisfied the applicant has the ‘necessary level of knowledge’ in English unless the applicant is already on the pharmaceutical list. New owners seeking changes to services must be treated as new applications.

All applications apart from the four exemptions will have to pass entry controls: neighbourhood, adequacy (encompassing competition and choice), and necessary or desirable.

Securing adequate provision of services will be PCTs’ key requirement, says the DoH, and if, as a starting point, a pharmaceutical needs assessment has determined whether access to pharmacy services in a neighbourhood is wholly adequate or wholly inadequate “then an application is likely to fail or succeed accordingly”.

Although the explicit criteria of competition and choice are not necessarily new, clearer emphasis will be placed on factors that promote them, including: level of access, choice and diversity in the neighbourhood, innovation in service delivery, services to specific populations/to meet disease needs, and overall long-term impact. Factors to consider within these criteria include: pharmacy opening hours, pharmacies unable to offer additional services due to high dispensing volumes, whether an application would secure a monopoly in the neighbourhood, and whether current service providers were responding flexibly to meet local needs.

### The control of entry exemptions

**Pharmacies based in approved retail areas, over 15,000sq m gross floor space away from town centres:**

- These must provide all the essential services in the new pharmacy contract, and any services determined by PCTs.
- There will be no limit on the number of contractors who can apply under this exemption.

**Pharmacies that intend to open for more than 100 hours per week:**

- Typical opening times could be 8am to 10.30pm Monday to Sunday or 6.30pm to 9am Monday to Friday and all weekend from 6.30pm Friday to 9am Monday.
- Pharmacies larger than 280sq m must comply with Sunday Trading Act requirements and, if they cannot ensure separate access, Sunday openings will be restricted to six hours.
- PCTs will be able to remove from the list any pharmacy that consistently fails to meet the opening hours requirement or if a serious breach puts patient safety at risk. It will be up to applicants to state how they will provide information about opening hours to allow monitoring by the PCT.
- A pharmacist must normally be on the premises during opening hours.

**Consortia establishing one-stop primary care centres:**

- Must be part of PCTs’ strategic service development plan.
- Does not apply to centres agreed before April 1 unless there is substantial new development.
- The centre can be on a campus site.
- The range and variety of services offered must be considerably above that expected from a usual GP surgery.

**Wholly mail order or internet pharmacy services:**

- Must provide the full range of NHS pharmacy services determined nationally.
- Must be registered with the RPSGB and have premises within the PCT.
- Must not provide ‘face to face’ NHS services – but can do so privately.
- Premises cannot be on the same site as a provider of personal medical services with a patient list.
- It will be the responsibility of applicants to set out how they will provide all the essential services.

### EDUcation

**CPD update**

Included with this week’s issue of C+D is a report of a round table discussion looking at the role of the pharmacists in optimising skin disease management.

The meeting, sponsored by Crookes Healthcare, looks at eczema and psoriasis and the role of emollients compared to aqueous cream.

And look out in next week’s issue for the latest in the Dendron/Over The Counter training modules for pharmacy assistants. The module looks at headache and offers pharmacy assistants the opportunity to win a prize for their pharmacy.
Senior cross-party politicians have highlighted six areas of concern as part of their call to safeguard patient choice when prescriptions go electronic.

A recent inquiry into developments in NHS IT has concluded that when the electronic transmission of prescriptions (ETP) is introduced patients’ freedom to choose may be removed, resulting in patients being directed to a particular pharmacy, the All-Party Pharmacy Group has warned. It has recommended that:

- Patients should be free to choose the pharmacy that dispenses their medication. The direction of electronic prescriptions by prescribers should be resisted.
- A national clinical champion for pharmacy should be identified and appointed, with the remit of communicating between the National Programme for IT and the profession.
- Pharmacists should be given appropriate role-based access to patient information, while ensuring that patients’ consent and confidentiality are respected.
- Cross-border arrangements for sending prescriptions and patient information electronically between the home countries should be clarified.
- Private prescriptions and Controlled Drugs should be incorporated within ETP roll-out plans.
- Pharmacists should be able to upload summary information about their contact with patients to the Care Record.
- APPG group chairman, Dr Howard Stoate, said: “Restricting freedom of choice... raises concerns about fairness and conflicts of interest. Direction of prescriptions will disadvantage many patients and many pharmacies.”

In a separate recommendation, the group has also called for the appointment of a clinical champion to improve communication between pharmacists and the Government over the introduction of new information technology.

Dr Stoate added: “The Government has appointed clinical champions for the medical and other professions to improve communication around IT changes and to ensure those changes are understood and supported. It appears to have overlooked pharmacy.

―TT changes will be crucial to the successful delivery of services under the new pharmacy contract.”

For more information:

**Propranolol recall**

Tillomed Laboratories has recalled a batch of Half Beta Programme 80mg capsules 28s (propranolol), because neither the carton nor the patient leaflet mention the product is sustained release.

The affected stock carries the batch number R04002192 and expiry date 12/08, and was first distributed on September 14. Pharmacists should quarantine all remaining stock and return it to their supplier for replacement. For more information, contact Tillomed’s customer care department on 01480 402405.

**Rx endorsement**

The Department of Health and the National Assembly for Wales have agreed to allow NCSO endorsement for the following item for March 2005 prescriptions:

- rifampicin 300mg capsules.

**Patient safety**

An All-Party Parliamentary Group on patient safety launched last week with its first meeting.

The group will examine issues such as the importance of technology, the blame culture in the healthcare system and the prescribing and administration of drugs. It will also raise awareness of patient safety issues in the NHS such as clinical negligence, medical error and drug safety.

Labour MP Dr Howard Stoate, who is establishing the group, said: “We want the group to enhance awareness of the issue not only within Parliament but also throughout the wider healthcare arena. In time, we hope to play a positive role in examining and influencing government policy.”

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**Skills for the Future**

**Module 17**

**Rheumatoid arthritis**

Is included with this issue

**Newcastle**

01732 377688

**Chemist Druggist** 12 March 2005
**Welsh divided over cut in script charges**

Opposition politicians in Wales have strongly criticised the Government for misdirecting spending towards abolition of prescription charges at the expense of greater priorities.

But after their criticisms of the proposal to reduce the charge from £3.50 to £2.50 from April 1 had failed, with the aim of abolishing it by the 2007 election, they admitted that if elected to government, the free prescriptions would probably stay.

Wales Liberal Democrat leader Michael German said: “I cannot see us wanting to reintroduce charges,” while a Conservative spokesman said: “We would have to look at that very carefully because of the political waves it would cause.”

Conservative Jonathan Morgan said this £3.50 million “election gimmick” will lead to an abuse of medicines through wastage “with pharmacists considering it a waste of money”.

Liberal Democrat Kirsty Williams would prefer the 37-year-old exemptions list to be updated, rather than the fee to be reduced so low that it becomes more cost effective for individuals to get a prescription for a benign, or legitimate condition, “they would normally buy over the counter”.

Rhodri Glyn Thomas, of Plaid Cymru, said the cash should be spent on patients with chronic illnesses.

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**England and Scotland raise script charges**

Prescription charges in Scotland and England will rise by 10p from April 1 to £6.50 per item.

The cost of prepayment certificates will rise to £33.90 for a four-month certificate and £93.20 for an annual certificate.

Commenting on the Scottish Executive’s commitment to review prescription charges for pensioners in light of health conditions and for young people in full time education and training, deputy health minister Rhona Frankin confirmed that a consultation this summer would seek views on making charges and exemption criteria fairer.

John Reid, the health secretary for England, defended his decision to authorise the increase in prescription charges, saying that: “It’s less than the rate of inflation.” He also did not rule out a review of the exemptions after the general election. “We keep this under constant review,” he said.

In spite of obvious anomalies, the health minister Rosie Winterton admitted that minsters were reluctant to reform the system because of the lack of a consensus. Joan Walley, the Labour MP for Stoke-on-Trent North, called on the Government to exempt asthma medication from prescription charges. Ms Winterton told her: “We have no plans to extend the existing list of medical conditions that give exemption from prescription charges.

“The list has been reviewed on a number of occasions but no consensus emerged. There is no consensus on what additional conditions might be included in any revised list of medical exemptions, or how distinctions could be drawn between one condition and another.”

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**Some Drug Tariff fees to go on April 1**

Some professional fees will be abolished on April 1 and redistributed to remaining fees under the new pharmacy contract.

The Pharmaceutical Services Negotiating Committee says the changes will be cost-neutral. The fees to be removed from Part IIIA of the Drug Tariff will be:

- Extemporaneous fees for unit dosage forms such as cachets, capsules and pills; special formula powders; aspirin dispensing and extemporaneous sterilisation.
- PSNC says these fees are rarely claimed. For any drug not listed in Part VIII of the Tariff, contractors will continue to be paid according to the manufacturer’s list price or special’s invoice.
- Further changes are expected to the arrangements for extemporaneous dispensing as work continues on the Drug Tariff simplification.

- The bulk prescription fee will go and contractors will receive the standard dispensing fee for each item dispensed on a bulk prescription, according to normal Drug Tariff rules. There will also be a container allowance for each item dispensed.
- As mentioned last week (C&D, March 5, p4), the urgent fees will be removed and funded locally. L.P.Cs should contact primary care trusts immediately to advise them of the need to make local arrangements.
- Fees for repays to trusses and for replacement of a complete appliance and/or supply of spare parts for stoma appliances, suprapubic bags and incontinence appliances will go. The special fee for appliances not covered in Part IIIA 2B and dressings will be removed and all products (drugs and appliances) will receive the same professional fee of 90p.
- To support the efficient processing of prescriptions, some of the endorsement codes for additional fees will be standardised. Future codes will be "ED" for extemporaneous dispensing and "MF" for elastic hose and trusses that need to be "measured and fitted". The requirement to endorse "CD" on prescriptions in Schedule 2 or 3 of the Misuse of Drugs Regulations 1985 has been removed.
- Guidance will be sent to contractors later this month.

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**Boots loses court case over Biggleswade health centre**

A legal battle between Boots The Chemists and Lloydspharmacy over who is to move into a new health centre in Bedfordshire has ended in victory for Lloyds at London’s High Court.

Boots had challenged the decision to let the NHS Services Appeal Authority to choose rival Lloydspharmacy for a new health centre in Biggleswade, Bedfordshire, claiming it was the preferred tenant of the centre’s developers. But last Friday the judge backed the Authority’s decision, ruling that it had dealt fairly with the rival claims from both pharmacies.

Boots argued that the Authority failed to take into account a letter from the developer confirming that it had reached a contractual agreement with Boots. It claimed that the letter would have added greater weight to its appeal had it been considered by the Authority’s Appeal Committee.

Boots said the developer had written to say that its offer was “financially more competitive” than Lloydspharmacy’s, and was formally accepting its offer for tenancy subject to Trust approval.

However, the Trust decided that there was little difference between the applications and granted permission to Lloydspharmacy, which had applied first.

On appeal, the Authority found that, because the pre-agreement between the developer and Boots was subject to the Trust’s approval, this in itself was not enough to show that Boots had secured a better position than Lloydspharmacy.

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**Question time**

This week’s question: Which topic will motivate you most to vote in the PPSGB Council elections this year?

- Professional issues
- Regulatory issues
- Representation
- Nothing – will not vote

You have until noon on March 15 to vote at www.dptopherarmacy.com. We will publish the results in C&D on March 19. Turn to page 14 for the results of last week’s question.
My pharmacist said

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Health exempted from EU services

The European Commission is to exclude the healthcare services sector from the proposed directive on the movement of services across Europe.

The general aim of the directive is to remove all barriers to the cross-border provision of services in the EU. However, critics have argued that in doing so it will reduce member states' control over working practices, open the door for companies to bypass labour and environmental standards, impose barriers to state regulation, and put private pressure on public services.

Following prolonged argument against the directive from parties such as trade unions and non-governmental organisations, EU internal market commissioner Charlie McCreevy has pledged to exclude healthcare services from the directive. In addition, he has promised to review the country of origin principle, which allows companies to move operational bases to other EU countries, to make sure that it does not undermine the social protection of workers.

NPA pharmacy practice director Colette McCreevy, who represents the UK delegation of the Pharmaceutical Group of the European Union, said: “This is a major, positive move forward. We have been lobbying long and hard for healthcare services to be removed from the directive since it came out 18 months ago.

“However, this is just a statement of intent – we need to see what will happen in fact when it comes to redrafting.”

Welcoming the EC's decision, the RPSGB said it had been actively lobbying with other organisations to highlight its concerns about the directive and calling for a radical rethink of some of the proposed legislation.

While accepting the need for a fair internal market, the Society has argued that it is in the public interest that services provided by healthcare professionals, including pharmacists, should be granted special status throughout the EU.

A key concern for the Society had been the "country of origin principle", which would allow service providers - including those offering health services - to operate in any member state under their own national standards.

RPSGB president Nicholas Wood said: "Pharmacy has come of age as far as presenting a powerful political case is concerned. Only last week, the Council spent an afternoon taking an in-depth look at the implications of the EU for pharmacists and health in the UK. Europe is a complex and often difficult territory in which to exert influence. This development is a welcome first step but it is for the European Parliament to decide what should happen next.

"Through AURE, we are now talking to the European Parliament to ensure that our concerns about the services directive are known and understood."

Change relationship with NHS, pharma told

The pharmaceutical industry needs to adopt a partnership approach when working with the NHS, a former junior health minister has said.

The increasing Government focus on primary care has provided a “springboard” for pharma to work in that sector, Baroness Julia Cumberlege said at a Takeda event recently. But trust needs building up between pharma and the NHS if partnerships are to succeed, she warned, and complementary and shared goals must be identified.

Dean Arnold from the DoH agreed that PCTs were the right place for pharma to start engaging. Although the NHS wants pharma to continue its manufacturing and R&D roles, the industry needs to redefine itself from "pill sellers" to “wellness partners”, he said.

This approach would benefit patients, healthcare professionals, NHS management and the overall UK economy. But pharma needs to recognise that PCTs are relatively new organisations, with “full agenda” and “a difficult juggling act” for joint working to thrive, Mr Arnold concluded.

Public health delivery plan published

The DoH has outlined a three-year plan to implement the objectives of its public health White Paper.

Delivering Choosing Activity sets out a framework and timetable to encourage people to make healthier lifestyle choices and reduce health inequalities at national, regional and local levels. The delivery plan is supported by the publication of two action plans entitled Choosing a Better Diet and Choosing Activity. Broadly, the document explains how:

- the existing work to improve public health via changes in behaviour and lifestyle will be extended
- health improvements targets will be delivered
- local governments and the NHS will collaborate to improve health outcomes at a local level.

In addition, the document states that the pharmacists public health strategy, due to be published this October, “will demonstrate how pharmacists and their staff can contribute to improving health and reducing inequalities”.

It will also help the DoH identity public health services that can be provided from pharmacies, the plan says.

For more information: www.dh.gov.uk

Boots issues profits warning

Boots The Chemists has warned the city that it will not be delivering on promises of £500 million in profits by its year-end.

Issuing an official profits warning just one month after making the boast, chief executive Richard Baker said that, in reality, the company was only likely to deliver profits of between £465m and £475m in April due to increased interest rates and subdued consumer spending across the high street.

According to the CBI, the sharpest year-on-year falls in retail sales have been seen in the community pharmacy sector. In its quarterly distributive trades survey, it reports that on balance 40 per cent of community pharmacists reported a year-on-year fall in sales, confirming fears of a slow start to the year and spreading pessimism that March will barely improve matters

Sales have also been sluggish elsewhere on the high street, with DIY products and household goods also being plagued by high levels of personal debt, stagnant house prices and mean interest rate hikes.

Retailers in most sectors have been cutting jobs at the fastest rate since 1992, says the CBI, reflecting the pressure sales and prices are now under.

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- Solutions is written by pharmacists, so it speaks your language
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We have the solutions
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The RPSGB's representation role was high on the agenda among candidates standing for election to Council at last Sunday's hustings held by the Young Pharmacists' Group.

Candidate Martin Astbury said: "If you want to secure strong representation you need to use your 15 votes to elect pharmacists whose prime concern is representing you."

Jonathan Emson said the key issues were attracting the RPSGB's membership, leading and managing pharmacy, recruiting the profession of the profession to stay on the Register.

John Gentle called for Council to be representative of the membership in its views and its thinking. He said he did not want to again see a Council that was so far removed from the ideals of the membership that it is routed at a branch representatives and at a special general meeting, and dragged into a high court battle.

John Jolley voiced concerns about the high level of resignations from the Register this year and said this was a testimony to the dissatisfaction felt by the membership to the policies on CPD, the retention fee structure and practising and non-practising members.

Dorothy Drury expressed concern about the present workload in pharmacies, which needed to be examined for the safety of the public.

The YPG also said it had been notified that 13 candidates would support Save Our Society aims.

Thirty pharmacists and three pharmacy technicians have put themselves forward for election to the RPSGB's Council.


Three pharmacy technicians standing for election are: Corrine Hunt, Lesley Morgan and Christopher Phillips.

In addition, Mr Buisson and Mr Khela are seeking election to the England constituency, Ian Mullen and Mr Thomson for the Scotland constituency and Mr Gartside, Mr Ranshaw and Mr Wells for Wales.

**Arbitration to settle LPC row**

Independent arbitration could be a way to resolve the long-running dispute between PSNC and North East London LPC.

Andrew McCoig, chair of the London Federation, is to bring North East London LPC back into the fold following the continuing refusal to pay the working levies to PSNC. He is keen to get the two organisations working together for the benefit of practice and hopes PSNC will address the matter in another way.

But at yesterday's LPC conference, PSNC chairman Barry Andrews said that "difficult negotiations" with NELPC had got nowhere.

He said it was clear the LPC had intention of paying its working levies.

"We believe we have done all we possibly can, and have ceased to provide services for them."

**DTI launches free business tools**

The DTI has launched three free tools to help small business owners and managers keep up to date with tax, employment and regulation issues.

Owners and managers can now receive e-mail alerts that highlight key tax dates as well as links to resources for completing the tasks, from businesslink.gov.uk, the Government's website for small businesses. They can also create tailored statements of employment and receive guidance on new and changing legislation before it comes into force.

**AAH lists convention speakers**

AAH has announced the line-up of speakers for its annual convention, which takes place in Sintra from Portugal from May 18 to 20.

National Prescribing Centre chief executive Clive Jackson, London Business School chief executive Simon Guilford, NICE clinical implementation systems programme director Nick Bent, and Manchester University's Dr Karen Hassall, will address delegates at the event.

Mr Jackson's presentation will be on how community pharmacies can maximise their potential in the 21st century.

"AAH's aim is to ensure community pharmacists have the best possible information so they can decide what suits their own business." AAH group managing director Steve Dunn said.

"But it's easy to lose sight of the bigger picture when you're as busy as our customers. So as well as having experts speak on the issues we all deal with every day, we've asked Simon Guilford to give us some ideas from other sectors on what makes a business successful."

Delegate tickets for the convention are still available and pharmacists should call the event office on 020 7420 1780 for further information.

**Numark own-brand sales top £14m**

Numark has announced own-brand sales of £14.5 million in 2004, helped by new product lines and an increased average spend per member.

The top performing categories were VMSC, up 31 per cent, and skincare, up by 25 per cent. This was supported by strong growth in OTC medicines, says Numark.

The company added that its own-brand range, which now included over 350 lines, had been subject to extensive branding over the past three years.

Numark owner and controller Helen Groves said the company planned to develop the range with new OTC medicines.
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St Helen’s rolls out antibiotic PGDs

St Helen’s Primary Care Trust has completed the roll-out of new patient group directions for chloramphenicol for simple conjunctivitis and trimethoprim for recurrent urinary tract infections.

Around 85 per cent of the PCT’s pharmacies are now offering the services and are paid around £5 for chloramphenicol requests and around £14 for trimethoprim requests to cover the consultation, dispensing and relevant diagnostic fees, as well as the drug costs.

The first pharmacists to dispense antibiotics under these PGDs started several months ago. Commenting, St Helen’s senior primary care pharmacist Helen Potter, said: “All the pharmacists consider this type of enhanced service very much to be part of their new role in the NHS.

“Every patient who has used the scheme reports gratitude, ease of access, professionalism and confidence with regard to the pharmacies.”

The PCT is also training locums and around 40 pharmacists in total have received PGD training. It expects to run an update course in the middle of this year.

As a result of this, and other PGDs, including emergency hormonal contraception for females over 12 and nicotine replacement therapy for the over 18s, the PCT is also considering rolling out a PGD for mupirocin (Bactroban) for impetigo.

However, medicines use review is also a priority for the PCT, head of medicines management Christopher Cutts has said.

**SEHD details IT cash distribution**

The Scottish Executive Health Department has detailed how it is to fund the training and IM&T aspects of the new pharmacy contract due in April 2006.

The Executive and SPGC agreed a £2 million infrastructure investment programme fund last year and planned to divide it between training (£750,000), premises (£500,000), IM&T (£500,000) and supplementary prescribing (£250,000).

Details of the training and IM&T aspects announced this week include:

- A payment of £650 per contractor per pharmacy as a contribution to costs incurred in training a member of staff to NVQ Level 2 from January 2004. Claims must be submitted by March 31, 2006.

- A payment of £50 per contractor per pharmacy towards upgrading PMR systems in readiness for implementation of ePharmacy applications to underpin the contract.

Contractors should ensure any upgrade is completed by September 30, 2005.

- Payments will be included with contractors’ March 2005 payments.

- The minimum specification for the pharmacy computer system is: Windows 2000 or XP, Pentium 350MHz, 256Mb of memory, 4Gb hard drive, backup device for PMR and responder databases, network interface card for NHSNet connection, and a dual bin laser printer.

The Scottish Executive has also issued clarification on the transitional payments for the new pharmacy contract, which were agreed with SPGC last year and took effect from last December.

All contractors should check the notification letter from NHS National Services Scotland of their baseline turnover for the purposes of the ‘material change of circumstances’ provision and any requests for exceptional payments should be submitted to SPGC initially. Health boards have written to contractors regarding the SE’s latest announcements this week.

**Pharmaceutical companies and patient groups have condemned the preliminary guidance on Alzheimer’s disease drugs published last week by NICE.**

In its draft document, NICE concluded that the high cost of AD products outweighed the benefits. The body said donepezil, rivastigmine and galantamine should not be recommended for use in mild-moderate disease, and memantine was not suitable for moderate-severe AD, though patients already on the products should continue treatment. The closing date for comments is March 22.

The ABPI called the recommendations “a devastating blow to patients” and “a significant deterrent to companies undertaking further research in this area”. In addition, the ABPI said it put the UK “out of step with the rest of Europe” where the products are available wherever they are licensed.

Alzheimer’s Society chief executive Neil Hunt said: “Despite the fact that these drugs are proven to work, NICE believes they aren’t good value for money... preventing people who may benefit from receiving a drug treatment that works will see us lose a decade of progress.”

**In brief**

Repeat dispensing

A repeat dispensing resource pack to support Welsh local health boards to set up the essential service for contractors is now available from NHS Wales.

The resource has been approved by the project implementation board of the new pharmacy contract at WAG, and is based on material used by the English repeat dispensing pathfinder sites and from DoH guidance.

A distance learning pack will also be available to all Welsh pharmacists from WCPEP and completion of this will fulfil the contract’s training requirement.

For more information:

www.psnc.org.uk
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Comment
from the Editor

With just over a fortnight until the first of
the new pharmacy contracts comes into effect,
the guidance to PCTs on control of entry is
being aired.

It makes for interesting reading, shedding
light on how the regulations will be policed in
England, and the exemptions for certain
categories are now relatively clear. It also
suggests an awful lot of money will be
devoted to legal expenses as the lawyers work
to interpret these new regulations.

Take the description of what constitutes a
town centre, for example, and the way in
which a big development may or may not link
to a town centre in determining a contract
application. It takes up so much space to
describe, you really wonder how workable the
regulations really are.

As for the new test of “competition and
choice”, PCTs will make decisions by
considering those current vogue words
“choice and diversity”. Just how diverse is
‘diverse’? And as for “innovation”, another
buzz word, will existing providers be asked if
they are prepared to be more “innovative”
before a new contract is granted? What
happens if an “innovative” new service
provider finds there is actually no sustainable
demand for those “innovative” services?

Unsurprisingly, the details on rural
dispensing have yet to emerge, but word is
that dispensing doctors are not best pleased.
Remember the Clothier ‘loophole’ and the
legal cases that generated?

It is unfortunate, then, that these details
have been so long coming. One of the original
triggers of the control of entry changes was
the Office of Fair Trading report. When it
was published in 2003, it called for a review in
three years’ time. Will PCTs really want to
start learning all over again in 2006?

What happens if
there is no
sustainable demand
for innovation?

Full marks to the NHS for recognising role, says Steve Dunn

Seize the prescribing moment

Moves to empower pharmacists to
independently prescribe
medicines should be welcomed
with open arms and a stampede
for training. The NHS gets full
marks for finally recognising the
role that pharmacists can play in
providing a more accessible
healthcare service.

At last a consultation paper has
recommended seven options to
extend these powers, and
pharmacists may soon be free to
use their skills in pharmacology
and therapeutics, to decide the
best medication for a wide range
of common illnesses, to admit
patients to hospital and manage
patients in acute pain.

Pharmacists should lose no time
in retraining to exploit this
opportunity, to get the
competencies required, and
should lobby for all the training
resources available, before John
Reid decides that nurse power is
the better option.

Pharmacists need to be aware of
the pressures new powers bring,
like accountability. Prescribing
professionals will be tightly
monitored, with all the necessary
systems and trails that requires.

But then the new contract is
already demanding a cultural
change in running a pharmacy, to
track, audit and record activities.
Auditing is the way of the future.

Pharmacy prescribing makes
particular sense in filling the ‘out-
of-hours gap’ and defusing the
crisis that arose when GPs
abandoned their out-of-hours
duties at New Year.

Already, GP co-operatives are
demanding more cash and for
PCT spending to be investigated.
Already, one co-op has folded.
PCTs, as local NHS healthcare
providers and fund-holders, have
duty to ensure that prescription
services are locally available.

Let us hope these beleaguered
PCTs have the sense to claw down
central funds to help pharmacists
undergo the advanced training to
broaden their prescribing roles.

Steve Dunn is group managing
director of A&H Pharmaceuticals.

Our online poll at
www.dotpharmacy.com
said...

7%
Yes - overwhelmingly

49%
No - will generally be against it

44%
Yes - reluctantly
Booming confidence is a shot in the arm

Pharmacists’ medicinal firepower looks certain to increase significantly in the near future. The news that the DoH is consulting on giving pharmacists independent prescribing powers (C&D, March 5, p5) is one of the strongest signals yet that the Government really will utilise the skills that we have to offer. Many of the Department’s publications merely mention pharmacists in passing or neglect to mention us at all, but John Reid’s promise to place pharmacy “at the heart of primary care” is recognition that’s long overdue.

So the timing of a survey showing pharmacists’ improved confidence at diagnosing conditions that require Prescription Only Medicines (C&D, March 5, p12) is perfect. Whether we are prescribing these medicines or selling them OTC makes little clinical difference and it looks like chloramphenicol eye drops will be the first new medicine we can give patients, one way or another.

I’m not sure I agree with the pharmacists that are hoping for more POM to P switches than P to GSL over the next five years, but it shows great optimism among the profession about the enhancement of our role.

And perhaps the biggest swing in our favour has come from GPs, who are coming round to the idea that we may be able to deal with a few more POM switches (C&D, March 5, p16). They’re still sceptical about our ability to sell hct-blockers and thiazides for hypertension, and beta-2 agonists for asthma, but we mustn’t expect to walk before we can run. After all, who would have thought that we’d be selling simvastatin OTC 10 years ago?

Nearly a pre-reg position, but not quite

The huge increase in the pre-registration grant (C&D, March 5, p4) propels my desire for a pre-reg student way up my list of priorities but probably still not quite high enough to make it a reality. I’ve always found tutoring pre-reg students incredibly rewarding but haven’t had one in recent years because of time and financial constraints. The increased grant makes finance less of an issue but unfortunately my time will become more precious than ever under the new contract. I will have more than enough to think about over the next couple of years looking after my own professional and business needs without being responsible for someone else’s.

Hopefully this welcome boost to pharmacist training will not be taken advantage of by unscrupulous contractors offering sub-standard tutoring. I expect the multiples will have the manpower to offer a few more pre-reg places but it would be a shame if this number was not matched by at least an equal number of independent places.

Ban smoking and give everyone a breath of fresh air

The Government has always had an ambivalent attitude to smoking, probably due to the huge tax revenue the habit generates. The failure to completely ban smoking in public places in recent public health White Paper is a further sign of its lack of willingness to tackle the problem head on. If Ireland, Scotland, Wales and parts of the United States can consider a ban, why not England?

We are all familiar with some of the shocking statistics related to smoking, but I didn’t know that a ban could have equally dramatic results. In the six months before the Irish ban came into effect, almost 7,000 smokers quit. And 41 per cent used NRT. If these figures were multiplied up to take into account the relative population of England the number of quitters would be staggering. A smoking ban in England would be great for public health but also brilliant news for pharmacists’ businesses and public profile.

The only pharmacy organisation that seems to campaign strongly on this issue is Pharmacy HealthLink. Perhaps this is an issue that pharmacists and their professional bodies should be getting behind with as much conviction as they can muster.

Fear and loathing

Angst levels within the NHS are rapidly going off the scale. The concern and worry over the implementation of the pay modernisation package will hit the heights in May, when most pharmacists in Scotland are to be matched to national job profiles. However, the current consultation on pensions is causing almost as much grief.

The existing arrangement is a final salary scheme where the pension is based on the person’s final years’ salary. While there are some improvements suggested in the consultation, the drawbacks are considered to more than outweigh these. One of the suggestions is for a pension based on their salary throughout their career.

While this might work perfectly well for GPs who peak around the middle of their career in terms of salaries, it improves nothing for those who work their way to the top over their career. It actually disadvantages anyone in this position.

Salaries in the public sector have traditionally been lower than those in the private sector and one of the main factors in retaining staff has been the assurance of a decent pension at retirement. If this benefit is lost, then a significant number of staff will decide to leave the NHS.

The other really contentious issue is the proposed increase to retirement age from 60 to 65. The prospect of having to work longer to achieve the benefits expected at age 60 does not appeal to anyone. A lot of staff feel betrayed by this consultation, especially those who have ensured that any potential shortfall has been addressed by careful financial planning.

Written by a senior hospital pharmacist
The knowledge

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Post your completed form, with a cheque payable to CMP Information Ltd, to: Mary Prebble, Pharmacy Editorial Projects, Sovereign House, Sovereign Way, Tonbridge, Kent. TN9 1RW

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PCTs target fraud to save £600k

The pharmaceutical bodies have launched the latest full-scale operation to tackle fraud in their 11 regions, following the success of previous campaigns which saw £50m of fraudulent claims identified and £1.3bn of savings secured.

The £87m (£54m from Social Security & Pensions, £1.3bn from fraudsters) was recovered by the National Health Service (NHS) between 1989-99, and resulted in 500 fraud cases being referred to the Police.

PCTs could be earning an average £600,000 a year from their new role of issuing prescription penalty charge notices.

The job of checking patients' prescription exemption claims and issuing penalty charges where appropriate was devolved to local level from the Counter Fraud and Security Management Service last year, following a DoI review of its arms length bodies. The CFSMS will issue its last penalty charge at the end of this month.

Since 2001, the DoI's exemption verification process has led to the issue of over 140,000 penalty charge notices and the recovery of more than £350,000 of original charge and £2.4m of penalty surcharges. Under the new system, PCTs will be allowed to retain penalty charge income for discretionary use, but must credit the relevant budget with the recovered original charge.

To fulfil the new role, the DoI is advising PCTs to appoint a local counter fraud specialist, with responsibility for deciding the issue of penalty charge notices and any subsequent necessary action. It has not set any penalty notice activity targets for 2005-06, to give PCTs time to settle into their new roles. It is also giving PCTs access to a patient fraud management system that, among other functions, can request prescription checks by month and pharmacy.

According to the DoI, checks on patients' evidence carried out in pharmacies and the issue of penalty charge notices reduced patient charge fraud from £171m in 1998-99 to £87m in 2003-04.

For more Information:

NI plans technician registration

The Pharmaceutical Society of Northern Ireland has outlined its plans to regulate dispensing and pharmacy assistants from the beginning of next year.

Supervising pharmacists will be able to declare dispensing staff competent under a "grandparent clause", provided they have previously completed an approved course or have relevant work experience.

Full details of the arrangements and minimum competencies will be finalised by PSNI Council shortly.

The standards for competence are likely to mirror those used by the RPSGB. However, PSNI has said the declaration will only apply to areas of work where the employee has specific duties and demonstrated competence, and staff will need to complete training to NVQ 2 standard if their responsibilities change.

Coronary heart disease therapy still needs more work

Although progress has been made in tackling coronary heart disease, further improvements are needed, a health watchdog has said.

Heart patients have benefited from improvements in care since the CHD National Service framework was implemented in 2000, says the Healthcare Commission in a report entitled Getting to the heart of it.

These include quicker treatment for heart attack patients and good uptake of smoking cessation services. But PCTs need to target those most at risk because of social or economic deprivation, smoking or obesity, to reduce the incidence of premature death.

Strategies that could be adopted include identifying high-risk people early so they can be given advice and treatment, and making smoking and obesity services more effective, the report says.

For more information:
www.healthcarecommission.org.uk

CCA COMMENT

Watch out, PBC is about...

...or practice-based commissioning, says Georgina Craig, head of communications and partnership development at the Company Chemists' Association.

They say there are no new ideas in politics – just recycled ones. And if so, then the Government's latest primary care policy initiative looks suspiciously like a recycled version of GP fundholding, which Labour itself threw out when it came to power in 1997.

Practice-based commissioning is the new buzz word in primary care trusts. It goes live in April 2005 and, for the uninitiated, here is a tough guide to why it matters and how it will work.

The main driver for PBC is service redesign. The Government has introduced "payment by results" in secondary care, which means that acute NHS trusts will only be paid for the work they do, rather than through block contracts, negotiated against an uplift in historical funding.

Payment by results should free up resources and make it easier for PCTs to commission other service providers and so facilitate a shift in services away from hospital and into the community.

This shift is the ultimate goal of both these policy initiatives. However, if there is no incentive for primary care to innovate and reconfigure, then change won't happen as there will be no alternative to secondary care provision. That is where PBC comes in. At the moment, practice-based commissioning – as the name suggests – is a mechanism whereby general practice takes control of the commissioning remit without actually holding a budget.

The rationale is that because GPs are the ones who make the bulk of referrals to secondary care, if they make the commissioning decisions and are incentivised to do things differently they will design alternatives to referral. For example, this could be GP specialist-led clinics for chronic disease management, primary care based dermatology specialists, community based diagnostic and treatment centres, or pharmacy-based anticoagulant monitoring.

To incentivise GPs, the DoI has said GP practices can keep any PBC savings they make.

The concept has been tested – and the best known example is North Bradford PCT, where it has reduced dermatological referrals to secondary care by 80 per cent as a result of primary care alternatives developed with general practice.

The question for community pharmacy is, how should we engage with PBC? It is tempting to think that the answer is to set out our stall and sell general practice the benefit of pharmacy-based enhanced services. While good relationships with general practice are important, on this issue pharmacy needs to be a bit more ambitious.

Given that at its core PBC is about front line professionals commissioning and redesigning services, community pharmacy arguably has a very valuable contribution to make to the commissioning process itself.

With our insight into how people manage their medicines – especially those with long-term conditions – our perspective should be taken into account when service redesign is discussed. Pharmacy needs to have a place at the practice-based commissioning table. Only then will we really be able to influence developments.
Husband and wife Purgent and Anjali Patel won £1,000 in the latest C&D Platinum Design Awards which has fired the whole team up with enthusiasm for the new contract. Gary Paragpur 

Walk in to Ruxley Pharmacy in Ewell in Surrey and you will find a modern professional-looking pharmacy offering a calm oasis from the busy junction outside. 

Despite its compact size, the shop boasts a purpose built consultation area (with plans for an additional consultation room), a touchscreen clinical information point for customers, and a prominent display of electrical items such as blood glucose meters and nebulisers. Bar the narrow dispensary, husband and wife team Purgent and Anjali Patel have completely re-fitted the shop in a cream and green colour scheme. 

Staff and customers describe it as “fantastic”, while Purgent says it has created a “better buying environment but in a subtle way.” He says his wish to have a consultation area, health literature display units and good disability access have all been met by the refit. “The impact on business has been terrific,” he says, adding that the improved layout of the pharmacy and the use of planograms has increased footfall and counter sales beyond his expectations. 

Both Purgent and Anjali qualified from Chelsea School of Pharmacy (now part of King’s College, London) in 1978 and 1980 respectively, and only a year later he bought a pharmacy across the road from this one. Eventually he bought his competitor and combined both at the current site in 1992. Although he says the pharmacy was in reasonable condition at the time, he decided to re-vamp the shop and dispensary with new shelves and carpets. 

But in late 2003, with thoughts turning to the various new services that would be required under the impending pharmacy contract, it was decided that a more substantial change was needed. Purgent turned to Nucare for advice, which recommended three suitable shopfitters. The quotes were very close, so he went to see examples of their work. 

It was the quality of Essex-based firm Crescent’s work that convinced Purgent. He was especially taken with the clever way Crescent converted the empty space above and below the shelving units into extra storage space, which allowed him ultimately to free up his stock room (he is now planning to convert it into a consultation room). The actual installation was relatively painless; the planning took about four weeks. The refit began on a Saturday and was completed by the following Thursday, with the shop only closed for a half day on Saturday. Although Purgent considered including the dispensary in the refit, the expense of removing a load-bearing wall plus the fact that the dispensary had not really outgrown the existing space, meant it was left as it was. 

As part of the refit, Nucare was called in to help with implementing category management. “It gave us an insight into merchandising,” says Purgent. He also took the opportunity to address the pharmacy’s future IT requirements, and installed a networked system with computer terminals in the dispensary, on the counter (for checking repeat prescriptions), and in the new consultation area. 

Is he pleased with the result? “Definitely,” he replies. Turnover is up 15 per cent and the use of the glass cabinet to display electrical items such as BP monitors, nebulisers, ear thermometers and glucose testing machines has been particularly successful. Although the pharmacy stocked such items before the refit, they were not on open display. Now he is selling at least one BP monitor a week and one nebuliser a month.
The key to developing new services, however, lies with the new consultation area. He is already using it when supplying emergency hormonal contraception, for his smoking cessation service, and also when the three local single-GP practices refer patients to him for medication reviews. Generally the patients – which number about three to four per month – are either confused about their treatment or have compliance problems.

Currently he provides the service without charge, but this should change under the new contract, which will pay contractors to provide at least four medicines use reviews per week in the first year, a target Purgent believes he can easily achieve. Interestingly, it’s not just customers who like using the consultation area, Purgent says it’s also nice for him to offer clinical services in a private environment.

So for a relatively modest spend of £25,000, Purgent has ensured his pharmacy is fit for the future. As well as the IT update, consultation area and new shelving, he has installed air-conditioning and CCTV. His only regret is that he didn’t convert the stock room into a consultation room (it was freed up by the extra storage in the shop). However, he has identified this as his next project, and expects to tackle it soon. He has already had quotes for the work and hopes to fit it with a sink, table, chairs, computer and couch.

Once it’s ready, he hopes to hire it out to other health practitioners such as chiropractors and podiatrists, as well as providing an allergy screening service himself. He is currently undertaking a diploma in allergy testing from the British Institute for Allergy and Environmental Therapy.

Keen to provide the best possible service to his customers, Purgent has installed the Pharmacy Channel health information service, and Healthpoint, a touch-screen information service, which lists details of 3,500 different clinical conditions including symptoms, preventative measures, and the role of the pharmacist. It also allows patients to print off the information free of charge.

Purgent says the feedback has been excellent, and the local GPs send patients to use it, as well as the local nurses.

So after a quarter of a century serving the local population, Purgent, Anjali and their staff, who have nearly 33 years of pharmacy experience between them, can look forward to the new pharmacy contract with confidence.

Ruxley Pharmacy, Ewell, Surrey

Winner Category 2: Special feature or partial refit involving 40 per cent or less of the shop floor - £1,000 prize

Shopfitter - Crescent Installations
Marching through the finishing line

It was a closely run race, but this year there was only one winner. Fiona Salvage caught up with her entrants in the Pharmacy Update Knockout competition are more akin to marathon runners than 100m sprinters in waiting for their
final moment of glory.

In fact, it's probably more like an ultra marathon. The quest begins in January and only in the following January does the winner receive that wonderful letter announcing their achievement.

It's 12 months' of work. Over 30 Pharmacy Update articles to score 100 per cent on the multiple-choice questions. Three further rounds of questions to battle through. At the start of the year, 408 candidates were eligible for Knockout. By March this had been whittled down to 137 individuals. However, come September it was just 14.

This year, though, there was one winner of the £2,000 first prize donated by Genus Pharmaceuticals. Margaret March, a pharmacist with Lloydspharmacy, in Worle near Weston-super-Mare, was this year's winner. Mrs March, who qualified in 1988, is no stranger to Pharmacy Update, but this was her first Knockout competition.

"I deliberately did the answers in time, but I didn't plan to win," she says. "I just did it, got them all right and carried on doing it."

It doesn't seem to have been a chore for Mrs March. "Most of the articles were really interesting and relevant to me as a community pharmacist. I have learnt a lot from doing it, which I have used in my job."

The articles Mrs March most enjoyed were those that updated her knowledge, especially covering subjects such as side effects. In fact, she has even recommended the Update articles to a pharmacist friend and would do so to other community pharmacists: "It's a good way of doing 30 hours," she says.

At the beginning of September, Mrs March received a letter telling her she was in the final 14 and was about to enter the final knockout stages of the competition. This part involves scoring 100 per cent on three extra quizzes and pitting your wits against the best of the best. Entries come straight into the CED office for marking; Mrs March faxed hers back, but says she didn't expect to win. The extra questions did take longer to do than the usual MCQs though, she remarks.

But her dedication to doing the work is unparalleled; after checking her e-mail on Boxing Day and realising another set of questions had arrived and the looming deadline would clash with a trip away over New Year, Mrs March sat down to do the final set while...
Do it for charity

Genus Pharmaceuticals, the sponsor of the Update MCQ, has pledged to donate a sum of money to charity depending on how many people register for Pharmacy Update.

If 1,000 people register, a charity, chosen by the most votes from Updaters, receives £2,000; 1,500 pharmacists signed up equates to £3,000; and 2,000 signed up means the charity receives £10,000.

Vote for your preferred charity when you sign up from the list below:

- **TB alert**
- **RPSGB Benevolent Fund**
- **Great Ormond Street Hospital Children's Charity**
- **Shelter**

While it’s too late to register for the Knockout competition, it’s not too late to sign up to Pharmacy Update.

GENUS PHARMACEUTICALS

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Deciding who to purchase your NeoClarityn™ and Nasonex from this year?

From 1 January, Schering-Plough have reduced the NHS-List Price of NeoClarityn (Tablets & Syrup) and Nasonex Spray

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<th>Product</th>
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<th>NEW NHS Price</th>
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<tbody>
<tr>
<td>NeoClarityn (30 tablets or 100ml syrup)</td>
<td>£7.57</td>
<td>£7.04</td>
</tr>
<tr>
<td>Nasonex Spray (140-dose unit)</td>
<td>£10.92</td>
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Major full-line wholesalers may be providing U.K. originated stock of NeoClarityn and Nasonex at the most competitive prices.
A balancing act

THE COLLEGE OF PHARMACY PRACTICE

This article can help in the following areas of competence as set out in the RPSGB's CPD manual: G17, G18, C15.

Zinc deficiency is common, but too much can interfere with copper, says nutritionist Ann Walker

It was not until 1961 that scientists first accepted that zinc deficiency could occur in humans. Indeed, it was Professor Ananda Prasad, working in Iran, who first described dwarfism among zinc-deficient men, and he has been a strong campaigner ever since for zinc supplementation in the developing world.

It is now clear that deficiency of zinc is widespread, not only in developing countries, but also in Western society. Severe deficiency leads to growth retardation and late sexual maturation, while a marginal deficit results in poor immune function. As dietary intake is generally low, even in Western societies, there is a strong case for supplementation for some groups. However, too much zinc is toxic as it interferes with copper metabolism. It is for this reason that zinc and copper are discussed together in this article.

Sources

Oysters are the richest source of zinc — just one oyster provides the full daily zinc requirement. No other food can match this, but shellfish and red meat are high in the nutrient, especially organ meats. Red meat contains about five times as much zinc as white meat, so substituting white for red meat leads to a substantial decline in intake.

Smaller amounts of zinc are found in whole grains, nuts and seeds, but because bioavailability is relatively poor, vegetarians are at risk of deficiency. Oysters are also a good source of copper, as are nuts, legumes, whole grains, sweet potatoes and dark leafy greens.

Function

Zinc is needed for every cell of the body. Indeed, it is an integral component of over 300 enzyme systems, having a structural, regulatory or catalytic role. Through the mediation of these enzymes, zinc is needed for health of the immune and nervous systems, wound healing, the sense of taste and smell, for DNA synthesis, normal growth, secretion of insulin, protein synthesis and membrane stability. Despite its importance, the human body contains only about 2g of the mineral and most is protein-bound in skeletal muscle (60 per cent) and bone (30 per cent).

As the body has no specific zinc reserve and because tissue release is slow, it is important to have a regular dietary supply, as plasma levels can drop rapidly, even when there is full repletion. For this reason, there is no accurate measure of zinc status.

Amounts of copper in the human body are even lower than those of zinc, totalling only about 70 to 80mg in an adult. However, copper also plays an essential part in the structure of key enzymes, including superoxide dismutase, which is necessary for the detoxification of free radicals.

Copper is also necessary for the activation of several enzymes involved in amino acid metabolism, and of ceruloplasmin, an enzyme necessary for iron absorption and its mobilisation from liver storage.

Enzymes activated by copper have crucial physiological roles in connective tissue formation, iron metabolism, central nervous system activity, melanin pigment formation, and protection against oxidative stress.

Maximum safe intake and toxicity

Table 1 shows that the RNI (reference nutrient intake) for zinc depends on age and gender, while the RNI for copper is not gender specific.

Long-term use of 100mg or more of zinc daily has caused severe copper deficiency, leading to anaemia, depressed immune function, and reduced levels of HDL cholesterol.

However, there are no known toxic effects of zinc at supplemental levels of 30mg per day or less.

In 2003, the UK Expert Vitamin and Mineral Group (EVM) set a safe upper level (SUL) of 25mg for supplemental zinc to be used long-term by adults. Although zinc supplements can give rise to nausea — even at the low levels found in multinutrient supplements — this effect is

Continued on page 24 ➤
transitory and harmless, and is rapidly relieved by drinking fluids to dilute stomach contents.

Copper is relatively non-toxic to humans and suspicions that it is a possible culprit in Alzheimer’s disease have not been substantiated. On the contrary, animal studies have indicated that an adequate intake of copper has a protective effect on the brain.3

Although there are reports of massive doses of copper causing gastrointestinal distress, these occurrences are rare. Because information on the toxicity of lower doses of copper is scarce in humans, and intakes from tap water supplied in copper piping may reach 1mg per day, the EVM (basing its decision on animal studies) erred on the side of safety and set an SUL for copper of 1mg per day for long-term supplementation.3

**Intake and deficiency**

The average diet, even in the Western world, may not provide sufficient zinc, especially for women, adolescents, infants and the elderly. Figure 1 shows that a large proportion of the UK population fail to reach RNI targets according to the National Diet and Nutrition Surveys (NDNS).3 About a third of the zinc intake in the UK comes from meat and meat products (see figure 3).

Following on from Prasad’s work in Iran, it is now recognised that zinc deficiency can severely hinder human development.1 This is particularly relevant in developing countries, although Western populations can also be affected. Although stunted growth and poor development of reproductive organs are the obvious signs of severe zinc deficiency, because of zinc’s multiple physiological roles mild deficiency is not easy to identify. Nevertheless, over the last decade a lack of zinc has been recognised to be associated with many diseases including chronic liver disease, chronic renal disease, glaucoma and even cancer. And there is now doubt that the immune system can be depressed even in moderate zinc deficiency.6

Zinc deficiency signs include loss of hair, diarrhoea, taste abnormalities, mental lethargy and increased susceptibility to infection, but these are general signs and can be associated with various other micronutrient deficiencies. Hence, practitioners who suspect zinc deficiency on account of these signs should look for the co-existence of other factors, such as alcoholism, poor food choice of digestive disease, when assessing the need for zinc supplementation.

Copper intake in the UK is also low in certain groups of the population. Figure 2 shows the percentage of those who failed to reach RNI targets from the NDNS Surveys—the intakes of women being especially low.3 A lack of copper results in anaemia, and it was the similarities between copper-deficiency anaemia and iron-deficiency anaemia that enabled scientists to understand copper’s special role in iron metabolism. However, copper-deficiency anaemia will develop only if deprivation is prolonged and severe.

Other effects of severe copper deficiency show up in infants and the young, and include low white blood cell count (WBC), fragile bones and susceptibility to infections. In adults, early features of low status include raised plasma cholesterol and increased risk of heart disease.

**Supplementation**

Supplementation with zinc at nutritional doses (≤25mg/day) is safe and may be appropriate for many to ensure nutrient repletion. Under these circumstances, there is evidence that long-term use of zinc can enhance immuno-competence and, especially in combination with antioxidants, slow the progression of age-related macular degeneration.5 However, the use of high doses (≥30mg/day) is controversial.

Firstly, to avoid copper deficiency, high-dose zinc supplements should always contain copper. Secondly, care needs to be taken with high doses because the immune system can be compromised by both zinc deficiency and by excessive intakes (over 100mg/day).

**The evidence base for benefit**

Most evidence for the benefits of modest zinc supplementation (less than twice the RNI) has come from studies in the developing world, where an estimated two billion people suffer from zinc deficiency. At least 33 studies of children in these countries have shown that zinc supplementation can enhance growth rate.6 Furthermore, the incidence and duration of diarrhoea and lower respiratory tract infections were also remarkably reduced.

Nevertheless, according to Prasad, this knowledge has not been enacted: “Despite all the evidence, practically no attention has been given to the problem of zinc deficiency by the world’s organisations. Growth retardation, increased susceptibility to infections and cognitive impairment are common in developing countries where nutritional deficiency of zinc is also prevalent.” He acknowledges that zinc deficiency rarely occurs in isolation, but co-exists with a deficit of other micronutrients.

Indeed, this may be a very important point for realising zinc’s full potential. In a study of pre-school children in Uganda, our own research found that zinc supplementation was ineffective in promoting growth of children whose diets were relatively poor, while it significantly improved growth of better-fed children, because they were less likely to be lacking other micronutrients.5

Table 1: UK reference nutrient intakes (mg/day) for zinc and copper

<table>
<thead>
<tr>
<th>Age (yrs)</th>
<th>1-3</th>
<th>4-6</th>
<th>7-10</th>
<th>11-14</th>
<th>15-18</th>
<th>19-50+</th>
<th>lactation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zinc (mg) Male</td>
<td>5</td>
<td>6.5</td>
<td>7</td>
<td>9</td>
<td>9.5</td>
<td>9.5</td>
<td>13</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
<td>6.5</td>
<td>7</td>
<td>9</td>
<td>7</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Copper (mg) Male &amp; female</td>
<td>6</td>
<td>9</td>
<td>11</td>
<td>13</td>
<td>16</td>
<td>19</td>
<td>24</td>
</tr>
</tbody>
</table>

Figure 1: The percentage of men and women in the NDNS surveys with daily intakes of zinc below their RNI

Figure 2: The percentage of men and women in the NDNS surveys with daily intakes of copper below their RNI

Continued on page 26
Women know they can find rapid relief and resolution from thrush using Canesten. But there’s one more thing that you can do for them.

Canesten® Thrush Cream – Product Information. Presentation: Canesten® Thrush Cream contains clotrimazole 2% w/w. Indications: Treatment of candidal vulvitis. To be used as an adjunct to treatment of candidal vaginitis. Can also be used for treatment of the sexual partner’s penis to prevent re-infection. Dosage and Administration: Adults: Apply to the vulva and surrounding area two or three times daily and rub in gently. Treatment should be continued until symptoms of the infection disappear. If after concomitant treatment of the vaginas, the symptoms do not improve within seven days, the patient should consult a physician. If the cream is being used for treatment of the sexual partner’s penis it should be applied two or three times daily for two weeks. Children: There is no clinical experience in the use of Canesten Thrush Cream in children. Contra-indications: Hypersensitivity to clotrimazole. Warnings and Precautions: A physician should be consulted if this is the first time the patient has experienced symptoms of candidal vaginitis or if any of the following are applicable: more than two infections of candidal vaginitis in the last six months, previous history of Thrush, or exposure to partner with a sexually transmitted disease, pregnancy or suspected pregnancy, aged under 16 or over 60 years; known hypersensitivity to imidazoles or other vaginal antifungal products. Medical advice should be sought if the patient has any of the following symptoms: irregular vaginal bleeding; abnormal vaginal bleeding or a blood-stained discharge; vulval or vaginal ulcers, blisters or sores; lower abdominal pain or dyspareunia; any adverse events such as redness, irritation or swelling associated with the treatment; fever or chills, nausea or vomiting, diarrhoea, foul-smelling vaginal discharge. This product may damage latex contraceptives therefore, patients should be advised to use alternative precautions for at least five days after using the cream. Side-effects: Rare: local mild burning or irritation immediately after use. Hypersensitivity reactions may occur. Use in Pregnancy: Only when considered necessary by a physician. Cost: 20g tube, £5.99. MA Number: PL 0010/0077. JHA Holder: Bayer plc, Consumer Care Division, Wythenshawe, Manchester, RG14 2JA. Legal Category: P. Date of Preparation: October 2001. © Registered trademark of Bayer AG.
Hence the full benefits of zinc supplementation of deficient children in developing countries is likely to occur only when intakes of other micronutrients are adequate, or nearly so.

There is good evidence that short-term use of high doses of zinc can alleviate cold symptoms, particularly in the early stages. It seems that viral penetration is inhibited by topical application to the throat or nose, and so nasal sprays can be used as well as lozenges. However, evidence from clinical studies suggests that only the gluconate and acetate forms have these anti-viral properties.

Studies of high-dose zinc treatment for acne have resulted in contradictory results, despite media hype. Because of the potential problems, prolonged high-dose regimes should not be used without medical advice, and only when accompanied by 1.5mg of copper daily to pre-empt copper deficiency.

Conclusions

Although the value of zinc supplementation to reduce stunting in the developing world has been shown repeatedly, this knowledge has not been enacted. Even in the UK, surveys show that low intake of zinc is widespread, with various disparate adverse effects. Low-dose intervention, ideally as part of a multi-nutrient supplement containing copper, would benefit the wellbeing of many people worldwide, including boosting immune health among populations in the West.

References:
3. ET M, Safe Upper Levels for...
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PIP code: 224-2568

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E: info@owenmumford.net

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Thalidomide may slow weight loss in pancreatic cancer

Thalidomide may slow down weight loss and wasting associated with advanced pancreatic cancer, a Portsmouth study has shown.

Fifty terminally ill patients who had lost at least 10 per cent of their body weight were randomly assigned to receive placebo or thalidomide 200mg daily for 24 weeks. Among the outcomes measured were changes in weight, change and bone-free muscle mass, quality of life and survival.

After four weeks there was a marked difference in weight change; with patients in the treatment group gaining a mean of 0.37kg compared to an average weight loss of 2.21kg in those on placebo. Bone-free muscle mass was also significantly different between the two groups, with the treatment and placebo groups showing an average gain of 1cm³ and loss of 4.6cm³ at four weeks respectively. Quality of life and survival rates were better in the thalidomide group, though neither was statistically significant.

The authors say that more work is needed to see whether the results apply to all cancers. They conclude: "In future, the combination of thalidomide with nutritional supplements and pharmacological agents may ultimately lead to a better clinical outcome."

In an accompanying editorial in Gut, Michael Stroud of Southampton General Hospital's Institute of Human Nutrition, describes thalidomide as "a cheap and generally safe drug, and a potentially useful anticancer agent".

For more information:

Gut 2005; 54: 540-545

St John’s wort found to show effect on blood

St John’s wort appears to increase clopidogrel’s antiagulant effect, emerging findings have shown.

Six patients took clopidogrel alone, then clopidogrel plus St John’s wort. All six showed a major decline in platelet aggregation when taking both drugs.

The study size means more research is needed, but patients and clinicians should be aware of the possible interaction, senior author and cardiovascular medicine professor Eric Bates warned.

The research was presented at the Annual Scientific Sessions of the American College of Cardiology this week.

CBT plus meds better for panic

Patients with panic disorders may benefit more from a combination of medication and cognitive behavioural therapy than medication alone, US researchers have said.

Ninety 120 patients received antidepressants or adjunctive medication and up to six CBT sessions over three months. The patients also received up to six follow-up telephone ‘booster’ sessions over the rest of the year. A similar number of subjects received “usual” treatment from their primary care practitioner, which usually consisted of pharmacotherapy.

Patients in the intervention group had substantially better outcomes than those receiving medication only. Nearly 30 per cent of the CBT group reported no panic attacks in the past month, minimal anticipatory anxiety about panic and a low agoraphobia score, compared to 16 per cent of the patients on medication only.

The authors conclude: "The outcomes achieved in this study cannot definitely be attributed to CBT alone."

For more information:

Arch Gen Psychiatry 2005; 62: 290-298

Stelazine unavailable

Stelazine spansules 2mg (pack sizes 90 and 250) and 10mg (pack size 30) will not be available for six to nine months, Goldshield Pharmaceuticals has said.

The company says that a manufacturing change has resulted in the products being in short supply or short-dated for the last six months. Although the company is working to remedy the situation, stocks are expected to run out soon and patients will need to be switched to alternative products. Stelazine 1mg and 5mg tablets and 15mg spansules remain available.

For more information:

Goldshield Medical Information
Tel: 020 8410 2592

MediSpoon

Shantys has announced that its 5ml MediSpoon is now available through wholesalers.

Available in five colours, the spoon has an ergonomic design allowing it to remain horizontal on a flat surface and a curved handle making it easier to administer medicines. The device is CE certified and complies with Drug Tariff specifications.

For more information:

See Price List
Shantys Ltd
Tel: 020 8595 7836

Larapam SR

Sandoz has launched a range of branded sustained-release tramadol products. Larapam SR is available in 100mg, 150mg and 200mg strengths and comes in packs of 60 tablets.

For more information:

Pip codes and prices: Larapam SR tablets 100mg 314-5521 £10.25, 150mg 314-5530 £14.37, 200mg 314-5547 £13.55
Sandoz Ltd
Tel: 01420 478301
Insulin resistance is increasingly recognised as a major public health risk. It is a condition that occurs when a person's insulin is not working properly to lower blood glucose levels.

Insulin resistance and Type 2 diabetes

Insulin resistance is now established as a root cause of Type 2 diabetes, with 92 per cent of patients with Type 2 diabetes being insulin resistant.

What is insulin resistance?

In a healthy person, insulin enables cells in the body to utilise blood glucose for energy. Insulin binds to receptors in the cell, allowing glucose molecules to enter the cell from the blood. In a person with insulin resistance, the cell's insulin receptor is less responsive to the insulin molecule, meaning that glucose cannot enter the cell and as a result blood glucose levels rise.

Identifying insulin resistance

People who are insulin resistant are typically older, overweight and physically inactive; they tend to have high blood glucose levels and high blood pressure. As a rule of thumb, a patient may be classed as insulin resistant if they fulfil at least three of the five following criteria:

- Abdominal obesity >102cm in men, >88cm in women
- Fasting plasma glucose >6.1mmol/L
- Blood pressure >130/85mmHg
- HDL cholesterol <1.04mmol/L in men, <1.29mmol/L in women
- Triglycerides >1.69mmol/L

What advice can I give patients about insulin resistance and Type 2 diabetes?

If patients can tackle their insulin resistance and control their blood glucose levels they will be less at risk of health problems.

Type 2 diabetes is a progressive disease and aggressive management is important to help prevent complications which can include renal failure, blindness, stroke and heart disease. Indeed over 75 per cent of deaths in people with Type 2 diabetes are due to cardiovascular disease.

Patients can stay in control by eating a balanced diet, being active and taking any medication prescribed by their doctor. Regular reviews to check the following will provide the best management for a Type 2 diabetes patient:

- Blood glucose control
- Blood pressure
- Unhealthy fat levels (such as cholesterol)
- Weight
- Legs and feet
- Eyes
- Kidney function
- General wellbeing
- Smoking
- Current treatment
- Compliance.

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Scholl’s flight socks get travel endorsement

Scholl Flight Socks have been given a spring makeover in time for the holiday season. The socks now come in a resealable pouch in which customers can store them. The pouch also has a hook which makes for easy in-store display and has been designed to resist crushing in transit. For the first time the Association of British Travel Agents (ABTA) logo is included on-pack alongside the Aviation Health Institute (AHI) logo. Language used on the packaging has been simplified to help customers understand the issues surrounding DVT.

Pouches have a clear window so customers can look at the socks and the sizing has been changed to make selection easier. The existing Knee Highs have been renamed “Flight Sock Sheer” to avoid confusion over the sock length.

Price: £12.99 each
SSL International Plc
Tel: 0870 122 2690

Spring relaunch for Zirtek

Zirtek is being relaunched with new look packaging in time for the hay fever season. The new packs will be brought in this month across the Zirtek tablet and solution range. The redesigned packs use bright green, yellow and purple for greater shelf presence. “We know from our own research that two out of three Zirtek users are repeat purchasers, suggesting satisfaction with Zirtek. By bringing in a fresh new look we hope to grow the brand by appealing to new consumers,” says brand manager Liz Welford.

For more information: UCB Pharma
Tel: 01753 534655

Clearasil Ultra treats spots faster

The new Clearasil Ultra range promises visibly clearer skin in three days and the launch is being backed by a high profile TV, radio and marketing campaign. Clearasil Ultra Treatment Cream combines salicylic acid with hydrogen peroxide to get rid of spots faster. Clearasil Ultra Deep Pore Treatment Wash contains salicylic acid, designed to help new spots forming and reduce redness in three days, together with hydrolyzed milk protein to control oil and shine.

Clearasil Ultra Deep Pore Treatment Pads contain salicylic acid and hydrogen peroxide. Clearasil Ultra Deep Pore Treatment Scrub contains exfoliating microbeads to unblock pores.

Prices:
- Deep Pore Treatment Wash £4.29;
- Deep Pore Treatment Pads £4.99;
- Deep Pore Treatment Scrub £4.29;
- Treatment Cream £4.99

Crookes Healthcare
Tel: 0115 953 9922

Sanex range for men’s skin

Skincare brand Sanex has been expanded with the addition of a range of products for men. The range has been divided into two variations: Sanex for Men Active and Sanex for Men Sensitive. Products include shower gel, deodorant, shaving foam and aftershave balm.

The launch is being backed by an £8 million marketing campaign which will include TV and press advertising, PR and sampling.

Prices:
- deodorant aerosol £1.99;
- deodorant roll-on £1.59;
- shower gel 250ml £2.49; shower gel 400ml £3.49; shaving gel £2.99;
- shaving foam £2.69; aftershave balm £4.29

Sara Lee H&BC UK
Tel: 01753 523971
Germolene gets Antiseptic Gel

First aid brand Germolene has been given a contemporary addition to its range – Germolene Antiseptic Gel.

The clear gel is the first product in the range to be fragrance-free. It can be used to cleanse skin and help prevent infection on cuts, grazes, insect bites, burns, scalds and spots.

Bayer is backing the launch with a £500,000 consumer press campaign.

Price: £1.99

Bayer Consumer Care
Tel: 01635 563000

Mums help redesign milk packs

Cow & Gate has redesigned its baby milk packs after consulting with over 1,000 mums. The new packs have storage space under the lid for the measuring scoop, the scoop leveler has been built into the top of the pack, and the lid shuts more securely.

For more information:
Nutricia
Tel: 01225 768381

Germolene

Aquafresh: All areas except U, CTV, GMTV
Calpol: All areas except U, GMTV
Kalms: five, GMTV, Sat
Kool 'n Soothe: All areas except C4, Sat
Kool 'n Soothe Migraine: All areas except C4, Sat
Lucozade-Energy: All areas except U, CTV, GMTV
Nytol: All areas except U, CTV, GMTV
Senseodyne: All areas except U, CTV, GMTV
Seven Seas Cod Liver Oil: All areas
Simple Women's Skin care range: All areas
Tena Lady: All areas except U, CTV, LWT, GMTV
Zocor Heart-Pro: A, M, LWT, C4, Sat
PharmaSite for next week: Otex – window. Ibuleve – in-store, Ibuleve – dispensary
Pharmacy Channel: Isovon/London 2012 Olympic Bid/Give it Up

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

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A growing number of pharmacies are installing robots as efficient dispensing becomes increasingly necessary. But what do we actually know about them? Vikki Miller talks to the people at the forefront of the robotic revolution.

Rise of the robots

They look nothing like R2D2 or C3PO - a distant relation perhaps. They don’t walk or talk, or save you from Darth Vader, but they could save your livelihood. They require commitment, patience and a substantial investment. But robots - or automated dispensing systems (ADS) as they are otherwise known - are set to be the next big thing in retail pharmacy.

The Government’s new agenda for the profession forces community pharmacists to reassess their priorities. The main source of income will no longer be dispensing fees, but provision of patient-centred clinical services. While dispensing will remain a core role, pharmacists will be expected to develop their cognitive skills and expand the range of services on offer. This is why key figures within the industry now argue that dispensing methods should be made as efficient as possible, and this is where robots come in.

Geoff Mackay, customer technology controller at AAH Pharmaceuticals, believes pharmacists are guilty of accepting a model of working practice that has been in place for over 25 years. He says: “Automation is a great opportunity for pharmacists to redefine their position, get new processes going and develop a role that is a lot more valuable. After a period of time, I think the industry will accept this. There is already huge interest out there.”

At present, however, there are only a handful of pharmacists operating automated dispensing systems. Taylor’s Family Pharmacy in St Helens was the first in the country to install a robot three years ago. Richard Hutton is a pharmacist there and says that robots are vital in freeing up time to pursue other services. They are also crucial in reducing dispensing errors, which are increasingly leading to litigation. Other advantages include clearing space on the shop floor for various services by placing the robot on a different level, and a reduced holding stock with a clear audit trail.

Andrew Gray has had a robot at his pharmacy in Berwick, Northumberland for nearly three years and is especially pleased that his technicians can now dispense individually at fixed workstations and that there is a calmer working environment. “They are now taking NVQs and one of them has completed a checking course,” he says. “I plan to have at least two at checking level so that they can check each other’s work, allowing them to proceed without interruption by the pharmacist. They enjoy the extra responsibility and because I have the robot, I don’t have to recruit and train any extra staff.”

But not everyone is convinced that they are a good investment. Some companies, most notably multiples, are put off the idea of installing a robot because they have yet to be extensively tried and tested in the UK market. Both Boots and Moss temporarily installed robots in selected stores and both decided not to roll them out nationwide.

Steve Churton, assistant pharmacy superintendent at Boots, says it was mostly technical hitches that caused the problems. “The interface between the robot and our internal system kept breaking down and we found that we couldn’t put some products, especially our own brand and some generics, into the system because it didn’t recognise the bar codes. We had the robot for three months.
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and then lost patience and pulled the plug."

In fact, all the pharmacists who already have robots have cited interface difficulties as their main problem. The robot needs to be able to 'talk' effectively with the existing pharmacy system, most importantly to produce the right labels. None of the existing robotic arm models have the mechanics or technology to automatically stick the label on the prescription (this has to be done manually) but there have been recent breakthroughs and Hassan Argomandkhah, who is building a health centre in St Helens, will be the first in the country to work with an auto-labelling system when his robot is installed in April.

All robot owners agree that having the right software is key to making the system work at its best, but none of the software houses have yet produced an infallible system. Even Neil Williamson, head of pharmacy planning and design at the National Pharmaceutical Association, calls the current software situation a "stumbling block".

Furthermore, Mark James, operations director at AAH Pharmaceuticals, questions whether ADS's really do reduce workload. He points out that they can take a long time to train and to have to be done manually on some machines, and queries if they really take up less space than the original shelving. His experience in wholesaling has taught him that manufacturers' electronic codes are not always reliable - he cites a 70 per cent first time recognition rate with the robot they use in the AAH warehouse - and that there can be up to nine different bar codes for one product, which destroys the argument that machines are more accurate.

"Pharmacists need to ask themselves if they have a good business case for buying a robot," he says. "It's very easy to be sold a concept. They should ask themselves: are the new processes really going to be more effective or am I just moving the problems?"

But, despite initial teething problems, every retail pharmacist who has purchased a robot so far does not regret the decision and points out that the benefits are too significant to ignore.

Mr Gray says: "I did have some problems but the pros do outweigh the cons. I think robots are the way forward and they are set to spread across the UK."

However, the high cost of the systems remains a significant factor in a pharmacist's purchasing decision. Entry-level machines start at around £80,000, but Mr Williamson is determined to make the systems more accessible to smaller independent pharmacists. He has been in talks with manufacturing companies about producing a smaller machine, which would cost between £15,000 and £30,000. He explains: "They would have the same function, just on a smaller scale. They would still be computer-driven and would require interface software but the pharmacist would need to stock it manually." But he adds: "These will take longer than the larger machines to come to the market. It will be a good few years yet."

Funding the expense of a robot is a problem which pharmacists have dealt with in varying ways. Mr Gray ended up getting a hire purchase deal from his main supplier being let down by his PCT, software companies and consequently the wholesaler, who had been willing to pay for the software. He says: "We were very disappointed but glad that the bank would lend us the money. They couldn't get the bank to help us and we could have received some support from the Government, but this was an unintended consequence of being let down by our technology supplier."

He says that the cost was made slightly more manageable because the equipment can be leased as computer technology, and so 100 per cent of the expenditure was tax deductible. The area PCT also gave a donation towards maintenance costs.

---

**Martin Bennet, Wickes Pharmacy, Sheffield**

"We were relocating and wanted to incorporate as much mechanisation as possible into the new premises. I'd seen automated dispensing systems at exhibitions and conferences so we decided to install one. We've been working with a robot for about three months now."

"I'm not convinced that it creates massive time savings, but it does change the way you work. Less skilled staff are now more useful."

"We're still getting used to having it here, though. We need to change and improve our working practices to learn to work with it, which I predict will take the best part of a year."

"But the customers have taken it all in their stride. We've installed a CCTV camera in the dispensary and a flat screen in the waiting room so they can watch it at work. They're always telling us how much they like it."

**Andrew Gray, Grays Pharmacy, Berwick-upon-Tweed**

"Buying an automated dispensing system began as a crazy idea when we decided to relocate next to a hospital's surgery, and we pursued it from there."

"Being a second community pharmacy in the UK to install a robot (we got ours in May 2002) was a struggle. There were no experts around so we had to do the pioneering work, such as help with the development of the software that links the robot to our existing labelling system. We've gone through three different software systems so far, and we're happy with the one we have now, but it should have been that way to start with."

"On the flipside, we've had access to our own engineer and loads of publicity - I've met two chief pharmaceutical officers because of the robot. Overall, the pros far outweigh the cons."

"I think we are at the beginning of a boom in the UK market. It's been slow until now because of the turn of pharmacists have been in over the new contract."

---

**Hassan Argomandkhah, HA Chemist, Liverpool**

"I'm due to install a robot this April because I'm building a health centre from scratch. I sat down and asked myself which way I thought processes were going and I realised that if dispensing was going to be only half of my income, I had to make sure that it was as efficient as it could be, to free myself for other services."

"It's a huge investment so it's very important to get it right and I'm determined to make the system into a 'pharmacist's friend'. I think good design is the key to success, but also not to be afraid of it. It's not going to remove the pharmacist's role - even the Government doesn't want that - it's all about getting the skills mix right."

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*Continued on page 36*
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The UK and European Automation Market Leaders
Siemens Logistics & Assembly Systems says it can organise leasing through its in-house financial services department. Other companies offer deals with external finance organisations, and Mr Hutton says he is in negotiations with a finance house about creating lease purchase arrangements to assist other pharmacists who want to invest.

Prices are set to drop as two new companies—Siemens Logistics and Dutch company Robopharma Ltd—enter the UK market, joining ARX Ltd, which has had a monopoly on the market for over three years. The UK has been typically slow on the uptake; mainland Europe has been automated for years now. Despite this, there is a confident belief among pharmacy planners and policy experts that, with the new contract looming, now is the time.

Mimi Lau, professional services controller for Numark, believes that the new companies will open up the market by bringing overdue competition and lower prices. She says: "We would support any member who wants to install a robot—I would even actively encourage it. They need to automate to use their resources more efficiently."

And as robots become more widespread, further possibilities for maximising their potential become apparent. Current suggestions include a 'hub and spoke' model, either for multiples that have a number of branches in one area, or even for wholesalers supplying individual outlets. The central 'hub', located in an out-of-town low rent district, could provide the dispensing for all the branches in the area, and an IT link between the branches—the 'spokes'—would allow PMRs to be shared. Patients could then choose the most convenient pharmacy to collect their prescription from.

This will be especially useful when electronic transfer of prescriptions rolls out, as regular prescriptions for chronic patients could be sent out to the relevant pharmacies from the hub ready assembled by a robot, saving pharmacists an estimated 80 per cent of their workload.

Furthermore, hospital robots could also prepare prescriptions for chronic patients during the night when they are used much less, if at all.

As the new contract and ETP draw closer, automation for retail pharmacists seems almost inevitable. Pharmacists need more free time and ADS can create it. By making dispensing more efficient, pharmacists will be able to realise their full potential and maximise their role as an integral part of NHS primary care services.

More over R2D2 and C3PO, the new generation of robots are on their way.

### At present, robots come in two forms

#### The first, and most common, type has a robotic arm.

To input medicine packs into the robot:

- The medicine packet is scanned and then placed on the conveyor by a person.
- The robotic arm then takes the pack and stores it in a space assigned by the robot.

To retrieve medicine packs from the robot:

- The item is selected using the existing pharmacy computer system.
- The robotic arm goes to collect the pack from where it knows it has stored it.
- The machine produces a label for the medicine pack.
- The pack is delivered, either by a conveyor belt or chute, to the workstation.

#### The second type, which could gain in popularity due to its lower price, is a vending machine.

To input medicine packs into the robot:

- Can be filled manually or automatically.
- The item is selected using the existing pharmacy computer system.
- The correct channel is engaged and will deposit the pack.
- The machine produces a label for the medicine pack.
- The pack is delivered, by a conveyor belt to the workstation or the pharmacist goes to the machine to pick it up.

### Name of automated dispensing system (most popular)

<table>
<thead>
<tr>
<th>Name of automated dispensing system</th>
<th>Average cost</th>
<th>Size</th>
<th>Picking speed</th>
<th>Software to interface with existing system?</th>
<th>Developed labelling system?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Siemens Logistics &amp; Assembly Systems</td>
<td>£70-85,000</td>
<td>1.6m x 2.5m x 2.4m</td>
<td>3 products per sec</td>
<td>Yes</td>
<td>Shortly</td>
</tr>
<tr>
<td>Siemens Logistics &amp; Assembly Systems</td>
<td>£90,000</td>
<td>12m x 1.7m x 3.6m</td>
<td>600 picks per hour</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Siemens Logistics &amp; Assembly Systems</td>
<td>£90,000</td>
<td>3,300 packs per hour</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Saving time and costs

An automated dispensing system, Apostore is designed to enhance the safety, speed and efficiency of pharmacy dispensing. The system utilises a high speed handling robot to automate the storage and retrieval process for inventories ranging from 6,000 to 25,000 packs. The system is suitable for both pharmacy retail and hospital use.

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Logistics and Assembly Systems
Pharmacy management

Editorial considers what can be learnt about automated dispensing from the secondary care sector

Are dispensing robots

So the robot produced an efficiency gain of 35 per cent and we might expect that we could save one third of our workforce. This is impressive by any standard, until one reflects that the new contract for community pharmacy implicitly assumes that staffing in a community pharmacy will be approximately on a basis of 3,000 items per person per month, equivalent to 24,000 script items and eight hour day to 15.6 items per person per hour including pharmacists.3

Our robot, judged on actual results, barely matches the efficiency already required in the community without a robot and is less impressive when the essential pharmacist labour is included. Worse, the machine has a set rate of working which is difficult to increase whereas there are still gains to be made in manual dispensing from better organization and layout.

Note, there are 30 days in a month, but an average of almost nine are Saturdays and Sundays. It is general to calculate on the basis of a 22 day working month, but community pharmacies still do a little work on Saturdays so I have taken that they work a 24 day month.

Dispensing error rates

Very recent work4 has shown that the dispensing error rate in community pharmacy is four patient threatening dispensing errors per 10,000 script items. This was a prospective study which examined 125,000 actual dispensed items for errors as they were put out for collection by patients.

A retrospective study5 in hospital pharmacies showed, as you would expect, a lower rate of 1.8 serious errors per 10,000. However, retrospective studies of dispensing error rates in general yield low figures and there is no reason to suppose that the hospital rate differs from that found in community pharmacy.

It certainly seems fair to take it that the British rate for serious dispensing errors is between two and four serious errors per 10,000 prescription items in both community and hospital practice.

The Welsh hospital robots produced savings on errors of 2.6, 2.9, 2.0 and 3.6 per 10,000 items dispensed in three different hospitals on four different occasions. The baseline error rates were not given, but as against four per 10,000 these are a halving to almost an elimination of the expected rate.

Distribution incidents reduced from 12.9 per 1,000 items distributed to 7.2 incidents per 1,000 items distributed. It was acknowledged that data was only collected for a relatively short period of time. This is a good result but the variability in error rates must give grounds for concern; one would expect machines to be more consistent.

Errors and mishaps

There is no published data on the machines' errors and mishaps, however information circulates within the local pharmaceutical community and perhaps allows a reconstruction of events, although allowance has to be made for the nature of such information.

As part of an investigation on workloads which I have been carrying out I looked at the results of the trials of dispensing robots in Welsh hospitals. I've already seen one of these robots at work, and I've also looked at the wholesalers' robots so it was interesting to see the practical results they produce. There are two main justifications for use of these robots: an increase in work efficiency and a reduction in the rate of dispensing errors.

Let's look at work efficiency first. The starting baseline is the normal rate of working. Without robots this was found to be 9.9 dispensed items per person per hour, equivalent to 64 items per seven hour day when allowances for tea breaks are made. There is, of course, additional pharmacist labour involved in the initial clinical checks which does not appear to be counted towards these figures.

In one of the dispensing robot trial hospitals the normal rate of working was a little higher at 11.6 items per technician per hour, equivalent to 75 items per day. After the robot was installed and had settled down, the rate of working rose to 15.7 items per technician per hour, equivalent to 102 items per day. This is, of course, lower than the manufacturer's claimed rate of working, but we need not be surprised at that and shall see why.
It appears that very occasionally the machine drops inside itself a bottle containing liquid. All dispensing has to cease while the broken remains and all the liquid are removed and the area cleaned. The important point here is that all dispensing has to stop while matters are rectified and serious delays ensue.

Similarly, the machine’s suction grip very occasionally sucks the end off a carton containing tablets and the debris jams the machine. Again all dispensing has to stop while the machine is cleared. These delays are one of the factors which reduce the work output from the claimed figures.

Once a product has been selected it is carried to the technicians by conveyor belts, being tipped from the belts at the appropriate technician point by guides which spring out from the sides of the conveyor under computer control. Very occasionally it happens that this mechanism delivers the product to the wrong technician. Then either the error passes undetected or time has to be spent discovering the right destination for the product and transferring it there. Very occasionally the bar code reader misreads a product as it is being loaded and the product is essentially lost (because mis-catalogued) unless and until a product with the misread bar code is needed.

Sometimes the misread bar code is misread again in the machine checking process, and sometimes it is not, so either an error or a delay occurs. One might imagine that over a period of years these misread lost products might build up in the machine so that regular audits of the stock would have to be carried out — obviously with all dispensing halted for the period of the audit.

The lesson here seems to be that bar codes are fine for checking that the right product has been dispensed but perhaps less good at storing and selecting products. Anyone with much experience running bar code reader tills will know that the

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reading is not at all 100 per cent accurate. Hopefully RFID (Radio Frequency Identification) will replace bar codes and be more reliable.

As for costs, the machines so far used have been leased at an annual leasing charge plus manufacturer’s maintenance contract cost of about £100,000. It seems likely that any new machines will in future be bought at an approximate cost of a million pounds each, which will lead to similar annual capital costs.

However, in each hospital heavy building alterations have been needed to accommodate the machines and these do not appear to have been included in either the capital or leasing costs of the installations. Also, in each case, temporary pharmacy accommodation has had to be provided, usually in hired Portakabins, and there have been high weekend overtime costs associated with moves in and out of these. Again these cost do not appear to have been included in the published costs of the projects.

Distribution errors are reduced to a lesser degree. To this extent the machines are perhaps not yet meeting the manufacturer’s claims. They cost £100,000 per year to run, with additional unknown (but heavy) capital costs for the building alterations needed to accommodate them.

It is possible that the machines are not cost effective, although the judgement is probably finely balanced. Any community pharmacy contemplating one of these machines would be well advised to critically review the published evidence given in the references to this short paper.

References:

Bob Gartside is pharmacy superintendent for Rowlands Pharmacy

In each hospital heavy building alterations have been needed

To summarise: the experience with dispensing robots in Welsh hospitals so far is that they bring technician productivity up to the average levels found in community pharmacy without robots and reduce, but do not eliminate, dispensing errors.

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Big pharma eyes up the wholesaler network

Concerns over product safety, parallel trade and cost savings could prompt European pharmaceutical companies to reduce the number of wholesalers they use, consultants are warning.

In a new report on the European pharma industry, business adviser KPMG concludes that medicines distribution could be poised for a major overhaul this year.

Pharmaceutical distribution networks are seen as one of the more stable features of the industry. However, with the growth of parallel trade, plus the emergence of major wholesale businesses such as Celesio, Phoenix and Alliance UniChem, the time is now right to seize the opportunity to work with a more focused distribution network, says Stephen Oxley, European head of pharmaceuticals at KPMG.

A more focused distribution relationship could also result in increased supply chain security. “This might go some way to improving manufacturers’ confidence in knowing where their stock is en route from factory to patient,” says Mr Oxley.

A key catalyst for change in the distribution network is the European political environment. According to KPMG, there is now growing optimism that the new EU Competition team is no longer so strongly opposed to initiatives that could impact on free trade.

Mr Oxley continued: “The timing has never been better for big pharma to reassess the old structure. Within Europe, big pharma seems to have been given more scope for manoeuvre so expect them to take it.”

Although European pharma industry representatives acknowledge the quality control systems implicit in traditional routes of supply, the European Association of Pharmaceutical Full-line Wholesalers (GRP), points out that full-line wholesalers fulfil an important role in the delivery of healthcare. And this suggests the wholesaling model is not likely to change in the way KPMG has postulated.

European legislation means that the reimbursement of medicinal products underlies the principle of subsidiarity, says GIRP. “So far, no medicines as such can be considered as a ‘European product’. Even the approximately 300 medicines for human use, which have been registered by the EMEA in its 10 years of existence, cannot be distributed Europe-wide because of national requirements to which these products need to be adapted. That’s why pharmaceutical wholesaling is a purely regional and at most a national business. The question whether a few pan-European distributors will deliver medicines throughout Europe in the near future is therefore not realistic.”

The vast range of medicines available requires wholesalers to stock an unusually high number of product lines. “Full-line wholesalers do not undertake any cherry-picking but ensure equally the permanent availability of all products, including orphan medicines. This ensures that even the most isolated patients can receive the most specialist medicines via their pharmacist in a safe and timely manner.”

Full-line wholesalers must also comply with strict obligations set out in European and national laws. GIRP argues that this ensures there is a continuous flow of all medicines, whenever and wherever they are needed.

“As long as the pharmaceutical markets will be national/regional due to the authorisation and reimbursement schemes, full-line wholesalers can only distribute on a regional and national level. The national provisions of the supply chain are therefore essential to the safe and continuous access of medicines to patients.”

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The question of whether your name shapes your destiny has resurfaced in the pharmacy sector.

While Andy Pothecary, who registered as a pharmacist in 2003, has had his name in the letters pages of the pharmacy press, another fitting name was promulgated by the Society recently.

The Hospital Pharmacist Group of the RPSGB and the Pharmaceutical Aseptic Services Group will hold a joint meeting on April 14 at Lambeth on the theme: "The Breckenridge Report Revisited - risk management of injectable therapy."

How appropriate, then, that the chairman will be Dr Richard Needle.

Well done to the NPA 5-a-side football team (pictured) for a sterling effort in the Hertfordshire Powerleague Business Challenge football competition. In blizzard-like conditions, they were unlucky not to qualify for the final stages, despite winning their final game 4-0. NPA chief executive John D'Arcy said: "There were a few cold and tired legs after all our work but it was a great experience."

Paula Tapley has joined Health Perception as brand training manager. Ms Tapley will be responsible for developing a national training programme to advise and educate retailers on the company's product range, and has joined from Re-Action Sales & Marketing.

Remploy Household and Toiletries has promoted Frank McAdam to the position of business manager. Formerly with Burlington Toiletries, Mr McAdam joined Remploy in 2001 as head of manufacturing, and has over 18 years' experience in the industry. Pfizer has made a number of senior appointments. Former president of Pfizer Global Pharmaceuticals Karen Katen has been named president of Pfizer Human Health. Jeff Kindler, who oversees the company's legal affairs worldwide, has assumed management responsibility for corporate affairs; David Shedlizar is being replaced as chief financial officer by Alan Levin, who joined Pfizer in 1987, and will take on responsibility for Pfizer Human Resources.

Leo Pharma's Claire Cameron was named pharmaceutical and sales professional of the year at the National Sales Awards. Ms Cameron, a senior sales representative, was recognised for growing sales 131 per cent ahead of the company average.
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