

Scottish Pharmacy Review



ISSUE 130 - 2021

ADHD IN CHILDREN

CHARACTERISTICS AND
APPROACHES TO CARE



SUBSTANCE DEPENDENCY

And lockdown pressures

CANCER RESEARCH

Making up for lost time

ENDOCRINE CONDITIONS

What are the coronavirus links?

SCOTTISH PHARMACY AWARDS

The recipients are revealed



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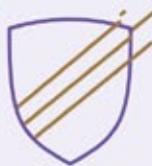
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*The 2'-FL (2'-fucosylactose) used in this formula is biosynthesised and structurally identical to the human milk oligosaccharide (HMO) 2'-FL, found in most mothers' breast milk¹

[†]MIMS, August 2020.

[‡]Studies conducted in healthy-term infants consuming standard Similac formula with 2'-FL (not Alimentum), compared to control formula without 2'-FL.

[§]Studies conducted in infants fed standard Alimentum formula without 2'-FL.

[¶]Parent reports from a single-arm study, where all infants were consuming an extensively hydrolysed formula before being switched to Alimentum with 2'-FL for 60 days. After 7 days of switching to Alimentum with 2'-FL, the majority of parents reported that the following persisting symptoms had improved or resolved: 84% of infants with constipation, 71% of infants with eczema, 100% of infants with vomiting.⁷

References. 1. Reverri EJ, et al. *Nutrients*. 2018;10(10):1346. 2. Goehring KC, et al. *J Nutr*. 2016;146(12):2559-2566. 3. Marriage BJ, et al. *J Pediatr Gastroenterol Nutr*. 2015;61(6):649-658. 4. Triantis V, et al. *Front Pediatr*. 2018;2:6:190. 5. Borschel M. *Allergy*. 2014;69(Suppl. 99): 454-572. 6. Sampson HA, et al. *J Pediatr*. 1991;118(4 Pt 1):520-525. 7. Abbott. Data on File (AL32). April 2020. 8. Borschel MW, Baggs GE. *T O Nutr J*. 2015;9:1-4. 9. Abbott. UK Alimentum Market Research. 2018.

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WELCOME

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EDITOR'S LETTER

Welcome to the latest edition of Scottish Pharmacy Review!

It was barely a week into the new year, and yet the familiarity of its predecessor tinged every part of me.

My stomach churned as the reality of COVID-19's escalation hit me with every news alert that bolted onto my phone screen. My eyes widened in horror as my social media pages swam with urgent calls from hospitals asking for off-duty staff to return immediately to work. My mind conjured up harrowing scenario after harrowing scenario; imagining how the vulnerable people in my life could be affected by the devastation.

So much about all these feelings are familiar – so much returns me to those dark days in March last year when I couldn't foresee how the pandemic could possibly be steered forward on a day-to-day basis, never mind how we could find a permanent way out of it.

These days may shroud us in the familiar darkness, but be assured, they are not the same – because we are not the same.

We now know that the rise in cases can be curbed by playing our part and staying at home when necessary. We can see optimism and innovation being regularly practiced via the roll-out of the vaccination programme. We are learning of coronavirus' impact on the individual facets of our sector – and the precautions which we must take to preserve and

protect the patients that they serve.

Knowledge is power and we have more of it. That's a theme we tap into in this edition as we examine how lockdown has created a pressure cooker for many people at risk of addiction, and the measures in place to help (page eight), and highlight new research relating to COVID-19 incidence and underlying endocrine conditions (page 18).

Additionally, the Sickle Cell Society share how you can help improve the overall quality of life of those affected by sickle cell disorder (page five), and we catch up with Clare Morrison, Director of the Royal Pharmaceutical Society in Scotland, about her transition into the post (page 40).

Don't forget to also check out the mental battle of chronic health which your patients may face (page 48), and the current state-of-play of bowel cancer and Inflammatory Bowel Disease (page 44), as well as the reveal of the exemplary 2020 Scottish Pharmacy Awards winners – and their journeys to success (page 27).

Take care.



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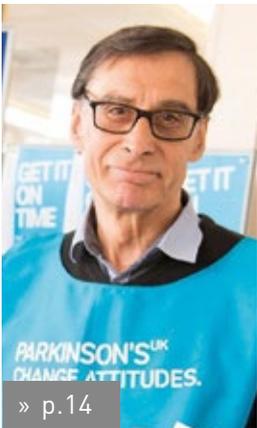
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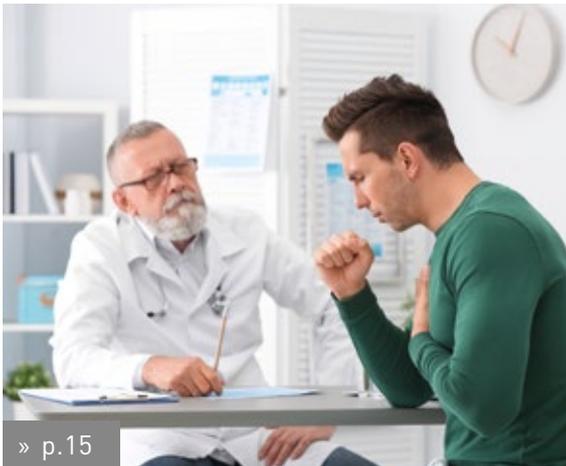
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CANCER

PAUSE FOR THOUGHT

Cancer researchers fear that progress for patients could be delayed by almost a year-and-a-half because of the effects of the COVID-19 pandemic, a new survey has indicated.

Scientists at The Institute of Cancer Research, London, told the survey that their own research advances would be pushed back by an average of six months by the initial lockdown, subsequent restrictions on laboratory capacity, and the closure of national scientific facilities.

With broader effects on charity funding, disruption of collaboration and personal interaction between scientists, and diversion of research efforts to COVID-19, the respondents estimated that major advances in cancer research would be delayed by an average of 17 months.

But the researchers remarked that science had now adapted in many ways to the pandemic and that long-lasting damage to cancer research could be mitigated through extra funding from charitable donations or government support – calling for investment in staffing, new technology – such as robotics – and computing power.

THE EFFECTS OF LOST TIME

The Institute of Cancer Research, which has discovered more cancer drugs than any other academic centre in the world, has, like many research organisations, been hit by cuts to its own fundraising income and to grants from other charities. The Institute of Cancer Research had to pause much of its work during the initial lockdown, and is now running a major fundraising appeal to help kickstart its research and make up for lost time.

The Institute of Cancer Research surveyed 239 of its researchers in order to detail the impact the pandemic has had on its research and to point towards ways of moving research forward again as quickly as possible.

Respondents explained that they had lost an average of 10 weeks of research time to the first lockdown itself, and that their own scientific advances would be pushed back by an average of six months. Almost all explained that COVID-19 had had an impact on their work –

Through the loss of national facilities and introduction of barriers to scientists working together, major advances in cancer research could be delayed by 17 months. Stay sussed on the repercussions of the delay – and the support that could accelerate recovery.

with 36 per cent saying it had had a ‘moderate’ impact, another 36 per cent a ‘substantial’ impact, and five per cent an ‘extreme’ impact.

The respondents were strongly supportive of efforts to keep labs open to prevent any further disruption to research advances for cancer patients. The Institute of Cancer Research’s labs have managed to stay open during the second lockdown period, while taking significant measures to help prevent risk of spread.

The Institute of Cancer Research’s researchers did feel that science had adapted to COVID-19 and that there were various ways to make up for lost time – over 60 per cent felt funding for extra staff time would help; almost 40 per cent wanted upgrades in technology, for example, for robotics; and 29 per cent, increased computing power.

SALLY’S STORY

Mother-of-two Sally Steadman-South, from Sheffield, is living with stage four melanoma. She was first diagnosed in 2014 at the age of 35, after having a mole removed on her chest. Despite trying numerous treatments, including surgery, radiotherapy and immunotherapy, the cancer continued to spread.

For the last two years she has been on the targeted drugs, dabrafenib – a treatment underpinned by The Institute of Cancer Research’s science – and trametinib, and currently has no evidence of disease.

Sally celebrated her 40th birthday with her family – a milestone she never thought she would reach.

Sally shared her concerns about

the impact of COVID-19 on cancer patients, saying, ‘The coronavirus has been especially devastating for many cancer patients – I have been lucky my treatment has been unaffected but we know many have not and their care has been affected. It’s also clear that future research advances have also been delayed.

‘I feel lucky that my treatment has worked well so far but I know that the cancer could become resistant to the drugs at any time. When you get a diagnosis like mine it changes what time means to you – maybe this pandemic has made many more people value and appreciate quality time with family and loved ones. I want to be around for school plays and sports days, see my daughter go to secondary school, and see my son enjoy his time there too, and start planning his own future.

‘We went to pick our Christmas tree and they are planting fields of new trees which will be ready in 2028. We agreed that this would be our new goal. I would be there to see this new field of Christmas trees and we would go as a family to pick one. We need to make up for the time lost to this virus so people like me can live longer and make important memories like these.’

For more information, and to support The Institute of Cancer Research’s kickstart appeal and help its researchers make up for lost time, visit www.ICR.ac.uk/KickstartICR.

SICKLE CELL DISORDER

SPOTLIGHT ON: SICKLE CELL DISORDER

Boost your awareness of sickle cell disorder and how you can help improve the overall quality of life of those affected by it with the Sickle Cell Society's expert insights.

WHAT IS SICKLE CELL DISORDER?

Sickle cell disorders (SCD) are a group of illnesses which affect your red blood cells. Sickle cell is a genetic condition, which means it is passed on from your parents and you are born with it; you can't catch it from other people.

SCD cause your normally round and flexible blood cells to become stiff and sickle-shaped, stopping the blood cells, and the oxygen they carry, from being able to move freely around the body and causing pain. This can cause episodes of severe pain. These painful episodes are referred to as sickle cell crisis. They are treated with strong painkillers, such as morphine, to control the pain.

People with sickle cell are also at risk of complications of stroke, acute chest syndrome, blindness, bone damage and priapism (a persistent, painful erection of the penis).

Over time, people with sickle cell can experience damage to organs, such as the liver, kidney, lungs, heart and spleen. Death can also result from complications of the disorder. Treatment of sickle cell mostly

focuses on preventing and treating complications.

The only possible cure for the disorder is bone marrow transplant but this is only possible for a limited number of affected individuals who have a suitable donor. A medicine called Hydroxyurea can significantly reduce the number of painful crises.

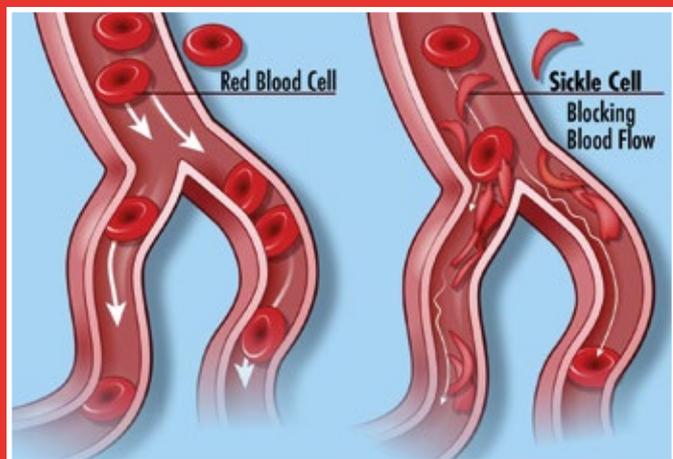
DID YOU KNOW?

- SCD is inherited from both parents; sickle cell trait is inherited from one parent
- SCD can affect anyone, although it predominantly affects people from African and Caribbean backgrounds
- One-in-76 babies born in the UK carry sickle cell trait
- Approximately 15,000 people in the UK have sickle cell disorder
- Approximately 270 babies with SCD are born in the UK every year
- A simple blood test will tell whether you have sickle cell trait or the disorder
- Children with SCD are at increased risk for stroke; the risk is highest

Continued onto next page



SICKLE CELL DISORDER



between the ages of two-and-16

- Episodes of pain may occur in sickle cell disorder and are generally referred to as a crisis
- People living with SCD are in the extremely clinically vulnerable group and have had to shield during the coronavirus (COVID-19) pandemic

THE SICKLE CELL TRAIT

Sickle cell trait is inherited when only one of your parents has passed on the sickle gene, and will never develop into sickle cell disorder. You do not have symptoms from sickle cell trait, so it is a good idea to have a blood test to see if you have sickle cell trait. If you have the trait, the majority of red cells in the blood are normal round-shaped cells. Some sickle-shaped cells may be present under certain conditions.

The trait is not an illness, but if you are planning to have children, then certain factors have to be considered. If your partner does not have sickle cell trait, then any children you have will not have sickle cell disorder, but they could have the trait (50 per cent chance). If you and your partner both have the trait, there is a 25 per cent chance that any child conceived may have sickle cell disorder and 50 per cent chance they will have the trait.

RECENT RESEARCH

The latest research is showing the possibility of two new drugs becoming available in the UK (subject to NICE and NHS England approval). For a long time, many sickle cell patients have had to rely on just one licensed drug (Hydroxycarbamide / Hydroxyurea). Hopefully, in the future, two new options (Crizanlizumab and Voxelotor) will become available. The Sickle Cell Society continue to support further research and innovation in new treatments for sickle cell, such as stem cell transplantation and gene therapy

In Scotland, on 10th July, the Scottish Medicines Consortium (SMC) completed its assessment of Hydroxycarbamide 100mg/mL oral solution (Xromi), and following review by the SMC Executive, advises NHS boards and Area Drug and Therapeutic Committees on its use in NHS Scotland.

Hydroxycarbamide (Xromi) is a licensed, strawberry-flavoured oral liquid formulation for the prevention of vaso-occlusive complications of sickle cell in patients over two years of age. It is expected to be used

in children under the age of nine years who find swallowing tablets difficult.

The Sickle Cell Society worked with Nova Laboratories on their patient-facing materials to ensure that they were clear and easy to understand.

This is great news for the sickle cell community in Scotland and shows the promising trajectory of treatments being made available for people living with sickle cell across the UK.

Hydroxycarbamide (Xromi) is also currently available in England and Wales.

THE IMPORTANCE OF BLOOD DONATION

The society's work on blood donation addresses the underrepresentation of African and Caribbean blood donors through a range of community engagement and online tools focused on raising awareness of sickle cell disorder and increasing regular blood donation in black-heritage communities.

Blood donation, and ensuring that there is a sufficient amount of ethnically-matched blood available, is essential for the treatment of people with severe sickle cell disorder.

Receiving regular blood transfusions can help prevent sickle cell crisis and are used to treat anaemia and other severe symptoms associated with the condition. Black donors are 10 times more likely to have the Ro and B positive blood types most commonly present in those with sickle cell disorder. Closely matched blood is needed as it is less likely to be rejected by people having frequent blood transfusions.

ABOUT THE SICKLE CELL SOCIETY

The Sickle Cell Society are the only national charity in the UK that support and represent people affected by a sickle cell disorder to improve their overall quality of life. First set up as a registered charity in 1979, the Sickle Cell Society have been working alongside healthcare professionals, parents, and people living with sickle cell to raise awareness of the disorder. The society's aim is to support those living with sickle cell, empowering them to achieve their full potential.

For their work, the society were independently assessed and awarded the 2018 GSK IMPACT Award – a national award that recognises charities that are doing excellent work to improve people's health and wellbeing.

The Sickle Cell Society work in a number of areas:

- Providing a national support and information helpline
- Working in parliament on policy as secretariat of the Sickle Cell and Thalassaemia All-Party Parliamentary Group
- Providing support, education, and activities through events, projects and an annual children's holiday (many of these are now delivered virtually)
- Working with Public Health England on delivering a world-leading screening programme
- Raising awareness of sickle cell and the need for more blood donors

For more information, and to make a donation to support the work of the Sickle Cell Society, visit www.sicklecellsociety.org or follow the team on social media @SickleCellUK on Facebook, Instagram, Twitter and LinkedIn.



Take control of sickle cell disease

Xromi® Hydroxycarbamide 100 mg/ml oral solution is indicated for the prevention of vaso-occlusive complications of sickle cell disease in patients over 2 years of age¹

Hydroxycarbamide should be considered in all children over the age of 2 years with sickle cell anaemia to reduce the complications of the disease²

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Abbreviated Prescribing Information: Xromi® (Hydroxycarbamide) 100mg/ml oral solution

Please refer to the Summary of Product Characteristics (SmPC) before prescribing.

Presentation: Oral solution, each 1 ml contains 100 mg hydroxycarbamide and 0.5mg methyl hydroxybenzoate.

Indications: For the prevention of vaso-occlusive complications of Sickle Cell Disease in patients over 2 years of age.

Dosage and Administration: The usual starting dose of hydroxycarbamide is 15 mg/kg/day and usual maintenance dose is between 20-25 mg/kg/day. The maximum dose is 35 mg/kg/day. Full blood cell count with white cell differential and reticulocyte count should be monitored every 2 weeks for the first 2 months following treatment initiation. Once a maximum tolerated dose is established, laboratory safety monitoring should include full blood cell count with white cell differential, reticulocyte count, and platelet count every 2-3 months. Elderly may be more sensitive to the myelosuppressive effects, consider reducing dose. Renal impairment If creatinine clearance (CrCl) < 60 ml/min reduce the initial dose by 50%. Close monitoring of blood parameters is advised. Must not be administered to patients with severe renal impairment (CrCl < 30ml/min). Hepatic impairment No data to support specific dose adjustments in hepatic impairment. Close monitoring of blood parameters is advised. Xromi is contraindicated in patients with severe hepatic impairment. Children Not recommended in children below the age of 2 years. Administration May be taken with or after meals at any time of the day but patients should standardise the method of administration and time of day.

Contraindications: Hypersensitivity to the active substance or to any of the excipients; Patients with severe hepatic impairment (Child-Pugh classification C), severe renal impairment (CrCl < 30 ml/min), myelosuppression, breast-feeding, pregnancy, concomitant anti-retroviral medicinal products for HIV disease.

Warnings and Precautions: Bone Marrow Suppression The complete status of the blood, including bone marrow examination, if indicated, as well as kidney function and liver function should be determined prior to, and repeatedly during, treatment. If bone marrow function is depressed, treatment with hydroxycarbamide should not be initiated. The full blood cell count with white cell differential, reticulocyte count, and platelet count should be monitored regularly. Hydroxycarbamide may produce bone marrow suppression; leukopenia is generally its first and most common manifestation. Thrombocytopenia and anaemia occur less often and are seldom seen without a preceding leukopenia. Bone marrow depression is more likely in patients who have previously received radiotherapy or cytotoxic cancer chemotherapeutic medicinal products; hydroxycarbamide should be used cautiously in such patients. The recovery from myelosuppression is rapid when hydroxycarbamide therapy is interrupted. Hydroxycarbamide therapy can then be re-initiated at a lower dose. Severe anaemia must be corrected with whole blood replacement before initiating therapy with hydroxycarbamide. If, during treatment, anaemia occurs, correct without interrupting hydroxycarbamide therapy. Erythrocytic abnormalities: megaloblastic erythropoiesis, which is self-

limiting, is often seen early in the course of hydroxycarbamide therapy. The morphologic change resembles pernicious anaemia, but is not related to vitamin B12 or folic acid deficiency. The macrocytosis may mask the incidental development of folic acid deficiency; regular determinations of serum folic acid are recommended. Hydroxycarbamide may also delay plasma iron clearance and reduce the rate of iron utilisation by erythrocytes but it does not appear to alter the red blood cell survival time. HIV patients Hydroxycarbamide must not be used in combination with anti-retroviral medicinal products for HIV disease and it may cause treatment failure and toxicities (in some cases fatal) in HIV patients.

Secondary leukaemia and skin cancer In patients receiving long-term therapy with hydroxycarbamide for myeloproliferative disorders, such as polycythemia, secondary leukaemia has been reported. It is unknown whether this leukaemogenic effect is secondary to hydroxycarbamide or associated with the patient's underlying disease. Skin cancer has been reported in patients receiving long-term hydroxycarbamide. Patients should be advised to protect skin from sun exposure. In addition patients should conduct self-inspection of the skin during the treatment and after discontinuation of the therapy with hydroxycarbamide and be screened for secondary malignancies during routine follow-up visits. Cutaneous vasculitic toxicities Cutaneous vasculitic toxicities including vasculitic ulcerations and gangrene have occurred in patients with myeloproliferative disorders during therapy with hydroxycarbamide. Due to potentially severe clinical outcomes, hydroxycarbamide should be discontinued if cutaneous vasculitic ulcerations develop. Vaccines The use of live vaccines should be avoided during treatment and for at least six months after treatment has finished and individual specialist advice sought. Leg Ulcers In patients with leg ulcers, hydroxycarbamide should be used with caution. Leg ulcers are a common complication of Sickle Cell Disease, but have also been reported in patients treated with hydroxycarbamide. Carcinogenicity Hydroxycarbamide is unequivocally genotoxic in a wide range of test systems. Hydroxycarbamide is presumed to be a transspecies carcinogen.

Safe Handling Parents and care givers should avoid hydroxycarbamide contact with skin or mucous membranes. If the solution comes into contact with skin or mucosa, it should be washed immediately and thoroughly with soap and water. Excipients Contains methyl parahydroxybenzoate (E218) which may cause allergic reactions (possibly delayed).

Interactions: The myelosuppressive activity may be potentiated by previous or concomitant radiotherapy or cytotoxic therapy. Patients must not be treated with hydroxycarbamide and anti-retroviral medicinal products concurrently, because of the risk of fatal and non-fatal pancreatitis, hepatotoxicity, fatal hepatic failure and peripheral neuropathy. There is an increased risk of severe or fatal infections with the concomitant use of live vaccines. Treatment with hydroxycarbamide and concomitant immunisation with live virus vaccines should only be performed if benefits clearly outweigh potential risks.

Pregnancy and Lactation: Not to be used during pregnancy. Both men and women of child bearing potential should use highly effective contraceptive measures both during the treatment and 3-6 months after stopping treatment. Discontinue breast feeding during treatment.

Side Effects: Very common Bone marrow depression including neutropenia, reticulocytopenia, macrocytosis, oligospermia, azoospermia. Common Thrombocytopenia, anaemia, headache, dizziness, nausea, constipation, skin ulcer, oral, nail and skin hyperpigmentation, dry skin, alopecia.

Uncommon stomatitis, diarrhoea, vomiting, elevated liver enzymes, hepatotoxicity, rash.

Unknown Parvovirus B19 infection, leukaemia, skin cancers (in elderly patients), weight gain, vitamin D deficiency, bleeding gastrointestinal disturbances, gastrointestinal ulcer, severe hypomagnesaemia, amenorrhoea, fever **Rare** Leg Ulcers **Very Rare** Systemic and cutaneous lupus erythematosus

Overdose: Immediate treatment consists of gastric lavage, followed by supportive therapy for the cardiorespiratory systems if required. Monitor for vital signs, blood and urine chemistry, renal and hepatic function and full blood counts for at least 3 weeks. Longer periods of monitoring may be required. If necessary, blood should be transfused.

Pack size: 1 glass bottle containing 150 ml Xromi (Hydroxycarbamide) 100mg/ml oral solution

Shelf life/Storage: 2 years. After first opening: 12 weeks. Store in a refrigerator (2°C - 8°C).

Legal Category: POM

Marketing Authorisation Number: EU/1/19/1356/001

Marketing Authorisation Holder: Nova Laboratories Ireland Limited, 3rd Floor, Ulysses House, Foley Street, Dublin 1, S01 W2T2, Ireland

Date of latest revision of brief prescribing information: 19th September 2019

Job number: XroABVPI001

NHS Price: £250.00

Further information including full prescribing information is available from: Nova Laboratories Limited, Martin House, Gloucester Crescent, Wigston, Leicester, LE18 4YL, UK. Tel: +44 (0)116 223 0100

Adverse events should be reported.
Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.
Adverse events should also be reported to Nova Laboratories Ltd, Martin House, Gloucester Crescent, Wigston, Leicester LE18 4YL

References: 1. Nova Laboratories Ltd, Xromi Hydroxycarbamide 100 mg/ml oral solution, Summary of Product Characteristics, 2019. 2. Qureshi A, Kivik B, Parham S, Kevan R, Anderson L, Adams M, Howard L (2018). Guidelines for the use of hydroxycarbamide in children and adults with sickle cell disease. Br J Haematol. 191: 450-475. Accessed 22/08/19 via: 10.1111/bjh.15289 3. Borchetta H, & Vianini L.F. Formulations for children problems and solutions, Special Issue Paediatric Prescribing, 2019. 79:3-109-110. A. Foster A, Vannoy C, Corra G, Bayse M, Gonzalez F, Dewald C, Forou P, Toppet M, Sanjan E. Hydroxycarbamide for treatment of severe sickle cell anemia: a pediatric clinical trial. Blood. 1996; Sep 15;88(6):1960-4. Accessed 22/08/19 via: <http://www.bloodjournal.org/content/88/6/1960.full.pdf>

For further information please contact: Nova Laboratories Ltd, Martin House, Gloucester Crescent, Wigston, Leicester, LE18 4YL T: +44 (0) 800 975 4840 F: +44 (0) 116 223 0101 E: sales@novalabs.co.uk

Date of Preparation: October 2019

Job Number: XroA4Advert001

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SUBSTANCE DEPENDENCY

ON DANGEROUS GROUND

Lockdown has created a pressure cooker for many people at risk of addiction. As a result, Dr Youssef Beaini, GP, GPwER Substance Misuse and Chief Executive at the BONDS™ Clinic, highlights what to look out for in your patients and how to subsequently deliver effective help.

COVID-19 has brought the greatest public health catastrophe of our times and caused a huge spike in pathological stress levels, with the number of adults experiencing depression doubling.ⁱ In primary care, many of us have already seen a large increase in consultations for mental illness.

Any form of prolonged stress can trigger addiction or substance dependency in high-risk people, but it can also trigger a spike in the general population who would not normally be at risk. Some people will 'self-medicate' with alcohol or drugs to try to cope with stress. Those already addicted to drugs or alcohol may struggle to get their usual supplies during lockdown, due to social distancing and disruption to medical supplies. Some people will be spending much more time at home with family or loved ones who may suddenly see indicators of addiction.

COVID-19 lockdowns have increased the risk of existing alcohol dependency worsening. For those who were previously abstinent, COVID-19 has been a risk factor for relapse, with a high risk of harmful misuse.ⁱⁱ Similar risks for other drug dependency would be expected, such as opioids and cocaine.

All of these factors have combined together to create a potential crisis in addiction.

HOW DO I SPOT THE SIGNS AND SYMPTOMS OF ADDICTION?

Each person's experience of addiction will be slightly different, but there are common signs and symptoms that may present directly to health professionals:

- Changes in mood, such as being depressed, anxious or elated
- Being tired all the time, or hyperactivity or physical agitation
- Changes in weight
- Changes in sleep, such as insomnia or hypersomnia
- Looking unwell at certain times but rapidly looking better soon after, in a repeating cycle
- Pupil size can be larger or smaller than expected
- Unexpected persistent cough without having an URTI or LRTI

Be cautious though – symptoms and signs can be due to other causes. Triangulation is key, as with a lot of medicine: it is much more useful to look for groupings of these signs and symptoms, rather than just one or two in isolation.

WHAT DO I DO IF I SUSPECT A PATIENT HAS AN ADDICTION ISSUE?

1. Apart from signposting or referring a patient to your local drugs or alcohol services, you can signpost patients and their loved ones to good national resources:

- www.nhs.uk/live-well/healthy-body/drug-addiction-getting-help
- www.talktofrank.com
- www.adfam.org.uk/help-for-families/useful-organisations

2. It is crucial to assess for any co-existing mental health disorders. Untreated depression or anxiety will massively increase the risk of relapse since patients often self-medicate as a maladaptive coping strategy. Our clinic's real-world audit data shows that around 70 per cent of substance dependency patients have a co-existing mental health disorder, or 'Dual Diagnosis'.ⁱⁱⁱ If depression or anxiety is present, consider treating while the patient seeks treatment for the dependency

3. Consider the risk of hepatitis or HIV and test if needed

4. Consider any safeguarding issues – are there any children at home?

SUBSTANCE DEPENDENCY



TREATMENT OPTIONS

The main goal of addiction treatment is to reduce harm to the person and to those around them, as well as to society in general.

For alcohol and non-opioid drugs, the two main approaches are abstinence or harm reduction if the person is not willing to consider abstinence.

For opioid addiction, there are two main options:

- Substitution therapy (methadone or buprenorphine)
- Abstinence

SUBSTITUTION THERAPY

There is a large body of evidence to support replacing the opioid with an alternative prescribed opioid that is less harmful. These don't give the same highs as other illicit opioids, such as heroin or fentanyl, and stay in the blood stream for longer.

Choosing this route can help to reduce the use of illicit opioids and allow the person a chance to work on psychological and medical treatment for their addiction, as well as trying to improve their social health through rebuilding family life or getting back to work.

The majority of UK services provide substitution therapy for opioids. Substitution therapy can aim

for abstinence in the longer-term or for 'maintenance' therapy where the substitute is continued long-term to reduce harm. The main risk of substitution therapy is that a person stays on it long-term or just misuses it to supplement their addiction.

ABSTINENCE

The abstinence option means that a person will undergo a 'detoxification' from the opioid and then embark on a programme to help them stay off the drug. Some people are highly motivated towards abstinence rather than longer-term substitution, and with the help and support of a professional team this is another valid option in NICE guidance.^{iv} Any option needs to be chosen using a shared decision-making process between the specialists, the individual, and their loved ones / family.

Any person wishing to become abstinent from opioids in particular must be made aware of the risks if they go back to using drugs. Once abstinent from opioids, a patient's body will gradually become more sensitive to them again and if they were to take a previously-used dose of opioids, there is a risk of overdose in the opioid-naïve state. Therefore, it is particularly important for abstinence-oriented treatment to include education on the risks of overdose if a person relapses

and the body's sensitivity to opioids after a detox.

At The BONDS™ Clinic, we operate an abstinence and supported recovery programme which helps individuals get back to life by using a Bio-Psycho-Social model to address the biological / medical, psychological and social features.

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PROMOTION

BUILDING A BRIGHTER FUTURE

From prioritising their members' best interests, and ensuring that they retain their decision-making power, to harnessing the profession's overall potential, Edinpharm is a crucial asset for independent pharmacies. To find out more, SPR chats to Mike Embry, Director at Right Medicine Pharmacy, and Jim Gallagher, Director, Gallagher Healthcare Limited, about their experiences with the non-profit buying group, and how Edinpharm's Order Management System is simplifying how they navigate their burgeoning workloads.



Edinpharm's Order Management System is designed to provide pharmacies with a method of ordering that removes the need for them to check availability and pricing for every order which they place. The pharmacy places one order to the Order Management System, and each line item on the order is then sent to the best priced supplier. If items are out-of-stock with that supplier, the system will cascade that item to the next best-priced supplier. All of this happens automatically, and the pharmacy will receive an order acknowledgement email with details of where everything is coming from.

This means that customers can be assured that they are always receiving the stock when they need it, at the best price, without having to manually check items with each supplier.

CAN YOU TELL SPR ABOUT THE BACKGROUND OF YOUR EDINPHARM MEMBERSHIP AND HOW IT CAME TO BE?

Mike: We joined Edinpharm, by invitation, in about 2005. Prior to that we just tried to order as much as possible from a shortliner and everything else went to a mainline wholesaler. Our order process was inefficient, time-consuming, and only moderately effective at obtaining the best prices. Joining Edinpharm allowed us to more consistently receive better pricing and reduced the effort required in doing so.

Since those early days, Edinpharm's approach has continued to evolve and improve, and I believe it continues to offer us, and other pharmacies, just about the best pricing mix available in the market place. Because of the order management software, this is with virtually no effort at the pharmacy level. Our pharmacy teams can concentrate on providing the best possible service to patients and only need to send one order which is then cascaded virtually through the various Edinpharm suppliers to ensure great prices and availability.

The Edinpharm team are always keen to hear from members, and either advise about how we can get the most out of our membership, or listen and adapt what they offer to ensure it is of maximum benefit to members.

Jim: Having previously been a member of another buying group, we joined Edinpharm some 10 years or so ago as we felt that

Edinpharm was more focused on supporting its members and more in tune with the changes associated with an evolving landscape within pharmacy, both as a healthcare service provider and as a business.

WHAT ROLE HAS THE ORDER MANAGEMENT SYSTEM PLAYED IN HELPING YOU MANAGE THE BURGEONING TIME AND RESOURCE DEMAND IN PHARMACY?

Mike: As mentioned, it has been instrumental in reducing the time taken to price check suppliers, send orders, and deal with out-of-stocks. Because of the virtual nature of the cascade, it's made extremely simple – we only send one order which is then cascaded through the various supplier partners.

Jim: The Edinpharm Order Management System has been helpful in allowing greater cost control within our buying function, while releasing staff and management time within each pharmacy to deliver services and advice to patients. We are able to tailor our use of the system to suit the particular needs and buying parameters of our business, allowing us an appropriate level of control of a critically important aspect of our business.

WHAT FEATURES OF THE ORDER MANAGEMENT SYSTEM HAVE BEEN ESPECIALLY INVALUABLE DURING THE COVID-19 CRISIS?

Mike: The fact that it reduces the time taken to send orders, and automatically cascades items from one supplier to the next if an item is out-of-stock i.e., the system does the hard work for you.

Jim: During the period of the COVID-19 pandemic we have been able to rely on the Order Management System for each of our pharmacies to order goods while receiving almost instant feedback of any items / lines not available which allows us to manage supply timelines or source elsewhere. Confidence in the system has also meant that additional demands on our pharmacy teams were kept to a minimum to allow them to continue to focus on the needs of our patients.

WHAT HAVE BEEN THE SUBSEQUENT BENEFITS FOR PATIENTS?

Mike: It has freed up our time from price-checking various suppliers, needing to send various orders, and managing out-of-stocks, so that we can spend more time with patients.

The other advantage of Edinpharm is being part of a buying group with lots of like-minded pharmacy contractors. We are always there to support each other with queries, which was fantastic during COVID as pharmacists and their teams had to quickly adapt to new ways of working and deal with things that we hadn't done before. That support network was fantastic.

Jim: In addition to the comments above in relation to the freeing up of staff and management time to respond to the needs of our patients, the system makes a significant contribution to the continuity of supply of goods as a result of the cascade function where if an item is out-of-stock from the primary supplier the system can allow the order to pass to an alternative supplier to avoid any delays in the supply chain.

For more information, visit www.edinpharm.co.uk.



edinpharm

supporting independent pharmacies

“ The buying power of a multiple, whilst retaining your independence. ”

The Edinpharm Team would like to **THANK OUR MEMBERS** and their teams, plus our committed suppliers, for stepping up in these unprecedented times. We salute you!

Our members have stayed open throughout and gone to huge lengths to source and deliver vital medication. They have kept their teams safe and protected, and all the way through this crisis, continued to support other members in the Edinpharm group both mentally and physically.

We are not just a buying group WE ARE A FAMILY!

Who are Edinpharm?

Edinpharm offer independent pharmacy and groups the following and more:

- One click ordering to 5 suppliers
- Independent ordering cascade system
- Great pricing across a whole basket
- Exceptional value membership

Most of all...

we are a not for profit buying group, with no shareholders to answer to. We invest for the best interests of our members.

Here's what a selection of our members have to say about being part of Edinpharm...

“ Over and above the competitive pricing, one of the greatest benefits I've experienced since joining Edinpharm is access to the pool of knowledge and experience of other members - There's a real sense of community - independent contractors willing to help and share advice. As an example I recently had issues with a fridge, within half an hour four members had been in touch to advise how they had managed similar situations. ”

- Neil, Connel Pharmacy, Oban

“ I really appreciate all the work you guys at Edinpharm are doing to help us through this current situation, it makes such a difference to know we have your support. ”

- Raz, Carmunock Pharmacy

Want to discuss our membership further? Get in touch...

info@edinpharm.co.uk | www.edinpharm.co.uk | 0131 441 3773

COW'S MILK ALLERGY

TAKING CARE

Claire Dobbs, a Community Pharmacist, shares with SPR her experience assisting and supporting patients with cow's milk allergy and the crucial role played by the profession during this turbulent time.

HOW PREVALENT IS COW'S MILK ALLERGY (CMA) WITHIN YOUR PATIENT COMMUNITY?

CMA has become increasingly prevalent in the local community. It is one of the most common food allergies, even more so than peanut allergy, in infants. Most children grow out of it by around five years of age but it can be a very challenging condition to both diagnose and manage for both the infant and parents.

IS IT DIFFICULT TO RECOGNISE THE SIGNS OF CMA WITHIN YOUR PATIENT COMMUNITY?

CMA can be delayed (Non-IgE-mediated) or acute (IgE-mediated). The most common is a delayed onset of symptoms, occurring within a few hours up to a few days after having food containing cow's milk. An acute allergy can see symptoms develop immediately after having cow's milk.

The immediate allergy is easier to diagnose, with symptoms such as itchy skin rashes, hives, swelling of the eyes and lips. Allergy testing can be undertaken to confirm the diagnosis.

Delayed CMA can prove more challenging to diagnose as the clinical manifestations are variable in type and severity and there are no skin or blood tests

for delayed onset CMA.

Symptoms typically include vomiting, loose stools, abdominal pain, food refusal / aversion, blood or mucus in the stools or constipation. Eczema and sometimes airway / nasal symptoms are also present.

In a community pharmacy setting it can be difficult to diagnose CMA as the symptoms experienced are common presentations that may not usually be attributed to this condition.

WHAT DIFFICULTIES HAVE YOU FACED WHEN TREATING INFANTS WITH CMA, BOTH IN TERMS OF PATIENT CARE AND ALSO LOGISTICALLY WITH ORDERS ETC?

In the pharmacy setting the difficulties faced are ensuring the most suitable prescribed infant formula is obtained in a timely manner for the patient. An appropriate hypoallergenic formula will be prescribed for the child by their GP or paediatric dietitian but often this involves trial and error to find the most suitable preparation for the child. Parents can find it frustrating when a newly-prescribed infant formula does not appear to ease the symptoms.

As a community pharmacist it is important to reassure parents that there are several alternative milk substitutes available on the market. We can advise other healthcare professionals as to what products are available and indeed what formulas are in stock with the wholesalers at the time.

Some specialist infant formulas are only stocked by one specific wholesaler so it is essential we have access to these products for a same day / next day delivery for the patient.

DO YOU BELIEVE THERE IS CURRENTLY ENOUGH TRAINING AND INFORMATION AVAILABLE FOR COMMUNITY PHARMACISTS SURROUNDING CMA?

Most community pharmacists will encounter children with CMA in the pharmacy setting. While it may not be a condition that some pharmacists are confident in dealing with there are resources available to help pharmacists expand their knowledge

on the subject. The specialist infant formula companies offer training packs for community pharmacists.

HAS THE COVID-19 PANDEMIC IMPACTED ON THE CARE OF THESE PATIENTS AND, IF SO, HOW WERE YOU ABLE TO OVERCOME THESE CHALLENGES?

Community pharmacies have shown resilience during this pandemic and have managed to overcome many obstacles.

Patients have greatly relied on the advice of community pharmacists for conditions such as CMA during the pandemic as we have remained accessible and continued to provide the majority of our services as normal. Parents concerned about their infant's feeding, on occasions, have resorted to telephone consultations with a pharmacist during lockdown.

Ensuring the pharmacy has adequate stock of specific specialised infant formula is essential to ensure a safe, efficient service. Also, the collection of prescriptions by pharmacy delivery drivers from GP surgeries has meant that patients still receive their medication within an appropriate time frame without having to go to the GP surgery.

WHAT ADVICE WOULD YOU GIVE THE PARENTS OF A NEWLY-DIAGNOSED INFANT?

I would assure parents that there are no associated long-term complications with CMA and that most children with delayed onset CMA will be milk tolerant by three years of age and for acute CMA by five years of age.

If a specialised infant formula does not ease symptoms there are alternatives that the dietitian or GP can prescribe.

When reintroducing cow's milk this should be done using the milk ladder but it is advisable to do this under the supervision of a healthcare professional. And, as always, community pharmacists are available and accessible to offer advice and support.

NEW
FOR COW'S
MILK ALLERGY

Similac

For healthcare professionals only

Help them face life's adventures

EleCare® is designed to help support the **immune needs** of formula-fed infants with severe cow's milk allergy and/or multiple food allergies.

EleCare is the first amino acid-based formula to contain 2'-FL**†, a major component of most mothers' breast milk:‡



Helps support the **immune system** in the gut and beyond¹⁻³

Contains 2'-FL* which has proven benefits on the gut and systemic immune responses[†]



Supports healthy growth and symptom resolution^{5,4-7}



Trusted by mums and healthcare professionals^{8,9}



Contact your local Abbott Account Manager to learn more or call Freephone Nutrition Helpline on 0800 252 882

IMPORTANT NOTICE: Breastfeeding is best for infants and is recommended for as long as possible during infancy. EleCare is a food for special medical purposes and should only be used under the recommendation or guidance of a healthcare professional.

*The 2'-FL (2'-fucosyllactose) used in this formula is biosynthesised and structurally identical to the human milk oligosaccharide (HMO) 2'-FL, found in most mothers' breast milk.[†]

†MIMS, September 2020.

‡Studies conducted in healthy-term infants consuming standard Similac formula with 2'-FL (not EleCare), compared to control formula without 2'-FL.

§Studies conducted in infants fed standard EleCare formula without 2'-FL.

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UK-2000065 September 2020


Abbott

PARKINSON'S

PARKINSON'S: A NEW PATH

Colin Cheesman was diagnosed with Parkinson's disease in 2001 and actively uses his experiences with the condition to help inform and shape the provision of services and support for people with Parkinson's. Colin has been keeping a record about living with Parkinson's. In this article he describes recent changes to his medication regime.



Colin Cheesman

Parkinson's disease can affect people in a host of different ways. I was diagnosed with Parkinson's in 2001, when I learned that the condition was both progressive and incurable, both of which remain true today. Some of the symptoms are obvious – such as tremor, difficulty in walking, problems with balance, and involuntary movements. In the last 20 years it has been recognised that the condition is also linked with a range of non-motor symptoms affecting mood and behaviour. These symptoms are not necessarily visible but are just as real.

Although we do not have a cure, we now know so much more about the condition. Doctors now have a wide range of treatments, which can be targeted at individual needs. However, Parkinson's is progressive which means that these treatments can lose their effectiveness over time, making it increasingly difficult to cope.

REVIEWING MY OPTIONS

Since my diagnosis, I have been extremely fortunate in having had excellent support and guidance, particularly in relation to the management of medication, and the progression of Parkinson's has been very gradual. However, in the last few months it became clear that my symptoms were becoming more severe and I was getting less relief from my usual medication. The drugs were no longer keeping me stable throughout the day. It was clearly time to review my options! Together with my very supportive neurologist and my wife (a major stakeholder in the outcomes), we discussed all the possibilities, which ranged from

increasing my current medication on the one hand, to brain surgery on the other. The result of this discussion was that I should increase my medication, but delivered through an apomorphine pump. I had always resisted having the encumbrance of an external device attached to the skin – but something had to be done!

HOW IT WORKS

The pump itself is a clever little device, capable of giving a constant infusion of the drug from morning until night. I carry it in a small pouch attached to my waistband. The drug is delivered through a very fine tube to a connection point in the skin. A new point on the skin is chosen each morning and the connection is made by placing a small spring-loaded device on the skin. A single click on the device leaves a ring of sticking plaster, about the size of a 50p piece with a small plastic connector mounted in the middle of it.

Once I had made the decision to go ahead, things moved very quickly. The specialist nurse team visited me at home and ran through the whole process until they were satisfied that we understood how to get the pump up and running. Their readiness and availability gave us enormous reassurance, and getting set up was all pretty straightforward.

When I first explored the idea of using this pump, it all felt a bit complicated. What would it really be like being hooked up 24/7? Would it involve a lot of time to set up and run? What if I wanted to swim, cycle or kick a football with my grandchildren? I need not have worried. At any time during the day, I can stop the pump and detach it from the body. The line is easily removed from the infusion point and replaced with a dummy cap. I can then do my activity and all that can be seen is something the size of a coat button stuck on the skin.

PROMISING RESULTS

It's early days, but I'm convinced that it's having a positive effect on me already. I can still sense the underlying symptom pattern of the day, but the pump has smoothed out the peaks and troughs so that overall my stability is much improved. Setting up for the day obviously takes a few minutes, but once I'm up and running I can pretty much forget about it.

Parkinson's disease has a bespoke impact on each person who has it. Thankfully, we now have a wide spectrum of treatments to tackle it, which can be different for every individual. I know I will have to review the situation again, but until then I am grateful to have the support and treatment that I need.

RISKY BEHAVIOUR

For people with lung conditions, the backlog of basic care could lead to an ‘avalanche’ of unscheduled admissions. How can the sector stay on top of this heightened pressure?

Every year annual winter pressures on the NHS are driven by a spike in respiratory hospital admissions. Plummeting temperatures, colds, flu – and now COVID-19 – can all cause symptoms to flare up and trigger potentially life-threatening exacerbations.

The government are calling on everyone to protect the NHS by taking steps to look after themselves, but Asthma UK and the British Lung Foundation have said that this can't happen if people with chronic lung diseases aren't receiving basic care, including monitoring, treatment and interventions, to keep themselves well and out of hospital.

While some people with lung conditions have been able to access basic care throughout this turbulent time, it has not been consistent. The pandemic has had a huge impact on people with lung disease, with many having experienced appointments being cancelled, annual reviews postponed, and face-to-face care suspended.

Asthma UK and the British Lung Foundation estimate that up to 1.8 million people with lung conditions could have missed out on annual reviews during lockdown, essential for helping people stay on top of symptoms and ensuring that they are on the correct medication.

GP practices have had to implement vast changes to the way in which they deliver care in order to protect staff and patients across the healthcare system from coronavirus. Challenges they have had to overcome include the shift to remote care at the height of the lockdown, the build-up of people waiting for specialist care referrals, and addressing the backlog of basic care which patients have missed due to COVID-19.

SEEKING RELIEF

Results of a survey conducted by Asthma UK revealed that over half (58 per cent) of respondents said that their asthma self-management was deteriorating and that they are using their reliever inhaler three or more times a week.

ASTHMA

CORONAVIRUS:
Recognise the symptoms

Symptoms	Common/Uncommon Symptoms range from mild to severe	asthma	non-asthma	Covid-19 Usual onset of symptoms	Flu Rapid onset of symptoms
Fever (FHR)	Common	No	No	Rare	Common
Cough	Common (usually dry and persistent)	Sometimes (usually dry and cough)	Sometimes (usually dry)	Mild	Common (usually dry)
Shortness of breath	Sometimes	Sometimes	No	No	No
Headache	Sometimes	No	Sometimes	Rare	Common
Sore throat	Sometimes	No	Very/ Usual	Common	Sometimes
Runny / stuffy nose	Rare	No	Common	Common	Sometimes
Diarrhoea	No	No	Common	Common	No
Aches and pains	Sometimes	No	No	Common	Common
Fatigue	Sometimes	No	Sometimes	Sometimes	Common
Shortness	Rare	No	No	No	Sometimes (in children)
Loss of taste and smell	Common	No	Common	Common	No

asthma.org.uk/coronavirus

Coronavirus symptoms checker

Source: www.asthma.org.uk/advice/triggers/pollen/

Utilising a reliever inhaler three times a week or more is a red flag that a person's symptoms are getting worse and they are at an increased risk of an asthma attack. Every day in the UK, an average of three people die from an asthma attack.

Asthma UK are now issuing an urgent call to anyone who is using their reliever inhaler three times a week or more to book an appointment with their GP as soon as they can, which might be offered over telephone or video call.

Sarah Green from Birmingham knows only too well how important it is to seek help if your asthma is getting worse. Her daughter Holly was using her reliever inhaler every day before she died from an asthma attack in 2016 at just 28-years-old.

Sarah said, 'When I look back on the months leading up to Holly's death, all the signs were there that she was really struggling with her asthma. I'd become used to seeing her puff on her blue inhaler every day and she was going through them really quickly. She had an asthma attack suddenly one evening and she was gone forever.'

'Holly was a busy mum of two young boys and was more focused on looking after them than taking care of her own health. I'd say to anyone with asthma, please do everything you can to look after yourself. I didn't realise how serious asthma could be until it took Holly away from me and left her twin boys without their mother.'

THE IMPORTANCE OF PLANNING AHEAD

Basic care relating to respiratory disease gets people in the best shape to prevent ending up in hospital. Asthma UK and the British Lung Foundation are now calling for an increase in support for primary care professionals, including pharmacists, GPs and nurses, in delivering the basic care respiratory patients need, to prevent an avalanche of unscheduled care and respiratory hospital admissions which could threaten to overwhelm the NHS.

Asthma UK and the British Lung Foundation have carved out a roadmap in an effort to restore and improve basic care – calling for changes in order to:

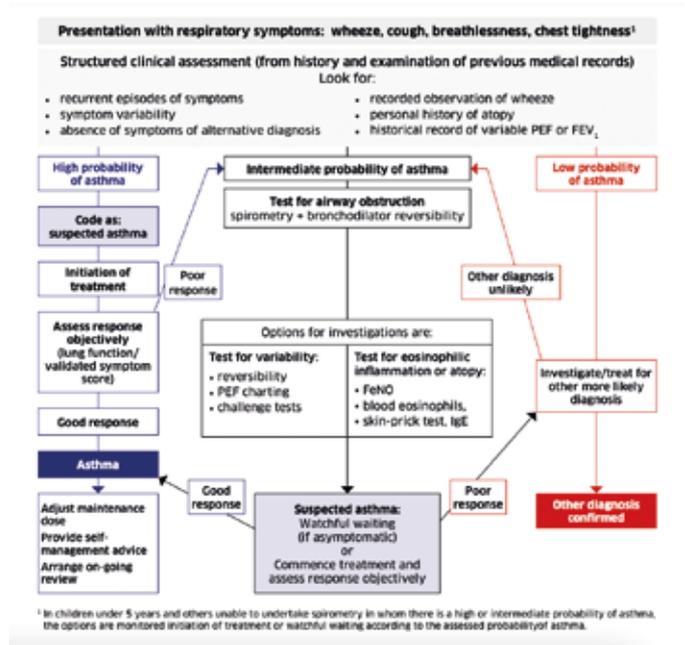
- Ensure that all GP practices have the digital tools they need to support video and telephone consultations, as well as face-to-face consultations
- Clearly communicate that patients can choose how they are seen based on their preferences and clinical need
- Outline how primary care can identify, diagnose and treat people with new symptoms of respiratory illness and also address the current backlog of diagnostic tests

- Support primary care professionals to address the backlog of annual reviews for respiratory conditions by prioritising those most at risk

Margaret Dempsey is 76 from Leicestershire and has asthma and bronchiectasis, along with other serious chronic health issues, including diabetes and a heart condition.

She explained, 'I've tried to get a face-to-face appointment at my GP practice recently, but they can only offer one over the phone. I want to be seen by a GP because I have multiple health issues and feel without being seen things might get missed.'

'This system isn't working for me and, if anything, is making my health worse. Over the last couple of months my lungs have really been playing up and I'm wheezing, coughing and bringing up mucus everyday which is a real struggle. I already feel incredibly isolated and my experiences so far have completely put me off contacting the doctor for more support. It feels like there's no point in trying.'



Presentation with respiratory symptoms

Source: <https://www.sign.ac.uk/media/1773/sign158-updated.pdf>

DON'T DELAY

Dr Andy Whittamore, a practising GP and Clinical Lead for Asthma UK and the British Lung Foundation, said, 'Prevention will play a crucial role in helping practices across the country manage seasonal pressures and support patients with lung conditions, including asthma and COPD, avoid urgent care. Annual reviews, a mainstay of lung disease basic care, need to resume to pre-COVID levels.'

'We want to remind and reassure anyone with a lung condition struggling with symptoms to seek help from their GP, delaying care could put your life at risk.'

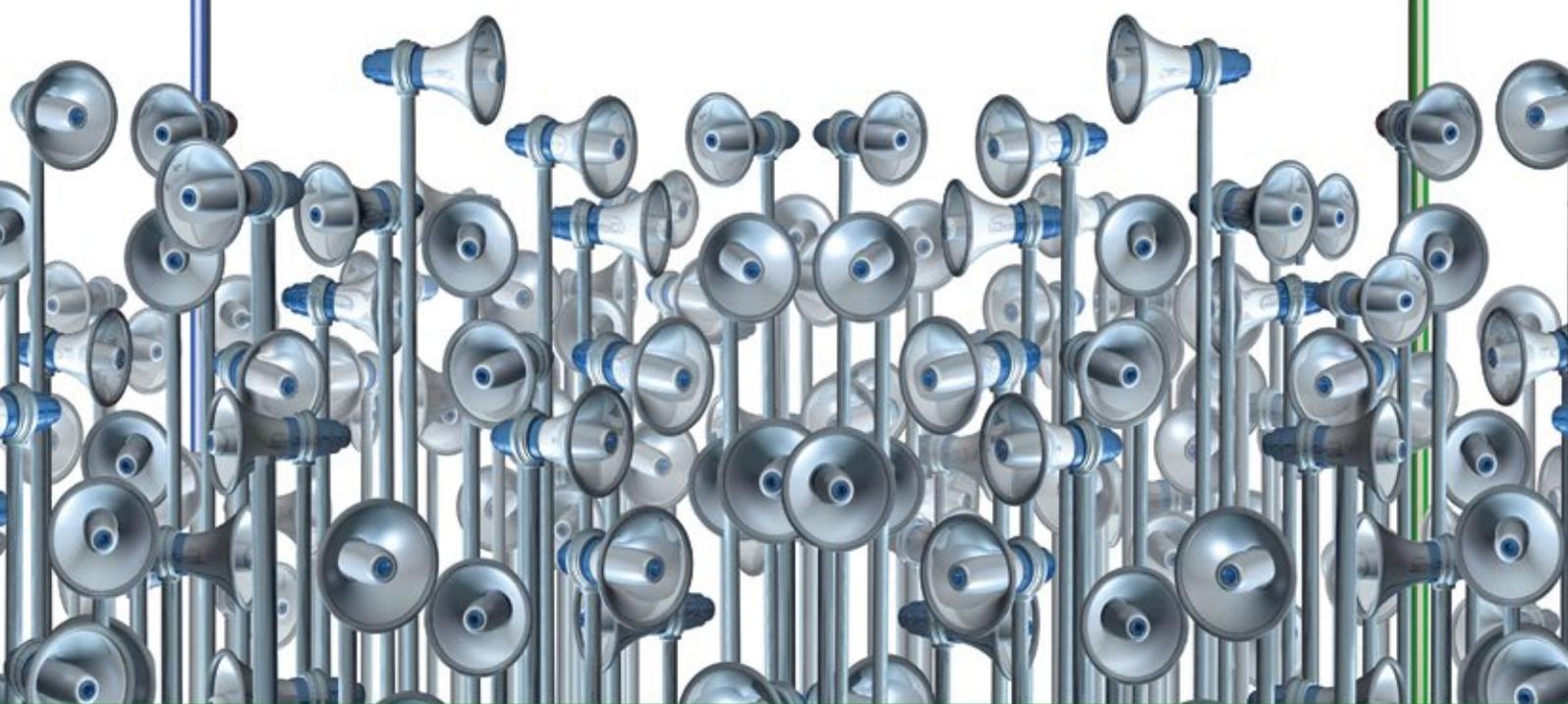
Tracey Lonergan, Policy Co-Ordinator for the Primary Care Respiratory Society, explained, 'Restoring the range of necessary services for patients with respiratory disease is critical if we are to avoid an imminent crisis not only for patients but also for the stability and capability of the NHS to deliver the care they need.'



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COVID-19

MAKING THE CONNECTION

With the release of recent studies showcasing strong links between the endocrine system and COVID-19 incidence and mortality, what are the connotations for patient management and the role of elevated support?

COVID-19 and interlinkages to endocrine and metabolic diseases was an important programme topic at the 2020 European Congress of Endocrinology (ECE) in which, over five days, panel sessions covered the science behind COVID-19 and endocrine and metabolic disorders, as well as e-consulting and e-support to endocrine patients in times of COVID-19.

‘One thing that is clear from the beginning of the pandemic is that patients with underlying endocrine diseases, like diabetes, obesity or the lack of vitamin D, were more at risk of developing severe COVID-19,’ commented Andrea Giustina, President of the European Society of Endocrinology.

He continued, ‘Therefore, disciplines that work in the prevention, such as endocrinology, can focus on creating a healthier population, which can be important in the preparation for pandemics like COVID-19.’

The need to address the links between endocrinology and COVID-19 has not gone unnoticed by policymakers. At the e-ECE opening ceremony, John Ryan, Director of Public Health, Country Knowledge and Crisis Management at the Directorate General for Health and Food Safety of the European Commission, said, ‘There is a huge issue regarding non-communicable diseases and the EU is investing heavily together with Member States in trying to find effective ways to prevent it, such as the Farm2Fork Strategy of the EU4Health programme.’

COVID-19 INCIDENCE HIGHER FOR THOSE WITH UNDERLYING ENDOCRINE CONDITIONS

There is evidence that people with underlying endocrine conditions, such as diabetes, obesity or autoimmune thyroid disease, face an increased risk of infection from COVID-19. In fact, vitamin D deficiency makes people more vulnerable to infection and may increase lung damage. In addition, recent studies show that certain underlying conditions, associated with exposure to endocrine-disrupting chemicals, are exacerbating the effects of COVID-19 in vulnerable populations.

ENDOCRINE CONDITIONS LEAD TO WORSE OUTCOMES FOR COVID-19

It has been proven that people suffering from underlying endocrine-related diseases, who are infected by COVID-19, are more likely to suffer severe symptoms, be admitted to intensive care units, as well as have an increased risk of death. For instance, in a study by Matteo Rottoli, obesity was shown to be a risk factor for respiratory failure, admission to the ICU and death among COVID-19 patients. In fact, patients with a body mass index over 35kg/m² had a dramatically increased risk of death.

Moreover, endocrine systems could suffer in the long-term from the impact of COVID-19, since the hormone system is the key regulator of body weight, energy expenditure and energy (food) intake. In fact, COVID-19 is associated with anorexia, dysgeusia, dysfunction of gastrointestinal absorption and severe weight loss, mostly from muscle mass.

URGENT POLICY ATTENTION IS NEEDED TO ADDRESS THESE INTERLINKAGES

The European Society of Endocrinology have stated in a COVID-19 and endocrinology position statement that we need urgent policy attention to address the structural factors and underlying conditions that render populations vulnerable and exacerbate healthcare crises, such as the COVID-19 pandemic. The upcoming EU4Health strategy needs a strong endocrine and metabolic element to achieve its objectives. Therefore, it is needed to focus on the following demands: an increase in research funding for the relationship between COVID-19 and hormones; a co-ordinated effort for global surveillance; new models of patient management; and increased collaboration between countries, policymakers and other stakeholders.

ABOUT THE EUROPEAN SOCIETY OF ENDOCRINOLOGY

The European Society of Endocrinology are working together to develop and share the best knowledge in endocrine science and medicine. The European Society of Endocrinology represent a community of over 20,000 European endocrinologists, enabling them to inform policymakers on health decisions at the highest level through engagement in advocacy efforts across Europe. It is by uniting and representing every part of the endocrine community that the society are placed in the best possible position to improve life for patients.

For more information, visit www.ese-hormones.org.

TAKING IT TO HEART

The pandemic has brought about increased consumer adoption of digital health options and a rise in demand for remote monitoring tools, as patients and clinicians strive to minimise exposure to the COVID-19 virus. SPR examines how one remote patient monitoring device could be adopted in order to curtail the need for clinic and hospital visits and offer reassurance to patients.

THE MEDTECH INNOVATION BRIEFING

NICE has developed a medtech innovation briefing (MIB) on KardiaMobile for the ambulatory detection of atrial fibrillation (AF). KardiaMobile is a portable single-lead ECG recorder, which works with a compatible mobile device (such as a smartphone or tablet) running the Kardia app. It analyses the ECG recording, which the patient can share with their physician for interpretation.

The KardiaMobile heart monitor and Kardia app is intended for adults to detect abnormal heart rhythms. It can be used in patients with existing AF (to determine AF burden), in patients after treatment (to investigate AF recurrence), and in patients with unclear palpitations (investigation). It is particularly suitable for people with suspected paroxysmal AF, which might not be detected using a standard 12-lead ECG if the person is not in arrhythmia at the time of recording. Because the KardiaMobile heart monitor is portable, readings can be taken at home, or in any other setting, and at any time of the day. This increases the

diagnostic yield of an arrhythmic episode being detected and recorded.

Evidence from 11 studies and 1,218 patients are summarised in the MIB, including two randomised controlled trials (RCTs), one pilot (case-control) study, one cohort feasibility study and seven diagnostic accuracy studies (comparators included 12-lead electrocardiogram [ECG], external loop recorder, transtelephonic monitor, and comparison of automated algorithm in arrhythmia detection versus clinical interpretation of KardiaMobile acquired ECG). Three of the diagnostic accuracy studies were done after AF therapy in a monitoring setting.

EXPERT OPINION

Comments on this technology were invited from clinical experts working in the field and relevant patient organisations. All six experts described the technology as innovative. One stated that it had already changed clinical pathways for those with suspected arrhythmia, and another stated that it had potential to change standard of care. Another suggested it could be used in novel

settings, outside of healthcare.

Four experts stated that the technology would help increased detection of AF, with two highlighting quicker time to diagnosis. Three experts commented on the ease of use of the device, two stated that the device offers reassurance to patients with palpitations and one stated that the technology was patient-orientated, enabling high correlation between recorded symptoms and captured data. The experts could see the benefits of the technology across a variety of patient groups and settings.

Four experts suggested that this technology could be more reliable than other methods because it could be used in a number of settings and at any time, including when symptoms happen. All experts stated that this technology had the potential to change standard care in some way (earlier diagnosis, quicker intervention, fewer hospital visits and referrals, fewer strokes), improving both patient outcomes and patient satisfaction.

Four experts stated that the technology would reduce hospital resource use (fewer hospital visits, referrals, investigations). Four

ATRIAL FIBRILLATION

experts referred to existing use in primary care and felt that use in community settings would increase. One expert stated that the technology had the potential to direct management to a primary care setting, and two experts stated that the technology would allow remote consultations (which are increasing because of COVID-19). Two experts also felt it was ideal for use in care homes, and for home visits, and two experts had used the device on patients who were unable to attend for a 12-lead ECG. One expert highlighted that KardiaMobile would lead to more efficient working, one stating that the device could be implemented by a range of staff, another commenting on how use of the device would lead to expansion of professional roles (for example, training). Two experts highlighted that reviewing the device output needs no additional staff or skills than interpreting outputs from the standard care 12-lead ECG. All experts agreed that use of the technology could reduce overall healthcare costs compared with standard care, and three referred to costs associated with reduction in stroke admissions. Two experts highlighted that KardiaMobile can detect other cardiac abnormalities, not just AF, and therefore has wider benefits.

All experts agreed that the device would be in addition to standard care, but four experts stated that there was potential for the device to replace standard care in some settings and patient groups, and one suggested that it could replace standard care in the next five years. One expert highlighted that the device would not directly replace 12-lead ECG for confirmation of arrhythmia because the instructions for use state that KardiaMobile interpretations should be reviewed by a medical professional for clinical decision-making.

PATIENTS' PERSPECTIVE

Representatives from patient organisations (AF Association and Arrhythmia Alliance) also contributed to the briefing. The patient organisation commented that patients who have AF are often anxious, stressed, exhausted, breathless, have heart pounding and are scared. The technology can provide

reassurance by confirming if symptoms are being caused by an arrhythmia. Patients can share evidence with doctors and carers or family members to make sure that their symptoms are managed appropriately. Without this evidence, patients can be left feeling alone and isolated.

Patient subgroups who could particularly benefit from the technology include symptomatic patients who have yet to be diagnosed, and those who have paroxysmal AF (which is hard to detect on a standard 12-lead electrocardiogram or Holter monitor).

The organisation noted that compared with long waits and travel to and from hospital or GP appointments (and appointments cancelled or postponed because of COVID-19), the technology is proven to be cost-efficient with the same or similar outcomes. In some cases, outcomes are better because the patient can keep the monitor for longer and capture intermittent spells of AF if needed. Patients prefer this technology to having electrodes on their skin for seven-to-14 days and having to travel back and forth to hospital.

The patient organisation thought that there was an urgent need for guidance on the technology and highlighted evidence in the European Heart Journal from Denmark that there was a 47 per cent reduction in AF detection in March and April 2020 compared with March and April 2019 because of the COVID-19 pandemic. This may have led to an increase in AF-related strokes. Having KardiaMobile readily available across the NHS and in pharmacies would: make sure that patients can capture their irregular heart rhythms; allow collection of the evidence to show their doctors AF; protect against AF-related stroke with anticoagulation therapy; help patients to access appropriate treatments to manage the symptoms and correct arrhythmia.

THE IPED STUDY

The IPED (Investigation of Palpitations in the ED) trial sought to clarify whether there is any benefit to adding a smartphone-based electrocardiogram monitoring

event recorder to standard care. The trial recruited patients presenting to the ED with palpitations and pre-syncope and no obvious cause in the ED. The principal outcome measure was the rate of detection of the underlying symptomatic rhythm at 90 days. This study shows that use of a smartphone-based event recorder increased the number of patients in whom an ECG was captured during symptoms over five-fold to more than 55 per cent at 90 days. These are clinically significant rhythms as they diagnose the underlying cause of the patient's symptoms. The smartphone-based event recorder also increased the number of patients diagnosed with cardiac arrhythmia.

KEY OUTCOMES

Statistically significantly more patients had symptomatic cardiac arrhythmias detected at 90 days in the intervention arm (n=11) than in the control arm (n=1, p=0.006). Mean time to symptomatic cardiac arrhythmia detection was reduced from 48.0 days in the control arm, to 9.9 days in the intervention arm (p=0.004). Serious outcomes at 90 days (including all-cause death and major adverse cardiac events) were 11 in the intervention arm and two in the control arm. Treatment was planned or ongoing in 12 patients in the intervention arm and six patients in the control arm. Cost per symptomatic rhythm diagnosis was £474 in the intervention arm, and £1,395 in the control arm. 80 out of 92 (87.0 per cent) patients found KardiaMobile easy to use.

The study determined that a smartphone-based event recorder should be considered as part of ongoing care for all patients presenting acutely to EDs with unexplained palpitations or pre-syncope. It is safe, non-invasive, easy to use and far more efficient at diagnosing the underlying cause of the patient's symptoms than current standard care, which in the healthcare system studied does not serve this patient group well.



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*Information on Atrial fibrillation in Scotland can be found at www.stroke.org.uk/sites/default/files/a_focus_on_atrial_fibrillation_in_scotland.pdf

ADHD

ALL KIDDING ASIDE

ADHD is underdiagnosed in the UK, with less than three per cent diagnosed and less than one per cent of the childhood population receiving medication as part of their treatment plan. Sparked by this startling incidence, Dr Tony Lloyd, CEO of the ADHD Foundation, sheds light on the diagnostic considerations for ADHD in children.

ADHD is a lifespan neurodevelopmental disorder that impacts on many aspects of physical and mental health. ADHD is costing the NHS substantial sums of money through hidden costs in other areas of healthcare – something that many clinicians, primary care practitioners and commissioners are not aware of.

The health outcomes and long-term healthcare costs for undiagnosed and untreated ADHD are now better understood. Undiagnosed untreated ADHD is a public health issue; ADHD correlates with increased risk of eating disorders, obesity, diabetes, allergies, hypertension, and increased risk of brain haemorrhage, early onset cardiovascular disease, lung cancer, injury through physical accidents, as well as increased risk of mental health comorbidities. Comorbidity with other neurodevelopmental conditions is the rule rather than the exception.

Early identification, intervention, assessment and diagnosis is therefore a new priority in NHS service design and delivery of ADHD in community paediatrics and CAMHS. NHS England, in conjunction with NICE, leading clinicians across a range of disciplines, and patient-led organisations, have established a national strategy committee to address how this need can be met. The need for a greater role in primary care, and how this is funded and implemented, is currently under discussion with Royal Colleges and the Department of Health. GP hubs and nurse-led clinics increasingly play a crucial role in safe, cost-effective pre- and post-diagnostic pathways across the UK. This will become more widespread as the post-pandemic recovery plan addresses even longer waiting times for assessments which, before the pandemic, were at a record rate of up to two years for children in some parts of the UK and up to five years for adults.

A National Expert Consensus Statement on Health Inequalities in ADHD, funded by the ADHD Foundation and led by Dr Suzy Young, Dr Tony Lloyd, CEO of the ADHD Foundation, and Professor Philip Asherson of King's College London, was to be published in

February 2021. This statement, endorsed by members of all Royal Colleges, also calls for a systemic approach to improving outcomes and life chances through improvements in training for clinicians and also in education settings so as to address the impact of environmental factors on the developing neurology of children. The Consensus Statement also emphasises research about the greater understanding of the interplay between genetic heritability and childhood experiences in the developing neurocognitive capacity of children, and how pervasive learner anxiety in childhood impacts on mental health in adulthood.

NICE guidelines state clearly that treatment should be multi-modal, providing psycho-educative approaches to empower patient self-care, psychological therapies, and parent skills training and peer group support. In practice, treatment is invariably limited to prescribing of medication. There is also growing concern among patient-led charities and support groups and primary care clinicians that children diagnosed with ADHD who are referred to CAMHS for psychological therapies – having reached the threshold for a referral (self-harm, attempted suicide and eating disorders) – are often declined on the premise that their ADHD is the cause, and therefore does not meet the criteria for psychological therapies, in breach of the Equalities Act of 2010 and NICE guidelines.

New models of care also offer the opportunity to provide more user-friendly environments for young people to access adult ADHD services, such as local GP surgeries and specialist hubs away from psychiatric hospital clinics and the opportunity to create lifespan services. This is critical for young people transitioning from community paediatric services and CAMHS to adult services who, understandably, do not view themselves as 'psychiatric' patients.

HOW DO WE IDENTIFY, ASSESS, AND TREAT ADHD

IN CHILDREN?

ADHD is genetic in origin and heritable. That doesn't always mean one or both parents also have ADHD, rather the combination of their genetic profile can result in having a child with ADHD. ADHD is a lifespan condition; by adulthood, many people have learned to live happy, healthy, and successful lives, using a range of interventions and strategies that include medication, daily exercise, healthy nutrition, stress management strategies, and what are known as 'executive functioning skills', to help them better plan and organise their lives, especially in school and in the workplace.

Many underachieve in education, with implications for life chances and economic wellbeing. The co-occurrence of autism (26 per cent) and dyslexia, dyscalculia and dyspraxia, evident in over 40 per cent of those with a primary diagnosis of ADHD, often results in education providers and parents assuming the child is of low academic ability.

Viewing ADHD as a spectrum disorder in the same way we do with autism will enable us to understand that the characteristics of ADHD are 'natural' presentations of human behaviour, but in a more extreme form. All children are hyperactive, inattentive, and impulsive – traits which decline with neurological maturation and, for those with ADHD, these characteristics can lessen when the brain reaches full maturity by early 20s. The developmental delay in certain brain regions of approximately three years can often present as immature behaviour or lack of ability to mainstream school teachers who expect levels of academic attainment to correlate with certain chronological ages and educational key stages.

ADHD presentation in children must be evident across at least two domains – home and school. There can sometimes be conflicting views between home and school due to misconceptions of what ADHD is and is not. In 2013, the DSM5 reclassified ADHD as a neurodevelopmental condition – as distinct from a behavioural disorder, reflecting both the developmental delay typical of ADHD and

recognising that children with ADHD don't always display context inappropriate 'distress' behaviours. Subjective opinion obtained from observations by parents and teachers should be investigated further if there is divergence of presentation between home and school.

Similarly, presentation of ADHD characteristics with children who have comorbid autism – even when it is a sub threshold for a secondary diagnosis of autism – can, at times, mask certain characteristics of ADHD. This also raises questions for clinicians about how children who display sub threshold comorbidities should be treated and what advice they give to parents and teachers about how their needs are understood and supported both at home and school.

THERE ARE THREE MAIN CHARACTERISTICS OF ADHD

INATTENTION

Resulting in poor concentration, poor working memory, cognitive overload, resulting in problems with task initiation and learner anxiety.

IMPULSIVITY

Presenting as impulsive actions, words, thoughts and emotions, that may cause social and communication difficulties, as well as frequent mistakes and repeating errors that the individual knows are incorrect or not contextually appropriate responses, but seems unable to control. Sadly, this is often interpreted as deliberate chosen behaviour that is inappropriate. In reality, ADHD impulsiveness is not a lack of self-awareness, or 'the rules', but a neurological impulse control that enables the child to consider the consequences until after the fact.

HYPERACTIVITY

More common in boys than girls, and one of the reasons boys are more often referred for diagnosis than girls. Hyperactivity doesn't impair academic performance, but is viewed as disruptive – sometimes deliberately so by adults who assume incorrectly that the child has the ability to always control this instinctive need to move. Many don't understand that the natural way to utilise the neurotransmitter dopamine is 'to move'.

SECONDARY CHARACTERISTICS

FREQUENTLY CONSIDERED BY CLINICIANS IN THE CONTEXT OF A CLINICAL INTERVIEW

- Low emotional resilience, frustration, and rejection sensitivity
- Concerns with sleep
- Family history of neurodevelopmental conditions
- Traumatic brain injury, including trauma arising out of epilepsy and developmental delay caused by pre-term births or perinatal trauma
- Age of parents at conception and whether the child was conceived with IVF that may impact on pre-term birth
- Poor executive functioning skills, such as poor emotional regulation, difficulty with 'working memory', resulting in cognitive overload, an inability to plan and organise tasks, and task initiation or completion. Feedback from parents and schools will also offer indications of poor executive functioning skills

ASSESSMENT AND DIAGNOSIS

Observational rating scales, such as Connors Scales, Swan Rating Scales and Vanderbilt, completed by parents and teachers, are commonly employed as part of the pre-diagnostic screening undertaken before the clinical interview. Common misconceptions and enduring myths about ADHD can skew the interpretation of the rating scales by parents and teachers and, as a consequence, there is an emerging trend of employing computer-based, objective, cognitive functioning tests, such as QB Test and QB Check, that are validated with an accuracy rate in excess of 83 per cent.

The added advantage of such tests is that QB Check can be administered by a trained teacher and form part of the initial screening before making a referral for a full clinical assessment. This also ensures that interventions can be put in place at home and school as soon as the concern is identified to avoid the traditional model of waiting for a formal diagnosis through the NHS which can take up to two years.

A Swan Rating Scale combined with a number of questions that GPs, school nurses and School Special Educational Needs Co-Ordinators may find useful can be found here: www.adhd.foundation.org.uk/wp-content/uploads/2019/04/ADHD-screening-with-SNAP.pdf.

MEDICATION

There are a number of different medicines for ADHD. Medicines for ADHD that are licensed in the UK are psychostimulants that regulate dopaminergic function such as, Methylphenidate, Lisdexamfetamine, and Dexamphetamine. Non-stimulant noradrenergic applications include Atomoxetine and Guanfacine.

Optimising medication requires gradual titration and sometimes employing stimulant and non-stimulant medications to meet the need of the unique neurology of the child. This should then be reviewed every six months and adjusted in line with physical and psychological development.

Many parents remain concerned about medication, but their efficacy and safety are proven. Clinicians are advised to listen to parents' concerns and take the time to explain that such medication is not meant to be used in isolation from other interventions and that they are not a 'morality pill' that teaches children how to behave, rather they simply improve cognitive functioning which in turn reduces anxiety, which is the main cause of context inappropriate behaviour.

NICE Guidelines 2018 on the diagnostic criteria and treatment of ADHD in England and Wales can be accessed via www.nice.org.uk/guidance/ng87.

CONCLUSION

Given that research in neuroscience suggests that one-in-five of the population have neurodevelopmental conditions, there is now a movement toward viewing such disorders as part of the natural variation in human neurocognitive capacity.

That prevalence is so high, from an evolutionary perspective, perhaps it is time we began to change the language derived from a deficit-based research paradigm that labels those on the edge of the standard distribution curve as 'abnormal' or 'disordered' and instead adopt a more strength-based approach, while also acknowledging and treating the impairment to wellbeing across both health, education and socio-economic wellbeing.

Our 19th Century concept of intelligence and how we measure this in education is being redefined by modern industry and commerce. This is especially true of those major growth industries of the 21st Century that are influencing culture and commerce, such as technology, bioscience and computer-driven creative design, who have been actively recruiting neurodivergent employees for over a decade.

An Audit of The Use of Ranolazine In Patients With Refractory Angina – a single centre experience.

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Narrative:

Despite being optimally treated with pharmacotherapy and revascularisation, up to 40% of patients with coronary artery disease still experience symptoms of angina. These patients have refractory angina and in a recent audit in Tayside we have found that ranolazine was well tolerated and to be effective in achieving symptoms control in this group of patients.

Background

The current Scottish Intercollegiate Guidelines Network (SIGN) 151 guidelines recommend the addition of dihydropyridine calcium channel blockers when angina symptoms are not achieved with beta blockers. Despite being optimally treated with pharmacotherapy and revascularisation, up to 40% of patients still experience symptoms with a significant proportion of patients with refractory angina. Ranolazine, a piperazine derivative, selectively inhibits late sodium currents and is of particular interest as it is currently not recommended routinely by SIGN guidelines and Scottish Medicine Consortium (SMC) but has been prescribed in Tayside, initially through IPTR since 2017 and recently through a Local New Medicine Treatment Protocol and Stable Angina Pathway. Real world experience of ranolazine prescribing in patients with chronic and often refractory angina is not widely reported. We therefore audited its use in Tayside to understand its prescribing pattern within our patient population and assess its effects on angina symptom relief.

Aim

Our aim was to identify patients with refractory angina and improve their symptoms and quality of life with addition of Ranolazine to their current anti-anginal management.

Methods

Electronic health records and prescribing data between 1st January 2012 and 31st December 2018 were retrospectively analysed. Data on baseline characteristics, prescribing information, past medical history, and angina symptom control were collected. Standard descriptive statistics were used for analysis.

Characteristic	Ranolazine group (n=35)
Age, years (mean ± SD)	71.4 ± 12.5
Age of first prescription, years (mean ± SD)	69.1 ± 12.1
Duration on Ranolazine, years (mean ± SD)	3.0 ± 2.2
Male	68.6%

Table 1: Baseline characteristics

Characteristic	Frequency (%)
Previous PCI	19 (54.3%)
Previous CABG	10 (28.6%)
Previous CABG and PCI	6 (17.1%)
No previous CABG or PCI	12 (34.3%)
Reason for prescription	
Recurrent angina	26 (74.3%)
Chronic stable angina	5 (14.3%)
No intervention options	3 (8.6%)
Part of research trial	1 (2.9%)
Concurrent medications	
Beta blocker	30 (85.7%)
Nitrates	32 (91.4%)
Calcium channel blocker	11 (31.4%)
Nicorandil	13 (37.1%)
Ivabradine	4 (11.4%)

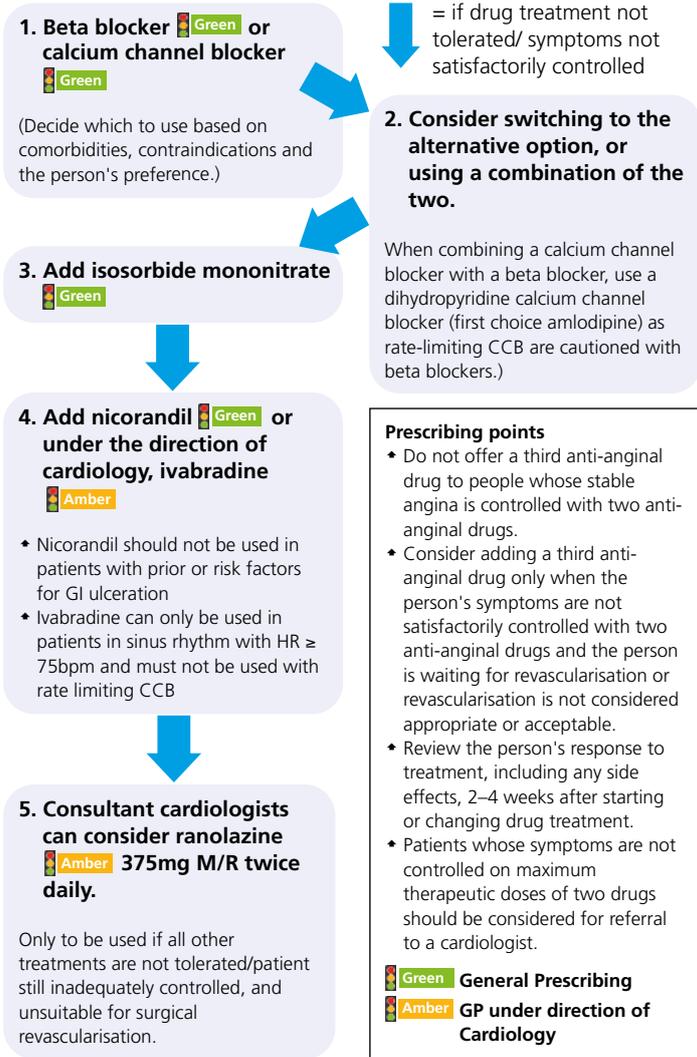
Table 2: Previous treatment characteristics

Combination	Frequency (%)
Beta blockers and nitrates	28(80%)
Beta blockers and dihydropyridine calcium channel blockers	9(25.7%)
Beta blockers, calcium channel blockers, and nicorandil	3(8.6%)
Beta blockers, calcium channel blockers, and nitrates	9(25.7%)
Beta blockers, calcium channel blockers, ivabradine	1(2.9%)

Table 3: Combination of current anti-anginals

Flow chart for sequence of drug treatment for stable angina

(adapted from SIGN 96 and NICE CG126)



Prepared by - Joanne McGeoghie (Specialist Clinical Pharmacist)

Approved by - Stuart Hutcheon (Clinical Lead for Cardiology)

Prepared - April 2017

Review - April 2019

Figure 1: NHS Tayside flowchart for Ranolazine prescribing

Combination	Frequency (%)
Ranolazine dose prescribed	
375 mg BD	22 (62.9%)
500 mg BD	12 (34.3%)
750 mg BD	1 (2.9%)
Effect on symptoms	
No change	8 (22.9%)
Improvement in CCS class	27 (77.1%)
Class II to Class I	22 (81.5%)
Class III to Class II	5 (18.5%)
Concomitant anti-anginals	
1 agent	3(8.6%)
2 agents	12(34.3%)
3 agents	16(45.7%)
4 agents	4(11.4%)

Table 4: Ranolazine dose and CCS class improvement

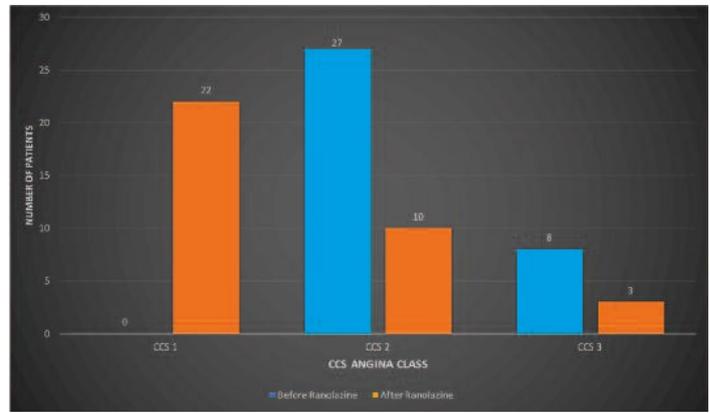


Figure 2: Change in CCS class

Result

35 patients were identified as suitable for inclusion in the audit. Mean age was 71.4 ± 12.5 years old and 68.6% were male. 23 patients (65.7%) had either a previous percutaneous coronary intervention (PCI) or coronary artery bypass graft surgery (CABG). The most common reason for ranolazine prescription was refractory angina (74.3%) with 375 mg BD being the most common dose (62.9%). Prescription of guideline-recommended anti anginals was high with 80% of patients being on a beta blocker and a nitrate prior to commencing ranolazine. Encouragingly, 27 patients (77.1%) reported an improvement in Canadian Cardiovascular Society (CCS) angina class and the rate of non-responders was 22.9%. No adverse effects leading to discontinuation of ranolazine was found.

Conclusion

In this audit of ranolazine use in refractory chronic stable angina, ranolazine provided symptom relief for significant number of patients who were on other guideline-recommended anti anginal agents.

Save the Date:

You are invited to join Professor Chim Lang on a Virtual Webinar chaired by Professor Adrian Brady titled: **Angina in Scotland - Meeting the Challenge on the 20th April 2021 at 5.30pm**, details on how to register will be available soon on the following website: <http://scothealthcare.com/>. This webinar will be sponsored by A. Menarini Farmaceutica Internazionale SRL and will contain promotional content.

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- Ranexa® significantly improved most SAQ and EuroQoL scores compared to ivabradine in patients with microvascular angina⁵

Prescribing Information: Ranexa (ranolazine) 375 mg, 500 mg, 750 mg Prolonged-release tablets. Please consult the Summary of Product Characteristics (SmPC) for full prescribing information. **Presentation:** Prolonged-release tablets containing 375 mg, 500 mg or 750 mg of ranolazine. 750 mg tablet contains E102 and lactose. **Use:** Ranexa is indicated as add-on therapy for the symptomatic treatment of patients with stable angina pectoris who are inadequately controlled or intolerant to first-line antianginal therapies (such as beta-blockers and/or calcium antagonists). **Dosage and administration:** Oral administration. Patients should be instructed to list their medication to their health care professional at each visit. **Adults:** Initial dose is 375 mg twice daily. After 2-4 weeks, dose should be titrated to 500 mg twice daily and, according to patient's response, further titrated to 750 mg twice daily. **Concomitant treatment with moderate CYP3A4 and P-glycoprotein (P-gp) inhibitors:** Careful dose titration is recommended. **Renal impairment:** Careful dose titration is recommended in mild to moderate renal impairment, and contraindicated in severe renal impairment. **Hepatic impairment:** Careful dose titration is recommended in mild hepatic impairment, and contraindicated in moderate to severe hepatic impairment. **Elderly:** Dose titration in the elderly should be exercised with caution. **Low weight:** Dose titration in patients with low weight should be exercised with caution. **Congestive Heart Failure (CHF):** Dose titration in moderate to severe CHF should be exercised with caution. **Paediatric patients:** No data are available in children below the age of 18 years. Ranexa tablets should be swallowed whole and not crushed, broken or chewed. They may be taken with or without food. **Contra-indications:** Hypersensitivity to the active substance or to any of the excipients. Severe renal impairment. Moderate or severe hepatic impairment. Concomitant administration of potent CYP3A4 inhibitors. Concomitant administration of Class Ia or Class III antiarrhythmics other than amiodarone. **Warnings and Precautions:** Caution should be exercised when prescribing or up titrating ranolazine to patients in whom an increased exposure is expected. QT prolongation: Caution should be observed when treating patients with a history of congenital or a family history of long QT syndrome, in patients with known acquired QT interval prolongation, and in patients treated with drugs affecting the QTc interval. **Interactions:** Co-administration with CYP3A4 inducers is expected to lead to lack of efficacy. **Renal impairment:** Check renal function at regular intervals during treatment. **Interactions:** **CYP3A4 inhibitors:** Increase plasma concentrations of ranolazine. Combining ranolazine with potent CYP3A4 inhibitors is contraindicated. **CYP3A4 inducers:** Avoid initiation with Ranexa during administration of CYP3A4 inducers. **CYP2D6 inhibitors:** May increase plasma concentrations of ranolazine. **Effect of ranolazine on other medicinal products:** Dosage adjustment of sensitive CYP3A4 substrates and CYP3A4 substrates with a narrow therapeutic range may be required. Lower doses of CYP2D6

substrates may be required. Caution with CYP2B6 substrates. Monitor digoxin levels following initiation and termination of Ranexa. Limit dose of simvastatin to 20mg once daily in patients taking Ranexa. Limit dose of atorvastatin and consider clinical monitoring taking Ranexa. Monitor blood levels of tacrolimus when co-administering with Ranexa and adjust tacrolimus dose accordingly. Also recommended for other CYP3A4 substrates with a narrow therapeutic range. **Drugs transported by the Organic Cation Transporter-2 (OCT2):** Plasma exposure of metformin increased in subjects with type 2 diabetes mellitus when co-administered with Ranexa. Theoretical risk that concomitant treatment with drugs known to prolong the QTc interval may increase the possible risk of ventricular arrhythmias. **Pregnancy and lactation:** Ranexa should not be used during pregnancy unless clearly necessary. Ranexa should not be used during breast-feeding. Effect on fertility unknown. **Side-effects:** Generally mild to moderate in severity and often develop within the first 2 weeks of treatment **Common (> 1/100 to < 1/10):** dizziness, headache, constipation, vomiting, nausea, asthenia. **Uncommon (> 1/1,000 to < 1/100):** anorexia, decreased appetite, dehydration, anxiety, insomnia, confusional state, hallucination, lethargy, syncope, hypoesthesia, somnolence, tremor, postural dizziness, paraesthesia, blurred vision, visual disturbance, diplopia, vertigo, tinnitus, hot flush, hypotension, dyspnoea, cough, epistaxis, abdominal pain, dry mouth, dyspepsia, flatulence, stomach discomfort, pruritus, hyperhidrosis, pain in extremity, muscle cramp, joint swelling, muscular weakness, dysuria, haematuria, chromaturia, fatigue, peripheral oedema, increased blood creatinine, increased blood urea, prolonged QT corrected interval, increased platelet or white blood cell count, decreased weight. In a long term study, acute renal failure was also reported with an incidence less than 1% in placebo and ranolazine patients. **Rare (> 1/10,000 to < 1/1,000):** hyponatraemia, disorientation, amnesia, depressed level of consciousness, loss of consciousness, coordination abnormal, gait disturbance, parosmia, impaired hearing, peripheral coldness, orthostatic hypotension, throat tightness, pancreatitis, erosive duodenitis, oral hypoesthesia, angio-oedema, allergic dermatitis, urticaria, cold sweat, rash, acute renal failure, urinary retention, erectile dysfunction, elevated levels of hepatic enzyme. Not known: myoclonus. Increased incidence of congestive heart failure and transient ischaemic attacks seen in patients with history of chronic angina who had incomplete revascularisation after percutaneous coronary intervention and treated within 2 weeks with ranolazine (1000 mg twice daily [dose not licensed in Europe]) in a placebo-controlled post-PCI trial. **Elderly, renal impairment and low weight:** In general, adverse events occurred more frequently among elderly patients and patients with renal impairment. Adverse events in patients with low body weight were similar to those of patients with higher weight. Please consult the SmPC for further information. **Package quantities and price:** 60 tablets. 375 mg: £48.98; 500

mg: £48.98; 750 mg: £48.98. Legal category: POM. Marketing Authorisation Holder: Menarini International Operations Luxembourg S.A. Marketing authorisation numbers: EU/1/08/462/001, 003, 005 Marketed by: A. Menarini Farmaceutica Internazionale SRL. Further information is available on request to A. Menarini Farmaceutica Internazionale SRL, Menarini House, Mercury Park, Wycombe Lane, Wooburn Green, Buckinghamshire, HP10 0HH, UK or may be found in the SmPC. Last updated: October 2020

Adverse events should be reported.
Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.
Adverse events should also be reported to A. Menarini Farmaceutica Internazionale SRL.
Phone no. 0800 085 8678 or email: menarini@medinformation.co.uk



Improves Diastolic Relaxation^{1,4}

References:

1. Ranexa® (ranolazine) Summary of Product Characteristics.
2. Stone PH *et al.* *Cardiol Clin* 2008;26:603-614.
3. Hasenfuss G *et al.* *Clin Res Cardiol* 2008;97(4):222-226.
4. Chaitman BR *et al.* *JAMA* 2004;291(3):309-316.
5. Villano A *et al.* *Am J Cardiol* 2013;112(1):8-13.

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STARS IN OUR EYES

The Scottish Pharmacy Awards transitioned online for its 2020 ceremony – honouring a number of the sector’s extraordinary trailblazers and the mark they’ve made.

In a year of uncertainty – and against conditions unforeseen and pressures unprecedented – pharmacists in Scotland have showcased their commitment, selflessness and courage more than ever before.

While ideally, we would pay tribute to the positive impact which the members of the sector have forged in person, in response to updated COVID-19 guidelines the Scottish Pharmacy Awards ceremony transitioned online.

The culmination of the hotly-contested process took place on a dedicated website – www.scottishpharmacyawards.info – on Wednesday 25th November in which key healthcare representatives and award sponsors submitted videos and special winner announcements.

Keeping apace with Scotland’s ever-

evolving delivery of healthcare services, 10 awards were up for grabs. With the categories spanning the different corners of the profession, the titles ranged from Hospital Pharmacy Team of the Year, to Respiratory Project of the Year and Student Leadership.

Rounding off the online reveal, the recipient of the prestigious Lifetime Achievement Award was announced – a recently-retired Rose Marie Parr, former Chief Pharmaceutical Officer for Scotland, in recognition of her tremendous contributions to pharmacy in Scotland and beyond.

Turn the page to find out more about our exceptional winners and their journeys to success!

WINNER

INNOVATIONS IN PRESCRIBING, QUALITY AND EFFICIENCY IN SCOTLAND AWARD

DR ANDREW RADLEY AND TEAM, HCV NHS TAYSIDE

Sponsored by Napp Pharmaceuticals Limited



Through the team’s dedication, determination and collaborative ethos, they have provided strong evidence that community pharmacy can work effectively with specialist teams from hospital to deliver care, thus enhancing the health of communities and populations.

The project aimed to establish a care pathway in community pharmacy, to enable people who inject drugs to obtain a cure for hepatitis C (HCV), without needing to access any other healthcare facility. In line with this, the team engaged with 56 community pharmacies in NHS Tayside, NHS Grampian and NHS Glasgow & Clyde, and trained them to test, diagnose, assess for treatment, and deliver a cure for HCV using direct-acting antiviral drugs.

In the pathway, pharmacy staff were trained to take a capillary blood sample from patients, and this was posted to the local laboratory for analysis of antibodies for HCV, hepatitis B and HIV. The pharmacies received back the results through the online laboratory system or through the post, subsequently informing the patient whether the test was negative or whether they required further evaluation.

For patients who showed antibodies for HCV, the pharmacy team organised for a nurse to visit the pharmacy and conduct a further series of safety bloods to evaluate the patient as suitable for treatment. The

pharmacies would organise for four or five test-positive patients to meet the nurse at a specific time and be bled. These results would also be returned to the pharmacy and the pharmacist would interpret the results and determine whether the patient was suitable to commence treatment. The further blood tests included a measure of the amount of circulating virus (PCR) and tests to enable the pharmacist to calculate the patient’s individual risk of cirrhosis (Fib-4).

If the pharmacist assessed the patients as suitable for treatment, then a community pharmacist independent prescriber wrote a prescription for a course of an appropriate direct-acting antiviral (DAA) drug, which varied according to HCV genotype. Patients were asked to pick up their DAA prescription at the same time as they received their prescription for Opioid Substitution Therapy.

By applying a co-design and co-production approach with the people who used pharmacy services and the staff who they wanted to deliver the service, the team ensured that the patients wanted to use the service and the staff were able to deliver it easily. The end-product of their efforts was a service specification that was agreed in partnership with the Board Community Pharmacy Committee.

‘I was delighted for our work to be recognised in this way and to win this award in the face of such strong competition. It has been a privilege to work with the Liver Research Group at the University of Dundee and pharmacies in NHS Tayside, NHS Grampian and NHS Glasgow & Clyde. Our project provided strong evidence that people with hepatitis C infection could be tested, diagnosed, assessed for treatment and cured of the virus, with all care provided in the community pharmacy. This represents a cutting-edge, world-beating standard of care that will be the envy of many other countries. I would like to recognise all the individuals and teams that led to the success of this work.’

Dr Andrew Radley and Team, HCV NHS Tayside

‘Napp once again are delighted to sponsor the Innovations in Prescribing, Quality and Efficiency in Scotland Award. It’s a fantastic opportunity to celebrate and recognise the excellent work delivered by pharmacy throughout Scotland, during what has been the most challenging of years. Well done to all the finalists in the category and congratulations again to the winner, Dr Andrew Radley and his team from NHS Tayside.’

Christine Allan Napp Pharmaceuticals Limited



INNOVATIONS IN PRESCRIBING, QUALITY AND EFFICIENCY IN SCOTLAND AWARD WINNER, DR ANDREW RADLEY, NHS TAYSIDE

JOINT WINNERS

MANAGEMENT OF SUBSTANCE DEPENDENCY IN THE COMMUNITY AWARD

Sponsored by Ethypharm UK



THE BUCHANHAVEN PHARMACY TEAM PETERHEAD

Serving a mixed demographic of the community – which encompasses a significant number of substance dependency patients – The Buchanhaven Pharmacy Team have garnered a reputation for delivering consistent and seamless care.

Their service has evolved over the years from a supplementary prescribing model with one pharmacist and up to just 12 patients to what it is today. This is due to the fact that the pharmacists have embraced every opportunity to further develop their training to constantly improve the service offered to this client group. Demonstrations of the help they deliver include injection technique, wound management, consultation skills, and more.

In line with the expansion of the service has been the strengthening of working relationships with all drug and alcohol support services to improve outcomes for their patients. Patients who access the clinic don't just receive a prescribing service, they gain support and engagement in all the additional offerings provided from the pharmacy. Also integral has been the pharmacy's emergence as one of the first in the area to engage in a 'dry blood spot testing' pilot to enable patients access to blood borne virus testing and treatment, even more important in their rural area where patients could have been disadvantaged by not accessing city services.

ELIZABETH MARR AND CLAIR SMITH NHS LANARKSHIRE

Elizabeth and Clair have been working with three GP practices to identify patients who are either on above recommended doses of opiate painkillers or overusing their prescribed opiates, and reducing their dose to the minimum required. For people whose original illness has recovered, the painkiller has been discontinued altogether.

The actions implemented within the programme included staff training initiatives, staff meetings to brainstorm, the reading of other trials around the same patient group, and meeting other people who have pain clinics. This has been in addition to interacting with the pain specialist team, and putting in place a training day for prescribing support pharmacists.

The results of their efforts, and the positive impact they have subsequently had on lives, has been formidable. In terms of feedback, numerous patients have described the outcome as 'getting my life back', while one patient reported that her husband has said that she is 'no longer a zombie'. The initiative has led to a substantial number of patients reducing how much painkiller they are taking; 10 engaging in exercise when they previously weren't before; and 30 being referred for physio. In the clinics the targeted opiates are now prescribed at levels below the NHS Lanarkshire average.



MANAGEMENT OF SUBSTANCE DEPENDENCY IN THE COMMUNITY AWARD JOINT WINNER, THE BUCHANHAVEN PHARMACY TEAM, PETERHEAD

'We were absolutely delighted to win this category which is an area our pharmacists have specialised in for many years, so it's even more special. During a very challenging year, this award was a very welcome reason for our team to smile. Our clients really welcome the great quality service offered by our team and they're a very rewarding client group to work with. Sharing in their successes is the best reward.'

The Buchanhaven Pharmacy Team
Peterhead

'For the first time we have deserved joint winners, Buchanhaven Pharmacy and Liz Marr and Clair Smith from NHS Lanarkshire. It is great to see the innovative work undertaken by both our winners in this award and shows what can be achieved by pharmacists and pharmacy in Scotland managing substance dependency in all its forms.'

Ken Sutherland
Ethypharm UK

'We are delighted to accept this award which we both feel really belongs to our whole team. In the community prescribing service in Lanarkshire addictions we have a fabulous team who look after each other well and so we are able to deliver excellent patient care. We have found this area of work to be beneficial to patients and their families and that is very rewarding. It is lovely to be recognised for the good practice and we are grateful for it.'

Elizabeth Marr and Clair Smith
NHS Lanarkshire



MANAGEMENT OF SUBSTANCE DEPENDENCY IN THE COMMUNITY AWARD JOINT WINNER, ELIZABETH MARR AND CLAIR SMITH, NHS LANARKSHIRE

WINNER

STUDENT LEADERSHIP AWARD

JENNIFER PRYOR

ROBERT GORDON UNIVERSITY

Jennifer is a dedicated and enthusiastic student who always takes the initiative in volunteering to support others; evoking respect from everyone she meets.

Prior to enrolling at Robert Gordon University, Jennifer was a clinical nurse specialist in acute pain management – attaining experience which has not only enriched her own studies, but has helped enlighten the learning of her peers. For example, when the Interprofessional Education (IPE) society – of which she was a member of the committee – commenced planning their Journey of the Surgical Patient event, Jennifer provided invaluable input. This included organising two face-to-face teaching sessions, putting together a number of resources, and contributing to a group chat for the pharmacy students who would be delivering the presentation.

Additionally, Jennifer discussed with the students the importance of regular pain assessment, the World Health Organisation analgesic ladder, analgesic adjuvants, advanced pain management techniques and alternative routes of administration. She mentioned different guidelines that are employed nationally and explained a couple of the less-commonly-used assessment tools that are available for specific patient groups, such as children and adults with dementia who can't verbalise.

Aware of the advantages which can be reaped from collaboration – and eager to encourage this approach – Jennifer highlighted the

benefits of effective pain management and how this involved the entire multidisciplinary team as often pain management is merely seen as a doctor prescribing analgesia and a nurse administering it.

When the IPE society kickstarted the organisation of another event, Jennifer once again was on hand to help. Based on her hospital experience she suggested another topic for it – Could it be Sepsis? – which was well-attended, effectively bolstered understanding of this life-threatening condition, and acknowledged the contributions and importance of many different professions working together.

Always going above and beyond in her efforts, within the community pharmacy Jennifer works in, she compiled a guide (both electronic and printed) for the pharmacy students, front counter staff and dispensers to use to aid them with decision-making relating to the new Pharmacy First scheme. She combined the NHS Pharmacy First Scotland Approved List of Products guidance from the previous Minor Ailments scheme and the Signposting Guidance for General Practice Teams found on the Community Pharmacy Scotland website into an easy-to-use document, and included red flags to look out for, counselling points, and alternative descriptions / names of conditions so that pharmacy staff and students with limited experience and without any medical training would be able to identify the conditions that patients were describing.

Sponsored by The Pharmacists' Defence Association



'I feel incredibly honoured to have won this award. Changing professions mid-way through a career has been a big challenge so I am delighted and grateful to have my achievements and hard work recognised.'

Jennifer Pryor
Robert Gordon University

'Jennifer demonstrated how she makes a positive contribution, highlighting how she leads from the front. We are delighted to recognise someone who is already building their contribution to the profession. Congratulations, and well done.'

Paul Day
The Pharmacists' Defence Association



STUDENT LEADERSHIP AWARD WINNER,
JENNIFER PRYOR, ROBERT GORDON UNIVERSITY

WINNER**RESPIRATORY PROJECT OF THE YEAR
AWARD****THE RESPIRATORY FAST-FORWARD PRESCRIBING GROUP
NHS AYRSHIRE & ARRAN**

The success of this project can be attributed to committed individuals, who have developed excellent inter-professional working relationships – both in the pharmacy and with external colleagues.

After discussion with the Respiratory MCN it was agreed that transformational change be directed towards the pulmonary rehabilitation resource in NHS Ayrshire & Arran, with it improving the quality of life for patients along with enhancement in self-sufficiency. A work programme was therefore devised under the sponsorship of the Respiratory Fast-Forward Prescribing Group, incorporating members of the community pharmacy and prescribing teams, a hospital pharmacist, the respiratory clinical nurse specialists, physiotherapy lead, a public health representative, a respiratory consultant and MCN manager, and chaired by a GP member with an interest in respiratory.

The group commenced implementing a comprehensive action plan to address respiratory prescribing, while also acknowledging and seeking to focus on the need to provide support through other therapies and interventions that would benefit the patient. The objectives within the programme included prescribing teams working alongside nurses to ensure compliance with formulary and appropriate switching and education of patients on respiratory medicines, and the issuing of prescribing bulletins, informing on progress with the work, introduction of guidelines and formulary, and data showing progress.

To support the primary care respiratory prescribing initiative, a community pharmacy respiratory project was cultivated – inspired by the recognition that community pharmacy can have a considerable impact on the patient's self-management of their condition.

'The Respiratory Fast-Forward Prescribing Group NHS Ayrshire & Arran were very pleased to receive the Respiratory Project of the Year Award as recognition of the hard work the team have put in to improve prescribing and patient care. As a result of the project we have been able to invest in the pulmonary rehabilitation service which has been much appreciated by our respiratory patients. The group continue to thrive, and the multidisciplinary aspect and the enthusiasm of the team working well together continue to generate new ideas.'

The Respiratory Fast-Forward Prescribing Group
NHS Ayrshire & Arran

'Teva UK is proud to celebrate the excellent work in this field, especially in light of the immense pressures on the respiratory teams with the COVID-19 pandemic.'

James Dale
Teva UK

Sponsored by Teva UK



The main aims of this project were to improve patient outcomes through a clinical review in the pharmacy to assess patients' inhaler technique, provide targeted information about relevant services available to patients with asthma and COPD, and promote the use of the local Asthma Action Plan (where appropriate).

Community pharmacies were invited to engage with the respiratory project, and once signed up, NHS Ayrshire & Arran provided a list of their patients (by CHI number) prescribed ≥ 12 SABA OR ≥ 14 ICS inhalers in the previous 12 months, to help identify the patients to target for a respiratory review. The pharmacies were also given appropriate resources and training to complete the reviews, including a structured review template (clinical review, inhaler technique assessment and public health advice on flu vaccination, smoking cessation and pulmonary rehab).

The results from engagement with the project have been exemplary, showcasing how practical enhancement to patient care can be secured. For example, where there was poor inhaler technique, correct technique was demonstrated; some patients were prescribed a spacer to improve technique; others were prescribed a different inhaler type by the IPP; and a number of individuals were referred to a GPCP or practice nurse for a change of treatment. As a result of the aforementioned work, they have been able to redirect the prescribing savings to fund the pulmonary rehabilitation service.



**RESPIRATORY PROJECT OF THE YEAR AWARD WINNER,
COLETTE KERR ON BEHALF OF THE RESPIRATORY FAST-
FORWARD PRESCRIBING GROUP, NHS AYRSHIRE & ARRAN**

WINNER

HOSPITAL PHARMACY TEAM OF THE YEAR AWARD

THE SURGICAL AND ANAESTHETIC CLINICAL PHARMACY TEAM NHS LANARKSHIRE

Sponsored by Ethypharm UK



Enthusiasm to take on new challenges, try new systems, and train others, all the while remaining vigilant and keeping medicines governance and patients' safety at the forefront of everything they do, are just some of the qualities which have contributed to the team's exceptional input.

The Surgical and Anaesthetic Clinical Pharmacy Team's provision of care is managed by two highly experienced clinical pharmacists who lead, develop, and manage the service to critical care, surgery and orthopaedics. Three band seven pharmacists additionally support the team, and together they deliver a clinical pharmacy service to acute surgical, receiving elective surgery, trauma, gynaecology and intensive care.

Significantly, they also offer advice to clinicians and the full multidisciplinary team within these specialties, and liaise closely with pre-assessment, theatres and the centralised bowel screening service for Lanarkshire, and are responsible for facilitating education, training and supervision to eight rotational band six pharmacists, pre-registration pharmacists and pharmacy students from Scottish universities.

With the rapid onset and development of the COVID-19 pandemic, the Surgical and Anaesthetic Clinical Pharmacy Team worked tirelessly to provide clinical services to patients in intensive care, high dependency and surgical / orthopaedic wards. This entailed the upskilling of staff,

dealing with the huge increase in patients admitted to intensive care with COVID-19, adapting new ways of working, and implementing new procedures for the ordering and supply of medicines. This included daily counts of all anaesthetic medicines and renal replacement fluid which had to be reported to the Scottish government.

The team have displayed excellent resilience and communication skills throughout – supporting each member with twice daily clinical briefs, and setting up an out-of-hours communication group, end-of-the-day pauses and thought for the day, with the objective of boosting staff wellbeing. As the pandemic progressed, the team members continually adapted, taking on increased flexibility, working numerous additional hours and cancelling planned leave in order to ensure that clinical cover wasn't compromised. Reaping further benefits to patients was their upskilling of pharmacists from other areas as a back-up resource should the entire team become unwell or be required to self-isolate.

Further showcasing the importance they place on collaboration, the team participated fully in national groups and teleconferences, as well as dialing into virtual teams' meetings with the intensive care clinicians and engaging almost daily across Scotland with the intensive care pharmacy groups.

'We are very proud of the way our team worked and all that we achieved during this unprecedented time and we are delighted to have this recognised at a national level. The whole team are over the moon that we have won this award.'

The Surgical and Anaesthetic Clinical Pharmacy Team
NHS Lanarkshire

'Ethypharm are delighted to be supporting the Scottish Pharmacy Awards 2020 Hospital Pharmacy Team of the Year Award. Congratulations to all involved for a fantastic performance in a very difficult year!'

Neil Peters
Ethypharm UK



**HOSPITAL PHARMACY TEAM OF THE YEAR AWARD
WINNER, THE SURGICAL AND ANAESTHETIC CLINICAL
PHARMACY TEAM, NHS LANARKSHIRE**

WINNER

EXCELLENCE IN DELIVERING SELF-CARE AGENDA IN COMMUNITY PHARMACY AWARD

Sponsored by Johnson & Johnson



THE CADHAM PHARMACY TEAM GLENROTHES

At the core of the team’s provision of care and service development has been a desire to inspire the hearts and minds of the public and promote prevention; gaining patients’ trust in order to support them to look after themselves better with their long-term health conditions.

The pharmacy’s unique skillset of medicines management and education of diseases and triggers has resulted in the team being impressively equipped to share their knowledge and expertise to help patients look after themselves better and reduce the risk of further acute episodes of illness. They place great importance on the promotion of services that will ultimately lead to a care treatment plan, which will encompass advice, buying product, private prescriptions and NHS treatment dispensing on the presenting complaint and long-term medical condition which they are aiming to improve the outcomes and quality of life with.

Recognising that in today’s society – with so much more screen time – dry eyes are increasingly common, the pharmacy offer a full eye consultation, rather than just allowing people to browse shelves of product. As well as investing in her pharmacists to be trained on common eye health issues so that they can offer advice and the most appropriate treatment for each individual, Bernadette has partnered with a company to facilitate further assistance. The software has enabled

Cadham Pharmacy to take images of patients within the practice via the AOS mobile phone app, all GDRP approved, to assess and treat surface eye conditions without the need to visit the optician. This mode of action can objectively grade the condition of the eye, giving a validated result of the condition, and when following up with the next visit or remote telemedicine call, the team can assess how the treatment is working by the grading score.

Additionally passionate about the early detection of skin cancer, the pharmacy partnered with Screen Cancer in which, since the launch of the service, around 10 people have been scanned, and two have had onward referral.

During the pandemic, the team have undertaken innovative ways of working to help the most vulnerable people in the community. Adjusting to the new normal, The Cadham Pharmacy Team have helped provide families with food parcels while collecting prescriptions; made themselves available for a cup of tea and a chat with older residents experiencing loneliness; delivered around 600 prescriptions and food parcels through the fire brigade and other volunteers; and set up a new patient access app for video consultations with parents and their children.

‘Winning the award has meant the world to my team, especially as a lot of our patients were able to benefit with better health outcomes during this COVID pandemic. We feel honoured and proud to accept this prestigious award and thank the sponsor and all involved in supporting community pharmacy and their teams.’

Bernadette Brown
Cadham Pharmacy
Glenrothes

‘Congratulations to Berni and her team at Cadham Pharmacy; a very deserving winner who has clearly worked with the patients and the services at the heart of what she does. Keeping the patient and their needs front and centre of the pharmacy strategy is so important in these difficult times. We have heard of ‘surgeries being stopped’, ‘I can’t see my GP or get to my practice’, but rarely do we hear of the closure of community pharmacy. It is due to the people working in pharmacy, and the people supporting them and doing so safely, that pharmacy is at the forefront of the NHS, and the first choice for patients more so than ever before.’

Graham Powrie
Johnson & Johnson



EXCELLENCE IN DELIVERING SELF-CARE AGENDA IN COMMUNITY PHARMACY AWARD WINNER, BERNADETTE BROWN, CADHAM PHARMACY, GLENROTHES

WINNER

COMMUNITY PHARMACIST OF THE YEAR AWARD

FIONA MCELREA
WHITHORN PHARMACY
NHS DUMFRIES & GALLOWAY

Fiona has a focused commitment to develop the pharmaceutical care and services for patients in Wigtownshire and beyond – consistently seeking the next thing which can enhance the patient’s relationship with their medicines and subsequently enhance their life.

In particular, Fiona has been a driving force for the roll-out of the Chronic Medication Service in the region and an early adopter of NHS Near Me for pharmacist-led patient consultations. However, this drive doesn’t stop at the front door of her pharmacy in that she has been integral to improving the day-to-day working relationship between community pharmacy, the primary care pharmacy team, and the GP practices. Fiona was also the first community pharmacist to provide a private flu vaccination service in Dumfries & Galloway, and has rolled it out in their other two pharmacies and supported her pharmacist colleagues with their training.

Dedicated to bolstering the future of the field, Fiona has been closely involved in developing the student pharmacy technician in primary care training programme, from the initial idea conception to the present day. The first student trained via this platform was under Fiona’s supervision and she continues to have students now – equipping them with encouragement, support and excellent knowledge to enable them to become competent technicians in a short period of time.

Furthermore, the working relationship between GP practices and community pharmacy has flourished with Fiona’s role as Pharmacy Champion. Demonstrative of the significance she places on

‘I was really delighted and surprised to win this award. This has been a very challenging year for everyone, so it was a lovely boost not just for me, but also for my hard-working pharmacy team and local community. I run a rural community pharmacy and I am a strong believer that no matter where we live, everyone is entitled to high quality healthcare. I am always aiming to better the care my whole team can offer, so this award is lovely recognition for this. Thank you.’

Fiona McElrea
Whithorn Pharmacy
NHS Dumfries & Galloway

‘Congratulations to the winner! I was very impressed by the quality and calibre of applications. The Scottish Pharmacy Awards has been instrumental over the years in stimulating innovative practice and encouraging exciting new developments even in these straitened times.’

David Thomson
Community Pharmacy Development & Governance

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Scothealthcare.com⁺

communication and patient access to services, Fiona, and the student pharmacy technician currently under her supervision, have established a Pharmacy First decision-making tool to help GP practice administration staff triage patients to the community pharmacy. Along with this tool they will deliver training on Microsoft Teams to all the GP practice staff in the locality, and it’s hoped that this will be shared across NHS Dumfries & Galloway.

Having been asked to join a national Care Home Specialist Interest Group recently, Fiona will be adopting a key role in utilising her community pharmacy expertise to boost the level of care these patients receive from pharmacy. For the first time, care home residents are eligible for pharmacy prescribing through Pharmacy First, so she is embracing the opportunity to promote and develop this service, as well as advise on topics, such as the re-use of certain medicines in care homes and the development of end-of-life medicine policies.



COMMUNITY PHARMACIST OF THE YEAR AWARD
WINNER, FIONA MCELREA, WHITHORN PHARMACY,
NHS DUMFRIES & GALLOWAY

WINNER

COMMUNITY PHARMACY PRACTICE OF THE YEAR AWARD

LOCHARDIL PHARMACY INVERNESS

Always moving forward and never standing still, the pharmacy team are continuously prepared to meet the demands of their patients, healthcare partners, and whatever the future may bring.

The pharmacy was designed with a huge dispensary and in line with the vision of presenting a modern setting, with two treatment rooms and four PMR systems, both which are fully equipped for all types of testing and enable the team to routinely carry out diabetes checks, strep throat testing, and a range of vaccinations, from a private flu service to travel vaccines.

The pharmacy has grown by 25 per cent year-on-year for the last four years despite not being within a mile of a GP surgery. This is testament to the fact that when individuals arrive at Lochardil Pharmacy they know that the team are doing all they can to help them, and that they will be treated like family.

Always eager to go above and beyond in their provision of care for patients, the team also do their best to assist other pharmacies in the city. For example, the ranitidine saga caused havoc and left pharmacy teams within GP surgeries left with hundreds of patients having to be swapped to other suitable products. This was particularly hard in finding substitutions for patients with renal difficulties and not all patients were able to move onto a different treatment in a straightforward manner. As a result, the pharmacy provided stock to help ease the flow of work

‘It’s a huge honour to have won this award given such a high standard of entries. It was just the tonic the team needed and winning the award will keep us motivated through this second lockdown. Times are hard for everyone and no sector is working harder than pharmacy at the moment, and it’s great that our team’s achievements are recognised as they truly deserve the merit and have risen to every challenge we have been faced with over the last year. They are a very special team.’

Lochardil Pharmacy
Inverness

‘It’s an honour being involved with the Scottish Pharmacy Awards which helps to showcase the fantastic work that’s going on in pharmacy across Scotland. The enthusiasm, energy and dedication of individuals and teams going for the awards each year is clear from the entries, and truly inspiring. The future of pharmacy is in safe hands!’

John McAnaw
Head of Pharmacy, NHS 24

Sponsored by Scottish Pharmacy Review

Scottish
Pharmacy
Review

streaming into GP surgeries with requests for alternatives for these patients.

Indicative of their forward-thinking approach, the pharmacy are currently working with a company called ODX who are developing a urine analysis machine that is the size of a shoebox and which can identify the responsible organism in an infected sample and aid prescribers in giving the correct antibiotic. The team ask their patients presenting with a urine infection for fresh samples for them to test in a timely manner and they are always willing to help.

Also impactful has been their close working relationship with the Highland Hospice in Inverness. They have, for several years, provided them with stock for their dispensary and prepared discharge medicines for patients at a moment’s notice so that they can return home when well enough and be with their loved ones in their final days. They embrace the responsibility and relish the chance to support the hospice and work closely with consultants and specialists on a daily basis – considering them part of their team.



**COMMUNITY PHARMACY PRACTICE OF THE YEAR AWARD
WINNER, LOCHARDIL PHARMACY, INVERNESS**

WINNER

INNOVATIVE USE OF TECHNOLOGY IN COMMUNITY PHARMACY AWARD

THE WELLBEING PHARMACIES GROUP
KIRKCALDY, FIFE

When considering convenience from a patient's point of view, and society's increasing expectation of 'on demand' convenience in other facets of life, the team were inspired and encouraged to kickstart the development of an out-of-hours prescription click and collect facility.

Having assessed several automated medicine collection solutions available in the UK and abroad, and spoken to and visited other pharmacies that had piloted them, the team felt that they were too expensive to achieve a return on investment for a small or average-sized pharmacy, and also that the platforms possessed significant operational and safety limitations. As a result, the group decided that it was necessary and more cost-effective to establish their own in-house solution to meet their needs, and approached a UK-based manufacturer to collaborate with in order to develop a bespoke product specifically for their pharmacies.

After 12 months, the prototype MedPoint collection machine was successfully installed in their High Wycombe Pharmacy in February 2019, while a further three machines have been introduced in other branches, and plans are in place to implement one in their Kirkcaldy,

'We are delighted to be recognised by our peers for this award. We have been working extremely hard on the development of the MedPoint 24/7 prescription collection concept within our group for over two years, a journey which led us to found a separate automation company trading as MedPoint with the support of Scottish Enterprise and InnovateUK. The use of automated collection has come on leaps and bounds recently, not least due to the pandemic and the fact that the MedPoint is the only solution on the market that fully automates scanning to eliminate risk of error and speed up the loading process has really set us apart from other options and our InnovateUK grant funding has enabled us to develop a completely freestanding SOLO MedPoint which people will start to see in Scotland very soon.'

The Wellbeing Pharmacies Group
Kirkcaldy, Fife

'The finalists in the category all evidenced some extremely original and pioneering uses of technology in their respective pharmacies and we would extend our congratulations to all the finalists and winners at the awards. Cegedim are always championing innovation in community pharmacy and share the details of trailblazers, who are leading the way in the industry. We were delighted to be involved in the awards again this year and proud to sponsor the Innovative Use of Technology in Community Pharmacy Award, which we were pleased to award to The Wellbeing Pharmacies Group on the night.'

Adam Dennett
Cegedim Healthcare Solutions

Sponsored by Cegedim Healthcare Solutions



Fife, branch early this year. Due to the success achieved through the initial installations, the team recognised that there would be considerable demand from other pharmacy operators, thus taking the decision to set up a separate company to become the only UK-based pharmacy automation supplier to enable them to advance the product further and market the MedPoint machines across the UK.

In light of the obstacles imposed by the pandemic, the team were aware of the urgent need for a more rapidly deployable solution to take the pressure off their busier health centre pharmacies in particular, which were experiencing significant queues due to social distancing and GP practices implementing a closed-door policy. In response to this – and reflective of the group's compassion for the community – within the space of seven weeks they worked day and night with their manufacturing partner to devise an entirely freestanding temperature-controlled model of the MedPoint which could be installed on any flat area of ground, such as a health centre car park, which was named the MedPoint SOLO.



INNOVATIVE USE OF TECHNOLOGY IN COMMUNITY PHARMACY AWARD WINNER, THE WELLBEING PHARMACIES GROUP, KIRKCALDY, FIFE

WINNER**LIFETIME ACHIEVEMENT AWARD****ROSE MARIE PARR****FORMER CHIEF PHARMACEUTICAL OFFICER FOR SCOTLAND**

From strengthening the sector in Scotland, and inspiring the enhancement of innovation and education, to instilling confidence in her colleagues and future pharmacists alike, Rose Marie Parr has been a remarkable leader for the profession – and a sore loss following her retirement after over five years as Chief Pharmaceutical Officer for Scotland.

Although Rose Marie's strides within the field of pharmacy have been immeasurable, her first steps included her completion of a Pharmacy undergraduate degree and postgraduate degrees at the School of Pharmacy at Strathclyde University, along with her Doctorate in Education at Glasgow University. Rose Marie further sharpened her expertise during her time working in hospital pharmacy in the 1980s-to-1990s in various posts in Lanarkshire Health Board and Forth Valley Health Board areas.

In 1993 Rose Marie became the Director of Postgraduate Pharmacy Education for Scotland with a remit for all postgraduate education for pharmacists in the NHS. In April 2002 Pharmacy Education was brought together with other professional educational groups into the special health board, NHS Education for Scotland (NES), which she became the Director of Pharmacy of.

Rose Marie is additionally past Chair of the Scottish Pharmacy Board of the Royal Pharmaceutical Society of Great Britain (RPSGB)

and a designated Fellow and Faculty Fellow of the RPSGB. She has also proceeded to carve out positive changes for the industry through her membership of the Scottish Medicines Committee and honorary Professorships at both Scottish Schools of Pharmacy; Strathclyde University in Glasgow and Robert Gordon University in Aberdeen.

In recognition of the mark she had cultivated thus far, and the boundless potential she possessed for driving pharmacy in Scotland further, Rose Marie succeeded Bill Scott as Chief Pharmaceutical Officer – a post which she flourished in for over five years.

Among Rose Marie's wealth of accomplishments in this post and the extensive reach of her collaboration has been the work undertaken to update both the undergraduate and postgraduate and career framework for pharmacy. Due to this vitally important process, efforts are in place to make sure that the profession is fit for the future – not just at present – but also in 10-to-20 years' time too. Critically, Rose Marie has been an invaluable support during the escalation of COVID-19; exuding warmth, reassurance and guidance when the profession and Scotland as a whole desperately needed it the most.

Congratulations to Rose Marie, our 2020 Lifetime Achievement Award honouree, and thank you for your contribution and kindness – an impact which will not only be ingrained in Scotland's pharmacy future, but in all those you have met and encouraged along the way.

'I am absolutely delighted at receiving the most prestigious pharmacy Lifetime Achievement Award this year. I am both humbled and thrilled to receive this acknowledgment of my work and life in pharmacy – a most fantastic and rewarding profession. My thanks go out to all of the pharmacy awards colleagues for this special recognition and I will sincerely treasure this award.'

Rose Marie Parr
Former Chief Pharmaceutical Officer for Scotland

'The Scottish Pharmacy Awards provide a wonderful opportunity to acknowledge the outstanding contribution that pharmacists and pharmacy teams across Scotland have made during 2020. My warmest congratulations to all the worthy winners and thanks to all who have supported the awards.'

Professor Alison Strath
Interim Chief Pharmaceutical Officer, Scottish Government



**LIFETIME ACHIEVEMENT AWARD WINNER,
ROSE MARIE PARR, FORMER CHIEF
PHARMACEUTICAL OFFICER FOR SCOTLAND**

Rethinking Pharmacy

The Cambrian Alliance Group Launches New Platform to Enable Pharmacies To Buy and Sell Stock From Each Other

The Cambrian Alliance Group today announces the launch of e-CASS market, a new platform designed to enable pharmacy contractors to buy and sell stock from each other with ease. The new platform will transform the way that contractors manage their surplus stock and also provide a vital new channel for contractors to source stock that may be in short supply via traditional methods. e-CASS is already the most widely used buying platform across independent pharmacy and this new additional platform continues to strengthen the Cambrian Alliance Group offer.

What is commonly referred to as 'dead stock' costs the average pharmacy approximately £12K per year, a significant cost at a time when independent pharmacy has never been under more pressure to maintain margin. e-CASS market will allow contractors to list stock and make it available to buy to a chosen and specified group of buyers or to the entire Cambrian Alliance Group membership of 1200. Following on from the success of e-CASS web which launched last year, the platform is easy to use, designed with contractor feedback in mind and meets with the usual high standards and reliability that the group have become known for.

Nathan Wiltshire, Group CEO said "We are really pleased to be able to bring yet another new product to the independent pharmacy market. When we first launched e-CASS some 10 years ago, it revolutionised the way that pharmacy thought about purchasing and delivered immediate benefits to our user community, we believe that e-CASS market will have a similar impact".

The new platform includes an industry first 'market match' feature available to buyers, which matches all available stock in the market to buyers specific requirements based upon their most recent product usages. The platform also ensures that buyers get notified every time relevant stock becomes available.

Use of the platform meets with current MHRA guidance with regards to the implications of the repeal of Section 10(7) for the supply of licensed medicines by pharmacy in that transactions are on a small and occasional basis and not for profit.

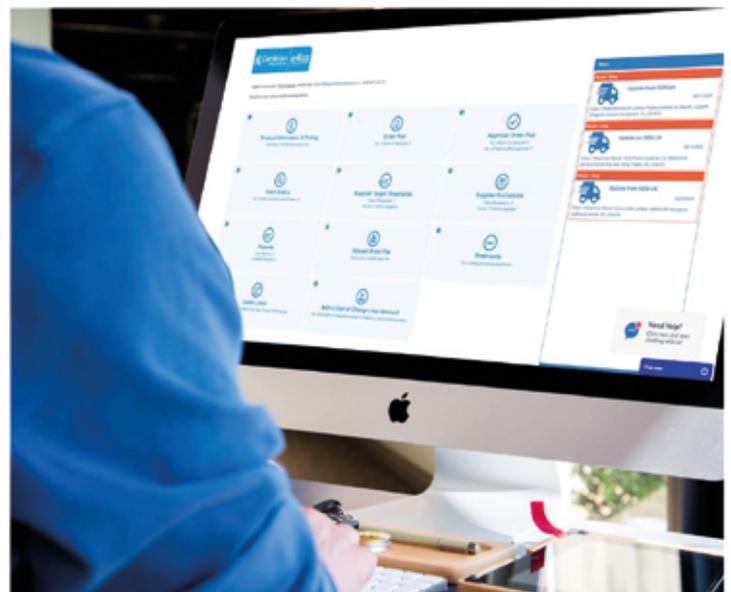
"The new platform gives contractors a vital alternative to supply at a time when product shortages and availability have never been more prevalent. In addition, we are pleased to be able to provide the market with a new tool that really enables contractors to help and support each other at such a challenging time". *Said Wiltshire.*

Editor's Note: For more information please contact Tom Griffiths at TomGriffiths@cambrianalliance.co.uk or 02920 782 957.

About Cambrian Alliance Group

Cambrian Alliance Group is the leading independent pharmacy buying group with over 1200 members across the UK. The group supports its members in achieving better purchasing margins by leveraging the buying power of its collective membership, which now exceeds £0.6Bn annually.

The group also develops technologies to support more efficient purchasing and stock management within independent pharmacy including e-CASS, e-CASS web, and e-CASS warehouse.





Introducing e-CASS Market

from The Cambrian Alliance Group



- ✔ e-CASS Market offers independent pharmacies the ability to trade stock with each other
- ✔ Use our unique Market Match feature to find stock available within our e-CASS Market community based upon your usages
- ✔ Customer specific email notifications for new product listings that you use, including price and tariff detail

**Saving you more time,
and more money.**

ROYAL PHARMACEUTICAL SOCIETY

IN SAFE HANDS

Clare Morrison, Director of the Royal Pharmaceutical Society in Scotland, chats to SPR about her transition into the post – particularly under the spotlight of the pandemic – and how the organisation is helping to protect and improve workforce wellbeing.

**ROYAL
PHARMACEUTICAL
SOCIETY**



Clare Morrison

HOW DID YOUR INTEREST IN THE PHARMACY SECTOR INITIALLY COME ABOUT?

When I was at school, I was initially interested in studying medicine but, when I was 16, I had the most amazing inspirational chemistry teacher so looked for a way to combine chemistry with helping patients. Pharmacy was the obvious choice, so I managed to get some work experience in the local hospital pharmacy and was hooked from then on! It was the best decision I ever made.

WHAT HAS YOUR CAREER PROGRESSION BEEN SINCE?

I started as a community pharmacist in London, and then spent a few years working in pharmacy journalism where I found out

how pharmacy was developing in Scotland. It was about the time of the launch of The Right Medicine pharmacy strategy and it described the kind of pharmacist I wanted to be, so I moved to the Scottish Highlands and returned to community pharmacy. I qualified as an independent prescriber and developed a number of prescribing services with local GP practices. That led to moving into NHS board roles, including working in GP practices and developing pharmacy services. I became increasingly interested in quality improvement and medicines safety, initially through leading the Scottish Patient Safety Programme's pharmacy pilot in NHS Highland, and then completing the Scottish Quality and Safety Fellowship. I also went to America to study healthcare improvement. Most recently, I developed the video consulting service NHS Near Me in NHS Highland and then led the national scale up across NHS Scotland.

WHEN DID YOU BEGIN WORKING AS PART OF THE ROYAL PHARMACEUTICAL SOCIETY (RPS)?

I joined the RPS Scotland team at the end of September 2020, so I'm still new in post.

WHAT HAVE BEEN YOUR HIGHLIGHTS AS THE RPS DIRECTOR FOR SCOTLAND THUS FAR?

The biggest highlight so far has been how welcoming pharmacists have been right across Scotland. The first step for me in coming into this role was to build relationships with pharmacy groups and organisations, as well as individual pharmacists, and that's what I have been trying to do. The COVID pandemic hasn't helped, because I would love to be out and about meeting people, but on the plus side working remotely means that I've been able to join more meetings than I would have been able to if I had been going by train or car.

ROYAL PHARMACEUTICAL SOCIETY

Linked with this is the wider engagement which it's important that the RPS does with politicians, other professions, and, of course, the public. I found our 24 days of pharmacy campaign in December, when we showcased pharmacists' work, really inspiring to be involved with. Alongside this, discussing our manifesto for the forthcoming Scottish Parliamentary elections with politicians has been interesting.

In terms of other highlights, I think what we have been doing over the past couple of months on workforce wellbeing is really important and I'm very keen that we continue to focus on this in Scotland.

HOW HAS THE SOCIETY BEEN IMPACTED BY THE CHALLENGES OF THE COVID-19 PANDEMIC? HOW HAVE YOU BEEN WORKING TO TACKLE THESE?

Back at the start of the pandemic, the RPS formed a COVID Response Team which includes staff from our policy, science, and research, guidance, and support, and communications teams. Together the COVID Response Team reviews the latest evidence and intelligence on COVID-19, produces guidance for RPS members, and decides on critical issues for pharmacy where we need to lobby government. During March and October 2020, over 9,000 pieces of intelligence were collected and analysed in order to provide fast access to key information for pharmacists. We also lobbied the government on PPE, recognition of pharmacy as NHS key workers, and on COVID testing and vaccination; and achieved extensive press coverage on pharmacy issues. I would really recommend looking at the COVID hub on our website (at www.rpharms.com/coronavirus) which contains a huge amount of information and resources, all put together by the COVID Response Team.

In terms of impacts of the COVID pandemic on the RPS itself, I think the biggest challenge is the same one that has faced everyone – how to work remotely and still be engaged with people. As I said earlier, I'd love to be meeting pharmacists across Scotland to better understand how

the RPS can support them. It's harder to do that remotely but we're trying through things like remote meetings, membership surveys, and using social media. I'm really excited to be able to tell you that in a few weeks' time we will be relaunching our RPS Scotland website which I hope will be much more engaging, both in providing information about what we're doing and, importantly, how pharmacists can get involved with the RPS.

HOW CAN THE PROFESSION ACCESS RELEVANT SUPPORT DURING THIS TURBULENT TIME – PARTICULARLY RELATING TO THEIR MENTAL HEALTH AND WELLBEING?

It is clear that the COVID pandemic has had a real impact on the population's wellbeing, and that is especially the case among healthcare professionals. At the end of last year, the RPS conducted a mental health and wellbeing survey with the charity Pharmacist Support which showed clearly how difficult things are for pharmacists. It showed that 33 per cent of respondents rated their wellbeing as not good; 10 per cent as poor; and 40 per cent as okay. It also found that 89 per cent of pharmacists were at risk of burnout. Most pharmacists said that COVID was having an impact on their wellbeing, but it wasn't the only cause, with other stresses, such as workload, inadequate staffing, long working hours, lack of breaks, lack of support and isolation, all having significant impacts.

The RPS is absolutely committed to improving pharmacists' wellbeing. In response to the survey, we launched a campaign for workforce wellbeing which you can see on our website (www.rpharms.com/recognition/all-our-campaigns/workforce-wellbeing). It explains what is needed to improve wellbeing, such as pharmacists having breaks in their working days, ensuring that pharmacy teams have access to wellbeing services and manageable workloads. We are currently asking other pharmacy organisations to join us in creating a workforce wellbeing pledge to commit to good practice for both wellbeing and inclusion in all pharmacy workplaces.

Support for pharmacists is available in a number of ways. The RPS has been providing some wellbeing workshops: coming up in March we have a workshop on time management. But it's also really important to signpost pharmacy teams to NHS wellbeing services – in Scotland that's the National Wellbeing Hub for anyone working in health and social care. It has fantastic resources and I would recommend it to all pharmacy teams: see www.promis.scot.

WHAT PLANS ARE ON THE HORIZON FOR THE RPS?

Right now, the RPS is really committed to improving workforce wellbeing. In addition to the pledge I mentioned earlier, we are also currently scoping a new RPS online community to enable pharmacists to network with each other. We hope that this will reduce some of the professional isolation pharmacists have identified, and give RPS members a safe space to connect with each other.

The RPS Scotland team has also started some really exciting work on creating a new vision for pharmacy in Scotland. We recognise that the government and every health profession is looking at how to recover and rebuild following the COVID-19 pandemic. Therefore, the RPS needs to create a vision for the pharmacy profession so that we can represent pharmacy and lobby for change where it is needed. The first step is to engage with practising pharmacists in Scotland so we accurately reflect their views, and we have started to do this.

Alongside this, we're also looking to the future, with work around encouraging the expansion of independent prescribing, and new innovations in fields, such as digital and pharmacogenomics.

And bringing it back to the RPS team in Scotland, I'm delighted that we will be joined in March by a new pharmacist, Laura Wilson, who is becoming our Policy and Practice Lead following the retirement of Aileen Bryson. So, it's an exciting time ahead. I'm delighted to be part of the RPS Scotland team, and I'd love to hear from pharmacists across Scotland about how we can support them.

MS

MULTIPLE SCLEROSIS, DISEASE MODIFYING TREATMENTS AND THE COVID-19 PANDEMIC

The COVID-19 pandemic continues to dramatically affect healthcare services and patients' lives. This is especially true for all people living with a chronic condition, including patients with multiple sclerosis, who are already dealing with an unpredictable and complex disease. In this article, Scottish Pharmacy Review and BMS aim to present a brief overview of MS and of the latest official guidelines on disease modifying treatments (DMTs) use during the pandemic, to help patients better understand and manage their condition.



Introducing the basics of Multiple Sclerosis (MS) to patients and presenting official guidance and considerations for treatment during the COVID-19 pandemic.

MS is a chronic, neurological disease that affects the central nervous system. In MS, the immune system mistakenly attacks myelin (the fatty insulation around nerve fibres), causing damage to axons and leaving lesions (scarring) that interfere with the transmission of signals from the brain to the body. Ultimately, the nerves themselves might deteriorate – a process that is currently irreversible.

While close to 85% of patients present with a relapsing form of the condition (Relapsing Remitting Multiple Sclerosis - RRMS), characterised by 'flare-ups' of disease activity and slow progression (worsening) over time, 10-15% exhibit symptoms of a progressive form of the disease, in which the condition is degenerative from the onset (primary progressive MS – PPMS).

Without disease-modifying therapy (DMT), about 40 per cent of patients diagnosed with RRMS will become progressive (Secondary Progressive MS – SPMS) within 10 years, a disease state characterised by fewer or no relapses but increasing disability.

(Sources: Lublin et al., 2014; Dobson & Giovannoni, 2019; Iwanowski & Losy, 2015; NHS UK)

WHO?

- The disease can affect people of all ages, but the most common onset occurs between the ages of 20 and 40.
- Around 130 000 people are currently affected by MS in the UK, with an increasing prevalence from South to North.
- Close to 7000 people are newly diagnosed with MS every year in the UK.
- MS is 2 to 3 times more common in women than in men.
- Among young adults, MS is the most common disease of the central nervous system to cause permanent disability in adults.
- MS can affect individuals of any ethnic group, though individuals of European ancestry appear to be at higher risk.
- Individuals with a first degree relative with MS have a 10 to 25 times greater risk of developing the disease than the general population.

(Source: MS prevalence Report January 2020, MS Society; Public Health England; NHS UK; Ramagopalan et al., 2010; Amecusa & McCanley, 2020)

WHAT?

MS patients can present with a wide range of symptoms, associated with the disruption of nerve signals across the body. The common initial symptoms of MS include visual disturbances, numbness and tingling, balance, walking difficulties and fatigue. Other symptoms include muscle stiffness and spasms, bladder and bowel problems and sexual dysfunction.

For more information about MS, visit: www.msstrust.org.uk, www.mssociety.org.uk, www.nationalmssociety.org; www.nhs.uk/conditions/multiple-sclerosis.

MS AND COVID-19

What is the impact of the COVID-19 pandemic on MS patients?

For England, NICE guidance for disease-modifying therapies for multiple sclerosis can be found at pathways.nice.org.uk/pathways/multiple-sclerosis. In Scotland, advice for DMT use can be found at www.scottishmedicines.org.uk/medicines-advice/. Additional information can be found at the website of the UK's two main MS charities: www.msstrust.org.uk and www.mssociety.org.uk. For more tailored treatment guidance and advice, better suited to their unique condition, people with MS should contact their local MS team.

OFFICIAL RECOMMENDATION ON DMT USE DURING THE COVID-19 PANDEMIC

The Association of British Neurologists (ABN) has recently published a guidance on DMT use in MS during the COVID-19 pandemic (November 2020 – to be reviewed in March 2021). This document constitutes an important point of reference for questions regarding DMT use during the current pandemic.

In addition, peer-reviewed datasets are starting to emerge on the potential risks and benefits associated with DMT treatment during the pandemic (Möhn et al., 2020; Laroni et al., 2020) and will help inform future decisions by regulatory agencies and MS teams.

COVID-19 VACCINATION AND DMT USE

The ABN has recently published a guidance on COVID-19 vaccination for people with neurological conditions (January 2021), which include MS.

PATIENTS FREQUENTLY ASKED QUESTIONS

WERE THE COVID-19 VACCINES TESTED ON PEOPLE WITH MS?

The vaccines were tested on large groups of patients in both the active and placebo groups. We do not know if people with MS were in those groups.

CAN I HAVE THE VACCINE IF I AM TAKING A DMT?

DMTs can affect the immune system. There exist some ongoing discussions as to which extent can DMTs affect the COVID-19 vaccines stimulation of an immune response, and the effect on the resulting protection it can confer to individuals. As more data become available, it is likely that ABN and NHS guidelines will be updated.

I HAVEN'T STARTED A DMT YET. SHOULD I HAVE MY VACCINE FIRST?

Talk to your MS team about the best strategy for you.

WHEN WILL I RECEIVE A VACCINE?

The order of priority is based on individual risk, and aims to protect the most vulnerable people and the health and social care systems. This means that the main criteria for the first phase of the vaccination programme will be age.

For patients with no other underlying health conditions apart from MS, we understand that they would be offered a vaccination at priority level six. This is because the list of underlying health conditions considered relevant by the Joint Committee on Vaccination and Immunisation (JCVI) includes chronic neurological disease. If you are older than 65, you will be invited to be vaccinated earlier.

Patients considered extremely clinically vulnerable, and who have been asked to shield, are likely to be included at priority level four. Pregnant women and children under 16 will not be included in this group as there is not enough safety data for the vaccines in these groups. This may change at a later date.

For more information about the priority levels for vaccination, official information is available at: www.gov.uk.

STAYING WELL DURING THE PANDEMIC: MS RESEARCHERS SPEAK OUT

Staying well has never been more important for people living with MS, say a group of MS rehabilitation researchers in a published editorial, as the COVID-19 pandemic disrupts lifestyle habits and coping resources. The researchers – representing the National MS Society's Wellness Research Work Group (US based) – present tips for people with MS and their healthcare providers to consider:

- Staying active can improve walking, balance, fatigue, depression and quality of life. If it's challenging now, engage in short bouts of physical activity throughout the day. Guidelines are available for ALL people with MS
- A healthy diet is associated with less depression, lower levels of disability and higher self-reported quality of life. But you don't need to overhaul your diet. Individuals should try simple changes, such as making half of their plate fruits and vegetables, and choosing olive oil or grapeseed oil. Reading labels is also encouraged – any food with less than five ingredients is less likely to have too much salt or refined sugar
- Addressing emotional wellness can not only alleviate the depression that affects people with MS, but can help with MS symptoms, such as pain and fatigue

(Source: Motil et al., 2020)

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BOWEL'D OVER

In this interview, Director of Research and PPIE (Patient and Public Involvement and Engagement) at newly-launched charity, Bowel Research UK, Lesley Booth, discusses why bowel research is so important – highlighting the crucial role played by the charity and offering key insight on the development of bowel research and what more needs to be done. Having been diagnosed with IBD herself, Lesley is uniquely placed to support the work of Bowel Research UK and has been a driving force behind the patient-centred approach to research championed by the charity.



Lesley Booth



CAN YOU GIVE US AN INSIGHT INTO THE CURRENT STATE-OF-PLAY OF BOWEL CANCER AND IBD?

It's estimated that around 42,000 new bowel cancer cases are diagnosed each year in the UK, where it is the fourth most common cancer. Since the early 1990s, bowel cancer incidence rates have remained stable in the UK. Every year over 16,000 people die from bowel cancer in the UK, however bowel cancer mortality rates have decreased by approximately 44 per cent over the last decade. (1) Survival rates are high if it is caught early but it is still the nation's second leading cancer killer, highlighting that many people are still not being diagnosed soon enough. Around half of the population are not adequately screened (2) and many patients end up in A&E at Stage III or IV diagnosis, rendering it potentially incurable.

The two major types of IBD are Crohn's disease and ulcerative colitis and there are up to 300,000 sufferers in the UK. It is a chronic inflammatory condition for which there is currently no medical or surgical cure. IBD is primarily a disease found in young people, with most cases being diagnosed when the patient is between 10-and-35 years, and the disease is becoming more common, particularly targeting adolescents. (3) Scientists don't know if this is due to diet, lifestyle or pollution.

WHY DOES AWARENESS AND SUBSEQUENT DETECTION REMAIN SUCH A MAJOR CONCERN IN SOCIETY?

Research shows that early diagnosis saves lives which is why raising awareness of symptoms and encouraging GP visits are so important. Qualitative studies suggest that stigma can discourage people from attending cancer screening. (4) There is significant reluctance and embarrassment when talking about bowel 'issues'. Social taboos often put bowel patients off visiting their GP and chronic and terminal diseases often present too late. This is of particular concern in the case of bowel cancer where patients who are diagnosed late have a poor prognosis compared to those that present early.

CAN YOU TELL US ABOUT THE ORIGINS OF BOWEL RESEARCH UK AND THE MOTIVATION BEHIND ITS ESTABLISHMENT?

Bowel Research UK was founded in 2020 following a merger between two well-respected charities – Bowel Disease Research Foundation and Bowel & Cancer Research. Together the two charities have over 50 years' worth of experience in helping to fund cutting-edge research, helping to make enormous progress in the fight against bowel

cancer and other bowel diseases. By focusing resources and expertise, we will be able to fund more research and ultimately impact more lives.

In the UK, bowel cancer and other bowel diseases require much more funding, particularly as these conditions can affect anybody; one-in-15 men and one-in-18 women will suffer from bowel cancer during their lifetime. We believe that a cure for bowel cancer and effective treatments to mitigate, or entirely eradicate, other bowel diseases remains possible – but only if we continue to fund leading research and invest in our scientific and medical communities.

In addition to research funding, we aim to raise the profile of bowel cancer and other bowel diseases in the UK. Embarrassment can cost lives and we believe that the unnecessary stigma around the bowel must be overcome in order to make progress.

HOW DID YOU GET INVOLVED WITH THE CHARITY AND WHAT HAS BEEN YOUR FOCUS?

I have had IBD for approximately 30 years and then, following a diagnosis of early-stage bowel cancer, I had an ileostomy in 2016. I had worked in the higher education sector for 25 years and have a strong understanding of research. I wanted to give back to the professions that had given so much to me, so I joined Bowel & Cancer Research in 2018 to connect patients to researchers and researchers to patients. I have felt truly humbled in meeting so many amazing people willing to give so much of their time to improve the lives and wellbeing of those suffering from bowel disease.

As the Director of Research and PPIE at Bowel Research UK, I play a key role in developing and delivering the charity's research strategy and driving the research agenda. This includes identifying research priorities, the research grant and PhD programmes, facilitating and overseeing partnerships, promoting patient and public involvement on a wide range of research activities, and the dissemination of research outcomes.

This year I have been heavily involved in CovidSurg, an international collaboration that was established to understand the outcomes of COVID-19-infected patients who undergo surgery. Covering 88 countries, 1,032 centres, and over 52,300 patients, CovidSurg has already influenced World Health Organisation guidelines and is informing the management of patients across the globe during the COVID-19 pandemic.

WHAT PRIORITIES NEED TO BE AT THE FOREFRONT OF THE BOWEL RESEARCH AGENDA?

Bowel Research UK has set out a clear list of priority areas to ensure that we effectively drive the bowel research agenda. Firstly, we need to encourage society to become more aware of, and to support, bowel disease research. We must ensure that we are offering up-to-date, accurate and accessible information on our research programme – including priorities, outcomes and impact – tailored to the needs of people affected by bowel diseases. This is a crucial step towards making research more user-friendly and ultimately more patient-centred. Embedding patient involvement and public engagement in developing our research and funding decisions is also a priority to ensure that research delivers on both clinical and patient needs. Additionally, we must ensure that we are supporting the scientists of tomorrow by funding the next generation of research 'rising stars' today. With this, we

can help to drive change as a result of our endeavours, and campaign for further investment in research.

WHEN IT COMES TO BOWEL DISEASES, HOW CAN HEALTHCARE PROFESSIONALS INCREASE THEIR MOMENTUM AND IMPACT IN SHAPING PATIENT CARE?

The mental and physical impact of bowel cancer and other bowel diseases on patients is often unimaginable and the best treatment option frequently changes from patient-to-patient. Patient-centred research is essential to improving the experience of people living with bowel cancer and bowel disease. Bowel Research UK is uniquely connected with patients, industry and researchers.

Healthcare professionals can enhance patient care through proactively working with patients on co-produced research to identify what patients regard as important. This includes listening to, informing and involving patients, and focusing on saving as well as improving patients' lives.

LOOKING AHEAD, WHAT WOULD YOU LIKE THE FUTURE TO HOLD FOR THE CHARITY AND BOWEL RESEARCH MORE WIDELY?

We want to eradicate bowel disease through researching cutting-edge treatments and investing in the best science. By pushing boundaries for health solutions and innovative models that connect care across the continuum and the lifespan, we aim to help educate and fund future research that might lead to a cure tomorrow.

We believe, however, that research into bowel cancer and other bowel diseases is heavily underfunded when compared with other conditions. We would like to see more funding and it is our duty to help spread the word and let people know that by funding research – together – we can save and improve thousands of lives.

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For more information, visit www.bowelresearchuk.org.

PROMOTION

THE NEXT CHAPTER

SPR catches up with Brendan Moffatt, Key Account Manager for Bestway Medhub, about his reflections on 2020 and what we can expect from Bestway Medhub in 2021.



Brendan Moffatt

Bestway Medhub is a short-line wholesaler supplying products and services to the independent pharmacy and dispensing doctor sectors, supporting over 3,000 customers across the UK. As part of the Bestway Group, the company has the backing of the largest independent wholesale business in the UK.

Established in 2015, Medhub has grown significantly, working to the values of being open and transparent, fair, and simple, with a dedicated Field and Telesales Team supporting customers day in and day out.

The business is led by Paul Insley, who sits on the Healthcare Distribution Association (HDA), a body that helps shape the wholesaling and distribution landscape to support the ever-changing and challenging world of pharmacy.

WHAT DO YOU LIKE ABOUT WORKING AT BESTWAY MEDHUB?

It's really exciting to be part of a business that is growing. No two days are ever the same and we are focussed on delivering an outstanding service to our customers and their patients. This is my third year working for Bestway Medhub and in that time the Field Sales Team has grown from three-to-10. I've been promoted to Key Account Manager and our Telesales Team has

doubled in size!

As a business we continue to innovate for the benefit of our customers – we've launched a buying platform and web portal, making it easier to order products with us and access past invoices and orders – we've also increased our ranges significantly. What I am most proud of is all through this growth we have stayed true to our values and customer promise – to be transparent, fair and simple. We have no minimum order values, no targets to hit, or rebates to keep track of at the end of each month. It's really as simple as the price you see is the price you pay, and we always strive to make sure that it's as competitive as it can be.

WHAT ARE YOUR REFLECTIONS FROM 2020?

The way pharmacy has stepped up and responded to the pandemic is incredible. While coping with their own worries, pharmacists and pharmacy teams have shown levels of determination every day looking after the health and wellbeing of their local communities, which I find inspirational. I felt an immense responsibility to make sure that we make the purchasing process as simple and hassle-free for our customers as possible during these challenging times.

For me, that's all about great partnership working and communication with my customers. At Bestway Medhub, I am trusted to do what's right for my customers and that empowers me to act quickly in their best interests. Also, our business values are more than just words – it's how we work. It's not our policy to go into huddle rates and retros – the price you see is the price you pay, so I can focus on what's most important to them.

WHAT CAN BESTWAY MEDHUB CUSTOMERS EXPECT IN 2021?

We will continue to grow and offer an improved experience to our customers – we're passionate about making our services accessible to as many independent pharmacies as possible.

We believe that making our offer simple and straightforward means our customers can focus on delivering great patient care.

We launched a web portal in 2020 giving our customers an additional order method, creating a self-service element that supports pharmacies 24/7. We plan to add new features to this, and we are increasing our range in line with customer feedback, adding OTC and surgical lines. We have a lot of work going on behind-the-scenes to extend our customer offer as the demand on pharmacy increases.

WHAT ARE YOU LOOKING FORWARD TO MOST IN 2021?

2020 was a challenging year and we've still got a long way to go before we can get back to seeing those we care and love – our family and friends. With three vaccinations now approved, for me, there is light at the end of the tunnel, and I hope that at some point this year I will be able to return to pharmacy and start meeting my customers face-to-face.

I've missed being in pharmacy and attending pharmacy events that give me a better understanding of the priorities for community pharmacy.

I am very much looking forward to seeing my customers and being able to thank them personally for their outstanding work over the last year – thank you to everyone in community pharmacy for everything you continue to do to support the nation's health and wellbeing.

For further information about opening an account with Bestway Medhub, to speak to an Account Manager or to find out more about the company's new ordering portal, call 0800 050 1055 or email Brendan Moffatt at brendan.moffatt@bestwaymedhub.co.uk.

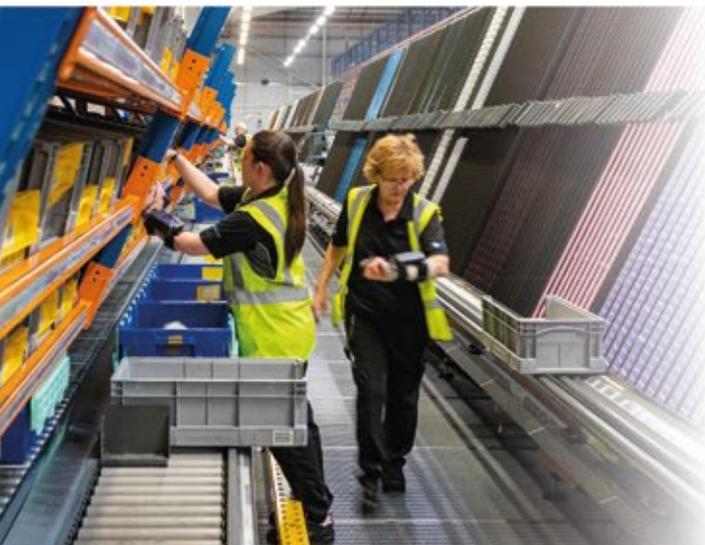


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BESTWAY MEDHUB

CHRONIC HEALTH

THE MENTAL BATTLE OF CHRONIC HEALTH

Despite the increased visibility of mental health and help available, there's one vulnerable group who are still being left out of the conversation – those living with chronic physical health conditions. Catriona Williams, from online health community, talkhealth, explains further.

In the past few years, mental health has become a hot topic – and with good reason. According to the mental health charity, Mind, one-in-four of us will experience a psychological issue or period of poor mental wellbeing at some point or other. Male suicide rates hit a two-decade high in England and Wales in September (according to ONS data) and experts have called poor mental health among young people an 'escalating crisis'.

EXPLORING THE CONNECTION

Body and mind are so connected – it's obvious that when things go wrong or become defective in one, the other is affected. We need only look at conditions like psoriasis to see how stress impacts on the biggest organ in the body. Endometriosis survivors often have to manage chronic pain and bleeding alongside depression and anxiety. IBS patients are often diagnosed with generalised anxiety disorders, while severe asthma can trigger panic attacks in some patients.

Living with a long-term illness can present various challenges to mental health and while it's not always possible to look towards a condition-free future, it's worth considering how we can reframe our understanding of physical wellbeing.

MANAGEMENT MECHANISMS

Each month at talkhealth, we interview a healthcare professional with the aim of providing our members with a little insight into their work. We recently spoke to Physiotherapist Tony Linkson on how therapy can help people managing chronic health. He told us that on a very basic level, simply having the focussed support of a person who's willing to listen and understand the challenges of illness can be liberating.

He went on to explain that 'another aspect of chronic illness is the possibility of exploring the ways in which life choices might be causing or exacerbating illness. I've worked with a large

number of people who have had physical ailments that heal once emotional and psychological issues have been processed.'

That, to many of us, might sound incredible, but it seems reasonable to suggest that the mind may wield more power over our chances of recovery from physical illness than some would have us believe.

As Tony explained, 'If and when a chronic illness can be remedied, sometimes people can find themselves habituated as an ill / vulnerable person or a person in pain.' That can be a fear response and talking therapies can help people to embrace health again and to let go of what may be negative coping mechanisms.

A MULTIFACETED PROBLEM

Of course, therapy isn't the be-all and end-all. At talkhealth, we work with lots of bloggers and patient advocates who spend much of their time building communities of people who live with similar issues. One such person is Clare Baumhauer, who has been busy raising awareness of vulval cancer and lichen sclerosus (LS) by setting up a support group and Instagram page. She was diagnosed with both conditions at 43 – nearly 40 years after first experiencing LS symptoms.

'The stress of not getting a diagnosis for many years did impact a lot on my mental health as you're led to believe that it's all in your head. Once I was diagnosed, I was so angry. Now it's hard to not always think that LS is going to turn to cancer again so it takes over my thoughts, especially at night,' she told us.

Clare went on to say that the single most useful tool she's found for coping with LS has been talking about the condition with other people living with it.

It's clear from Clare's experience that the mental health aspect of chronic health is multifaceted; isolation, frustration and fear come together to send patients into a spiral.

talkhealth is a patient-centric platform that largely looks at ways in which people can better self-manage their long-term issues. While we understand the need for better and more comprehensive mental health support, we're focussed on addressing the specific challenges that chronic health can pose to mental wellbeing. As such, we've been busy interviewing mental health professionals on how therapy and self-care can help those of us who are managing complicated health profiles. We understand that it's impossible to implement a blanket approach to mental health; not only does everyone have their own ways of coping with challenging situations, but even patients with the same physical condition will find that it metabolises mentally in different ways.

BUILDING AN OPEN SPACE

Talking and allowing people to open up about their experiences is such an obvious tool but it's still the most effective one. Our online expert clinic on LS – a debilitating and often embarrassing condition that affects millions of women – was one of the most popular clinics that we've ever done. It's not that LS is so incredibly common; its popularity was down to the fact that it's such a difficult subject to openly discuss. Giving people the space to vent, confide, and receive advice was hugely powerful.

We're fortunate that our platform improves the mental health of our members almost as a byproduct; connecting and creating communities necessarily affords people a space to open up and share the burden.

For more information, visit www.talkhealthpartnership.com.

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Prescribers should refer to summary of product characteristics for full prescribing information.

Approval Code: Inf EU-GB-0143

Date of Preparation: November 2020

References: 1. Diurnal. Alkindi® Summary of Product Characteristics. Available from <https://www.medicines.org.uk/emc/product/9032/smpc>;
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