



Scottish Healthcare Review

ISSUE 142 - 2024

CYSTIC FIBROSIS

Building towards a brighter future for patients



DIABETES

Latest developments
and resources

SCOTTISH HEALTHCARE AWARDS

Who claimed the titles?

STAMMERING

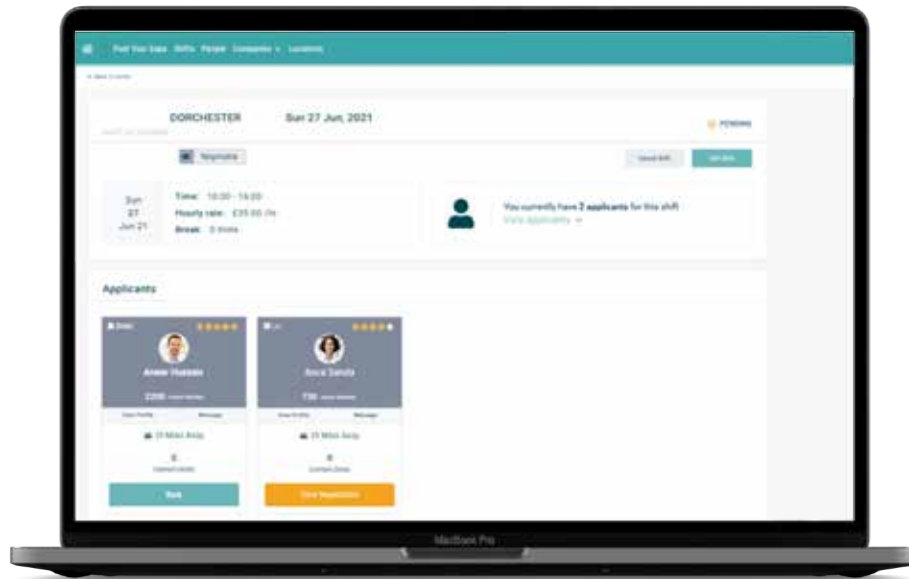
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KYRON MEDIA

www.scothealthcare.com

EDITOR

SARAH NELSON

sarah.nelson@kyronmedia.co.uk

MANAGING DIRECTOR

CHRIS FLANNAGAN

chris.flannagan@kyronmedia.co.uk

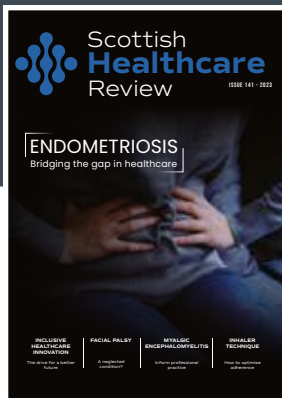
HEAD OF DESIGN

MEGAN BUCKLEY

design@nimedical.info

ACCOUNTS

info@kyronmedia.co.uk



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WELCOME

EDITOR'S LETTER

Welcome to the latest edition of Scottish Healthcare Review!

As the clock dashed towards 12 on 31st December, a new year was heralded in – and with it, the barrage of expectations and aspirations that the fresh time frame inevitably brings.

The fireworks sparked by my neighbours were drowned out by the internal pledges I made to myself for 2024 – I would be better in so many ways; healthier, fitter, kinder, smarter. It was only when I awoke the next morning and tried to craft my plan of improvements that I realised I didn't know where to start. My sheer overwhelm was curbing any meaningful change and left me at a standstill. I lost motivation and wanted to give up completely – and it was only day one.

The age-old adage is true; change doesn't happen overnight, but that shouldn't mean the quest for it should be stalled completely when it doesn't. I may still wish to achieve the big-picture results, but perhaps I don't need to undertake all the big-picture resolutions at once to make this happen. So, I'm choosing to charge 2024 with less pressure than I have in years gone by. One goal at a time, one step at a time, might just be enough.

I aspire to emulate the healthcare professionals I speak to every day – for a multitude of reasons – but notably, their ability to break down monumental change into realistic, attainable steps and strategies. Exemplifying this, the British Stammering Association have outlined the recommendations for helping those with stammers communicate effectively within the procedures of healthcare settings (page 16). Likewise, Diabetes Scotland have carved out the support and resources available for people living with diabetes and healthcare professionals working in communities across Scotland – helping bolster the future of the serious and complex condition (page nine).

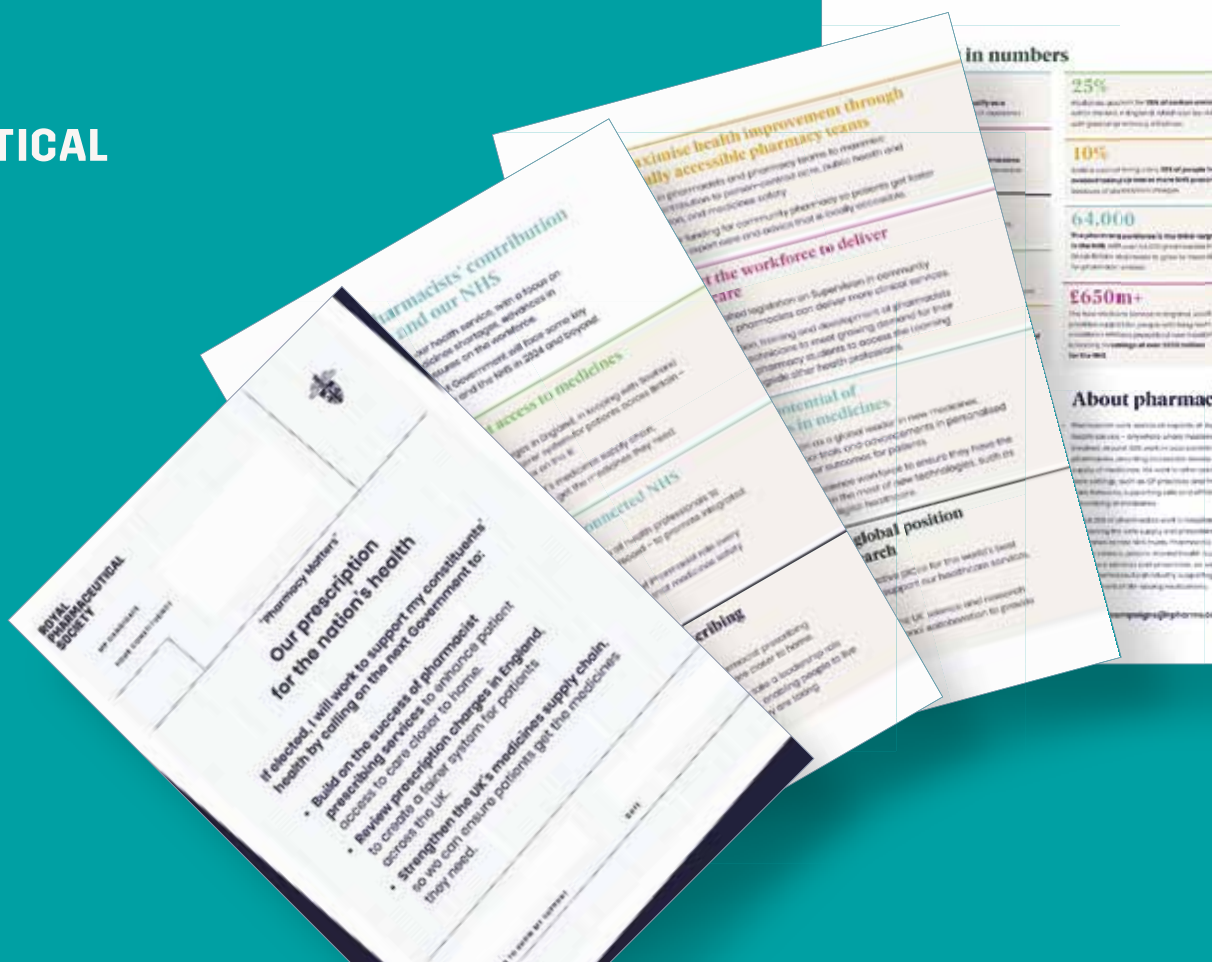
Also in this issue of SHR, read up on Prostate Cancer UK's major new comprehensive framework for the professional development of specialist prostate cancer nurses (page five); how healthcare professionals can improve care for people with lupus (page 14); and the Royal Pharmaceutical Society Scotland's latest commentary on sector change and crucial appointments (page four).

Before you go – find out how you can be at the forefront of an ongoing journey to advance cystic fibrosis care (page 32), and how elements of vascular disease require greater awareness (page 21). Check out the reveal of the 2023 Scottish Healthcare Awards winners, too (beginning on page 23)!

Happy reading!

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www.rpharms.com/manifesto

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Manifesto for pharmacy.



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With eating disorders on the rise, how can healthcare professionals help?



FORWARD THINKING

In this issue's instalment, the Royal Pharmaceutical Society for Scotland reflect on recent governmental announcements and the promise which the appointments present for the profession and future policies.

NEIL GRAY MSP APPOINTED CABINET SECRETARY FOR NHS RECOVERY, HEALTH AND SOCIAL CARE

Scotland's First Minister, Humza Yousaf, has appointed Neil Gray MSP to be Cabinet Secretary for NHS Recovery, Health and Social Care.

Commenting on the announcement, Laura Wilson, Director of Royal Pharmaceutical Society (RPS) Scotland, said, 'I would like to congratulate Neil Gray on being appointed to this position.'

'Pharmacists across Scotland are providing high-quality, person-centred care to patients every day in a variety of settings, including in hospital, GP practices and in community. Pharmacists are an integral part of healthcare in all settings and we need to maximise the skills and potential of the profession.'

'We have a bold ambition for the future of pharmacy, Pharmacy 2030, which

demonstrates the potential of the whole profession to transform patient care, experience and safety.

'Top of our list of policy priorities is ensuring pharmacists in all settings have read write access to patient records to support prescribing decisions. Governments in England and Wales are moving at pace on this issue, with access being granted for community pharmacists imminently. RPS wants a similar commitment from Scottish government to ensure pharmacists in Scotland have access to national shared electronic patient records. With all pharmacists coming out of undergraduate training as prescribers from 2026, this issue is more urgent than ever.'

'RPS will be seeking an introductory meeting with Mr Gray as soon as possible to discuss shared patient data and our other policy priorities including introducing workforce planning for pharmacy and progressing our work on environmental sustainability in healthcare settings.'

'I look forward to working with Mr Gray in his new role.'

CHRISTINA MCKELVIE MSP APPOINTED MINISTER FOR DRUGS AND ALCOHOL POLICY

The Scottish government has announced that Christina McKelvie has been appointed Minister for Drugs and Alcohol Policy, following the resignation of Elena Whitham MSP as Drug and Alcohol Minister.

RPS would like to put on record our thanks to Ms Whitham for working with us during her time as Drug and Alcohol Minister, and particularly for her efforts to bring in a new national service to provide emergency access to supplies of naloxone. RPS Scotland has consistently called for naloxone to be available from every community pharmacy for supply to people who use drugs, family, healthcare professionals, and for it to be available in all clinical settings for use in emergencies. This new service across the community pharmacy network is a huge step forward in achieving this, and is recommendation number one from our policy on pharmacy's role in reducing harm and preventing drug deaths.

We know there is so much more to do to reduce harm and prevent drug deaths across Scotland and look forward to working with Ms McKelvie to take many of our policies on this forward. We will be writing to Ms McKelvie to secure an introductory meeting with her as soon as possible.

Laura Wilson stated, 'Pharmacy teams have a huge role to play in reducing harm and preventing drugs deaths across Scotland. We're pleased with some of the policy steps which have been taken so far, most notably the national naloxone service brought in last year, which is extremely welcome.'

'There is still so much to do, and we look forward to working with Ms McKelvie, and Scottish government more widely, to implement additional policies to reduce harm and prevent drug deaths.'

A PILLAR OF SUPPORT

We're currently encountering a climate in which the prostate cancer Clinical Nurse Specialist (CNS) workforce is declining, while the number of men diagnosed with the disease is rising – with the provision of CNS expertise being subsequently spread unevenly across the UK. Joseph Woollcott, Policy & Health Influencing Manager at Prostate Cancer UK, highlights the launch and fundamental functions of the professional development framework for prostate cancer nursing, and what this can mean for patient care enhancement.



BAUN Conference 2023

CNSs are vital to a man who is navigating prostate cancer. They provide cost-effective, high-quality, and consistent care across the entire patient pathway, reducing appointment cancellations, unnecessary hospital admissions, and alleviating doctor contact.

This is backed up by NICE recommendations and results from the National Cancer Patient Experience Survey.

Alarming, the prostate cancer CNS workforce is decreasing, while the number of men diagnosed with the disease is increasing, so the provision of specialist nursing expertise is spread unevenly across the UK.

In 2019 in Scotland 8.54 per cent of filled CNS posts have urology as an area of practice (35 / 410). This is lower than other areas, for example, breast where CNSs equates to 17.8 per cent (73 / 410) of the workforce. That same year in Scotland, there were 4,066 cases

of prostate cancer and 4,895 cases of breast cancer. Therefore each urology CNS in Scotland in 2019 would have an average of 116 patients, compared to each breast CNS with an average of 67.

The need to grow the CNS workforce is urgent. We need to see more nurses trained as prostate cancer specialists so that every man with the disease gets the expert care he deserves.

AN IMPORTANT NEW FRAMEWORK

In response to this need, Prostate Cancer UK launched a major new comprehensive framework for the professional development of specialist prostate cancer nurses at the 2023 British Association of Urological Nursing (BAUN) annual conference in November.

This landmark publication has been created to guide nurses, their line managers and their employers on the core skills, knowledge and training that nursing staff working in prostate cancer will gain and demonstrate as they progress in the role.

It has been written by a team comprising nurses working in prostate cancer, researchers, and men who have used prostate cancer services.

The new Professional Development Framework for Specialist Prostate Cancer Nursing can be used by nurses at all levels – from those aspiring to work in prostate cancer care, to existing prostate cancer specialist nurses with varying levels of experience. It contains detailed information, such as outlines of specific nursing roles, the skills, education, and capabilities required for them. It is designed to aid nurses in understanding job-matching, the case for promotion, how to speak with managers, and other actions, priorities, or goals that are essential for career progression in prostate cancer specialist nursing.

The document is also directed towards employers and policymakers, communicating the vital, complex, and varied contributions that specialist prostate cancer nurses provide, and how they can be best supported.

Understanding that value and implementing consistent expectations on nurses according to their role, responsibilities and pay-banding, is crucial to a consistent model and delivery of care. Too often junior nurses are asked to do things above the responsibilities of their role without the commensurate training, experience and support, let alone remuneration.

In 2018 a specialty report into urology was published by the NHS programme Getting it Right First Time (GIRFT). GIRFT is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

Within this report the need for a standardised training curriculum for specialist nurses is highlighted repeatedly and is first in the list of recommendations:

'Specialist nurses are crucial providers of urology care, particularly in outpatients' settings, and yet, at present, there is little or no

PROSTATE CANCER



Chiara de Biase, Director of Support & Influencing at Prostate Cancer UK, at the BAUN Conference launching the framework

evidence of a systematic, proactive approach to the recruitment, training, development and retention of urology specialist nurses. There is no standard training curriculum for urology specialist nurses; training is typically provided in an ad-hoc manner.

‘While there is a clear need to establish formal training posts, career development should also be addressed so that specialist nurses can progress their careers, making urology an attractive specialty for nurses who are looking to subspecialise.’

Defining an agreed framework for the professional requirements of prostate cancer nursing will help to make the career path for junior nurses more transparent and accessible, while reducing variation in services across regions.

There are innumerable pieces of work to fulfil these ambitions, especially through Health Education England’s Aspirant Cancer Career and Education Development (ACCEND) programme.

However, the need for specialist focus within prostate cancer and in understanding Prostate Cancer UK’s place as a vector for information and guidance to healthcare professionals, we sought to deliver this work in line with ACCEND for those interested in working in prostate cancer.

ABOUT PROSTATE CANCER

- Prostate cancer is the most common cancer in men
- More than 52,000 men are diagnosed with prostate cancer every year on average – that’s 143 men every day
- One-in-eight men will get prostate cancer
- Around 475,000 men are living with and after prostate cancer
- Every 45 minutes one man dies from prostate cancer – that’s more than 12,000 men every year
- Prostate cancer is curable if caught early, but early-stage prostate cancer often has no symptoms, so it is vital that men know their risk
- Men are at higher risk if they are over-50, Black, or have a father or brother who has had prostate cancer
- To help men check their risk in 30 seconds, Prostate Cancer UK have an online risk-checker available at www.prostatecanceruk.org/risk-checker

Anyone with concerns about prostate cancer can:

- Contact Prostate Cancer UK’s specialist nurses in confidence on 0800 074 8383, or via email, webchat or WhatsApp at www.prostatecanceruk.org/nurses
- Access online and printed health information at www.prostatecanceruk.org/information
- Speak to trained volunteers with experience of prostate cancer at www.prostatecanceruk.org/one-to-one

ABOUT PROSTATE CANCER UK

Prostate Cancer UK is the largest men’s health charity in the UK, striving for a world where no man dies of prostate cancer. The charity works to give every man the power to navigate the disease: by helping men understand their risk through our award-winning online risk-checker; by providing them with trusted support and the information they need to make the right treatment choices for them; or by empowering them to make improvements for their path ahead, and for the paths of generations to come.

Prostate Cancer UK is the driving force in prostate cancer research in the UK. Investing millions into the best researchers in the world to unravel the complexity of the disease, the charity has improved how men are diagnosed through funding cutting-edge technology like more accurate MRI scans. The charity works to give men precise and personalised care with the right treatments at the right time, for the best chance of living the full life they want and spending more time with those they love.

Prostate Cancer UK also supports men living with and after prostate cancer, providing services like a specialist nurses helpline to give expert advice, and working with the NHS and its clinical champions to change the healthcare system that men are more involved in decisions and empowered to navigate prostate cancer.

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WINDOWS OF OPPORTUNITY

InnoScot Health is continuing to tap into the ever-evolving healthcare environment – supporting the development and adoption of transformational innovations for improved patient care. The team highlight some of their fresh progress.

Innovation Can Play a Key Role in Scotland's Fight to Reduce 'Pandemic of Frailty'

INNOScot HEALTH INNOVATION MANAGER, FRANCES RAMSAY, REFLECTS ON WHY SCOTLAND MUST LEVERAGE INNOVATIVE SOLUTIONS AND DO MORE WITH LESS AMID CLAIMS OF AN EPIDEMIC OF FRAILTY THAT HAS BEEN ACCELERATED BY THE PANDEMIC.

Dawn Skelton, Professor of Ageing and Health at Glasgow Caledonian University, recently spoke of her belief that the social restrictions of successive lockdowns had contributed to a steep rise in frailty.

However, while she noted that the NHS Scotland workforce is 'seeking solutions' with falls and fractures among older adults 'on the increase quite considerably', InnoScot Health believes that with the right support, staff determination can be channelled into effective, lasting innovation.

Professor Skelton said of NHS Scotland's 160,000-strong workforce: 'In their working day, they live and breathe the increase in frailty of older people three years on from that first prolonged lockdown.

'The continued shielding, lack of routine, long-term condition management and social isolation have had a huge effect on older people's physical function and the ability to maintain independent living.

'This, coupled with the considerable staffing issues across health and social care, mean that services are now struggling with a rehabilitation pandemic.'

The answer must be innovative new ideas generated by those very staff who know the issues inside out and have the knowledge and experience to identify the correct solutions.

Professor Skelton called for 'proper, effective interventions' – and we at InnoScot Health believe that a lot of those already exist, but more are needed during this vital time of recovery and reform and must be carefully integrated where they can be most effective.

With approximately 35 per cent of the population over-65 identified as mildly frail, 15 per cent moderately frail, and five per cent severely frail, we must urgently accelerate dedicated frailty-targeting innovation.

There are opportunities alongside the challenges – not only to make lives better,

but also to realise time and cost savings that can then be redeployed back into the NHS.

In 2022, a survey of the NHS Scotland workforce was conducted independently on behalf of InnoScot Health, finding that remote monitoring was seen as a key area of ongoing innovation for 86 per cent of staff.

Last year, Inhealthcare partnered with NHS Scotland to scale up remote monitoring pathways, including blood pressure monitoring, hypertension, and chronic pain management, as part of NHS Scotland's Connect Me programme, allowing patients to interact and communicate with healthcare professionals through the use of mobile apps, text messages, and automated phone calls.

With the larger roll-out underpinned by Inhealthcare's digital health platform, it is expected that more patients will be able to self-manage their health needs safely and confidently at home and spend less time travelling to appointments.

Increasingly, the technology can provide a range of remote benefits – from monitoring the effects of starting and stopping treatments, to providing important notifications and reminders, as well as offering advice and support.

Like all effective technologies though, they work best when human management and interaction is placed to the fore.

Likewise, NHS Scotland can be enhanced by technological breakthroughs, but they will remain supplementary to human skill and ingenuity.

Workforce innovators have the power to maximise limited NHS Scotland resources by targeting simple or complex ideas that make best use of what they already have in abundance – insight and experience.

Furthermore, while patients are reaping the benefits of innovation, it requires staff who understand the issues first-hand for it to be embedded properly.

Working in partnership with NHS Scotland for the past 20 years, InnoScot Health is encouraging those knowledgeable staff to help tackle the country's growing frailty problem.

INNOSCOT HEALTH

The formal health service partner aims to tap into their expertise and together help to develop new innovations that can help people live better in later life or cope with long-term health conditions.

InnoScot Health's frailty innovation call supports NHS Scotland innovators from any NHS health board and any role or medical discipline and encourages them to get in touch with their ideas.

We believe that our call to health and social care professionals is timely, with innovation representing true empowerment for those who need it most.

Fundamentally, it is all about improving quality of life while supporting NHS Scotland to adapt to changing demographics, demand for services, and current challenges.

InnoScot Health offers the opportunity for health and social care professionals to submit those ideas for new and innovative approaches to frailty – whether that be concept, technology, device, or service.

The package of support for staff with ideas to support NHS Scotland includes up to £25,000 of seed funding, regulatory support, project management, and our innovation expertise.

Our frailty innovation call is open to anyone working across NHS Scotland and harnesses the wide spectrum of our talented health and social care professionals.

Next Generation of Innovators Inspired by Support from Collaborative Health and Social Care Initiative

FORMAL NHS SCOTLAND PARTNER, INNOSCOT HEALTH, IS PROUD TO BE PART OF A COLLABORATIVE PROGRAMME AIMING TO DEVELOP FRESH HEALTH AND SOCIAL CARE INNOVATIONS THAT CAN HELP SOLVE CLINICAL PROBLEMS.

Led by Heriot-Watt and Edinburgh Napier Universities with InnoScot Health support, the initiative – labelled a 'first-of-its-kind research collaboration' – has seen engineering and nursing students pooling capabilities and know-how to hone breakthrough ideas.

It is hoped that the programme could help to progress innovations into products, leading to better patient outcomes while aiding healthcare staff in integrating innovative approaches into their daily activities.

InnoScot Health signed a Memorandum of Understanding with Heriot-Watt's Medical Device Manufacturing Centre in 2022, leveraging significant expertise to accelerate medical and healthcare opportunities.

The organisation has now helped to encourage what it calls 'the next generation of health and social care innovators' by providing real-world project briefs to teams of Heriot-Watt engineering students while helping them build consulting and client engagement skills.

The promising ideas from NHS Scotland innovators were first submitted to InnoScot Health, which has since acted as their client and liaison point.

The learnings of the student engineering project teams – enhanced by clinical insights from Edinburgh Napier University's nursing students and access to its specialised clinical simulation facilities – are now expected to lead to improved co-designed projects.

There are currently three ideas being developed, each of which have originated from different health boards across the country – a catheter redesign from NHS Fife; cannula cuff from NHS Forth Valley; and wobble stool from NHS Grampian.

InnoScot Health Innovation Manager Fiona Schaefer said, 'Collaborating on this Heriot-Watt and Edinburgh Napier University link-up offers an excellent and important opportunity for engineering students to learn more about the demands of health and social care, to understand how products are used, and see a simulated NHS environment in action.'

'Likewise, nursing students and healthcare professionals can offer feedback on prototypes with the opportunity to test them more easily and safely than would have been possible by going into hospitals and healthcare settings.'

'At the same time, they have also been encouraged to think about innovation, to realise that they have a lot to offer, and recognise the value of their know-how for future career progression. We hope this inspires them to see opportunities to develop new ideas when they soon start working in health and social care as registered healthcare professionals.'

She added, 'Developing NHS ideas with student teams offers a great way to take forward early ideas to get closer to practical solutions. It's clear that all three teams are really engaged, and we're excited by the possibilities. I have also recently spoken to Occupational Therapy and Physiotherapy Masters students who have innovation modules as part of their course so hope there may be new avenues of innovation to explore with them too.'

Maiwenn Kersaudy-Kerhoas, a Professor in Microfluidic Engineering at Heriot-Watt University and the lead academic for its new global research institute in Health and Care Technologies, has been described by InnoScot Health as 'instrumental' in realising the link-up with Edinburgh Napier University through its Professor of Simulation and Clinical Skills, Cathal Breen.

Maiwenn said, 'This collaboration will ensure an excellent student experience and we are very enthusiastic about the interface between nursing and engineering.'

'Nurses are the closest to patient needs on a daily basis. By championing this first-hand knowledge and expertise, we enable nurses to co-create and help deliver innovation. Alongside this, our engineering students benefit from detailed real-world feedback on their health and care engineering concepts.'

Cathal Breen, Professor of Simulation and Clinical Skills at Edinburgh Napier, commented, 'Nurses are an untapped reservoir of innovative solutions for the health and care sector.'

'In this new agreement, our students will identify potentially suitable clinical problems and work with engineering students at Heriot-Watt to design solutions to real-life clinical problems. It is hugely exciting.'

HERE FOR YOU, HERE FOR YOUR PATIENTS

Diabetes is a serious and complex condition that affects nearly 340,000 people in Scotland, with an estimated 1.1 million people in Scotland at increased risk of developing type 2 diabetes. Bringing the seriousness of diabetes to light, Diabetes Scotland tells SHR about support the charity offers for people living with diabetes and healthcare professionals working in communities across Scotland.

DIABETES IS SERIOUS

Diabetes is the fastest growing health crisis of our time, affecting more people than any other serious health condition in the UK – more than dementia and cancer combined.

The latest Scottish Diabetes Survey figures (2022) show that the number of people in Scotland living with diabetes has risen by more than 11,000 in a year. Of the almost 340,000 people with a diagnosis of diabetes, approximately 88 per cent are living with type 2 diabetes, about 10 per cent are living with type 1, and two per cent with the other forms of the condition.

Diabetes is a relentless condition. Every diagnosis is life-changing and the fear of serious complications is a life-long reality for people living with diabetes. There is currently no known cure for any type of diabetes. However, with the right treatment, knowledge and support, people living with diabetes can lead a long, full and healthy life.

Diabetes Scotland, part of leading charity Diabetes UK, offers a range of support, resources and advice for people living with, and at risk of, diabetes.

Signpost your patients to the charity's resources and make the most of diabetes care learning, development and involvement opportunities.

To speak with a member of the Diabetes Scotland team or learn more about their work, email scotland@diabetes.org.uk.

SUPPORT FOR PEOPLE LIVING WITH DIABETES

CONNECTING WITH OTHERS



Adjusting to the knowledge that you or a family member has diabetes takes time and it is often helpful to meet other people who have been through a similar situation. They can offer understanding, help and support at an important time.

A good way of finding this help is to join a local support group. Diabetes Scotland support groups offer people living with diabetes a chance to meet and share experiences with others. They are run by volunteers and meet on a regular basis, often with a speaker on a topic like diet or exercise.

There are also some specialist groups for parents, children and young people with diabetes.

EMOTIONAL HEALTH AND WELLBEING SUPPORT FOR PARENTS AND CARERS



Diabetes is not just a physical condition; it can affect people emotionally too. Parents have told Diabetes Scotland that caring for a child with type 1 diabetes can put all sorts of pressure on them as carers and that it can be

DIABETES

difficult to manage their thoughts and feelings around living with the condition.

So, the charity has developed AcT1on, a therapeutic-based programme that helps caregivers accept the thoughts and feelings they have around a child's condition and supports with managing the emotions around this.

The programme is free of charge, self-guided and has been reviewed and shaped by parents and healthcare professionals.

YOUTH-LED PEER SUPPORT



To support children and young adults aged 11-to-25 living with type 1 diabetes, Diabetes Scotland runs Together Type 1.

The initiative provides a safe space for young people to share their stories of living with type 1 diabetes, develop their understanding of diabetes and its effects, and build confidence in managing their condition. Young people get the chance to connect, take part in fun activities and access hands-on training and skills development.

For full details, visit www.diabetes.org.uk/in_your_area/scotland.

SUPPORT FOR HEALTHCARE PROFESSIONALS

CONTINUOUS PROFESSIONAL DEVELOPMENT



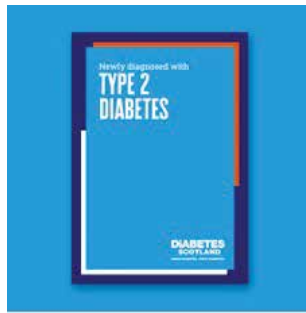
Diabetes UK has developed training and improvement programmes to help healthcare professionals keep up-to-date with developments in diabetes care.

Training courses, leadership programmes and competency frameworks are available to everyone working in diabetes care at all levels.

Free e-learning modules are RCN-accredited and include modules designed to equip non-diabetes specialists with the knowledge, skills and confidence to support people living with diabetes with diabetes technology, type 2 diabetes remission and their emotional and psychological wellbeing.

For more information, visit www.diabetes.org.uk/for-professionals/learning-and-development.

NEWLY DIAGNOSED WITH TYPE 2 DIABETES TOOLKIT



To help healthcare professionals support their patients, Diabetes UK has compiled a range of free resources and information.

Diabetes Scotland's Newly Diagnosed with Type 2 Diabetes Toolkit helps patients get to grips with the condition and can be a useful tool in your consultations with newly diagnosed patients. The toolkit includes information about type 2 diabetes in general, medication, and help on managing the condition yourself. It also has useful sections on remission and the importance of routine checks.

TYPE 2 DIABETES REMISSION HUB



New research has shown that for some people it is possible to put their diabetes into remission. Diabetes UK's type 2 remission hub aims to support people living with diabetes and healthcare professionals. It has over 20 pages of information on what remission is, how people can try going into it – including

nutrition advice, and what support is available from health services across the UK, and Diabetes UK.

For some people, putting their type 2 diabetes into remission can help lower their blood pressure, cholesterol and body weight which can help reduce the risk of diabetes-related complications, whether patients go into remission or not.

For more on Diabetes UK's remission hub, visit www.diabetes.org.uk/diabetes-the-basics/type-2-remission.

RESOURCES

Visit the Diabetes UK website for a wealth of information and access to Learning Zone, an online education and self-management tool. A range of patient information leaflets and posters are also available to order free of charge (P&P may apply) or to view as a digital download via the Diabetes UK shop.

Diabetes UK also operates the only dedicated diabetes helpline in the UK. Staffed by trained advisors with counselling skills, the helpline supports callers with any diabetes-related questions or problems by phone at 0141 212 8710 or by email at scotland@diabetes.org.uk, Monday-to-Friday, 9am-to-6pm.

To order copies of the Newly Diagnosed with Type 2 Diabetes Toolkit, speak with a member of the Diabetes Scotland team, or learn more about their work, email scotland@diabetes.org.uk.

KEEP IN TOUCH

- Scan this QR code for the Diabetes Scotland website



- Facebook, X, Instagram: @diabetesscot

MENARINI GROUP HAVE BEEN HELPING PEOPLE LIVING WITH DIABETES FOR OVER 30 YEARS



To find out how **Invokana** can support people living with type 2 diabetes, contact us here:



Invokana (canagliflozin) 100mg and 300mg tablets

PRESCRIBING INFORMATION (GB)

Presentation: canagliflozin 100mg and canagliflozin 300mg, film-coated tablets. **Indication:** Adults with insufficiently controlled type 2 diabetes mellitus as an adjunct to diet and exercise: (1) as monotherapy when metformin is considered inappropriate due to intolerance or contraindications, or (2) in addition to other medicinal products for the treatment of diabetes. **Dosage and administration:** Recommended starting dose is 100mg once daily, preferably taken before the first meal of the day. Tablets should be swallowed whole. In patients needing tighter glycaemic control and tolerating canagliflozin 100mg once daily, dose can be increased to 300mg once daily if eGFR ≥ 60 mL/min/1.73 m². [Refer to SmPC for initiating in elderly, renal impairment, and dose adjustment according to eGFR]. Care when increasing dose in patients ≥ 75 years of age, patients with known cardiovascular disease (CVD), other patients for whom the initial canagliflozin-induced diuresis poses risk. Correct volume depletion prior to initiating canagliflozin. Consider lower doses of insulin/insulin secretagogues if using canagliflozin as an add-on therapy. No dose adjustment in mild or moderate hepatic impairment; not recommended in severe liver impairment. **Contraindications:** Hypersensitivity to active substance or excipient. **Warnings and Precautions:** [Refer to SmPC for more detail] Renal impairment Limit dose to 100mg once daily in patients with eGFR < 60 mL/min/1.73 m². Regardless of pre-treatment eGFR, patients on canagliflozin may experience an initial fall in eGFR that attenuates over time. Monitor renal function prior to and after initiating canagliflozin. Also monitor after initiating concomitant products that may reduce renal function. Patients at risk of volume depletion Canagliflozin induces an osmotic diuresis which may reduce intravascular volume and decrease blood pressure (BP). Caution should be exercised in patients for whom a canagliflozin-induced drop in BP could pose a risk. Advise patients to report symptoms of volume depletion. Canagliflozin is not recommended for use in patients receiving loop diuretics or who are volume depleted. Diabetic ketoacidosis (DKA) Rare cases of DKA, including life-threatening and fatal cases, have been reported in patients treated with SGLT2 inhibitors. Presentation of DKA may be atypical. Risk of DKA appears to be higher in patients with moderately to severely decreased renal function who require insulin. Assess patients immediately if symptoms occur, regardless of blood glucose level. Where DKA is suspected/ diagnosed, discontinue canagliflozin immediately. Treatment should be interrupted in patients hospitalised for major surgical procedures or acute serious medical illnesses; monitor ketones (preferably blood ketones) in these patients. Before initiating canagliflozin, consider factors in patient history that may predispose to ketoacidosis. Canagliflozin should not be used for treatment of patients with type 1 diabetes. Lower limb amputations In long-term clinical studies in patients with type 2 diabetes with established CVD, or at least 2 risk factors for CVD, canagliflozin was associated with an increased risk of lower limb amputation versus placebo (0.63 vs 0.34 events per 100 patientyears, respectively), and this increase occurred primarily in the toe and midfoot. Before initiating canagliflozin, consider factors in patient history that may increase risk for amputation. Consider careful monitoring of patients with a higher risk for amputation, and counsel patients. Consider stopping canagliflozin in patients who develop events which may precede amputation. Necrotising fasciitis of the perineum (Fournier's gangrene). This rare but serious and potentially life threatening event requires urgent surgical intervention and antibiotic treatment. Advise patients to seek medical attention if they experience a combination of pain, tenderness, erythema, or swelling in the genital or perineal area, with fever or malaise. Urogenital infection or perineal abscess may precede necrotising fasciitis. If Fournier's gangrene is suspected, discontinue canagliflozin and institute prompt treatment. Elevated haematocrit Haematocrit increase was observed with canagliflozin treatment, therefore monitor in patients with already elevated haematocrit. Elderly (≥ 65 years old) Elderly patients may be at a greater risk for volume depletion, are more likely to be treated with diuretics, and to have impaired renal function. Genital mycotic infections Vulvovaginal candidiasis, and balanitis/balanoposthitis were reported in clinical studies. Urinary tract infections Complicated UTIs including pyelonephritis and urosepsis have been reported. Temporary interruption of canagliflozin should be considered. Cardiac failure Experience in New York Heart Association (NYHA) class III is limited, with no experience in clinical studies with canagliflozin in NYHA class IV. Urine laboratory assessments Patients taking canagliflozin

will test positive for glucose in their urine. Lactose intolerance Tablets contain lactose. Patients with galactose intolerance, total lactase deficiency, or glucose galactose malabsorption should not take this product. Sodium content Each tablet contains < 1 mmol sodium (23 mg). **Interactions:** Diuretics: canagliflozin may add to the effect of diuretics and increase risk of dehydration and hypotension. Insulin and insulin secretagogues: a reduced dose of these agents may be required if used in combination with canagliflozin. Canagliflozin is metabolised primarily via glucuronide conjugation mediated by UDP glucuronosyl transferase 1A9 (UGT1A9) and 2B4 (UGT2B4). Canagliflozin is transported by P-glycoprotein (P-gp) and breast cancer resistance protein (BCRP). [Refer to SmPC for treatment adjustments and monitoring advice if using canagliflozin concomitantly with an inducer of these enzymes and/or transport proteins]. Enzyme inducers such as St. John's wort, rifampicin, barbiturates, phenytoin, carbamazepine, ritonavir, efavirenz may decrease canagliflozin exposure. Cholestyramine may also decrease canagliflozin exposure. Digoxin, dabigatran, simvastatin, rosuvastatin and some anti-cancer product concentrations and/or exposures may be increased with concomitant use of canagliflozin. 1,5-anhydroglucitol (1,5-AG) assay: increases in urinary glucose excretion with canagliflozin can falsely lower 1,5-AG levels. Lithium: The concomitant use of an SGLT2 inhibitor with lithium may decrease serum lithium concentrations. Monitor serum lithium concentration more closely during treatment with canagliflozin, especially during initiation and dosage changes. **Fertility, pregnancy and lactation:** The effect of canagliflozin on fertility in humans has not been studied. Do not use canagliflozin during pregnancy or when breast-feeding. Discontinue canagliflozin when pregnancy is detected. **Effects on ability to drive and use machines:** Canagliflozin has no or negligible influence on ability to drive and use machines. However, patients should be alerted to the risk of hypoglycaemia when canagliflozin is used as add-on therapy with insulin/ insulin secretagogue, and to the elevated risk of adverse reactions related to volume depletion. **Adverse reactions:** [Refer to SmPC for more detail including other ARs] Safety and tolerability was conducted in pooled analysis of placebo-controlled, clinical studies. The most commonly reported ARs were hypoglycaemia in combination with insulin or a sulphonylurea, vulvovaginal candidiasis, urinary tract infection, and polyuria or pollakiuria. ARs leading to discontinuation of $\geq 0.5\%$ of all canagliflozin-treated patients were vulvovaginal candidiasis and balanitis or balanoposthitis. Other common ARs, including safety data from other trials and reports from worldwide post-marketing, were pyelonephritis, urosepsis, constipation, thirst, nausea, dyslipidaemia, and increased haematocrit. Anaphylactic reaction and angioedema have been reported rarely. The frequency of necrotising fasciitis of the perineum is not known. Refer to SmPC for more information regarding renal-related events, diabetic ketoacidosis, lower limb amputation, volume depletion, genital mycotic infections and bone fracture. **Package quantities and price:** Price for both 100mg and 300mg tablets is £39.20 per pack. (30 tablets per pack). **Legal category:** POM. **Marketing Authorisation holder:** Janssen-Cilag Ltd, 50-100 Holmers Farm Way, High Wycombe, Buckinghamshire, HP12 4EG, UK. **Marketing Authorisation number:** PLGB 00242/0698 (100mg) and PLGB 00242/0699 (300mg). **Marketed by:** A. Menarini Farmaceutica Internazionale SRL, Menarini House, Mercury Park, Wycombe Lane, Wooburn Green, Buckinghamshire, HP10 0HH. Further information is available on request to A. Menarini Farmaceutica Internazionale SRL, or may be found in the SmPC. **Prescribing Information prepared:** August 2023.

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 A. Menarini Farmaceutica Internazionale SRL. Phone 0800 085 8678 or email: menarini@medinformation.co.uk

Please refer to the Summary of Product Characteristics (SmPC) before prescribing. Prepared: October 2023. PP-IN-UK-0395.



**A. MENARINI
FARMACEUTICA
INTERNAZIONALE SRL**

ALL IN A DAY'S WORK

Under the spotlight of community pharmacy transformation in Scotland, Gary Buchanan MRPharmS, Independent Pharmacist Prescriber, reflects on his professional journey – tapping into the added skills, educational opportunities and evolving responsibilities he has harnessed along the way.



Gary Buchanan

Following successful completion of my MPharm at the University of Strathclyde and subsequent pre-registration training year, I qualified as a pharmacist and joined the General Pharmaceutical Council register in 2014. Through my studies I completed many work placements in the Scottish Highlands. Employment opportunities facilitated my inevitable move north, away from the central belt. I was attracted by the lifestyle with great outdoors – with beaches and hills on the doorstep to disengage from the stresses of work as required. I've been lucky enough to meet my wife and start a family, and naturally Inverness has become home.

I was attracted to community pharmacy from my first experience working with an experienced community pharmacist in a rural local village. I admired the way that she interacted with her patients; it was clear that she provided an integral service as part of the wider primary care health team.

I secured a role with a large multiple community pharmacy business which gave me the opportunity to work as a 'relief pharmacist'. By undertaking this role early in my career, I was exposed to a wider variety of community pharmacy practice. From this experience I moved to a store-based role which provided new challenges, such as care home medication provision and support. I carried out this role in a large shopping centre pharmacy in Inverness. Here I was able to develop my leadership skills under an experienced manager which enabled me to take on a role as a pharmacist store manager. I enjoyed the challenges that managing a business brought as a pharmacist. I enjoyed working to support and develop a team and ensure that my pharmacy was working to the best standard that it could.

With the changes to the community pharmacy contract in Scotland and the transition from the NHS Minor Ailments Service to the new NHS Pharmacy First, the role of a community pharmacist was evolving and expanding the scope of the pharmaceutical care it already was providing.

I was fortunate to secure an NHS Education for Scotland-funded (NES) place to undertake my independent prescribing (IP) course with Robert Gordon University (RGU). This was vital in developing the skills that I required to work autonomously as a clinician. With the support of a forward-thinking and training-focused local GP practice, and with the NES-developed clinical skills training days, I quickly learned basic examination skills and improved my consultation skills.

I undertook my IP course throughout the COVID-19 pandemic, and this presented several challenges, with many consultations moving away from face-to-face appointments and highlighting the importance of utilising technology to support remote consultations – giving me the tools that I would implement later in other areas of practice to develop services further.

An opportunity to move role to an independent pharmacy chain with experienced IP pharmacists provided the best environment to nurture my skills and maximise them to the fullest. The new role challenged my mindset and pushed me to put my clinical skills at the heart of my consultations to support patients in a wider range of settings. The NHS Scotland Pharmacy First Plus (PF+) service enabled

me to assess, diagnose and formulate treatment plans for patients presenting with common clinical conditions. Working alongside additional pharmacist cover, with appropriately-skilled support teams, including pharmacy technicians, and experienced managers, I have been able to utilise my training to the fullest and subsequently maximise the impact the service can have on my local community.

Building on this initial training experience has pushed me to seek out new learning opportunities. With the support of my employer, I have been fortunate to undertake an Advanced Consultation and Examination Skills course with RGU. This has supported me in my continued professional development. Day-to-day in practice the patients that present to the pharmacy hasn't necessarily changed. PF+ is very much an add-on to the existing Pharmacy First service, but the tools available to support me to help the patient has led to a more encompassing service.

I feel equipped to provide further treatments, such as antibiotics where indicated for acute sore throats for example. It has also supported me to provide a more detailed level of communication when making onward referrals. There are some patient presentations that can be in some instances more complex. I refer to a recent suspected case of sensorineural hearing loss that presented to me recently. Due to the nature of a walk-in service you must ensure you work safely within your competency.

Perhaps this supports the argument for full read / write access to patient notes. What I have learned through my career is the vital part that community pharmacy plays in the wider healthcare team and the opportunity available to us to develop our professional role, should the services be appropriately-funded.

Out-with the NHS services, my growing skillset has also supported me to develop in areas of private health services, such as aural care, working with third party support to provide enhanced services, such as ear wax removal. Additionally, the demand for private health and wellbeing services has increased and I am now responsible for the delivery of a medication-supported weight management clinic.

I enjoy promoting and supporting the role of community pharmacists. I am currently building my core advanced portfolio for the Royal Pharmaceutical Society, and I have a role with RGU as an e-tutor in common clinical conditions, supporting the development of the learning materials to reflect current practice.

It is an exciting time to be a community pharmacist!

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A PAINFUL CONVERSATION



Debbie Kinsey

Lupus is an uncommon, complex, and poorly-understood disease. With its many symptoms and a lack of awareness,

it can often be overlooked by a GP or consultant which may delay diagnosis and starting necessary treatment to contain the disease and limit potential damage to the kidneys, heart, skin, and lungs. In this edition of SHR, Debbie Kinsey, Health Information Officer, LUPUS UK, depicts how more knowledge of lupus among healthcare professionals is vital to reduce these delays and improve care for people with the condition.

WHAT IS LUPUS?

Lupus is a chronic autoimmune condition in which the immune system mistakenly attacks the body's own tissues. The most common form of lupus, and what people are usually referring to when they use the term, is systemic lupus erythematosus (SLE). SLE can impact any part of the body, including the skin, joints, kidneys, and heart.

Cutaneous lupus primarily affects the skin, though some people with cutaneous lupus also experience some systemic symptoms, such as fatigue. In rare cases, certain medications have been known to lead to lupus-like symptoms. This is referred to as drug-induced lupus and normally resolves once the causative medication is stopped.

The causes of lupus are not fully understood, though research has provided evidence suggesting that genes, hormones, and infections, including viruses, may play a role. It is not infectious or contagious.

WHO DOES IT AFFECT?

Lupus is a rare disease, affecting approximately one-in-1,000 people in the UK. Lupus can impact anyone, though disproportionately affects women and people of African-Caribbean and Asian ancestry. It can present at any age, and the most common age of onset is between 15-and-40, with most diagnoses being made between the ages of 37-and-50. However, around one-in-five lupus diagnoses have childhood or adolescent onset.

WHAT ARE THE COMMON SYMPTOMS?

SLE can have a wide variety of symptoms and can range from mild-to-severe, and rarely do two people share the exact same experience. Symptoms can also come and go as people experience 'flares', or times when their illness worsens. Flares can last from a few hours to a few months, and often require further treatment.

The two most commonly-reported symptoms of lupus are joint / muscle pain and extreme fatigue. Other symptoms can include skin rashes, light sensitivity, flu-like

Living with lupus and its fluctuating, varying symptoms can be challenging, and people often have to learn how to adapt to manage their symptoms and the impact of medication. Because it's a rare disease, many people with lupus first learn about the condition when they are diagnosed and often don't know anyone else with lupus.

COMING SOON

LUPUS UK are holding an Information Day in Edinburgh on Saturday 11th May 2024 at Novotel Edinburgh Park, 15 Lochside Avenue, Edinburgh, EH12 9DJ.

The event will run from 1pm-to-4.30pm. We will have guest presentations from:

- Dr Helen Harris (Consultant Rheumatologist) – 'The Lupus Treatment Pipeline' (working title)
- Dr Caroline Whymark (Consultant in Anaesthesia and Pain Management) – 'Lupus & Pain Management' (working title)
- Joanne Dobson (Lupus Clinical Nurse Specialist) and Dervil Dockrell (Clinical Specialist Occupational Therapist) – 'Lupus and Fatigue Management' (working title)

We can accommodate up to 140 delegates and would be pleased to welcome patients, families and healthcare providers. Tickets will be free of charge, but registration is required

The registration link is advertised on our website and social media platforms.

ABOUT LUPUS UK

'Finding people who understand what you're talking about and going through makes all the difference in the world.'

LUPUS UK is the only national registered charity supporting people with lupus and assisting those approaching diagnosis.

LUPUS UK has peer-led regional groups around the country, who arrange meetings (occasionally with talks from healthcare professionals and researchers), publish local newsletters, and organise fundraising events. LUPUS UK produces a wide range of information resources, and awards grants for lupus-related research, specialist lupus nurses in NHS hospitals, and welfare.

LUPUS UK offers advice and information to anyone who wants or needs it. You can reach us via our helpline on 01708 731 251 (Monday – Friday, 9am – 5pm), visit our website at www.lupusuk.org, uk, or email HeadOffice@LupusUK.org.uk.

symptoms, brain fog, headaches / migraines, oral / nasal ulcers, and hair loss. About one-in-three people with SLE will develop kidney disease, called lupus nephritis. An increased risk of miscarriage is also a complication of lupus, but, with close monitoring, many people with lupus now have successful pregnancies.

The symptoms of lupus can mimic other conditions, which can make it more difficult to diagnose. It is also common for people with lupus to have comorbidities, such as Raynaud's phenomenon, Sjögren's syndrome, and antiphospholipid syndrome, among others.

HOW IS IT DIAGNOSED?

Lupus can be challenging to diagnose as the symptoms can mimic other diseases and may change over time. There is no definitive test for lupus, and there can be poor knowledge about the condition among healthcare professionals. Diagnosis is usually made by a rheumatologist through a combination of considering the person's medical history and symptoms alongside blood tests and other testing as appropriate, such as skin or kidney biopsy.

HOW IS LUPUS TREATED?

There is no cure for lupus – it is a chronic condition. However, there are a variety of different medications that can help to manage it. With careful monitoring and a treatment programme, with medication

adjusted as needed, lupus can be controlled and most patients are able to live a normal lifespan.

The choice of treatment will vary depending on the specific symptoms a person experiences and their severity.

Common treatments include:

- Anti-malarials, such as hydroxychloroquine – these may be sufficient for people with moderately active lupus to avoid using steroids
- Steroids – have been vital in the improvement in lupus care and have been life-saving in some cases. Once the symptoms or flare is under control, the dosage may be gradually reduced or it may be possible to transfer to other medication
- Immunosuppressants – are widely used in more severe disease and require regular monitoring. The most commonly-used are azathioprine, methotrexate, and cyclophosphamide, and a newer immunosuppressant specifically designed for lupus nephritis called voclosporin is also beginning to be used within the NHS
- Biological therapies – target certain pathways in the immune system that are associated with inflammation and active lupus. Rituximab and belimumab are two such drugs that are used to treat lupus. Biological treatments are used to treat moderate and severe lupus, and when other treatments have not been successful

WHAT SUPPORT IS AVAILABLE TO PEOPLE WITH LUPUS?

STAMMERING



MAKING THEIR VOICES HEARD

Ensuring healthcare accessibility for everyone demands consideration of individual needs, including the needs of those who stammer. STAMMA, the British Stammering Association - the UK's leading charity for those who stammer - published findings that uncover challenges navigating the healthcare system for those who stammer. They emphasise the crucial role of patient interaction, particularly over the phone, and recommend changes in the way healthcare is delivered to accommodate diverse patient needs. Here, STAMMA delve deeper into the patient journey of those who stammer.

STAMMA recently carried out a survey that explored the experiences of people who stammer when they come into contact with healthcare services. Many respondents were quick to acknowledge the pressures that staff working in healthcare services face, and there were some wonderful stories of very positive experiences. Overall, however, the findings highlighted pressing concerns which are outlined here. They led to the development of some simple recommendations, a handy patient contact guide, and free training resources for healthcare settings.

STAMMERING

Stammering (also known as stuttering) is when someone repeats sounds or words, prolongs sounds, or has a silent block where a sound or word gets stuck. The person knows what they want to say, but can't get it out in that moment. You might notice physical effort as the person works hard to get out the sound or word.

Approximately eight per cent of children experience a period of stammering, and at least one per cent of adults stammer.

One crucial aspect of stammering is that it's not always obvious that someone has a stammer. There are lots of reasons for this. Stammering fluctuates, in broad waves from year-to-year and month-to-month, but also in narrower waves from day-to-day, situation-to-situation, or moment-to-moment. Indeed, it is often said that the only constant thing about stammering is its inconsistency. In addition to those fluctuations, many people who stammer often find they stammer more when they are tired or unwell, all of which can play into situations when they come into contact with healthcare services.

Some people who stammer go to great lengths to mask or hide the visible and audible aspects of stammering. Often this is due to fears of a negative or unhelpful reaction from others. To mask stammering is extremely effortful and often achieved in ways that limit communication, such as:

- Swapping words or finding a different, less specific, way of saying something
- Using lots of filler sounds, such as 'um' and 'er' or taking a run-up at a stammered word by repeating a phrase or sentence that came before
- Saying less
- Avoiding a situation altogether

STAMMERING AND HEALTHCARE SERVICES - THE CHALLENGES

People who stammer are just as prone to health issues as the rest of the population and often find themselves struggling to communicate effectively within the rigid procedures of healthcare settings.

PHONE CONTACT

The telephone is a source of anxiety for many people who stammer. The fact that the person on the other end of the line can't 'see' that the person is stammering tends to make telephone conversations particularly challenging.

STAMMERING

For example, in STAMMA's recent survey 68 per cent of respondents reported that the only route to booking an appointment with their GP was via the phone. Yet 41 per cent of respondents who stammer said they found it 'very difficult' to use the phone to book appointments, in contrast to only 23 per cent of those who do not stammer.

54 per cent of respondents who stammer reported significant mental distress around using the phone in a healthcare context. Respondents reported they had been hung up on, misunderstood, rushed, laughed at, or simply not given enough time to explain their needs. This led some to delay making appointments or even avoid them altogether, with a subsequent impact on their health.

'I was really struggling on the phone, like the kind of block where you're not even saying anything. And the receptionist was so busy that they just hung up on me.'

'With my heart pounding, I dialled the number, only to be greeted by a brisk, impatient voice at the other end. I began to speak, but my stutter was particularly bad that day. The receptionist cut me off several times, clearly frustrated by my pauses and repetitions. I felt rushed, as though I was an inconvenience. Things took a turn for the worse when I heard laughter at the other end. I was crushed. The humiliation was unbearable, and I hung up without completing the call. I felt ostracized, misunderstood, and dejected. The incident left such a profound impact on me that I decided not to call again, despite my worsening health.'

'I find the present system where everything is done by telephone to be incredibly challenging. Even trying to call for an appointment makes me nervous. After waiting at least 20 minutes to speak to the receptionist, she told me that she couldn't hear me and I should speak clearly. I replied that I had a speech impairment and can't speak clearly. She then said she would put the phone down on me, was that okay? Clearly, it was not okay as I was not offered any alternative way to make an appointment by email or online booking system.'

'Just recently the doctor thought I sounded out of breath on the phone and wanted me to have a chest X-ray because she thought I sounded like I had a chest infection. I said no I was just finding using the phone difficult because of my stammer.'

'... endless waiting in the phone queue, and being cut off because I can't speak quickly enough or the auto machine doesn't understand me.'

'They can hear I am struggling to speak and ask lots of questions. I just wanted to scream, why are you making it so hard for me.'

So many health services offer phone-only routes to contact and appointment

management, yet these can exclude many people who stammer, particularly if staff are not trained to recognise stammering and respond appropriately. As one of the respondents so clearly articulated, 'We need more patient, empathetic voices on the other end of the phone, and multiple ways of communication – online, emails, or text, as alternatives to calling. These are not luxuries; they are necessities. No-one should have to risk their health because they fear the booking process.'

IDENTIFICATION PROCEDURES

Saying specific words on demand is difficult for many people who stammer. But that is exactly what identification procedures require. They tend to be particularly tough for people who mask or deal with their stammering by swapping words or finding a different way to say something. You can't simply change your name, your date of birth, your address, or the name of your condition or medication. For this reason many people who stammer find giving these specific details or terms under time pressure a significant trigger for stammering.

'Then when I do manage to get through to someone they then ask my name and date of birth which I dread and always get stuck on.'

'In one instance, they thought I was trying to impersonate somebody else because I couldn't share my details fast enough.'

'They refused to speak to me about my own medical condition, saying I was 'being hesitant' when giving my date of birth so they believed I was not the patient.'

'Pharmacies need to be more aware of stammering – they can become quite impatient when you are collecting a prescription and they ask for your address, they presume you haven't heard them and keep asking you for it even though you are trying to speak.'

FACE-TO-FACE

STAMMA's survey revealed that even face-to-face interactions can be bruising for people who stammer.

'I asked the senior nurse which ward my wife was on and stammered. She burst out laughing and turned to the others expecting them to share the joke.'

'I went to get my prescription and I struggled to tell them why I was there and what my name was. I was already anxious which made my speech even less fluent. Then they asked which medication I was after and I didn't get past the first syllable before they finished the word for me. In the end they didn't even have my prescription so I went through all that for nothing. I cried when I got home.'

'I landed in hospital with a doctor who

refused to speak to me as he didn't have time to wait for me. He would only speak to my husband.'

RECOMMENDATIONS AND RESOURCES

RECOMMENDATIONS

In response to the survey findings, STAMMA has made the following recommendations:

- Flexible communication channels: more than one channel for booking appointments, getting a prescription, etc., so that patients can choose the channel by which they can communicate most effectively
- Training: training for frontline staff in healthcare settings so that they can engage with patients who stammer appropriately and supportively
- Opt-in patient record flags: the implementation of opt-in patient record flags for people who stammer. This way, frontline staff can be proactively alerted that a patient stammers and allow time for the patient to speak or communicate in the way which works best for them

RESOURCES

In response to the survey findings, STAMMA created a series of resources.

- Patient Contact Guide: a compact downloadable guide that gives practical tips for making the patient journey accessible for people who stammer. You can download the guide via the QR code at the bottom of the page or access it at www.stamma.org/about-us/campaigns/making-gp-bookings-accessible/recommendations
- Training: STAMMA also develop short training videos and offer free online workshops to staff working in healthcare settings. Visit www.stamma.org/training for more details, contact training@stamma.org or call STAMMA's helpline on 0808 808 0002 and request a return call from the Training Team



THE PHARMACISTS' DEFENCE ASSOCIATION

A WARM WELCOME

The Pharmacists' Defence Association welcomes Neil Gray MSP as Scotland's Cabinet Secretary for NHS Recovery, Health and Social Care.

A new Health Secretary has been appointed in Scotland following the resignation of Michael Matheson MSP. As the new Cabinet Secretary responsible for NHS Scotland and wider health policy, Neil Gray can address many critical issues for the benefit of patients, pharmacists and the wider public.

Until his promotion to his new post, Neil Gray was an approachable and admired Cabinet Secretary for Wellbeing, Economy, Fair Work and Energy, and the Pharmacists' Defence Association (PDA) previously met with him as part of a Scottish Trades Union Congress delegation to discuss fair work. The PDA welcomes his appointment and hopes to continue the positive dialogue with him in his new post.

The PDA believes pharmacists currently face potential burnout due to their working conditions. They need to see changes, such as more time for professional development and assured levels of staffing, to enable them to fully utilise their professional skills and expertise and benefit more patients for a range of currently unmet needs.

With the right conditions, Scotland's pharmacists can bring much more to the

profession that will improve patient outcomes and reduce pressure on other parts of the NHS. The PDA, as the representative of those pharmacists, are ready to come to the table and talk with the government, civil servants, health boards, and pharmacist employers to ensure this can be achieved. Through the PDA the issues of concern for employed and locum pharmacists across the health sector can be raised with the Cabinet Secretary and his department.

As well as wanting to ensure fair funding for the NHS to support a sustainable and properly supported workforce across all areas where pharmacists practice, the PDA will be calling for Neil Gray to introduce the provisions of Scotland's Fair Work legislation into the community pharmacy sector. This will ensure that the voice of the workforce is heard equitably, alongside the voice of employers.

The PDA would welcome Neil Gray emphasising the importance of pharmacists as an integral part of NHS healthcare delivery in Scotland and the importance of them practicing in fair work environments.

Locum, part-time, and portfolio workers

constitute a significant proportion of the pharmacist workforce and yet they are often unable to access opportunities for training and development. The PDA will therefore encourage the Cabinet Secretary to support ways that training can be more accessible for the entire profession, including funded access to become independent prescribers.

Action is also urgently required to change the community pharmacy contract which continues to pay pharmacist owners when they choose to take the commercial decision to temporarily close pharmacies at short notice rather than engaging locum pharmacists at a reasonable rate, citing non-existent pharmacist shortages. Scotland's patients deserve better than closed doors and exclusion from essential NHS services.

The PDA looks forward to working constructively with the new Cabinet Secretary.



GP Pharmacists

The PDA provides comprehensive membership for all the work of a pharmacist in a GP practice, including pharmacists working in GP practices for the first time.

Membership of the PDA gives you:

- Professional indemnity insurance whilst working as a pharmacist*
- Representation and advice for fitness to practise hearings
- A dedicated team of primary care pharmacists and legal experts on hand to provide support and advice
- A PDA Plus benefits package of discounts and special offers
- Membership of the PDA Union - the only independent trade union in the UK exclusively for pharmacists
- Each year you are a member, we will donate £1 to the charity that helps pharmacists.



Join the PDA today at: the-pda.org/join



Let's stay connected! Follow us on social media



* The insurance included with PDA membership is arranged and administered by The Pharmacy Insurance Agency (PIA) Ltd who are authorised and regulated by the Financial Conduct Authority (Register No 307063).

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A PRESSURE POINT



Jane Hanna

Concerns over access to life-saving medicines are being propelled forward by epilepsy charity, SUDEP Action, in a bid to raise more awareness of the severe repercussions which the restrictions could bring.

Epilepsy charity, SUDEP Action, is calling for more to be done to ensure that people with epilepsy have better access to life-saving medicines.

The charity has expressed concerns about changes to the prescribing of the drug sodium valproate which came into effect from 31st January 2024.

Jane Hanna, Director of Policy and Influencing for SUDEP Action, says that the valproate issue is compounding other NHS pressures relating to the vital supply of epilepsy medicines to patients.

She explained, 'Medicines are the first line of defence against preventable epilepsy deaths, including SUDEP. At the moment, the epilepsy scene is frightening because of restrictions on access to medicines, either through shortages or through national medicines policy – and this is happening against a context of rising NHS waiting lists and massive backlogs.'

SUDEP stands for Sudden Unexpected Death in Epilepsy. It is when someone with epilepsy dies and no other cause of death can be found. At least 21 people with epilepsy die each week in the UK. Research shows that SUDEP is connected with seizures, particularly tonic-clonic seizures, but no-one knows the exact cause and there may be no single explanation. However, research is clear that in many people with epilepsy, risks can be reduced – with seizure control being a key way to improve safety.

Last year, the MHRA announced new restrictions which mean no-one under the age of 55 will be newly-prescribed sodium

valproate unless two specialists agree there is no other effective or tolerated treatment, or there are 'compelling reasons that the reproductive risks do not apply.'

According to the MHRA, about one-in-nine babies born to mothers taking valproate will have birth defects and about 30-to-40 of 100 will have learning difficulties. The MHRA has also said that there is a risk of reduced fertility in men and boys taking valproate.

However, for around 10 per cent of people with generalised epilepsies, valproate is the first-line defence against hospitalisation and the risk of sudden unexpected death in epilepsy.

SUDEP Action has raised concerns that there is little understanding nationally on how to apply the new directive around sodium valproate, which remains an effective treatment option for many with epilepsy who can't or don't want to have children. The charity has also voiced concerns that the number of patients managed in primary care by GPs is unknown, so introducing patient pathways will burden an already-stretched secondary care service.

Jane Hanna continued, 'There is no single drug for epilepsy – instead, we need a toolbox of medicines and combinations for some 40-plus different forms of epilepsy. Everyone's epilepsy is individual so it's really important people get the most effective treatments for them and that they are able to have proper discussions around the benefits and risks of medicines, as you would expect for any other condition.'

ABOUT SUDEP ACTION

SUDEP Action is the only UK charity supporting and working alongside those whose loved ones have died from an epilepsy-related death. Its support service is tailored and led by what the bereaved need and want – which can include advocacy, information, advice and involvement in research through its Epilepsy Deaths Register. The support service can also assist and empower families in their interactions with the coronial service and other agencies.

Additionally, the charity provides free award-winning tools, including:

- The SUDEP & Seizure Safety Checklist: for clinicians to discuss and review epilepsy risks with their patients so potentially life-saving interventions can happen
- The EpSMon app: helping people with epilepsy to quickly monitor any changes to their condition and wellbeing in-between appointments

To contact SUDEP Action, call 01235 772 850 (main office) or 01235 772 852 (support line) or email info@sudep.org.

SUDEP Action 
Making every epilepsy death count



MAKING THE CONNECTION

Vascular disease is the collective term for diseases of the veins and arteries, in which every part of the body to which blood flows can be affected by it. It's as common as cancer and heart disease and accounts for 40 per cent of deaths in the UK, many of which are preventable. Mr Neeraj Bhasin BSc(Hons) MB BS MD MInstLM FRCS(Eng), Consultant Vascular Surgeon and Chair of The Circulation Foundation, sheds an expert light on the importance of promoting awareness to achieve optimised patient care and appropriate interventions.



Mr Neeraj Bhasin

When individuals discuss vascular disease, generally, the first thought is about the heart, and sometimes stroke. These conditions receive significant funding, public awareness, levels of treatment and intervention, supported by public health campaigns. There are several other vascular conditions, that can be caused by exactly the same underlying process that causes heart

attacks or strokes, that can be exceptionally disabling and distressing for patients, lead to loss of limb or life, and have a huge economic impact for the individuals and the wider NHS. However, these other conditions do not receive that same level of public awareness, and this can lead to a lack of recognition, investment, and interventions in this large cohort of patients.

The Circulation Foundation (www.circulationfoundation.org.uk) is the charity arm of the Vascular Society of Great Britain and Ireland, partnered with other vascular societies (Rouleaux Club, Society of Vascular Nurses, and The Society for Vascular Technology of Great Britain and Ireland). The Circulation Foundation covers conditions, such as peripheral arterial disease (also referred to as peripheral arterial occlusive disease or peripheral vascular disease), abdominal aortic aneurysms, carotid surgery following a stroke or TIA, and varicose veins, among others.

The Circulation Foundation has three main aims:

- To support vital research into vascular disease
- To support individuals living with vascular disease
- To raise awareness of the impact vascular disease has on our patients, their carers, and the wider NHS

A common condition within this group is Peripheral Arterial Disease (PAD), atherosclerotic disease of the lower limb arterial supply (narrowing or blockages of the main arteries in the leg) – the same pathological process leading to heart attacks. PAD produces a spectrum of disease from asymptomatic, though Intermittent Claudication (IC) to Chronic Limb-Threatening Ischaemia (CLTI).

IC is muscle discomfort in the lower limb reproducibly produced by exercise and relieved by rest. CLTI is defined by the presence of PAD in combination with rest pain, gangrene, or a lower limb ulceration over two weeks duration. As well as creating a functional disability (limited mobility due to restrictive pain) and risk of limb loss, symptomatic PAD also signifies a six-fold increase in cardiovascular mortality. It is estimated that 3.2 million people had PAD in the UK in 2015, representing 6.9 per cent of the population.

One of the first-line, lifestyle-based, non-invasive treatments is exercise. This is proven to improve pain-free and maximum walking distance, and quality of life. NICE guidance advocates a supervised exercise programme to deliver this. Where cardiac rehabilitation

classes are widely accessible, it seems only approximately 38 per cent of centres can offer a supervised exercise programme for PAD patients.

To try and address this, and secondary to the limitations that occurred in COVID, The Circulation Foundation produced an infographic to guide patients through a self-directed exercise for claudication. Being aware that we serve culturally diverse populations, as a charity, we are conscious of the impact of health inequalities on disease outcomes and progression. We have therefore translated this infographic into 15 other languages to make this treatment more accessible. This is available as a free resource for your patients who may have IC: www.circulationfoundation.org.uk/exercise-intermittent-claudication.

In terms of medical treatment for PAD, a study of 4.6 million individuals in the UK between 2006-and-2015 showed the incidence of coronary artery disease was stable but mortality rates were falling, whereas the incidence of PAD fell by 15 per cent but mortality rates did not. Only 55 per cent of PAD patients were prescribed long-term statins. The Vascular and Endovascular Research Network collected cardiovascular profiles of PAD patients to assess practice against UK and European best medical therapy guidelines. 78 per cent remained active smokers with only 11.1 per cent being prescribed high-dose statin therapy and 39.1 per cent on an antithrombotic agent. This further highlights discrepancies in the management of different forms of vascular disease.

To try and keep blood flowing to the legs there are approximately 6,800 surgical operations per year, and 14,500 minimally-invasive radiological procedures across Great Britain and Ireland. Unfortunately, there are also approximately 3,800 major limb amputations with the obvious physical, psychological and economic impact that brings.

The advanced form of PAD, CLTI, which occurs in approximately one-in-five patients with vascular disease, has been estimated to cost £200 million per year for the NHS and unfortunately also leads to approximately 45 per cent of these patients dying in two years, and approximately 50 per cent in five years, equivalent to, or worse than, some cancers.

We need to ensure that all healthcare sectors work together to increase the awareness of these conditions and deliver holistic, personalised care to our patients, to give them the best experience and outcomes.

You can discover more about vascular disease, or watch our informative podcasts, at The Circulation Foundation website – www.circulationfoundation.org.uk – or through our social media channels on Facebook, X (formerly Twitter), and Instagram.



DAY IN THE LIFE

A
SUCCESS
STORY

Michelle Strachan offers SHR a peek into her career path – from her first steps into the profession, to her current post at Crimond Pharmacy, and continued cultivation of new areas of expertise.



Michelle Strachan



I moved to Scotland in 2004 from Houston, Texas, with a BSc in Biology and considered at that time what I wanted from a career. I knew I didn't want to be stuck at a desk all day and wanted to leave work each day knowing that I've helped someone, so I chose to pursue a career in pharmacy starting with enrolling at Robert Gordon University (RGU) in September 2004. This was one of the best decisions I have made as I love my job as a community pharmacist!

After qualifying in 2009, I spent the next 11 years as the manager in a busy community pharmacy, expanding the services offered to patients, such as flu and travel vaccines, and treating common clinical conditions through the Minor Ailment Service. We really embraced this service and encouraged our patients to come to the pharmacy first for minor illnesses. When the Pharmacy First service was launched, our patients were already accustomed to accessing care for common conditions through the pharmacy, so this service was very popular and well-received. When the opportunity became available to complete my independent prescribing (IP) course to deliver Pharmacy First Plus (PF+) and prescribe in the community pharmacy, I jumped at the chance! I had become increasingly frustrated when referring patients for conditions I knew I was competent to treat but did not have a PGD in place to prescribe for these patients.

I completed my IP qualification from RGU in 2020 and took on a new position at my current place of work, Crimond Pharmacy near Fraserburgh. Although the pharmacy serves a small local population, we are increasingly busy, with patients from the surrounding areas accessing our PF+ service to treat common clinical conditions. Much of my day is now spent consulting with patients, leaving much less time for checking prescriptions, so we

have used our two accuracy-checking technicians to ensure the smooth running of the dispensary. No two days are the same, which makes the job interesting and challenging too. We work very closely with the local healthcare teams to provide seamless care for our patients.

Our pharmacy has recently been chosen as finalists for the Working in Partnership category at a ceremony due to take place shortly. The work we have done to improve our triage system and streamline the acute care of our patients through the appropriate use of the PF+ service has had a significant impact on the care of our patients, improving their access to prompt assessment and treatment for minor conditions. This has also had a significant impact on the number of GP and nurse appointments for these types of conditions which are more suitably treated in the pharmacy, freeing up appointments for chronic disease management and more complex patients. Community pharmacy in Scotland has changed dramatically in the past 15 years, and as more pharmacists become prescribers and use their knowledge and skills to deliver the PF+ service, this will continue to change the way patients use their pharmacies.

I am always looking for ways to improve my practice and further my development and recently enjoyed completing the Clinical History Taking and Examination Skills for Advancing Practice course at RGU. Along with two of my colleagues, I am currently working on my RPS advanced practice portfolio which is challenging me to develop areas of practice not normally seen in community pharmacy. I have recently taken on an additional role as North Regional Tutor for Experiential Learning with RGU and I'm enjoying the challenge of working in a different sector and learning new skills.



Scottish Healthcare Awards

Shining Examples

The talent and triumphs of Scotland's healthcare professionals once again took centre stage at the 2023 Scottish Healthcare Awards.

The Scottish Healthcare Awards celebrates the extraordinary healthcare initiatives being spearheaded throughout the last 12 months and beyond, from pharmacy technicians, to cardiology teams.

The annual event, hosted by publishing company Kyron Media, provided a much-needed opportunity to unite the sector at the Marriott Hotel in Glasgow in a ceremony which was to both resonate and encourage. This year, senior broadcast journalist, Martin Dowden, hosted a turnout of 250-plus industry experts and students, who gathered for the reveal of the 11 competitive category winners.

In the closing moments, the 2023 Special Recognition Award was presented to Bernadette Brown, owner of Cadham Pharmacy Health Centre, for her innovative, passionate, and unfaltering commitment to the improvement of patient care throughout the community.

Funds were also raised throughout the evening for Pharmacist Support - a well-established, independent and trusted charity supporting pharmacists and their families, former pharmacists, trainee pharmacists and pharmacy students.

All the winners and their reactions will be featured over the following pages. Congratulations again!



CARDIOLOGY TEAM OF THE YEAR AWARD **WINNER**

SPONSORED BY NOVARTIS



‘We were pleasantly surprised to receive the nomination, and then be selected as the best in Scotland. This just goes to show that hard work and single-minded dedication to improving patient outcomes do pay off. It has motivated us to aim for even greater heights next year.’

**The Cardiac Arrhythmia and Implantable Devices Unit Team
NHS Fife**

‘As part of our commitment to support cardiovascular care in Scotland, Novartis were delighted to sponsor the Cardiology Team of the Year Award. Many congratulations to Dr Jagdeep Singh and the Cardiac Arrhythmia and Implantable Devices Unit Team at NHS Fife. An excellent initiative bringing more advanced cardiology care closer to the patient and having a positive impact on patient experience at the same time. A worthy winner.’

**Derek Wallace
Novartis**



Cardiology Team of the Year Award winner, the Cardiac Arrhythmia and Implantable Devices Unit Team (NHS Fife), with Derek Wallace, Novartis, and Adrian Brady, Honorary Professor of Cardiology and Consultant Cardiologist

SUSTAINABILITY IN HEALTHCARE AWARD **WINNER**

SPONSORED BY TEVA UK



‘The award is wonderful recognition for the multidiscipline team of clinicians, estates staff and external architects that delivered the new NHS Tayside Children’s Theatre Suite Project. It was an honour to receive the award on behalf of the team. Thank you.’

**The Children’s Theatre Suite Project Team
NHS Tayside**

‘Addressing sustainability in healthcare is incredibly important so it was fantastic to see all the finalists for this category. I was really impressed with the team at NHS Tayside who somehow found the time to go above and beyond their day-to-day roles and transform the Children’s Theatre Suite. They had considered both the children’s care and sustainability which made this project a fantastic winner.’

**Becky Wright
Teva UK**



Sustainability in Healthcare Award winner, the Children’s Theatre Suite Project Team (NHS Tayside), with Becky Wright, Teva UK, and Wendy Rayner, Head of NHS Circular Economy Programme

HOSPITAL PHARMACY TEAM OF THE YEAR AWARD **WINNER**

SPONSORED BY ETHYPHARM UK



'We were delighted to receive this award and pleased that our work was recognised nationally. There were high quality submissions from all the other teams and it was great to see the good work that is being done by hospital pharmacy teams throughout Scotland.'

The Critical Care Team
Queen Elizabeth University Hospital

'It's great to see Queen Elizabeth University Hospital win the Hospital Pharmacy Team of the Year Award for such an outstanding entry. Congratulations to the team, keep up the good work.'

Ken Sutherland
Ethypharm UK



Hospital Pharmacy Team of the Year Award winner, the Critical Care Team, Queen Elizabeth University Hospital, with Ken Sutherland, Ethypharm UK, and Jennifer Murphy, Senior Clinical Pharmacist Critical Care

FEMALE HEALTH INITIATIVE OF THE YEAR AWARD **WINNER**

SPONSORED BY KENT PHARMA



'I was really thrilled to receive the award for the Female Health Initiative of the Year. I feel it's a fantastic achievement and recognition for myself and my team at Leven Medical Practice. I feel this award each year really helps to showcase everyone's work towards improving women's health and health inequalities, and encourages Scotland's women's health plan.'

Sian Stapleton and the South Edinburgh Primary Care Team

'Kent Pharma are delighted to sponsor the award for Female Health Initiative of the Year. We understand the many challenges women face both physically and mentally, throughout their lives and the importance placed on access to appropriate healthcare. We recognise the dedication and commitment shown by everyone working in this area and the significant impact that your hard work has on the lives of your patients. We would like to congratulate all finalists who have been nominated in this category and a very worthy winner.'

Steve Thompson
Kent Pharma



Female Health Initiative of the Year Award winner, Sian Stapleton and the South Edinburgh Primary Care Team, with Steve Thompson, Kent Pharma, and Rosie McCluskey, Endometriosis Clinical Nurse Specialist

PHARMACY TECHNICIAN OF THE YEAR AWARD **WINNER**

IN ASSOCIATION WITH THE ASSOCIATION OF PHARMACY TECHNICIANS UK



'Pharmacy was a huge change in career for me when I started four years ago, and to be receiving such recognition already is incredible. It's a huge surprise to win this award, but all my thanks have to go to the wonderful members of the teams I work with. Without their support and expertise, I'd never have progressed this much so quickly!'

Sean Robertson

'Pharmacy Technician of the Year Award is one of the prestigious awards for pharmacy technicians in Scotland and helps to celebrate the achievements of our ever-evolving and wonderful profession.'

Hazel Jamieson

The Association of Pharmacy Technicians UK



The Pharmacy Technician of the Year Award being collected on behalf of its winner, Sean Robertson, with Melanie Bryan and Hazel Jamieson, the Association of Pharmacy Technicians UK

PHARMACY STUDENT LEADERSHIP AWARD **WINNER**

SPONSORED BY THE PHARMACISTS' DEFENCE ASSOCIATION



'I am so grateful to have had the opportunity to participate in this award and am still a bit in shock to have won it! The others in the category were so accomplished and the win would have been well-deserved by anyone. I am very proud of my work with Robert Gordon University PharmSoc and I can't wait to continue this in my final term of university.'

Maeve Joyce

Robert Gordon University

'The landscape of pharmacy is changing in ways unimaginable even a few years ago and the Pharmacists' Defence Association is delighted to support thousands of students around the UK. Undergraduates like Maeve Joyce, who at the beginning of their careers can demonstrate true leadership, are an inspiration to all of us.'

Maurice Hickey

The Pharmacists' Defence Association



Maurice Hickey, The Pharmacists' Defence Association, and Laura Wilson, the Royal Pharmaceutical Society for Scotland, collecting the Pharmacy Student Leadership Award on behalf of its winner, Maeve Joyce, Robert Gordon University

ASTHMA / COPD PROJECT OF THE YEAR AWARD **WINNER**

SPONSORED BY TEVA UK



'We were delighted to be chosen to receive this award for our work using data to drive service improvement, and it reflects the hard work of all our team members – physiotherapists, dietician, psychologist and clinical support worker, who, on a daily basis, provide excellent quality care to our patients. The key to this project's success has been collaborating with experts in the partnership – data analysts, the digital lead, and the performance team to codesign a clinical dashboard. This has allowed clinicians to use data and digital processes to develop and improve patient care in an innovative way – more to come in the future!'

The Midlothian Community Respiratory Team

'It was a wonderful evening being back with everyone at the event as sponsors of the Asthma / COPD Project of the Year Award. We heard so many outstanding stories on the night recognising the significant contributions being delivered by all of the nominees through their dedication to delivering patient care. Congratulations again to the Midlothian Community Respiratory Team for winning the award.'

Adam Higgins
Teva UK



Asthma / COPD Project of the Year Award winner, the Midlothian Community Respiratory Team, with Adam Higgins, Teva UK, and Tom Fardon, Respiratory Lead for the Scottish Access Collaborative at the Scottish Government

MANAGEMENT OF SUBSTANCE DEPENDENCY AWARD **WINNER**

SPONSORED BY ETHYPHARM UK



'We are incredibly proud of all the staff who have worked diligently through some very tough times to ensure our patient group receive a high-quality standard of care and treatment that has resulted in the service achieving this award. Achieving the award has raised morale within the service and reinforced to staff how valued they are and how important the work they do is.'

The NHS Dumfries and Galloway Specialist Drug and Alcohol Service Team

'Ethypharm were delighted to sponsor the Management of Substance Dependency category at the Scottish Healthcare Awards, and we'd like to say congratulations to the excellent finalists. It was our great pleasure to present the award to NHS Dumfries and Galloway Specialist Drug and Alcohol Service Team for the work they do helping people with complex challenges in turning their lives around.'

Stephen Malloy
Ethypharm UK



Management of Substance Dependency Award winner, the NHS Dumfries and Galloway Specialist Drug and Alcohol Service Team, with Stephen Malloy, Ethypharm UK, and Duncan Hill, Specialist Pharmacist in Substance Dependency

PHARMACY LOCUM OF THE YEAR AWARD **WINNER**

SPONSORED BY LOCATE A LOCUM

LOCATE
A LOCUM

'I'm absolutely thrilled to be named the Scottish Healthcare Awards Pharmacy Locum of the Year! Who knew that all those days juggling prescriptions, patient queries, and the occasional surprise delivery could lead to this moment? This award is a testament not just to my work, but to the vibrant communities and fantastic teams I've had the joy of working with. It proves that passion, a dash of humour, and a whole lot of care can make a world of difference. Here's to more adventures in pharmacy – may our prescriptions always be accurate, and our patient smiles plentiful. Thank you for this incredible recognition!'

Beata Burske

'Locate a Locum were delighted to sponsor Pharmacy Locum of the Year at the Scottish Healthcare Awards. It was fantastic to see so many dedicated healthcare professionals being rewarded for delivering such a high standard of care and expertise to local communities. Congratulations again to the Pharmacy Locum of the Year winner, Beata Burske, the recognition was so well-deserved for your efforts.'

Olivia McKearney

Locate a Locum



Pharmacy Locum of the Year Award winner, Beata Burske, with Olivia McKearney, Locate a Locum, and Fiona McElrea, Whithorn Pharmacy

COMMUNITY PHARMACY PRACTICE OF THE YEAR AWARD **WINNER**

SPONSORED BY KYRON MEDIA

 **Kyron
Media**

'We are absolutely delighted to win this award! It is great to be recognised for all our recent improvements in the pharmacy and the hard work of our staff.'

The Alloway Pharmacy Team

'Congratulations to the Alloway Pharmacy Team who have demonstrated an exceptional commitment to their community and an ever-innovating standard of service delivery. Good luck in the future!'

Chris Flannagan

Kyron Media



Community Pharmacy Practice of the Year Award winner, the Alloway Pharmacy Team, with Chris Flannagan, Kyron Media, and Chris Miller, Primary Care and Community Pharmacy Co-Ordinator

DEVELOPMENTS IN THE MANAGEMENT OF MULTIPLE SCLEROSIS AWARD **WINNER**

SPONSORED BY NOVARTIS



'We are delighted to receive this Scottish Healthcare Award for developments in multiple sclerosis. This is a wonderful recognition of all the work the multiple sclerosis team at the clinic has done to improve care for people with newly-diagnosed multiple sclerosis.'

The Anne Rowling Clinic Multiple Sclerosis Team
NHS Lothian

'Novartis is proud to support the Scottish Healthcare Award in multiple sclerosis as part of our commitment to helping people with multiple sclerosis live independently. This recognises the contribution of those that deliver exceptional care for people with multiple sclerosis across the UK and whose dedication and hard work supports people living with multiple sclerosis to live fulfilled lives.'

Niall Hegarty
Novartis



Developments in the Management of Multiple Sclerosis Award winner, the Anne Rowling Clinic Multiple Sclerosis Team, NHS Lothian, with Niall Hegarty, Novartis, and Pushkar Shah, Consultant Neurologist and MS Team Lead

SPECIAL RECOGNITION **WINNER**

**ROYAL
PHARMACEUTICAL
SOCIETY
Scotland**

IN ASSOCIATION WITH THE ROYAL
PHARMACEUTICAL SOCIETY SCOTLAND

'I was honoured to have received the Special Recognition Award. Of course it is a true team effort from all of my team supporting me and we are proud to be providing excellent pharmaceutical care to our community and working so very hard for the public we serve.'

Bernadette Brown
Owner, Cadham Pharmacy Health Centre

'I was honoured to present such a prestigious award to such a worthy winner in Bernadette. Her creativity, innovation and leadership demonstrate the amazing opportunities available within the profession of pharmacy to deliver excellent care at the heart of our communities.'

Fiona McIntyre
Royal Pharmaceutical Society for Scotland



Special Recognition Award winner, Bernadette Brown, owner, Cadham Pharmacy Health Centre, with Fiona McIntyre, Policy and Practice Lead for RPS Scotland



Scottish Healthcare Awards



Scottish Healthcare Awards



SAVING THEIR BREATH

As one of the UK's most common life-threatening inherited diseases, understanding cystic fibrosis is core to ensuring that patients receive the most effective care possible. In this article, the Cystic Fibrosis Trust survey the condition's impact and the severity of symptoms, as well as their mission to accelerate research and recognition – and how we can play a part.

Cystic fibrosis is an inherited genetic condition that affects over 11,000 people in the UK. The condition is caused by a faulty gene which controls the movement of salt and water in and out of your cells. One-in-25 people carry the cystic fibrosis gene and you must have two biological parents with the gene to have a one-in-four chance of the child having cystic fibrosis.

Cystic fibrosis affects many organs and tissues within the body, including the lungs, which become clogged with thick, sticky mucus, making it hard to breathe and clear away infection-causing bugs and particulates in the air. The digestive system is also often affected, with the tubes that transport enzymes out of the pancreas becoming blocked by mucus, meaning that people with cystic fibrosis need to take supplementary enzymes with meals to help digest food.

The median age of death of someone with cystic fibrosis is just 33, and people with the condition may have to take up to 40 pills daily, plus undergo gruelling physiotherapy to stay somewhat well. Lung infections can make people with cystic fibrosis very ill, sometimes requiring them to receive IV treatments, either at home or in hospital. Antimicrobial resistance, where the lung infections are resistant to the medicines used to treat them, is a serious problem for people with cystic fibrosis.

People with cystic fibrosis are also unable to meet up in person with other people with the condition, as they carry bugs in their lungs which can be incredibly harmful to each other. There is no cure for cystic fibrosis and while modulator treatments do exist, not everyone can access them due to their genotypes, or tolerate the side-effects.

HOW ARE PEOPLE DIAGNOSED WITH CYSTIC FIBROSIS?

All newborn babies in the UK are now screened for cystic fibrosis shortly after birth using the heel-prick blood test. This tests for the most common mutations of the gene that causes cystic fibrosis.

Around one-in-10 children with cystic fibrosis are diagnosed before, at, or shortly after birth, due to a condition called meconium ileus that causes the gut to become blocked with meconium – a thick, dark, sticky substance that is made in all babies' intestines before being born. Urgent surgery may be needed to relieve the blockage.

Some children born earlier than 2007 who were not screened at birth, or those with more unusual mutations of the cystic fibrosis gene, may be diagnosed later in life, after they have become unwell and developed symptoms.

WHAT ARE THE SYMPTOMS OF CYSTIC FIBROSIS?

In people with cystic fibrosis the lungs make thicker sputum (mucus) than normal, which can trap bacteria in the small airways and lead to infection. Symptoms that typically develop include persistent cough, wheezing, shortness of breath and breathing difficulties and repeated chest infections.

Thickened mucus secretions block the normal flow of digestive juices from the pancreas, which means food can not be digested or absorbed properly, in particular fatty foods and fat-soluble vitamins (vitamins A, D, E and K). This can cause malnutrition, leading to poor growth and poor weight gain, a bloated abdomen and tummy aches, constipation and prolonged diarrhoea.

Other symptoms can include sinus infections and nasal polyps.



Some adults with cystic fibrosis may also get cystic fibrosis-related diabetes, arthritis, osteoporosis and liver problems.

Symptoms usually first develop within the first year of life, but in a minority of cases may not appear until later in childhood or beyond. The severity of symptoms can vary and not all people with cystic fibrosis will have every symptom.

HOW DOES CYSTIC FIBROSIS AFFECT DAILY LIFE?

Cystic fibrosis affects everyone differently, but for many it involves a rigorous daily treatment regime, including physiotherapy, oral, nebulised and occasionally intravenous antibiotics, and taking enzyme tablets with food. Some people with cystic fibrosis will have a feeding tube overnight.

For those who are very ill with cystic fibrosis and have very poor lung function, daily life can be a struggle as basic tasks can leave them breathless. Some patients use a wheelchair to get around and oxygen to help them breathe.

HOW IS CYSTIC FIBROSIS TREATED?

People with cystic fibrosis often have to undergo a rigorous daily regime of treatments to stay healthy. This can include taking inhaled and injected drugs to clear mucus and fight infections, taking dozens of enzyme pills to digest food, and having physiotherapy morning and night.

People with cystic fibrosis may also need a transplant. Lung transplants are the most common type for people with cystic fibrosis, as usually these are the organs most affected by cystic fibrosis. However, some people will have problems with their liver, kidneys or pancreas, and may need these organs transplanted.

WHERE DO PEOPLE WITH CYSTIC FIBROSIS GET THEIR CARE?

The majority of adults with cystic fibrosis go to one of the specialist cystic fibrosis centres in the UK. Children may have a shared-care

arrangement, where they have some of their care at a local hospital and some at the nearest specialist cystic fibrosis centre, though the centre takes responsibility for their health.

It's vitally important that those with cystic fibrosis receive appropriate healthcare to ensure a better quality and length of life. Therefore, we strongly recommend that people with cystic fibrosis receive care from the multidisciplinary team of specialist doctors, nurses and allied health professionals at a recognised specialist cystic fibrosis centre. This includes specialist cystic fibrosis dietetic care and physiotherapy and should also include psychosocial support.

ABOUT THE CYSTIC FIBROSIS TRUST

The Cystic Fibrosis Trust is the only UK-wide charity dedicated to uniting for a life unlimited for everyone affected by cystic fibrosis. The trust funds cutting-edge research, provides confidential advice, support, and information on any aspect of cystic fibrosis, including help with financial support.

2024 marks the trust's 60th anniversary. Over the years we've seen vast improvements in the care, treatment, and life-expectancy of people with cystic fibrosis, but there is still no cure. People with cystic fibrosis are living longer, but more complex challenges are arising with the cost-of-living, the impact of ageing, and a higher risk of some comorbidities.

The trust is working hard to adapt and evolve to the changing needs of the cystic fibrosis community and continues to fund research that is a priority for those with cystic fibrosis, provide up-to-date support and advice, and be at the forefront of an ongoing journey to find a cure for it.

HOW YOU CAN SUPPORT US

From running a marathon to hosting a tea party, there are lots of ways you can help work towards a life free from the limits of cystic fibrosis. You can visit our website page at www.cysticfibrosis.org.uk/get-involved/join-us to find out how you can join Team Cystic Fibrosis, sign up for one of our events, and raise money for the trust.

Alternatively you can donate directly to us at www.cysticfibrosis.org.uk/get-involved/donate.

Your donation will help provide vital information and support to people affected by cystic fibrosis and fund research to find better treatments that work for everyone. We are extremely grateful for every single donation we receive; we wouldn't be able to achieve what we do without these.

PROMOTION

RISE TO THE CHALLENGE

With the industry facing mounting pressures and expectations, investment in technology is key to the survival of community pharmacists, explains Edward Platt, Senior Commercial Director of Omnicell's UK community pharmacy division, in addition to Omnicell's UK & Ireland hospital division.



Edward Platt

At a time when eight pharmacies are closing down every week in the UK, community pharmacists south of the border will be looking to learn from the experiences of their peers in Scotland now the government's much-hyped Pharmacy First programme has launched in England. Many pharmacists in Scotland will no doubt remember the optimism, as well as the apprehension and anxiety, the scheme generated when it was launched back in July 2020.

Nearly four years on, community pharmacies in Scotland have carried out more than 3.3 million consultations under the scheme. Few can argue that it has helped make better use of pharmacists' clinical skills and position them as 'key' providers of urgent care to the growing needs of patients and supporting the over-stretched NHS. Looking further ahead, and across the whole of the UK, it will also, potentially, make pharmacies even more important to their communities and more accessible than local GPs.

However, it doesn't address the ongoing challenges facing the sector as a whole. A survey carried out by ITV's Tonight programme further highlighted the backdrop of current staff and drug shortages – there are currently 111 different medicines routinely in short supply – double the number in 2022. In addition, many community pharmacists are faced with abuse from customers, not to mention a £1.3 billion funding gap. Worryingly, a staggering 96 per cent were concerned their pharmacies are not financially viable.

Yet at this time of crisis, I do believe there remains a lack of understanding about the huge impact technology can have in enabling them to manage many of the pressures they face, while remaining financially viable. For many, there really needs to be a change of mindset. If I could offer one piece of advice to community pharmacists, it is to be more growth-focused.

Investment in technology is crucial. Pharmacists and pharmacy technicians typically enter this industry to support their communities. They don't want to be worried about ordering and managing stock, and completing mundane manual tasks.

Technology will enable them to do this and can support them in three key ways; stock management and pack handling, packing, checking of MDS trays and finally, through a safe and secure collection point, such as the Pharmaself24 Collection Kiosk – banks have 24 / 7 cash machines, and pharmacies can offer a similar level of service for prescription collection. Solutions such as these enable pharmacists to focus on patients, and crucially, free up time for alternative revenue streams. In addition, they can boost patient safety, through the reduction of medication errors. Technology is here to help.



CASE STUDY

Richard Grahame is a community pharmacist based in Falkirk, Scotland, and owns six pharmacies. His decision to invest in collection technology has been so successful, he is about to purchase his fourth Pharmaself24 collection kiosk later this year:

'I invested in our first Pharmaself24 collection kiosk for my Callendar Pharmacy in Falkirk in June 2020, and was really happy with my decision straightaway. We're a very busy pharmacy and it made complete sense to take the leap. It gave us new potential to grow our share of prescriptions without the costs associated with expanding our already over-subscribed home-delivery service. It immediately took the pressure off staff and freed up significant amounts of time to spend on the more acute needs of patients instead. I have always tried to be forward-thinking where my business has been concerned and knew that this would help take the heat off my customer-facing staff, in addition to opening doors to a significant number of new patients. In addition, we could see the challenges which were impacting the sector and felt technology was the only way of helping us grow and future proof the business.'

The impact of Pharmaself24 on the turnover of prescriptions has been significant. Since it was installed in his two pharmacies in Falkirk, for example, Richard estimates, combined, they now manage approximately 600 bags a week, which equates to approximately 2,500 bags a month. Omnicell estimates the preparation of every bag takes approximately four minutes. Therefore, with the installation of Pharmaself24 technology, Richard is now saving approximately five hours every day across these two pharmacies, which can be spent instead on patient-facing care.

'While I understand it is a big decision to make such investment, particularly at a time when funding is at an all-time low, I truly believe it's the only option for community pharmacies if they want to survive, and prosper, in the current climate.'

The technology has played a major role in helping Richard and his team fully engage and hit the ground running with the Pharmacy First initiative in Scotland.

'I believe Pharmacy First is key in helping community pharmacists evolve from being regarded simply as a 'shop', to become an integral part of the health system. I understand how many can see change as a disruptor, but it's part of a natural evolution and is not something to be scared of. If done properly, it will encourage more footfall, loyalty and money to help pharmacists grow and ensure they remain stalwarts of their community.'

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THE ROAD TO RECOVERY

**Eating disorders are on the rise – how can health professionals help?
Tom Quinn, Director of External Affairs at Beat, the UK’s eating disorder charity, discusses.**

There’s a misconception that eating disorders are rare mental illnesses. But as the UK’s eating disorder charity, we know that this couldn’t be further from the truth. In Northern Ireland, in 2020 the Youth Wellbeing Prevalence Survey stated that one-in-six children and young people across the country are displaying patterns of an eating disorder. In Wales, we estimate that almost 60,000 people have an eating disorder, and in Scotland, eating disorder cases increased by over a quarter during the pandemic.

Eating disorders can affect every system in the body, but it’s not always apparent that an eating disorder is causing physical issues, meaning that your patient might approach you with supposedly unrelated symptoms. As a healthcare professional, you could be one of the first people to spot that somebody is struggling with an eating disorder. That’s why it’s so important you’re able to access quality training and identify the early warning signs.

IDENTIFYING THE ALARM BELLS

Eating disorders affect people of all ages, genders and backgrounds. There are many different types of eating disorders, and people will often try to hide their illness, which makes it tricky to spot if somebody is struggling. But the sooner somebody accesses quality treatment, the better their chances of making a full recovery, so it’s crucial to signpost patients to support at the earliest opportunity.

Anorexia is the most well-known eating disorder but it’s actually one of the least common. Binge eating disorder is the most common, with one-in-50 people in the UK affected in their lifetime, and more people develop bulimia or OSFED than anorexia. There are several signs and symptoms to look out for, including:

- Strict dieting and avoiding food they think is fattening
- Taking a very long time to eat meals
- Becoming fixated on exercise, such as running, even in bad weather
- Anxiety, particularly about eating in front of other people
- Eating large amounts of food (bingeing)
- Purging after bingeing by vomiting, over-exercising, using laxatives or fasting

One of the most important things to remember is that eating disorders don’t have a ‘look’ – they are serious mental illnesses that affect people of any weight, BMI or size. While there can be physical symptoms, such as changes in weight, dental issues, stomach problems or circulation issues, psychological symptoms are usually the biggest indicators that somebody is unwell.

WHAT’S CHANGED SINCE THE PANDEMIC?

While it’s not the only reason why an eating disorder would develop, the pandemic had a catastrophic impact on people across the UK. We supported people of all ages who felt incredibly isolated and anxious as they worried about the health of loved ones, struggled to adjust to lockdowns, and were unable to see friends and family as normal. Given that eating disorder behaviours tend to emerge in response to stress, it’s

no surprise that the numbers of people needing support surged during the pandemic.

We’re still feeling these effects today – especially among children and young people. In Scotland, we provided over 10 times the number of support sessions to or about under-18s between April 2022-and-March 2023, in comparison to before the pandemic. In Northern Ireland, we had over 13 times the number of helpline calls from or about 11-to-17-year-olds in the same time period, and 17 times for 13-to-17-year-olds in Wales.

It’s important that when we talk about eating disorders, we don’t forget the families behind-the-scenes, guiding their loved one towards recovery while supporting their own mental health. Signposting families to quality support is just as important as referring patients to eating disorder services.

QUALITY TRAINING

Nobody can provide excellent care without excellent training, advice and support. As part of our work raising awareness of eating disorders, we develop training courses to help healthcare professionals across Scotland, Northern Ireland and Wales. We know that time is tight, so our courses are time-efficient and most can be completed whenever works best for you.

Beyond the Symptoms is one of our CPD-accredited training programmes, which helps healthcare professionals to confidently spot the physical and psychological signs of an eating disorder and intervene early. Delivered by experienced eating disorder clinicians, this course is designed to help a variety of people, including GPs, nurses, dentists and cardiologists. We also run free online training for GPs and primary care clinicians and campaign for every professional to access the tools they need to help every patient.

National guidelines are also in place, including SIGN guidelines (Scottish Intercollegiate Guidelines Network) which outline best practice for healthcare professionals in Scotland, and NICE guidelines (National Institute for Health and Care Excellence) for Northern Ireland, Wales and England. No matter where you are in the UK, you’re never alone when supporting a patient with an eating disorder. Full recovery is possible and, with the right tools, you can help your patient and their family along this journey.

For more information, contact Scotlandhelp@beateatingdisorders.org.uk or 0808 801 0432. Beat also runs online support groups and a web chat service for those with eating disorders, but also for those worried about a loved one, patient or pupil at www.beateatingdisorders.org.uk. Training courses are available for healthcare professionals at www.beateatingdisorders.org.uk/training-events/find-training.



Tom Quinn

IN WITH THE NEW

From fostering students' potential, to fuelling the improvement of workplace wellbeing culture, SHR checks in on how Pharmacist Support – the profession's independent charity – proceeds to help the sector take crucial steps forward.

PHARMACIST SUPPORT INTRODUCES GROUNDBREAKING COURSE: 'EMBRACING A WORKPLACE WELLBEING CULTURE' FOR PHARMACY MANAGERS AND LEADERS

Pharmacist Support is excited to announce the launch of its transformative new course, 'Embracing a Workplace Wellbeing Culture,' specially designed for pharmacy managers and leaders.

This pioneering course aims to empower professionals in the pharmacy sector with the knowledge and tools to foster a positive and supportive workplace culture.

The 'Embracing a Workplace Wellbeing Culture' course directly addresses the unique challenges faced by pharmacy managers and leaders in cultivating a healthy environment for their teams. Drawing on extensive research and industry insights, the course offers practical strategies that can be implemented immediately, contributing to improved team wellbeing and performance.

Danielle Hunt, Chief Executive, and Melissa Cochrane, Wellbeing Development Manager, at Pharmacist Support, expressed their enthusiasm for the course.

Danielle stated, 'The evidence from our joint annual Workforce Wellbeing surveys with the Royal Pharmaceutical Society show that the pressures on the pharmacy workforce continue to negatively impact on mental health and wellbeing. We have seen consistently very high levels of burnout, with around 50 per cent of respondents citing a lack of work-life balance, lack of protected learning time and lack of colleague or senior support as factors which have negatively impacted their mental health and wellbeing.'

She added, 'Research by Mind has found that 56 per cent of employers would like to do more to improve staff wellbeing, but they don't feel they have the right training or guidance.'

'In today's dynamic pharmacy landscape, effective leadership is not just about managing operations; it's also about nurturing the wellbeing of your team,' said Melissa.

'A supportive line manager can make a huge difference in terms of wellbeing in the workplace. However, the reality is that many managers are promoted because of their job-based skills but have not been trained in mental health and wellbeing and may not have the interpersonal skills to manage these issues sensitively.'

According to the Chartered Institute of Personnel and Development, positive relationships with line managers are associated with higher levels of job satisfaction, commitment, and loyalty, which, in turn, are linked with higher levels of performance.

For more information and to register for the 'Embracing a Workplace Wellbeing Culture' course, visit www.pharmacistsupport.org/how-we-can-help/wellbeing-service/embracing-a-workplace-wellbeing-culture.

ALLIANCE HEALTHCARE UK AND PHARMACIST SUPPORT ANNOUNCE THREE-YEAR PARTNERSHIP TO SUPPORT THE CHARITY'S STUDENT BURSARY SCHEME

Pharmacist Support has announced a transformative three-year partnership with Alliance Healthcare UK – the UK's largest medicines wholesaler – in support of the Pharmacist Support Student Bursary Scheme.

The profession's independent charity annually opens its Student Bursary Scheme to fully-accredited pharmacy schools across Great Britain. This initiative provides a lifeline to third year (or fourth year for those undertaking a five-year sandwich degree) MPharm students who are facing unexpected adversity.

The scheme is designed to support outstanding students who have demonstrated exceptional qualities in overcoming ongoing adversity, and financial hardship, and have received an endorsed expectation by their university for a positive contribution to the field of pharmacy in Great Britain.

Successful applicants are awarded bursaries of either £3,000 or £5,000.

'Our collaboration with Alliance Healthcare UK marks a significant step forward in our ongoing commitment to supporting future generations of pharmacists,' explained Danielle Hunt.

'Together, we aim to make a positive impact on the lives of these students, providing them with the resources they need to overcome challenges and pursue successful careers in pharmacy.'

'Alliance Healthcare UK shares our commitment to empowering the next generation of pharmacy professionals and this collaboration will strengthen our collective efforts to nurture talent and promote excellence in the pharmacy sector. By committing to a longer-term relationship, Alliance Healthcare UK becomes an integral part of our strategic vision, contributing to the development and execution of services that create lasting change within the pharmacy sector. This multi-year partnership allows us to plan and execute initiatives that have a sustained impact over time. It provides stability, enabling us to allocate resources more efficiently and plan for the future with confidence.'

Marie Evans, Managing Director, Alliance Healthcare UK, added, 'We are excited to partner with Pharmacist Support on their annual Student Bursary Scheme. This partnership reflects our commitment to investing in the future of pharmacy professionals and fostering a supportive environment for aspiring talent in the field. We believe in the importance of investing in the education and wellbeing of aspiring pharmacists, and this partnership aligns perfectly with our values and commitment to making a positive impact on the communities we serve.'

The three-year partnership signifies a long-term commitment to fostering positive change in the pharmacy sector, providing opportunities for growth and success. Pharmacist Support and Alliance Healthcare UK look forward to making a meaningful contribution to the lives of these students through the Pharmacist Support Student Bursary Scheme.

For more information about the Pharmacist Support Student Bursary Scheme, visit www.pharmacistsupport.org/i-need-help-managing-my/student-experience/national-bursary-scheme.



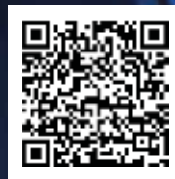


PHARMACIST
SUPPORT

Our vision is for no one in our pharmacy family to face challenging times without us by their side.

Pharmacist Support is an independent, trusted charity, providing a range of free and confidential services to pharmacists and their families, former pharmacists, trainees and pharmacy students.

We need your help to continue making an impact. Please scan the QR code to make a donation and help us to support our pharmacy family. Thank you.



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Guiding the Way

New updates are showcasing the impact, and helping bolster the safety, of faecal microbiota transplant as treatment for recurrent or refractory *Clostridioides difficile* infection, and other potential indications.

In a step towards advancing medical treatment options, the British Society of Gastroenterology, alongside the Healthcare Infection Society (HIS), have released a set of draft guidelines for external consultation on the use of faecal microbiota transplant (FMT) as a potential therapy for recurrent or refractory *Clostridioides difficile* infection (CDI), and other indications.

Clostridioides difficile (formerly *Clostridium*) – also called *C. difficile*, or informally just ‘*C. diff*’ – is a major cause of healthcare-associated diarrhoea, and is increasingly present in the community. (1) Since its recognition as a significant healthcare-associated infection, multiple infection control measures and treatment modalities have been explored and this remains an evolving field. (2)

FMT, a procedure involving the transfer of screened healthy donor faeces into an affected patient’s gastrointestinal tract, has gained increasing attention in recent years for its potential to treat various gastrointestinal disorders (especially recurrent or refractory CDI), and even disorders beyond the gut.

The guidelines serve as an update to the first version of the joint BSG / HIS FMT guidelines, first published in 2018, and reflect the fast-moving updates in the literature since this point.

They have been developed through extensive collaboration between experts in the field, and provide a comprehensive framework for healthcare professionals to understand and evaluate the use of FMT for treatment of *C. difficile* and, potentially, for other conditions.

The primary focus of these guidelines is to standardise the clinical and research aspects of FMT to ensure its safety and efficacy.

KEY POINTS ADDRESSED IN THE DRAFT GUIDELINES INCLUDE:

- Patient selection: recommendations for identifying suitable candidates for FMT, particularly for those with recurrent or refractory *difficile* infection
- Donor screening: protocols for donor screening and selection to minimise potential risks and ensure recipient safety
- FMT procedure: protocols for the procedure itself, including preparation, when it should be offered, and the best ways to administer it
- Research: encouraging further research to expand FMT applications and improve its effectiveness

Benjamin Mullish, Chair of the FMT Working Party, and one of the principal authors of the draft guidelines, stated, ‘These guidelines represent a significant step toward standardising and regulating the use of FMT, ensuring the best possible outcomes for patients while upholding the highest standards of safety for this major healthcare-associated infection.’

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INNOVATIVE E-LEARNING PLATFORM TO STRENGTHEN TRAINING IN INFECTION PREVENTION AND CONTROL

The HIS has unveiled a new e-learning platform designed to educate and empower healthcare professionals. This initiative aims to strengthen education as a core tool in the fight against healthcare-associated infections and in improving patient safety.

James Price, Chair of the Professional Development Committee, expressed, ‘The release of the e-learning platform is a significant step towards creating a modernised learning environment for the infection prevention and control community. The Professional Development Committee, alongside the HIS team, have spent a lot of time and effort to perfect the platform and I want to express my gratitude to the whole team.’

The modules are delivered by world-class experts in their field.

Dr Elisabeth Ridgway, President of the HIS, emphasised the importance of the course as part of infection control professionals’ education pathways, stating, ‘Infection control is pivotal to patient safety, and creating this innovative course allows us to provide relevant and up-to-date content for a wide range of healthcare professionals.’

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



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THE WHOLE PICTURE

Many children experience difficulties when taking medications, both prescribed and OTC. This can often be due to the formulation, the flavour, the colour, or even sometimes just the name. When a child is neurodivergent, however, these issues can multiply exponentially. Such children are often focused on a pattern of familiarity, routine and understanding what the plan is everytime an action is carried out.

Changes due to school holidays, for example, can be overcome simply with an explanation of 'school is closed' but when it comes to medication and especially those which are prescribed, these traits of a neurodivergent child can present real difficulties, causing potential issues with compliance.

In my own experience, my son has recently been diagnosed with dyspraxia, which is usually associated with fine motor skills problems, difficulty in concentrating for an extended period, and balance issues. There are, however, additional symptoms which focus on knowing what is going to happen with his daily routine – he prefers the same brand of food, same brands of clothing, and the same flavour of paracetamol for when he is feeling unwell.

Changing the formulation of a medication for my son would not be possible and would ultimately result in him not wanting to take it. This would lead to the medical complaint not being resolved and further affecting his day / night.

If this is taken in the context of a lyophilisate formulation or an oral dispersible one, the changes may be irrelevant to a wide number of patients, however, children and especially neurodivergent children, will more often than not act negatively to this change.

The impact this seemingly minimal decision from the prescriber can have on the family network can't be underestimated. In the instance of desmopressin, if the formulation is changed, and the patient either does not want to take it or refuses to take it, this can lead to their nocturnal enuresis not being controlled and therefore having sequential effects on the family.

Lack of sleep for the parents / siblings / other family members is a high possibility on top of additional washing and / or purchasing of bedclothes, sleep wear etc.

This can then lead to an increase in stress of the parents at work and siblings at school. All this will have occurred due to the

Fusing his own first-hand experience with the population's evolving needs, SHR's Chris Flannagan reflects on the benefits of the lyophilisate vs oral dispersible.

prescriber innocently changing the formulation of the patient's treatment which is an issue that can be easily avoided.

If a neurodivergent patient's overall medical needs are thought of as a whole, and not just for one particular treatment, then their condition can be managed effectively and efficiently without an increase in stress for their family unit.

Davina Richardson, Children's Specialist Nurse, Bladder & Bowel UK, explained, 'Many children become anxious about taking medication. They may worry about whether the texture or taste will be unpleasant and whether it will be difficult to swallow, particularly if it is a tablet. Once a child is used to a medication, changing formulation may cause their anxieties to re-emerge. For children with sensory differences that affect smell, taste, or touch this may be a particularly significant issue, that may cause stress for child and parent.'

'Children may have different responses to different formulations of the same medication and the different formulations may have different requirements for administration that needs adjustment to routines. Therefore, the rationale for changing formulation should always be to benefit the child, either by trying to increase response, or to make administration more straightforward and acceptable to the individual.'

* The article has been created in collaboration with BBUK & SHR. Funded by Ferring pharmaceuticals.

* The content in the article is author's own opinion.

* Prescribing Information & AE reporting can be found on the right.

job code: UK_IE-MN-2400001 February 2024

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Prescribing Information: DesmoMelt® 120 and 240 micrograms oral lyophilisate. **Please consult the full Summaries of Product Characteristics before prescribing.** **Name of Product:** DesmoMelt 120 micrograms oral lyophilisate; DesmoMelt 240 micrograms oral lyophilisate; **Composition:** 120 or 240 micrograms of desmopressin (lyophilisate as acetate). **Indications:** Treatment of primary nocturnal enuresis (5 to 65 years of age). **Dosage and administration:** Children and adults (5–65 years of age) with normal urine concentrating ability: Initial dose of 120 micrograms sublingually at bedtime and if this dose is not sufficiently effective, the dose may be increased up to 240 micrograms, administered sublingually. Fluid restriction should be observed. DesmoMelt is intended for treatment periods of up to 3 months. The need for continued treatment should be reassessed by means of a period of at least 1 week without desmopressin. If adequate clinical effect is not achieved within 4 weeks following dose titration the medication should be discontinued. In the event of signs or symptoms of water retention and/or hyponatraemia treatment should be interrupted until the patient has fully recovered. When re-starting treatment fluid restriction should be enforced. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. Known or suspected cardiac insufficiency and conditions requiring treatment with diuretics, moderate and severe renal insufficiency. DesmoMelt should only be used in patients with normal blood pressure and they should not be used in patients with known hyponatraemia, syndrome of inappropriate ADH secretion or patients (SIADH) over the

age of 65. Exclude diagnosis of psychogenic polydipsia (resulting in urine production exceeding 40 ml/kg/24 hours). **Side Effects:** Common; headache. Please consult the full Summary of product characteristics for further information about side effects. **Special Warnings:** Take care in patients with reduced renal function and/or cardiovascular disease or cystic fibrosis. In chronic renal disease the antidiuretic effect of DesmoMelt would be less than normal. Fluid intake must be limited to a minimum from 1 hour before until the next morning (at least) 8 hours after administration. Treatment without concomitant reduction of fluid intake may lead to water retention and/or hyponatraemia with or without accompanying signs and symptoms. All patients and, when applicable, their guardians should be carefully instructed to adhere to the fluid restrictions. **Precautions:** Severe bladder dysfunction and outlet obstruction should be considered before starting treatment. Elderly patients and patients with serum sodium levels in the lower range of normal may have an increased risk of hyponatraemia. Treatment with desmopressin should be interrupted during acute intercurrent illnesses characterised by fluid and/or electrolyte imbalance (such as systemic infections, fever, gastroenteritis). Caution should be used in: illnesses characterized by fluid and/or electrolyte imbalance; patients at risk for increased intracranial pressure. Hyponatraemia should be avoided by careful attention to fluid restriction and frequent sodium monitoring in case of concomitant treatment with drugs known to induce SIADH, treatment with NSAIDs and some antidiabetics of the sulfonylurea group particularly chlorpropamide. **Special precautions**

for storage: None. **Presentation:** Carton containing 30 oral lyophilisates in blister strips. **Marketing Authorisation Number:** 120 micrograms 03194/0094. 240 micrograms 03194/0095. **Marketing Authorisation Holder:** Ferring Pharmaceuticals Ltd., Drayton Hall, Church Road, West Drayton, UB7 7PS. **Legal Category:** POM. **Basic NHS Prices:** 30 x 120 micrograms £30.34. 30 x 240 micrograms £60.68. **Date of Preparation:** March 2023. All trademarks registered to Ferring. **PI approval code:** UK-MN-2300008

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 Ferring Pharmaceuticals Ltd. Tel: 0800 111 4126. Email: medical.uk@ferring.com

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MULTIPLE SCLEROSIS

HOLDING OUT HOPE

An international team have demonstrated that the injection of a type of stem cell into the brains of patients living with progressive multiple sclerosis is safe, well-tolerated – and has a long-lasting effect that appears to protect the brain from further damage.

An exciting new study, led by scientists at the University of Cambridge, University of Milan Bicocca and Hospital Casa Sollievo della Sofferenza (Italy), represents a significant step towards developing an advanced cell therapy treatment for progressive multiple sclerosis (MS).

Over two million people live with MS worldwide, and while treatments exist that can reduce the severity and frequency of relapses, two-thirds of MS patients still transition into a debilitating secondary progressive phase of disease within 25-to-30 years of diagnosis, where disability grows steadily worse.

In MS, the body's own immune system attacks and damages myelin, the protective sheath around nerve fibres, causing disruption to messages sent around the brain and spinal cord.

Key immune cells involved in this process are macrophages (literally 'big eaters'), which ordinarily attack and rid the body of unwanted intruders. A particular type of macrophage, known as a microglial cell, is found throughout the brain and spinal cord. In progressive forms of MS, they attack the central nervous system, causing chronic inflammation and damage to nerve cells.

Recent advances have raised expectations that stem cell therapies might help ameliorate this damage. These involve the transplantation of stem cells, the body's 'master cells', which can be programmed to develop into almost any type of cell within the body.

Previous work from the Cambridge team has shown in mice that skin cells re-programmed into brain stem cells, transplanted into the central nervous system, can help reduce inflammation, and may be able to help repair damage caused by MS.

Now, in research published in the Cell Stem Cell, scientists have completed a first-in-human, early-stage clinical trial that involved injecting neural stem cells directly into the brains of 15 patients with secondary MS recruited from two hospitals in Italy. The trial was conducted by teams at the University of Cambridge, Milan Bicocca and the Hospitals Casa Sollievo della Sofferenza and S. Maria Terni and Ente Ospedaliero Cantonale and the University of Colorado.

The stem cells were derived from cells taken from brain tissue from a single, miscarried foetal donor. The Italian team had previously shown that it would be possible to produce a virtually limitless supply of these stem cells from a single donor – and in future it may be possible to derive these cells directly from the patient – helping to overcome practical problems associated with the use of allogeneic foetal tissue.

The team followed the patients over 12 months, during which time they observed no treatment-related deaths or serious adverse events. While some side-effects were observed, all were either temporary or reversible.

All the patients showed high levels of disability at the start of the trial – most required a wheelchair, for example – but during the 12-month follow-up period none showed any increase in disability or a worsening of symptoms. None of the patients reported symptoms that suggested a relapse and nor did their cognitive function worsen significantly during the study. Overall, say the researchers, this points to a substantial stability of the disease, without signs of progression, though the high levels of disability at the start of the trial make this difficult to confirm.

The researchers assessed a subgroup of patients for changes in the volume of brain tissue associated with disease progression. They found that the larger the dose of injected stem cells, the smaller the reduction in this brain volume over time. They speculate that this may be because the stem cell transplant dampened inflammation.

The team also looked for signs that the stem cells were having a neuroprotective effect – that is, protecting nerve cells from further damage. Their previous work showed how tweaking metabolism – how the body produces energy – can, in turn, reprogramme microglia from 'bad' to 'good'. In this new study, they looked at how the brain's metabolism changes after the treatment. They measured changes in the fluid around the brain and in the blood over time and found certain signs that are linked to how the brain processes fatty acids. These signs were connected to how well the treatment works and how the disease develops. The higher the dose of stem cells, the greater the levels of fatty acids, which also persisted over the 12-month period.

Professor Stefano Pluchino from the University of Cambridge, who co-led the study, reflected, 'We desperately need to develop new treatments for secondary progressive MS, and I am cautiously very excited about our findings, which are a step towards developing a cell therapy for treating MS.'

'We recognise that our study has limitations – it was only a small study and there may have been confounding effects from the immunosuppressant drugs, for example – but the fact that our treatment was safe and that its effects lasted over the 12 months of the trial means that we can proceed to the next stage of clinical trials.'

Caitlin Astbury, Research Communications Manager at the MS Society, added, 'This is a really exciting study which builds on previous research funded by us. These results show that special stem cells injected into the brain were safe and well-tolerated by people with secondary progressive MS. They also suggest this treatment approach might even stabilise disability progression. We've known for some time that this method has the potential to help protect the brain from progression in MS.'

'This was a very small, early-stage study and we need further clinical trials to find out if this treatment has a beneficial effect on the condition. But this is an encouraging step towards a new way of treating some people with MS.'

TAKING STOCK

95 per cent of UK farmers under the age of 40 rank poor mental health as one of the biggest hidden problems impacting farmers today – sparking the fruition of an important campaign aiming to drive dialogue and bring greater awareness to the issues facing the industry.

Farming in the UK has been hit by an increase in flooding, drought, and heatwaves in recent years.

The effects of the relentless season of storms have had huge consequences for those whose lives and livelihoods depend on the land. Fields flooded, crops destroyed, and animals in danger, have made recent headlines – but this is only the tip of the iceberg. The UK's farming industry has faced many challenges over the past few years, but the emerging mental health challenge may prove the most devastating.

A GROWING CONCERN

A recent study by leading rural charity, the Farm Safety Foundation (Yellow Wellies), revealed that poor mental health among farmers and agricultural workers is of growing concern. In a sample of 450 farmers under the age of 40, respondents almost universally (95 per cent) agreed that poor mental health is the biggest hidden problem facing the industry today.

In addition, the research showed a very clear relationship between average working hours and mental health (as measured by WEMWBS). Those with shorter working hours demonstrated higher levels of mental wellbeing, 61 per cent of farmers surveyed work at least a 10-hour day, 15 per cent working a 14- or 15-hour day, with many rarely or never taking a day off. This is something that is giving charities like the Farm Safety Foundation real cause for concern.

In an industry that continues to have the poorest safety record of any occupation in the UK, making sure farmers are prioritising their physical and mental wellbeing has never been more important. 21 farm workers lost their lives in farm accidents in 2022 / 2023, however, there were 36 suicides registered in England and Wales by those working in the farming and agricultural industry in 2021 according to the Office of National Statistics.

MIND YOUR HEAD CAMPAIGN

As a result, the charity has been focusing on the issue through its seventh annual Mind Your Head campaign. The campaign will continue to raise awareness of the various challenges facing the UK's farming industry, break down the stigma attached to poor mental health in the farming sector, but recognise that there are steps being taken to address it.

Stephanie Berkeley, Manager of the Farm Safety Foundation, explained, 'Mind Your Head launched in 2018 when concerns about Brexit, policies, administration and legislation were causing increased anxiety in the industry.

Fast-forward seven years and the campaign has grown and is now recognised by 67 per cent of farmers in the UK. Mental health is always a sensitive subject but it's something that is thankfully growing in importance and profile. The answer to the question 'who cares?' is everyone – and everyone should.

'Agriculture is a proud and hardworking industry and vital to the UK economy. Far from being downtrodden, the UK's farmers are resilient and resourceful and committed to finding ways to tackle any challenge they face. Over the years we've been encouraged by the growing numbers of farm businesses and organisations wanting to learn more about how to help their workers and suppliers, as well as the incredible individuals taking steps to improve their mental wellbeing and, in this year's campaign, we will be highlighting them and hopefully inspiring many more to do the same.'

The charity has also been working with film director, Rebecca Rose, and Swift Rocket Films to premiere an original award-winning independent British short film that explores the aftermath of suicide in a farming family.

WAKE is a film about how a family comes to terms with tragic loss and how they cope both psychologically and practically.

Rebecca Rose commented, 'WAKE raises awareness of the under-reported social issue of mental health and suicide in the seemingly idyllic countryside setting and how simple conversations about feelings can start a process to prevent the downward spiral toward the finality of suicide.'

Starring Gavin and Stacey actress Alison Steadman OBE, Poldark's Mark Frost, Emmerdale's Louisa Clein, and rising star Stuart Campbell, the film toured international film festivals in 2022 / 2023, and the charity launched it through their social media channels as part of the Mind Your Head campaign.

BBC Countryfile presenter Adam Henson, who last year launched the Keeping on Track podcast to raise awareness of mental health difficulties among farmers and rural communities, joins the team again. Adam is no stranger to the challenges of rural life, however the shock of losing a farming friend to suicide in 2018 inspired him to start campaigning and raising awareness of the mental health issues affecting the industry.

'I have lived on a farm and been involved in farming all my life,' he reflected. 'As anyone working in farming knows, every day brings potential joy and disaster – you never quite know what is going to happen and there are many things you can't control.'

For more information on the Mind Your Head campaign, visit www.yellowwellies.org or follow them on social media – @yellowwelliesUK on Facebook, Instagram and X using the hashtag #MindYourHead.

ASTHMA

CLOSE TO HOME

For a significant proportion of asthma patients, their day-to-day life is shrouded in triggers and spent strategising methods for keeping unnecessary exacerbations at bay. How can they maximise the safety of their home setting?

THE GLOBAL INITIATIVE FOR ASTHMA: COMMON ASTHMA TRIGGERS

Firstly, individuals should try to discover what triggers their asthma. Common triggers include tobacco smoke, cold air and exercise.

- Individuals should be strict about no smoking inside their home and other places where they spend time. Exposure to tobacco smoke makes asthma worse in most people
- Cold air triggers symptoms more easily when individuals aren't getting enough treatment for their asthma, and increasing their dose of anti-inflammatory medication will often help
- Exercise is important and should normally not be discouraged, because asthma symptoms during or following exercise can usually be prevented by good medication
- Pressure on the chest can be caused by situations like sleeping on their back as this builds the pressure, making the individual uncomfortable and asthmatic. They can prevent this by simply getting a memory foam mattress

Some allergens can be avoided. For example, if the patient is allergic to horses or cats they should keep away from them. Other allergens and environmental triggers, such as house dust mites, pollen and air pollution, are more difficult to avoid completely.

There is a difference between triggers that cause inflammation (inducers) and those that only cause temporary symptoms. Full advice about which allergens and environments patients should avoid can only be given after talking to their doctor and often after they have been tested for allergies.

WHAT CAN PATIENTS DO TO IMPROVE THEIR HOME ENVIRONMENT IN GENERAL?

It is important that their home is easy to ventilate and keep clean, particularly the floors. Wood, tile or linoleum flooring is better than fitted textile carpeting, which tends to collect a lot of dust, dust mites and allergens.

In general, they shouldn't keep furry animals or birds, even if they're not specifically allergic to them, as they will lead to an increase in the amount of house dust.

The individual should try to avoid strong perfumes, aftershave, deodorants and fragrant flowers inside the house, as these are all possible triggers of asthma. They shouldn't allow anyone to smoke indoors (and avoid other smoky environments, such as bars).

WHAT ABOUT ALLERGIES TO DUST MITES?

House dust mites and their allergens are difficult to avoid. Individuals should try to keep their house, and especially the living area and the bedrooms, dry and well-ventilated. They should avoid textile floor coverings. If possible, someone else should do the cleaning and floors should be mopped instead of vacuuming them.

It can be a good idea to encase pillows, quilts and mattresses in airtight covers that do not allow dust mites or their allergens to pass

through. Alternatively, they should wash their pillow, blanket and bedding regularly at 60C. Previously, it was recommended that their pillow is put in the freezer regularly to reduce the number of dust mites, but this is unnecessary if a cover is attained for the pillow and mattress that doesn't let the dust mites through. A vacuum cleaner with a HEPA (high efficiency particulate air) filter and double bags can be used. Individuals can also feel better if they avoid having dust-collecting textiles and furniture.

For more information, visit www.ginasthma.org.

INDOOR METABOLITES REVEALED AS KEY INDICATORS IN ASTHMA AND ALLERGIC RHINITIS

In a groundbreaking study published in the journal *Eco-Environment & Health*, researchers have made a pivotal discovery concerning asthma and allergic rhinitis (AR). This work underscores the critical roles of indoor microorganisms and metabolites, shedding new light on the environmental factors that trigger these prevalent respiratory conditions.

INDOOR METABOLITES: A CHEMICAL FINGERPRINT OF THE HOME ENVIRONMENT

This study, conducted by researchers in China and Malaysia, takes a novel approach by focusing on indoor metabolites and chemicals – the products of both microbial and human activity in the home environment. Using high-throughput technologies, the team compared the dust composition of homes with children diagnosed with asthma, AR, or both, with homes of healthy children. The analysis revealed distinct differences in the chemical profiles of the two groups. Homes with diseased children had higher levels of mycotoxins (toxic fungal metabolites) and synthetic chemicals like herbicides, insecticides, and food / cosmetic additives.

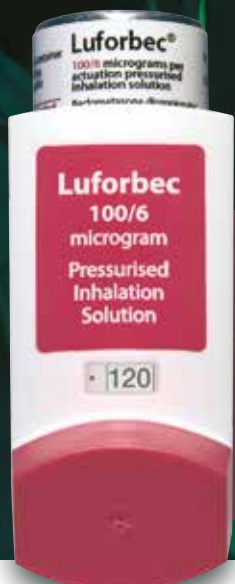
Conversely, homes of healthy children were enriched with beneficial environmental microbes and metabolites like keto acids, indoles, pyridines, and flavonoids (astragaloside and hesperidin).

Excitingly, the researchers developed a model based on these characteristic metabolites and chemicals that could accurately predict the prevalence of asthma and AR in an independent dataset from Malaysia. This suggests that analysing dust for its chemical fingerprint may be a more reliable and consistent way to assess environmental risk for these diseases than studying the complex and variable microbiome.

TOWARDS A 'METABOLICALLY HEALTHY' HOME ENVIRONMENT

The study's findings pave the way for exciting new possibilities in preventing and managing childhood asthma and AR. By testing for specific metabolites in household dust, we could potentially identify homes with unhealthy chemical profiles and implement targeted interventions. This could involve promoting the growth of beneficial microbes through probiotic sprays or adjusting ventilation systems to reduce toxin exposure.

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ACHIEVED THROUGH CARBON OFFSETTING²⁻⁴



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ukrespiratory@lupin.com



or scan here

Luforbec 100/6 is indicated for adult asthma and COPD (FEV₁ <50% predicted normal).⁵ Luforbec 200/6 is indicated for asthma in adults.⁶

Prescribing Information: Luforbec[®] 100/6 and 200/6 pressurised metered dose inhaler (pMDI)
Consult the full Summary of Product Characteristics (SmPC) before prescribing. **Presentation:** Pressurised inhalation solution. Luforbec 100/6 pMDI: Each dose contains beclometasone dipropionate (BDP) 100 micrograms (mcg) and formoterol fumarate dihydrate 6 mcg. Luforbec 200/6 pMDI: Each dose contains beclometasone dipropionate (BDP) 200 mcg and formoterol fumarate dihydrate 6 mcg. **Indications: Asthma:** Regular treatment of asthma where use of an inhaled corticosteroid/long-acting beta₂-agonist (ICS/LABA) combination is appropriate; patients not adequately controlled on ICS and as needed short-acting beta₂-agonist, or patients already adequately controlled on both ICS and LABA. **COPD (Luforbec 100/6 only):** Symptomatic treatment of patients with severe COPD (FEV₁ <50% predicted normal) and a history of repeated exacerbations, who have significant symptoms despite regular therapy with long-acting bronchodilators. **Dosage and administration:** For inhalation in adult patients (≥18 years); not recommended for children and adolescents under 18 years. **Asthma: Maintenance therapy:** Luforbec 100/6 pMDI: 1-2 inhalations twice daily. Luforbec 200/6 pMDI: 2 inhalations twice daily. The maximum daily dose is 4 inhalations, ensuring a separate short-acting bronchodilator is available as needed. Patients should receive the lowest dose that effectively controls symptoms. **Maintenance and reliever therapy (Luforbec 100/6 pMDI only):** Luforbec can be taken as a regular maintenance treatment and as needed in response to asthma symptoms: 1 inhalation twice daily (morning and evening) plus 1 additional inhalation as needed in response to symptoms. If symptoms persist after a few minutes, an additional inhalation is recommended. The maximum daily dose is 8 inhalations. Patients should be advised to always have Luforbec available for rescue use. Close monitoring for dose-related adverse effects is needed in patients who frequently take high numbers of Luforbec as-needed inhalations. **COPD (Luforbec 100/6 pMDI only):** 2 inhalations twice daily. Luforbec pMDI can be used with the AeroChamber Plus[®] spacer device. BDP in Luforbec is characterised by an extrafine particle size distribution which results in a more potent effect than formulations of BDP with a non-extrafine particle size distribution (100mcg of BDP extrafine in Luforbec are equivalent to 250mcg of BDP in a non-extrafine formulation). When switching patients from previous treatments, it should be considered that the recommended total daily dose of BDP for Luforbec is lower than that for non-extrafine BDP containing products and should be adjusted to the individual patient's needs. **Contraindications:** Hypersensitivity to the active substances or to any of the excipients. **Warnings and precautions:** Not intended for initial management of asthma. Treatment should not be initiated during an exacerbation, or during significant worsening or acutely deteriorating asthma. Treatment should not be stopped abruptly. Medical attention should be sought if treatment is ineffective. Patients should be advised to take Luforbec every day even when asymptomatic. Treatment should be discontinued immediately if the patient experiences a paradoxical bronchospasm. Use with caution (which may include monitoring) in patients with cardiac arrhythmias, especially third

degree atrioventricular block and tachyarrhythmias, aortic stenosis, hypertrophic obstructive cardiomyopathy, severe heart disease, particularly acute myocardial infarction, ischaemic heart disease, congestive heart failure, occlusive vascular diseases, arterial hypertension, aneurysm, thyrotoxicosis, diabetes mellitus, phaeochromocytoma and untreated hypokalaemia. Caution should be used when treating patients with known or suspected prolongation of the QTc interval (QTc > 0.44 seconds). Formoterol itself may induce QTc prolongation. Potentially serious hypokalaemia may result from beta₂-agonist therapy and may also be potentiated by concomitant treatments (e.g. xanthine derivatives, steroids and diuretics). Particular caution is advised in severe asthma as this effect may be potentiated by hypoxia. Caution is recommended in unstable asthma when a number of rescue bronchodilators may be used. Formoterol may cause a rise in blood glucose levels. Luforbec should not be administered for at least 12 hours before the start of anaesthesia if halogenated anaesthetics are planned due to risk of arrhythmias. Use with caution in patients with pulmonary tuberculosis or fungal/viral airway infections. An increase in pneumonia and pneumonia hospitalisation in COPD patients receiving ICS has been observed. Clinical features of pneumonia may overlap with symptoms of COPD exacerbations. Systemic effects of ICS may occur, particularly at high doses for long periods e.g. Cushing's syndrome. Cushingoid features, adrenal suppression, decrease in bone mineral density, cataract and glaucoma and more rarely, psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression and aggression. Consider referral of patients reporting blurred vision or visual disturbances to an ophthalmologist as causes may include cataract, glaucoma or rare diseases such as central serous chorioretinopathy. Prolonged treatment with high doses of ICS may result in adrenal suppression and acute adrenal crisis. **Interactions:** Possibility of systemic effects with concomitant use of strong CYP3A4 inhibitors (e.g. ritonavir, cobicistat) cannot be excluded hence caution and appropriate monitoring is advised. Beta-blockers should be avoided in asthma patients. Concomitant administration of other beta-adrenergic drugs and theophylline may have potentially additive effects, therefore exercise caution. Concomitant treatment with quinidine, disopyramide, procainamide, phenothiazines, antihistamines, monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants can prolong the QTc interval and increase the risk of ventricular arrhythmias. L-dopa, L-thyroxine, oxytocin and alcohol can impair cardiac tolerance towards beta₂-sympathomimetics. Concomitant treatment with MAOIs including agents with similar properties (e.g. furazolidone, procarbazine) may precipitate hypertensive reactions. Concomitant treatment with xanthine derivatives, steroids, or diuretics may potentiate a possible hypokalaemic effect of beta₂-agonists. Hypokalaemia may increase the likelihood of arrhythmias in patients receiving digitalis glycosides. There is a small amount of ethanol in Luforbec pMDI hence a theoretical potential for interaction in particularly sensitive patients taking disulfiram or metronidazole. **Pregnancy and lactation:** Use only during pregnancy or lactation if the expected benefits outweigh the potential risks.

Effects on driving and operating machinery: Unlikely to have any effect on the ability to drive and use machines. **Side effects: Common:** Pharyngitis, oral candidiasis, headache, dysphonia, pneumonia (in COPD patients). **Uncommon:** Influenza, oral fungal infection, oropharyngeal candidiasis, oesophageal candidiasis, vulvovaginal candidiasis, gastroenteritis, sinusitis, rhinitis, granulocytopenia, allergic dermatitis, hypokalaemia, hyperglycaemia, restlessness, tremor, dizziness, otosalginitis, palpitations, electrocardiogram prolonged QTc interval, ECG change, tachycardia, tachyarrhythmia, atrial fibrillation (in COPD patients), hyperaemia, flushing, cough, productive cough, throat irritation, asthmatic crisis, diarrhoea, dry mouth, dyspepsia, dysphagia, burning sensation of the lips, nausea, dysgeusia, pruritus, rash, hyperhidrosis, urticaria, muscle spasms, myalgia. **Very rare:** Thrombocytopenia, hypersensitivity reactions, including erythema, lips, face, eye and pharyngeal oedema, adrenal suppression, glaucoma, cataract, dyspnoea, exacerbation of asthma, peripheral oedema, decreased bone density, growth retardation in children and adolescents. **Unknown frequency:** Psychomotor hyperactivity, sleep disorders, anxiety, depression, aggression, behavioural changes (predominantly in children), blurred vision. Refer to SmPC for full list of side effects. **Legal category:** POM **Price and Pack:** £3.98 1x120 actuations. **Marketing authorisation (MA) No(s):** PL 35507/0204, 35507/0205 **MA holder:** Lupin Healthcare UK Ltd, The Urban Building, Second Floor, 3-9 Albert Street, Slough, Berkshire, SL1 2BE, United Kingdom. **PL Last Revised:** November 2023. AeroChamber Plus[®] is a registered trademark of Trudell Medical International.

Adverse events should be reported. Reporting forms and information can be found at <https://yellowcard.mhra.gov.uk> or search for MHRA Yellow Card in the Google Play or Apple App store. Adverse events should also be reported to Lupin Healthcare UK Limited on +44 (0)1565 751 378 or EU-PV@lupin.com

Ref: 1. NHS BSA. Drug Tariff. <https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/drug-tariff> Accessed: November 2023. 2. Certifications of carbon neutrality for Luforbec 100/6 and 200/6 pMDI. 3. Carbon Footprint Limited, Luforbec Life Cycle Assessment Report 2022. Data on File. 4. MIMS: Inhaler Carbon Emissions. <https://www.mims.co.uk/inhaler-carbon-emissions/respiratory-system/article/1739635>. Accessed: November 2023. 5. Luforbec 100/6 pMDI. Summary of Product Characteristics (SPC), Lupin Healthcare UK Limited. 6. Luforbec 200/6 pMDI. Summary of Product Characteristics (SPC), Lupin Healthcare UK Limited. Fostair[®] is a registered trademark of Chiesi Ltd

PANCREATIC CANCER

FOR THEIR INFORMATION

Despite being one of the biggest cancer killers in the UK, public awareness of pancreatic cancer and its symptoms is extremely low and therefore people may not consider their symptoms to be important and may delay visiting their doctor. Pancreatic Cancer Action drive forward the urgency in helping individuals secure a prompt diagnosis and medical assistance.

WHAT YOU NEED TO KNOW

Pancreatic cancer is the fifth biggest cancer killer and the 10th most common cancer in the UK. In the UK, approximately 10,500 people are diagnosed with pancreatic cancer every year. That's 29 people every day. Of these, 26 people will die every day.

The five-year survival rate for pancreatic cancer in the UK is 7.3 per cent, a statistic that has not improved significantly in 50 years, while breast cancer survival rates have doubled in this time.

Pancreatic cancer has the lowest survival rates of all 22 common cancers. This is largely due to late diagnosis. Patients are often diagnosed late due to their vague symptoms masking as other, less severe conditions. Examples include IBS, gallstones, and diverticulitis.

Pancreatic cancer occurs when a malignant tumour forms in the pancreas. Early diagnosis of pancreatic cancer is important because if it can be diagnosed and treated at an early stage, before it has spread or grown too large, then survival rates for patients are significantly better.

Currently, only around 10-to-20 per cent of pancreatic cancer patients are diagnosed at an early stage and in time for potentially life-saving surgery. However, if surgery is an option, then it increases the patient's five-year survival from 7.3 per cent to around 29 per cent.

There are many reasons why pancreatic cancer is diagnosed late:

- There is currently no screening tool that can be used to detect the cancer before people have symptoms (e.g. like there is a mammogram test for breast cancer)
- There is no simple diagnostic tool (such as a blood test) for the disease
- Pancreatic cancer often presents with vague symptoms that make it difficult to diagnose. For some people, symptoms only appear at a late stage of the disease
- Public awareness of the disease and its symptoms is low. Therefore, people may delay visiting their doctor as they do not consider their symptoms serious
- There are barriers to people visiting their GP, for example, due to embarrassment, inability to make an appointment, or difficulty accessing local health services
- Healthcare professionals lack awareness of the disease and lack the confidence to diagnose it. This may cause delays in organising appropriate tests or referrals to specialists
- Patients often bounce around the system between services, causing appointment and diagnosis delays

Pancreatic Cancer Action is the only UK pancreatic cancer charity dedicated to saving lives through early diagnosis.



PANCREATIC CANCER AWARENESS MONTH

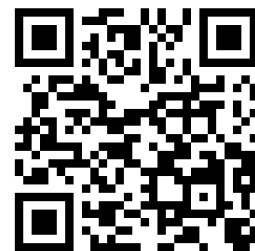
In November 2023, we launched our #MISSED campaign to raise awareness of the signs and symptoms of pancreatic cancer to improve the statistics around missed diagnoses. Patients will visit their GP an average of four times before being diagnosed, with at least one patient visiting their GP 23 times before a correct diagnosis.

Data also shows that 43 per cent of pancreatic cancer patients are diagnosed when admitted to A&E, but by this point, for over half of these patients, it is too late for any curative treatment.

SO, WHAT ARE PANCREATIC CANCER ACTION DOING TO CHANGE THINGS?

At Pancreatic Cancer Action, we provide the world's first CPD-accredited healthcare professional e-learning modules for GPs and pharmacists.

These can be accessed by scanning here:



If you'd like to learn more about Pancreatic Cancer Action, our work or would like more healthcare information, email healthinfo@panact.org or call us on 0303 040 1770.

Signs & Symptoms of pancreatic cancer



Low mood or depression Continued feeling of sadness

Mid-back pain or discomfort

Upper abdominal pain or discomfort

Pain on eating or loss of appetite

Indigestion Not responding to medication

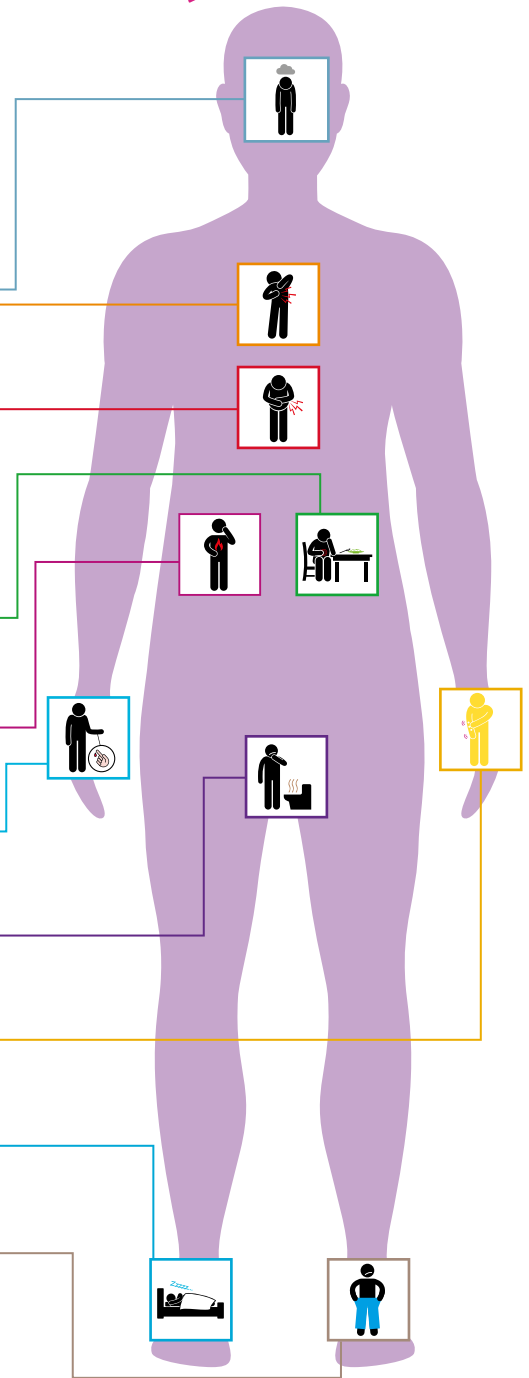
Diabetes New onset type 2

Pale and smelly stools That don't flush easily

Jaundice Yellowing of the skin and whites of the eyes, &/or very itchy skin

Fatigue Persistent feeling of tiredness or exhaustion

Unexplained weight loss Without trying



DO NOT IGNORE THEM!

If you persistently experience one or more of these symptoms which are not normal for you, **contact your GP straight away** or call the **NHS 111 Service**

Saving lives through early diagnosis

Common Misdiagnosis

- Gallstones
- Gastritis
- Irritable Bowel Syndrome
- Gastroenteritis
- Indigestion
- Liver disease
- Muscular pain and Diverticulitis



BODY DYSMORPHIC DISORDER

BENEATH THE SURFACE

It's reported that two per cent of the population have Body Dysmorphic Disorder, however, the condition is under-diagnosed due to resistance and shame in seeking help. The Body Dysmorphic Disorder Foundation help us grasp the 'hidden condition' better and how we can assist in relieving suffering for people with BDD by advancing research, treatments and awareness.

WHAT IS BODY DYSMORPHIC DISORDER?

Body Dysmorphic Disorder (BDD) is a mental health condition that causes individuals to develop a strong pre-occupation with a perceived flaw or defect in their appearance. The most common concerns are usually around facial features e.g. skin, hair, nose, eyes, chin, and teeth. However, any part of the body can become a focus of concern.

Usually, the 'flaw' is very minor or non-existent, however, those suffering are plagued by intrusive and all-consuming thoughts about this flaw, how they view themselves, and how they feel they are perceived by other people. The intrusive thoughts become extremely debilitating and individuals commonly become housebound, unable to engage in day-to-day activities, relationships or work. The fear and shame of being seen becomes overwhelming and often those suffering become isolated, withdrawn and depressed. Sadly, the rate of suicide in BDD is high, with approximately 80 per cent of people with BDD experiencing suicidal thoughts, and about one-in-four attempting suicide.

HOW MIGHT YOU KNOW SOMEONE IS EXPERIENCING BDD?

People with BDD typically carry out a range of repetitive behaviours to try to cope with their appearance concerns e.g. try to camouflage their perceived flaw by covering it with clothing, excessive amounts of make-up, or using other parts of their body. They can also spend huge amounts of time examining their appearance in mirrors and other reflective surfaces (known as 'checking') or may avoid looking in mirrors as they find this too distressing. It is very common for people with BDD to also spend a lot of time carrying out grooming routines, such as applying make-up and cosmetic products. This is not about vanity; it's about trying to correct their perceived defects in an attempt to look 'normal'. Lots of people compare their appearance to others and seeking reassurance from friends and

family. Some people with BDD engage in behaviours that can be harmful when they are trying to improve their appearance e.g. picking spots or skin, which may cause scars and further anxiety.

Overall, you may notice someone has become withdrawn from social activities, spending a lot of time checking their appearance or researching how to change their appearance. They will present with sadness and low mood, anxiety, low self-esteem and feeling disgusted by themselves.

IS IT TREATABLE?

The good news is that BDD is treatable. The bad news is that lots of medical professionals are still not aware of the symptoms or treatment pathways. In reading this article, you are contributing towards raising awareness and improved understanding of BDD.

The evidence-based treatment for BDD is specialised Cognitive Behaviour Therapy (CBT) with exposure and response prevention and SSRI medication. Upon diagnosis, individuals will be offered one or both of these treatment pathways. Currently, there is a significant lack of resource in providing appropriate treatment through public health services. Where individuals have the resource to do so, they are often encouraged to access treatment privately. However, not everyone has the resource to access private treatment, leading their BDD to deteriorate and leaving them at significant risk of harm to themselves. BDD is considered a chronic condition, which rarely improves without treatment.

Unsurprisingly, many individuals with BDD seek cosmetic procedures. Since they are seeing themselves very differently to how they really look, changing themselves physically seems like the logical option. However, the majority of people with BDD who engage in cosmetic treatments report that their symptoms worsen, there is no difference, or the pre-occupation moves to a different body part. Engaging in cosmetic treatments or surgery can be extremely dangerous for someone with BDD, often leading to increased suicidal thoughts and attempts.

HOW CAN YOU HELP?

The key areas you can offer support are through education and funding. Share this article with your colleagues, educate others in knowing the symptoms and signpost anyone you are concerned about to the BDD Foundation to access suitable support and guidance in accessing treatment. Perhaps you could circulate a flyer or add it to a work notice board. Medical professionals need to be aware of this common and poorly-understood condition, and you can find some tailored resources at www.bddfoundation.org/support/supporting-someone-with-bdd/information-for-mental-health-professionals.

You can also support through funding or sponsorship. The BDD Foundation is a small charity with limited resource and funding. We offer those suffering and waiting on treatment an E-Helpline, online and in-person support groups, a 20-week group CBT therapy programme, information and guidance, and educational webinars. However, there is so much more we need to provide those suffering, which can be possible with your support. Donate or get in touch today if you'd like to support us in a longer-term capacity.

For more information, visit www.bddfoundation.org or email info@bddfoundation.org.

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A significant progress in the treatment of endometriosis, in a once daily tablet^{1,2}



Dienogest is a 4th generation selective progestin having anovulatory and anti-proliferative effect in endometrial cells, as well as anti-inflammatory and anti-angiogenic actions.⁵

- Reduces endometrioma volume by 75%⁶
- Preserves the ovarian reserve⁷
- As effective as GnRH agonists in relieving endometriosis-associated pain⁸
- Presents a favourable adverse events profile vs GnRH agonists⁸

Women treated with Zalkya[®] 2mg experienced hypoestrogenic symptoms less frequently than women treated with Leuprolide acetate.⁸

References

1. Vercellini et al., Fertility and Sterility Vol. 105, No. 3, March 2016.
2. Zalkya[®] Summary of Product Characteristics, September 2023.
3. Declaration Haupt Pharma Münster GmbH: 27092021, September 2021.
4. Declaration Haupt Pharma Münster GmbH: 0202202, February 2022.
5. Sasagawa S et al, Steroids 2008; 73: 222-231.
6. Angioni et al. Gynecological Endocrinology 2019.
7. Muzii et al., Gynecological Endocrinology 2019.
8. Strowitzki T. et al, Human Reproduction, Vol.25, No.3 pp. 633-641, 2010.

Prescribing information

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

Name and active ingredient: Zalkya[®] 2mg film-coated tablets. Each tablet contains 2mg dienogest. **Indications:** Treatment of endometriosis. **Posology and method of administration:** One tablet daily without any break, taken preferably at the same time each day with some liquid as needed. The tablet can be taken with or without food. Tablets must be taken continuously without regard to vaginal bleeding. When a pack is finished the next one should be started without interruption. Treatment can be started on any day of the menstrual cycle. Any hormonal contraception needs to be stopped prior to initiation of Zalkya[®]. If contraception is required, non-hormonal methods of contraception should be used (e.g. barrier method), (see SmPC section 4.2). **Contraindications:** Zalkya[®] should not be used in the presence of any of the conditions listed and should any of the conditions appear during the use of Zalkya[®] treatment must be discontinued immediately: active venous thromboembolic disorder, arterial and cardiovascular disease, past or present (e.g. myocardial infarction, cerebrovascular accident, ischemic heart disease), diabetes mellitus with vascular involvement, presence or history of severe hepatic disease as long as liver function values have not returned to normal, presence or history of liver tumours (benign or malignant), known or suspected sex hormone-dependent malignancies, undiagnosed vaginal bleeding or hypersensitivity to the active substance or to any of the excipients listed (see section 6.1 of the SmPC). **Special warnings and precautions for use:** Precautions should be taken regarding serious uterine bleeding: If bleeding is heavy and continuous over time, this may lead to anemia (severe in some cases). In the event of anemia, discontinuation of Zalkya[®] should be considered. Changes in bleeding pattern; (see SmPC section 4.8). Circulatory disorders: Treatment should be stopped at once if there are symptoms of an arterial or venous thrombotic event or suspicion thereof, tumours: The risk of having breast cancer diagnosed in users of progestogen-only preparations is possibly of similar magnitude to that associated with combined oral contraceptives (COC). However, for progestogen-only preparations, the evidence is based on much smaller populations of users and so is less conclusive than that for COCs. These studies do not provide evidence for causation, osteoporosis: In patients who are at an increased risk of osteoporosis a careful risk-benefit assessment should be performed before starting Zalkya[®] because endogenous estrogen levels are moderately decreased during treatment with Zalkya[®] (see section 5.1). Other conditions (see SmPC section 4.4). **Interactions:** Inducers or inhibitors of CYP3A4 may affect

the progestogen drug metabolism. An increased clearance of sex hormones due to enzyme induction may reduce the therapeutic effect of Zalkya[®] and may result in undesirable effects e.g. changes in the uterine bleeding profile. A reduced clearance of sex hormones due to enzyme inhibition may increase the exposure to dienogest and may result in undesirable effects. Substances increasing the clearance of sex hormones (diminished efficacy by enzyme-induction), e.g.: phenytoin, barbiturates, primidone, carbamazepine, rifampicin, and possibly also ocarbazepine, topiramate, felbamate, griseofulvin, and products containing St. John's wort (Hypericum perforatum), (see SmPC section 4.5) **Fertility, pregnancy and lactation:** Zalkya[®] must not be administered to pregnant women because there is no need to treat endometriosis during pregnancy. Treatment with Zalkya[®] during lactation is not recommended. Based on the available data, ovulation is inhibited in the majority of patients during treatment with Zalkya[®]. However, Zalkya[®] is not a contraceptive. Based on the available data, the menstrual cycle returns to normal within 2 months after cessation of Zalkya[®] treatment. (see SmPC section 4.6) **Adverse reactions:** Undesirable effects are more common during the first months after the start of treatment with Zalkya[®] and subside with continued treatment. The most commonly reported adverse reactions of Zalkya[®] are ($\geq 1/100$ to $< 1/10$): weight increase, depressed mood, sleep disorder, nervousness, loss of libido, altered mood, headache, migraine, nausea, abdominal pain, flatulence, abdominal distension, vomiting, acne, alopecia, back pain, breast discomfort, ovarian cyst, hot flashes, uterine / vaginal bleeding including spotting, asthenic conditions and irritability. Uncommon ($\geq 1/1000$ to $< 1/100$): anemia, weight decrease, increased appetite, anxiety, depression, mood swings, autonomic nervous system imbalance, disturbance in attention, dry eye, tinnitus, unspecific circulatory system disorder palpitations, hypotension, dyspnoea, diarrhoea, constipation, abdominal discomfort, gastrointestinal inflammation, gingivitis, dry skin, hyperhidrosis, pruritus, hirsutism, onychoclasia, dandruff, dermatitis, abnormal hair growth, photosensitivity reaction pigmentation disorder, bone pain, muscle spasms, pain in extremity, heaviness in extremities, urinary tract infection, vaginal candidiasis, vulvovaginal dryness, genital discharge, pelvic pain, atrophic vulvovaginitis, breast mass, fibrocystic breast disease, breast induration, Oedema. **Presentation:** 2 x 14 white film-coated tablets packed in PVC (250 µm) - Aluminium (20 µm) push-through-blister. **Pack Size:** 28 film-coated tablets. **NHS Cost:** £20.50. **Legal Classification:** POM. **MA Number:** PL 21844/0037. Distributed by Kent Pharma UK Ltd. **Date of preparation:** February 2024. UK21/007/02 SmPC Sept 2023.

Adverse events should be reported: Reporting forms and information can be found at: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to Kent Pharma UK Ltd on 01233 506574 or medical@kent-athlone.com. For a copy of the SmPC or further medical information, please contact: medical@kent-athlone.com. Additional information available on request.

For further information on this product, please contact your Kent Pharma Hospital Key Account Manager or our customer service team.



Kent Pharma UK Ltd | 2nd Floor | Connect 38 | 1 Dover Place | Ashford | Kent | TN23 1FB
Tel 0845 437 5565 | Email: customer.service@kent-athlone.com
www.kentpharma.co.uk