Scottish Pharmacy Review

ISSUE 132 - 2021

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One remarkable overdose prevention campaign helping to save lives

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WELCOME

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EDITOR'S LETTER

Welcome to the latest edition of Scottish Pharmacy Review!

I'm an organiser at heart and I always have been. Lists, timetables, schedules, deadlines – I swear by them all. I remember on my 14th birthday, when all my friends had asked for scooters and skateboards, I begged for a specific lilac leather Filofax which I had seen in our local stationery shop months prior. It's not like I had any actual plans to record – besides the timings of my favourite Nickelodeon programmes (which I already knew by heart anyway) – yet I persevered and ensured that every page was promptly filled with my plotting and rambles.

However, like the rest of the population, the last year stripped me of my forward-thinker status and forced me to be solely in the present; for once in my life focussing only on each day instead of beckoning the next. The time I usually spent inking my plans was transferred into refreshing my news apps. The effort I typically invested into checking my friends' future availability, I transferred into checking up on their daily wellbeing.

And now that the grains of normality are slowly stacking up again and making plans is no longer viewed as an infeasible prospect? Well, I'm terrified. I missed the organiser that I was and am, but stepping into this role again feels daunting. What if, once solidified, my expectations collapse again? What if looking ahead is just too scary and fragile?

After compiling this edition's content, I'm realising that there is more hope to be found in adapting and moving forward than there is in remaining still. It's this ethos that underpins our upcoming 2021 Scottish Pharmacy Awards which – in compliance with updated COVID-19 guidance – will celebrate the sector and its unwavering heroes. You can check out the latest updates and how you can continue to stay in the know from page 21.

Also in this issue, The Aplastic Anaemia Trust share not only the pandemic's impact on the aplastic anaemia community, but their plans to understand this ever-shifting landscape (page 42), the Scottish Association for Mental Health tackle the profession's worsening mental health (page 11), and the Age UK team present tips for helping patients grapple with the burden of urinary incontinence (page 14).

Elsewhere, check out the launch of a new healthcare campaign, The Hidden Lifesavers (page four), and new findings which depict why IBD services in Scotland require more resources and support (page six).

Take care.

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Formerly known as Medical Communications 2015 Ltd, the company is at the forefront of cross-platform publishing and events for pharmacists and healthcare professionals across the UK.

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HEALTHCARE CAMPAIGN

THE HIDDEN LIFESAVERS

An overdose prevention campaign is encouraging people who use drugs to do something remarkable – save a life.

This spring saw the launch of a healthcare campaign unlike any other. The Hidden Lifesavers was a poster campaign encouraging people who use drugs to carry another drug – naloxone.

It marked the first nationwide effort to talk specifically about opioid overdose prevention, and how the drug naloxone can reverse an opioid overdose, caused by drugs like heroin.

The campaign ran as posters on the street and in pharmacies, in cities where overdose rates are high – places like Manchester, London, Birmingham, Cardiff, Glasgow and Edinburgh, as well as others. This was a campaign with true reach.

What made the campaign unique was not only that it was talking directly to people who use drugs – it was co-created by people who've used drugs. All the individuals featured were real people, and the adverts reflect their individual reasons for carrying naloxone.

From Lea's shocking story about being brought back from the brink, to Nicky's harrowing tale about losing the love of his life to overdose, the campaign was about making a real connection using real stories.

WHY IT MATTERS

Opioid overdose deaths are all too common in the UK. Every year, thousands die, and the number is only increasing. 3,380 people lost their lives to opioid-related overdoses in the UK in 2019.[1–3]

Naloxone can reverse an opioid overdose. It's been used for decades by ambulance crews and in hospital settings to save lives. As part of UK law, it's free and legal to carry by almost anyone, following short training.

So why are people still dying? The reason could be simple. Currently, few people who use drugs carry naloxone. Only around five-to-16 per cent of those at risk of an overdose – predominately those who use heroin – carry it. [4]

People who use drugs may be more likely to witness an overdose. They could be the ones best placed to save a life.

It was from this insight that the Hidden Lifesavers campaign was born.

'I WENT TO 40 FUNERALS IN ONE YEAR.'
LEE'S STORY

No-one flies the flag for naloxone like Lee. He's a well-known advocate for it in his hometown of Nottingham, and he knows many in the drug-using community. Sadly, this also means he knows many who have died. Lee has lost countless friends. In 2019, he estimates he went to 40 funerals. He says there were more – but he just couldn't bear to go to another. It's an unthinkable amount of loss for anyone. But it's this experience that motivates Lee in championing naloxone even more.

THE CREATIVE APPROACH

The Hidden Lifesavers was created by healthcare communications agency Havas Lynx Group and funded by pharmaceutical company Ethypharm.

The challenge Havas Lynx Group and Ethypharm faced was finding a way to connect with the drug-using community. It's a community that is, by its nature, very difficult to reach. People in this community have spent their lives being marginalised and ignored – and as such, are understandably sceptical of outsiders.

In short, they had little reason to listen to an advertising campaign.

So Havas Lynx Group spoke to the only people this community trusted: people who use drugs. The only people who have experienced the true reality of an overdose.

But not only that – these particular people were also the few that carried naloxone.

As Andy from Redcar, a naloxone advocate who has previously used heroin, explains, 'People will listen to me, because I've lived their life, I've walked in their shoes.'

The agency teamed up with renowned street photographer Harry F Conway and travelled across the UK, from Nottingham to Dundee, to shoot and interview these individuals. The stories they shared were wide and varied, but with one thing in common: they'd all lost someone they loved. Best friends. Brothers. Partners. Parents. Deaths that they knew might have been prevented with naloxone.

Their stories became the campaign. Every headline is built on their experiences and every shot is a true reflection of their character. The truth is used in all its brutal power.

For the first time, a marginalised community had a campaign speaking directly to them. With a message they couldn't ignore: Carry naloxone. It could help save a life.

Reception for the Hidden Lifesavers has been widely positive. Niamh Eastwood, Executive Director of Release, has tweeted, 'What I LOVE most about the overdose awareness & #naloxone campaign is that people with lived experience are front & centre of it, as well as part of the planning, developing & design behind it. Truly inclusive.'

The challenge of opioid overdose is great and it won't be solved overnight. But the Hidden Lifesavers is a step forward in ensuring that people who use drugs are given support, dignity and every opportunity to save the people they love.

No-one should die from an opioid overdose anymore.

For more information, visit www.naloxone.org.

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MAKING THEIR VOICES HEARD

Evidence from over 800 people in Scotland with Crohn's or Colitis – also known as Inflammatory Bowel Disease (IBD) – and 14 specialist IBD health services illustrates that the picture of care across Scotland is costing some patients their health and the NHS millions in unnecessary emergency treatment. How can better support be secured for the 44,000 people in Scotland living with this complex condition? Crohn's & Colitis UK, as part of IBD UK, explore.

A new report from IBD UK – a coalition of leading health specialists in Crohn's and Colitis care, including charities, professional organisations and Royal Colleges – reveals a picture of IBD care in Scotland which was already troubled prior to the COVID-19 pandemic. The 'Crohn's and Colitis Care in the UK: The Hidden Cost and a Vision for Change' report is the most comprehensive assessment of UK care ever undertaken from the unique perspective of both the services delivering care and the patients receiving it.[1]

The impact is significant, with research conducted by NHS Lothian citing a figure of one-in-every-125 people living with IBD in Scotland; extrapolated to the population, this is approximately 44,000 people.[2] Lifetime costs for IBD are comparable to heart disease and cancer, yet IBD is not as well-known or understood among the general public, with 79 per cent of people surveyed saying they felt the public had little to no understanding of IBD.[3] The report showed that services are under strain and struggling to meet the 2019 IBD Standards put in place to ensure the best outcomes for patients.[4]

Sarah Sleet, CEO at Crohn's & Colitis UK and Chair of IBD UK, explained, 'Crohn's and Colitis are serious conditions which aren't taken seriously. They cost the NHS as much as cancer and heart disease for each patient, and can be as devastating, but they lag behind in the recognition and support needed to improve lives. Unacceptably high levels of emergency care and delays to diagnosis, investigations, and surgery, exacerbated by the COVID-19 pandemic, are signs of services under pressure and a model of care which is not working. The report sets out a vision for change – this needs to be prioritised by governments across the UK and supported with a defined long-term strategy.'

TOO MUCH VARIATION

The report reveals that one of the key issues in Scotland is the variation in terms of service provision, processes, and staffing levels between services across the country, meaning that people with Crohn's and Colitis don't always have access to the full range of specialist care they need. Most services are falling far short of meeting the IBD Standards recommendations for crucial roles, including IBD nurse specialists, dietitians, and psychologists. 92 per cent of respondents in Scotland reported that they didn't have a personalised care plan which helps them meet their goals, and just over half (54 per cent) felt that their care was co-ordinated with other specialist services. Those who didn't have access to a team of IBD specialists were more likely to report that they felt unable to cope with their condition over the previous year.

'I've needed to access dietitians, mental health professionals and rheumatologists linked to my IBD but I've struggled when services haven't been joined-up or easy to access. I've rarely been asked about my mental health or fatigue, although these have been hugely debilitating. Over the years, I've played the middleman, managing my care between my GP and consultants.'

Anisha Gangotra, 37, living with Ulcerative Colitis

INFLAMMATORY BOWEL DISEASE

A WORK-IN-PROGRESS

Scotland has seen progress on IBD care in the last few years. 'Scotland Leading the Way: A National Blueprint for IBD in Scotland'[5] was published in 2016 with the support of the Scottish government, and in 2017, the Scottish Parliament Cross Party Group was formed to raise awareness among parliamentarians of the issues faced by people living with IBD and to oversee the implementation of the recommendations within the blueprint. From these, Crohn's & Colitis UK, in partnership with the Modernising Patient Pathways Programme, continue work with a focus on person-centred care and supported self-management currently with pilot projects, the outcomes of which will be scaled up across Scotland.

'Scotland has led the way in IBD care. Through joint working between the Scottish government, clinicians, people living with IBD and Crohn's & Colitis UK, we launched the UK's first National Blueprint for IBD in 2016. We then co-produced a flare card to help people with IBD recognise flare symptoms and access appropriate support and an individual care plan. This report gives us the evidence we need to further develop and embed this work across all services in Scotland, ensuring everyone in Scotland with IBD receives safe, consistent, high-quality personalised care.'

Dr Ian Arnott, IBD Clinical Lead, Modernising Patient Pathways Programme, Scottish government

THE WAITING GAME

It's hugely important that people with IBD and healthcare professionals recognise flares – when symptoms are more troublesome – so that they can receive timely treatment. The report found that it's taking too long for people with Crohn's and Colitis to be diagnosed, delaying their treatment and support, and resulting in potentially avoidable flares and emergency care.

In Scotland, over a quarter (25 per cent) of patient survey respondents waited over a year for their diagnosis, the highest figure out of all four nations. Over two-thirds (69 per cent) reported waiting more than the recommended four weeks from referral to a specialist to being seen, and 38 per cent visited A&E at least once before diagnosis. This should not be the norm for people with IBD. Not only does this have a human health impact, but it's incredibly costly to the NHS as the report showed that the cost of managing someone in a flare is up to six-times higher than when they are in remission.

'Over one-to-two years before I was diagnosed, I went to the GP several times. My diagnosis was sudden and scary. At 4am one morning, I was in terrible pain and couldn't move an inch. I felt like something inside was going to pop, so an ambulance was called. I had a CT scan which showed that my bowel was perforated and I had contracted sepsis. I needed emergency surgery, which resulted in a stoma being formed to allow my bowel to rest... It had a big impact on my mental health.'

Jacob Hodgson, 19, living with Crohn's

Once diagnosed, care for people with Crohn's and Colitis is not proactive and is focused on medication, rather than the wider impact of the conditions. People are often left struggling with severe pain, extreme fatigue, anxiety, and problems outside the gut, with 90 per cent of patient survey respondents in Scotland reporting that they found it hard to cope with having Crohn's or Colitis over the previous year. 60 per cent of people in Scotland were not asked about mental health and wellbeing. Left unchecked and unchallenged, we risk losing the potential of more future generations of young people with IBD unable to live fulfilling, productive lives.

'It is exhausting. I find that every day I need to figure out how to get a 'balance' so I can carry out my work duties to the best of my ability, be able to still have some sort of contact with my friends and be able to recharge. I struggle mentally with this condition as it takes me a while to bounce back after a flare-up, and any hospital admission or appointment has an impact on my job, and then fears around sickness records and pay cause me to be stressed out too, which can contribute to an ongoing flare.'

Kirsty Gibson, from Ayrshire, 30, living with Ulcerative Colitis

'The pandemic has undoubtedly given the NHS increased pressures, but we need to ensure that people with Crohn's or Colitis are not left behind as services rebuild post-pandemic. It is vital that their needs are recognised and prioritised accordingly. The consequences of not doing so would be profound on those living with Crohn 's and Colitis who may be facing potentially life-changing complications. COVID-19 is highlighting and widening variation in the quality of IBD care and people with IBD are facing even longer waits for elective care, surgery and investigations. We need urgent action to ensure better and more equitable care.'

Elaine Steven, Policy Lead (Scotland and Northern Ireland)

A PLAN OF ACTION

This coalition of experts in IBD care want political decision-makers in Scotland to ensure that IBD continues to progress and become recognised as an NHS priority with a clear government strategy over the next five years.

Other recommendations found in the report include:

- A public health campaign to raise awareness of Crohn's and Colitis symptoms
- Faecal calprotectin to be used consistently by all GPs to speed up diagnosis (this is the poo test used to help identify possible IBD)
- Improved government resourcing of IBD services to enable appropriate and timely care
- Care planning and support for people to have the knowledge and skills to manage and live well with their condition
- Rapid access to investigations and flare pathways in place
- Surgery waiting times for IBD to be reduced

Given the cost and impact, and an ageing population, this is a timebomb for the NHS and a condition that needs to be recognised and prioritised.

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IBD UK
Strategy
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CROHN'S & COLITIS UK

PROMOTION

ABBEY CHEMIST IMPROVES THE PATIENT JOURNEY

'Caring for our community' has always been the ethos of Abbey Chemist. Through its three pharmacies, employing around 40 people, the family-run business is committed to improving every aspect of the patient journey and playing a key role within the community in providing first contact services for patients. As part of the non-profit Edinpharm Buying Group, Abbey Chemist is gaining the benefits of lower cost access to technology, medicines and products – including direct integration with Pharmacy Manager from Cegedim Healthcare Solutions which automates access to Edinpharm's Order Management System and delivers fast-track access to the best value medicines.

FAMILY PHARMACY

Abbey Chemist was founded by pharmacist Asgher Mohammed in 1986 in Paisley. Two further pharmacies were added, in later years, and Asgher's son Siraj Mohammed has joined the business as pharmacy director and superintendent. The community pharmacies have always focused on improving patient care by providing a wide range of services, an approach that is increasingly key to NHS strategy in Scotland as the pharmacy becomes the first point of patient contact.

The new demands facing community pharmacy have created additional requirements for robust, reliable and easy-to-use PMR systems. Abbey Chemist has been using Pharmacy Manager from Cegedim Healthcare Solutions since it was first introduced and, explains Siraj Mohammed, has benefitted from the upgrades, redesign and enhancements that have been delivered over the past few years.

Nearly all of Abbey Chemist's 40 staff have access to Pharmacy Manager and everyone has found the software easy to use.

'With so much change and the increasing demands on community pharmacy, a reliable, user-friendly PMR system is essential,' he says.

BUYING GROUP

Abbey Chemist is part of Edinpharm, a non-profit buying group that supports pharmacies by providing professional support and buying power. Edinpharm's relationship with Cegedim Healthcare Solutions provides its 225 community pharmacy members with not only a better price for the technology, but also integration between its Order Management Solution and Pharmacy Manager to automatically provide pharmacies with access to the lowest priced medicines.

Each month Edinpharm assesses the cheapest medicines available from wholesalers to ensure its community pharmacies gain access to the best prices. The integration with Pharmacy Manager ensures that whenever a product is ordered, the system automatically looks for the best priced medication – if that is out-of-stock, it then cascades through each wholesaler to find the next best value in-stock items.

The order process is further enhanced by Pharmacy Manager which automatically populates its Order Management System as soon as an item is dispensed – while also providing pharmacists with a chance to confirm, delete or change the order numbers.

EPOS INTEGRATION

As a busy chain of pharmacies – one of which is located next door to a health centre – Abbey Chemist has also recently taken advantage of the integration of Pharmacy Manager with an electronic point of sale (EPoS) system to provide staff with immediate access to dispensing information from the till.

As Siraj Mohammed says, 'Allowing front staff to check Pharmacy Manager at the till is so much better for the patient journey. There is no need to leave the patient at the till and go into the back to find an available computer and check the status of the patient's prescription. The whole workflow can be completed in front of the patient – saving time and improving their experience.'

Siraj estimates the Pharmacy Manager / EPoS integration saves between five and 10 minutes during an average patient interaction, time that has a huge impact on the time each patient has to spend in the pharmacy.

He confirms, 'Patients can get frustrated if they are left waiting. Providing access to Pharmacy Manager from the till is a slicker, more efficient process that provides a much better patient experience.'

Another improvement that has proved hugely beneficial to the patient experience, especially during the peak of the COVID-19 pandemic, is the integration of text messaging with Pharmacy Manager.

'Using the text message service to tell people when their prescriptions are ready has improved the patient experience and reduced the number of patients coming to the pharmacy too early. Now they only come in when the prescription is ready, which helps to minimise queues and improves the patient journey,' Siraj says.

MANAGING CHANGE

With Scotland still running a mix of paper and electronic prescription, he confirms Pharmacy Manager can easily support this hybrid system – even accepting barcode numbers when a GP decides to telephone the pharmacy with a prescription. 'However the prescription is received, the process is easy to manage, clear and concise,' he says.

As community pharmacists take an ever-increasing role in providing first contact support for patients throughout Scotland, the demands on the PMR have continued to expand. The huge push in Scotland for Pharmacy First, with the NHS remunerating pharmacies for consultations as well as products, is a key example. With so many different services available – from UTIs to gluten-free advice – pharmacists now have to record a lot of information both to ensure they are remunerated and provide information to a patient's GP.

Siraj Mohammed says, 'You need a quick, efficient way to record information and process the service – especially when you don't have much time. Pharmacy Manager lets you record these consultations easily, ensuring we receive the remuneration as well as quickly providing information to the GP.'

CONCLUSION

Abbey Chemist is able to benefit from all the fantastic features within Pharmacy Manager with preferential pricing as Edinpharm members. The buying group supports its independent community pharmacy members with professional support and buying power, whilst allowing them to retain independence. Edinpharm can also offer members preferential rates with other PMR suppliers.

For more information, visit www.edinpharm.com.

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- Support Network - Benefit from the collective knowledge and experience of other independent pharmacies
- A stronger, collective voice for feedback of ideas or raising concerns to suppliers and CPS
- Make your own decisions about your business

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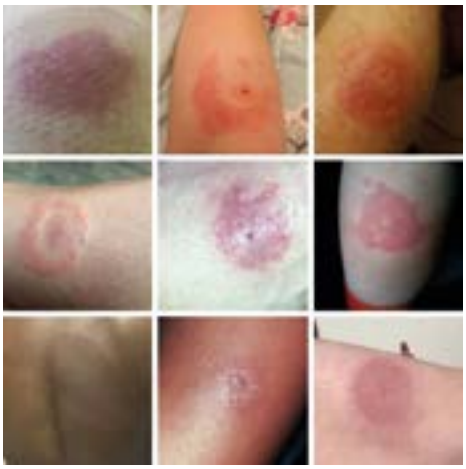
LYME DISEASE

A SIGN OF THINGS TO COME

With Lyme disease incidence on the rise in the UK, an increasing number of people are turning to their local pharmacy for health advice. Get the lowdown from Lyme Disease UK, and discover how your knowledge can empower your patients as they navigate the risks.



WAKE UP TO LYME

After a year of COVID-19-related lockdowns, and the current warmer temperatures, many of us are eager to get back outside. On the path to normality, we will need to continue to observe the guidelines that protect us from coronavirus and support the NHS, but also be more aware of the risks of Lyme disease.

The symptoms of acute Lyme disease can overlap with COVID-19 symptoms, with fatigue, fever and exhaustion being common in both cases – yet it's largely unknown, and very often untreated or misdiagnosed.

As we return to parks and private gardens, both being places ticks are active, it's important to be aware of how to prevent tick bites, know what to do if we are bitten, and help prevent further cases of Lyme disease this summer.

WHAT IS LYME DISEASE?

- Lyme disease is caused by a corkscrew-shaped bacterium called Borrelia
- Lyme disease can be transmitted via a tick bite
- Ticks can carry other infections, such as Anaplasma and Babesia
- Ticks are arachnids and can be as small as a poppy seed

WHAT ARE THE RISKS?

- Infected ticks can be found all over the UK
- Infected ticks are found in woodland, heathland and parkland, but can also be found in urban parks and gardens
- You can be infected in any month, but it's most likely in spring / summer
- The Big Tick Project found ticks on one-in-three dogs

PREVENTATIVE ADVICE

- Wear insect repellent during outdoor activities and consider treating outdoor clothing with permethrin
- Avoid walking through long grass and stick to pathways
- Wear light-coloured clothing and brush off any visible ticks
- Wear long sleeves and long trousers
- If you have to walk in long grass, tuck trousers into your socks and check for ticks when you get home. Also use tick prevention on your pets and thoroughly check them for ticks after they have been outdoors

REMOVING A TICK

- Never pull off a tick with your fingers, normal tweezers, or any other tool not designed for the job
- Never smother the tick in oil or Vaseline
- If you save the tick, it can be tested for infections
- There is no minimum time a tick needs to be attached to pass an infection, however, do remove it as soon as possible

DIAGNOSING LYME DISEASE

- Lyme disease can be hard to diagnose as tick bites can be easily missed
- The most obvious sign of Lyme disease is an Erythema Migrans (EM) rash, often referred to as a bullseye rash. An EM rash takes at least three days or more to appear after a bite, generally isn't itchy or painful, and then gradually spreads outwards. EM rashes can be atypical and do not always appear as the more easily-identified ringed-type rash
- Be aware that not everybody develops an EM rash so other symptoms to look out for are 'summer flu', headaches, neckache, fatigue, joint pain, muscle pain and generally feeling very unwell. In children facial palsy (drooping of the face on one side) and behavioural changes can also indicate Lyme disease

TREATING LYME DISEASE

Early treatment is key. An EM rash is diagnostic for Lyme disease and treatment should be started without the need for a blood test. The blood test used for Lyme disease is unreliable in the first four-to-six weeks after a bite and can produce a false negative result. This is because it's an antibody test and the body can take that long to make the antibodies to the bacteria that cause Lyme disease. The blood test should be repeated if it was carried out during this early window and returned a negative result.

The GP will be able to advise on the best antibiotic for their patient. However, Doxycycline is commonly prescribed to adults and Amoxicillin for children. It's essential to be aware that treatment for children for Lyme disease is based on their age and weight as the dosage is much higher than usually prescribed for other infections. The NHS doesn't normally recommend treating prophylactically unless pregnant or immunocompromised.

FOR THE PHARMACIST

Pharmacists can play a role in advising people how to remove a tick correctly if necessary, possibly stock tick remover tools in their first-aid section, and be able to advise what symptoms the person should look out for after a tick bite. Awareness of how EM rashes look and behave can help people avoid a possible misdiagnosis of ringworm and cellulitis, which can delay diagnosis and treatment. Customers who have a suspected EM rash should be advised that they should seek medical advice promptly so treatment can be started.

For more information, visit www.lymediseaseuk.com. Lyme Disease UK can also be found on Facebook, Twitter and Instagram.

BENEATH THE SURFACE

As the true reach of COVID-19's consequences continue to be unravelled, with 78 per cent of frontline health workers in Scotland burnt out by the pandemic, how can we foster awareness of – and support for – the profession's mental health?

Fiona Benton

Thousands of frontline healthcare workers are being offered a lifeline of mental health support after new figures from the Scottish Association for Mental Health (SAMH) revealed that the vast majority (78 per cent) of workers in the sector reported worsening mental health since the pandemic began.

The research, carried out by 3Gem on adults in Scotland employed in the frontline healthcare sector, also found that younger people aged between 25-to-34 have been the hardest hit.

Increased feelings of stress and anxiety is also commonplace, with over three-quarters (77 per cent) of those surveyed noting a rise. Among the main barriers preventing frontline health workers from accessing support include not feeling like their problems were big enough (48 per cent), waiting times (37 per cent), and being too busy (24 per cent).

Now, burnt out workers will be able to access Time for You – a new, free service which offers immediate access to three different levels of mental health support, ranging from self-help resources, to access to talking therapies like cognitive behavioural therapy with trainee psychologists from Glasgow Caledonian University.

The much-needed online and virtual mental health support service will help address these concerns, and is being provided by SAMH in partnership with Glasgow Caledonian University and Living Life to the Full.

Fiona Benton, Assistant Director of Delivery and Development at SAMH, explained, 'Frontline workers have been some of the hardest hit by the pandemic, and it's extremely worrying to discover so many are struggling. While carrying out some of the most important jobs to keep our local communities going, many have experienced high levels of anxiety and stress, not to mention the worry for the safety of themselves, their loved ones, and the people they help within their roles.

'Add to that the pressure many frontline workers were experiencing even before lockdown, and it became clear to us that it has never been more important that frontline workers get the mental health support they need and deserve.

'We know from the research that frontline workers feel they would benefit from help such as talking therapies like cognitive behaviour therapy and access to self-help resources, so we hope that Time for You will be a valuable resource for many people. We urge anyone who is struggling to reach out and take the first step – it's okay to not be okay.'

Time for You is not just for those who are classed as key workers, but also for those who have been required to continue to work throughout the pandemic to keep the nation running. The service will be able to support up to 4,000 people and as well as healthcare workers, is open to frontline workers in the retail, social care, transport and food and supply sectors.

Vickie Fyfe, Service Manager at Time for You, explained that they are already seeing the positive impact, saying, 'Many people who connect with us are in a really low place and are not sure where to turn – whether that be due to not knowing who to speak to, worried about the stigma of speaking about their mental health in the workplace, or because they think the problems they are experiencing are not big enough to bother others with.

'The Time for You service is for anyone who is struggling with their mental health – and with three levels of support available, we are able to find the right level of support for each person. It's been overwhelming to see the difference we're making so far, and I hope we can reach many more people over the coming months.'

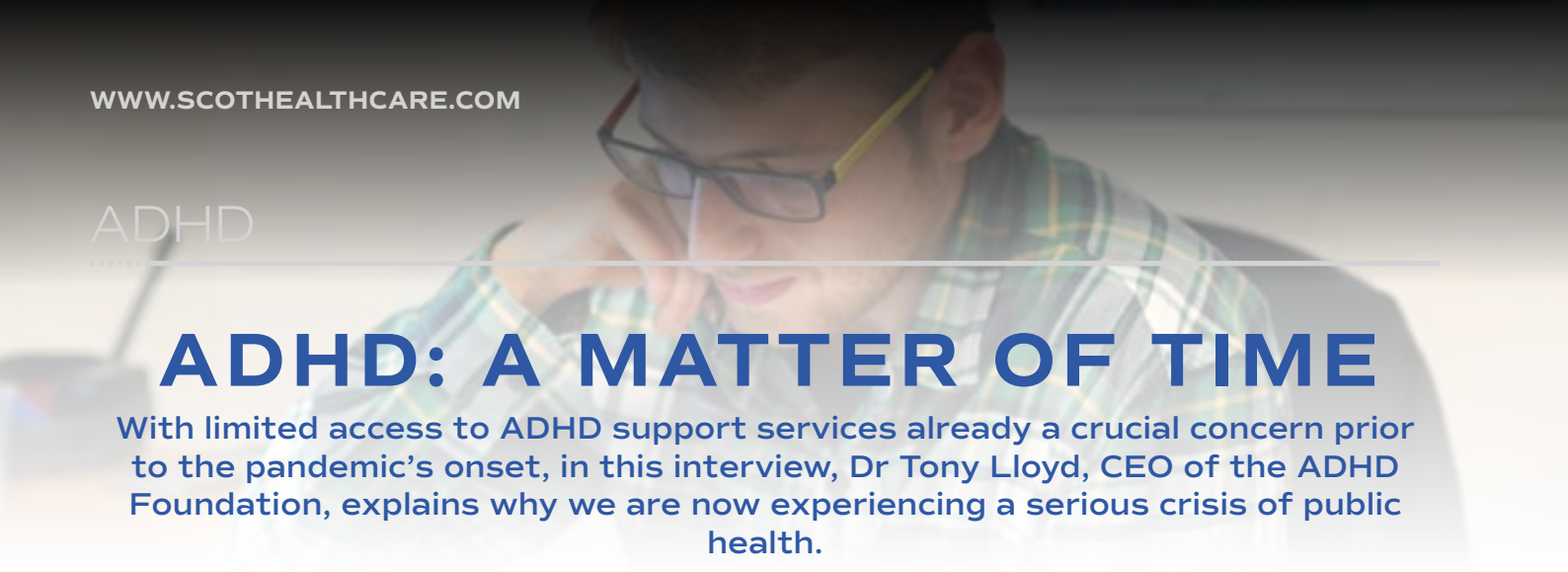
Time for You is provided by SAMH, Living Life to the Full and Glasgow Caledonian University; and funded by Foundation Scotland's Response, Recovery and Resilience Fund, support by the National Emergencies Trust.

Dr Bryan McCann, Sport and Exercise Psychologist and Lecturer in Psychology at Glasgow Caledonian University (GCU), also commented, 'Frontline workers have been superheroes during the pandemic to make sure that vital services are available to the public. They have been under a huge amount of strain, and some frontline workers are likely feeling the effects of that strain. The Time for You service provides frontline workers with invaluable support during these challenging times.

'GCU is delighted to be able to work with SAMH to help deliver the Time for You service. Our trainee psychologists are providing one-to-one support to frontline workers through the service, and we are conducting an evaluation which will help to enhance the service so that it provides the most appropriate support.'

'Foundation Scotland has responded to the rapidly changing needs within Scotland's communities throughout the pandemic, enabling organisations to deliver vital services on the ground thanks to funding from our donors. The impact on those working tirelessly to help others during this difficult time has been significant, particularly regarding their mental health. By supporting SAMH to deliver the Time for You programme, we're confident frontline workers will feel more equipped, trained and able to cope with the continuing pressures they face during such uncertain times,' added Helen Wray, Head of Programmes at Foundation Scotland.

For more information, visit www.samh.org.uk/timeforyou.



ADHD: A MATTER OF TIME

With limited access to ADHD support services already a crucial concern prior to the pandemic's onset, in this interview, Dr Tony Lloyd, CEO of the ADHD Foundation, explains why we are now experiencing a serious crisis of public health.

HOW HAS THE PROVISION OF ADHD SERVICES BEEN IMPACTED BY THE PROGRESSION OF THE PANDEMIC?

The impact has been quite severe – though with variations in different parts of the UK. Some NHS services have managed to provide some support and appointments virtually – but for the most part, many children haven't had follow-up appointments. Adults are waiting longer – up to seven years in some parts of the UK.

DO YOU THINK THE PREVALENCE OF ADHD DIAGNOSES HAS CHANGED DURING THIS TIME?

Prevalence no; but the number of children seeking support is estimated to have doubled in the past 12 months in some parts of the UK. For adults contemplating requesting a diagnosis and professional support for the first time in their lives – yes definitely. Capacity for adult ADHD services in the NHS is quite literally 'in crisis'.

ADHD is a complex neurodevelopmental condition. The interplay between genetics and environment and how this impacts 'presentation' (symptoms) is also a complex one. What we know is that many young people really struggle, but aren't referred for an assessment or support because:

- A – They're academically good
- B – They can't have ADHD because they weren't naughty as a child
- C – They're female and frequently women display less hyperactivity – the most noticeable feature of ADHD – so they're overlooked, especially in school. Also, the presentation of ADHD in adult women is quite different (look at the webinar on this by Dr Sandra Kooij, on the clinician's section of our website at www.adhdfoundation.org.uk)

In summary – the impact of the pandemic for those who were managing ADHD okay and had not sought a diagnosis or treatment has been to the extent that they have become overwhelmed, and significantly from a clinical perspective, are now 'impaired' by ADHD to the extent that presentation / symptomology meets the threshold for a formal diagnosis and medical intervention.

WHAT OPTIONS ARE RECOMMENDED FOR ADULTS TO MANAGE THEIR ADHD?

By the NHS – none. People wait years for an assessment – if they can actually get a referral – as some areas of the UK actually put a cap on the number of referrals they receive in a year, so it looks like their waiting lists are being managed successfully.

There's no universal psycho-educative or psycho-social support offered to people either before or after diagnosis. Medication is the first and only line of treatment – contrary to what NICE guidelines say.

Treatment should be multi-modal – we can't expect people to take responsibility for their health and subsequent life chances / employment etc. if we don't actually explain to them what ADHD is and isn't.

Stigmatising and stereotyping in the media, up until a few years ago, has left many people confused and others overly-reliant on the medical model that 'the doctor will fix me because there is something wrong with me'. The reality is that habitual daily lifestyle changes need to be made – in exactly the same way they would if you have diabetes.

So, for ADHD, managing this successfully means:

- A – Medication for some people
- B – Daily exercise
- C – Good nutritional regimen
- D – Good sleep
- E – Strategies to support executive functioning skills
- F – Daily habitual stress reduction strategies to reduce the threshold of the stress response in the ANS
- G – CBT for those in crisis or those struggling with comorbid problems, such as anxiety, depression, and any life crisis that may have overwhelmed their ADHD-related fragility

HOW CAN HEALTHCARE PROFESSIONALS ENCOURAGE MORE INDIVIDUALS TO ACCESS SUPPORT?

They probably wouldn't because the NHS is struggling because of COVID and there is a severe chronic lack of capacity because many NHS commissioners sadly don't understand that undiagnosed untreated ADHD correlates with anxiety and depression (42 per cent); eating disorders – especially obesity and increased risk of type 2 diabetes; increased risk of self-harm and attempted suicide (18 per cent); increased risk of hypertension and stroke in adults; early onset of cardiovascular disease; and reduced life-expectancy of 11 years. In children – double the number of visits to the family GP for infections, allergies, migraines, accidents etc.

So, the NHS doesn't know how much untreated ADHD is costing them because commissioners don't know anything about the condition because of the pervasive cultural stigma and prejudice and enduring myths.

Quite honestly, there's nowhere for people to go for help. The third sector organisations are few and far between and mostly run by volunteers who aren't skilled mental health practitioners. Our service is struggling to deal with the overwhelming volume of calls every day from people all over the country who are anxious, frustrated, and angry about the lack of access to health services on the NHS. There is no 'funded' national helpline.

Healthcare professionals can also advise individuals to look at all the resources on our website so that they can learn how they can better manage ADHD so they can start to make the necessary lifestyle changes now – because they will have a long wait to see an NHS ADHD specialist and they can't afford to leave ADHD unmanaged while they are waiting.

There will be many new resources on our website that are free to access and download.

For more information, visit www.adhdfoundation.org.uk.

Dropping the price of ADHD treatment

shouldn't mean dropping the standards for patients.[1–3]*

Xaggitin® XL. A bioequivalent that could potentially save the NHS up to 50% vs Concerta® XL.[2,3]

Xaggitin® XL
prolonged-release methylphenidate tablets

Xaggitin® XL is indicated as part of a comprehensive treatment programme for Attention Deficit Hyperactivity Disorder (ADHD) in children aged 6 years of age and over when remedial measures alone prove insufficient. Treatment must be under the supervision of a specialist in childhood behavioural disorders. Diagnosis should be made according to the current DSM criteria or ICD guidelines and should be based on a complete history and evaluation of the patient. Diagnosis cannot be made solely on the presence of one or more symptom. Xaggitin® XL treatment is not indicated in all children with ADHD and the decision to use the medicinal product must be based on a very thorough assessment of the severity and chronicity of the child's symptoms in relation to the child's age.[1]

*Xaggitin® XL demonstrated bi-phasic bioequivalence to Concerta® XL.[2] DSM, Diagnostic and Statistical Manual of Mental Disorders; ICD, International Classification of Diseases; NHS, National Health Service. **References:** 1. Xaggitin® XL prolonged-release methylphenidate tablets. Summary of Product Characteristics. Available at: https://www.medicines.org.uk/emc/product/2704/smpc#gref. Last accessed June 2021; 2. Ethypharm data on file: bioequivalence data. March 2021; 3. British National Formulary: methylphenidate hydrochloride. Available at: https://bnf.nice.org.uk/medicinal-forms/methylphenidate-hydrochloride.html Last accessed: June 2021.

Prescribing Information for Xaggitin XL® (methylphenidate hydrochloride) prolonged-release tablets. Please refer to the Summary of Product Characteristics (SPC) before prescribing.

Presentation: Available in a range of doses. Prolonged-release tablets containing 18mg, 27mg, 36mg or 54mg of methylphenidate hydrochloride, equivalent to 15.6 mg, 23.3 mg, 31.1 mg or 46.7 mg of methylphenidate, respectively. **Indication:** Attention Deficit/Hyperactivity Disorder (ADHD): Indicated as part of a comprehensive treatment programme for ADHD in children aged 6 years of age and over when remedial measures alone prove insufficient. Treatment must be under the supervision of a specialist in childhood behavioural disorders. Diagnosis should be made according to the current DSM criteria or ICD guidelines and should be based on a complete history and evaluation of the patient. Diagnosis cannot be made solely on the presence of one or more symptom. *Xaggitin XL treatment is not indicated in all children with ADHD and the decision to use the medicinal product must be based on a very thorough assessment of the severity and chronicity of the child's symptoms in relation to the child's age.* **Dosage and Administration: Refer to SPC for details and recommendations:** For oral use. Take once daily in the morning. The tablet must be swallowed whole with liquids and must not be chewed, broken, divided, or crushed. It may be administered with or without food. *Pre-treatment screening:* Conduct a baseline evaluation of a patient's cardiovascular status including blood pressure and heart rate prior to prescribing. A comprehensive history should document concomitant medications, past and present co-morbid medical and psychiatric disorders or symptoms, family history of sudden cardiac/unexplained death and accurate recording of pre-treatment height and weight on a growth chart. *Ongoing monitoring:* growth, psychiatric and cardiovascular status should be continuously monitored. Patients should be monitored for the risk of diversion, misuse and abuse of methylphenidate. *Dose titration:* Careful dose titration is necessary at the start of treatment. Dose titration should be started at the lowest possible dose and may be adjusted in 18 mg increments at approximately weekly intervals. The maximum daily dosage is 54 mg. *Patients New to Methylphenidate:* Lower doses of short-acting methylphenidate formulations may be considered sufficient to treat patients new to methylphenidate. Careful dose titration by the physician in charge is required. The recommended starting dose is 18 mg once daily. *Patients Currently Using Methylphenidate:* Dosing recommendations are based on current dose regimen and clinical judgement. Please refer to the SPC for dose conversion. *Long-term (more than 12 months) use in children and adolescents:* Methylphenidate treatment is usually discontinued during or after puberty. If prescribed for extended periods (over 12 months), the long-term usefulness of treatment with methylphenidate should be periodically re-evaluated with trial periods off medication to assess the patient's functioning without pharmacotherapy. It is recommended that methylphenidate is de-challenged at least once yearly to assess the child's condition. *Dose reduction and discontinuation:* Treatment must be stopped if the symptoms do not improve after appropriate dosage adjustment over a one-month period. If paradoxical aggravation of symptoms or other serious adverse events occur, the dosage should be reduced or discontinued. *Adults:* In adolescents, whose symptoms persist into adulthood and who have shown clear benefit from treatment, it may be appropriate to continue treatment into adulthood. Initiation of treatment with Xaggitin XL in adults is not appropriate. *Elderly or children under 6 years:* Xaggitin XL should not be used due to lack of data. **Contra-indications:** Hypersensitivity to the active substance or to any of the excipients, glaucoma, phaeochromocytoma, during treatment with non-selective, irreversible monoamine oxidase (MAO) inhibitors, or within a minimum of 14 days of discontinuing those medicinal products, hyperthyroidism or thyrotoxicosis, diagnosis or history of severe depression, anorexia nervosa/anorexic disorders, suicidal tendencies, psychotic symptoms, severe mood disorders, mania, schizophrenia, psychopathic/borderline personality disorder, diagnosis or history of severe and episodic (Type I) Bipolar (affective) Disorder that is not well-controlled, pre-existing cardiovascular disorders including severe hypertension, heart failure, arterial occlusive disease, angina, haemodynamically significant congenital heart disease, cardiomyopathies, myocardial infarction, potentially life- threatening arrhythmias and channelopathies (disorders caused by the dysfunction of ion channels), pre-existing cerebrovascular disorders, cerebral aneurysm, vascular abnormalities including vasculitis or stroke. **Precautions and Warnings: Refer to SPC for details and recommendations:** *Long-term use (more than 12 months) in children and adolescents:* Careful ongoing monitoring for cardiovascular status, growth, appetite, development of de novo or worsening of pre-existing psychiatric disorders. Psychiatric disorders to monitor for include (but are not limited to) motor or vocal tics, aggressive or hostile behaviour, agitation, anxiety, depression, psychosis, mania, delusions, irritability, lack of spontaneity, withdrawal and excessive perseveration. The use of methylphenidate for over 12 months in children and adolescents with ADHD should be periodically re-evaluated. Recommended that methylphenidate is de-challenged at least once yearly to assess the child's condition. *Use in adults, elderly or children under 6 years of age:* see above. *Cardiovascular status:* Careful history and physical exam should be carried out to assess for the presence of cardiac disease, and patients should receive further specialist cardiac evaluation if initial findings suggest such history or disease. Cardiovascular status should be carefully monitored. Blood pressure and pulse should be recorded at predefined intervals. *Sudden death and pre-existing structural cardiac abnormalities or other serious cardiac disorders:* Sudden death has been reported in association with the use of stimulants of the central nervous system at usual doses in children. *Misuse and cardiovascular events:* Misuse of stimulants of the central nervous system may be associated with sudden death and other serious cardiovascular adverse events. *Cerebrovascular disorders:* Contraindicated in those with certain cerebrovascular conditions (see above). Patients with additional risk factors should be assessed at every visit. Cerebral vasculitis is a very rare idiosyncratic reaction and this diagnosis should be considered in any patient who develops new neurological symptoms consistent with cerebral ischaemia. *Psychiatric disorders:* In the case of emergent psychiatric symptoms or exacerbation of pre-existing psychiatric disorders, methylphenidate should not be given unless the benefits outweigh the risks to the patient. *Consult SPC for additional information for specific psychiatric disorders. Growth:* Moderately reduced weight gain and growth retardation have been reported with the long-term use in children. Treatment interruption may be necessary. *Seizures:* Use with caution in patients with epilepsy. If seizure frequency increases or new-onset seizures occur, methylphenidate should be discontinued. *Abuse, misuse and diversion:* Use with caution in patients with known drug or alcohol dependency because of a potential for abuse. *Priapism:* Patients who develop abnormally sustained or frequent and painful erections should seek immediate medical attention. *Use with serotonergic medicinal products:* Serotonin syndrome has been reported following co-administration with serotonergic medicinal products. If concomitant use is warranted, prompt recognition of serotonin syndrome is important: these may include mental-status changes, autonomic instability, neuromuscular abnormalities, and/ or gastrointestinal symptoms. Discontinue methylphenidate as soon as possible if serotonin syndrome is suspected. *Withdrawal:* Careful supervision is required during withdrawal. Long-term follow up may be required. *Fatigue:* Should not be used for the prevention or treatment of normal fatigue states. *Choice of methylphenidate formulation:* This would be the decision of the treating specialist. *Drug screening:* Methylphenidate may induce a false positive laboratory test for amphetamines, particularly with immunoassay screen test. *Renal or hepatic insufficiency:* No data available. *Haematological effects:* Discontinuation of treatment should be considered in the event of leukopenia, thrombocytopenia, anaemia or other alterations, including those indicative of serious renal or hepatic disorders. *Excipients:* Contains lactose, therefore patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine. **Interactions:** *Pharmacokinetic interaction:* Caution is recommended at combining methylphenidate with other medicinal products, especially those with a narrow therapeutic window. Methylphenidate is not metabolised by cytochrome P450 to a clinically relevant extent. Inducers or inhibitors of cytochrome P450 are not expected to have any relevant impact on methylphenidate pharmacokinetics. However, reports indicate that methylphenidate may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (e.g. phenobarbital, phenytoin, primidone), and some antidepressants (tricyclics and selective serotonin reuptake inhibitors). When starting or stopping treatment with methylphenidate, it may be necessary to adjust the dosage of these medicinal products already being taken and establish plasma concentrations (or for coumarin, coagulation times). *Pharmacodynamic interactions: Anti-hypertensive medicinal products:* may decrease the effectiveness of anti-hypertensives. *Use with medicinal products that elevate blood pressure:* Caution. *Use with alcohol:* Patients should abstain from alcohol during treatment. *Use with serotonergic medicinal products:* See above. *Use with halogenated anaesthetics:* Risk of sudden blood pressure increase during surgery. If surgery is planned, methylphenidate treatment should not be used on the day of surgery. *Use with centrally acting alpha-2 agonists (e.g. clonidine):* Long-term safety of concomitant administration has not been systematically evaluated. *Use with dopaminergic (agonists and antagonists including antipsychotics) medicinal products:* Caution. **Fertility, pregnancy and lactation:** *Fertility:* No relevant effects observed. *Pregnancy:* Data from a cohort study of in total approximately 3,400 pregnancies exposed in the first trimester do not suggest an increased risk of overall birth defects. There was a small increased occurrence of cardiac malformations corresponding to 3 additional infants born with congenital cardiac malformations for every 1000 women who receive methylphenidate during the first trimester of pregnancy, compared with non-exposed pregnancies. *Breast-feeding:* Methylphenidate is excreted in human milk. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from methylphenidate therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. **Effects on ability to drive and use machines:** Can cause dizziness, drowsiness and visual disturbances including difficulties with accommodation, diplopia and blurred vision. It may have a moderate influence on the ability to drive and use machines. If affected, patients should avoid potentially hazardous activities. **Undesirable effects:** *Very common (≥ 1/10):* insomnia, nervousness and headache. *Common (≥ 1/100 to < 1/10):* nasopharyngitis, upper respiratory tract infection, sinusitis, anorexia, decreased appetite, moderately reduced weight and height gain during prolonged use in children, affect lability, aggression, agitation, anxiety, depression, irritability, abnormal behaviour, mood swings, tics, initial insomnia, depressed mood, decreased libido, tension, bruxism, panic attack, dizziness, dyskinesia, psychomotor hyperactivity, somnolence, paraesthesia, tension headache, accommodation disorder, vertigo, arrhythmia, tachycardia, palpitations, hypertension, cough, oropharyngeal pain, upper abdominal pain, diarrhoea, nausea, abdominal discomfort, vomiting, dry mouth, dyspepsia, alopecia, hyperhidrosis, pruritus, rash, urticaria, arthralgia, muscle tightness, muscle spasms, erectile dysfunction, pyrexia, growth retardation during prolonged use in children, fatigue, irritability, feeling jittery, asthenia, thirst, changes in blood pressure and heart rate (usually an increase), weight decreased and alanine aminotransferase increased. **Consult SPC for other side effects. Overdose:** There is no specific antidote to methylphenidate overdosage. Treatment consists of appropriate supportive measures. See SPC for treatment guidance. **Marketing authorisation number and Basic NHS Price:** All strengths are sold in packs of 30 prolonged-release tablets. Xaggitin 18 mg PL 01883/0359 - £15.58; Xaggitin 27 mg PL 01883/0360 - £18.40; Xaggitin 36 mg PL 01883/0361 - £21.22 and Xaggitin 54 mg PL 01883/0362 - £36.80. **Marketing authorisation Holder:** Macarthys Laboratories Ltd, T/A Martindale Pharma, Bampton Road, Harold Hill, Romford, Essex, RM3 8UG, United Kingdom. **Legal category:** POM. **Further information:** Martindale Pharma, Bampton Road, Romford, RM3 8UG. Tel: 01277 266 600. **Date of Preparation:** February 2021

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Martindale Pharma, an Ethypharm Group Company. Tel: 01277 266 600. e-mail: drugsafety.uk@ethypharm.com

Date of preparation: June 2021
Job code: UK-XAG-27

Ethypharm

URINARY INCONTINENCE

A MATTER OF URGENCY

People of all ages can experience issues controlling their bladder, to the extent that their daily lives are significantly affected, and they plan their activities around a toilet, or avoid going out at all. The Age UK team overview the condition and the different channels which can be pursued to help those with the condition achieve an enhanced quality of life.

WHAT IS URINARY INCONTINENCE?

Urinary incontinence is the inability to control your bladder, so that you accidentally lose urine from it.

WHAT CAUSES URINARY INCONTINENCE?

Causes of urinary incontinence may include:

- Weak pelvic floor muscles
- Changes in the nerves controlling the bladder or pelvic floor
- Overactive bladder
- Enlarged prostate (for men)

SYMPTOMS OF URINARY INCONTINENCE

- Leaking urine when coughing, sneezing, laughing or exercising
- Leaking urine before getting to the toilet
- Passing urine frequently
- The urgent need to pass urine
- Difficulty starting to pass urine
- Wetting the bed when asleep
- A feeling that the bladder doesn't empty completely

PROFESSIONAL HELP

Individuals may not feel entirely comfortable talking about their bladder problem, but telling someone – especially a health professional – is the best way for them to get the help they need.

GETTING PROFESSIONAL HELP

Bladder and bowel issues are not just an inevitable part of getting older. People don't simply have to put up with them – and they certainly shouldn't have to face them alone. They can talk about what they're experiencing with their doctor who will ask questions about their symptoms, may examine them and then suggest treatment or exercises to tackle the problem or ways to minimise its effect on their everyday life. If the individual lives in a care home, they can ask the manager to arrange an appointment with the doctor or the district nurse.

Alternatively, the individual can ask their doctor about their local NHS continence service. In some areas they can self-refer, in others they must be referred by a health professional.

The doctor or continence service may suggest a referral to a hospital specialist, who might want to carry out tests to help diagnose the problem.

WHAT WILL A HEALTH PROFESSIONAL NEED TO KNOW?

A health professional may ask the individual some questions like these to help them understand how their bladder is working:

- When did your bladder problems start?
- How often does leaking happen?
- How much is lost?
- How are you dealing with it?
- How much, what and when are you drinking?
- Can you feel when your bladder is full?
- Have you noticed any other symptoms, such as pain or discomfort?
- What medications (including over-the-counter and herbal) are you taking?

HOW IS URINARY INCONTINENCE DIAGNOSED?

If an individual experiences a bladder problem, talking to a health professional is the first step they can take. A doctor can assess their symptoms, identify the cause, and discuss what treatment or exercises may help cure or tackle their problems.

To help diagnose the problem, the doctor may ask for or perform these tests:

- A diary of the individual's bladder habits
- A physical examination to assess their bladder, pelvic floor muscles (women) or prostate (men)
- A sample of their urine for testing
- A blood test to check the health of their kidneys
- An ultrasound scan of the individual's bladder

Some tests may help the doctor find the cause of their incontinence or a temporary problem, such as a urine infection, that can be treated quickly.

HOW IS INCONTINENCE TREATED?

Managing a weak bladder or bowel is an individual thing and sometimes more than one treatment is needed. Treatments include:

- Exercises to help strengthen the muscles surrounding the bladder (pelvic floor exercises) or bowel
- Bladder or bowel training
- Medications
- Surgery may be an option if other treatments haven't worked

For more information, visit www.ageuk.org.uk.

RELATIONSHIP BETWEEN INCONTINENCE AND FREQUENT UTIS

UTIs are a common and treatable condition affecting men and women of all ages; however, are more commonly seen in women and the frequency of infections tends to increase with age.

UTIs and incontinence have a two-way relationship where either can cause the development of the other. While both UTIs and incontinence can give you a sudden urge to urinate or frequent bathroom trips, UTIs are painful and incontinence is not. UTI symptoms may also involve strong smelling urine, pelvic pain, fever, or your urine to be cloudy or pink.

Having incontinence increases your chances of developing repeated UTIs. Whenever you urinate, your system is washing out bacteria. With some types of incontinence, it's difficult to empty your bladder completely. When urine remains in your bladder, it increases your chances of developing a UTI.

Whenever you urinate, especially if you have incontinence, make sure to empty your bladder completely. Don't hold urine for too long – it's essential to urinate frequently enough.

It's important to treat UTIs, especially in the elderly, as if left untreated, the infection can spread to the kidneys, causing damage or, in severe cases, kidney failure. SPR

MacroBID®
(nitrofurantoin) 100mg
Prolonged-release Capsules

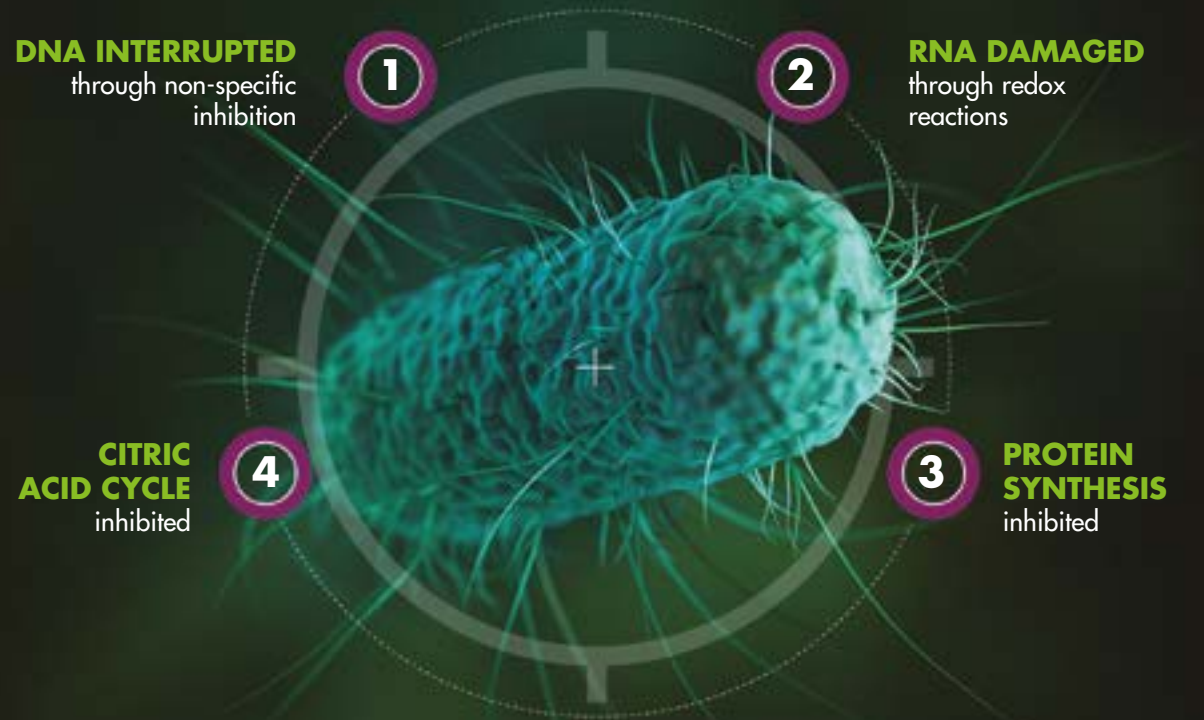
For UK Healthcare Professionals only

ADVANZ PHARMA

At first signs of lower UTI, treat with MacroBID®, an empirical choice for low resistance rates[1-4]

Anecdotal evidence from an observational study suggests antibiotic therapy should be initiated at first sign of symptoms of lower UTI.[2]
Data from a large case series of women with long-standing lower UTI symptoms (n=1996, mean duration of symptoms 6.5 years)[2]

Multiple modes of action help reduce the risk of resistance.[5,6]



MacroBID®: A first choice for uncomplicated lower UTI[4]

UTI: Urinary tract infection MacroBID® is indicated for the treatment of and prophylaxis against acute or recurrent, uncomplicated lower UTIs or pyelitis either spontaneous or following surgical procedures, in patients over 12 years of age[7]

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PRESCRIBING INFORMATION
Macrobid 100mg Prolonged-release Capsules (nitrofurantoin)
Presentation: Hard gelatin capsule containing the equivalent of 100mg of nitrofurantoin in the form of nitrofurantoin macrocrystals and nitrofurantoin monohydrate. **Indications:** *Adults and children over 12 years of age:* Treatment of and prophylaxis against acute or recurrent, uncomplicated lower urinary tract infections or pyelitis either spontaneous or following surgical procedures. Specifically indicated for the treatment of infections when due to susceptible strains of *Escherichia coli, Enterococci, Staphylococci, Citrobacter, Klebsiella and Enterobacter.* **Dosage and administration:** For oral use. *Adults and children over 12 years of age: Acute or recurrent uncomplicated UTI and pyelitis:* 100mg twice daily for 7 days. *Surgical Prophylaxis:* 100mg twice daily on the day of the procedure and 3 days thereafter. *Elderly:* Unless significant renal impairment exists, dosage as for normal adult. *Children under 12 years:* Not recommended. **Contraindications:** Hypersensitivity to nitrofurantoin, other nitrofurans or to any of the excipients. Patients suffering from renal dysfunction with an eGFR below 45 ml/minute. G6PD (glucose-6-phosphate dehydrogenase) deficiency. Acute porphyria. In infants under three months of age as well as pregnant patients at term (during labour and delivery). **Precautions and warnings:** Not effective for the treatment of parenchymal infections of a unilaterally functioning kidney. Nitrofurantoin may be used with caution as short-course therapy only for the treatment of uncomplicated lower urinary tract infection in individual cases with an eGFR between 30-44 ml/min to treat resistant pathogens, when the benefits are expected to outweigh the risks. A surgical cause for infection should be excluded in recurrent or severe cases. Caution is advised in patients with pulmonary disease, hepatic dysfunction, neurological disorders, allergic diathesis, anaemia, diabetes mellitus, electrolyte imbalance, debilitating conditions, vitamin B (particularly folate) deficiency. Acute, subacute and chronic pulmonary reactions have been observed in patients treated with nitrofurantoin. Nitrofurantoin should be discontinued immediately in case of any pulmonary reactions and at any signs of haemolysis in those with suspected G6PD deficiency. Chronic pulmonary reactions (including pulmonary fibrosis and diffuse interstitial pneumonitis) can develop insidiously and may occur commonly in elderly patients. Peripheral neuropathy and susceptibility to peripheral neuropathy, which may become severe or irreversible has occurred and may be life threatening. Treatment should be stopped at the first signs of neural involvement. Close monitoring of patients receiving long-term therapy is warranted (especially in the elderly). May discolour urine and cause false positive urinary glucose test. Gastrointestinal reactions may be minimised by taking the drug with food or milk, or by adjustment of dosage. Hepatic reactions, including hepatitis, autoimmune hepatitis, cholestatic jaundice, chronic active hepatitis, and hepatic necrosis occur rarely. Fatalities have been reported. Patients should be monitored periodically for changes in biochemical tests that would indicate liver injury. The drug should be withdrawn immediately if hepatitis occurs and appropriate measures should be taken. Patient should be monitored closely for appearance of hepatic or pulmonary symptoms and other evidence of toxicity for long term treatment. Discontinue treatment if otherwise unexplained pulmonary, hepatotoxic, hematological or neurological syndromes occur. **Interactions:** Food or agents delaying gastric emptying, magnesium trisilicate, probenecid, sulfinpyrazone, carbonic anhydrase inhibitors, urine alkalising agents, quinolone anti-infectives, oral typhoid vaccine, interference with some tests for glucose in urine. **Pregnancy and lactation:** Should be used at the lowest dose as appropriate for a specific indication, only after careful assessment. Contraindicated in infants under three months of age and in pregnant women during labour and delivery because of the possible risk of haemolysis of the infants immature red cells. Nitrofurantoin is detected in trace amounts in breast milk**.** Breast feeding an infant known or suspected to have an erythrocyte enzyme deficiency (including G6PD deficiency), must be temporarily avoided. **Undesirable effects:** *Serious:* Acute pulmonary reactions (commonly manifested by fever, chills, cough, chest pain, dyspnoea, pulmonary infiltration with consolidation or pleural effusion on chest x-ray, eosinophilia), chronic pulmonary reactions, pulmonary fibrosis; possible association with lupus-erythematous-like syndrome, collapse, cyanosis, cholestatic jaundice, chronic active hepatitis, autoimmune hepatitis, hepatic necrosis, peripheral neuropathy including optic neuritis, exfoliative dermatitis, erythema multiforme (including Stevens-Johnson syndrome), Lupus-like syndrome associated with pulmonary reaction, drug rash with eosinophilia and systemic symptoms (DRESS syndrome), cutaneous vasculitis, anaphylaxis, angioneurotic edema, agranulocytosis, leucopenia, granulocytopenia, haemolytic anaemia, thrombocytopenia, glucose-6-phosphate dehydrogenase deficiency, megaloblastic anaemia and eosinophilia. ***(Please refer to the Summary of Product Characteristics for detailed information).*** **Overdose:** *Symptoms:* Gastric irritation, nausea and vomiting. *Management:* Nitrofurantoin can be haemodialysed. Standard treatment is by induction of emesis or by gastric lavage in cases of recent ingestion. Monitoring of full blood count, liver function tests and pulmonary function, are recommended. A high fluid intake should be maintained to promote urinary excretion of the drug. **Legal Category:** POM. **Basic NHS Price:** £9.50 per pack of 14 capsules. **Marketing authorisation number:** PL 12762/0052. **Marketing authorisation holder:** Mercury Pharmaceuticals Ltd (a member of the Advanz Pharma group of companies), Capital House, 1st Floor, 85 King William Street, London EC4N 7BL, UK. **Date of revision:** March 2021 [ADV/MAB/PI/0001]

Adverse events should be reported. Reporting forms and information can be found at **www.mhra.gov.uk/yellowcard**.
Adverse events should also be reported to **Advanz Pharma Medical Information** via telephone on **+44 0 8700 70 30 33** or via e-mail at **medicalinformation@advanzpharma.com**

Date of preparation: July 2021
ADV/MAB/PM/0288

TAKING IT TO HEART

As aspects of the pre-COVID world begin to return, one shift in the sector looks set to remain – our increased uptake and reliance on remote technology. Experts reflect on this accelerated adoption, and how innovation has proven particularly beneficial for both healthcare professionals and patients in relation to the monitoring of heart rhythm.

KAREN MCCAMMON, HEALTH SERVICE INSIGHT MANAGER, BRITISH HEART FOUNDATION

WHAT ARE THE RISKS OF ATRIAL FIBRILLATION AND WHY IS EARLY MEDICAL INTERVENTION SO ESSENTIAL?

Atrial fibrillation (AF) is one of the most common abnormal heart rhythms. In a normal heart the heart's pumping action is controlled by regular electrical messages produced by part of the heart called the sinus node.

AF occurs when additional, irregular electrical messages are sent from other places in and around the atria (the upper chambers of the heart). These irregular messages make the atria quiver or twitch, which is known as fibrillation.

AF is diagnosed in thousands of people, however, it's estimated that thousands more people may have the condition and not be aware of it. It's an important arrhythmia to detect as it increases the person's risk of stroke five-fold and prescribing blood thinners to those with AF and other risk factors, such as diabetes and high blood pressures, will significantly reduce their risk of stroke.

The most common symptoms are palpitations, breathlessness, dizziness and syncope. However, as many as 25-to-30 per cent of people don't have symptoms. Therefore, we rely on pulse checks of people at risk to pick it up. At the start of the COVID pandemic, with less people receiving face-to-face care the opportunities to detect AF fell.

WHAT ADVANTAGES IS REMOTE MONITORING TECHNOLOGY GENERATING FOR AF PATIENTS?

It's easy for patients to use and became particularly important during the COVID-19 pandemic when the need to reduce hospital attendances for investigations, such as heart monitoring, was even greater.

The new technology is here to stay, it's very welcome and I'm sure with the pace of technological developments at the minute there is much more to come. However, we have to make sure we avoid exacerbating health inequalities by digital exclusion.

LOOKING AHEAD, HOW CAN HEALTHCARE PROFESSIONALS ENCOURAGE THEIR PATIENTS TO BE MORE AWARE OF THEIR HEART HEALTH AND MORE INCLINED TO PRESENT TO THEIR HEALTHCARE PROFESSIONAL FOR HELP?

Healthcare professionals can support patients by fully explaining their conditions and the medications prescribed. It's about giving patients the knowledge. They should also discuss the importance of asking for support and / or seeking help and advice if they are unsure of symptoms and try to build that rapport with patients. They should also ensure that annual reviews are carried out when required.

They can also support patients to educate themselves as well. Knowledge is power. The British Heart Foundation website has huge amounts of information on specific conditions as well as procedures, lifestyle advice and more. We also have free booklets that can be ordered through our website which are a valuable source of information to patients.

For more information, visit www.bhf.org.uk.

TRUDIE LOBBAN MBE, FOUNDER OF ARRHYTHMIA ALLIANCE

'Arrhythmia Alliance has been introducing pulse checks in COVID-19 vaccine centres to help detect AF. Results have been incredible. Such a simple, free, test that can literally saves lives – all too often we are aware of our heart rate yet do not realise the importance of also knowing the rhythm of our heart. Manual pulse checks or the use of digital technology through downloadable apps on our phones can help detect potentially fatal arrhythmias (heart rhythm disorders) – and can quite simply save us from sudden death or stroke.

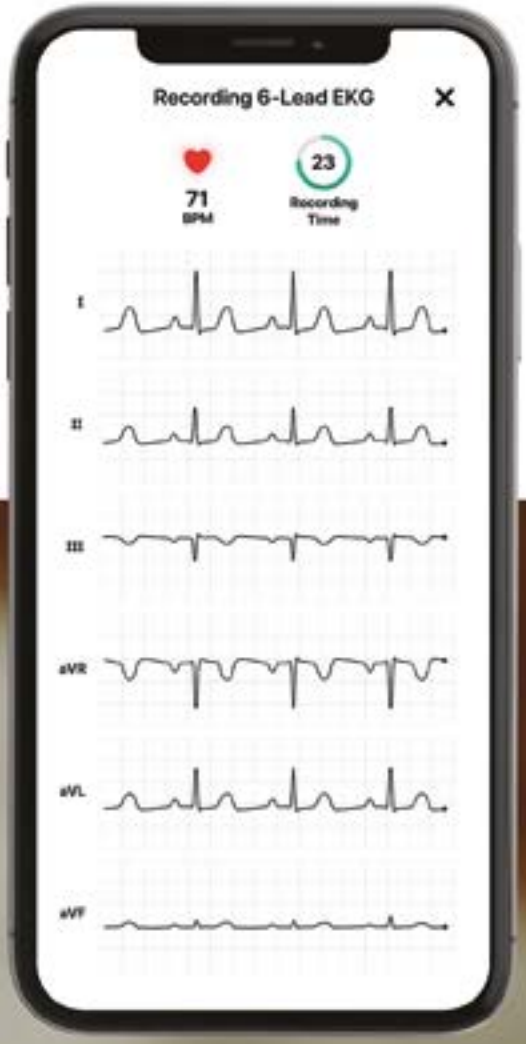
'This simple task that anyone can do not only saves lives but also saves the NHS money from treating and managing the ongoing care for someone who survives a stroke for example. We recommend regular pulse checks and discussion with your doctor throughout the year. We urge everyone to take just 30 seconds to listen to the rhythm of their heart and those of their loved ones – spread the message – save a life.'

Arrhythmia Alliance has produced videos teaching people how to check their pulse manually or using downloadable apps which detect irregular heart rhythms.

For more information, visit www.knowyourpulse.org.

SEAN WARREN, BUSINESS DIRECTOR UK AND IRELAND, ALIVECOR

'The COVID-19 pandemic has forced immense pressure on NHS Trusts nationwide, and forced their way of working to change dramatically – including a significant demand to improve efficiencies within patient care. As such, there has been a rapid drive to enhance some legacy processes that are no longer fit-for-purpose, with intuitive digital solutions that enable frontline staff to make informed decisions, deliver improved standards of care and patient outcomes. We are honoured to be supporting this transformation of clinical processes with KardiaMobile technology, and are delighted to be enabling rapid, remote diagnosis of cardiac arrhythmias, in partnership with our brilliant NHS healthcare professionals.'



6 is better than 1.

Detect atrial fibrillation remotely with KardiaMobile 6L, the world's first and only FDA-cleared, CE-marked, 6-lead personal ECG.

There are more than 96,000 people in Scotland living with AF*. What if they could monitor AF from home?

With KardiaMobile 6L, you'll receive an unparalleled view of your patients' heart activity in just 30 seconds. Get real-time, medical-grade ECGs sent directly to you—no appointment required.

Learn more about remote patient monitoring in Scotland with KardiaMobile 6L.

AliveCor®

alivecor.co.uk/sco

Please visit alivecor.com/guidestart for a complete listing of indications, warnings and precautions.

*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

COW'S MILK ALLERGY

TO WHOM IT MAY CONCERN

Cow's milk protein allergy is a common cause of parental anxiety, with pharmacists and primary healthcare professionals adopting a fundamental role in ensuring that patients are appropriately treated and / or signposted to receive the best possible care and outcomes – all the while involving the parents and family during each stage of the process. Holly Shaw, Clinical Nurse Advisor at Allergy UK, explains further.

For many patients with symptoms of a food-related reaction, the community and primary care setting is the first point of contact that they will have with a healthcare professional. It's important that healthcare professionals working in these settings have the skills and knowledge to manage these patients' needs.

The National Institute for Health and Care Excellence (NICE) quality standard for the diagnosis and assessment of food allergy QS118 emphasises the important role that community-based healthcare professionals have in the diagnosis and assessment of IgE and non-IgE-mediated food allergies in children. (NICE, 2016)

Cow's milk protein allergy (CMPA) can be a challenge to diagnose, and healthcare professionals working in community and primary care settings need to be equipped with the skills and knowledge to recognise allergic symptoms. They must also be able to signpost to or initiate the first steps of a food allergy diagnosis with the goal of an accurate and timely diagnosis. It's important that CMPA is recognised and diagnosed promptly, especially in instances of IgE-mediated allergy, due to the risk of anaphylaxis (a severe and potentially life-threatening form of allergic reaction). An accurate and timely diagnosis is also important to ensure infants' growth is not restricted and that their nutritional requirements are met.

Research data on food anaphylaxis published in the British Medical Journal showed that hospital admissions for food-induced anaphylaxis have increased from 1998-to-2018 and that cow's milk was responsible for 17-of-the-66 (26 per cent) of deaths in school-aged children: the most common single cause of fatal anaphylaxis. (Conrado et al, 2021)

DEFINING CMPA

CMPA occurs when the immune system mistakenly identifies a protein found in cow's milk as harmful. The initial stage is called 'sensitisation': the immune system responds to the protein as if it's harmful and mounts an immune response as a defence mechanism involving the production of IgE antibodies. After this initial sensitisation or priming of the immune system, signs and symptoms of an allergic reaction are experienced on re-exposure to cow's milk.

There are many factors causing delays in diagnosis reported to Allergy UK's Helpline by parents of infants who are presenting symptoms suggestive of CMPA. These include parents' concerns not being taken seriously, and multiple presentations to different healthcare settings and professionals. A study on diagnosing CMPA highlighted that the average number of GP visits over 12 months was more than 18, demonstrating the barriers parents face when trying to gain a timely diagnosis. (Lozinsky et al, 2015)

CMPA VS LACTOSE INTOLERANCE

CMPA is often confused with lactose intolerance. In lactose intolerance, the milk sugar causes the problem and in cow's milk allergy it is the protein: casein and whey.

THERE ARE TWO FORMS OF LACTOSE INTOLERANCE

Primary lactose intolerance involves production of low levels of the lactase enzyme, or in inherited lactose intolerance no lactase is produced. Secondary lactose tolerance can present following gastroenteritis or gastro-related complaints. This form is transient and passes with symptom resolution after a few weeks.

Symptoms of lactose intolerance are related to the gastrointestinal system, presenting minutes to hours after the ingestion of foods containing lactose. An important key message is that lactose intolerance is not an allergy so will not result in an allergic reaction. The symptoms noted below are commonly seen in infants / children (age-dependant) with a lactose intolerance:

- Frequent crying / unsettled
- Loose and watery stools (may be green / yellow in colour)
- Trapped wind (bloated stomach /

bringing knees up to chest)
- Noisy bowel sounds
- Nausea and / or vomiting
- Complaining of abdominal discomfort

It's important from a diagnostic pathway perspective to be able to differentiate between the two, and the key to an accurate diagnosis starts with taking a detailed allergy-focused clinical history.

CMPA has an immunological origin which may lead to IgE-mediated, or non-IgE-mediated, or a combination of both. The symptoms of CMPA are broad and can be commonly experienced in other common infantile illnesses like colic and reflux. (Preece, 2016)

SYMPTOMS AND TIMINGS OF COW'S MILK ALLERGY

KEY FEATURES OF IGE-MEDIATED FOOD ALLERGY

- Symptoms occur quickly after ingestion of the food allergen (usually within minutes)
- Allergic symptoms often are multi-systemic, including the following systems, cutaneous, gastrointestinal, respiratory and cardiovascular
- Severe cases have the potential to result in the most severe and life-threatening allergic reaction (anaphylaxis)

KEY FEATURES OF NON-IGE-MEDIATED FOOD ALLERGY

- Symptoms appear from several hours to a day after ingestion
- Symptoms are mainly isolated to the gastrointestinal system
- Delayed food allergies don't cause anaphylaxis and symptoms of hives or angioedema aren't seen in this type of allergy
- Allergic symptoms may be classified as mild, moderate or severe. However, it's important to note that some of these symptoms, such as reflux, colic and constipation, are commonly seen in this young age group
- The signs and symptoms observed by parents / and or carers will depend upon the severity of the allergic reaction. In most cases these will be mild-to-moderate. Mild allergic symptoms may also mimic the gastrointestinal symptoms listed before as seen in lactose intolerance

There can also be skin-related symptoms which include:
- Urticarial rash (hives)
- Angioedema around the eyes / lips
- Erythema
- Pruritus
- Immediate or delayed eczema flare

Signs and symptoms of food allergy may affect individually the respiratory, cutaneous or gastrointestinal systems, or a combination of systems. Where the respiratory system is involved the infant or child may experience difficulty breathing, which parents may articulate as noisy or fast breathing, a persistent cough or wheezy / rattly chest. Symptoms of a severe allergic reaction can affect the circulation and result in hypotension in an infant / child. This may result in an infant becoming pale and floppy, while older children may say they feel dizzy or faint.

INVESTIGATING A SUSPECTED FOOD ALLERGY

Identifying which diagnostic tests are suitable for the mechanism of allergy requires an understanding of IgE and non-IgE-mediated allergy. Allergy testing for IgE-mediated food allergy identifies the presence of IgE antibodies to the suspected food allergen, in this case cow's milk protein from a blood or skin prick test.

FOR SUSPECTED IGE-MEDIATED ALLERGY, SPECIFIC IGE LEVELS ARE MEASURED BY

1. Allergen-specific IgE blood test
2. Skin prick test

This choice should be guided by the allergy-focused clinical history, the patient's age, the suitability of the test and the resources available in the primary care setting. It may be necessary to refer to a local allergy service for testing and further management.

DIAGNOSING NON-IGE-MEDIATED FOOD ALLERGY

Where delayed onset of symptoms is identified, then blood or skin prick testing won't be helpful. This form of food allergy is diagnosed using an elimination and re-introduction diet of the suspected food allergen. This trial should always be guided by a healthcare professional. Specialist dietetic referral may be required to support parents with food eliminations and appropriate replacements to ensure nutritional requirements are met during and after the trial as needed depending on diagnosis. The aim of this elimination diet is to look at symptom resolution on avoidance and determine when the food is introduced (usually after a strict two-to-four weeks of elimination) if the allergy symptoms are reproducible on re-introduction. If symptoms are reproduced, this indicates an allergy. If symptoms persist despite avoidance an alternative diagnosis and / or work-up would be required.

It's important to highlight unproven methods of allergy testing which have no scientific basis and aren't reliable to those seeking diagnosis. (Niggemann & Gruber, 2004) This type of testing is often advertised as a convenient and cost-effective way, and can be appealing to parents and or those seeking a timely diagnosis. However, it can result in unnecessary dietary exclusion of major food groups and pose the risk of an unnecessarily restrictive diet. These tests include:
- Hair analysis
- Vega testing
- Cytotoxic food testing
- Serum IgG antibodies
- Iridology
- Homeopathy
- Herbal medicine

Fortunately, most children will grow out of their cow's milk allergy in early childhood. Until that happens, GPs or allergy specialists will work with families, usually with the supporting help of a dietitian, to ensure that the child remains healthy while excluding all forms of cow's milk from their diet.

There are lots of resources on cow's milk allergy available on Allergy UK's website, including detailed information on symptoms, and guidance on diet, weaning and symptom-tracking.

For more information, visit www.allergyuk.org.

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NEW & IMPROVED FOR COW'S MILK ALLERGY

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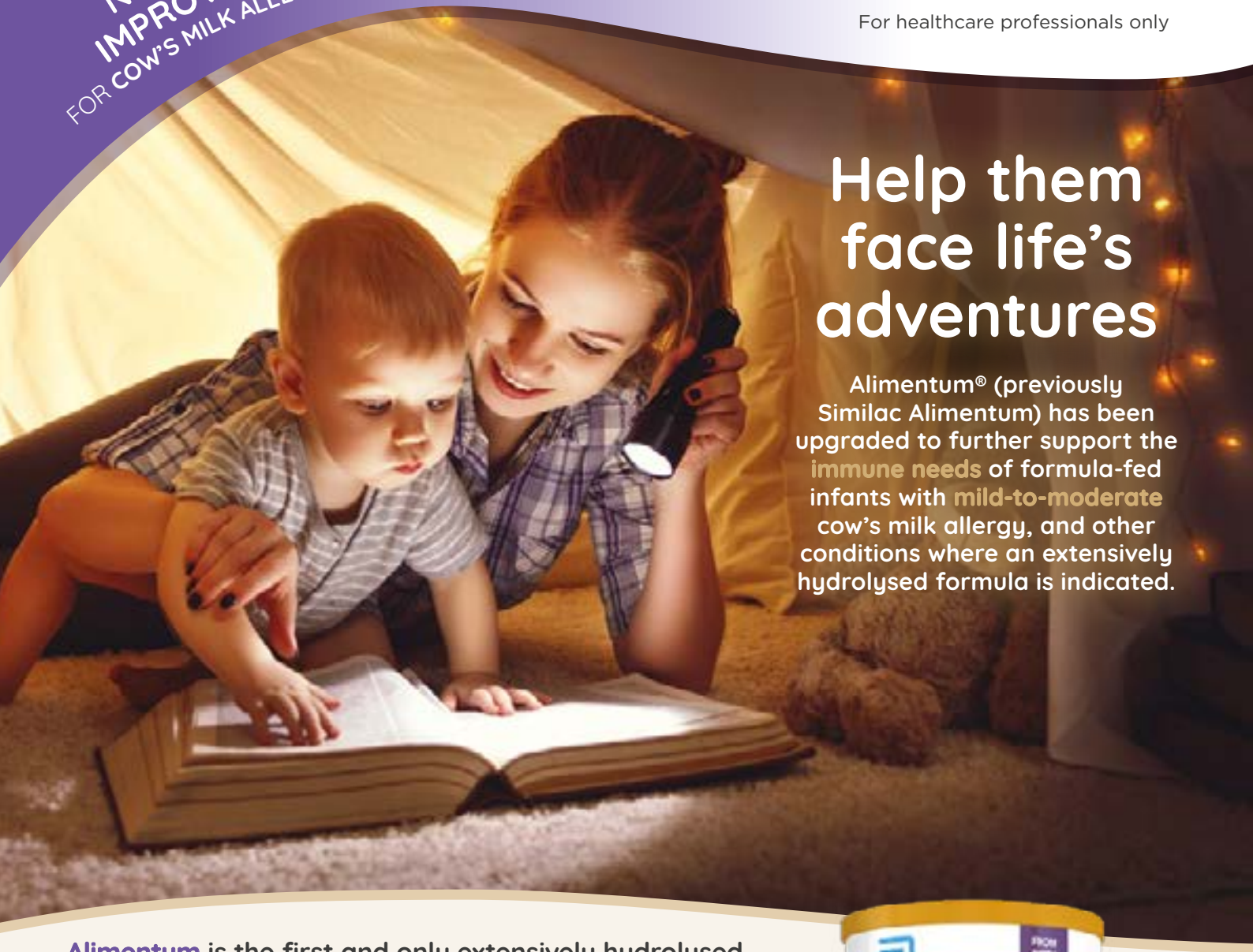

Help them face life's adventures

Alimentum® (previously Similac Alimentum) has been upgraded to further support the immune needs of formula-fed infants with mild-to-moderate cow's milk allergy, and other conditions where an extensively hydrolysed formula is indicated.

Alimentum is the first and only extensively hydrolysed formula to contain 2'-FL*†, a major component of most mothers' breast milk:[1]

Helps support the immune system in the gut and beyond[1–4]
Contains 2'-FL* which has proven benefits for the gut and systemic immune responses‡

Clinically shown to be hypoallergenic[§] **and improve CMA symptoms fast**[¶5–7]

Well tolerated and highly trusted formula[7–9]

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. Alimentum 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.[1]
†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]

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UK—2000071 August 2020

Abbott

Scottish Pharmacy Awards

TIME TO SHINE

As the countdown to the 2021 Scottish Pharmacy Awards nears completion, stay in the know and find out the latest developments first-hand – including who has made this year's shortlist of finalists.

The Crowne Plaza Hotel, Glasgow

24th November 2021

ALL IN THE DETAILS

Through every daunting day we have encountered during the pandemic and every hardship Scotland has had to face, our health heroes have remained strong and unwavering as pillars of inspiration – and we could not be more grateful.

Now it's time for us to take your accomplishments to the stage and showcase your continued efforts and expertise – and the irreplaceable impact they have crafted – at the 2021 Scottish Pharmacy Awards.

In accordance with COVID guidelines, this year's ceremony will be kicking off on 24th November at the Crowne Plaza, Glasgow, in which the winners will be honoured in an array of categories which range from Management of Substance Dependency in the Community, to Pharmacy Student Leadership. And with the Special Recognition Award winner also to be unveiled, it's set to be an evening to remember.

JUST A CLICK AWAY

Coinciding with the rebrand of our umbrella company as Kyron Media, our online channels have evolved and emerged as go-to destinations for in-the-moment updates about our events, publications, and so much more.

Keep an eye on the addresses below as in the coming weeks they will not only reveal the names of our Scottish Pharmacy Awards finalists, but the extraordinary paths these individuals have blazed.

In the meantime, as we continue the build-up to the event, take another peek at our 2021 Scottish Pharmacy Awards categories over the following pages.

www.scottishpharmacyawards.info

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Kyron Media

Scottish Pharmacy Awards

The Crowne Plaza Hotel, Glasgow

Wednesday 24th November 2021

Excellence in Delivering Self-Care Agenda in Community Pharmacy

Sponsored by Johnson & Johnson

Johnson & Johnson is proud to sponsor this award, demonstrating a culture that promotes patient self-care in community pharmacy, through the use of category management techniques, clear category signposting and visible promotion of pharmacy services.

Johnson & Johnson

Johnson & Johnson are proud to sponsor the award Excellence in Delivering Self-Care Agenda in Community Pharmacy. This award recognises that community pharmacy is putting the patient at the heart of its business, an area in which we know community pharmacy works hard at. Putting the patient at the centre of your business is very important and at Johnson & Johnson we demonstrate this too through our Credo commitment.

UK/JJ/18-12724f

Management of Substance Dependency in the Community

Sponsored by Ethypharm

Substance dependency is unfortunately a growing problem in Scotland and quite often it is the pharmacist who is at the forefront of this patient service. This category is aimed at all pharmacists or pharmacies which have developed and successfully adapted to improve the management of their substance dependency services for the patient.

Ethypharm

Ethypharm is proud to sponsor an award which recognises the vital work pharmacy does with this vulnerable group of patients. These have been challenging times but excellence will always generate opportunities where excellence will always stand out. This award recognises those who have made a difference to these patients and those who strive for excellence to ensure these patients receive the best possible care and therefore the best likelihood of desired outcomes. At Ethypharm we are fortunate to be able to work with and support professionals who make a valuable contribution to the substance dependency community and we hope that by working together we can achieve better results for these patients. Congratulations to all the nominees in this category as well as the deserving winner. You have all demonstrated excellence and a commitment to enhance the services offered by your collaboration.

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Scottish Pharmacy Awards

The Crowne Plaza Hotel, Glasgow

Wednesday 24th November 2021

Business Development of the Year

Sponsored by AAH Pharmaceuticals

The Business Development of the Year Award is targeted at independent pharmacies which have endeavoured to enhance their business by driving forward an innovative marketing strategy and raising its standards. The category is not focused on profit and is aimed at independent pharmacies which have been developed and marketed successfully to improve both business and service to the patient.

AAH Creating a healthy future together

AAH Pharmaceuticals is delighted to announce its sponsorship of the Business Development of the Year Award. At AAH we are committed to supporting community pharmacy in Scotland. In an ever-changing world the Business Development Award is especially important. It is given in recognition of innovation to community pharmacy, whether that is delivery on improved service to patients, or improving operational efficiency in pharmacy to ensure pharmacy teams can spend more time with patients.

Pharmacy Student Leadership

Sponsored by The Pharmacists' Defence Association

Strong leaders are driven by their vision of what their organisations could become. The role of a leader is to make people feel strong, informed, unified and capable. Leaders need to have a combination of relentless effort, steadfastness, competence and attention-to-detail. Is this you or someone you know?

pda the pharmacists' defence association

The PDA is the largest pharmacists' membership organisation and only independent trade union exclusively for pharmacists in the UK. The not-for-profit organisation is proud to represent employed and locum pharmacists across all areas of practice and is the long-standing sponsor of the Student Leadership Award category. The PDA recognise that the student leaders of today may one day be the leaders of the profession. This category highlights examples of the positive difference that these individuals are already making for their peers and communities.

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Scottish Pharmacy Awards

The Crowne Plaza Hotel, Glasgow

Wednesday 24th November 2021

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Vichy and La Roche-Posay pharmacy skincare brands are co-developed, recommended and prescribed by health professionals around the world. Advice is pivotal to the success of our brands which is why we are delighted to be supporting the award for Pharmacy Assistant of the Year. We know how important the role pharmacy assistants play in providing seamless experiences that tell the customer that you care about them as people.

Pharmacy Assistant of the Year

Sponsored by Vichy and La Roche-Posay

Pharmacy assistants are the frontline of empathy and support in community pharmacies all over Scotland. This award serves to recognise an exceptional individual for their superb product knowledge and customer care skills. The Pharmacy Assistant of the Year Award, sponsored by Vichy and La Roche-Posay, has been created to recognise those pharmacy assistants who go above and beyond in caring for the health of their customers.

Innovative Use of Technology in Community Pharmacy

Sponsored by Cegedim Healthcare Solutions

Technology is at the heart of pharmacy and this award aims to acknowledge the excellent projects in this category, recognising exceptional quality of service and innovation through the use of technology. This award is open to pharmacy teams who have implemented initiatives to improve patient care and inter-professional working through the introduction of innovative technology.

cegedim Healthcare Solutions

Cegedim is delighted to be sponsoring the 2021 Scottish Pharmacy Awards. It is a great opportunity to formally recognise, celebrate, and reward the achievements of outstanding Scottish pharmacists and pharmacy teams who have made a real difference to the profession and to the lives of their patients, which often goes unnoticed. The independently-judged Scottish Pharmacy Awards recognise excellence and outstanding dedication to a profession that Cegedim are proud to be involved with.

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Scottish Pharmacy Awards

The Crowne Plaza Hotel, Glasgow

Wednesday 24th November 2021

Ethypharm

Ethypharm is proud to sponsor an award which recognises the vital work hospital pharmacy teams do. These have been challenging times but excellence will always generate opportunities where excellence will always stand out. This award recognises those who have made a difference to patients and those who strive for excellence. At Ethypharm we are fortunate to be able to work with and support professionals who make a valuable contribution to hospital pharmacy and we hope that by working together we can achieve better results for patients. Congratulations to all the nominees in this category as well as the deserving winner. You have all demonstrated excellence and a commitment to enhance the services offered by your collaboration.

Hospital Pharmacy Team of the Year

Sponsored by Ethypharm

The Hospital Pharmacy Team of the Year Award has been developed to recognise hospital pharmacy teams from all backgrounds who are at the forefront of their profession, whether developing best practice models or implementing improvements in patient care. This is your opportunity to nominate peers and colleagues who have demonstrated outstanding dedication and commitment to the pharmacy profession or to submit your own team's work for consideration.

Mental Health Project of the Year

Sponsored by Kyron Media

The coronavirus pandemic has changed the mental health landscape and affected everyone in Scotland and across the world. Coronavirus has increased anxiety for people with pre-existing mental health issues. People who were previously unaffected by mental health problems are now experiencing these for the first time and suicidal thoughts have increased, especially among young adults. Our pharmacy community has been at the forefront of dealing with these issues when they themselves may have been struggling. We want to celebrate the tireless work carried out by the Scottish pharmacy community in helping those with mental health issues.

Kyron Media

Kyron Media are delighted to sponsor this award in recognising the incredible work going on to help those with mental health issues throughout Scotland. It can sometimes be overlooked that pharmacy staff themselves may be struggling just as much but, all the while, putting patient care to the forefront. This award is to recognise the extraordinary efforts in tackling mental health issues throughout a global pandemic.

www.scottishpharmacyawards.info

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@kyronmedia

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Scottish Pharmacy Awards

The Crowne Plaza Hotel, Glasgow

Wednesday 24th November 2021

Scottish Pharmacy Review

Scottish Pharmacy Review is delighted to sponsor this award highlighting the achievements, innovation, collaboration and dedicated work of community pharmacy practices across the country. This is even more prevalent given the extenuating issues arising from the global pandemic. Community pharmacy has been at the forefront of patient care across Scotland – a presence which has never been as integral than over the last 12 months.

Independent Community Pharmacy Practice of the Year

Sponsored by Scottish Pharmacy Review

The Independent Community Pharmacy Practice of the Year Award is targeted at pharmacies who have demonstrated high standards of healthcare delivery. The pharmacy may display excellence in a particular professional aspect which ensures outstanding service to the consumer.

Special Recognition Award

The 2021 Special Recognition Award will be honouring one inspiring individual. The recipient will not only have forged a better path for the profession through their innovation, expertise and hard work, but throughout their years of working have identified and harnessed the importance of collaborative team working and communication. Against the particular COVID-related challenges of the last 12 months, the impact of our pharmacy sector has never been as vital — and we are thrilled to be able to bestow this honour on one formidable representative.

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EPILEPSY: IN THE WORKS

Despite awareness of the workplace-related issues impacting individuals with epilepsy growing, practical action in tackling their occurrence has been worryingly slow. SPR takes a look at the enormity of the problem, and the new support in place to help.

The stark correlation between employment incidence and epilepsy continues to strike an astounding chord – in which less than 40 per cent of people with epilepsy of a working age are in employment, according to figures from the Office of National Statistics. And those who are earn, on average, 11.8 per cent less than people without the condition.

Why are we allowing this bleak portrait to persist against the backdrop of our forward-thinking society? When trying to decipher the attributable factors which have been coming into play, a major barrier for people with epilepsy to get and stay in work was revealed as a lack of understanding around the condition, Epilepsy Action said. A 2016 YouGov survey indicated that a quarter of respondents (26 per cent) were concerned about working with someone with epilepsy. Of those, nearly two-thirds (63 per cent) commented that it was because they didn't know how to help a colleague having a seizure. Additionally, individuals with epilepsy have reported being humiliated in front of colleagues, demoted, redeployed, or even made redundant because of their epilepsy.

MILES' EXPERIENCE

Miles'* company became aware of his epilepsy and treated him fairly and equally initially. However, after Miles had a seizure one morning before work, things changed.

'When they found out I had a seizure off-site, they made my life hell. They sent me to occupational health, where I explained that I was fine to work, as my condition was stable. I was told to see a neurologist. Again, I explained I was fit to work, that my seizures are rare and happen within an hour or so of waking. The occupational health doctor Googled 'epilepsy at work' and then advised no working at heights or lone working. I wasn't even allowed to stand on a ladder. When I objected, he told me I wasn't a neurologist and couldn't vouch for my own safety. He said he had to err on the side of caution.

'I faced seizure-based jokes from my manager, including that I should be on a dog lead. The most humiliating thing was when they amended the doctor's report and said I needed to walk around in a harness and a restraint. Despite all my experience and training, I was told I was no longer good enough to work there and offered a lump sum to leave. I refused, quit my job and took legal action.

'During this process, I've found out more. The company were saying that I was in denial about my epilepsy. That I was just seeking a settlement. They now deny ever knowing I had epilepsy, which hurts. They were the only firm ever to accept me when I told them about my condition and to let me work freely.

'People with epilepsy should not have to face stigma from employers who don't understand it. They fear that person will have seizures in the workplace. The fear and the not knowing leads to discrimination. I also believe occupational health need to be given further training. In my case, they were over-cautious, again thinking solely of me having a seizure at work. In fact, the law states I can work freely if epilepsy is not an issue for me, or a safety issue to others. I proved that for many years, yet that right was taken away from me on health and safety grounds.

'I want to show everyone, from people who have epilepsy to friends and family, that you can live a normal life with epilepsy.'

name changed

A SOURCE OF SUPPORT

In light of what Epilepsy Action call 'a dire need for more understanding of the condition' at work, an array of resources and assistance are now lining the road for change. In particular, the charity's Employer Toolkit has been designed to give employers the confidence to help staff with epilepsy. It includes templates to provide support, assess risks and talk about epilepsy, in addition to offering descriptions of a range of different seizure types, as well as access to detailed first-aid videos.

Daniel Jennings, Senior Policy and Campaigns Officer at Epilepsy Action, explained further, 'Most employers want to do the right thing and support their staff, but often lack knowledge around equality laws and safety issues. Some people with epilepsy don't disclose their condition, for fear of a negative reaction. We hope this toolkit will prompt positive discussions between staff and managers. A few conversations could make a world of difference.'

SEIZURE ACTION PLANS

As conveyed in the Employer Toolkit, epilepsy is different for everyone. To understand how epilepsy affects an employee, it's a good idea for employers to work with them to complete an individual seizure action plan.

They can ask their employee to complete the 'My epilepsy' template on the toolkit and talk to them regarding their epilepsy in order to boost understanding.

If the employee usually recovers quickly after a seizure, they might be able to get straight back to work. Or they might just need a quiet place to rest, before going back to work. Their seizure action plan should say where they can rest.

If they normally take longer to recover from a seizure, they might need to go home. Their seizure action plan should include options for how they will get home, and who will travel with them, if necessary. This should be in line with company policies and procedures for anyone who becomes unwell at work.

For more information, visit www.epilepsy.org.uk.

PAIN

A PAINFUL CONVERSATION

For many years the oral route had been considered the most popular route of administration for analgesics, however transdermal delivery is becoming increasingly popular and with good reason. SPR discusses the benefits in administering transdermal patches for opioid drug delivery and how many common issues may be dealt with, resulting in a better end result for the patient.

PRACTICAL BENEFITS OF TRANSDERMAL PATCHES

The delivery of drugs through the skin has been a challenging area for drug delivery over the years however with advancements in technology and research more and more drug substances (including hydrophobic, hydrophilic and macromolecules) are now able to be administered transdermally.

Transdermal drug delivery offers not only a steady, continuous delivery of the analgesic but one which may result in a decreased side-effect profile. As the drug substance passes through the skin and into the patient's systemic circulation, it bypasses the stomach, the liver and the 'first pass' metabolism associated with the oral route. This will increase the bioavailability of the opioid. As the bioavailability is increased, the amount of actual drug administered is lower – this is of particular importance in treating hepato-compromised patients but will also lead to a reduction in traditional side-effects experienced by the majority of patients, such as nausea and vomiting.

In comparison with the oral route of administration, plasma level peaks and troughs are not experienced with transdermal drug delivery. This results in a constant, even delivery into the circulation and maintains clinically therapeutic levels within the patient. In the case of an opioid, the patient does not feel the pain 'coming back' close to their next dose and ensures analgesia is maintained throughout treatment. This is vitally important for the patient as they do not experience elevated levels of pain throughout each 24-hour period.

It's of great value in treating elderly patients who may usually have issues with compliance. Many transdermal patches are intended for use for several days (up to a week) which greatly reduces the chances of overdose. Elderly patients may become confused while taking their medication (even with the use of a daily / weekly blister pack). Caution must always remain however when changing the patch to ensure proper guidelines are followed and the 'old' patch is not left on. In addition, the patient's relatives have a visual aid to know that their elderly relative is receiving their medication and reassurance they haven't taken too much without having to even ask.

As transdermal patches have a high degree of ease associated with self-administration, added to the 'pain free' nature (when compared to injectables) they also aid compliance with patients suffering from chronic illnesses.

When starting patients on certain analgesics, transdermal patches should be considered as they offer many benefits when compared to oral or injectable forms of the drug. As technology advances and improved transdermal drug delivery systems are implemented we are certain to see many more products available in this form.

NEW RECOMMENDATIONS FOLLOWING A REVIEW OF THE RISKS OF DEPENDENCE AND ADDICTION ASSOCIATED WITH PROLONGED USE OF OPIOID MEDICINES (OPIOIDS) FOR NON-CANCER PAIN

Before prescribing opioids, discuss with the patient the risks and features of tolerance, dependence, and addiction, and agree together a treatment strategy and plan for end of treatment.

ADVICE FOR HEALTHCARE PROFESSIONALS

- Opioid medicines (opioids) provide relief from serious short-term pain; however long-term use in non-cancer pain (longer than three months) carries an increased risk of dependence and addiction
- Discuss with patients that prolonged use of opioids may lead to drug dependence and addiction, even at therapeutic doses – warnings have been added to the labels (packaging) of UK opioid medicines to support patient awareness
- Before starting treatment with opioids, agree with the patient a treatment strategy and plan for end of treatment
- Explain the risks of tolerance and potentially fatal unintentional overdose, and counsel patients and caregivers on signs and symptoms of opioid overdose to be aware of
- Provide regular monitoring and support especially to individuals at increased risk, such as those with current or past history of substance use disorder (including alcohol misuse) or mental health disorder
- At the end of treatment, taper dosage slowly to reduce the risk of withdrawal effects associated with sudden cessation of opioids; tapering from a high dose may take weeks or months
- Consider the possibility of hyperalgesia if a patient on long-term opioid therapy presents with increased sensitivity to pain
- Consult the latest advice and warnings for opioids during pregnancy in the product information and in clinical resources
- Report suspected dependence or addiction to any medicine, including to an opioid, via the Yellow Card scheme

For more information, visit www.gov.uk/drug-safety-update/opioids-risk-of-dependence-and-addiction.

This article has been sponsored by Zentiva Pharma UK Limited

NEW Rebrikel Transdermal Patch

(buprenorphine)

- **Potential cost savings of up to 69% versus BuTrans®/generic buprenorphine transdermal patches[1,2]**
- **Bioequivalent to BuTrans®[3]**
- **Indicated for the treatment of non-malignant pain of moderate intensity when an opioid is necessary**

Available in the following strengths: 5µg/hour, 10µg/hour & 20µg/hour

[1]Based on Scotland Drug Tariff August 2021. https://www.isdscotland.org/health-topics/prescribing-and-medicines/scottish-drug-tariff/; [2]DMD https://services.nhsbsa.nhs.uk/dmd-browser/search (Accessed 19th August 2021) [3]Data on file.

Rebrikel (Buprenorphine) 5 µg/h, 10 µg/h, 20 µg/h Transdermal patch Prescribing Information. Prescribers should consult the SmPC before prescribing.

Presentation: Each transdermal patch contains 5mg, 10mg, 20mg of buprenorphine releasing 5µg, 10µg, 20µg of buprenorphine per hour respectively.

Indications: Treatment of non-malignant pain of moderate intensity in adults when an opioid is necessary for obtaining adequate analgesia. Not suitable for treatment of acute pain.

Dosage and administration: Rebrikel should be administered every 7th day. Rebrikel 5 µg/h should be used as the initial dose. Titration: Dose should not be increased before 3 days. To increase the dose, a larger patch should replace the patch currently worn or a combination of patches should be applied in different places. Not recommended to use more than 2 patches at the same time regardless of strength. Conversion from opioids: Can be used as an alternative to treatment with other opioids.

Method of Administration: Apply to non-irritated, intact skin of the upper outer arm, upper chest, upper back or the side of the chest, but not to any parts of the skin with large scars. Apply immediately after removal from the sealed sachet. Press the patch firmly in place with the palm of the hand for approximately 30 seconds. The patch should be worn continuously for 7 days. *Duration of administration:* Do not prescribe for longer than absolutely necessary. If long-term pain treatment is required then careful and regular monitoring should be carried out. *Discontinuation:* Rebrikel is to be followed by other opioids. A subsequent opioid should not be administered within 24 hours after removal of the patch. *Patients with fever or exposed to external heat:* Advise patients to avoid exposing the application site to external heat sources. Fever may also increase absorption resulting in increased risk of opioid reactions.

Special Populations: *Patients under 18 years of age:* Not recommended. *Elderly:* No dosage adjustment required. *Renal impairment:* No dosage adjustment required. *Hepatic impairment:* Use with caution and carefully monitor patients during treatment.

Fertility, pregnancy and lactation: *Pregnancy:* Rebrikel should not be used during pregnancy and in women of childbearing potential who are not using effective contraception. Regular use during pregnancy may cause drug dependence in the foetus, leading to withdrawal symptoms in the neonate. If prolonged use is required, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure appropriate treatment is available. Administration during labour may depress respiration in the neonate, therefore an antidote for the child should be readily available. Towards the end of pregnancy high doses of buprenorphine may induce respiratory depression in the neonate even after a short period of administration. *Breastfeeding:* Not recommended as buprenorphine may be secreted in breast milk and may cause respiratory depression in the infant. *Fertility:* No human data available.

Contraindications: Opioid dependent patients and for narcotic withdrawal treatment, conditions in which the respiratory centre and function are severely impaired or may become so, patients with known hypersensitivity to buprenorphine or the excipients, patients receiving MAOIs or have taken them within the last two weeks, patients suffering from myasthenia gravis and delirium tremens.

Special warnings and precautions: Use with caution in patients with convulsive disorders, head injury, shock, a reduced level of consciousness of uncertain origin, intracranial lesions or increased intracranial pressure, or in patients with severe hepatic impairment. Buprenorphine may lower the seizure threshold in patients with a history of seizure disorder. Significant respiratory depression has been associated with buprenorphine, particularly by the intravenous route. A number of overdose deaths have occurred when addicts have intravenously abused buprenorphine, usually with benzodiazepines concomitantly. Additional overdose deaths due to ethanol and benzodiazepines in combination with buprenorphine have been reported. Not recommended for analgesia in the immediate post-operative period or in other situations characterised by a narrow therapeutic index or a rapidly varying analgesic requirement. Rebrikel should not be used at higher doses than recommended. Drug dependence, tolerance and potential for abuse: prolonged use may lead to drug dependence (addiction), even at therapeutic doses. Individuals with current or past history of substance misuse disorder (including alcohol misuse) or mental health disorder are at increased risk. A comprehensive patient history should be taken before prescribing. Explain risks of developing tolerance to patients. Patients should be closely monitored for signs of tolerance, misuse, abuse or addiction. Overuse or misuse may result in overdose and/or death. Drug withdrawal syndrome: a withdrawal strategy for ending treatment with buprenorphine should be put in place prior to starting treatment. Drug withdrawal syndrome may occur upon abrupt cessation of therapy or dose reduction. When a patient no longer requires therapy, taper the dose gradually to minimize symptoms of withdrawal. Tapering from a high dose may take weeks to months. Opioid drug withdrawal syndrome is characterized by some or all of the following: restlessness, lacrimation, rhinorrhea, yawning, perspiration, chills, myalgia, mydriasis and palpitations. Other symptoms include irritability, agitation, anxiety, hyperkinesia, tremor, weakness, insomnia, anorexia, abdominal cramps, nausea, vomiting, diarrhoea, increased blood pressure, increased respiratory rate or heart rate. When withdrawal occurs, it's generally mild, begins after 2 days and may last up to 2 weeks. Hyperalgesia: may be diagnosed if patient on long-term opioid therapy presents with increased pain. This might be qualitatively and anatomically distinct from pain related to disease progression or to breakthrough pain resulting from development of opioid tolerance. Pain associated with hyperalgesia is more diffuse than the pre-existing pain and less defined in quality. Symptoms of hyperalgesia may resolve with a reduction of opioid dose. Opioids can cause sleep-related breathing disorders including central sleep apnoea (CSA) and sleep-related hypoxemia.

Drug Interactions: MAOIs (including patients who have received MAOIs within the previous 2 weeks), CYP3A4 inhibitors, enzyme inducers (e.g. phenobarbital, carbamazepine, phenytoin and rifampicin), general anaesthetics (e.g. halothane), benzodiazepines, other opioid derivatives (analgesics and antitussives containing e.g. morphine, dextropropoxyphene, codeine, dextromethorphan or noscapine), antidepressants, sedative H1-receptor antagonists, alcohol, anxiolytics, neuroleptics, clonidine and related substances.

Effects on ability to drive/use machines: May influence patient's ability to drive and use machines particularly in the beginning of treatment and in conjunction with other centrally acting substances including alcohol, tranquillisers, sedatives and hypnotics. Prescribers to give individual recommendations to patients. A general restriction is not necessary in cases where a stable dose is used.

Undesirable effects: Anaphylactic reaction, anaphylactoid reaction, anorexia, confusion, depression, insomnia, nervousness, anxiety, hallucinations, psychotic disorder, drug dependence, headache, dizziness, somnolence, tremor, syncope, seizures, palpitations, tachycardia, angina pectoris, circulatory collapse, dyspnea, respiratory depression, respiratory failure, constipation, nausea, vomiting, abdominal pain, diarrhoea, dyspepsia, dry mouth, Ilius, diverticulitis, pruritus, erythema, rash, dermatitis contact application skin discolouration sweating, exanthema, muscular weakness, urinary retention, erectile dysfunction, application site reaction, tiredness, asthenic conditions, peripheral oedema, drug withdrawal syndrome, drug withdrawal syndrome neonatal.

Pack size and UK list price: Rebrikel 5 µg/h transdermal patch (PL 17780/0876) pack size:4 £5.53, Rebrikel 10 µg/h transdermal patch (PL 17780/0874) pack size:4 £9.93, Rebrikel 20 µg/h transdermal patch (PL 17780/0875) pack size: 4 £18.09.

Legal category: POM

Marketing Authorisation Holder: Zentiva Pharma UK Limited, 12 New Fetter Lane, London, EC4A 1JP, UK

Date of Preparation: 19 June 2021 Ref: 13642

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Zentiva via email to PV-United-Kingdom@zentiva.com or via phone on 0800 090 2408.

ZENTIVA

For more information contact
zentiva.specialty@zentiva.com

Date of Preparation: August 2021 Ref: 14558

ASTHMA

SAVING FACE

More than 12 months on, the connotations of COVID-19 continue to affect the delivery of asthma care, with new statistics highlighting that 1.3 million people at greatest risk of deadly asthma attacks in the UK haven't received face-to-face support during this time. Why is the absence of this in-person approach prompting wide concern? SPR takes a look.

More than one million people in the UK with asthma who are at the highest risk of having a potentially fatal asthma attack have not had a face-to-face annual review with their GP or asthma nurse during the pandemic, according to recent figures released by Asthma UK.

The charity are concerned that people who are encountering uncontrolled symptoms, such as using a reliever inhaler three times a week or more, or waking in the night feeling breathless, with a cough, tight chest or wheezing, are missing out on attaining the level of asthma care they require that could prevent them from experiencing a life-threatening asthma attack.

Asthma UK's new report, 'Asthma Care in a Crisis', has revealed that of those most at risk of an asthma attack:

- Over one-quarter (28 per cent) haven't had their annual asthma review where medication is assessed
- One-in-five (21 per cent) haven't had their inhaler technique checked. Using an inhaler in the right way can mean that the full dose of medicine can get into your lungs where it is needed, keeping asthma attacks at bay
- Nearly half (47 per cent) haven't had a written asthma action plan which includes information on which medicines you need to take every day to prevent an asthma attack and what to do if your asthma is getting worse

Overall, asthma care levels are stagnating due to the backlog of care created by the pandemic, with an estimated 3.5 million people with asthma not receiving all elements of basic asthma care. Basic asthma care consists of an annual review, inhaler technique check and written asthma action plan, and it should be provided by GP surgeries, according to the NICE best practice guidelines.

Asthma UK are calling for GPs to urgently prioritise asthma reviews for people with uncontrolled symptoms, who are most at risk of having an asthma attack and conduct them face-to-face (for example, where there is a clinical need).

Since March 2020, GP practices have had to make vast changes to the way they deliver routine care to protect staff and patients across the healthcare system from coronavirus, including the shift to remote care via phone or video. While this may be appropriate for some people with asthma, there are cases when it is clinically necessary to be seen face-to-face.

For example, it's easier for GPs to spot if people are struggling with their asthma if they can check their lung function with a peak flow or spirometry tests and face-to-face appointments mean that GPs can ensure that people with asthma are using their inhaler properly and getting the medicine they need. This is vital as nearly half of people with asthma aren't using their inhaler properly, which means that the full dose of the medicine can't get into their lungs.

Asthma UK's latest figures also demonstrate that three-quarters of people (77 per cent) with asthma who had an annual review would prefer to have it conducted face-to-face and this was even higher for those with uncontrolled asthma (80 per cent).

The charity are urging the NHS in all nations to put a plan in place to ensure that basic asthma care is made available to everyone and that patients at highest risk are seen face-to-face. This should include clear instructions to healthcare professionals on how to prioritise people to see in person, implement guidance on delivering lung function tests safely and provide reassurance for people with asthma that they can visit a GP surgery safely. It should also provide clear guidelines on how to best manage care remotely, to ensure that there are no short-cuts that impact the quality or safety of care.

It's also vital for people with asthma to take up face-to-face or remote appointments when offered so that they have the best chance of managing their asthma well and avoiding an asthma attack.

DANIEL'S STORY

Daniel Taylor, 27, is a Gardener from Manchester and went to A&E last October after having a major asthma attack where he received treatment. He later had a GP appointment but was only able to get one over the phone.

He said, 'My asthma took a turn for the worse when I started waking up at night with a tight chest, feeling wheezy and breathless. I managed symptoms at home with my reliever inhaler, but two days later I had an asthma attack. I was coughing uncontrollably and could barely talk. It was terrifying. My wife drove me to A&E where I was put on equipment to help me breathe and given steroid tablets to help calm down the inflammation in my airways.

'Within two days I spoke to my GP and asthma nurse over the phone. We talked through what had happened and what medication I was on and I was prescribed a different, stronger inhaler and sent a video on how to use it. I was hoping to be offered the option of a face-to-face appointment, especially because I had just received emergency treatment in hospital, but I wasn't given the choice.

'Being seen face-to-face would have given me the reassurance that I am okay and that I am using my new inhaler correctly, something which I'm not confident in, especially because it's been over a year since I've had this checked. I think it's so important that people with asthma are made to feel like they have a choice in how they receive care because phone and video appointments don't always work for everyone.'

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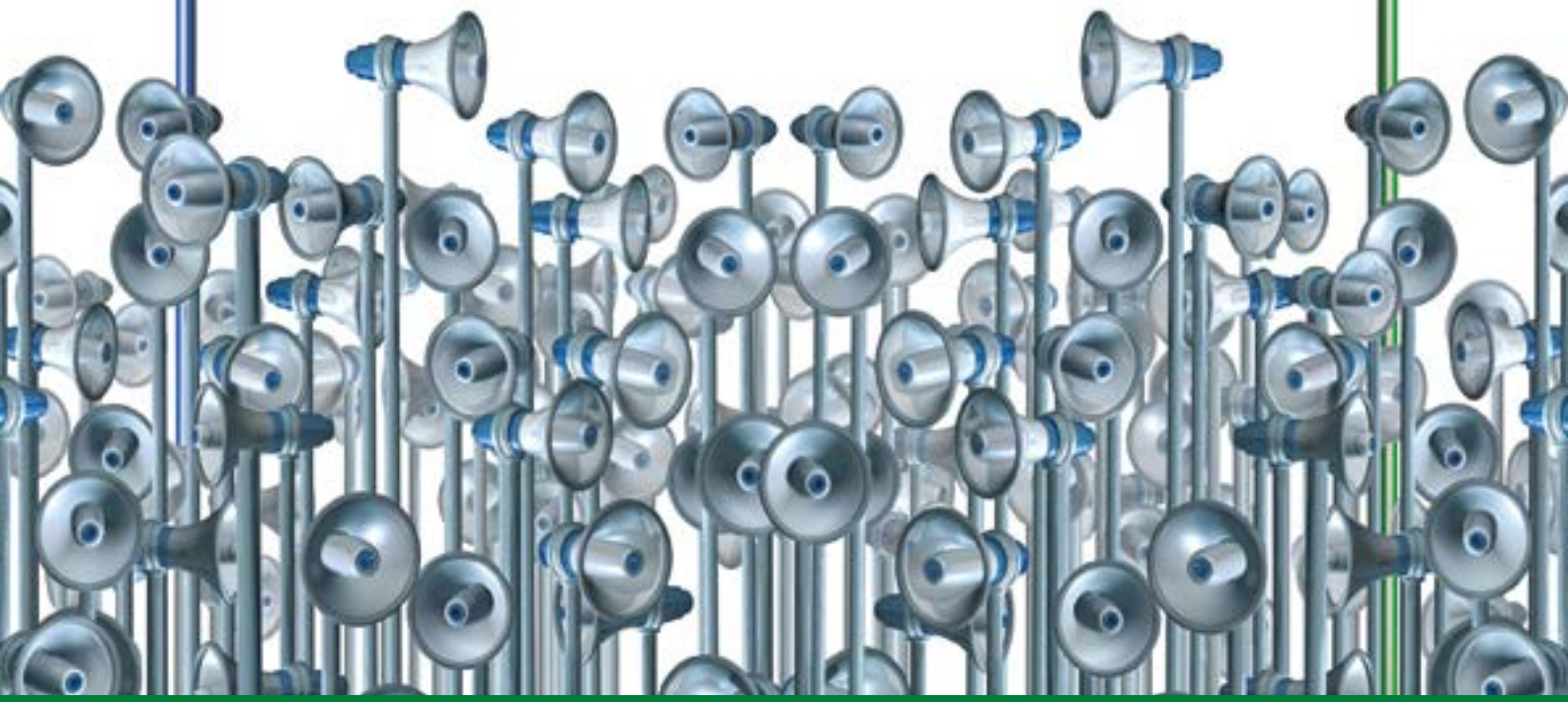
Spend time with anyone from the **Lupin Healthcare team** and you will feel the pride in the partnerships we have developed.

Collaboration, teamwork and trust are the key to developing effective partnerships which stand out from the crowd and are pivotal to the continued success of our pursuit in **delivering quality medicines and value to the patient and the *NHS***.



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NHS PHARMACY FIRST SCOTLAND

AT YOUR SERVICE

SPR sheds light on the design and launch of NHS Pharmacy First Scotland, and what this provision of support means for people living in Scotland.

NHS Pharmacy First Scotland is an NHS community pharmacy service that aims to encourage people to go to their local pharmacy for support with minor and acute health conditions, thereby reducing the number of GP consultations and visits to Emergency Departments for minor health complaints.

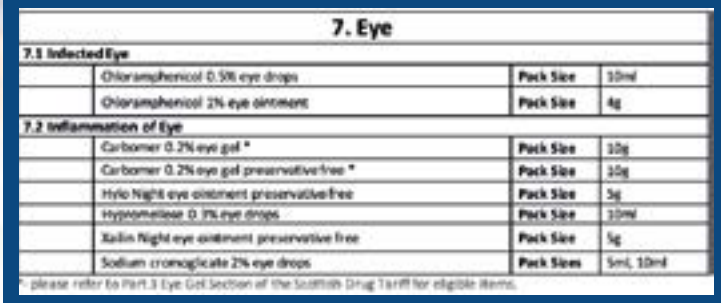
It has replaced the Minor Ailment Service which community pharmacies delivered for more than 10 years. It also forms part of the national community pharmacy contractual framework.

This new service will help people access the right care in the right place, without having to go to their GP practice or local Accident and Emergency Department for non-urgent treatment.

Scotland has nearly 1,260 community pharmacies across all health board regions and the Pharmacy First Scotland scheme gives each pharmacy the opportunity to not only become an even more valuable asset in primary care but also take on further responsibility when it comes to the diagnosis and treatment of your patients.

Before the scheme can be used the pharmacist needs to ensure the patient is either registered with a GP practice in Scotland or that they live in Scotland. The following consultation form must be completed:

The approved list of products available can be found at www.sehd.scot.nhs.uk/publications/NHS_Pharmacy_First_Scotland_Approved_List_of_Products_v11_1_July_2021.pdf where they are categorised into one of 10 categories as shown:



7. Eye			
7.1 Infected Eye			
	Chloramphenicol 0.5% eye drops	Pack Size	10ml
	Chloramphenicol 1% eye ointment	Pack Size	4g
7.2 Inflammation of Eye			
	Carbomer 0.2% eye gel *	Pack Size	10g
	Carbomer 0.2% eye gel preservative free *	Pack Size	10g
	Hylo Night eye ointment preservative free	Pack Size	5g
	Hypromellose 0.3% eye drops	Pack Size	10ml
	Xailin Night eye ointment preservative free	Pack Size	5g
	Sodium cromoglicate 2% eye drops	Pack Sizes	5ml, 10ml

* please refer to Part 3 Eye Gel Section of the Scottish Drug Tariff for eligible items.

1. Gastrointestinal system – Dyspepsia, GI reflux, gripe / colon / wind pain, IBS, acute diarrhoea, constipation and haemorrhoids
2. Respiratory – Allergy, cough, nasal congestion and nasal allergy
3. Central nervous system – Travel sickness, analgesics and antipyretics and migraine
4. Musculoskeletal and joint pain
5. Infections – Vaginal candidiasis, fungal skin infections (not including nail), warts / verrucae, cold sores, threadworm, headlice, scabies / pubic lice, impetigo
6. Cystitis – Refer to specific NHS board for further details
7. Eye – Infected eye and inflammation of the eye
8. Ear – Removal of ear wax
9. Mouth – Oral ulceration and oral thrush
10. Skin – Eczema and allergy – refer to specific NHS board for further details

Health Secretary Jeane Freeman further explained the importance of the service, saying, 'During COVID-19 pandemic people followed public health guidance closely and used their local pharmacy for medical advice and help.

'The launch of NHS Pharmacy First Scotland will make sure that people across Scotland can continue to do this. It gives access to the right care in the right place, getting medical support that is closer to home and often with no waiting time or appointments needed.

'While the NHS is there for all of us, we don't all need to go to accident and emergency. For many of us, it is not the right place for the care we need. NHS Pharmacy First Scotland provides a local service, giving local access to healthcare help for many illnesses.

'The COVID-19 pandemic has been an immensely difficult and trying period for community pharmacy in Scotland but also a time when the pharmacy community was invaluable in ensuring that patients were provided expert frontline healthcare without delay or long waiting times.

'The range of ailments to diagnose and treatments available to dispense for community pharmacy is a validation of how integral our profession is to the overall healthcare service in Scotland and how, by using this scheme, we can positively affect the daily lives of our patients.'

Recommend Xailin® for your dry eye patients

Preservative free in the eye

Xailin® Gel

Multi-dose eye gel for long-lasting relief of dry eye sensations.

Xailin® Gel lubricates and protects the eye, providing long-lasting cooling and soothing relief from dry eye sensations such as soreness, irritation or gritty sensations.[2]

Xailin® Night

Lubricating eye ointment. Night-time relief for dry eye sensations.

Xailin® Night provides soothing relief for your patients suffering from night-time dry eye sensations including soreness, irritation and grittiness by acting as a barrier against moisture loss.[1]

Xailin® Night & Xailin® Gel are on the approved list for NHS Pharmacy First Scotland[3]

Eye drops that contain a preservative when they reach the eye can have the following impacts[4]:

- Induce toxicity and adverse changes to the ocular surface
- Induce corneal and conjunctival epithelial cell apoptosis
- Damage corneal nerves
- Delay corneal wound healing
- Interfere with tear film stability
- Cause loss of goblet cells
- Many studies have highlighted that preservative containing eye drops can have severe implications with long-term use

For more information, contact your local Scotland VISUfarma representative or VISUfarma Head Office.

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1. Xailin® Night Instructions for Use (IFU) **2.** Xailin® Gel Instructions for Use (IFU) **3.** NHS Pharmacy First Scheme: https://www.cps.scot/media/3998/circular-pca-o-2020-18-and-pca-p-2020-24-nhs-pharmacy-first-scotland-optometry-pharmacy-guidance-and-referral-form-6-november-2020.pdf last accessed July 2021 **4.** Jones, L.J. et al. TFOS DEWS II Management and Therapy Report. The Ocular Surface 15 (2017) 580-634.

VISUfarma the eye health company

VISU/UK/Xa/0012 Date of preparation: July 2021

DRY EYE SYNDROME

SETTING THEIR SIGHTS HIGHER

SPR presents a snapshot of dry eye syndrome, as well as the role and benefits of preservative-free eye drops in the management process.

Dry eye can be an extremely uncomfortable and irritating condition caused when the eye does not produce enough tears or the tears produced evaporate too quickly.

It can be recognised by common symptoms including:

- Dryness
- Burning sensation
- Gritty eye feeling that gets progressively worse throughout the day
- Redness
- The sensation that there is something in your eye
- Pain

While there may be many reasons for a patient to experience dry eye, the following illustration identifies the six main causes:

The NHS.uk website recommends the following for patients to initially try when self-treating dry eye:

Do	Don't
• Keep your eyes clean • Take breaks to rest your eyes when using a computer screen • Make sure your computer screen is at eye level so you do not strain your eyes • Use a humidifier to stop the air getting dry • Get plenty of sleep to rest your eyes • If you wear contact lenses, take them out and wear glasses to rest your eyes	• Do not smoke or drink too much alcohol • Do not spend too long in smoky, dry or dusty places • Do not spend too long in air conditioned or heated rooms • Do not stop taking a prescribed medicine without getting medical advice first – even if you think it's causing your symptoms

When self-treatment has been tried patients may look for advice from community pharmacists on the best method / product to resolve this issue.

Eyes drops are the recommended treatment for dry eye as we all know, however, the question has become increasingly prevalent – to use traditional eye drops or preservative-free eye drops?

Multi-use eye drops contain various preservatives but the majority will contain benzalkonium chloride (BAC). BAC is a very efficient preservative and effectively nullifies the risk of infection caused by varying pathogens and bacterial growth however, they were never designed to be kind and gentle to the eye itself. It is thought to provoke a pro-inflammatory response of the surface of the eye that causes the breakdown of the oily layer on the surface of the tear film.

Continual use of products containing BAC can actually harm corneal and conjunctival epithelial cells which can result in the decreased production of tears and maintenance of the tear film. This chain of events can actually then cause dry eye, the very condition the patient is attempting to resolve.

In more extreme circumstances, this loss of the epithelial cells can lead to damage to the surface of the cornea leading to a deterioration in the patient's vision. An alternative option is the increasing role that preservative-free eye drops / ointments can play in treating dry eye / eye inflammation.

Monodose containers have several advantages, most notable that they do not contain preservatives – in this case the preparation / product is always sterile with no opportunity for it to be contaminated. The treatment is then applied in one dose with no drug being retained for further use.

Preservative-free formulations have been shown to significantly improve symptoms in patients with severe dry eye disease while showing little to no adverse effects. This is the optimal end result for any treatment and would suggest that preservative-free eye drops / ointment should be considered on a longer-term basis.

PARKINSON'S: KEYS OF POSSIBILITY

New research has been published that sheds an important light on how the production of a key protein in the brain is controlled – and its implications could pave the way for new treatments for a wide range of neurological conditions, including Parkinson's.

Fresh insight into protein production inside brain cells could help tackle Parkinson's. In a study part-funded by Parkinson's UK, researchers investigated a section of genetic material known as antisense long non-coding RNA (lncRNA), which helps fine-tune the production of the protein tau inside brain cells. This precision in tau regulation is crucial for smooth functioning of the nerve cells.

Understanding the mechanism which helps regulate tau production could be the key to developing better treatments for conditions including Parkinson's, Alzheimer's, corticobasal degeneration and progressive supranuclear palsy.

The team's findings – published in Nature – indicate that tau, along with other key proteins involved in brain function, are controlled by very similar lncRNAs. This insight could help scientists develop the ability to control the production of these proteins and, in turn, the development of certain neurological conditions. The international team comprised of researchers from University College London, the Francis Crick Institute, University of Trento, Italy and the Karolinska Institute in Stockholm, Sweden.

Lead investigators Professor Rohan de Silva and Dr Roberto Simone, from University College London, further explained, 'Tau plays a really vital role inside our brain cells. It helps to stabilise and maintain the cytoskeletal structures that allow different materials to be transported to where they are needed. We know that too much tau is detrimental – the excess, unused tau converts into toxic species that may be responsible for damaging cells and driving the spread and progression of disease. However, despite the fact that tau has been studied for more than three decades, until now we did not know how neuronal cells exactly control tau protein production.

'Excitingly, we found that the lncRNA that controls tau is not unique. Other key proteins we know to be involved in neurological conditions, including alpha-synuclein in Parkinson's and beta-amyloid in Alzheimer's, could be controlled by very similar lncRNAs. This means we may have found the key to regulating the production of a whole range of proteins involved in brain function and the development of these devastating conditions.

'It's early days but we hope that these exciting new insights will lead to the development of drugs that can keep tau and other proteins under control, and that these therapies could be life-changing for degenerative brain conditions that as yet, we can't slow or stop.'

'Tau is emerging as one of the key determinants of different rates of progression in Parkinson's so understanding how this protein is regulated may be vital to finding better treatments and a cure for Parkinson's,' added Professor David Dexter, Associate Director of Research at Parkinson's UK.

'This important research provides fantastic new insights into how tau production is controlled inside brain cells, and presents an exciting new opportunity for developing therapies that target this. It's especially exciting to see that similar mechanisms may be involved in controlling the production of many other key proteins implicated in other neurological conditions, as it suggests strategies targeting these mechanisms could be effective across many conditions'

PARKINSON'S: DID YOU KNOW?

According to Parkinson's UK's estimates, one-in-37 people alive today in the UK will be diagnosed with Parkinson's in their lifetime, with around 145,000 people living with a Parkinson's diagnosis in the UK in 2020.

Broken down within the UK, for 2020, that's:

- England: 121,000
- Scotland: 12,400
- Wales: 7,600
- Northern Ireland: 3,900

With population growth and ageing, this is likely to increase by a fifth, to around 172,000 people in the UK, by 2030. Every hour, two more people are diagnosed – that's the same as 18,000 people every year.

Furthermore, the number of people with Parkinson's under the age of 50 is estimated to be 1,752 (1.2 per cent of people with a diagnosis of Parkinson's are under the age of 50). As well as that:

- 50-to-59 years old: 8,889
- 60-to-69 years old: 25,916
- 70-to-79 years old: 60,083
- 80-to-89 years old: 40,420
- 90+ years old: 7,553

PROMOTION

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Paul Insley, Head of Bestway Medhub and Wardles

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To celebrate their sixth birthday last month and mark this key business milestone the team decided to raise awareness and over £2,000 for the sector's leading wellbeing charity, Pharmacist Support.

Paul Insley, Head of Bestway Medhub and Wardles, said: *"We've come a long way over the last six years, and I am very proud of how we have stayed true to our values of being transparent, fair and simple – something I know our customers truly appreciate when working with us.*

"The last 18 months has been incredibly tough for everyone, and coronavirus has affected all our lives. I've seen first-hand the increased pressure that has been put on pharmacists and their teams, but as always, the pharmacy sector has risen to the challenge and shown its true value. I have been inspired to see the hard work, resilience and passion from the pharmacy sector and that is why we chose to mark our sixth business anniversary milestone by raising awareness and funds for the profession's leading wellbeing charity.

"I am delighted that we've raised £2,282 for Pharmacist Support, which will go directly towards building wellbeing workshops as well as counselling and peer support for those that need it. As a pharmacist myself, I know the importance of charities and wellbeing services like this. Taking some time to look after their own health and wellbeing is essential while they put their focus and energy into caring for their patients and the local communities they serve."

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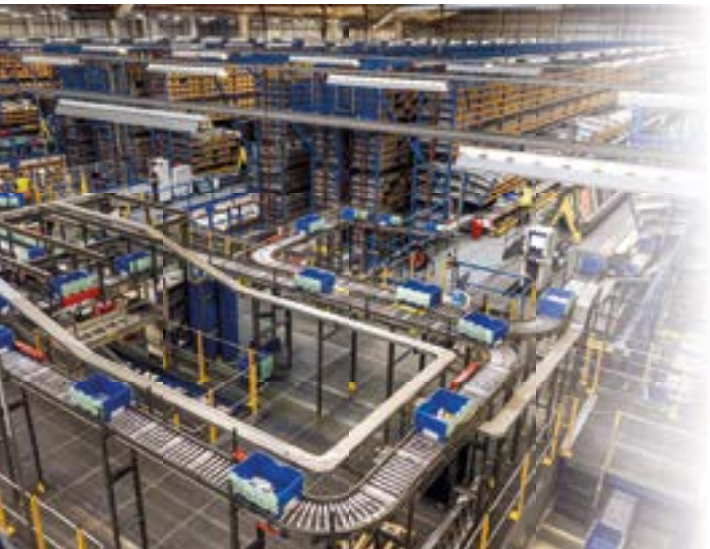

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MENOPAUSE

PAUSE FOR THOUGHT

For many women, approaching the menopause transition can be both daunting and draining, imposing a multifaceted impact on their life. SPR takes a look at one of the key struggles they may encounter, as well as why individuals require optimal support not just from their healthcare professionals, but society as a whole.

EASING VAGINAL DRYNESS

BY DR NUTTAN TANNA, PHARMACIST CONSULTANT IN WOMEN'S HEALTH

Many women struggle with vaginal dryness (atrophy) during the menopause. Vaginal dryness is caused by the thinning, drying and inflammation of vaginal tissues, and can happen as their oestrogen levels fall. Doctors often describe the condition as the genitourinary syndrome of the menopause (GSM).

SIGNS AND SYMPTOMS

Women may have vaginal dryness, with burning and discharge, genital itching and vaginal infections. Some women have burning when weeing and an urgent and frequent need to pass urine. They may have urinary tract infections and urinary leakage. Other symptoms are light bleeding after sex, discomfort and low vaginal lubrication during sex, and shortening and tightening of their vaginal canal. Many women feel too embarrassed to discuss these symptoms with their GP. But if they have any unexplained vaginal spotting or bleeding, or unusual discharge, burning or soreness, in particular, it's important to seek medical help.

SELF-HELP

A community pharmacist can advise on the different products available without a prescription. For painful sex, women can try vaginal moisturisers or water-based lubricants. A vaginal moisturiser applied every few days may last longer than a lubricant. Lubricants are applied just before sexual activity and are used to help reduce discomfort during sex. If these products don't work, they should see their doctor.

There are many products available. Women can ask for a product that doesn't contain glycerin or warming properties if they're sensitive to these to avoid irritation. If they're using condoms, they should avoid products containing petroleum jelly, as petroleum can break down latex condoms on contact.

Smoking affects blood circulation, causing less blood flow to the vagina and nearby tissues, so stopping smoking may help. Regular sexual activity helps to increase blood flow to their vaginal tissues and makes these more elastic.

PRESCRIBED PRODUCTS

Many women find HRT helps vaginal dryness. If it doesn't, they may also be prescribed vaginal oestrogen replacement therapy (vaginal ERT). Vaginal oestrogen products contain either oestradiol (estradiol) or oestriol (estriol). Women may have some itching and irritation in and around the vagina at the beginning of treatment, but this should settle down. If not, or if they have any vaginal bleeding, this should be checked out by their doctor.

Community pharmacists can be advised to read the SPC for the licensed vaginal ERT products, available as vaginal tablets, vaginal creams and vaginal ring, for their ongoing CPD.

ABOUT THE AUTHOR

Dr Nuttan Tanna is a Pharmacist Consultant in women's health. She runs weekly menopause and osteoporosis medication management clinics at Northwick Park Hospital, in Harrow, Middlesex, and is also actively involved in education and research.

For more information, visit www.menopause-exchange.co.uk.

WORKING TOWARDS CHANGE

Menopause symptoms can have a significant effect on all aspects of women's lives, including their attendance and performance at work. Not all employees going through the menopause will want to raise the issue with managers or colleagues. But if they do, it is important that they feel supported, understood and heard.

'The impact of the menopause at work shouldn't be underestimated,' says Norma Goldman.

'Physical and emotional symptoms can have a huge impact, not just affecting women who are going through the menopause, but also their colleagues. Many women don't seek the help they need, instead suffering in silence. Employers can help by putting the right policies in place, offering menopause training to employees and making simple, practical workplace changes to improve employee wellbeing.'

In the Autumn 2020 issue of The Menopause Exchange newsletter, Norma Goldman, Founder and Director of The Menopause Exchange, writes about menopause policies and guidance.

The result of further investigation into the feedback of those experiencing the menopause while at work has led to The Chartered Institute of Personnel and Development (CIPD), the professional body for HR and people development, calling on employers to break the workplace taboo and provide better support for working women.

The CIPD's research surveyed 1,409 women experiencing menopause symptoms and was led by YouGov. Of those who were affected negatively at work, they reported the following issues:

- Nearly two-thirds (65 per cent) said that they were less able to concentrate
- More than half (58 per cent) said that they experience more stress
- More than half (52 per cent) said that they felt less patient with clients and colleagues
- Nearly a third of women surveyed (30 per cent) said that they had taken sick leave because of their symptoms, but only a quarter of them felt able to tell their manager the real reason for their absence

Privacy (45 per cent) was the number one consideration for women choosing not to disclose. A third (34 per cent) added that embarrassment prevented them from saying why they had to take time off, and another 32 per cent said that an unsupportive manager was the reason.

To break the stigma associated with the menopause, The CIPD is recommending that employers educate and train line managers so they are knowledgeable and confident to have sensitive conversations with staff about their symptoms and any adjustments that might be needed.

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

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ADVANZ PHARMA

COELIAC DISEASE

BITING BACK

Although society's coeliac disease knowledge is progressively improving, with the symptoms often vague and broad, the condition remains tinged with too much misunderstanding. Here, the Guts UK charity team explore its complexity, in addition to the recommended courses of action when a diagnosis is suspected.

Coeliac disease is an autoimmune condition where gluten, a protein found in wheat, barley or rye, causes inflammation to the small bowel villi, resulting in malabsorption.

Approximately one per cent of the UK population have coeliac disease; it occurs in all ethnicities, and it's suspected that one-in-seven people remain undiagnosed. The reason coeliac disease occurs is currently unknown and it's suspected that alongside a genetic predisposition, there are suspected environmental factors that are behind the cause of the development of coeliac disease. The incidence in first-degree relatives is 10 per cent.

WHAT ARE THE SYMPTOMS?

Symptoms of coeliac disease can be wide-ranging, and occasionally vague, for example, abdominal discomfort, bloating, and a change in bowel habit – diarrhoea or constipation. People can have weight loss and symptoms of nutritional deficiencies, such as osteoporosis or anaemia. There are occasionally other symptoms, such as ataxia and a skin condition called dermatitis herpetiformis that's linked to damage from gluten.

Some people don't have symptoms and are discovered to have coeliac disease during an investigation for other problems, such as bone disease, autoimmune thyroid disease and anaemia as these are associated with coeliac disease. Other associated conditions are type 1 diabetes, Down's syndrome and Turner syndrome.

It's important to also test people with suspected IBS in adults for coeliac disease as the diagnosis has a four-fold increase in people meeting an IBS diagnosis compared to the general population. (Ford et al, 2009)

DIAGNOSIS

Diagnosis of coeliac disease is by serology initially, using total immunoglobulin A (IgA) and IgA tissue transglutaminase (tTG) as the first choice, if this test is weakly positive then IgA endomysial antibodies (EMA) if IgA tTG is weakly positive.

Prior to testing, it's vital that people eat sources of gluten (wheat, barley or rye) in more than one meal per day for at least six weeks before the test to ensure that they have adequate antibodies in their blood for detection. These tests may be sufficient alone to test for coeliac disease in some adults over 55 and young children but in other cases an endoscopy will be required, and when it is, again it's important that the patient continues to eat gluten to ensure a diagnosis.

WHAT NEXT?

The treatment for coeliac disease is a gluten-free diet and it's very important that strict avoidance is maintained for life to ensure health.

Gluten is found in foods containing wheat, barley and rye – obvious sources are bread, pasta, biscuits, pastry and wheat-based breakfast cereals. Gluten is also found in foods where it might be less likely to be suspected. Wheat is frequently used in products to impart texture and used as additives to act as thickeners, extenders, emulsion stabilisers and binders in processed foods and processed meats such as sausages, for example. Wheat can also be present in small amounts as a food contaminant during the production process and people with coeliac disease need to avoid all sources of contamination.

This can mean that the diet is complex and people who are diagnosed should be referred to a dietitian for dietary education and reviewed to ensure that the diet remains gluten-free. Early education is important so that the person can quickly become confident in following a gluten-free lifestyle.

A wide range of foods are naturally gluten-free but there are also staple foods that are developed specifically for the gluten-free diet, such as breads, breakfast cereals, crackers and flour.

The cost of these staple gluten-free foods is higher and in Scotland, Wales and Northern Ireland gluten-free foods can be provided on prescription to ensure that people do have access to the foods that they need and are able therefore to follow the diet and stay well.

Once diagnosed people with coeliac disease should be considered for a referral for a DEXA scan and as patients with coeliac disease can also have hyposplenism vaccinations against influenza and pneumococcal infections may be recommended. They should have an annual review to ensure continued recovery from the gluten-free diet and any continued symptoms should be investigated by a gastroenterologist, therefore the patient should be referred in this situation. Lymphoma of the small bowel occurs in a very small number of people with coeliac disease after many years, especially if they continue to eat gluten so it is important that the cause of continued symptoms is investigated.

Coeliac disease is more common than previously thought and the treatment once diagnosed is to follow a strict gluten-free diet. If the diet is followed, most people will recover well and have a life-expectancy the same as the general population.

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APLASTIC ANAEMIA: STRENGTH IN SUPPORT

In this edition of SPR, Ellie Dawes and Connor Gardner – on behalf of The Aplastic Anaemia Trust – cast a spotlight on the impact of COVID-19 for people affected by aplastic anaemia.

On 4th January 2021, Boris Johnson blared out of the TV with a now-familiar message, 'Stay home, protect the NHS, save lives.' Panic set in in the Gardner household, where Connor, Rachel and one-year-old Max had been isolating for two weeks.

Baby Max had been diagnosed with aplastic anaemia (AA) in September, an ultra rare bone marrow failure that stops production of blood cells. Max required urgent treatment, but luckily his mum Rachel was a match, and the family had been booked in for a stem cell transplant in just two days' time.

After a worried phone call, the family were relieved that the transplant would go ahead as planned. But a change in visiting rules left them stunned. After the transplant, Connor was supposed to be able to visit his partner and son for an hour each day. A hurried change in the rules now meant that Connor would be able to visit Max, but he and Rachel would never be in the same room together.

'This was my toughest point, mentally,' said Connor. 'Was mine and Rachel's relationship going to suffer? Will Max suffer not having us both there by his side during his tough days? What if he takes a turn for the worse?'

Throughout the pandemic, unpredictable and sudden changes across the healthcare system have shaken the lives of patients and triggered after-effects that we may never fully understand. The small team at The Aplastic Anaemia Trust have been witness to many of these invisible effects of the pandemic, and are keen to understand more.

HAS COVID-19 DELAYED TREATMENT?

As far as we know, treatment delays over the pandemic seem to be relatively rare for AA patients, probably due to the urgent nature of treatments like Max's stem cell transplant.

A study by Anthony Nolan of patients with blood cancer and blood disorders, including AA, surveyed 273 people between 30th March-and-8th May 2021. Just 14 per cent of respondents reported having a treatment postponed, but others reported difficulties in accessing essential non-emergency services.

One participant said, 'I kept ringing my GP but I couldn't get a phone consultation for a really long time because they were overwhelmed. I didn't feel like they were treating my needs as important as they would have been if the pandemic hadn't been going on. It absolutely feels like we've been left behind.'

Replacing face-to-face appointments with online and phone consultations may have some advantages for people with an ultra rare disease who routinely have to travel long distances. However, while respondents in Anthony Nolan's survey reported some benefits to remote appointments (including feeling safer from COVID-19), the majority would much rather be seen face-to-face (73 per cent).

Connor, Rachel and Max

INCREASED MORTALITY

The Aplastic Anaemia Trust (AAT) anticipate an increased mortality rate from AA during the pandemic, as people have been slower to be diagnosed. As an ultra rare disease, it is unlikely there will ever be data on this, but the charity have already seen an unusually high demand for bereavement support, and are launching new support groups in response. An analysis in July 2020 estimated that deaths from cancer in the UK could rise by 20 per cent. (BMJ 2020;369:m1735)

WILL THE COVID VACCINES WORK FOR PATIENTS WITH AA?

Vaccination anxiety is nothing new for AA patients. Every autumn, as cold and flu season approaches, The AAT is inundated with inquiries about the flu vaccine and whether people with AA should have it.

The answer is widely debated among medical professionals, and many patients receive conflicting advice. There is a theoretical risk of relapse of AA or a drop in a patient's blood counts following any

vaccination, particularly the flu jab. However, a viral infection like flu can be problematic for AA patients as it can further suppress blood counts or increase their risk of secondary infections or pneumonia. Each case is weighed up individually based on the evidence available, which is anecdotal and limited.

With COVID-19 vaccinations hailed as our saviour, and the only route out of lockdown, it was therefore no surprise to find fear and anxiety rippling through communities of AA patients.

Concerns about the safety of the COVID vaccine made up 30 per cent of all The AAT's support interventions, rising to 50 per cent at times of government changes to the guidance. In January 2021, The AAT's webpage about the COVID-19 vaccine accounted for a quarter of their website traffic.

The Anthony Nolan patient survey found that over half of patients surveyed (58 per cent) are concerned that the vaccine may not be effective for them. As a result, many patients are planning to stay safe at home. A shocking 29 per cent of respondents said that they plan to continue shielding even after receiving both doses of the vaccine. 44 per cent said they have 'no idea' when they will stop shielding, with almost one-in-10 (eight per cent) saying that they think it could be a year or longer.

The AAT and Blood Cancer UK are funding urgent research into the efficacy of the COVID-19 vaccines in AA patients, with preliminary results expected. The pandemic has exacerbated a need for more research into vaccine safety and efficacy in general for patients with conditions like AA and similar disorders.

THE PRACTICALITIES OF SHIELDING

It's hard to imagine the impact of over a year of shielding for people who are simultaneously going though gruelling treatment for a life-threatening disease. The practical considerations of this for many people have been overlooked.

One member of The AAT's community described how her 24-year-old son was told by a nurse in February 2020 to 'go home and live like a hermit!' She reported that they received no support from social workers or mental health teams. While they felt well-supported by the hospital, there was no wider consideration of the holistic support her son needed. 'We have had palpable moments of fear, panic, worry and confusion,' she said. 'It has been a difficult time. Excruciating.'

The family didn't know how to safely house their clinically-vulnerable son, who was sharing a house with frontline workers.

After pressuring the local authority, they managed to secure housing where he could shield safely. 'No-one talks about how people who need to live alone for health reasons can achieve that,' his mum said.

COMMUNITY SUPPORT

The AAT created online peer-to-peer support groups, which were a source of practical support as well as mental wellbeing. 'We were sharing practical tips like contacting the shops directly for deliveries when Wales was not operating a priority list for food shopping,' one group member said. The charity ensured that AA patients were provided with Clinically Extremely Vulnerable status letters by their GPs. The charity even launched facemasks, provided for free to AA patients.

In the early stages of the pandemic, contact to The AAT's support line increased fourfold. They put professional wellbeing support in place, in partnership with Maggie's centres, and hired new support staff to manage demand. Much of the team's time was spent wading through newly-released government advice, speaking with clinicians, and translating it into recommendations for people with AA.

SECURING RAPID ACCESS TO ELTROMBOPAG

In spring 2020, The AAT was concerned that patients who would otherwise be candidates for a stem cell transplant might be unable to have one, due to pressures on the NHS. The charity's trustee, Dr Judith Marsh, worked closely with NHS England to secure approval for eltrombopag for these patients.

Eltrombopag is given as a tablet to improve blood counts and can reduce the urgent requirement for stem cell transplant or immunosuppressive therapy. Gaining access to eltrombopag involved a laborious process of individual funding requests – which were often rejected by individual clinical commissioning groups.

The drug reduces a patient's chances of requiring hospital admission until they can receive definitive treatment, so it made sense to make it more easily available while COVID-19 cases are high.

Thanks to effective advocacy work, a new policy was approved by the Department for Health in summer 2020, removing these barriers and recommending eltrombopag as a bridging treatment for adult patients with severe or very severe AAT during the COVID-19 pandemic. The drug is now funded centrally for everywhere in the UK.

A CLEARER PICTURE

The AAT continue to respond in an agile way to patient needs arising as a result of the pandemic. But the charity urgently need to form a clearer picture of the challenges people affected by AA are facing. It's not enough to rely on anecdotal information or evidence, like the Anthony Nolan survey, which can tell us about only some AA patients (those who have had a stem cell transplant), or make assumptions based on data about similar conditions, like cancer, which are not rare diseases. In 2021, the charity's plan has been to invest in evidence-gathering, to understand this ever-shifting landscape and what it means for the community they support.

A HAPPY ENDING FOR BABY MAX

Sometimes, patients prove themselves more than capable of making their voices heard. When the Gardners found themselves facing months with their family split in half, Connor decided enough was enough. He went home and did what many of us might do – he posted a long rant on Twitter.

'I well and truly let rip regarding the rules, which had been pushed onto the hospital trust from the government, and how unfair it is for any child going through something so horrendous without having the support of both parents,' he said.

Connor was letting off steam. But the family's story took off.

'My rant reached an audience of 31,307,' he said. The story was covered by the BBC, The Sun, the Mirror, the Daily Star, Metro and the Daily Mail, and Connor was soon contacted by his MP.

A few days later, the matron at the hospital informed the family that the rules had been changed. Connor, Rachel and Max, and other families like them, would be able to spend an hour together each day.

'When Rachel came to visit on that day it felt so special, like a huge victory,' Connor said. 'Sitting on the floor with Max running between us, laughing to himself, was so special – and something which should have never been restricted.'

Max had a number of infections after his transplant, but after 137 days in hospital, the family finally brought him home at the end of May. He is doing well.

To find out more about AA and the work of The AAT, visit www.theaat.org.uk.

the aplastic anaemia trust

NEWS

THE PHARMACY SHOW RETURNS THIS OCTOBER

We know, it's been a difficult period, with greater pressure than ever before, and it's been tough not having access to the kind of events that help you get better at what you do.

But thankfully that's changing. The Pharmacy Show is the major gathering for the pharmacy professionals of the sector for over a decade. The event will champion the pharmacy profession and invites all to come together for two days of education, networking opportunities and, of course, fun! Nowhere else can pharmacies in the UK find inspiration and insight to tackle the biggest challenges while finding new ideas to help them survive and thrive.

SPR is delighted to be working with The Pharmacy Show as media partners this year.

HERE'S WHAT YOU CAN EXPECT

- Access all eight theatres, covering a huge range of topics and discussions around current issues to move you forwards in your career
- Meet face-to-face with vendors and suppliers that can streamline the day-to-day workings of your practice
- Arrange an overdue catch-up, relax and socialise with friends and colleagues or meet with like-minded connections from online communities
- Try out new equipment and technology and compare similar products to identify what best suits you

You´re only a heartbeat away from securing your pass for The Pharmacy Show 2021!

Visit www.thepharmacyshow.co.uk to register for your FREE pass. Now that's got to be a big plus.

VIAGRA CONNECT® TRIAL SIZE TWO PACK

Following the easing of lockdown restrictions, pharmacies across the country should expect to see an increased footfall of people coming in looking for advice around sexual health products, including products to help treat erection problems (EPs). With all lockdown restrictions having been lifted, consumers will be having more sex, with three quarters (74%) of those experiencing EPs planning to visit a pharmacy to stock up on sexual health products, so it is important pharmacies are well stocked and staff feel confident to advise consumers across an array of different sexual health needs. Viagra Connect® provides training materials for the development of soft skills and advice on how to approach conversations around sensitive topics such as EPs, and the new Viagra Connect trial size two pack is now available for men who are worried about trying an EPs treatment for the first time.

For further information, visit www.viagraconnect.co.uk.

DEMAND FOR SEXUAL HEALTH PRODUCTS EXPECTED TO ACCELERATE

With UK lockdown restrictions having now eased, new research by Viagra Connect reveals an expected increase in demand for sexual health products. Rob Elliott, Marketing Director, Viatris, comments, 'Pharmacists can expect an increase in footfall, and prepare in advance to ensure sexual health categories are well stocked, and ensure staff feel confident to advise consumers across an array of different sexual health needs, including advice around EPs. Viagra Connect with its wealth of information and training materials for pharmacy staff will enable them to provide advice for the estimated five million men in the UK suffering from EPs. The new trial size two pack is ideal for those sufferers wanting to try the original and trusted EP treatment, making it easier for men and their partners to re-connect this summer.'

£1 MILLION TO TACKLE SOCIAL ISOLATION AND LONELINESS

Projects supporting carers and disabled people are among nine initiatives that are set to share £1 million to confront loneliness and isolation as a result of the pandemic.

It comes as part of a £10 million commitment to support a new five-year social isolation and loneliness plan, and marks the delivery of a commitment for the first 100 days of this government.

The funding was announced by the Minister for Equalities and Older People, Christina McKelvie, on a visit to meet members of the Glasgow Disability Alliance, which is receiving money for initiatives including one-to-one counselling and online courses designed to help disabled people stay connected.

Other organisations to benefit include Youthlink, which will receive funding to help young people, and Chest Heart & Stroke Scotland, which will use the additional money for its Kindness Caller programme.

The Minister for Equalities and Older People explained, 'Research has shown that loneliness and social isolation have increased for some during the pandemic, and we know this has disproportionately affected young people, carers and those with disabilities.

'Whether by providing access to counselling, learning opportunities or just a friendly voice to talk to over the phone, this new funding will help ensure people can stay connected and get the support they need.

'Social isolation and loneliness can affect anyone and can have a harmful effect on people's health and wellbeing. That is why we are developing a new five-year plan and we will invest £10 million across this parliament.'

STEROID COULD REDUCE HEAVY MENSTRUAL BLEEDING

Women who experience heavy menstrual bleeding could have their blood loss reduced by treatment with a common anti-inflammatory steroid, research suggests.

The study could pave the way for dexamethasone to be used as a safe, effective therapy – the first new class of treatment for heavy menstrual bleeding in nearly 20 years. It's the first time an anti-inflammatory steroid has been trialed to treat this common health problem, which affects around one-in-four women in the UK and can persist for years.

The most commonly-used treatment for reducing menstrual bleeding – a hormone-releasing device that is inserted into the womb cavity – is highly effective. However, nearly one-fifth of new users are dissatisfied with the side-effects, which include unpredictable bleeding. It's also unsuitable for women who are trying to get pregnant.

The trial – undertaken by a team from the University of Edinburgh – involved 107 women aged between 21 and 54 years old who had experienced heavy menstrual bleeding for time spans ranging from six months to 37 years. The study found that women who were given a 0.9 mg dose of dexamethasone twice daily for five days showed an average reduction in menstrual blood loss volume of 19 per cent.

Researchers have indicated that the findings mean that dexamethasone could be a future treatment option for women whose heavy menstrual bleeding harms their quality of life or health. It could also be employed by women who experience unacceptable side-effects with hormonal treatment but don't want surgical treatment, and those who wish to try for pregnancy.

''This trial evolved from groundbreaking laboratory research and years of multidisciplinary collaboration between clinicians and methodologists, combined with specialist expertise in new efficient and ethical approaches to trial design. It has been an exciting and gratifying journey,' commented Dr Pamela Warner, Reader in Medical Statistics at the university's Usher Institute.

MEDICAL TRAINING PARTNERSHIP ANNOUNCED IN GLASGOW

A number of organisations involved in the training of healthcare professionals have joined forces in a partnership to enhance access to professional skills and education facilities across Glasgow. The Healthcare Skills and Simulation Collaborative involves NHS Greater Glasgow & Clyde, the Royal College of Physicians and Surgeons of Glasgow, NHS Education Scotland (NES), NHS Golden Jubilee, and NHS Lanarkshire.

The partnership will open up opportunities for healthcare professionals, including doctors in training, and those in more senior roles, to access world-class clinical training in dedicated spaces that have been designed to mimic a real hospital environment. The simulation facilities have been kitted out with hospital beds and equipment, with anatomical models specifically designed for teaching healthcare professionals.

Recent medical graduates starting their hospital careers as foundation year doctors will be among the first to use some of the new facilities as they begin their induction programme at the newly kitted out facility at the Royal College of Physicians and Surgeons of Glasgow.

Speaking about the launch, NES Medical Director, Professor Stewart Irvine, said, 'We are delighted to support this initiative. The pandemic saw our clinical skills team work with partners to create a dedicated education and simulation hub at the Louisa Jordan Hospital, delivering essential training to hundreds of staff. We're pleased to be able to build on that success with the new facility at the Royal College of Physicians and Surgeons of Glasgow, which is part of a wider network across Scotland.'

NEW PLATFORM WILL BENEFIT PHARMACY BUYERS

The Cambrian Alliance Group has recently launched e-CASS market, a new platform designed to enable pharmacy contractors to buy and sell stock from each other with ease.

The new platform is set to 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,' said Nathan Wiltshire, the Group's CEO.

Cambrian Alliance Group boasts a membership of 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 claims that 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.

'We are really pleased to be able to bring yet another new product to the independent pharmacy market,' Wiltshire continued.

'When we first launched e-CASS some ten 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 regard 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,' Wiltshire added.

'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.'

Cambrian Alliance Group | e-CASS A Cambrian Alliance Innovation

Rethinking Pharmacy

The Benefits of Being a Cambrian Alliance Group Member

We know that your business is your world, and that's why at the Cambrian Alliance Group our goal is to help your business grow from strength to strength.

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3. Our price comparison stock ordering tool e-CASS is used by hundreds of pharmacies across the UK helping 98% of them boost their profits and save time.
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NEWS

£500,000 TO STUDY HOW DRUG-HANDLING IMPACTS ON EFFICACY

The University of Dundee's MEMO Research Unit has been awarded £500,000 as part of an international effort to ensure protein drugs, such as insulin and monoclonal antibodies, work as effectively as possible.

RealHOPE (real handling of protein drugs) is a four-year, €3.1 million project, led by RISE Research Institutes of Sweden, in which research partners across Europe and America are studying how the handling of protein drugs in hospitals, pharmacies, clinics, logistics, and private homes affect their efficacy.

Protein drugs have been widely used in recent decades, resulting in significant improvements in the treatment of severe and life-threatening diseases but improper handling may result in degradation, with accompanying changes in how they work. The research, funded by the Innovative Medicine Initiative, will see partners work with pharmacists, doctors, nurses, distributors, patients, and carers to compare what really happens with what should happen.

The project will then evaluate how sub-optimal storage / transport conditions affect the chemical / physical behaviour of these medicines. It will also engage with the education of all the stakeholders involved around the distribution, preparation and use of these drugs to guarantee their stability and efficacy.

FIRST SCOTTISH PHARMACIST CLINICAL ACADEMIC FELLOWS APPOINTED

The first cohort of Scottish Pharmacist Clinical Academic Fellows (SPCAFs) has been offered to six applicants, strengthening future pharmacy research.

Clinical academic pharmacist fellowships in Scotland are designed to drive forward evidence and practice in relation to the development of pharmacy services in Scotland as well as support the Pharmacy Postgraduate Career Framework review. These posts will provide the opportunity to develop research skills applied to a defined clinical area through completion of a research project and qualification.

The first cohort of SPCAFs (2021-to-2023) are:

- Joanne Adam, NHS Tayside
- Derek Jamieson, NHS Greater Glasgow & Clyde
- Laura Karim, NHS Grampian
- Mairi-Anne McLean, NHS Greater Glasgow & Clyde
- Alison O'Prey, NHS Greater Glasgow & Clyde
- Lyndsay Steel, NHS Orkney

Recruitment for these posts was a collaboration between NHS Education for Scotland (NES), Robert Gordon University and the University of Strathclyde, and funded by the Scottish government's Chief Pharmaceutical Officer. As experienced pharmacists, the SPCAFs will develop research skills and professional leadership in their clinical areas through the development of evidence-based practice, while maintaining links to their current service.

Professor Anne Watson, Postgraduate Pharmacy Dean, NES, said, 'NES Pharmacy is very proud to announce the appointment of the first SPCAFs. This is a fantastic opportunity for the fellows to gain essential research and professional leadership skills, while being supported by the Schools of Pharmacy, the service and NES. We hope that the research outputs from these fellowships will not only advance pharmacy practice in Scotland, but will also help us embed research into everyday practice for the profession.'

YOU'RE INVITED TO THE CLINICAL PHARMACY CONGRESS 2021 THIS 24TH-TO-25TH SEPTEMBER 2021 AT THE EXCEL, LONDON

The Clinical Pharmacy Congress 2021, the largest gathering for the clinical pharmacy profession in the UK, is back face-to-face this 24th-to-25 September 2021 at the ExCeL London.

Over two days, you can create a bespoke programme of content to reflect your unique training needs, meet face-to-face with vendors to find products and services that enable you to continue with your brilliant patient care, plus catch-up and network with like-minded peers, and colleagues.

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- Access to all theatres including:

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- Leadership
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- Hear great case studies and learnings to take back to work
- Plus practical content:

- Medicines Optimisation Workshops
- Practical Skills Zone
- Mini-Mock Calculation Workshops

- Hundreds of vendors to explore
- Catch-up with friends
- Countless social events and networking opportunities
- Join the CPC Awards
- Showcase Theatre – NEW

You´re only a heartbeat away from securing your pass for CPC 2021!

Tickets are valued at £499+VAT, however, 3,200 education grants are available. Find out more at www.pharmacycongress.co.uk.

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*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.[1]
†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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