A welcome from the DDA Chief Executive Matthew Isom

Welcome to the latest of our educational supplements brought to you in association with Actavis.

As the election campaign begins in earnest, the NHS will become a key focus of interest. Unfortunately, more often than not when politicians refer to the NHS, they almost always mean the hospitals and GP surgeries in towns and cities. For the eight million patients of dispensing practices, which can only be found in rural areas, and the doctors who provide the service, this can become a little wearing.

What might be a wonderful solution to the problems of urban areas, like federating practices for example, may not necessarily be of any practical use in a vast area of remote and rural Britain where the population is sparse, the transport network is less well developed and 3G and superfast broadband are just the stuff of glitzy TV and newspaper advertisements.

The NHS Five Year Forward View says: "Smaller independent practices will continue in their current form where patients and GPs want that." The DDA agrees and we have launched a Rural Manifesto which will help remove pressure from local district general hospitals providing patient-centred care closer to home, as the NHS Five Year Forward View envisages.

The DDA encourages its members to invite their local candidates to visit their local dispensing practices during the election campaign. Only by meeting the patients and the healthcare team will candidates see for themselves the vitally important, and often unsungrole of the dispensing doctor practice.

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Actavis Academy
The Training Resource

DISPENSING DOCTORS' ASSOCIATION
EDUCATIONAL SUPPLEMENT ONLINE

Booking registration open now for 2015 DDA conference

The 2015 Annual Conference will take place on October 21-22, 2015 and marks the return of this key DDA event to the Best Practice Show.

Plans for the 2015 Annual Conference are now well underway. Here are four good reasons to attend:

1. Among the conference presentations planned, GPs and Dispensary Managers will learn the latest about the funding for their dispensing services and up to date information about changes to NHS general practice contracts.

2. Dispensary Managers and Teams will receive updates on the latest best practice in NHS dispensing, including expert advice on stock control and procurement.

3. Members of the DDA Board, who are all dispensing GPs, will be on hand throughout the Best Practice show to network with visitors and share their decades of first-hand experience of GP dispensing and of running GP-owned pharmacies.

4. For DDA Members, there will be priority access to the first free copies of the DDA's Dispensing Guidance 2015. This will update the current 2012 Dispensing Guidance. Once published, this seventh edition of the publication will continue to be a must-have resource for achieving quality in dispensing practice.

To book your complimentary place, please visit the DDA website, http://www.dispensingdoctor.org/conference/

Actavis Academy website redesign/ DDA Training Seal

Look out next month (May) for the launch of the Actavis Academy course: Harnessing patient power. This is the second of four courses for dispensing practice staff expected to receive the DDA Training Seal during 2015.

The course aims to help dispensing practices to gain skills including identifying what patients want from your dispensing practice and how to use general practice patient surveys to help dispensaries identify areas for quality improvement.

The course is the second to receive the DDA Training Seal, which is awarded only to the best quality training and following review by the DDA's multidisciplinary Training Review team. The first Actavis course to receive the DDA Training Seal is the 'Cost Effective Dispensary course'. Like the Harnessing patient power course, this is freely available to dispensing practice staff on the recently redesigned Actavis Academy e-learning website, www.actavisacademy.co.uk created by Actavis to provide quality clinical and business knowledge, for all those working in the modern day NHS.

The redesign aims to give easier access to information, news, e-learning, CPD and regular accredited training courses designed specifically for all m embers of the dispensing practice team.

Celecoxib enters first Category M of 2015-16

Celecoxib 100 and 200mg have entered Category M in the April adjustment, both showing a reimbursement price reduction of over 80% compared to their last non Category M price.

In the first adjustment of the new 2015-16 NHS year, 273 existing Category M lines have seen price reductions and 255 have seen their prices rise.

Top fallers compared to the previous Category M adjustment in January include: modafinil 200mg tablets; rivastigmine 9.5mg/24hours transdermal patches and dapsone 50mg tablets.

Top risers since January include: exemestane 25mg tablets; naftidrofuryl 100mg capsules and dipyridamole 100mg tablets.

37 items have unchanged prices, and there are no removals.

To view the full April 2015 price changes, visit DDA Online at:

http://www.dispensingdoctor.org/resources/dispensary-management-zone/category-m-updates/

Additions			Size	Jun-14	Jul-14	Price Change	% price Change
Celecoxib 100mg capsules			60	£21.55	£4.20	-£17.35	-81%
Celecoxib 200mg capsules			30	£21.55	£3.86	-£17.69	-82%
Top Price Fallers	**Size**	**Jun-14**	**Oct-14**	**Jan-15**	**Apr-15**	**Price Change**	**% price Change**
Modafinil 200mg tablets	30	£74.95	£57.49	£47.65	£24.71	-£22.94	-48%
Rivastigmine 9.5mg/24hours transdermal patches	30 patch		£55.54	£42.39	£31.69	-£10.70	-25%
Dapsone 50mg tablets	28	£45.91	£49.29	£38.59	£29.55	-£9.04	-23%
Piroxicam 0.5% gel	112g	£5.75	£13.44	£11.80	£4.04	-£7.76	-66%
Valsartan 160mg capsules	28	£2.47	£9.74	£11.84	£6.01	-£5.83	-49%
Top Price Risers	**Size**	**Jun-14**	**Oct-14**	**Jan-15**	**Apr-15**	**Price Change**	**% price Change**
Exemestane 25mg tablets	30	£4.94	£4.94	£4.92	£22.48	£17.56	357%
Naftidrofuryl 100mg capsules	84	£6.27	£6.65	£13.34	£28.18	£14.84	111%
Dipyridamole 100mg tablets	84	£3.43	£3.70	£3.98	£12.14	£8.16	205%
Fosinopril 20mg tablets	28	£2.32	£2.48	£2.45	£7.21	£4.76	194%
Pizotifen 1.5mg tablets	28	£1.58	£2.15	£4.50	£8.10	£3.60	80%

Wavedata price trend analysis

Dispensing GPs lose their generic advantage and continue to pay the price for PIs

ONLINE EXCLUSIVE!

During March dispensing doctors and pharmacies were seen to pay very similar prices for generics. This is a continuation of a long term pattern with generic companies giving equal treatment to the two classes of customer.

However, when it comes to PIs, dispensing doctors continue to pay more than pharmacies - which over the month have appeared to be paying less.

Key among the price 'risers' for March are the three strengths each of metoprolol tabs, olanzapine orodispersible tabs and trimethoprim tabs. Headline fallers include three strengths of perindopril tabs and two strengths of each of candesartan tabs and risperidone tabs.

Risers

March dispensing doctor prices for glyceryl trinitrate tabs 500mcg x100 rocketed by 424% after Actavis increased prices from about £2.00 to about £14.00. However, good deals below £2.00 were still available in the market.

The average price of metoprolol tabs 100mg x28 rose in March by 179% as Actavis increased prices. Good deals below £1.00 were still available to dispensing doctors, however.

The Department of Health's NCSO list for March featured all three packs of trimethoprim and trimethoprim tabs 200mg x6 rose by 106% in March. Good deals below £3.00 were still available.

Fallers

In March the price of tizanidine tabs 2mg x120 fell on average by 65% as some of the higher Actavis prices being offered to dispensing doctors disappeared from the market. This left the best deals of below £4 available through just four suppliers.

Memantine tabs 20mg x28 saw a reduction in its dispensing doctor selling price of 48% in March as Actavis reduced prices. Dispensing doctors were able to find prices below £2.00.

Perindopril tabs 8mg x30 dropped in price by 48% in March after Actavis' prices disappeared from the market. The best dispensing doctor deals were available at below £0.70.

Brought to you exclusively by the Dispensing Doctors' Association

Be the first to see it! Full analysis of pricing trends during April will be available to DDA members in the first week of May – but only on DDA Online. The full March purchase price analysis data is now available to DDA members in the Dispensary Management Zone of DDA Online at:
http://www.dispensingdoctor.org/resources/dispensary-management-zone/monthly-purchase-price-analysis/

Are Parallel Imports set to increase?

Reduced wholesale and manufacturer discounts have had a significant impact on practice income. In an attempt to reduce purchase costs and reverse losses, practices may consider importing. But is it ethical? And, are there still enough branded products available to make it profitable?

Photodisc

There is a view that a rate of €1.30 is the tipping point for exports to turn into imports. In an article published in Today's Pharmacist in January 2015, shortliner company Waymade plc reports a 50 per cent growth in overall imports into the UK, including huge products like Mirapexin, Lyrica, Spiriva, Seretide, and even branded generics, refrigerated products using dedicated cool transport, and controlled drugs. Waymade reports that in its own business there have been "redoubled efforts and concentration on parallel imports from Europe". It adds: "This certainly indicates that parallel imports are very much back and available. We are pushing ahead and increasing our active licences to over 1,000 products."

DDA/Wavedata purchase analysis (also see page two) demonstrates heightened awareness of PIs in UK dispensaries, and in January analysis, Wavedata reports that for the first time in over a year, dispensing doctors were getting better deals for parallel imports. From March, 2015 until June 2016, the European Central Bank (ECB) will be running a programme of quantitative easing (QE), totalling some €1.1 trillion ($1.24 trillion). Whether this will see a further devaluation in the Euro depends on how effectively the markets have already factored in QE.

The consequences of parallel trade

Parallel trading takes place within the European Market and thanks to the Treaty of Rome, the movement of medicines across Europe is an entirely legal process. But it is not without its consequences. Speaking to the Guardian newspaper in 2008, big Pharma argued that parallel trade took £1.2bn from their revenues, describing this as "money that goes to a middle man instead of being put to constructive use", such as research and development.

It is also possible that this potential for loss of margin could affect where manufacturers choose to launch high cost products, resulting in selective availability to patients of innovative drugs.

Pfizer has been reported as also connecting the parallel trade to counterfeits. In 2008, the Office of Fair Trading in its market study on medicines distribution in the UK recognised that new models of distribution offered suppliers the potential not just to reduce counterfeiting but also to "control brand image, and to manage the supply chain and product safety more effectively". As a result, to this day Pfizer products such as Pregabalin remain very difficult to obtain as a PI.

Since the introduction of the Direct to Pharmacy distribution model, practices have seen a huge reduction in the range and size of wholesale and manufacturers' discounts; paradoxically, with no change in the dispensing practice clawback rate, falling discounts mean that more products are dispensed at a loss – which makes PI more attractive, especially now that the Euro is devaluing.

Parallel trade also has the potential to create an imbalance between supply and demand. When UK shortages were making the headlines, manufacturers adamantly maintained that they were providing enough stock to meet 110-120% of UK demand. They blamed exports for the ongoing domestic market supply shortages. The DDA has joined the UK pharmacy representatives in taking a firm stance against exports that create UK shortages. The evidence suggests that dispensing practices have heeded this advice.

Putting financial gain ahead of patient benefit is considered unethical by both professions. Key ethical questions to consider with parallel trade are: When stock is imported, do imports always stop when patient demand is met, or does a surplus occur? And, does a surplus in one country mean a shortage in another?

Patients' perspective

As practices will know from their own experiences, patients can become anxious when their dispensing doctor or pharmacy has difficulty obtaining stock.

Non-English packaging can also cause confusion and overlabelling can make it harder to open foil packaging. Inconsistent drug shapes and colours can also make patients think that they have the wrong medication.

DDA Board members offer the following views on their use of PIs:

Dr Philip Koopowitz: "Our practice does not actively seek out PIs, but when availability of UK-sourced products becomes scarce, we do look at them."

Mark Stone, a new board member and dispensing practice pharmacist: "We are not purchasing PIs at the moment. However, we await events."

Current and future usage

Dr Wayne Turner of Dispensing Doctor Solutions Ltd believes that PIs are certainly on the increase, and his advice is that practices use PIs as an alternative to high cost, low or no discount drugs, and ethical branded lines which are likely to be loss-making after clawback.

• Conclusion •

Parallel Importing is legal, but there are ethical concerns. Some patients may find them confusing.

The Government has not addressed clawback, while discounts have fallen; this means that more products are dispensed at a loss.

Dispensing doctors and pharmacies will see more companies selling an increased portfolio of PI products. If purchased well, significant reductions in purchase prices are possible.

For the full version of this feature, please visit the DDA website:
http://www.dispensingdoctor.org/news/parallel-imports-set-increase/

Dispenser Education Modules: Test your knowledge

DDA Dispenser Education Module (DEM) training is designed to provide practice dispensary staff with information to improve the way patients manage their conditions. Available free and exclusively to DDA members, each DDA DEM includes various activities and multiple choice questions to help dispensers put the theory of their learning into practice, and to help staff identify any areas needing a quick recap. DDA Members can find activities and questions relating to this DEM on Adherence in the DEM library, located on the DDA Website at: **http://www.dispensingdoctor.org/resources/clinical-zone/dispenser-education-modules/**

Adherence is good for patients and good for the NHS

It is thought that as many as half of all medicines prescribed for long term conditions are not taken as directed, which – assuming the product has been prescribed appropriately – means the patient doesn't get the anticipated benefit and wastes valuable NHS resources.

Aims

By the end of this article, you will:

- know what is meant by the term 'adherence'
- understand that non-adherence to a medication regimen may be intentional, unintentional, or both
- be able to list some of the factors that can influence whether or not a patient takes their medication as prescribed
- be aware of some of the measures that can be taken to try and improve medication adherence.

What is medication adherence?

Medication adherence (sometimes referred to as compliance or concordance) is defined as the extent to which a patient's actions matches the recommendations made about medicines they have been prescribed.

Non-adherence is a significant issue, with the proportion of medicines for long term conditions that are not taken as recommended estimated at between 33 and 50 per cent.

The impact of medication non-adherence is far-reaching. Not only are medicines wasted, but patients do not get the full benefit of the items they are prescribed. This, in turn, is likely to lead to continuing or increased ill-health, which can lead to further prescribing and increased hospital admissions. This, of course, has a knock-on effect on the already-strained finances of the NHS and the patient's quality of life.

Non-adherence can have many causes, which fall into two categories:

Unintentional non-adherence occurs when the patient is unable to take their medication as prescribed because of factors that are beyond their control. Some reasons for this include the following:

- **Impaired mobility** is all too easy to overlook as a cause of non-adherence. A patient who is housebound, for example, cannot physically collect their prescription or dispensed medication and may not be able to find someone to do it for them. Similarly, someone who is wheelchair-bound will not be able to reach their medication if it is placed on a high shelf by a well-meaning and safety conscious friend or relative.

- **Poor dexterity**, eg, a patient with arthritis in their hands who is unable to open a child-proof container or pop tablets out of a blister pack.

- **Swallowing difficulties**, however minor, can have a significant impact on a patient's ability to take medication as directed.

- **Visual impairment** seems an obvious barrier to taking a medicine as directed, but a patient can fall foul of a prescriber who assumes that counselling will be provided at the time of dispensing and a dispenser who believes that the patient would have been issued with full instructions when the prescription was written, and does not make any adjustments to the usual small-print label.

- **Cognitive impairment** can play a large part, particularly for individuals with dementia and older patients who may get confused as a result of other illnesses such as urinary tract infections or uncontrolled diabetes.

- **Lack of understanding** should not be underestimated as a factor. A medication regimen that includes a number of drugs that need taking at different times of the day, or failure to grasp a technique required to take a drug correctly, eg. inhalers, can both have a significant impact on adherence.

- **Lack of information**, such as the provision of inadequate advice at the time of prescribing or dispensing, failure to master a particular technique needed to use a product correctly such as that required for inhalers, or failing to provide information in a patient's native language if they have no knowledge of English.

- **Poor mental health**, for example conditions such as depression, can result in the patient forgetting to take their medication as directed.

- **Socioeconomic factors** are significant for some. A patient on a low income who pays for their prescriptions, for example, may be financially constrained into choosing between several items that are prescribed at the same time, and an individual who is homeless or caught up in substance misuse may be concerned with fulfilling more immediate needs.

Intentional non-adherence occurs as a result of the patient deciding to not follow the directions issued to them by the prescriber. Some reasons for this include:

- **Lack of confidence** in prescriber, eg. someone who is not convinced that the item prescribed for them is the right drug because they were not given an opportunity to ask questions is unlikely to be enthusiastic about taking it.

- **Concerns about side effects** or dependence, whether real or imagined. For example, it is not unknown for patients with terminal cancer to shy away from taking the strong opioids they need to manage their pain because they are worried about being sick or becoming addicted.

- **Beliefs** about conditions or medicines can go either way in terms of adherence. For example, a patient who has only ever used once daily formulations and is prescribed something that needs taking several times a day may believe that once a day is fine for the new drug which leads to under-dosing, whereas someone who feels that the painkillers they have been prescribed are beneficial but not quite good enough may end up double-dosing and therefore taking too much.

- **Lack of symptoms** can be a powerful demotivator for adherence, particularly with regards long-term conditions. A good example is hypertension, a condition that rarely has symptoms but requires lifelong treatment, a concept many patients struggle with as they perceive no benefit.

- **Inconvenience** can similarly put people off taking their medication as directed. For example, some who is prescribed a drug that needs taking four times a day may find it difficult to take the doses during the day when they are at work.

In many cases, there is more than one factor that results in a patient not taking their medication as directed, and both unintentional and intentional factors may be at play.

Photodisc

Impaired mobility is all too easy to overlook as a cause of non-adherence

Addressing non-adherence

It is important that non-adherence is not seen as solely the patient's problem. Instead, it is better viewed as an issue that healthcare professionals can have a significant impact on, by ensuring the patient is engaged with their health and any decisions that are made about it, any potential problems to adherence are identified and rectified as easily as possible, and ongoing support is provided. Dispensary staff have an important role to play, as they are well placed to try and understand what motivates an individual to start and continue with treatment, to spot any adherence issues early and to address any practical barriers that may influence their ability to adhere to a medication regimen.

Some points to bear in mind:

- Every patient is different, so rather than searching for a 'one size fits all' solution to non-adherence, dispensary staff need to adapt to the needs of the person in front of them at the time.

- A non-judgemental attitude is essential. Non-adherence is common, and most patients will not take their medication as prescribed at some point.

- Don't make assumptions about patient's knowledge or preferences about their treatment.

- Information should be tailored to meet the individual patient's needs, which may mean providing it in a different language, using large print labels or another adjustment.

- The information given should be relevant to the patient's personal circumstances and easy to understand (no jargon), and the patient encouraged to discuss it.

- Offer repeat information to patients with long term conditions, because their understanding and concerns may change over time.

- Listen to any concerns a patient might have about their medicines, and address them yourself if you can or by referring the patient to another member of the practice team.

- Be open to referring patients back to the prescriber if patients want to discuss stopping a certain drug, trying alternative treatments or therapies, and minimising the number of medicines being taken.

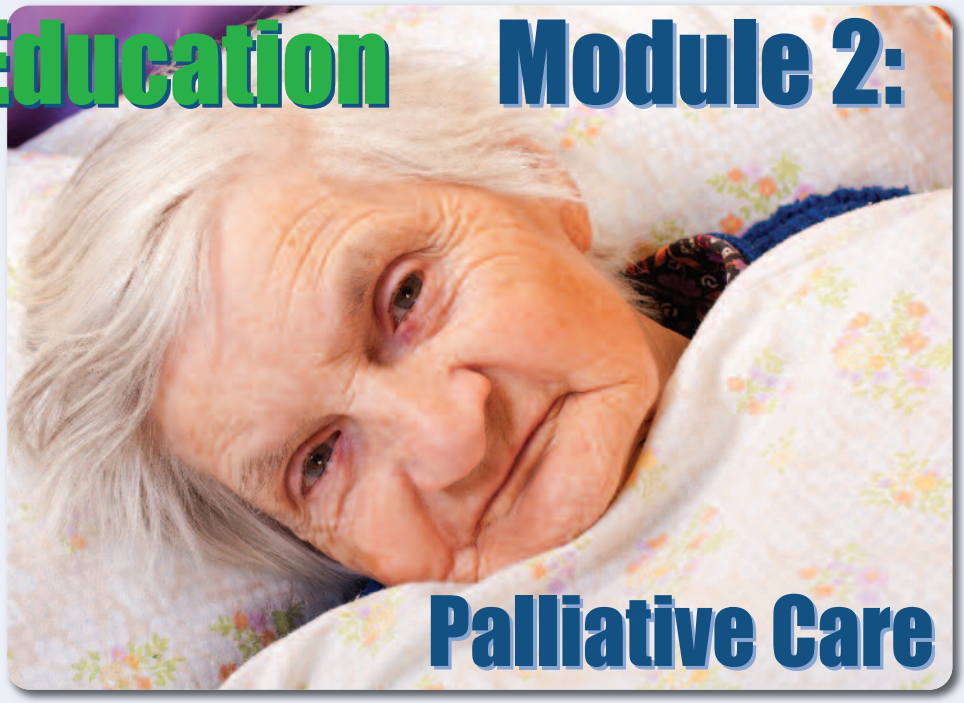
- The amount of information provided to a patient when they pick up dispensed medication can be overwhelming, so make sure they know where to find information, whether in the form of a pack insert or other resources such as NHS Choices.

- Interventions to overcome non-adherence should only be used if a specific issue has been identified. For example, a multi-compartment compliance aid may be a good option for someone who is motivated to take their medication as directed but is struggling with the number of drugs and dose frequency, but it will not help someone who isn't happy about taking multiple medicines.

Dispenser Education Modules: Test your knowledge

Each DDA DEM includes various activities and multiple choice questions to help dispensers put the theory of their learning into practice, and to help staff identify any areas needing a quick recap.
Activities and questions relating to this DEM on Palliative Care can be found on the DDA Website, DDA Online at:
http://www.dispensingdoctor.org/resources/clinical-zone/dispenser-education-modules/

Dispenser Education Module 2: Palliative Care



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The principles of palliative care apply to all life-limiting illness

Palliative care is often associated with cancer, but the specialised support provided by a multidisciplinary team focused on relieving symptoms and stress can – and should – be applied to any life-limiting illness; the aim will be to make life as comfortable as possible for patients and their families.

Aims

By the end of this article, you will:
- know what is meant by the term 'palliative care'
- be aware of some of the symptoms patients may experience towards the end of their life and how they may be managed.

What is palliative care?

Palliative care has been defined by the National Institute for Health and Care Excellence (Nice) as the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. At what can be a very difficult time for everybody affected, the overarching goal is to achieve the best quality of life.

Palliative care is often thought of as something that is the domain of hospices, and these specialist residential units certainly have an important place in this area of healthcare. Hospices are smaller and quieter than hospitals, and residents benefit from care provided by a team of professionals including doctors, nurses, social workers and counsellors, and specially trained volunteers. In a hospice people can receive individualised care in an atmosphere that feels calm and homely.

However, hospices are not the only places in which palliative care is delivered. As long as staff have the competence, a residential care home may be a better option for an existing resident, particularly if they might find a move upsetting. Similarly, some people prefer to remain in their own home and either visit a hospice during the day or are visited by the palliative care team in order to receive the support they need.

Pain management in palliative care is a vital part of making sure the patient is comfortable, and families and friends take great comfort in knowing someone is pain-free. The topic of pain is covered in a separate Dispenser Education Module, so will not be discussed any further here. Instead, this module will concentrate on the management of other symptoms that may occur towards the end of an individual's life.

Upper gastrointestinal symptoms

Nausea and vomiting are very common, particularly in patients with advanced cancer, and one can occur without the other. Antiemetics should be used during the first few days of opioid therapy for pain, but are not usually recommended beyond this time. This is because the body learns to tolerate the opioid and continuing the antiemetic puts the patient at risk of other side effects.

Metoclopramide is usually used first if the nausea and vomiting has a gastric cause, whereas problems caused by metabolic issues such as renal failure respond better to haloperidol. Cyclizine is preferred for motion sickness and raised intracranial pressure. Other drugs that may be used include levomepromazine, dexamethasone or ondansetron, and severe symptoms warrant a non-oral route of administration until the nausea and vomiting are controlled. Regardless of the antiemetic used, treatment should be regularly reviewed.

Dry mouth may be also due to opioids or other drugs such as antiemetics, antimuscarinics such as hyoscine or antidepressants. Patients taking these drugs should be referred to the doctor for treatment review. Otherwise, patients suffering dry mouth can be advised to adopt oral hygiene measures such as using a small or medium head toothbrush with soft bristles and fluoride toothpaste at least twice a day. Chewing sugar-free gum, sucking ice or pineapple or using an artificial saliva preparation may also provide relief, as can increasing fluid levels to ensure the patient is not dehydrated, and using lip balm to moisturise dry lips.

Oral thrush should be treated using nystatin oral suspension, though a single high dose of fluconazole may be used if life expectancy is short.

Anorexia, a reduced desire to eat, can be difficult to distinguish from nausea, and

any reversible cause should be tackled. Measures such as offering small portions more often, and frequent snacks instead of large meals can be beneficial, otherwise corticosteroids may help, particularly if the patient has swallowing difficulties due a tumour causing an obstruction.

Lower GI symptoms

Constipation almost goes hand in hand with the opioid therapy that is so common in palliative care, and it can be very distressing for the patient. Prevention is better than treatment, and regular laxative use is commonly recommended at the same time as the analgesia – a commonly used laxative is co-danthramer, which comprises a faecal softener with an agent that stimulates bowel muscles. If treatment is needed, an arachis oil or phosphate enema may be used. Some of the lifestyle measures that can help prevent constipation such as increasing fluid intake can have a place, but others such as overhauling diet and getting plenty of exercise are not.

Diarrhoea might be considered unlikely in a patient group that is highly likely to be on opioid analgesics, but it does affect a proportion. Addressing the cause is the best management strategy, for example, reviewing medication or treating an infection, and the patient should be assessed for constipation with overflow, and treated if this is diagnosed. Symptomatic treatment with loperamide or codeine may be needed.

Gastrointestinal obstruction can be mechanical in origin – due to cancer, constipation or stricture formation, for instance – or functional – eg, caused by nerve damage, drug treatment or a metabolic imbalance. It may happen over hours or days and be partial or complete. Common signs include nausea, vomiting, pain and abdominal distension. It should be managed by treating the cause, though surgery is sometimes necessary.

Respiratory symptoms

Breathlessness, sometimes referred to as dyspnoea, is common in patients nearing the end of live, and it can get increasingly worse in the last few weeks of life. This condition usually has several contributing factors, some of which are treatable (heart failure, pulmonary oedema, chest infection, anaemia, bronchospasm, and anxiety are all examples) and others that are not, such as the patient's psychological state. Reversible causes should be addressed, and non-pharmacological measures such as providing reassurance, relaxation techniques, increasing air movement by placing a fan nearby and positioning the patient in order to aid their breathing can all help. Drug treatments that may be helpful include corticosteroids to reduce oedema caused by inflammation, opioids to decrease the sensation, anxiety and pain levels, and benzodiazepines to ease anxiety and relax muscles. Nebulised medication – saline to loosen viscous secretions and salbutamol to dilate the airways – can also help, as can oxygen therapy for patients who are hypoxic (have lower than normal levels of oxygen in their blood).

Cough may be disease- , or treatment-related and can serve a useful purpose in helping the patient clear sputum from the chest. Once underlying causes have been identified and tackled, cough products such as simple linctus can help, and codeine linctus or morphine oral solution may be employed to relieve a dry cough if the patient is not already on opioids for pain. Carbocisteine and nebulised saline can help if the cough is chesty.

Haemoptysis, or coughing up blood, can be frightening and needs investigating to ensure there isn't an underlying infection, pulmonary embolism, GI ulcer or haematological cause. The drugs etamsylate and tranexamic acid can be used either singly or in combination if the symptom continues, and the patient should be closely monitored to ensure the condition doesn't develop into a life-threatening haemorrhage.

Excessive respiratory secretions are probably the symptom people associate most with patients at the very end of their life (it is sometimes referred to as the 'death rattle') and this can be very upsetting. An injection of three antimuscarinic drugs, given as a continuous infusion if necessary, can make a huge difference by drying up the secretions but care needs to be taken to avoid the patient getting a dry mouth, which can be very uncomfortable.

CNS symptoms

Confusion, sometimes called delirium, may develop due to the patient's medical condition or as a result of drug treatment or withdrawal, and this can be very disturbing, particularly if the patient becomes agitated or restless. Confusion needs careful assessment and any contributing factors should be managed if possible. Providing reassurance to the patient and their loved ones, and ensuring a calm and quiet environment can help. Drug treatment is generally only used if the confusion is marked and persistent, and may involve an antipsychotic or benzodiazepine. Regular review is essential as sedating drugs can exacerbate the problem.

Anxiety is understandable but can aggravate other symptoms so requires careful management by acknowledging the patient's fears and discussing them or providing support in the form of talking therapies. Once any underlying causes have been addressed, and if the patient is still struggling, medication such as a benzodiazepine, beta-blocker or antidepressant may be considered.

Depression is also not uncommon, and is treated in much the same way as anxiety, though only antidepressant agents are employed. In people with a short prognosis, such agents are not appropriate because of the amount of time they can take to have an effect.

Insomnia may result from pain or other symptoms caused by a medical condition. These should be handled before sleep aids are used, though if fear is at the root cause of the problem, a benzodiazepine can make a difference, not only to night sleep but also to daytime symptoms as a consequence.

Other symptoms

Hiccups are surprisingly common in palliative care patients and can be quite uncomfortable. Peppermint water can help if the hiccups are the result of gastric distension pressing on the vagus nerve, or metoclopramide if reflux is the cause. Other drugs that may be used include baclofen, haloperidol, chlorpromazine, nifedipine, gabapentin and midazolam.

Sweating is best tackled by measures such as lowering the room temperature, adjusting bedding, using a fan, tepid sponging and layering cotton clothing, as well as treating any underlying cause such as pain or infection. Paracetamol, NSAIDs, amitriptyline and propranolol may be tried if the problem persists.

Pruritis, or itchiness, often responds to distraction techniques, keeping skin cool and hydrated, using an emollient, and damage can be limited by keeping fingernails short. At this stage of life, pruritis tends not to be related to histamine levels, so the traditional approach of using antihistamines is unlikely to be effective – unless sedating properties are required. Instead, the source of the symptom – which may be a drug such as an opioid – should be addressed.

2015 Election spotlight


Photodisc

The DDA has launched its 2015 Election Rural Practice Manifesto. This calls on Government to allow rural dispensing practices to improve their care by ensuring they all have:

- access to superfast broadband
- access to the Electronic Prescription Service (EPS), which is not currently available for dispensing practices
- district and social services teams based in rural practices, not miles away in the nearest town
- community pharmacists as part of the practice team, helping to manage chronic diseases and medicines optimisation.

Until the election on May 7, the DDA will be actively lobbying Government to improve the environment for dispensing practices. Practices and their patients can help us by adding their support to this work.

Rural Practice Manifesto Toolkit

To help practices with local lobbying, the DDA has created a Rural Practice Manifesto Toolkit, which contains ideas and template letters for your practice websites and for your patients. Please help us to help you by using these resources in your local level lobbying.

Please visit the DDA Website to access the Rural Practice Manifesto and Toolkit at **http://www.dispensingdoctor.org/about-the-dda/dda-political-lobby-documents/**

Rural practice in Scotland: keeping people out of hospital

Scottish politicians need to find ways to support small rural practices. Failure to do so will see these vital hubs of community health services disappear, leaving patients in large, lowly populated areas with poor access to healthcare, the Dispensing Doctors' Association warns MSPs as they seek support from rural voters in this year's general election.

Some 1.1 million people– over one in five of Scotland's population - live in remote and rural areas, and from their rural GP they enjoy the following unique contribution to healthcare provision:

- 24-hour care: many rural GPs continue to carry full responsibility for 24 hour care, and despite moves to shift workload to other professionals
- Scope of care: in many remote practices the GP also provides a variety of other services, e.g. GP-led specialist clinics in areas like dermatology and paediatrics, immediate (BASICS) care, medical support to search and rescue services. Some of this work is not contractually recognised despite requiring specific training.

Sustainable solutions needed

In a paper calling for sustainable solutions for remote and rural healthcare, Scottish GP representatives outline three action points for MSPs:

- To develop a new contract for GPs, which protects the viability of practices that provide care in remote and rural areas


The Aberfoyle Surgery was forced to stop dispensing to two in every three of their patients

- To recognise the role of dispensing GPs in remote and rural areas
- To eradicate current inequalities in access to good primary healthcare provision in rural areas.

GPs: filling the breach in rural Wales

Rural GPs in Wales are stepping in to "fill the breach" left by NHS cost-cutting and service 'notspots', Assembly Members are being told this week. Funding and status for rural general practice should be improved to recognise the vital support these practices offer Wales' rural people.

Around one million people – almost one in three Welsh people - live in rural areas, many of whom are older and are among the most vulnerable in Welsh society. In very rural areas, such patients may access a wide range of healthcare services from their general practice, including a medicine dispensing service, as practices step in to fill the void left by the absence of other healthcare service providers.


Rural GPs are stepping in to fill NHS service 'notspots'

AMs are urged to do all that they can to strengthen – rather than destabilise – rural general practice.