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further evidence to accumulate, including studies that it has only recently commissioned.

While we do have concerns about the wisdom of extending prescribing now, we believe that most nurse and pharmacist prescribers will act within their areas of competence. For example, a fully trained specialist respiratory nurse might prescribe a short course of oral corticosteroids for a patient with acute asthma but would be extremely unlikely to alter the drug treatment of a patient with diabetes or epilepsy without training in managing these conditions.

To limit the potential risks from extended prescribing, health professionals must be trained to prescribe appropriately and safely in the clinical subjects in which they are likely to practise. The current schemes for training nurse and pharmacist prescribers are too short to fully equip a professional for independent prescribing practice. It is essential that additional training, support, and mentorship are available after such training programmes.

In addition, nurse and pharmacist prescribers must have access to all the tools they need to help them prescribe safely. One worrying finding from the recent study on independent nurse prescribing in primary care was that only 5% of nurses had access to systems providing computer generated prescriptions and most were probably missing out on the potential benefits of computerised alerts for drug interactions and allergies.¹⁰ This problem could have been predicted from the way that nurse prescribing was introduced whereby the guide for implementation¹¹ expected nurses to hand-write prescriptions rather than being allowed to use a clinical computer system. Thorough risk assessments should be done nationally and locally before prescribing is extended to new clinical areas.

Also, it will be important to have strong clinical governance to help to identify any prescriber, medical or non-medical, exceeding his or her competency. With appropriate training, support, and governance in place,

extended prescribing could combine the benefits of high quality pharmaceutical care with greater convenience and improved access to treatment for patients.

Anthony J Avery *professor of primary health care*
(tony.avery@nottingham.ac.uk)

Mike Pringle *professor of general practice*

Division of Primary Care, University of Nottingham Medical School, Queen's Medical Centre, Nottingham, NG7 2UH

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Competing interests: AJA is a co-investigator on a Department of Health funded study of supplementary prescribing by nurses and pharmacists. He has also advised the Royal Pharmaceutical Society of Great Britain on a study it commissioned on prescribing by pharmacists and commented on the appropriateness of nurse prescribing as part of a Department of Health funded study of independent nurse prescribing.

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European developments in labelling allergenic foods

More still needs to be done

The new European Union directive on food labelling, requiring manufacturers of packaged foods to detail clearly the presence of certain known allergens, comes into effect later this month.¹ This welcome legislation will directly benefit the many people who experience adverse reactions to foods and could save lives, given the increasing numbers of people with IgE-mediated food allergy who may develop anaphylaxis after even minimal exposure.^{2,3} Similar initiatives are being pursued in the United States, Australia, and New Zealand, indicating that the plight of those who live with the daily threat of allergic reactions to foods is, in some countries at least, at last being taken seriously.⁴⁻⁶

Manufacturers of packaged foods containing any of 12 major allergens (see box) will, as of 25 November this year, be obliged by the European Union regulations to label these ingredients. Importantly, this new legislation removes the previously unhelpful "25%

rule," which exempted labelling of constituent ingredients if they amounted to less than 25% of the final product, thereby resulting in an appreciable risk of inadvertent exposure to, for example, nuts in chocolates.⁷ Even use of the smallest quantities of these 12 ingredients will now require labelling.

Although many manufacturers have already begun implementing this new requirement, consumers need to be aware that stocks of products manufactured and packaged before 25 November may continue to be sold. It is also important to note that other ingredients of compound preparations may in some cases be exempt from labelling if they constitute less than 2% of the final product. Given that sensitisation may be increasing to, for example, certain stoned or exotic fruits such as apples or kiwi fruit used in small quantities in desserts or jams, this is worrying.^{8,9}

More concerning, however, is the exclusion from these EU regulations of freshly prepared foods, because

Specified food allergens covered by the new European Union directive

- Cereals containing gluten
- Crustaceans
- Eggs
- Fish
- Peanuts
- Soya beans
- Milk
- Nuts
- Celery
- Mustard
- Sesame seeds
- Sulphur dioxide and sulphates

most severe anaphylactic reactions to food occur when eating out in restaurants and cafes.¹⁰ Vulnerable people are left with one of two options—either to take the risk of asking about the ingredients of food and trusting in the advice of catering staff, many of whom will have not received any training in the dangers of food allergies, or to curtail or completely avoid eating out. The European Union should adopt the same requirements as Australasia, where all food suppliers have to make available to consumers detailed information on ingredients on the packaging, or on a display alongside the food, or to the purchaser on request.⁶

Furthermore, this EU legislation will do nothing about the highly frustrating general warning “may contain traces of nuts.”¹¹ To protect people with food allergies effectively, production lines for the main allergens should be separated completely from other production lines in factories and other settings for processing and packaging food products. In the meantime, food suppliers should provide consumers with a much clearer idea of the likelihood of trace exposure to nuts and other products.

Policy makers, legislators, and food suppliers need to appreciate that neither underplaying nor overplaying the risks of exposure to allergenic foods are helpful for those living with what is often a highly debilitating

lifelong condition. People with food allergies need accurate, clear, and easily understood information to make truly informed choices and to live with and control their condition with a sense of confidence.

Chantelle Anandan *research fellow*
Aziz Sheikh *professor of primary care research and development*

(Aziz.Sheikh@ed.ac.uk)
Division of Community Health Sciences, University of Edinburgh, Edinburgh EH8 9DX

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Competing interests: AS has family members with serious food allergies and serves on the Scottish Executive’s Review of Allergy Services in Scotland Working Group. CA has no competing interests.

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Primary care trusts: do they have a future?

Yes as guardians of public sector commissioning; no as service providers

Primary care trusts (PCTs) are the local statutory organisations in the English NHS responsible for improving public health, providing primary health care, and commissioning secondary and tertiary care services for populations of around 250 000 people. When created in 2002 primary care trusts were intended to become powerful local purchasing agencies, rooted in primary care, and well placed to integrate primary health care, community services, and hospital care.¹ In the international context, one of the most notable features of primary care trusts has been the continuing belief by NHS policy makers in England in the value of integrating the purchasing of health care with the delivery of primary care. However, over the past year or more the view that primary care trusts are failing to “punch their weight” in the health system has gained currency, in particular in relation to their supposed inability to achieve strategic change in secondary care.²⁻⁴

This has led to renewed interest in strengthening the commissioning function in the NHS. The assumption is

that there will be fewer primary care trusts and that these will concentrate on funding and contracting for primary care, supporting the purchasing of other services led by practice based commissioners, and divesting themselves of their provider responsibilities such as community nursing and health visiting.⁵ This is driven partly by the perception of the trusts’ “failure” as commissioners. But it is arguably driven more so by policy makers’ encouragement of a greater range of providers of primary care beyond traditional NHS general practice⁶ and the planned roll out of practice based commissioning (a scheme whereby practices are delegated a purchasing budget for their enrolled population) to all general practices in England by the end of 2006.⁵

The recent encouragement of a more plural primary care market, where patients can choose to enrol with or use a greater range of providers as well as conventional general practices, arguably represents the strongest reason for a change to primary care trusts. Practice based commissioning challenges their com-

See *News* p 1164

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