

How swimming can benefit physical and mental health

What are the latest developments in hay fever?

Raising allergy awareness

Reviewing and refreshing the role of GPNs in Scotland

How to implement supported self-management in wound care

Barriers women face when accessing cervical screening

Tick-borne encephalitis: advising travellers

Proactive PSA testing in high-risk men

Children and young people's mental health

Do GPNs hold the key to unlocking
the problem of severe
asthma?

Importance of trained
paediatric clinicians
in primary care



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STEP-DOWN APPROACH



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PREVENT/RESTORE	PROTECT	PROTECT/REPAIR	REPAIR
	MILD* SKIN DAMAGE	MODERATE* SKIN DAMAGE	SEVERE* SKIN DAMAGE
Skin care for patients with incontinence - Use a suitable cleanser - Pat skin dry - Apply appropriate barrier product to protect skin from moisture, irritants and further damage, enabling restoration of the skin barrier - Complete Data/Incident report	Erythema of skin only Dry and intact but irritated and at risk of breakdown! Apply barrier cream every 3rd wash/twice a day OR Apply barrier film once a day	Moderate Erythema Less than 50% damaged skin Oozing and/or bleeding may be present Apply barrier film once a day	Large area of Erythema More than 50% damaged skin Oozing and/or bleeding may be present REFER TO TYN, CONTINUENCE NURSE OR GP



References:
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Managing director

Alec O'Dare

alec@woundcarepeople.com

Editor-in-chief

Jaqui Walker, general practice nurse/
advanced nurse practitioner,
Stirling, Scotland

Editor/publisher

Binkie Mais

binkie@jcn.co.uk

Events and business manager

Georgina Holder

georgina@jcn.co.uk

07946 421654

© Wound Care People Limited 2025
Unit G, Wixford Park, George's Elm Lane,
Bidford on Avon, Alcester B50 4JS

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t: +44(0) 1789 582000

e: binkie@jcn.co.uk

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General practice nursing: a force to be recognised



Past editorials, both my own and others I have read, reflect on the joys of spring; the warmer weather and the beauty of gardens in full bloom. This year we have all of this, and I am enjoying the weather and taking time to value and appreciate nature each day. I find this form of mindfulness helpful for my overall wellbeing within a busy day-to-day routine. However, I am also aware that this time of year doesn't bring joy for all. In particular, those with hay fever can really struggle with the kind of weather and subsequent hay fever levels we have experienced this year. Where I live, the goat willow seeds are blowing everywhere — beautiful to look at but potentially sensitising for those prone to hay fever.

I found it interesting in our 'Practice matters' article to read further about the impact of hay fever on individuals and understand more about its management, including the link between allergic rhinitis and asthma and taking a united approach to this including, where appropriate, the use of immune therapies. There is also an excellent article from Julie Lennon on severe asthma, which further explains the role of immune therapy and how to identify those who may benefit.

Kathy Kenmuir, professional
nurse advisor for primary care at the

Scottish Government, has shared her experience of working within a wide team of stakeholders to refresh Transforming Roles paper 6 — the role of the general practice nurse.

I am delighted to see the work we do, the value we bring and the potential for growth within our role to help better meet the needs of our local populations articulated clearly in this publication. My journey from trainee GPN, to skilled GPN, to trainee ANP to advanced GPN has taken many twists and turns while I tried to work out what my day-to-day work should involve. I do feel this document represents what I have to offer in terms of a holistic advanced level clinical role to manage long-term conditions, help people enhance their health and further develop my scope of practice within women's health. Alongside this, I enjoy teaching, quality improvement and I hope within each of my roles provide leadership to further enhance the service we provide. I plan to share Kathy's article within my clinical setting to ensure our role is fully understood and given the environment needed to blossom further. I would like to thank everyone who has contributed to the development of Transforming roles — it makes me proud to be a general practice nurse and to appreciate and feel at home with my identity as an advanced practitioner within this role.

Please write in with your experiences of the changes within general practice nursing and how we can describe and document our vital role at all levels of practice and within different settings across the UK.

Jaqui Walker, editor-in-chief

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Jaqui Walker, general practice nurse/
advanced nurse practitioner, Stirling

Jennifer Aston, primary care educator
and ACP ambassador, Cambridge and
Peterborough Training Hub; Royal
College of General Practitioners
AHP/nurse representative

Susan Brown, advanced nurse practitioner/
general practice nurse, Alba Medical Group,
Bannockburn Health Centre

Matthew Cain, senior lecturer in adult
nursing and MSc nursing course leader,
University of Huddersfield; primary care
educator, NHS England; Queen's Nurse

Edwin Chamanga, head of nursing, tissue
viability and fundamentals of care, Epsom
and St Helier University Hospitals NHS Trust

Cheryl Crawford, practice sister, South
Beach Medical Practice, Ardrossan

Jude Harford, paediatric nurse practitioner,
Adam Practice, Poole, Dorset

Steve Holmes, general practitioner partner,
The Park Medical Practice, Shepton Mallet,
Somerset; clinical respiratory lead, NHS
England and Improvement South West

Leanne Hume, lead nurse for independent
health and social care, Royal College of
Nursing; Queen's Nurse

Julie Lennon, Queen's Nurse; ANP/GPN;
NES education supervisor/adviser,
Aultbea and Gairloch Medical Practice

Joanne Loades, independent nurse
consultant in cardiovascular disease, Norwich

Caroline McIntyre, primary care
pharmacist, Forth Valley Royal Hospital,
Larbert

Callum Metcalfe-O'Shea, UK professional
lead for long-term conditions, Royal College
of Nursing (RCN)

Rebecca Penzer, dermatology specialist nurse,
honorary lecturer, University of Hertfordshire

Michelle Phillips, senior nurse manager —
North and Nottingham, Operose Health

June Roberts, consultant nurse, assistant
director of nursing, Salford Royal NHS
Foundation Trust

Michelle Treasure, independent nurse
educator, Dragon Respiratory; respiratory
nurse specialist, Asthma+Lung UK



I'm really excited to be part of the editorial board and be an integral part of helping GPNs to develop and share innovative practice and drive the profession forward. With unprecedented pressures on our service, it is fantastic to be involved with an easily accessible journal that addresses the many services that we deliver, and shares best practice so that we can reach our goal of providing safe and effective care.

Jude Harford



I am honoured to join the editorial board, bringing with me extensive experience in general practice nursing, where I developed

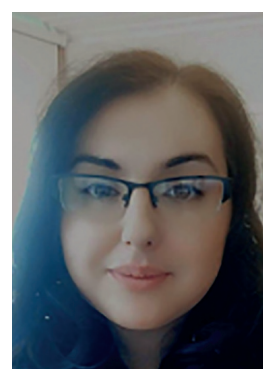
a strong commitment to long-term condition management and preventative healthcare. I believe general practice nursing teams play a crucial role in delivering high-quality, safety-critical care that not only improves patient outcomes, but also reduces hospital admissions. Throughout my career, I have had the privilege of leading multisite healthcare organisations, with a particular focus on training and developing nursing teams. Supporting the next generation of nursing professionals has always been a key priority in my work. In my recent role with the Royal College of Nursing, I have been closely involved in promoting innovative practices and knowledge sharing across the sector. I am excited to contribute to the editorial board's mission of providing vital, up-to-date educational resources that support the ongoing professional development of nursing staff.

Leanne Hume



I am thrilled to join the editorial board. I am passionate about improving quality of care across primary care. I enjoy acting as a change agent in general practice to improve patients' experiences and always strive to ensure that high quality, person-centred care is achieved. I am excited to be able to share ideas and discuss topics imperative to our role with like-minded healthcare professionals.

Cheryl Crawford



I am delighted to have been invited to represent the *Journal of General Practice Nursing* editorial board. It is a privilege to review

and contribute to the work of our incredible colleagues and authors. As a primary care pharmacist, I work closely and collaboratively with experienced general practice nurses (GPNs) and understand and appreciate the dedication, compassion and diverse skill mix GPNs bring to the multidisciplinary team. In these uncertain times, when the challenges and pressures faced in primary care and the health service as a whole are unprecedented, it has never been more imperative for us to keep up to date with current best practice and to be proactive in developing interprofessional relationships to support the delivery of high-quality patient care. I feel the journal is an excellent resource to promote evidence-based, person-centred care across the multidisciplinary team, and I look forward to supporting the up and coming content.

Caroline McIntyre



I am delighted to join the editorial board of the *Journal of General Practice Nursing* so that I can better

contribute to advancing the standards of care within healthcare services. With over 22 years of experience in clinical governance, quality assurance, and leadership, I am dedicated to improving patient outcomes and promoting collaboration across multidisciplinary teams. As a Queen's Nurse and a strong supporter of evidence-based practice, I am committed to facilitating discussions on best practices and sharing insights gained from my work at local and national levels. I see this opportunity to be part of the board as a chance to contribute to developing strategies that will empower healthcare professionals and enhance patient care.

Michelle Phillips



It is a privilege to be invited to join the editorial board. I have been nursing for 30 years and in general practice

for over 16 years. The change in general practice is nothing short of amazing. I am currently working in a dual ANP/GPN role which I am passionate about and proud of the way we can make a difference to our patients' lives. My love of chronic disease management pushed me into finding a dual role where I can utilise all my skills, sometimes in every consultation. I am also a keen supporter of new GPNs embarking on their careers, and this journal is a fantastic tool to learning. I love reading the articles and look forward to recapping, updating and broadening my knowledge in other areas.

Susan Brown



It is a real honour to be invited to the editorial board of such a prestigious nursing publication, especially when I have been using the *Journal of*

General Practice Nursing to guide my own clinical practice over the last decade. With a passion for education within primary care, I am very aware of the rapidly changing landscape of practice nursing, the role of the GPN as a 'gatekeeper' to the NHS and the increased workload that is expected of us on a daily basis. Education is fundamental to achieving a stronger, more informed nursing workforce who are better prepared to meet the diverse needs of the ever-changing population. Patient outcomes are improved when nurses are confident and able, readily employing their skills of critical thinking and using evidence-based principles of care. Education, of course, is key in achieving all of this. I am excited for the opportunity to contribute to such a valuable publication and I hope I will be able to bring some positive insights and facilitate the growth and development of the journal going forward.

Michelle Treasure



Having the opportunity to review and share knowledge around long-term conditions and primary care nursing is a great honour as part of the editorial board. The GPN

workforce is crucial to providing high standards of care across multimorbidity, and promoting best practice through the journal will only serve to enhance standards further. Primary care continues to shine as a diverse care sector that requires GPNs to be versatile, competent and confident in their daily practice, and this journal aims to inspire all GPNs to provide the best, evidence-based care possible.

Callum Metcalfe-O'Shea



It is an honour and such an exciting opportunity to have been invited to represent the *Journal of General Practice Nursing* editorial

board. As an academic, nurse and NMC registered nurse teacher, this opportunity will give me the chance to review contemporary research and share evidenced-based practice to deliver high quality patient-centred care, as well as raising the profile of practice and community nursing. I am so proud to be a nurse and Queen's Nurse and the impact that all of us in this profession have on patients' lives. I am a big advocate for working in primary care and promoting the career opportunities that are available to nurses and other healthcare professionals within the sector. This journal is a great platform for collaborating with like-minded healthcare professionals working in primary care and I look forward to representing the journal as a board member.

Matthew Cain



My passion for education has given me such an amazing general practice nursing career. To be invited

to become a member of the editorial board for the *Journal of General Practice Nursing* provides the opportunity to contribute to a journal with high standards and vision. Education is what drives good clinical practice; the characteristic adaptability and resilience demonstrated by staff is founded on sound principles. It is a privilege to be part of the editorial board, contributing to the strategic commitment of enabling access to educational material, which is contemporary, relevant and valued.

Julie Lennon

In each issue we investigate a topic affecting you and your practice. Here, we ask...

What are the latest developments in hay fever?

Like an annoying party guest who turns up before you've had a chance to crack open the wine and choose a suitable playlist, the hay fever season seems to be arriving earlier each year. But is this early onslaught of sneezing, coughs and runny noses a trick of our collective imaginations, an effect of climate change, or simply a function of changing allergen patterns?

While not usually life-threatening, hay fever — or allergic rhinitis to give the condition its more official title — can be debilitating, with sufferers experiencing a range of issues from mild cold-like symptoms to congestion and sinus pressure. In extreme cases, it can lead to a life-threatening asthma attack or anaphylaxis, while for general practice nurses (GPNs) even milder symptoms can interfere with their ability to see patients and go about their daily work.

As we head out of a long dark UK winter and into spring, we take a look at the latest developments in hay fever and what the most up-to-date treatment options are.

A BAD YEAR

Hay fever affects up to 13 million people in the UK to varying degrees and is caused by an allergy to the pollen produced by trees, grass and weeds, with each having a different seasonal onset.

As we hit spring, the main culprit is tree pollen, with the tree-related hay fever season beginning roughly in March, although the pollen from some trees such as



It is great to see this condition highlighted as we move into the warmer months, as it can often be overlooked in its seriousness in terms of impact on quality of life for patients. It is a common condition in primary care that nurses will see, and discussions on conservative measures and what treatments are available are key to reducing symptom burden. GPNs particularly play an important part in having those first conversations, utilising knowledge on what is available over the counter for treatment, and also identifying times when further treatment may be required. Supporting patients at any stage of their condition will improve patient outcomes and understanding more specialist treatments, like immunotherapy, will further enhance the care patients receive.

Callum Metcalfe-O'Shea

UK professional lead for long-term conditions, Royal College of Nursing

“ Hay fever affects up to 13 million people in the UK to varying degrees and is caused by an allergy to the pollen produced by trees, grass and weeds, with each having a different seasonal onset.

alder and hazel can begin to affect sufferers as early as January. The tree season is followed by the grass pollen season, the most widespread of the hay fevers and running roughly from May to July. Then finally it is the turn of weed pollen, which runs from June to September. The severity and spread

of hay fever can be affected by various atmospheric conditions, for example wind can spread pollen over wide areas, whereas rain may suppress it. Similarly, major towns and cities are often less affected than rural areas ('When is hay fever season in the UK' — www.metoffice.gov.uk).

Unfortunately, this year, the tree pollen season is predicted to be particularly severe, with warmer temperatures and dry weather contributing to a perfect storm of allergens. Added to this, trees that produce pollen go through alternating years of higher and lower production, and according to researchers at the University of Worcester, 2025 is set to be a particularly severe year ('Already experiencing hay fever? Experts predict a severe season for allergy sufferers' — www.bbc.co.uk).

WHAT EXACTLY IS HAY FEVER?

Hay fever is an allergic condition caused by the tiny pollen grains resulting from the reproductive processes of trees, weeds and flowering plants. Pollen is transferred to plants of the same species by insects or the wind, but unfortunately these tiny particles also contain proteins, which many of us are allergic to. This commonly results in hay fever, but also allergic asthma and eczema ('Is hay fever season starting earlier in the UK, with the pollen count rising?' — UKHSA.blog.gov.uk).

Unfortunately, scientists have yet to come up with a cure for hay fever, and unlike the symptoms of a common cold, which usually lasts for one to two weeks, hay fever symptoms can last for months, and include ('Hay fever' — www.nhs.uk):

- Sneezing and coughing
- Blocked or running nose, or mucus in the back of the throat known as postnasal drip
- Itching affecting the eyes, throat, mouth, nose and ears
- Swollen skin under the eyes, known as 'allergic shiners'
- Loss of smell
- Sensitivity and pain affecting the head and forehead
- Headaches and extreme tiredness due to a lack of sleep.

IS HAY FEVER WORSENING DUE TO CLIMATE CHANGE?

There is some evidence that climate change is driving more severe outbreaks of hay fever, with a number of causes including some tree and grass pollen seasons beginning earlier, higher spring and summer temperatures, and increasing planting of trees and areas of woodland (ironically, often in an effort to combat the effects of carbon emissions).

Also, according to the UK Health Security Agency (UKHSA), climate change is driving changes in the potency of pollen, in some cases increasing the amount of allergy causing agent contained in each grain. Climate change is also



From what I've seen over the years, there's definitely been a noticeable shift in the hay fever season. It seems to be rolling in earlier, and patients are attending surgery with symptoms long before we'd usually expect them — sometimes as early as January with tree pollen, which catches many off guard. We're also seeing more people affected overall, and those who already suffer are often experiencing more intense or prolonged symptoms. Whether it's climate change, changes in local flora, or simply increased awareness leading to more diagnoses, there's certainly no shortage of sneezing and itchy eyes in clinic.

One thing that really stands out for me is just how disruptive hay fever can be to daily life — it's not just a bit of a sniffle. People often come in absolutely worn out from poor sleep due to nasal congestion, or struggling to focus at work because of constant itching and headaches. It can be particularly tough on those who also have asthma, where allergic rhinitis can act as a trigger.

For anyone with a respiratory condition such as asthma, it's especially important to make sure their annual review is up to date and they're taking their preventer medication as prescribed. We know that hay fever can worsen asthma symptoms, so staying on top of treatment is key. If symptoms do deteriorate or they start noticing wheeze, chest tightness or breathlessness, I advise them to get in touch with their GPN asthma nurse as soon as possible — NEVER just wait it out.

In terms of hay fever management, I try to offer a layered approach depending on symptom severity. For most people, regular use of a non-drowsy antihistamine alongside a corticosteroid nasal spray does the trick, but only if they're using them correctly and consistently — always check the technique! Nasal sprays especially need a bit of coaching; it's amazing how many patients don't realise they need to aim it away from the septum. I also recommend saline rinses for those who are really congested or suffering with post-nasal drip. For more severe cases, especially those whose quality of life is being significantly impacted year on year, don't be afraid to initiate a referral to specialist services.

Preventative advice plays a huge role too. I always talk to patients about checking the pollen forecast, showering, and changing after being outdoors, and using barrier balms around the nostrils. Sunglasses and staying indoors on high pollen days sound basic, but they really do help. It's about building a routine during the season, not just reacting when symptoms flare up. The trick is catching it early and sticking with treatment — a message I find myself repeating every spring!

Leanne Hume

Lead nurse for independent health and social care, Royal College of Nursing; Queen's Nurse



Hay fever or allergic rhinitis, to give it its correct name, can be a debilitating condition. It is a common condition affecting an estimated 25% of the UK population, with approximately £140 billion spent on remedies to treat it. It appears to vary in intensity from year to year with some people having less or no symptoms in different years and symptoms may completely or significantly reduce over time. However, for many people it is a nuisance which not only affects their ability to work but also their quality of life, preventing them from doing some of the things they would like to be doing during the spring and summer months when symptoms are worse.

Most people are able to self-manage the condition with 'over-the-counter' (OTC) preparations, but severe sufferers may need to have a greater understanding of specific triggers to their symptoms. Hay fever can also be associated with other allergic conditions such as asthma and skin conditions.

The NHS recommends OTC management for most people. There are a wide range of treatment options available at pharmacies, but these can be an expensive way of managing the condition, especially if people buy branded options. Simple, non-drowsy antihistamines can be helpful, although the mainstay of treatment is a steroid nasal spray started several weeks before symptoms are likely to start. Sodium cromoglicate eye drops can be the next step and patients may also need to step up to a prescribed antihistamine, such as fexofenadine. As pharmacies need to make a profit, the more expensive branded treatment may be promoted when generic options are usually just as effective. It is a matter of trial and error to find which preparations are most effective for each individual.

Self-care is the mainstay of treating hay fever for most patients, so it's important that individuals are able to identify what appears to trigger their symptoms and start treatment well in advance of when they know that those triggers are likely to appear. For example, being aware that early symptoms are usually triggered by tree pollens may be helpful in starting treatment early. High pollen counts or when grass cutting starts as well as seasonal or regional changes also need to be considered.

If nasal mucosa and eye irritation become severe it is quite hard to get back on top of symptoms, so starting treatment early with something such as a nasal spray can be beneficial. For many patients, it may seem that taking an oral antihistamine is a good solution, but it's often better to target treatment to those symptoms that cause the most problem, for example, nasal congestion or eye watering and itching.

Where symptoms are severe, there is a case for referral to an allergy clinic to identify specific triggers. Patients may be allergic to multiple triggers and also have other troubling symptoms, such as worsening eczema or asthma, associated with hay fever symptoms increasing. If patients' asthma symptoms worsen during the hay fever season, they may need to consult their asthma nurse and increase asthma inhalers to manage symptoms.

There is some hope for those suffering these severe symptoms as immunological treatments, such as 'Grazex', are now available via specialists. It is a long and expensive treatment but may suppress the symptoms to a far more tolerable level. In general practice, we can prescribe medication such as fexofenadine at reasonably high doses to manage those with more moderate hay fever symptoms. In really acute cases, particularly where an individual may be about to sit an important exam, it might be appropriate to administer a short course of oral steroids to suppress the really debilitating symptoms.

There are some simple things that can make quite a considerable difference to those suffering mild-to-moderate symptoms, i.e:

- *Checking the pollen count locally (www.metoffice.gov.uk)*
- *Closing windows at night, especially during hot weather and high pollen season*
- *Applying petroleum jelly around the entrance to the nose to trap the pollen particles that trigger symptoms*
- *Wearing glasses may also provide a barrier and deflect pollen*

- Wearing a mask can also reduce the amount of pollen which is inhaled
- Saline douching may help wash out some of the pollen
- Start using a generic nasal corticosteroid several weeks before the known trigger is predicted
- Add in sodium cromoglycate eye drops if there are eye symptoms
- Add in an oral antihistamine such as cetirizine or loratadine.

Seek help for severe symptoms or if other conditions such as asthma or eczema flare up in association with hay fever.

Jenny Aston

Queen's Nurse; advanced nurse practitioner; ACP ambassador, Cambridge and Peterborough Training Hub

NHS Choices. Available online: www.nhs.uk/conditions/

driving a shift in the distribution of certain plants in the UK, with some highly allergenic species becoming more prevalent ('Is hay fever season starting earlier in the UK, with the pollen count rising?' — UKHSA.blog.gov.uk).

DEVELOPMENTS IN HAY FEVER TREATMENT

It's not all bad news for hay fever sufferers. There are a range of treatments that, while not

offering a cure as such, can ameliorate the symptoms.

First-line treatment options for people diagnosed with hay fever include a range of modalities including intranasal corticosteroids and antihistamines, and oral and nasal decongestants. Patients may also be advised to perform nasal saline irrigation, which can flush mucus and allergens from the nose ('Hay fever' — www.mayoclinic.org).

For those with severe disease, immunotherapy has traditionally been prescribed, with regular injections of pollen allergen used to 'reset' the patient's immune response over time, often years, in the hope of a cessation of their symptoms. Various types of pollen allergen can be used for people with allergies to different varieties.

However, more recently sublingual immunotherapy (SLIT) has been developed for use in patients with a severe allergy to grass pollen. SLIT comprises a tablet containing pollen extract that is designed to dissolve under the patient's tongue and modify their immune system over time so that they do not have such a strong reaction. According to the National Institute for Health and Care Excellence (NICE), immunotherapy is the only treatment that can modify disease progression, with remission even possible at the end of the treatment course ('Allergic rhinitis — scenario — management' — nice.org.uk).

There is also an ongoing study underway at the Royal Brompton and Harefield Hospitals in London into a drug called dupilumab, and whether when given alongside SLIT this drug will improve the immunotherapy's effectiveness and help to shorten the treatment period required ('Trust researchers begin hayfever study ahead of spring' — www.rbht.nhs.uk).

WHAT TO BE AWARE OF

As well as the more sophisticated



I have spent many years attempting to treat and manage patients who suffer with allergic rhinitis (AR), and I can tell you one thing — it is not as straightforward as it would seem! A large majority of patients I care for are asthmatic and it is now well understood that there is an inextricable link between AR and asthma; the clearest connection being the shared physiological response. In both asthma and AR, the body's immune system is reacting to an identified foreign substance; albeit harmless. This then triggers a cascade of inflammatory processes which result in some of the typical symptoms (cough, sneeze, itchy eyes and nose) we see in patients in primary care.

The relationship between asthma and AR is not always identified by healthcare professionals, who may continue to view and treat the conditions separately; perhaps not even recognising the effects they have on one another. In 1997, Grossman used the term 'one airway, one disease' to suggest that we should consider a shift in perspective and begin to view these diseases not as distinct and separate, but rather as a continuum of the inflammation within the same airway. Despite this, we know that AR currently remains under-recognised and poorly managed, with detrimental effects on a patient's physical, psychological and social wellbeing (www.pcrs-uk.org/sites/default/files/One%20Airway%20PROOF1%20300322.pdf).

Asthma and AR co-exist in a considerable number of patients (Allergy UK), and it is essential when treating these conditions, that we consider the 'whole airway.' Asthmatic patients with AR often present with poorer control due to a greater amount of inflammation in the airway. Naturally, this places them at a higher risk of having an asthma exacerbation. A recent survey conducted by Asthma & Lung UK reports that one in three people said that pollen triggers their lung condition symptoms.

From my own experience, I have seen asthmatic patients who have presented in a 'revolving-door' like fashion into general practice, with worsening respiratory symptoms, only to be told simply to 'increase their inhaler'. While this is often effective in managing asthmatic symptoms, it does not address underlying AR which should involve an individualised approach to treatment, frequently including a combination of nasal sprays, oral therapy, and optical treatments.

One final thing to consider in all of this is, 'do patients actually do as we advise?' For example, the advice around starting antihistamines and other AR treatments recommends that they should start at least two weeks before the onset of the pollen season and with continued daily use. Likewise, if we are advocating nasal sprays for our patients, have we demonstrated or taught how to use them? It may seem simple, but I can assure you that I have seen many errors over the years concerning incorrect use of nasal sprays by both patients and healthcare professionals, some of which would make your 'eyes water'!

Michelle Treasure

Independent nurse educator (Dragon Respiratory); respiratory nurse specialist, Asthma + Lung UK

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treatments for hay fever, there is some simple advice that GPNs can provide for patients to avoid the worse symptoms of hay fever, or at least ameliorate the effects. These include ('Hay fever and allergic rhinitis' — www.allergyuk.org):

- Monitoring pollen forecasts each day to check when the pollen count will be

particularly high, often on dryer warmer days. On these days, patients can be advised to remain indoors as much as possible

- On days when there is a high pollen count, patients should be advised to shower and wash their hair when they have been outside, as well as changing

their clothes. Washing should also not be dried outside during a high pollen count

- Patients can also be advised to apply petroleum jelly (such as Vaseline) or a non-medicinal allergen barrier balm to prevent pollen entering the nostrils.

The NHS also provides some



As we approach the summer months with longer days and warmer weather, not everyone welcomes the change — particularly those who suffer from severe hay fever and seasonal allergies. Like many allergies, hay fever can impact all aspects of life, including both physical and mental health.

For individuals who have never experienced hay fever before, the symptoms may initially resemble a head cold that does not improve, potentially leading to social isolation due to concerns about spreading illness. It's important to recognise the signs and symptoms of hay fever and seek appropriate support and guidance.

This is especially crucial for those with long-term respiratory conditions such as asthma. During hay fever season, common allergens can exacerbate existing symptoms and significantly increase the risk of severe asthma attacks, as there are often shared triggers.

That's why it's so important to take extra care during the summer months. Be kind to yourself by recognising the signs of hay fever early, finding gentle ways to ease your symptoms, and keeping any essential medications close by to help you manage ongoing health conditions safely.

Matthew Cain

Senior lecturer in adult nursing and MSc nursing course leader, University of Huddersfield; primary care educator, NHS England; Queen's Nurse

treatments available may mean that rather than viewing spring and summer as an ordeal, some of your patients may be able to venture outside and enjoy the warmer weather. Who knows, they may even thank you for it, which in the often-thankless day-to-day routine of practice nursing is not something to be sniffed at. **GPN**

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useful 'dos and don'ts' on how to prevent symptoms, including ('Hay fever' — www.nhs.uk):

- Do wear sunglasses or a mask to prevent pollen from entering the nasal passages and eyes
- Do keep windows and doors shut indoors
- Do vacuum regularly and dust surfaces with a damp cloth
- Do not mow lawns or keep fresh flowers in the house
- Do not smoke or visit smoke-filled environments — this can exacerbate symptoms
- Do not let pets indoors if possible because they can carry pollen.

Another important consideration for GPNs is to consider the link between allergic rhinitis and asthma because both conditions can co-exist and can exacerbate symptoms. For example, inflammation in the nasal

passages caused by hay fever can potentially spread to the patient's lower airways, exacerbating their asthma symptoms. This connection is known as united airway disease (UAD) and an integrated care plan that seeks to manage both conditions is important, with one recent review suggesting that treatment may include 'allergen-specific immunotherapies, biological therapies and home-based continuous positive airway pressure (CPAP)' ('Manifesto on united airways diseases' — www.tandfonline.com).

While hay fever might not be the most life-threatening or painful condition you might have to deal with in your consultations this spring, it can still present even mild sufferers with a range of unpleasant symptoms. Understanding the triggers of hay fever as well the range of

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Having the right knowledge at the right time can change the course of an allergy journey

Raising allergy awareness



Allergy UK launched a powerful campaign, 'I Wish I Knew...' in April, developed in response to rising allergy cases; with one in two people in Europe estimated to be living with an allergy by 2026 according to the European Academy of Allergy and Clinical Immunology.

The campaign, which will run for at least the next 12 months, kicked off by highlighting 'three things' that everyone — healthcare professionals, patients and the general public — should know about allergy:

- Allergies can develop at any age
- Allergies can exacerbate other health conditions, such as asthma
- Getting an allergy diagnosis is crucial — it's the key to accessing the right care and support.

Our aim is to ensure that anyone who may be affected by allergy one day can recognise symptoms early and seek support to control and manage their allergy. The right knowledge at the right time can change the course of an allergy journey.

As well as the impact of allergies themselves, research shows that they can make other health conditions worse. A recently released report shows how uncontrolled asthma is a risk factor for fatal anaphylaxis (National Child Mortality Database [NCMD], 2024), while 90% of patients with eczema have an

additional allergic condition (Allergy UK and Sanofi, 2021). Meanwhile, people with hay fever are four times more likely to suffer from other conditions driven by allergy, such as asthma and eczema (Natasha Allergy Research Foundation, no date).

Allergies can appear at any time — childhood, puberty, pregnancy or even later in life. This campaign is an important opportunity to raise awareness about the experiences of people living with allergies. It is vital that anyone who is newly experiencing allergy symptoms can recognise the red flags to seek support.

Nurses will know that early intervention can even change the course of an allergy and people should be empowered with the right information to enable them to take advantage of this.

An allergy diagnosis is key to managing symptoms, preventing severe reactions and complications and improving quality of life. It can open the door to appropriate treatment pathways plus information about how to live safely with an allergy. If new persistent symptoms appear or an existing condition worsens without a clear cause, allergy could be the missing piece of the puzzle.

We are fortunate that many people have shared their experience of allergy with us. Four years ago, Sacha Bell offered her two-year old son, Indigo, a Brazil nut to taste and then watched in horror as his face turned red and started to swell. Luckily, Sacha had an antihistamine at hand to give him, while shouting

for her mum and dad for help. She told us: 'We realised we needed to take him to hospital immediately. My dad drove us there — we called ahead and so the staff were waiting for us outside'.

Indigo was having an anaphylactic reaction, the severe allergic reaction which can be life-threatening and can occur within seconds of exposure to an allergen. Follow-up tests determined that Indigo is allergic to Brazil nuts, cashews, pistachios, pecans and walnuts and Sacha monitors his diet accordingly while also preparing for Indigo to be able to self-manage his condition with professional guidance as he gets older.

The 'I Wish I Knew...' campaign aims to explore a broad spectrum of allergic conditions, from food allergies and indoor allergies to hay fever and allergies in babies and has its own dedicated website, which patients might find useful: www.allergyuk.org/i-wish-i-knew/

The main Allergy UK website remains a font of information for healthcare professionals and people living with allergy: www.allergyuk.org/

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Amena Warner, head of clinical services, Allergy UK





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 Raising awareness and improving the lives of people with lower limb conditions

Legs matter: why GPNs hold the key to lower limb care

**LEGS
MATTER!**

Summer has arrived and many of us are daring to get our legs out! That prospect isn't an option for some people, however.

Across the UK, millions live with lower limb wounds and swelling that is preventable, and treatable — yet too often are given suboptimal care. These conditions can have a huge impact on a patient's quality of life (Franks et al, 2006; González-Consuegra and Verdu, 2011) and a significant burden on the NHS (Guest et al, 2020).

Some of you may have heard of Legs Matter. We are a coalition of charities and not-for-profit organisations, working under the governance of the Society of Tissue Viability. At the heart of this campaign lies a unique opportunity: empowering general practice nurses (GPNs) to become frontline champions of lower limb care.

WHY LEGS MATTER

The Legs Matter campaign highlights a stark reality, namely that too many people in the UK are suffering needlessly from leg and foot conditions that go unnoticed until they become severe or life-limiting. This is harm.



Lower limb conditions are often early warning signs of wider systemic issues, including diabetes, venous insufficiency, and peripheral arterial disease (PAD). Early diagnosis and intervention not only improve clinical outcomes, but also reduce long-term healthcare costs (Guest et al, 2020).

THE GPN ADVANTAGE

GPNs are perfectly placed to detect early signs of lower limb problems. Positioned in communities, often with long-standing relationships with patients, GPNs can assess subtle changes in skin condition, circulation, and mobility. Their role bridges the gap between acute care and prevention (Smyth, 2024).

Early intervention is key. Venous leg ulcers, for example, can take an average of 200 days to heal without appropriate compression, but when treated early, healing times can drop significantly (Ashby et al, 2014). Unfortunately, outdated wound care models often focus on dressing changes without addressing underlying pathology.

The Legs Matter campaign reframes lower limb care as essential, not optional. It encourages a structured, evidence-based approach to prevention and management.

Kate Williams, associate director of wound care, Accelerate CIC

MAKING EVERY CONTACT COUNT (MECC)

As the first point of contact for many patients, GPNs are ideally positioned to 'make every contact count' by integrating lower limb assessments into routine care (Ritchie, 2021). Whether during diabetes reviews, cardiovascular assessments, or long-term condition reviews, these opportunities are critical for early detection.

ADVOCACY AND CULTURAL CHANGE

Another goal of the Legs Matter campaign is tackling stigma. Some patients feel shame or resignation about leg and foot issues — believing them to be inevitable consequences of ageing or existing conditions.

GPNs can challenge this narrative. By initiating non-judgmental conversations and using accessible language ('leg MOTs', for example), they can normalise lower limb health and empower patients to seek support. This cultural shift is critical to improving health-seeking behaviours.

At a systems level, GPNs can also act as advocates — championing improved access to compression products, equitable wound care services, and public health campaigns. Their voice is needed at commissioning tables and clinical governance forums alike.

AWARENESS WEEK 2025

10–14th June 2025 is Legs Matter Awareness Week. This annual event is a glorious celebration of colour and high-quality lower limb care.

**SAY IT.
SHARE IT.
CHANGE IT**

**Your voice
could
change
everything**

**LEGSMATTERWEEK
09 – 13 JUNE**



Engagement from nurses across the country is amazing, with events ranging from wearing colourful socks to work, baking cakes, bunting, posters, and even one team who dressed up in inflatable flamingo outfits to raise awareness across their hospital!

So, what can you do for awareness week?

- If you haven't already, check out our website www.legsmatter.org there is so much information for you and your patients
- Become a Legs Matter Champion (new for 2025)
- Practical things, such as a link to the Legs Matter website on your practice website
- Posters in the waiting room (available free from www.legsmatter.org)
- Upskill so that you are confident in early recognition and treatment of lower limb wounds and swelling
- Know when to refer on
- Escalate gaps in service provision — you may not

be able to fill the gaps, but nurses have a responsibility to highlight where the system leads to suboptimal care.

THE ROAD AHEAD: A CALL TO ACTION

Despite the fun of awareness week, there is a serious message behind the cake sales and whacky socks. The UK faces growing demand on community health services. With an ageing population and increasing multimorbidity, proactive lower limb care is not optional, it's essential.

GPNs are more than capable of meeting this challenge. Their clinical acumen, community positioning, and holistic patient relationships uniquely equip them to lead in early intervention.

Let us shift the narrative from wound management to preventative care. And let us ensure that no patient suffers needlessly when early help was possible. **GPN**

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 Acknowledging the significant role that GPNs play in healthcare

Reviewing and refreshing the role of GPNs in Scotland

Transforming Roles is a flagship programme of work in Scotland. It aims to provide strategic oversight, direction and governance to develop and transform nursing, midwifery and allied health professional (NMAHP) roles to meet the current and future needs of Scotland's health and care system. It also ensures that there is a nationally consistent, sustainable education and career pathway approach so that practitioners are appropriately prepared for new and enhanced roles. NHS Education Scotland (NES) provides strategic oversight and works in collaboration with key stakeholders to lead education development to support the Transforming Roles agenda.

General practice nursing in Scotland is not new to Transforming Roles and in 2018 had its first publication released to coincide and reflect the changes in health and social care policy (new 2018 GMS Contract). It was titled, *Transforming Roles (TR) paper 6: Developing the general practice nursing role in integrated community nursing teams*, and was built in partnership with the Scottish Government and Scotland's chief executive nurse directors.

Four years on it was acknowledged that the role of



“From engagement with GPNs at all levels, it was decided that any development needed to be done in partnership with nursing and their employers — to be contemporary, relevant to population health need and reflect the dynamic environments that all levels of GPNs worked in.

the general practice nurse (GPN) had expanded in scope, including managing more complex cases, long-term condition management, prescribing responsibilities, etc, alongside a greater recognition of their value to primary care. This learning was clear through engagement and workshops that were organised by the Scottish Government and NES and attended by almost 200 general practice nurses (GPNs). Honest reflections from GPNs provided a strong and clear narrative that a refreshed paper was needed. It was also learnt that GPN advanced practice needed greater clarity, as the growth of advanced nurse practitioners (ANPs) in primary care were often associated with acute and urgent care. From engagement with GPNs at all levels,

Kathy Kenmuir, professional nurse advisor for primary care, Primary Care Directorate, Scottish Government

it was decided that any development needed to be done in partnership with nursing and their employers — to be contemporary, relevant to population health need and reflect the dynamic environments that all levels of GPNs worked in.

A refreshed paper and its associated activity required commitment from multiple agencies and Scottish Government alongside NES GPN and NMAHP teams, national GPN leadership and wider. These coalesced forces created an oversight group. To provide clarity and structure, the work was organised under three themes:

- The WHY
- The WHAT
- The HOW

(Scottish Government, 2025a).

There were several critical pieces to this (*Figure 1*).

The critical piece to help GPNs understand their role lies in the 'How' section — 'How will GPNs deliver on their role'. A framework was built to support this based on the NMAHP framework — a core product from NES (2025). There are additional GPN competencies at levels 5, 6 and 7.

NES also created a series of short, informative videos featuring GPNs. These videos showcase each level of the framework, offering real life examples of GPN roles and responsibilities, skills, and key education undertaken.

To augment all of the above, it was imperative to make this work meaningful to employers and managers. Thus, a supplementary document was created for GPs and practice managers to help them understand what the paper meant to them, how they should implement

it and why practices need GPNs (Scottish Government, 2025b).

Throughout the build of the papers and associated documents, the narrative was kept alive using an 'open secret' position, i.e. publishing in the NES GPN journal, discussing at GPN leads meetings (including representatives from each health board) and beyond, with progress being clear at all levels.

The final papers were published in February 2025 and formally launched by the Cabinet Secretary for Health and Social Care (<https://staffnews.nhsforhvalley.com/cabinet-secretary-launches-new-practice-nurse-publications-at-carronbank/>). It was incredibly powerful and rewarding to have GPNs recognised and endorsed at ministerial level.

The next phase of the work requires consistent visibility and implementation. This is in its early stages and there is a willingness to do this well and learn from the first TR6 paper (Scottish Government, 2018). A series of webinars have been held as a first step into this space, but it is going to require much more. NES are working on a plan which will involve an implementation group leading the roll out and several headlines are appearing, such as:

- Facilitation support materials and how to use the framework
- Continuing to understand core and ongoing educational needs
- Integration with community nursing colleagues
- Flexible education to meet the needs of individual practices
- An agile response to national policy and population health requirements.

The GPN role has pivoted since its inception and it is without doubt that this role will continue to develop and diversify to meet the needs of the populations it serves. **GPN**

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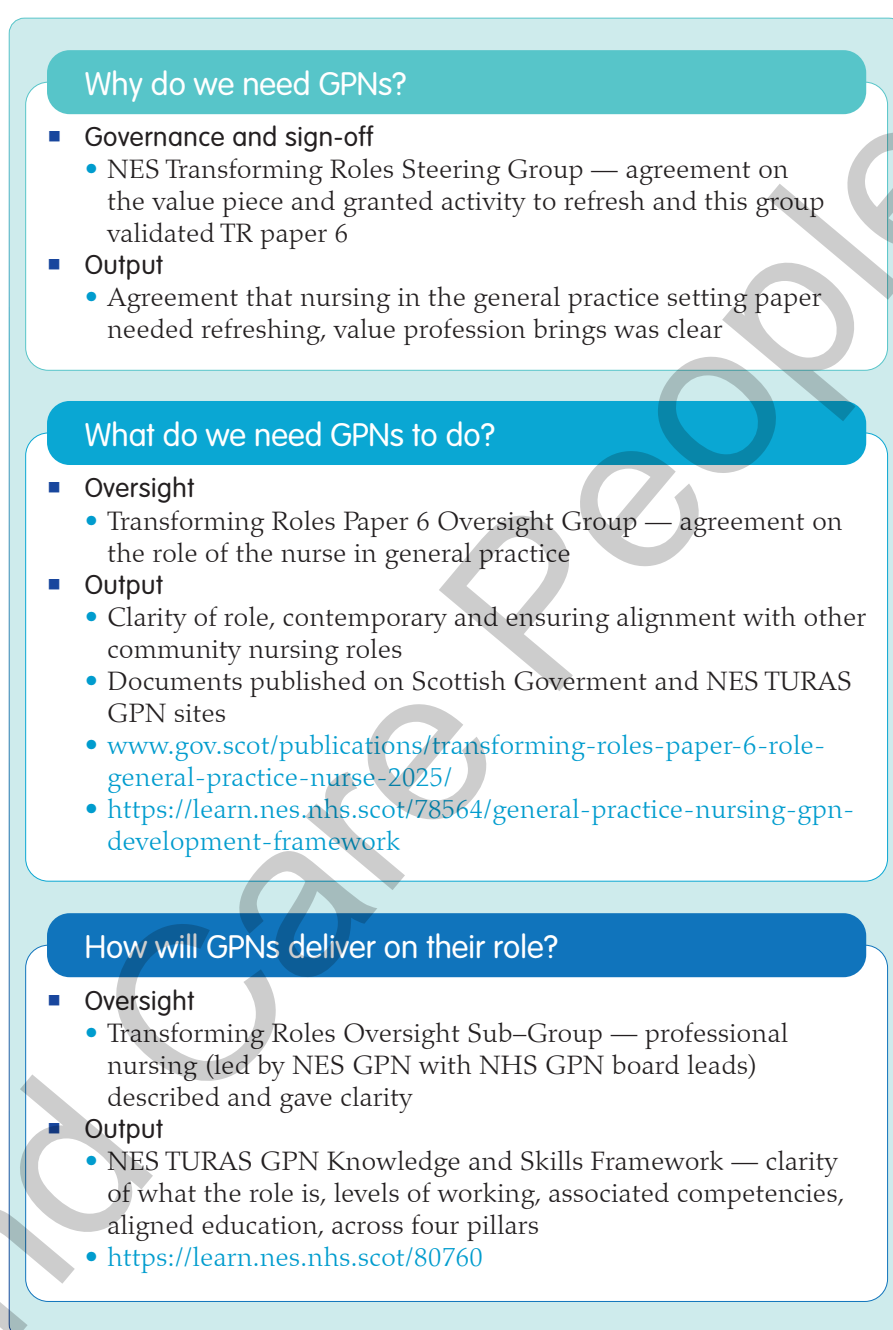


Figure 1.

Key themes underpinning the revised Transforming Roles paper for GPNs .

“The GPN role has pivoted since its inception and it is without doubt that this role will continue to develop and diversify to meet the needs of the populations it serves.

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Swimming, an inclusive and impactful form of exercise

How swimming can benefit physical and mental health



Here, Callum Metcalfe-O'Shea, UK professional lead for long-term conditions at the Royal College of Nursing (RCN), talks to Andrew Power, water wellbeing specialist at Swim England, the national governing body for swimming and aquatic sports in England, about the importance of swimming in providing physical and mental wellbeing benefits and highlighting the crucial role that GPNs play in supporting these conversations.

Swimming and aquatic activity offer significant benefits to both the physical and mental wellbeing of individuals across all age groups and levels of ability (Swim England, 2017). For those living with long-term conditions, the water provides a uniquely supportive environment to improve strength, mobility and confidence (Swim England, 2023).

General practice nurses (GPNs) are often the first point of contact for patients managing multiple long-term conditions, from diagnosis to death (Hamel et al, 2022). As such, GPNs build relationships with patients that place them in a key position to promote health-enhancing behaviours and support people to live longer, healthier lives (Hamel et al, 2022).

By signposting to community services, such as those offered through swimming pools and leisure centres, nurses can play a vital role in encouraging safe and accessible physical activity (Royal College of Nursing [RCN], 2024). Now, thanks to a nationwide commitment from hundreds of public swimming pools, there is an increased effort to remove barriers and promote more inclusive opportunities for health-promoting activity in the water through Swim England's work (Swim England, 2025).

This commitment is being driven by Swim England's (2024) 'Swimming as Medicine' campaign and their water wellbeing programme, which works with pool operators to make aquatic facilities more accessible, inclusive, and responsive to the needs of those with long-term health conditions.

Through this article, swimming as a health intervention is clearly an option available for GPNs to support patients with multiple conditions. Andrew Power answers some key questions to highlight the campaign and how GPNs can get involved.

Q Can you tell us more about the 'Swimming as Medicine' campaign and what inspired it?

A 'Swimming as Medicine' came following some external research commissioned in 2020 to investigate how we could best leverage healthcare professionals to engage in discussions around being more active, using swimming. GPs, physiotherapists and nurses emerged as strong influencers, but there was also a recognition that there are different constraints on professionals being able to either ask, suggest or equip their patients to be more active. The campaign was a way of increasing the salience of swimming in professionals' minds, encouraging discussions with patients, between professionals, and the national discussion around the importance of lifestyle in the prevention and management of people with long-term health conditions.

Q What kind of physical and mental health benefits can patients experience through regular swimming or aquatic activity?

A Our 'Health and Wellbeing Benefits of Swimming report' in 2017, combined not only the evidence from a series of systematic reviews examining the physical health,

wellbeing and physiological benefits of swimming, but also the benefits to communities and public health from the sport as well as detailing the economic case for swimming's health and wellbeing benefits. Some headlines from this included:

- Swimmers' reduced mortality rate, even compared with other active populations
- The impact of swimming on musculoskeletal (MSK) health, with strong evidence on the positive impact on chronic pain, hip and knee osteoarthritis.

Mental wellbeing was also strong and something further emphasised in a YouGov poll commissioned by Swim England (Swim England, 2018), which identified reduced symptoms of anxiety or depression in adults who swim, including 492,000 people reporting reduced GP visits and 490,000 reducing or no longer needing to take medication for their condition as a result of swimming.

It was clear from our research that water is unique and the properties of buoyancy, viscosity, thermodynamics and hydrostatic pressure each having unique value in supporting people in a positive way who might normally find it difficult to be active. In our experience, it is very hard to identify a person or population who wouldn't benefit from swimming or just simply moving more in water.

Q How does the water wellbeing programme support people living with long-term conditions?

A Our water wellbeing programme was developed in 2018 following years of research and insight and is a framework for pool operators to follow, to develop more accessible, more inclusive and more welcoming facilities, pathways and opportunities. We have developed a range of resources, training opportunities and models of delivery to inform the operation of pools and ensure that they are better aligned to serve the needs of local populations, particularly those with the greatest barriers to access. With this comes an accreditation process as a mark of quality assurance, denoting the highest standards of care and support. There are currently 204 public pools following this framework which are accredited, with an expectation that we will reach 400 pools by the end of 2026. This means that there are now tens of thousands of hours of personalised support, particularly for people with long-term health conditions, in pools up and down the country.

Q What are some of the common barriers patients face when accessing swimming opportunities, and how is Swim England working to reduce these?

A The 'England Swims' research (2022) was our largest piece of diversity research ever conducted and closely examined the barriers to swimming in non-swimmers with different ethnic backgrounds, faith groups and also people with long-term health conditions. It was clear that people with long-term health conditions had the greatest number of barriers to swimming. But the barriers are wide-ranging and different for everyone. For some, cost or travel could be an issue, while for others, body-consciousness or cultural barriers could prevent them from swimming. In other cases, the barriers could be physical capability, fear or anxiety. Not everyone can swim and Swim England are working hard to ensure as many children as possible get the opportunity to learn what is an important life-skill, and also one that can support health and longevity throughout the life-course. We also recognise though, that individuals can enjoy the benefits of being in water in



Photograph: Africa/Shutterstock

other ways, without necessarily having to swim, or be a strong swimmer. This is something our water wellbeing framework focuses on, providing opportunities for everyone to be active in a way that suits them, whether that be group exercise in water, walking or simply floating!

Q Why is it important for general practice nurses to be aware of these resources and programmes?

A This is a really important question. As a population, most of us do not manage to build enough activity into our lives and so much gets in the way of this. But, the fact remains that we do need to find ways to overcome our barriers. In general practice, there are numerous opportunities both to encourage and help people navigate around their personal barriers. Often barriers are perceptions, which can be easily overcome, but the solutions are not always known. For example, getting in and out of a swimming pool if you are frail or have poor mobility might be too much of a challenge even to try, but many pools these days have hoist or lift systems in place that can make entering and exiting the pool a more comfortable experience. Being armed with this knowledge and solutions to other barriers, might enable a change in someone's lifestyle that could be transformative and empower them to take control of their health and wellbeing, and in a way that is palatable to them.

Q Are there any specific conditions or patient groups where swimming might be particularly beneficial?

A I mentioned the evidence around MSK and chronic pain earlier, but they are not the only population who struggle with mobility and discomfort during activity. People who struggle to be active because of excess weight can benefit significantly from being in water. Depending on the depth, the buoyancy of water means that a proportion of the body's weight is taken by the water (up to 80% when submerged up to chest level). This is why we can float in water, but also why movement can feel almost effortless, thus making it easier to be active.

Q How can nurses start a conversation with a patient about engaging in aquatic activity, especially if they are hesitant or unsure?

A I guess in general practice the starting point needs to be about physical activity generally, what does a person like to do, followed by what they feel capable of doing. Opportunities like dancing, walking, running or cycling are all good and if they feel positive about any of these options, that is great. But, particularly for those who feel they cannot be active, especially if the barriers to starting are mobility or pain, low function, poor fitness, or anxiety —

swimming or any kind of movement in water could be the solution. Our 'England Swims' research also identified that one in three people with a long-term health condition would prefer to swim, if that option was suggested. This links to the supportive nature of water which seems to be intuitive. Again, in the same research, people with long-term health conditions felt more capable of being active in water than on land. So, be ready to talk about physical activity with patients, but include swimming or aquatic activity in all its forms in conversations too.

Q Is there a way for nursing teams to find out what pools or programmes are available in their local area?

A Swim England manage the PoolFinder system (see: swimming.org/poolfinder), which holds details on over 3,600 pools in England, Scotland and Wales. This allows anyone to search for their local pool, by postcode or location name, and also allows you to filter the search for pools that have specific accessibility options, types of pool and what activities are offered such as learn to swim options, family swims, aquatic fitness, or maybe gender-specific sessions. Our water wellbeing accredited pools can also be identified using PoolFinder, thus allowing professionals or patients to identify a pool suited to their needs.

Q Can you share any examples or success stories from patients who have benefitted from the programme?

A There are many, but if I could focus on some of the 'stars' of our 'Swimming as Medicine' campaign. Darren from Leamington Spa, featured in the first campaign video. Having had some serious challenges, including weeks spent in hospital in an induced coma with Covid-19, he decided that he wanted to do something to improve his health and noticed his local practice held a supported weekly run. He struggled to even walk, which was picked up by his GP who walked and

talked with him, with both coming to the conclusion that swimming might be a better option for him. Now a regular swimmer, swimming has brought him back to good health and helped him lose stones in weight.

In our third campaign with the RCN, Dawn from Shropshire developed arthritis in her hips and neck, making her life more narrow, losing her mobility and becoming depressed as a result. She decided to join an aqua fitness class at her local pool and from that point everything changed. She describes water as 'magic' — something that plenty of others share the same view on, with many more stories up and down the country of the transformative effects of water-based activity.

Q What resources are available for healthcare professionals who want to learn more or start referring/signposting patients?

A We developed an 'Aquatic Activity and Swimming for Health' eLearn with NHS England, the Aquatic Therapy Association of Chartered Physiotherapists and University of Nottingham, as an introduction to understanding the benefits, recognising any special considerations that might be needed, and identifying resources to safely and confidently signpost people to aquatic activity opportunities. This free eLearn located on the NHS Learning Hub takes about 30 minutes to complete.

We have also developed 14 fact sheets on swimming with health conditions, each focusing on an individual state of health, such as asthma, cancer, diabetes, MSK conditions and many more. The fact sheets help to break down some of the misconceptions that people might have about their ability to enjoy the benefits of being active in water, offering top tips and suggestions to get the most out of the experience.

Both are great resources and have been accessed by thousands of healthcare professionals already, with over 300,000 views by members of public on Swim England's 'Just Swim' website and nearly 30,000 downloads.



Footnote...

Depending on your location, the Swim England equivalent governing bodies Swim Ireland, Scottish Swimming and Swim Wales each have specific programmes and knowledge of nation-specific pool operators. Please get in touch directly. Respective website information is:

- <https://swimireland.ie/get-swimming/>
- www.scottishswimming.com/active-communities
- www.swimwales.org/health-and-wellbeing-hub/

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How to implement supported self-management in wound care

Wound care presents a substantial burden on the NHS, clinicians, and patients. Promoting supported self-management has emerged as a key strategy to empower patients in proactively managing their wounds. When implemented appropriately, it can improve treatment adherence, enhance patient wellbeing, reduce the need for clinical appointments, and lower healthcare costs. The Covid-19 pandemic accelerated this shift by limiting face-to-face care, highlighting the importance of equipping patients with the knowledge, skills, and confidence required for effective self-management. Clear terminology and standardised approaches are essential for enabling the successful implementation of patient self-care. Products such as Flaminal® (an enzyme alginogel®), with its simplicity and versatility, offers a practical solution that supports patient-led wound care while promoting sustainable healthcare delivery.

KEY WORDS:

- Wound care
- Supported self-management
- Patient autonomy
- Patient-centred care
- Decision-making

Luxmi Dhoonmoon

Nurse consultant tissue viability, London North West University Healthcare NHS Trust



Recent estimates suggest that approximately 3.8 million individuals in the UK are currently living with wounds, generating an annual cost of £8.3 billion to the healthcare system (Guest et al, 2020). This figure is projected to rise substantially over the coming years, driven by an ageing population with increasingly complex comorbidities (Guest et al, 2020). Beyond the economic impact, the personal burden of living with a non-healing wound significantly affects patients' physical, social, and psychological wellbeing (Blackburn et al, 2021).

Most wound care takes place within the community setting (Guest et al, 2020), and with the decline in the number of community nurses over the last 10 years (Queen's Nursing Institute [QNI], 2019) the challenge to provide care for patients with wounds will become worse with the demand outstripping current resource. This mismatch between demand and available

“... successful implementation of supported self-management relies on patients possessing the necessary knowledge, skills, and confidence to manage their health and long-term conditions effectively.

resources has placed considerable pressure on NHS services. In response, NHS England and NHS Improvement (no date), the All-Party Parliamentary Group on Vascular and Venous Disease (VVAPPG, 2023), and the National Wound Care Strategy Programme (NWCSP, 2023) have proposed the need for a more sustainable model of service delivery — one that reduces the burden on healthcare services, improves clinical outcomes, and addresses variations in care quality.

One such proposal is the promotion and implementation of a supported self-management model. This approach encourages patients to take greater ownership of their wound care, fostering proactive rather than reactive management (VVAPPG, 2023). Supported self-management is anticipated to yield numerous benefits, including:

- Improved adherence to treatment plans
 - Enhanced patient awareness of their condition
 - Better overall wellbeing and physical health
 - Reduced time and costs associated with frequent healthcare appointments
- (NHS England and NHS Improvement, no date; Kapp and Santamaria, 2020).

Economic benefits are also expected at the organisational level across NHS services (NHS England and NHS Improvement, no date; VVAPPG, 2023).

However, successful implementation of supported self-management relies on patients possessing the necessary knowledge, skills, and confidence to manage their health and long-term conditions effectively. There is also a recognised need for consistency in the language used to describe these approaches. Terms such as ‘supported self-management’, ‘self-care’ and ‘shared care’ are often used interchangeably, yet they may imply different levels of patient involvement depending on the context and the clinician’s approach (NHS England and NHS Improvement, no date; Blackburn et al, 2021; Saghdaoui et al, 2023).

This confusion in terminology can lead to both clinicians and patients being unclear of their roles and responsibilities and can hinder adherence to the management plan and reduce the likelihood of its successful implementation (Blackburn et al, 2021). However, when implemented appropriately, supported self-management can offer significant benefits for individuals, which may include:

- Greater flexibility in treatment, such as reducing the need to wait for appointments or nurse visits and enabling individuals to manage daily activities, such as showering when it is convenient for them (Kapp and Santamaria, 2020)
- Reduction in pain and a positive impact on quality of life and wellbeing (Kapp and Santamaria, 2020)
- Patients having a deeper understanding of their condition and a sense of control, which can positively influence physical, mental, and social wellbeing (Blackburn et al, 2021).

This article explores the concept of supported self-management and examines effective strategies for its implementation to enhance patient autonomy and improve outcomes for patients, clinicians, and NHS organisations. It also presents a case series undertaken by the author, which illustrates how supported self-management and an easy to use enzyme alginogel primary dressing

Table 1: Principles of supported self-management (adapted from NHS England and NHS Improvement, no date; Wounds International, 2016)

■ Puts the individual at the centre of their care
■ It recognises what matters most to them, considering their life as a whole, including relationships, personal interests and everyday challenges
■ People are treated as equal partners in discussions and decisions about their health and wellbeing, with their experiences and knowledge of their own lives respected
■ People are encouraged to set their own goals and are given help to create realistic plans by breaking these goals into smaller, manageable steps
■ Support is tailored to the patient’s personal aims, rather than being based on what others think they should achieve. The approach focuses on building their skills, confidence and motivation to take control of their own health
■ People are offered the tools and guidance needed to improve physical health and manage symptoms

enabled patients with a variety of complex wounds to be discharged from an acute care setting into community-based care.

WHAT IS SUPPORTED SELF-MANAGEMENT?

Self-management is increasingly recognised as a key component in the effective management of chronic conditions such as diabetes and chronic obstructive pulmonary disease (COPD) (Saghdaoui et al, 2023). The Covid-19 pandemic further accelerated the move toward self-management, as public health measures such as social distancing, isolation, and reduced face-to-face appointments required patients and carers to take a more active role in managing their health (Saghdaoui et al, 2023). This was particularly evident in wound care where reduced access to healthcare professionals, including tissue viability nurses, general practitioners, general practice nurses, and community nurses, shifted more responsibility to individuals (Brown, 2020).

Supported self-management enables people to make informed and conscious choices about their health. It involves developing the knowledge, skills, and confidence necessary to actively participate in their care (NHS England and NHS Improvement, no date). However as mentioned, various terms are used interchangeably, such as self-care, self-management, and supported self-management — each with subtle but important differences between them.

Self-care is typically broad and self-initiated, often involving individuals, families, or caregivers in managing health-related behaviours. It may or may not include support from healthcare professionals and covers general aspects of health maintenance and minor condition management (Saghdaoui et al, 2023).

Supported self-management, on the other hand, is a more structured and targeted approach. It involves a collaborative partnership between healthcare professionals and patients, particularly for managing long-term or complex conditions (Zulec et al, 2019; Blackburn et al, 2021). This relationship is grounded in mutual trust and respect, which enhances the individual’s capacity to engage in ongoing management of their condition (Brown, 2020).

Importantly, supported self-management goes beyond practical tasks like changing a dressing. It includes patient education about their condition, the development of skills to carry out wound care safely, understanding when to seek professional advice, and making broader lifestyle changes such as improving nutrition and increasing physical activity (Saghdaoui et al, 2023; Table 1).

BARRIERS TO SUPPORTED SELF-MANAGEMENT

Effective two-way communication between patients and clinicians is vital for enabling supported self-management. However, time constraints in clinical settings can

limit opportunities for meaningful discussion, including explaining treatment options or educating patients about their condition (Joseph-Williams et al, 2017). Lack of information, education and support from healthcare professionals can lead to patients/caregivers using inappropriate products to cleanse and redress their wounds, which could result in a lack of wound progression and chronicity (Kapp and Santamaria, 2017).

Additionally, patients with low health literacy may be less likely to understand the information that is being given to them, with little incentive to be motivated in shared decision-making or supported self-management (Brown, 2020).

Some patients may also feel that decision-making and treatment are solely the responsibility of clinicians, making them hesitant to ask questions or participate actively in their care. Conversely, some clinicians may feel uneasy or even threatened when patients take a more active role in treatment planning (Wounds International, 2016).

Joseph-Williams et al (2017) identified additional barriers, such as the belief among some clinicians that they are already practising supported self-management simply by delivering evidence-based treatment. However, this approach may overlook the importance of aligning care with patient preferences and priorities, which do not always match clinical guidelines.

Zulec et al (2019) further highlighted that many patients report feeling excluded from care decisions, which can negatively impact their adherence to care plans, reduce satisfaction with services, and weaken trust between healthcare professionals and patients.

A common assumption is that patients do not wish to be involved in shared decision-making and self-management (Wounds International, 2016). While this may apply to some, many individuals feel empowered by being active participants in

their care. It is therefore essential that clinicians offer supported self-management as an option when appropriate and are willing to engage with patients as equal partners in their care (Wounds International, 2016).

“Open, two-way communication between patients and clinicians plays a crucial role in encouraging shared decision-making, a core element of supported self-management.”

SUCCESSFUL IMPLEMENTATION OF SELF-MANAGEMENT

Wounds UK (2023) emphasises the need for a shift away from a passive, dependent model of care towards a patient-centred approach tailored to individual needs and focusing on what matters most to them. Open, two-way communication between patients and clinicians plays a crucial role in encouraging shared decision-making, a core element of supported self-management (Blackburn et al, 2021).

Promoting self-management should begin as early as possible in a patient's wound care journey (Wounds UK, 2023). It is important for clinicians to assess what the patient or their caregiver understands about supported self-management and what they are willing or able to undertake (Wounds International, 2016). While some patients may not feel ready to take on responsibility or make care decisions, this may change over time. Therefore, regular reassessment at each visit is essential (NWCSP, 2023).

Successful implementation of supported self-management depends on several key factors, for example:

- Patient consent, willingness, capacity, and understanding

should be clearly established early in treatment

- Delivering knowledge and education at a level that enhances patient/caregiver understanding and allows them to participate in decision-making around care planning
- Supporting patients/caregivers to have the confidence and competence to undertake supported self-management safely
- Evaluating what the patient experiences in their care journey (patient-reported experience measure [PREM]) and the impact their care and treatment has on their health and wellbeing (patient-related outcome measure [PROM]) (NHS Wales executive, no date)
- Clear communication about expectations, roles, and limitations

(Zulec et al, 2019; Wounds International, 2016; Wounds UK, 2023).

Importantly, not all patients or situations are suitable for supported self-management (Wounds UK, 2023). Clinical assessment should determine whether it is safe and appropriate. Factors that may limit suitability include:

- Lack of cognitive capacity or understanding
 - Physical limitations, such as poor dexterity or visual impairment
 - Safeguarding concerns involving caregivers or the care environment
 - Clinical red flags, such as a deteriorating category IV pressure ulcer requiring close monitoring
- (Wounds UK, 2023).

Practice point

Flaminal's® ease of use, versatility and antimicrobial protection make it a solution for supported self-care. Safely promoting patient autonomy and self-confidence, it can provide peace of mind when supporting continuity of care within both clinical and home settings (King 2023; Dhoonmoon, 2024).

Table 2: Checklist for supported self-management (adapted from NWCSP, 2023; Wounds UK, 2023)

■ Patients/caregivers should be able and willing to undertake supported self-management
■ Patients/caregivers should have the ability to undertake supported self-management, which includes physical dexterity and mental capacity
■ Patients/carers should have sufficient knowledge and understanding of the condition and treatment options. This may include aspects such as skin care, nutrition, exercise, how to cleanse and redress the wound safely and and carry out the dressing regimen
■ Patients/caregivers should be provided with written instructions in a manner that they can understand and follow
■ Patients/caregivers should have a demonstration with instructions on how to apply the dressing safely and correctly, giving time for them to practice under supervision if they wish
■ Care planning should include what is important to the patient and be agreed in collaboration with the patient and clinician
■ The dressing and cleansing regimen should be easy and safe for the patient/caregiver to follow
■ Patients/caregivers should be given equipment to undertake dressing changes, e.g. dressing packs, gloves, wound dressings, emollients
■ Patients/caregivers should be encouraged to monitor their wound progress or document any changes — this could be with a wound diary or taking pictures of their wounds with a mobile phone
■ Patients/caregivers should be aware of how to recognise red flags such as infection or wound deterioration and how to seek help
■ Follow up appointments should be given in an agreed time frame when treatment plans can be re-evaluated

To ensure safety and effectiveness, clinicians can use a checklist, such as one developed by the NWCSP (2023), to assess patient suitability and prepare them for supported self-management (Table 2).

Lastly, while encouraging autonomy, it is vital to ensure that adequate support structures are in place. Patients and caregivers should not feel alone in managing care, as this could lead to increased wound severity or emotional burnout. Collaborative working, where individuals feel both empowered and supported, is key to achieving long-term success in self-management (Wounds UK, 2023).

PROMOTING SUPPORTED SELF-MANAGEMENT WITH FLAMINAL®

To support greater patient involvement in self-management, it is essential to select a dressing regimen that is both simple and safe for patients or caregivers to apply. Flaminal® is one such product that meets these criteria, providing an accessible option in community or home care settings (King, 2023; Dhoonmoon, 2024).

Flaminal® is an enzyme alginogel® recommended for treating wounds with a low to high volume of exudate, particularly those at risk of infection under medical supervision only (White, 2014; King, 2023). Its formulation combines three components for effective wound healing (King, 2023):

- A debriding gel
- An absorbent alginate
- An antimicrobial enzyme system.

The product is suitable for a wide range of wound types, including those with slough, necrotic, or granulating tissue, and wounds showing signs of infection (Beele et al, 2012; White, 2014).

Flaminal® Hydro has a lower alginate content 3.5% (g/g) and is indicated for slightly to moderately exuding wounds, while Flaminal® Forte has a higher alginate content 5.5% (g/g) and is indicated for moderately to highly exuding wounds (Flen Health, 2021).

Key benefits of Flaminal® include:

- **Autolytic debridement:** supports removal of devitalised tissue, creating an optimal wound bed environment for healing
- **Antimicrobial protection with no reported resistance:** Flaminal's® enzyme system destroys a broad spectrum of bacteria, including those commonly found in chronic wounds
- **Moist wound healing:** the alginate absorbs excess exudate, maintaining a moist environment conducive to healing
- **Non-cytotoxic:** safe for both wound tissue and surrounding skin, as all activity happens within the gel matrix, once physically absorbed from the wound bed
- **Edge protection:** forms a layer of alginate flakes to protect wound edges from maceration, preserving healthy tissue
- **Protease modulation:** helps regulate excessive protease activity, which can hinder wound healing (Beele, 2012; King, 2023).

In the author's clinical experience, Flaminal® is a versatile primary dressing suitable for use throughout many phases of wound healing from inflammation onwards and can be used throughout all stages of the wound infection continuum (International Wound Infection Institute, 2016). Its multi-modal composition with many ways of application simplifies wound care, making it easier for both clinicians and patients to use, across all age groups and in difficult-to-dress areas.

Moreover, Flaminal® is designed for ease of application, accommodating wounds of various shapes and sizes. This adaptability makes it a practical choice for supported self-management, as it allows caregivers and patients to confidently participate in wound management. Its atraumatic removal also



CASE SERIES

This case series focuses on a collection of 10 patients in a four-week time period in an acute setting before being discharged to the community, using Flaminal® as the primary dressing. The wound aetiologies varied, including a diabetic foot ulcer (DFU), pressure ulcer, *pyoderma gangrenosum* (see *opposite*), skin damage caused by incontinence (see *Patient case*), and a post-surgical wound — representing a variety of challenging wounds that clinicians treat day-to-day within nursing. The main aim of the case series was to enable supported self-management through using Flaminal® to optimise patient outcomes and quality of life. Details of wound progression and treatments were captured on internal forms provided by Flen Health, which included information on wound assessment, pain scores and patient and healthcare professional expectations and feedback.

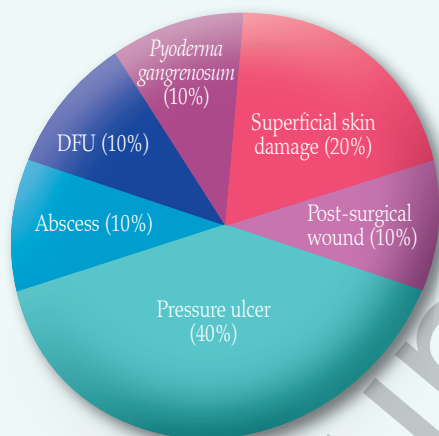


Figure 1.
Wound types included in the case series (n=10).

Results

Of the 10 patients included in the series, there were a mixture of wound aetiologies (Figure 1). On average, the wounds had been present for 14.7 days before Flaminal® was introduced into the treatment plan.

Debridement

Promoting autolytic debridement was a primary objective for 80% of patients (n=8), with the author reporting that in 100% of wounds, Flaminal® improved the wound bed by the effective removal of sloughy and necrotic tissue.

Patient case: Skin damage and fungal infection

Patient D was a 79-year-old lady who presented with areas of skin damage with a fungal infection. She had been admitted due to diarrhoea. Her past medical history included chronic kidney disease (CKD), type 2 diabetes and she was on apixaban due to a recent pulmonary embolism (PE). She was bedbound and doubly incontinent, with a low body mass index (BMI) and had carers three times a day.

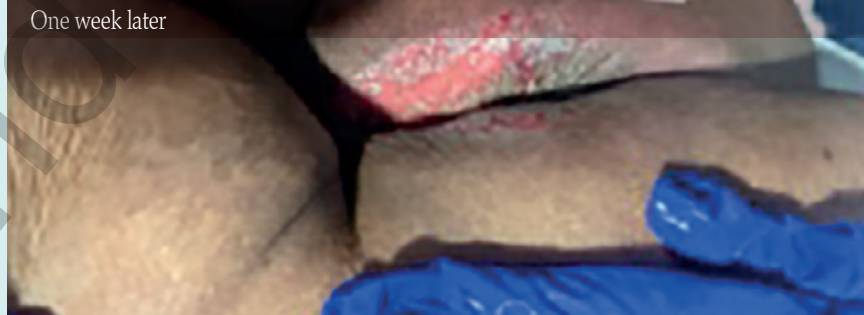
A hoist was usually used for transfers, but due to her pain she had not been able to sit out for one week prior to her admission. She reported her pain as 8 at initial assessment (on a scale where 0=least pain and 10=most pain). She was started on Flaminal® Forte after good skin hygiene, and her carers were advised to apply a pea-sized amount at each episode of continence care. She was to have one pad and be repositioned frequently. The carers were also advised not to apply a secondary dressing to the affected areas of skin.

At initial assessment



After one week signs of fungal infection had reduced, and there was no bleeding on contact. The patient now reported her pain as 4, a 50% reduction from initial assessment and she was able to be hoisted out for two hours in a chair for meal times only.

One week later



Two weeks later all open areas between her buttocks had epithelialised and all signs of fungal infection had gone. There was no bleeding and she reported no pain. She was now able to be fully hoisted out in a chair for up to four hours to enable her to get back to baseline and ensure a safe discharge.

At discharge, the patient was given education on regular skin care and toileting for her carers at home and advised to continue with maintaining good skin integrity.

Two weeks later



Bioburden

Eighty percent of wounds (n=8) were classified as deteriorating, with the remaining 20% (n=2) reported as stagnant. Infection was suspected in 70% of wounds (n=7) and therefore reduction in bioburden was a primary aim for these patients. Malodour was present in 71% of those wounds suspected of infection (n=5). The author reported that in 100% of these seven wounds, there was a reduction in signs of infection and malodour after Flaminal® was initiated in the treatment plan.

Exudate management

At presentation, 30% of wounds had a high volume of exudate (n=3), 40% of wounds had a moderate volume (n=4) and 30% a low volume (n=3). The author reported that Flaminal® managed the moisture well in 100% of wounds in this patient cohort. In 80% of patients there was a reduction in dressing change frequency (n=8).

Discussion

The introduction of Flaminal® into the treatment plan of these patients facilitated an improvement in pain, wound bed condition, signs of infection and exudate volume. These factors contribute to successful wound progression throughout various stages of healing. The versatility of where and how this primary dressing can be used is a benefit both to healthcare professionals and patients, giving simplicity and peace of mind.

Enabling supported self-management was a primary objective for the author so that these patients could be discharged from the acute setting into community care. Patient motivation can often be influenced by the attitude of clinicians and how supported they feel. This support can reduce the fear of the wound deteriorating (Parfitt et al, 2021). Alongside healthcare professional

support and education, this case series highlights how Flaminal® as a primary wound dressing can empower patients to take control of their treatment through supported self-management and improve their quality of life, allowing a return to work and family life commitments.

Patients in this series were receptive to using Flaminal®, with many reporting reduced pain and improved sleep. This also led to improved mobility, ability to undertake physiotherapy and rehabilitation, and allowed them to return to work or normal daily activities.

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Patient with pressure ulcer to the heel



Patient with pyoderma gangrenosum



Amputation site of patient with diabetic foot ulcer



enhances patient comfort and safety, promoting positive experiences and outcomes in self-managed care (King, 2023; Dhoonmoon, 2024).

CONCLUSION

Supported self-management plays a vital role in empowering patients to take an active role in their care, improving both clinical outcomes and overall wellbeing. By selecting simple, safe, and effective treatment options, such as Flaminal®, clinicians can facilitate greater patient and caregiver involvement in wound management.

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Key points

- Wound care presents a substantial burden on the NHS, clinicians, and patients. Promoting supported self-management has emerged as a key strategy to empower patients in proactively managing their wounds.
- Supported self-management includes patient education about their condition, the development of skills to carry out wound care safely, understanding when to seek professional advice, and making broader lifestyle changes such as improving nutrition and increasing physical activity.
- Collaborative working, where individuals feel both empowered and supported, is key to achieving long-term success in self-management.
- Flaminal® (an enzyme alginogel®), with its simplicity and versatility, offers a practical solution that supports patient-led wound care while promoting sustainable healthcare delivery.

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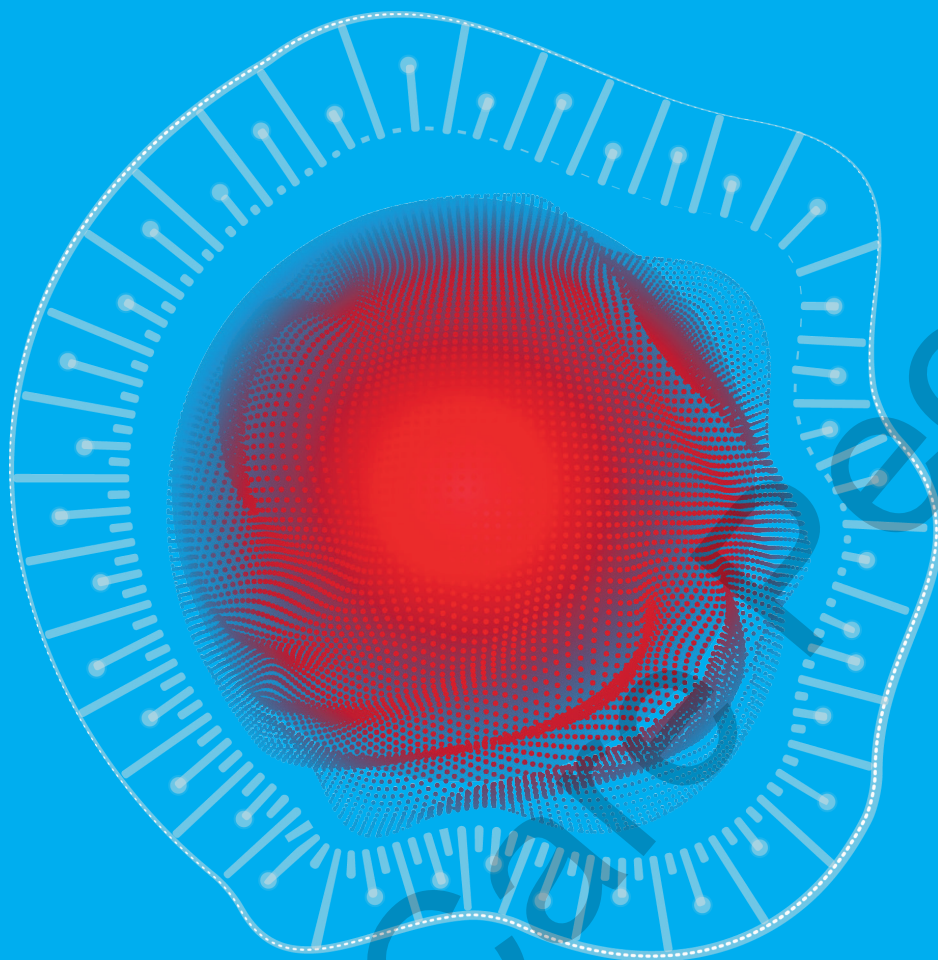
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Practice point

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Barriers women face when accessing cervical screening

Cervical cancer is one of the main causes of death among women with a cervix globally, and yet it is mostly preventable. Screening programmes within the UK, for example, fail to be accessed by many due to a plethora of reasons, including failing to see cervical screening as a priority and concerns around the screening process itself. In light of failure to attend, many women receive a late diagnosis of cervical cancer and sadly treatment plans can be limited in their success. This paper highlights the importance of reducing the barriers associated with cervical screening and emphasises the importance of healthcare professionals taking positive action to increase the numbers attending. It also highlights the importance of young people receiving the human papillomavirus (HPV) vaccination (both girls and boys), as this has been proven to significantly reduce the risk of cervical cancer. Cervical screening does not eliminate cervical cancer, but it can help to detect it early and, in so doing, increase the chances of survival.

KEY WORDS:

- HPV vaccination
- Cervical cancer
- Cervical screening
- Inequalities

Melaine Blake

Staff nurse, acute medical assessment unit — short stay, Good Hope Hospital, Birmingham

Catherine Best

Visiting lecturer, Birmingham City University; Queen's Nurse



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According to the World Health Organization (WHO), cervical cancer is the fourth most common cancer among women with approximately 660,000 new cases being diagnosed in 2022 and around 350,000 deaths occurring, with approximately 94% of these deaths being in low- and middle-income countries (WHO, 2024). Reasons for this are complex and include:

- Lack of public health priority
- Reduced healthcare resources
- Cultural barriers
- Ineffective technology
- Inability to provide effective prevention and treatment strategies

(Vu et al, 2018).

Furthermore, unlike high-income countries, low-income countries do not have robust frameworks in place to ensure healthcare programmes are effectively delivered, resulting in

difficulties establishing policies for screening and timely treatment (Vale et al, 2021).

According to Cancer Research UK (2020a), cervical cancer is the 14th most common type of cancer in the UK, with around 3,300 new cervical cancer cases evident every year (2017–2019) and 853 deaths (2017–2019). With one in 142 females being diagnosed with cervical cancer during their lifetime (Cancer Research UK, 2020a), such a figure should be considered unacceptable when regular cervical screening can prevent around 70% of cervical cancers developing [in England] (NHS England, 2024) and is available to women with a cervix between the ages of 25 and 64 (NHS, n.d.).

So, why does this travesty continue, especially in the UK, when policy clearly defines how cervical

programmes are to be managed? The reasons appear to be complex. Disappointingly, one concern appears to be a lack of understanding of the importance of cervical screening itself (Adedimeji et al, 2021).

CERVICAL SCREENING

According to Wearn and Shepherd (2024):

Cervical screening aims to detect precancerous, and often symptomless, abnormalities within the cervix, and prevent cervical cancer morbidity and mortality.

It is not, as many believe, designed to detect cervical cancer, rather it is designed to be a preventative measure (Wearn and Shepherd, 2024). Despite this emphasis, according to statistical data for England in 2022–2023, only

68.7% of eligible individuals aged 25–64 attended for cervical screening (NHS, 2023a). It is therefore clear that while women are being invited for cervical screening, a significant proportion fail to attend. Reasons are again multifaceted, with the following playing a part:

- Deprivation (Douglas et al, 2016)
- Embarrassment (Marlow et al, 2019)
- Associated stigma (Marlow et al, 2019)
- Practical barriers (Wilding et al, 2020)
- Previous experiences of screening (Chorley et al, 2017).

However, before addressing these issues in more detail, it is important to understand the potential impact of one of the greatest risk factors to a woman's health, that of human papilloma virus (HPV).

HUMAN PAPILLOMA VIRUS (HPV)

A significant proportion of all women who are sexually active will be exposed to HPV at some point in their life (WHO, 2024). In 90% of cases, HPV viruses cause little concern and are naturally cleared within two years — the immune system controlling and in due course destroying the infection. However, persistent infection can lead to cervical cancer in women (WHO, 2024).

A worldwide strategy recommended by WHO (2024) to help prevent cervical cancer is for all countries to provide HPV vaccinations and ensure a robust cervical screening programme is in place. Vaccination against HPV is considered the most effective way to prevent HPV infection, cervical cancer and other HPV-related cancers, and cervical screening can help detect cancers early, essentially leading to the provision of a more effective treatment plan (WHO, 2024).

According to the WHO (2020), between 2006, when the HPV vaccines were first licensed, and 2017, more than 100 million girls received at least one HPV vaccine, 95% of which were in high-income

countries. However, while in excess of 85% of high-income countries have introduced HPV into national immunisation programmes, disappointingly less than 30% of low- and middle-income countries, and less than 60% of upper-middle-income countries had done so (WHO, 2020). To address this disparity, the WHO (2020) argues that there is a need for the successful implementation of a triple intervention strategy, the aim of which is to ensure that:

- 90% of girls globally will have received full vaccination against the HPV vaccination by the age of 15
- 70% of women will have been screened by high performance test by the age of 35 and again by 45
- At least 90% of identified precancerous lesions and invasive cancers will have been treated.

However, for this to be optimally effective, the WHO (2020) argues that there needs to be a strong recognition that cervical cancer is a global public health concern, which requires a multidimensional level of involvement, including the galvanising of political support from international and local leaders, the strengthening of healthcare systems, and the development of effective and robust health promotion initiatives. All of which should take place alongside gaining broad support for universal healthcare coverage and the mobilisation of effective resources. Equally important however, is the requirement to be sensitive to women's needs and essentially take into account the barriers that prevent or hinder the uptake of cervical screening, especially in low-income countries. Examples of which include 'individual, social, cultural, health system and structural factors' (Petersen et al, 2022).

While it is evident in the literature that exposure to HPV can be a strong risk factor in developing cervical cancer, there are many more factors that have the potential to increase risk, including deprivation (Douglas et al, 2016), associated embarrassment (Marlow et al,

2019), and lack of practical support in accessing services (Wearn and Shepherd, 2024). The associated stigma has also led to women failing to attend cervical screening with many being worried that this was a sign (to others) that they were sexually active (Marlow et al, 2019). This was exacerbated by the fact that there were some who believed that cervical cancer occurred as a result of promiscuity, especially among those who held staunch religious beliefs (Marlow et al, 2019).

DEPRIVATION

Deprivation is recognised as being one of the key reasons why some women do not attend their cervical screening appointments (Douglas et al, 2016). Furthermore, a report published by Cancer Research UK (2020b) found that women living in the most deprived areas in England were more likely to die from cervical cancer in comparison to those living in the least deprived areas. Reasons as to why cervical cancer rates are more prevalent in deprived areas are multifaceted and may be due to, for example, higher rates of smoking increasing the risk of death by 21% compared to non-smokers (Cancer Research UK, 2015). Furthermore, sexual risk behaviours, such as age of first sexual experience and number of sexual partners, are significant risk factors associated with HPV infection, the persistence of infection, and the development of HPV-associated cancers (Rettig et al, 2015).

Moreover, research undertaken by Douglas et al (2016) examined cervical screening coverage in primary care trusts (PCTs) in England and found that PCTs with higher levels of deprivation also had lower coverage of cervical screening. Similarly, Wilding et al (2023) found screening uptake to be the lowest in young women (below 30) who came from deprived backgrounds.

Research undertaken by Ferdous et al (2018) identified a number of barriers to accessing cervical screening faced by immigrant women in Canada, including cultural, language, knowledge-

related, economic, healthcare system-related, and individual-related. Deprivation according to Farquharson et al (2022) is also linked to poor education outcomes.

EMBARRASSMENT

A recurring theme within the literature is embarrassment (Marlow et al, 2019; Wilding et al, 2020), with many women delaying or avoiding cervical screening due to feeling scared, vulnerable and referring to their bodies as being private (Marlow et al, 2019). Furthermore, embarrassment is also considered a common obstacle in cervical screening due to concern that it will be undertaken by a man (Bennett et al, 2018). To reduce such levels of concern, Westwood and Lavery (2021) suggest ways in which the NHS can help women overcome such barriers, such as providing chaperones as standard practice, affording the option to bring along a friend or partner, and the suggestion that women wear something comfortable, i.e. a long skirt to help cover up (NHS, 2025). Equally, policy should state that cervical screening will always be undertaken by a woman.

It has also been suggested that home self-sampling cervical screening could improve the uptake of screening (Chao and McCormack, 2019). Although this could be considered an effective measure, it could equally be seen as unsafe, if, for example, results were inaccurate and resulted in unnecessary investigations (Yeh et al, 2019). Furthermore, while self-sampling may be considered a useful approach to cervical screening (in that it helps to detect HPV), it does not address the fears that many women may have about taking the sample themselves. Women may be concerned about hurting themselves or 'getting it wrong'. Nonetheless, according to Morgan et al (2019), self-sampling is considered a cost-effective method, and has the potential to increase screening coverage among those who fail to attend. However as they argue, more information is needed about the reliability and accuracy of

self-sampling to increase women's confidence in its use. In the current climate when the barriers women experience continue to exist, it could be argued that self-sampling is better than nothing.

“A recurring theme within the literature is embarrassment (Marlow et al, 2019; Wilding et al, 2020), with many women delaying or avoiding cervical screening due to feeling scared, vulnerable and referring to their bodies as being private.

STIGMA

Concerns regarding perceived stigma associated with a diagnosis of HPV infection and cervical cancer have been highlighted in the literature (Peterson et al, 2022). Women involved in research undertaken in Western Kenya for example, expressed the fear that if they tested positive for HPV and/or were diagnosed with cervical cancer, they would associate this with shame and self-blame, especially if they had been unfaithful in their relationship (Ginjupalli et al, 2022).

Further analysis shows that women's lack of awareness is also associated with the stigma of cervical screening. For example, research by Marlow et al (2019) carried out in England involving women aged 50–64 from an ethnic minority and lower socio-economic background determined that there was a widespread lack of awareness about cervical cancer in their countries of birth. It could be argued therefore that those moving to England would not necessarily be aware of the cervical screening programmes and services available. Fatalism was associated with the risk of developing cervical cancer (the belief that such events are predetermined and

therefore inevitable), as was the belief that women develop cervical cancer as a result of having behaved badly (Marlow et al, 2019).

These findings are also supported by Ragan et al (2018) and Bateman et al (2019), whose research indicate that women from ethnic minority backgrounds associate HPV with promiscuity, prostitution and infidelity, fearing that diagnosis would result in blame and rejection by their partners. As with research undertaken by Marlow et al (2019), these women also referred to the disease as being a punishment for their sins or an inescapable fate. The associated concerns leading to feelings of shame or guilt, resulting in self-isolation out of fear of discrimination or social rejection — the impact of which can lead to anxiety and depression (Torode, et al, 2021).

Consequently, these myths and misconceptions have long contributed to the reduced uptake of cervical screening resulting in late presentation and therefore late diagnosis and a higher incidence of cervical cancer among ethnic minority women in low- and middle-income countries (Torode et al, 2021).

PRACTICAL BARRIERS

Myriad practical barriers have also been identified as a reason why women do not access cervical screening (Wilding et al, 2020). Reasons identified included GP opening hours being inconvenient, making it difficult to access screening during working hours (Ryan et al, 2020), and access to childcare (Wilding et al, 2020). Furthermore, as long as a woman felt healthy, cervical screening was not always seen as a priority, there being more important things to worry about (Bennett et al, 2018). However, this viewpoint should be a cause for concern as the early stages of cervical cancer often present with little or no symptoms (Stapley and Hamilton, 2011). Those that may be apparent include unusual vaginal bleeding, which can occur after sexual intercourse, between periods or after the menopause

(Stapley and Hamilton, 2011). Sadly, however, many of these symptoms only become apparent in the advanced stages (Mishra et al, 2011). It is essential that such viewpoints be effectively understood and systems put in place to mitigate the effect, including the provision of effective health promotion information that meets the needs of all women.

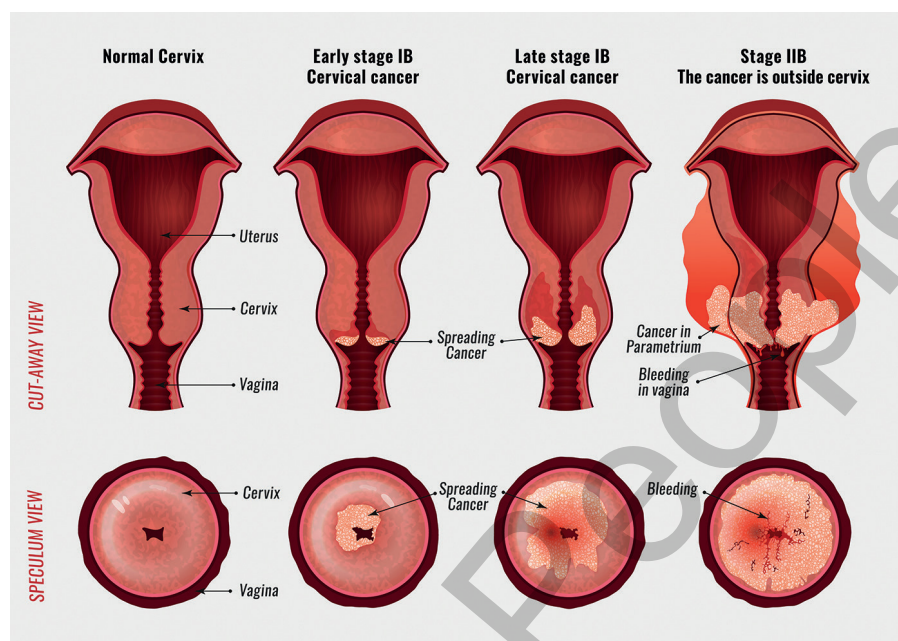
HEALTHCARE PROFESSIONALS

Previous unfavourable experiences of cervical screening have been shown to impact negatively on women attending future cervical screening (Marlow et al, 2019). Such negative experiences include healthcare professionals' bedside manner, level of empathy and experience, and any associated pain and discomfort (Marlow et al, 2019).

Research undertaken by Chorley et al (2017) also demonstrated that a lack of explanation about the procedure and opportunity to ask questions impacted negatively on women attending for cervical screening. Moreover, as previously said, the same research also highlighted that many women were concerned about the cervical screening being undertaken by a male nurse, with participants expressing concerns about nudity and the sexual connotations of the procedure resulting in negative emotional reactions (Chorley et al, 2017).

COVID-19 PANDEMIC

It is difficult to write a paper that demonstrates the importance of attending for cervical screening and HPV vaccination without making reference to the impact that the Covid-19 pandemic had on the routine screening of women. In England, for example, routine invitations for cervical screening were reduced from early April 2020 to June 2020, resulting in a backlog of women awaiting screening (Merrifield, 2020). While NHS cervical screening services have made inroads into reducing the number of women still requiring cervical screening, it remains apparent that eligible women do not



Photograph: Double Brain/Shutterstock

“ Previous unfavourable experiences of cervical screening have been shown to impact negatively on women attending future cervical screening (Marlow et al, 2019).

take up this potentially lifesaving process (NHS, 2023b).

In addition, although efforts to advance cervical screening programmes in low- and middle-income countries had been making some inroads, the pandemic disrupted global cancer screening efforts. The strain on such services disproportionately impacting on the ability of low- and middle-income countries to maintain this course due to limited resources (Vahabi et al, 2023).

ADDITIONAL RESEARCH NEEDED

This article has discussed a number of barriers associated with accessing cervical screening primarily in relation to BAME (black, Asian, and minority ethnic) and white women. Future research is necessary to identify wider groups in society that have not been considered, or have not been considered sufficiently enough, for example lesbians, bisexuals, transgender and queer, as these groups of people

may still be at risk due to a lack of associated knowledge and potential discriminatory factors. For example, previous research undertaken by Haviland et al (2020) found that gender identity, expression and sexual orientation were barriers to cancer screening. Therefore, to reach cervical cancer elimination targets within the UK, a more holistic approach to research is needed to increase and identify barriers of screening uptake among underserved populations within these communities.

It is equally important to consider access to cervical screening for those with learning disabilities. Byrnes et al (2019) in their systematic review of attitudes towards cancer among people with learning disabilities, found that people with learning disabilities can be influenced in their decisions by their carer(s). Such influence can potentially have a negative impact depending on the attitudes of the carer towards those with a learning disability accessing cervical screening.

Myriad barriers therefore exist that governments and both local and national healthcare services need to address to reduce the devastating impact of a cervical cancer diagnosis, including those associated with inequalities in health (Jallah et al, 2023). Recognising the significant barriers associated with accessing HPV vaccination and cervical screening and the co-relation

between these barriers and failure to attend may help provide the support necessary to successfully eliminate cervical cancer for good (Toh et al, 2017).

CONCLUSION

This paper highlights the significant barriers that limit women's ability to access cervical screening. Culture, misapprehensions, myths and misconceptions can all have a negative impact on the decision to attend and lead to many women never undergoing cervical screening. Equally, a lack of cervical screening availability is an obvious barrier. Health promotion campaigns such as Cervical Cancer Awareness month held in January within the UK can help raise the profile and importance of such screening, and it is important that nurses in all professional fields see their role as being about 'making every contact count' (MECC).

Asking the right questions and allaying preconceived fears, showing compassion and offering help and support may be all that is needed to encourage a woman to attend for screening. Do not assume that every woman you see will understand the importance of cervical screening or that every woman attends — from the evidence, this is simply not true.

In a global society where women's health is essential, the emphasis should be on eliminating a disease that causes so much suffering when it is, in the main, preventable. **GPN**

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Revalidation Alert

Having read this article, reflect on:

- Why cervical screening is important
- The impact of HPV on a woman's health
- Practical barriers as to why women may not access cervical screening
- How you encourage and support women to attend for cervical screening.

✓ Then, upload the article to the free GPN revalidation e-portfolio as evidence of your continued learning: www.gpnursing.com/revalidation

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Key points

- Cervical cancer is one of the main causes of death among women with a cervix globally, and yet it is mostly preventable.
- Screening programmes within the UK fail to be accessed by many due to a plethora of reasons, including failing to see cervical screening as a priority and concerns around the screening process itself.
- It is not, as many believe, designed to detect cervical cancer, rather it is designed to be a preventative measure.
- Myriad practical barriers have also been identified as a reason why women do not access cervical screening.
- In a global society where women's health is essential, the emphasis should be on eliminating a disease that causes so much suffering when it is, in the main, preventable.

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Tick-borne encephalitis: advising travellers

Tick-borne encephalitis (TBE) is a viral infection spread by the bite of an infected tick. Eating or drinking raw (unpasteurised) milk or dairy products from infected animals (cows, goats and sheep) is also a risk. Ticks carrying TBE are found in forests, grasslands, moors and wooded areas (including urban parks) in many parts of Asia and Europe. Most people infected with TBE do not become seriously ill, but TBE can cause a severe, potentially life-threatening central nervous system illness. TBE vaccine is a private travel vaccine in the United Kingdom (UK) and is recommended for those visiting TBE affected areas, if their activities and/or job put them at increased risk or they will be living in a TBE endemic region.

KEY WORDS:

- Ticks
- Travel
- Bites
- Repellents
- Vaccine

Mary Gawthrop

Specialist nurse (travel health), National Travel Health Network and Centre

WHAT IS TICK-BORNE ENCEPHALITIS?

Tick-borne encephalitis (TBE) is a viral infection mainly spread by a bite from an infected tick. TBE is a risk when humans are exposed to ticks carrying the virus while walking in forests, grasslands, forests, moors and wooded areas (Human Animal Infections and Risk Surveillance group, 2023), including city/urban parks, in many parts of Asia and Europe. While infection causes mild or no symptoms for most people, in rare cases the TBE virus can attack the central nervous system, causing long-term neurological symptoms. Very rarely TBE can be fatal (Human Animal Infections and Risk Surveillance group, 2023; UK Health Security Agency [UKHSA], 2023).

The World Health Organization (WHO) describes TBE as an important cause of central nervous

system viral infections, and estimates that up to 12,000 clinical cases of TBE are reported annually. However, they also advise that this figure could be a significant underestimation of the actual total number of clinical cases (WHO, 2024).

TBE is caused by a ribonucleic acid (RNA) virus, which is a member of the family Flaviviridae and has five, closely related main subtypes:

- European — spread by *Ixodes ricinus* ticks; endemic in rural and forested areas of central, eastern and northern Europe
- Far-Eastern — spread mainly by *Ixodes persulcatus* ticks; endemic in far-eastern Russia and in forested regions of China and Japan
- Siberian — spread by *Ixodes persulcatus* ticks; endemic in the Urals region, Siberia, far-eastern Russia and some areas of north-eastern Europe
- Baikalian — spread by *Ixodes persulcatus* ticks; found in East Siberia
- Himalayan — a type of squirrel (*Marmota himalayana*) is the primary host, found in the Qinghai-Tibet Plateau in China (UKHSA, 2023).

The range and severity of illness vary between subtypes, with the European subtype associated with milder disease and the Siberian subtype associated with more significant disease (European Centre for Disease Prevention and Control, 2024a).

HOW DOES TBE SPREAD?

TBE is transmitted primarily through the bite from an infected tick in outdoor and rural environments (Zacharias et al, 2024). However, eating or drinking unpasteurised dairy products from infected



livestock is also a risk (European Centre for Disease Prevention and Control, 2024b).

TBE does not spread directly between people. There are rare case reports of transmission through organ transplants, blood transfusion, via the transplacental route and through breastfeeding. Infection has also followed laboratory sharps injuries (UKHSA, 2023; European Centre for Disease Prevention and Control, 2024b).

WHERE IS TBE FOUND?

TBE is found in eastern, central, northern and western Europe, northern China, Mongolia and the Russian Federation (WHO, 2024).

Russia, including Siberia, consistently reports the most cases internationally. Asian countries with reported TBE cases or virus activity include China, Japan, Kazakhstan, Kyrgyzstan, Mongolia and South Korea. During the past 30 years, the range of TBE virus transmission appears to have expanded to new geographic areas and to higher elevations. This is likely to be due to a complex combination of changes in diagnostics and surveillance, changes in human activities, and other socioeconomic, ecologic and climatic factors (US Centers for Disease Control and Prevention, 2024a).

European TBE virus is endemic in rural and forested areas of central, eastern and northern Europe, with highest rates reported from Czechia, Estonia, Latvia, Lithuania and Slovenia (UKHSA, 2023). TBE has become a growing public health concern in Europe, with thousands of cases reported annually (European Centre for Disease Prevention and Control, 2024a). An increase in TBE cases in Europe has been reported (Zacharias et al, 2024), with a north-west bound spread reported in continental Europe (Van Heuverswyn et al, 2023).

Other European countries reporting TBE cases and/or with known endemic areas include Austria, Belarus, Belgium, Bosnia, Bulgaria, Croatia, Denmark,

Finland, France, Germany, Hungary, Italy, Liechtenstein, Moldova, Netherlands, Norway, Poland, Romania, Serbia, Slovakia, Sweden, Switzerland, Ukraine and the UK (US Centers for Disease Control and Prevention, 2024a).

Until 2019, locally acquired TBE was not reported in the UK. Since 2019, a total of four locally acquired TBE cases have occurred in England and Scotland. The first, a highly probable TBE case, was reported in July 2019 after a tick bite in the New Forest, Hampshire. In July 2020, a second probable TBE case was also diagnosed in Hampshire. A third case was reported in September 2022 after a tick bite in Scotland, with a fourth case being reported in England in October 2022, after a tick bite in North Yorkshire (Human Animal Infections and Risk Surveillance group, 2023).

TBE RISK SEASONS

Ticks are most active during the warmer months of the year. Most TBE cases occur during April–November, with peaks in early and late summer when ticks are most active (US Centers for Disease Control and Prevention, 2024b). In Europe, most cases currently occur between June and November, with July usually having the highest number of reported cases (European Centre for Disease Prevention and Control, 2024c).

TICKS

Ticks are often found in forests, wooded and grassy areas (European Centre for Disease Prevention and Control, 2024c). This includes city parks and grasslands in urban areas (Malkhazova et al, 2020). The main reservoirs of TBE virus are small wild vertebrate hosts (rodents), although larger mammals, like wild deer, are also important reservoir hosts for adult ticks (European Centre for Disease Prevention and Control, 2024b).

Ticks live on the ground, climbing onto grasses and bushes up to a height of about 80cm. There they wait for animals and humans to pass so they can latch on. Once on a host, ticks prefer to move to soft

skin before biting. Tick bites are painless and it is often not possible to sense a tick moving across the skin (European Centre for Disease Prevention and Control, 2024c).

Ixodes tick larva are tiny and difficult to see (usually about the size of a freckle or speck of dirt). After feeding, adult ticks become engorged and can grow to the size of a coffee bean. Common areas for ticks are armpits, backs of knees, elbows, groin and hairline (TravelHealthPro, 2024).

SYMPTOMS

The average incubation period for TBE infection is seven days, but can be up to 28 days (usually shorter for foodborne infection). Approximately two-thirds of human TBE virus infections have no symptoms.

When symptoms do occur, TBE infection often has two phases. An initial viraemic phase lasting approximately five days associated with non-specific symptoms such as fever, fatigue, headache, myalgia and nausea. This phase is usually followed by an asymptomatic interval and apparent recovery, lasting seven days. The second phase begins about seven days after initial resolution of symptoms and involves the central nervous system. Typical presentations are meningitis, inflammation of the spinal cord (myelitis), pain that radiates along a nerve (radiculitis) and paralysis (UKHSA, 2023).

DIAGNOSIS

TBE is diagnosed when antibodies to TBE virus are detected in samples of blood or less commonly, in cerebrospinal fluid. During the first phase of the illness, TBE virus can sometimes be detected in blood or urine samples by polymerase chain reaction (PCR) testing (TravelHealthPro, 2024).

In the UK, testing for TBE infection is arranged via the UKHSA Rare and Imported Pathogens Laboratory (RIPL). Acute encephalitis of any cause is a notifiable disease. If TBE is suspected, the referring clinician should contact a clinician at RIPL to discuss the case. This makes

sure that the correct samples are sent for testing; see the RIPL website for more information: www.gov.uk/government/collections/rare-and-imported-pathogens-laboratory-ripl.

TREATMENT

There is no specific treatment or antiviral drug therapy for TBE. Meningitis, encephalitis or meningomyelitis require hospital admission and supportive care based on syndrome severity (European Centre for Disease Prevention and Control, 2024a).

Anti-TBE intravenous immunoglobulin (a blood product containing antibodies from previously TBE infected individuals) and steroid therapy have been administered for both post-exposure prophylaxis and treatment, mainly in Russia. In Europe (including in the UK), anti-TBE immunoglobulin use has been discontinued. This is because of concerns about the possibility of more severe clinical manifestations due to antibody-dependent enhancement (European Centre for Disease Prevention and Control, 2024b).

TBE PRE-TRAVEL RISK ASSESSMENT

Risk of TBE virus infection for an individual traveller depends on several factors:

- Destination of travel
- Duration of travel in risk area
- Season of travel
- Activities undertaken
- Tick activity in country visited
- Vaccination status of the traveller (TravelHealthPro, 2024).

Practice point

- TBE risk is expanding across Asia and Europe
- Bite avoidance and tick awareness are an integral part of TBE prevention strategies for travellers
- TBE vaccine, a private vaccine in the UK, can be considered for at risk UK travellers, following a consultation with a travel healthcare professional.

In TBE endemic regions, travellers are at risk in rural areas, forests, grasslands, woods and urban parks; anywhere they can be exposed to infected ticks. Outdoor activities and working or spending long periods of time in endemic areas increase risk, but cases have also been reported after short trips. Most infections result from tick bites acquired in forested areas while bicycling, birdwatching, camping, fishing, hiking, or collecting berries, flowers, or mushrooms. People with outdoor occupations like farmers, forestry workers, military personnel training in forested areas, are also at increased risk (US Centers for Disease Control and Prevention, 2024b).

While food-borne TBE infection is unusual in travellers, it has been reported (Camprubí et al, 2020). For that reason, the importance of avoiding unpasteurised milk, cheese and other dairy products should be stressed to travellers, even if they have decided to have the TBE vaccine course.

TBE remains rare in UK travellers, with only seven imported cases reported in the UK between 2014 and 2018 (Human Animal Infections and Risk Surveillance group, 2023).

However, the UKHSA (2023) advises that anyone travelling outside the UK should check if they are visiting a place where TBE is present, using the TravelHealthPro website country information pages: <https://travelhealthpro.org.uk/countries>.

TBE PREVENTION

All travellers to TBE endemic areas in spring, summer and autumn should be advised to take risk avoidance measures, namely:

- Consider TBE vaccination if your activities or occupation put you at increased risk or if you are living or planning to live in an endemic country
- Avoid eating and drinking all unpasteurised 'raw' dairy products
- Follow bite avoidance advice, including covering up with appropriate clothes and using effective insect repellents, such as those containing 50% DEET

Practice point

Tick bite avoidance and tick detection measures, including advice about the correct way to remove a tick, should be discussed with UK travellers visiting TBE risk regions.

- See TravelHealthPro Insect and tick bite avoidance factsheet for more detailed advice: <https://travelhealthpro.org.uk/factsheet/38/insect-and-tick-bite-avoidance/>
- Wear light-coloured clothes to make ticks easier to spot
- Check clothes and whole body for ticks regularly
- Remove any ticks as soon as possible, using the right technique, with a pair of fine tipped tweezers or tick remover — see NHS 'Tick-borne encephalitis (TBE) — Removing a tick that has bitten you' advice at: www.nhs.uk/conditions/tick-borne-encephalitis/
- If you have any signs/symptoms of illness within 28 days of a tick bite, get prompt medical advice, mentioning any relevant exposures (tick bites) and all travel history
- If you are in the UK and have flu-like symptoms after a tick bite, contact your GP or call NHS 111 (UKHSA, 2023).

TBE VACCINATION

WHO advises that vaccination offers the most effective protection against TBE. It recommends people from non-endemic visiting endemic areas should be offered vaccination if their trip includes extensive outdoor activities (WHO, 2020). Some TBE endemic countries, such as Austria, offer TBE vaccination routinely to their entire population (Zacharias et al, 2024).

Ideally, the best time to start a TBE vaccine course is in the winter. This is to ensure protection before the tick season starts in spring. TicoVac® and TicoVac Junior® are inactivated TBE vaccines (known in some countries as FSME IMMUN® and FSME

IMMUN Junior®) licensed in the UK (TravelHealthPro, 2024) (Table 1).

Studies show that TicoVac® vaccination provides equivalent antibodies against European, Siberian and Far Eastern TBE virus strains (Pfizer, 2021).

WHO (2020) states that all the currently available global TBE vaccines are considered safe and effective.

As TBE virus infection in pregnancy can cause severe illness (Velay et al, 2023) and TBE vaccines are not contraindicated in pregnancy (Velay et al, 2023; TravelHealthPro, 2024), vaccination can be considered. However, TBE risk would have to justify offering vaccination. General information about advising pregnant travellers, including offering vaccines and insect and tick bite avoidance advice is available on the TravelHealthPro website: <https://travelhealthpro.org.uk/factsheet/45/pregnancy>.

Travellers at risk of TBE may also be at risk for other tick-borne pathogens, as infection with more than one tick-borne illness has been reported. This is because the ticks that carry TBE virus can also spread other illnesses, including anaplasmosis, babesiosis and Lyme disease (US Centers for Disease Control and Prevention, 2024b).

TBE vaccine provision in the UK
In the UK, TBE vaccine is not provided via the NHS (Health and Social Care in Northern Ireland, undated; Llywodraeth Cymru, 2023; NHS, 2024; Public Health Scotland/ NHS Inform, 2024).

➤ Reflective practice

- Peter, 27, works for a large German bank. His company is scaling down its UK operations and he has been offered a long-term posting to Frankfurt. What would you advise him about TBE?
- Ewa, 35, brings her one-year-old daughter, Rose, into your surgery for her first mumps, measles and rubella (MMR) vaccine. She explains it is important for her to make sure that Rose is protected against measles, as they visit her extended family in Poland frequently and she has heard there is a lot of measles in Poland. She also mentions that they are spending next summer there. What would you advise Ewa about TBE risks? Would you advise her to arrange TBE vaccination courses for herself and Rose?
- Roisin, 23, has just finished university. She is flying to Mongolia next week and then planning to travel overland to China, where she will be teaching English in Tianjin for a year. She then plans to spend some time travelling independently. She thinks she had a course of TBE vaccine when she went on a gap year before university, but she can't find her vaccine records. Would you offer her a TBE vaccine booster? What other advice might you give her?
- Paul, 48, has epilepsy, which is well controlled with carbamazepine. He works in forestry conservation and has just got a promotion, which means he will be spending long periods of time in Eastern Europe. His employers have advised him to arrange a TBE vaccine course, but he is concerned that it might affect his epilepsy. How could you reassure him?

However, TBE vaccination is available as a private travel vaccine for UK residents visiting TBE risk areas abroad. Some NHS general practice (GP) surgeries provide private travel vaccines; if not, travellers can be seen at a private travel clinic or pharmacy (NHS, 2024).

CONCLUSION

TBE is rarely reported in UK travellers, with a total of seven confirmed imported cases in returned UK travellers between 2014 and 2018 (Human Animal Infections and Risk Surveillance group, 2023). However, given the expansion of TBE in Asia and mainland Europe (Van

Heuverswyn et al, 2023), increased awareness of TBE risks among healthcare professionals is key. This will enable clinicians to highlight TBE risks to UK travellers visiting endemic countries and advise them regarding TBE prevention.

A safe and effective WHO approved vaccine is available in the UK for at risk travellers. **GPN**

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Vaccine	Schedule	Accelerated schedule	Length of protection	Age range
TricoVac® 0.5ml	3 doses on days 0, between 1 and 3 months, and 5 to 12 months after the second dose*	2nd dose can be given 2 weeks after the 1st dose	**First booster no more than 3 years after 3rd dose. After this, boosters may be given at 5-year intervals if at risk	16 years of age and older
TricoVac Junior® 0.25ml	3 doses on days 0, between 1 and 3 months and 5 to 12 months after the second dose*	2nd dose can be given 2 weeks after the 1st dose	First booster no more than 3 years after 3rd dose. After this, boosters may be given at 5-year intervals if at risk	1 year of age and above until 16 years old
* After the first two doses, sufficient protection can be expected for the ongoing tick season (protection rate over 90% after the second dose)				
**In those aged over 60 years, booster intervals should not exceed three years				

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- European Centre for Disease Prevention and Control: Tick-borne encephalitis (TBE) in Europe: new maps published: www.ecdc.europa.eu/en/news-events/tick-borne-encephalitis-tbe-europe-new-maps-published
- National Travel Health Network and Centre (NaTHNaC) advice line for health professionals: telephone: 020 7383 7474. See here for opening times: <https://travelhealthpro.org.uk/contact>
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Proactive PSA testing in high-risk men in general practice

Prostate cancer screening in asymptomatic men is contentious and there is currently no national screening programme in the UK. Routine asymptomatic prostate-specific antigen (PSA) testing is often considered ineffective due to its diagnostic limitations and risks of overdiagnosis and subsequent overtreatment. This project undertaken by the author's trust utilised the Prostate Cancer UK toolkit to engage men in making informed, personalised decisions regarding PSA testing. Men identified as being at elevated risk were contacted by text message and offered information about the risks and benefits of PSA testing, access to a personalised risk checker from Prostate Cancer UK and a direct testing pathway. The approach aimed to support informed decision-making in prostate cancer screening using the PSA blood test.

KEY WORDS:

- Prostate cancer
- Prostate-specific antigen testing
- Screening
- Informed decision-making
- Patient-centred approaches

Carl Armstrong

Advanced nurse practitioner,
Chapelford Medical Centre



Prostate cancer is the most common cancer affecting men, with over 55,000 new diagnoses each year in the UK. One in six men will be diagnosed with prostate cancer in their lifetime, the risk is even higher for Black men, with one in four being affected, and the disease accounts for approximately 12,000 deaths annually — an average of 150 diagnoses per day and one death every 45 minutes (Cancer Research UK, 2023).

Early prostate cancer is often asymptomatic. Thus, promoting awareness of risk factors is crucial for early detection when the disease is more likely to be curable.

Guidelines from Public Health England (PHE 2020, updated 2022) and the National Institute for Health and Care Excellence (NICE, 2022) suggest that all men over 50 may request a PSA blood test from their GP practice. However, they

“Early prostate cancer is often asymptomatic. Thus, promoting awareness of risk factors is crucial for early detection when the disease is more likely to be curable.”

do not advocate that healthcare professionals proactively raise the issue with asymptomatic men. Consequently, many men must seek information independently or rely on sources that may provide inaccurate or misleading details.

Both NICE (2022) and PHE (2020, updated 2022) report that the PSA test is not suitable as a routine screening tool due to insufficient sensitivity and specificity, which can lead to false positives, false negatives and unnecessary invasive procedures. There is also

ongoing debate regarding the risk of overdiagnosis and subsequent overtreatment of prostate cancers that may never affect morbidity or mortality and the potential harms of treatment options (Loeb et al, 2014; McCaffery et al, 2019).

Sociological factors add complexity to the issue of prostate and bladder health, as men are generally less likely to seek primary healthcare compared to women (Wang et al, 2013; James et al, 2017). Furthermore, men may display reluctance in discussing genitourinary health concerns.

COVID-19: POST PANDEMIC

The Covid-19 pandemic has had a significant impact on prostate cancer diagnosis, particularly for early-stage disease. Prostate Cancer UK (2023a) estimates that 13,000 men have missed a prostate cancer diagnosis due to the pandemic, potentially

leading to more advanced, less curable disease in the future.

PROJECT DESCRIPTION

This article outlines an initiative designed to identify men at elevated risk of prostate cancer and facilitate informed decision-making regarding prostate-specific antigen (PSA) testing. The project was based on the Prostate Cancer UK toolkit — *Toolkit for Primary Care Networks to implement the Directed Enhanced Service Specification on prostate cancer in England* (Prostate Cancer UK, 2023a) — and was adapted to meet local population needs.

The project was run by the author, an advanced nurse practitioner (ANP) in a GP practice with 7500 registered patients. Its primary objectives were to provide essential information on prostate cancer signs and symptoms and to offer digitally informed decision aids, including direct access to PSA blood testing. This initiative was supported by an in-practice information drive using leaflets and posters detailing signs and symptoms of prostate cancer.

Target population and exclusions

The initiative targeted three key groups:

- Men aged 50–70 registered at the author's practice. This aligns with guidance from the 'Prostate cancer risk management programme' (PCRMP) (Gov. UK, 2015), PHE (2020, updated 2022) and the NICE Clinical Knowledge Summary (2022)
- Black men aged 45–70: owing to the higher prevalence of prostate cancer in this group, as recommended by Prostate Cancer UK (2023a)
- Men aged 45–70 with a recorded family history of prostate cancer. Evidence shows an increased incidence in men with an affected father or brother (Bruner et al, 2003; Cancer Research UK, 2023).

Men were excluded if they:

- Already had a diagnosis of prostate cancer
- Had undergone a PSA blood test within the last 12 months

- Were clinically unsuitable (for example, receiving end-of-life treatments).

Identified patients were contacted by text message, which invited them to assess their personal risk using the Prostate Cancer UK risk checker (Prostate Cancer UK, 2023b). The risk assessment comprised three questions regarding age, family history and ethnicity, without considering specific symptoms. The text message also provided access to counselling resources on PSA testing and offered the option to book a PSA test directly or schedule an appointment for further guidance. A follow-up 'nudge' text was sent one week later. All results were reviewed in primary care by a GP or ANP and managed according to the NICE guidelines for suspected cancer recognition and referral (2015, updated 2025).

Outcomes

During a 12-week period starting in November 2023, 689 men meeting the inclusion criteria were contacted. Data indicated that:

- 689 men received a text message
- 238 completed the risk checker
- 226 were identified as high risk
- 12 were identified as low risk
- 226 opted for a PSA blood test
- 18 had an elevated PSA result
- 12 received a two-week wait urology referral
- 10 underwent a prostate magnetic resonance imaging (MRI) scan
- Seven had a prostate biopsy
- Four received a new prostate cancer diagnosis
- Two diagnoses were clinically significant (Gleason score >3+4).

Discussion

The response was positive, with 37% of contacted men using the risk checker and 32% opting for a PSA test. Notably, the number of high-risk men identified using the risk checker equalled the number who underwent testing. However, it is unclear whether all high-risk men were tested or if some lower-risk individuals still also opted for the PSA blood test after reviewing the information provided.

Practice point

Prostate cancer screening remains controversial, with the potential benefits of early detection needing to be balanced against the risks of overdiagnosis and overtreatment (Leenan et al, 2025).

A direct booking option via text message allowed men to schedule their PSA blood test without a further prior consultation. The initial text message sent to the identified target group included counselling on the PSA blood test's benefits and limitations, with a link to Prostate Cancer UK's risk check website. While this improved access, it also meant that some men might have arranged the test without fully considering pre-test instructions (such as avoiding strenuous exercise or ejaculation for 48 hours), potentially leading to falsely elevated results, or may have arranged the PSA blood test without considering the potential limitations of the test or the possible next steps for further investigation in the case that the PSA test returned elevated.

Digital rectal examination

The project deliberately did not include digital rectal examinations (DRE) to avoid deterring participation. Men were directed to seek further consultation if they had any queries, concerns or relevant symptoms by arranging an appointment at the surgery.

DRE is used to assess the prostate for signs of prostate cancer, such as a hard gland with palpable nodules, or benign enlargement, characterised by a smooth, firm, enlarged gland. However, a normal-feeling prostate does not rule out the presence of a tumour (Office for Health and Improvement Disparities, updated 2024). Concerns about DRE deter men from seeking healthcare (Kirby et al, 2024). Kirby et al (2024) noted that DRE is often seen as emasculating and anxiety-inducing. Furthermore, Black men face more cultural stigma around the DRE examination, but also have higher risk of dying from

prostate cancer (Lloyd et al, 2015). Krilaviciute et al (2023) concluded that DRE is not effective for prostate cancer screening.

Results

The vast majority (93%) of tests returned normal PSA results, with 7% elevated. In cases of elevated PSA, one-third did not receive a referral due to alternative explanations or patient choice. Among 12 men referred on a suspected cancer pathway, 10 underwent MRI, with three being discharged without further intervention and seven proceeding to biopsy. Four men were diagnosed with prostate cancer, of which two were clinically significant (Gleason score >3+4). Of the two men diagnosed with clinically significant prostate cancer, one man received radical prostate radiotherapy, and the other underwent radical prostatectomy, both with curative intent. At 12-month reviews, both had no signs of disease recurrence. Overall, the incidence of clinically significant cancer was low (0.7%), underscoring the challenges of blanket asymptomatic PSA screening.

Positives of the project

The positives of this project to identify men at high-risk of prostate cancer included:

- **Early detection:** two clinically significant cancers were

identified, demonstrating that informed, personalised decisions can yield early detection

- **Enhanced awareness:** the project increased awareness of prostate cancer risk factors and symptoms, even among those who did not undergo further testing

“Prostate cancer screening in asymptomatic men remains contentious. Routine PSA testing yields few clinically significant cancers, and while early detection can be lifesaving, it must be balanced against the risks of overdiagnosis and overtreatment.”

- **Improved communication:** the initiative facilitated better communication between male patients and the practice, leading to new diagnoses and timely referrals for related conditions, including benign enlarged prostate, overactive bladder and penile conditions
- **Patient empowerment:** the provision of comprehensive information enabled men to make informed health decisions
- **Safety:** no immediate adverse events (e.g. sepsis, infection) were identified following the project, including in those who underwent invasive investigation via biopsy.

Limitations

On the other hand, limitations of the project included:

- **Screening efficacy:** trials such as the ProtecT (Donovan et al, 2016) and CAP (Martin et al, 2018) suggest that increased cancer detection does not necessarily translate into improved survival and may lead to overtreatment with adverse effects. Currently, asymptomatic PSA screening is not advised by PHE or NICE
- **Psychological impact:** the referral on suspected cancer pathways, awaiting investigation, and/or detection of clinically

insignificant cancers may impose unnecessary psychological stress and treatment burdens

- **Digital exclusion:** reliance on digital communication may exclude those without access to such platforms
- **PSA test limitations:** with approximately 15% false negatives (NICE, 2022; PHE, 2020, updated 2022), a normal PSA result does not rule out cancer and may falsely reassure patients that they do not have a prostate cancer and mean that they do not seek further medical advice where appropriate
- **Resource implications:** the project incurred additional costs related to phlebotomy, clinical time and subsequent investigations.

CONCLUSION

Prostate cancer screening in asymptomatic men remains contentious. Routine PSA testing yields few clinically significant cancers, and while early detection can be lifesaving, it must be balanced against the risks of overdiagnosis and overtreatment. The findings of this project reflect national policies on asymptomatic screening, yet demonstrate that when provided with tailored information, men are motivated to engage in informed decision-making. PSA testing should form part of a broader clinical dialogue, with shared decision-making underpinned by clear clinical guidance. Primary care is an essential setting to support such informed, patient-centred approaches to prostate health. **GPN**

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Practice point

At the time of writing, the planned TRANSFORM trial in the UK aims to compare multiple prostate cancer screening options, including PSA testing, multiparametric MRI (mpMRI) and risk-adapted strategies that incorporate novel biomarkers and risk calculators, to determine the safest, most accurate and cost-effective method. The findings from TRANSFORM are expected to provide further evidence to guide screening policies and clinical practice (Prostate Cancer UK, 2024). The trial is not yet open for recruitment, but it is expected that the first men will be invited to participate in the trial in 2025.

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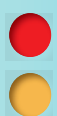
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Revalidation Alert

Having read this article, reflect on:

- The risks and benefits of PSA testing
- Your awareness of risk factors for early detection of prostate cancer
- The conversations that you can have with patients to help them make informed decisions around prostate cancer screening.



Then, upload the article to the free GPN revalidation e-portfolio as evidence of your continued learning: www.gpnrnursing.com/revalidation

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Key points

- Prostate cancer screening in asymptomatic men is contentious and there is currently no national screening programme in the UK.
- Routine asymptomatic prostate-specific antigen (PSA) testing is often considered ineffective due to its diagnostic limitations and risks of overdiagnosis and subsequent overtreatment.
- Sociological factors add complexity to the issue of prostate and bladder health, as men are generally less likely to seek primary healthcare compared to women.
- This article outlines an initiative designed to identify men at elevated risk of prostate cancer and facilitate informed decision-making regarding PSA testing.
- The findings of this project demonstrate that when provided with tailored information, men are motivated to engage in informed decision-making.

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Children and young people's mental health: brief interventions

The mental health and wellbeing of children and young people (CYP) is an area of growing concern, with many experiencing challenges that do not meet the threshold for specialist services but still requiring support. This is the third part in our series on CYP's mental health. The first explored the assessment and referral process (Al-Yassin, 2024), and the second described the THRIVE framework for intervention and the role that general practice nurses (GPNs) can play in psychoeducation, and the 'thriving' and 'getting advice' quadrants (Al-Yassin, 2025). This third part takes a practical approach and shares cognitive behavioural therapy (CBT) informed self-help techniques that can be shared with CYP and families for both anxiety and low mood. It also gives some thought to managing risk and the role of collaborative safety plans in this.

KEY WORDS:

- Mental health
- THRIVE Framework
- Self-help
- Cognitive behavioural therapy
- Safety planning

Dr Amina Al-Yassin

GP with specialist interest in CAMHS and clinical lead for children's services, Brent, NW London



Photograph: Yuri A/Shutterstock

EQUIPPING CYP AND FAMILIES WITH APPROPRIATE SELF-HELP TECHNIQUES

General practice nurses (GPNs) regularly come across young people in their line of work, and those who feel comfortable doing so may be well-positioned to provide some mental health support — be it opportunistically, if concerns are identified as part of another presentation, or as the focus of a consultation. Their role could be essential in both the early identification of mental health concerns and in preventing mental health issues from worsening. Previous articles have illustrated the assessment and referral process, the THRIVE framework, important lifestyle advice, including sleep hygiene, and resources that can be signposted to (Al-Yassin, 2024; 2025).

“ CBT focuses on the interconnectedness of thoughts, emotions, and behaviours to promote healthier coping strategies and overall mental wellbeing.

This third article in the series discusses some self-help techniques that can be taught to children and young people (CYP) and their families. Implementing this will be dependent on the skills and comfort of the GPN and the time available. It is not mandated for all, especially as sufficient resources have already been signposted to in which these techniques are described.

Many common self-help techniques are based on cognitive behavioural therapy (CBT), so it is

useful to have a basic understanding of this. CBT focuses on the interconnectedness of thoughts, emotions, and behaviours to promote healthier coping strategies and overall mental wellbeing. It suggests that in order to change your emotions (how you feel, such as anxiety or low mood), you can either change your behaviours or your way of thinking about the situation — hence CBT techniques are often either behavioural or cognitive in focus (Figure 1).

SELF-HELP TECHNIQUES FOR ANXIETY

Self-help techniques for anxiety include those based on managing the physical symptoms of anxiety, challenging anxious thoughts and challenging or reducing behaviours that can perpetuate anxiety such as 'avoidance'.

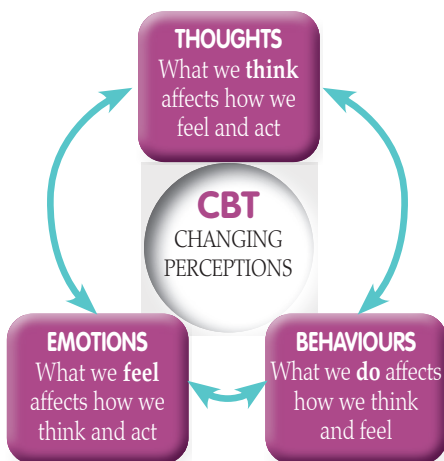


Figure 1.
Cognitive behavioural therapy (CBT).

Managing the physical symptoms of anxiety

Many techniques are commonly recommended to help manage the physical symptoms of anxiety. The rationale behind this is that anxiety leads to activation of the sympathetic system and the 'fight or flight' response, which can lead to physical symptoms such as palpitations, rapid breathing or sweating (LeWine, 2024). In turn, these symptoms may then cause more anxiety — especially if they are misinterpreted as meaning one is unwell or under threat — which feeds into a vicious cycle. By managing the physical symptoms of anxiety (even if we don't feel relaxed), slowing the breathing and calming this stress response, we can break the vicious cycle by activating the soothing system in the brain (the parasympathetic system) (LeWine, 2024).

Breathing techniques

There are many breathing techniques which are unified by one fundamental principle: slow the breathing down and take notice of it. In starfish breathing (Figure 2), CYP are encouraged to hold their hand out in front of them and breathe in as they trace up on their fingers and breathe out as they trace down their fingers (www.actcommunity.ca/wp-content/uploads/2024/01/Star-fish-breathing.pdf).

In square breathing (Figure 3), CYP are asked to breathe in for four seconds, hold for four seconds, breathe out for four seconds and

hold for four seconds, repeating the cycle until they feel calmer. A helpful video to demonstrate this technique is: www.youtube.com/watch?v=EhZdehpfodQ&t=8s.

Grounding techniques

Grounding techniques are simple exercises which help to bring attention back to the present moment. At times of anxiety, panic or stress, they can gently shift the focus away from negative or distressing thoughts and back to a place of calm or control (Trauma Research UK, 2024). There are many different techniques but they often have a sensory focus. In the 5-4-3-2-1 technique, the young person is encouraged to engage their senses by identifying: 5 things you see, 4 you feel, 3 you hear, 2 you smell, and 1 deep breath. It can reduce anxiety and distress by anchoring awareness to the here and now (Trauma Research UK, 2024).

A variation on this technique which may be suitable for younger children is 'Spidey senses', which makes the technique fun through association with a well-known superhero. Children are asked to switch their senses up to a superpower level and take it in turns to really focus in on what they can hear, what they can see, what they can taste, what they can smell and what they can feel. Guide children to stay in this heightened sense of awareness state for about two to three minutes (<https://ow.ly/jLy150VCaF5>).

Progressive muscle relaxation

Progressive muscle relaxation (PMR) involves tensing and relaxing muscle groups in sequence to first create tension in the muscle before releasing it. The technique is used to help promote relaxation, reduce anxiety, and physical muscle tension and improve sleep (Toussaint et al, 2021). Combining PMR with deep, relaxed breathing is an effective combination. The person is encouraged to sit or lie down comfortably and start with their feet — squeezing and then relaxing their toes... before moving onto their calves... thighs... abdominal muscles... etc working up the body until they reach the face.

For younger children, this technique can be adapted and made more engaging by relating it to animal movements or other actions, for example, stretching arms out in the air like a cat or picking lemons from a tree and then squeezing them (to tense and relax the fists).

Muscles are at their most relaxed straight after a contraction, and therefore this technique is a quick way to reduce muscle tension and promote relaxation (Toussaint et al, 2021). PMR has been found to reduce stress and has a positive impact on depression and anxiety (Toussaint et al, 2021).

Managing anxious thoughts (cognitive techniques)

In CBT, it is suggested that to change emotions (how you feel, such as anxiety or low mood) you



Figure 2.
Starfish breathing.

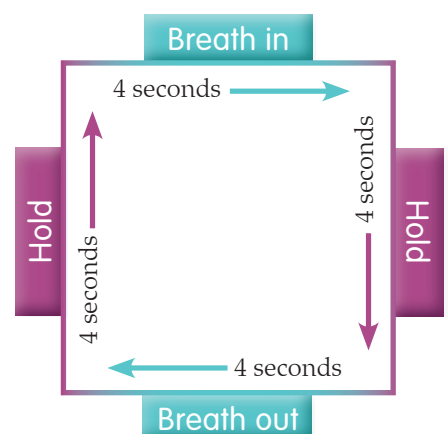


Figure 3.
Square breathing.



Figure 4.
The Worry Tree (adapted from Hibbert, nd).

can either change your behaviours or your way of thinking about the situation.

We will now discuss some cognitive techniques that can be used to manage anxious thoughts. In ‘thought challenging’, CYP are encouraged to learn to take a step back and challenge unhelpful thoughts that may be feeding into the anxiety (such as ‘I am going to fail this exam’ or ‘all dogs are dangerous’) by first noticing the thought (‘catch it’), then really thinking about what evidence really exists to support this thought (‘check it’) and over time succeeding in changing the thought into a more helpful or realistic one (‘change it’). This is called the ‘catch it, check it, change it’ technique. For younger children, this could be explained as becoming a ‘thought detective’. This could include asking questions like:

- How likely is the outcome you’re worried about?
- Is there good evidence for it?
- Are there other explanations or possible outcomes?
- Is there good evidence for alternative ways of looking at the situation?
- What would you say to a friend if they were thinking this way? (NHS, 2025).

Worry tree

Another useful cognitive technique is the Worry Tree. The Worry tree is a structured tool to manage worry by categorising concerns (Figure 4). It guides individuals to identify if the worry is solvable

or not. If the problem is solvable, CYP are encouraged to take action (either immediately or schedule it in for later); and if not, they are encouraged to let the worry go by using techniques like mindfulness or ‘worry time’ (Hibbert, n.d.).

Worry time

The worry time technique involves scheduling a specific daily time (approximately 15 minutes) to think about and address worries. Outside this period, individuals postpone worrying by redirecting their thoughts and reminding themselves that they can think about them during ‘worry time’. During ‘worry time’, they are able to focus solely on their concerns, brainstorming solutions if needed and encouraging themselves to stop again at the end of worry time.

A similar and popular technique to use with children is the ‘worry box’. This can be used separately to or alongside the ‘worry time’ technique. Children are encouraged to write or draw out their worries and then put them in a box as part of ‘letting go’ of the worries. This can either be done with a trusted adult or alone, but is a helpful technique for emotional expression. Children can be encouraged to make and decorate their worry box. More information is available at: www.youngminds.org.uk/parent/blog/how-to-make-a-worry-box-a-guide-for-parents/.

Dealing with anxiety-related behaviours (avoidance and exposure techniques)

Avoidance in anxiety involves steering clear of situations, thoughts, or feelings perceived as threatening. While it provides temporary relief, in the long term avoidance reinforces fear, maintaining the anxiety cycle (<https://ow.ly/f4NY50Vxqto>), and over time, it limits functioning and worsens distress. As an example, a person who believes that ‘all dogs are dangerous’ may avoid going to a park where dogs may be encountered or may cross the street if a dog is about to pass. While this avoidance behaviour may provide some temporary relief, it actually causes an increase in anxiety in the long term. It reinforces the feeling that dogs are indeed dangerous because the person never has the opportunity to have a positive (or neutral) experience with a dog, which may help to reduce the strength of this belief. If instead, the person does gradually expose themselves to the feared stimulus, this may cause an increase in anxiety in the beginning, however this will eventually extinguish and resilience will be built. Gradual exposure to feared stimuli is a key tenant in anxiety treatment and can help to reduce avoidance and hence build resilience, and break the cycle of fear (Craske et al, 2008). A key technique here is the ‘fear ladder’ (Williams, 2014). This involves creating a list of feared situations, ranking them from

Table 1: Unhelpful thinking styles (adapted from: www.unh.edu/pacs/unhelpful-thinking-styles)

Thinking style	Definition	Example
Catastrophising	Seeing only the worst possible outcome of a situation	Now that I’ve failed this maths exam, I am never going to university
Overgeneralisation	Making broad interpretations from a single event	That girl didn’t smile at me, nobody ever likes me
Black and white thinking	Thinking in absolutes, seeing only one extreme or the other. You are either good or bad, wrong or right, etc	If I don’t succeed at this project, I’m a complete failure
Personalisation	Holding oneself personally responsible for an event that is not entirely under one’s control	If I had played better, our football team would have won that match
Mind reading	Interpreting the thoughts and beliefs of others without hearing directly from those individuals	My teacher thinks I’m a failure
‘Should’ and ‘must’ statements	Sometimes, by saying ‘I should’ or ‘I shouldn’t’ or ‘I must’ you can put unreasonable demands or pressure on yourself	I shouldn’t have any sugar, I must always eat completely healthily



Figure 5.
The depression-inactivity cycle.

least to most anxiety-provoking, and systematically facing each one, starting from the least fearful, to build confidence and reduce anxiety:

1. **Identify the fear:** write down the specific fear or anxiety-provoking situation
2. **Break it down:** list related situations that vary in intensity, from least to most fearful (e.g. for a fear of public speaking, this could range from imagining speaking in front of others to giving a speech to a large audience)
3. **Rank the situations:** rank these situations from least to most anxiety-inducing
4. **Start small:** begin with the least anxiety-provoking situation and face it
5. **Gradual progression:** once you feel comfortable with a step, move to the next one on the ladder. Each successful step builds confidence and reduces fear
6. **Re-evaluate:** if anxiety is persistent, then pause and take time to revisit earlier steps before continuing

Adapted from Williams, 2014.

If CBT self-help techniques have been discussed in a consultation, it is useful to choose one or two to actually put into practice, recap

them at the end and set activities for the CYP to practice at home and arrange a review appointment to recap this and see whether it has helped. A helpful bank of resources and techniques for anxiety is available at: <https://weheartcbt.com/anxiety>.

The previous section discussed key techniques for managing anxiety, including relaxation techniques (breathing, grounding and progressive muscle relaxation) and cognitive techniques, including thought challenging, worry tree and worry time techniques. The importance of avoiding avoidance and the fear ladder as a key technique in this area has also been covered. The next section discusses relevant techniques for managing low mood.

SELF-HELP TECHNIQUES FOR LOW MOOD

Self-help techniques for low mood include those based on challenging negative thoughts, identifying unhelpful thinking traps and managing the behaviours related to low mood — specifically, the depression-inactivity cycle (Mazzucchelli et al, 2010).

DEALING WITH LOW MOOD RELATED BEHAVIOURS (DEPRESSION-INACTIVITY CYCLE)

When dealing with low-mood, it may be easier to tackle the low-mood related behaviours than to try and change the low-mood related thinking patterns and therefore behavioural management techniques (such as behavioural activation) are often used before cognitive techniques.

The depression-inactivity cycle occurs when low mood reduces motivation and energy, leading to withdrawal from activities that people usually find valuable or enjoyable, such as hobbies or seeing friends (Figure 5). This inactivity and withdrawal in turn reinforces feelings of worthlessness and hopelessness, worsening the depression (Martell et al, 2010).

Breaking the cycle involves gradually increasing engagement in activities that bring achievement or pleasure, helping to lift mood and restore a sense of purpose. At first, the depressed young person may not wish to engage in these activities but approaching a 'fake it until you make it' approach — where they gradually push themselves to do things until they eventually feel motivated (rather than waiting for the motivation to kick in first) is key. This is called behavioural activation and is a key CBT technique (Martell et al, 2010). A diary could be used to schedule activities in advance, with the focus being placed on those defined by the acronym BACE, namely:

- Care for the **b**ody
 - Promote a sense of **a**chievement
 - Provide **c**onnection with others
 - Give a sense of **e**njoyment
- (Fuchs and Taylor, 2019).

These need to be of personal value to CYP themselves rather than suggested or prescribed by professionals.

MANAGING NEGATIVE THOUGHTS (COGNITIVE TECHNIQUES)

When introducing the idea of cognitive techniques to manage negative thinking in low mood, it is

Practice point

Although the solution to the increased demand for mental health services lies in an increased national focus on CYP's wellbeing, providing more neighbourhood-based accessible services for early intervention, expanding the network of mental health support teams in schools, and investing further in CYP's mental health, there is still much to be gained by ensuring that all professionals who work with CYP have insight into their mental health and wellbeing needs and are able to provide some level of support and onward signposting as required.

Practice point

The THRIVE framework (Wolpert et al, 2019) is a good way of thinking about CYP's mental health and wellbeing and how best to support them (Al-Yassin, 2025).

often useful to give an explanation to CYP and their families. This could be something like: 'Did you know that our brains are built to notice danger and problems first? This helped humans stay safe a long time ago. But sometimes, it means we think more about the bad stuff and less about the good, which can make us feel sad or worried. Lots of things — like tricky life experiences, hard times, how our bodies work, or even not moving around much — can make those sad or negative thoughts stronger. When we feel low, our thoughts, feelings, and what we do can get stuck in a kind of loop, and it can be hard to feel better. But the good news is, scientists have found that if we try to change the way we think and what we do, it can help us feel better and break that loop' (adapted from Cowan, 2024a).

CYP can be encouraged to either remember or keep a diary of examples of negative thinking which they have had about themselves, situations or others, and be encouraged to challenge these thoughts. This could then be reviewed with the professional or trusted adult to identify any negative patterns in thinking or any unhelpful thinking styles (Table 1). Thought challenging (which was described in the anxiety section) is a helpful technique here too and CYP could be encouraged to think alternative or more helpful thoughts.

There are many other examples, and useful printable resources online that can be shared with CYP and families (www.getselfhelp.co.uk/docs/unhelpfulthinkinghabitswithalternatives.pdf).

Once again, as a reminder, if CBT self-help techniques have been discussed in a consultation, it is useful to choose one or two to actually put into practice, then at the end set activities for CYP to practice at home and arrange a review appointment to recap this and see whether it has helped. A helpful resource is the 'Think good, feel good' CBT workbook for children by Paul Stallard.

BEYOND 'GETTING ADVICE' — THE ROLE OF GPNs AND PRIMARY CARE

While a large proportion of 'getting help', 'getting more help' and 'getting risk support' quadrants, which are part of the THRIVE framework (Wolpert et al, 2019; see part 2 of this series, Al-Yassin, 2025) are the remit of specialist mental health services depending on local commissioning arrangements and operational procedures, the role of primary care may, in the author's clinical experience, include:

- Identifying any new or escalating mental health concerns and risk and referring appropriately to the 'getting help'/'getting more help' provider, such as child and adolescent mental health services (CAMHS) (Al-Yassin, 2025)
- While CYP are waiting for support, review regularly, supporting 'wait well' using some of the signposting resources and techniques described. Encourage engagement with and participation in any community-based programmes or activities that may support mental wellbeing. An example of this are the 'discovery colleges' (community-based NHS wellbeing workshops), which have been developed in many areas
- Shared care for any medications prescribed
- Facilitating transition after discharge from these services or between child and adult services.

Where any risks are identified, e.g. harm to self, harm from others or harm to others, it is important to discuss these with the primary care clinician on-call and the 'getting help'/'getting more help' provider such as CAMHS in a timely manner appropriate to the level of risk. Acute risks, such as active suicidality or active self-harm, will necessitate emergency care or assessment in the emergency department. Less acute risks (such as a history of self-harm), should still be discussed with clinicians in primary care or CAMHS, who may wish to undertake a full risk

Remember...

Supporting CYP and their families with their mental health can be difficult. The importance of the uniquely placed, community-based, compassionate care that can be provided by a GPN cannot be understated. GPNs are respected and trusted by so many CYP, and there is power in each word you say. A heavy dose of listening and validation of the struggles will go a long way. This is important, but not easy work, and GPNs should look out for their own mental health and that of their colleagues — your local employee assistance programme, the Royal college of Nursing's counselling services, or your own GP will be valuable for anyone who is struggling.

assessment and consider drawing up a safety plan.

Safety planning templates may be found online and can easily be incorporated into text messaging services, so that the discussion can be followed up with a written plan to be referred to when needed. A safety plan is a collaborative discussion that addresses the following questions.

- What are the signs, e.g. situations, distressing thoughts or feelings that may trigger suicidal thoughts? Or thoughts to self-harm? (warning signs)
- What are some of the things that you can do to distract yourself when you are having suicidal thoughts or thoughts to self-harm? (coping strategies)
- Who can you turn to if you are feeling suicidal/self-harm? (cope by connecting with others and support by using social contacts)
- Which professionals or agencies can you contact when feeling suicidal/self-harm?
- What things (e.g. sharp objects, ligatures or medications) can be removed or limit access to in order to keep you safe? (ensuring a safe environment)
- Who will be supervising the child or young person?

High quality evidence from randomised controlled trials is lacking for the use and clinical effectiveness of safety plans, but they are in widespread use because they are acknowledged as good practice and may lead to reducing repetition of self-harm. Safety plans should be created collaboratively between young people and clinicians, with input from family members or carers when appropriate, and should be accessible to the person and healthcare professionals who may be named as a source of support, such as the GP or mental health team. The plan should document the person's protective factors and requires regular review. Indeed, safety plans are dynamic documents which should be adapted as needs and circumstances change. Although non-specialists will not in general lead on developing a safety plan with a young person (this would occur more commonly in mental health services), they may be involved in reviewing it, amending it, and considering it in their management plans (Mughal et al, 2024).

CONCLUSION

The mental health and wellbeing of CYP is a shared responsibility across various sectors, including education, families, and healthcare. General practice nurses may contribute to early intervention by equipping CYP and their families with accessible, evidence-informed self-help techniques, such as those based on CBT principles. These strategies, when appropriately introduced and supported, can help young people to navigate anxiety and low mood and develop positive coping mechanisms. **GPN**

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Key points

- The mental health and wellbeing of children and young people (CYP) is an area of growing concern, with many experiencing challenges that do not meet the threshold for specialist services but still requiring support.
- General practice nurses (GPNs) regularly come across young people in their line of work, and those who feel comfortable doing so may be well-positioned to provide some mental health support.
- Many common self-help techniques are based on cognitive behavioural therapy (CBT), so it is useful to have a basic understanding of this.
- CYP can be encouraged to either remember or keep a diary of examples of negative thinking which they have had about themselves, situations or others.
- Safety plans should be created collaboratively between young people and clinicians, with input from family members or carers when appropriate. They are dynamic documents which should be adapted as needs and circumstances change.

Do GPNs hold the key to unlocking the problem of severe asthma?

Asthma is now considered a heterogeneous disease rather than a single airways condition, with distinct endotypes defined by the immunological and inflammatory pathways. These endotypes help to explain the underlying variable clinical presentations, which are defined as phenotypes (Kuruvilla et al, 2019; Holguin et al, 2020). This article examines how the role of the general practice nurse (GPN) can help to identify patients on the asthma register, who have as yet undiagnosed severe asthma and may benefit from targeted biological treatment.

KEY WORDS:

- Severe asthma
- Difficult-to-treat asthma
- Identification
- Management
- Treatment pathways

Julie Lenon

ANP/GPN; NES academic advisor;
ARTP spirometry assessor; senior clinical lead,
Education for Health, Aultbea and Gairloch
Medical Practice

Asthma affects eight million people in the UK (National Institute for Health and Care Excellence [NICE], 2023), with an estimated 200,000 with severe asthma (Asthma and Lung UK, 2022). In context, for every 100 patients on the asthma register, four will have severe asthma (Asthma and Lung UK, 2022). In 2023, 2.29% of patients with severe and life-threatening asthma died within 30 days of admission and 1.78% within 90 days of admission to hospital (National Asthma and COPD Audit Programme [NACAP], 2023). The National Review of Asthma Deaths (NRAD) (Royal College of Physicians [RCP], 2014) reported that of the 155 patients whose asthma severity could be estimated, 39% appeared to have severe asthma. Against this backdrop, 2–3% of primary care appointments per year are for asthma management (NICE, 2023). Of those patients with suspected severe asthma from primary care, 72% have not been reviewed by a specialist in the past

year (Ryan et al, 2021). Approximately 60,000 patients are currently living with severe asthma in England, of these, fewer than 1:5 patients are accessing targeted biologic treatments, which can potentially change the outcome and quality of life for people with severe asthma (Health Innovation Oxford, 2023).

In the author's clinical experience, early recognition of the symptoms and presentation of severe asthma in primary care is essential, as this can differentiate between difficult asthma and severe asthma and identify patients who may be eligible for life-saving targeted treatment such as biologics.

DIFFERENTIATING DIFFICULT-TO-TREAT ASTHMA AND SEVERE ASTHMA

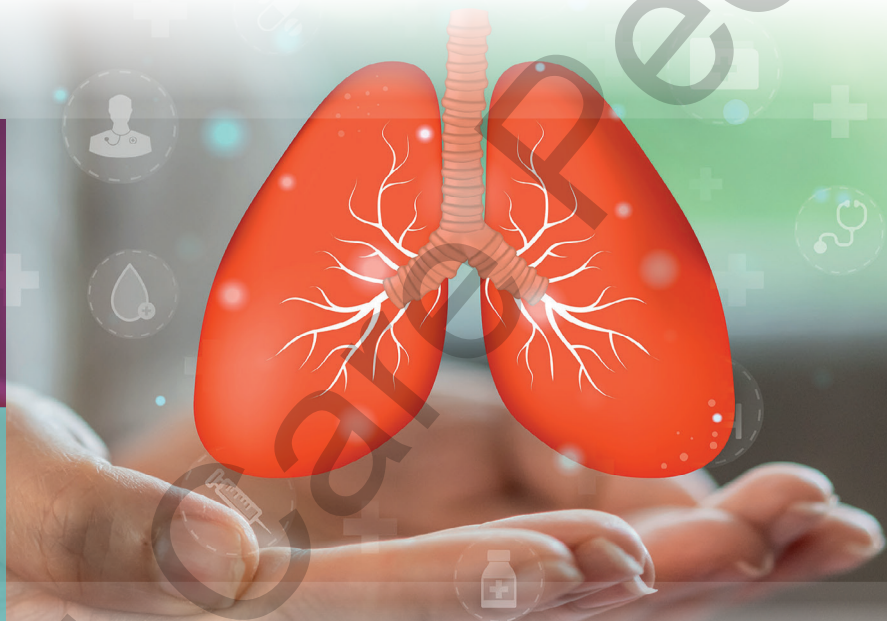
The Global Initiative for Asthma (GINA) in its difficult-to-treat and severe asthma guideline offers insight

into differentiating difficult-to-treat asthma and severe asthma, describing two conditions (GINA, 2024a).

Difficult-to-treat asthma

GINA confirms that difficult-to-treat asthma presents with persistent asthma symptoms despite medium or high dose inhaled corticosteroids (ICS), in combination with another agent, such as a long-acting beta agonist (LABA) or maintenance oral corticosteroids or patients requiring high dose ICS+LABA to maintain good symptom control. The importance of systematically investigating modifiable factors that might be contributing to symptoms is highlighted (GINA, 2024b).

Recognising any modifiable factors is a fundamental part of the asthma review which a general practice nurse (GPN) would discuss during the consultation. The most important modifiable factors include assessing and correcting inhaler



technique, discussing adherence to medications and any barriers to adherence, as well as identifying trigger factors that may exacerbate the patient's asthma and examining any comorbidities that can contribute to or mimic symptoms (GINA, 2024a).

Roche et al (2022) in their systematic literature review investigating inhaler technique show that many patients demonstrate poor technique, with results ranging from 1.2–100%, depending on the device. GINA (2024a) confirms that up to 80% of patients demonstrate incorrect technique. GPNs can demonstrate, assess, and signpost patients to organisations such as Chest Heart and Stroke Scotland, Asthma and Lung UK or My Lungs My Life, which have a variety of resources for patients to access.

Sub-optimal adherence is another identifiable contributing factor for difficult-to-treat asthma. GINA (2024a) reports that up to 75% of patients do not adhere to the prescription. In a systematic review, Zhang (2023) identified several key findings to barriers to sub-optimal adherence, including patients' health perceptions, misjudgement of their condition and cultural beliefs. A finding from van Boven et al (2016) suggested effective communication between the patient and healthcare provider had a significant role in engaging and motivating people with asthma to adhere to their medication.

Comorbidities that may contribute to symptoms and quality of life include:

- Rhinitis
 - Vocal cord dysfunction
 - Gastro-oesophageal reflux
 - Psychiatric disorders
 - Obesity
 - Obstructive sleep apnoea
- (Kaplan et al, 2020).

GINA (2024a) expands this list to include bronchiectasis, cardiac disease and kyphosis due to osteoporosis. It is important that GPNs investigate according to clinical suspicion to maximise the management of any co-existing condition.

Modifiable risk factors include exposure to triggers. A key finding from the NRAD confirmed that no trigger was documented in 49% of those people who died (Levy, 2014). Unless the patient is aware of trigger factors that exacerbate their asthma, they are not in a position to avoid such triggers to minimise the impact of exposure. The NRAD report emphasised that triggers for asthma should be elicited and documented in the medical records and in the patient's personal asthma action plan (PAAP) (Levy, 2014; RCP, 2019). This is supported by the NICE, British Thoracic Society (BTS), Scottish Intercollegiate Guidelines Network (NICE/BTS/SIGN, 2024a) and GINA (2024b).

Severe asthma has debilitating consequences and can have a significant emotional burden for the person living with this severe asthma phenotype.

Severe asthma

Severe asthma is a phenotype of asthma which is difficult to control, even with optimised inhaled asthma medication and addressing the modifiable factors (Severe Asthma Toolkit, 2019; Health Innovation Oxford, 2023; GINA, 2024a, b; NICE/BTS/SIGN, 2024a). The pathophysiology of severe asthma is complex, driven by various inflammatory pathways which are the backdrop to biologic therapy — an innovative group of medicines that target the different inflammatory pathways (Health Innovation Oxford, 2023).

Severe asthma has debilitating consequences and can have a significant emotional burden for the person living with this severe asthma phenotype. It can affect their contribution to the workforce and ability to socialise, leading to feelings of isolation and loneliness (Foster et al, 2017; Nunes et al, 2017). Stubbs et al (2022) identified

approximately 50% of patients have co-existing anxiety and depression, resulting in a poorer quality of life. A study from the Netherlands suggests that the prevalence of severe asthma worldwide is approximately 3.7% (Hekking et al, 2015).

With nearly 4% of people with asthma in the UK population estimated to have severe asthma, this equates to four people in every 100 on the asthma register (Asthma and Lung UK, 2024). However, large numbers of patients with possible severe asthma in the UK are unrecognised in primary care (Ryan et al, 2021). Thus, emphasis should be placed on the necessity to confirm the probability of severe asthma to expedite a referral to secondary care for further investigations and appropriate management.

Pathophysiology of severe asthma

The Severe Asthma Toolkit (2019) suggests severe asthma phenotypes can be defined by the pattern of the patient's own biomarkers, patterns of inflammation, and immune cell types.

The World Asthma Phenotypes (WASP) study was started in 2016 and has been conducted in five centres — the UK, New Zealand, Brazil, Ecuador and Uganda (Barreto et al, 2016). The objective was to combine detailed biomarker and clinical information to better understand and characterise asthma phenotypes.

The Severe Asthma Toolkit (2019) offers a breakdown of inflammatory asthma phenotypes as:

- Allergic asthma, defined by raised immunoglobulin E (IgE)
- Eosinophilic asthma, defined as raised blood eosinophils ≥ 300 cells/ μ , sputum eosinophils $\geq 3\%$ and increased fraction exhaled nitric oxide (FeNO). FeNO is driven by IL-13 and reflects the degree to which blood eosinophils are present in the airways. Blood eosinophils are driven by IL-5 and reflect the systemic pool of available eosinophils (Wang et al, 2023)
- Non-eosinophilic asthma, with absence of raised eosinophils.

Phenotyping or endotyping of the person's asthma facilitates a more tailored approach to treatment and management. Consideration must be given to the presence of a T helper cell type 2 (Th2) driven inflammatory response, such as IL-4, IL-5 and IL-13 (Kyriakopoulos et al, 2020). Asthma endotypes may be broadly regarded as type 2 (T2)-high or T2-low (Kuruvilla et al, 2019). Neutrophilic asthma, often identified as <2% eosinophils and <= 61% neutrophils in sputum, appears to involve an IL-8 mediated neutrophil response, resulting in neutrophil activation stimulating airway hyper-responsiveness (Pembrey et al, 2018). Stratification according to the patient's own biomarkers will help to identify the targeted treatment from the available biologics (Talwar et al, 2022).

T2-high asthma is the most well-defined endotype. The important treatable trait is the presence of raised type 2 airway inflammation (type 2-high) (Howell et al, 2023). Biomarkers, including blood eosinophils, FeNO, and serum IgE and allergy tests are useful surrogate measures of type 2 inflammation (Pavord et al, 2017). T2-low asthma presents with either neutrophilic or paucigranulocytic inflammation, tends to be more resistant to inhaled corticosteroids, and involves various asthma phenotypes related to obesity, smoking, late onset (usually after the age of 40 years) or occupational exposures (Peri et al, 2023). There is an unmet need for the identification of biomarkers that can help the diagnosis and

endotyping of T2-low asthma (van Rijt et al, 2016).

IDENTIFYING PATIENTS WITH SUSPECTED SEVERE ASTHMA

The NHS Health Innovation Network (Health Innovation Oxford, 2022) published a consensus pathway to improve care for people living with severe asthma. This document confirms indicators for uncontrolled asthma, including the patient presenting with any of the following over the last 12 months:

- Two or more courses of oral corticosteroids (OCS) for asthma
- One or more hospital admission or emergency department attendance for asthma
- Six or more short-acting beta-agonists (SABAs) prescribed
- Poor symptom control assessed using a validated questionnaire, i.e. the Asthma Control Test (ACT)
- Patient taking maintenance oral steroids for asthma.

This definition is supported by Asthma and Lung UK (2022) which advises that any patient who fulfils these criteria should be asking their healthcare professional (HCP) for a referral to secondary care for detailed assessment of their asthma. This line of questioning during the asthma consultation can be integral to the asthma review provided by the GPN to support the patient in their understanding of their asthma as part of negotiated person-centred care.

GPNs, pharmacists or GPs can help facilitate modification of any behavioural choices, such as diet

and exercise, weight management, smoking and social influences, as well as reviewing inhaler technique, adherence, trigger exposure, FeNO, peak flow (PEF) and blood eosinophil count (Health Innovation Oxford, 2022). The importance of identifying and optimising the management of any comorbidities, such as anxiety and depression, is essential; left untreated, these conditions can worsen asthma control, leading to unnecessary escalation of asthma therapy (Khan et al, 2023).

HASTE TOOL FOR GPNs

The HASTE checklist (Figure 1) is a prompt for GPNs, pharmacists and GPs responsible for supporting patients with asthma in primary care (Holmes et al, 2022). If the patient is still experiencing ongoing symptoms and the answers to the HASTE questions are yes, referral to severe asthma specialist services is indicated. The HASTE checklist can help GPNs with their decision-making, ensuring appropriate referral in a timely fashion.

There is a clear consensus that patients with severe asthma should be systematically evaluated by a dedicated multidisciplinary service utilising a team experienced in the assessment and management of severe asthma (NICE/BTS/SIGN, 2024b). Specialist severe asthma services will provide a multidisciplinary team (MDT) approach, and the patient may be reviewed by a variety of healthcare professionals including:

- Respiratory nurse specialists: to improve outcomes for people living with severe asthma
- Respiratory consultant: as part of the MDT to act as clinical gatekeepers to:
 - Ensure appropriate access to high cost technologies including biological agents
 - Prevent inappropriate use and unnecessary risk to patients
 - Ensure cost-effective use of resources to the NHS
- Radiographer/radiologists: for investigations such as high resolution computerised tomography (HRCT) to detect any comorbidities

H	High intensity treatment: Is the patient already on the high end of the treatment?
A	Adherence: Is the patient taking their medication at the correct dose and frequency?
S	Severe exacerbations: Has the patient had 2=/+ of OCS or been hospitalised due to asthma in the last 12 months?
T	Technique: Is the patient's inhaler technique correct?
E	Exclude other conditions: Are conditions that mimic or exacerbate asthma being managed?

Figure 1.
Haste Checklist (source: Academic Health Sciences Network, 2022).

- Ear, nose, throat (ENT) specialists: to investigate and optimise the management of comorbidities in asthma including allergic rhinitis, chronic rhinosinusitis with and without nasal polyposis
- Psychologists: to access cognitive behavioural therapy (CBT) or talking therapies to help patients cope with the emotional burden and associated psychological impact of living with severe asthma
- Physiotherapists: specialist skills that physios can offer include breathing exercises, such as the active cycle of breathing and relaxation techniques
- Pharmacists: supporting identification and referral of patients in primary care, ward-based pharmacists may identify and refer suitable patients for assessment for asthma biologic treatment
- Speech and language therapists (SLT): timely and appropriate input from SLTs can reduce the frequency and severity of symptoms and lessen health costs. SLTs support people with respiratory conditions through teaching them rescue breathing strategies, throat and upper body relaxation exercises, giving advice on how to maintain a healthy larynx, including throat care advice, behaviour change techniques and offering psychological support.

Pathways for referral may differ geographically, however, all specialist centres will identify the suitability of targeted therapy, although regional differences will highlight different service provision for children and young adults depending on the specifics of the commissioning proposals. HCPs should familiarise themselves with local service pathways.

TREATMENT PATHWAYS — TARGETED THERAPIES

In severe asthma, treatment moves away from the traditional model of a step-wise approach to that of targeting the underlying inflammatory pathways with targeted therapy using monoclonal

antibodies (mAbs). These mAbs target the molecular mechanisms which are driving the airway inflammation, blocking these specific inflammatory pathways (Blaiss et al, 2017). Identifying the inflammatory biomarkers is critical to support a targeted therapy approach.

“In severe asthma, treatment moves away from the traditional model of a step-wise approach to that of targeting the underlying inflammatory pathways with targeted therapy using monoclonal antibodies (mAbs).

Severe asthma specialist centres will investigate the patient's individual endotype, identifying which inflammatory biomarkers are causing the clinical characteristics, and the phenotyping to determine management and treatment pathways. Detailed assessment is required to inform the selection of targeted therapies which are likely to benefit individual patients. Once identified, targeted therapy using a particular mAb can start.

There are currently six biologics approved in the UK and available on the NHS for severe asthma targeted treatment (Asthma and Lung UK, 2023), namely:

- Omalizumab was approved by NICE (2013) for the prophylaxis of severe persistent allergic asthma. Its mode of action is to target IgE, an antibody produced by the immune system, inhibiting the binding of the IgE antibody to IgE receptors on cells that can lead to inflammation and worsened allergic symptoms (Kumar and Zito, 2023)
- Mepolizumab was approved by NICE (2017a) for treating severe refractory eosinophilic asthma. Eosinophilic asthma is a phenotype of asthma characterised by the higher than normal presence of eosinophils in the lung and sputum. IL-5 is

the major cytokine responsible for eosinophil growth, activation and survival. Mepolizumab inhibits IL-5 signalling, significantly reducing peripheral eosinophil counts (Ghassemian et al, 2021)

- Reslizumab was also approved by NICE (2017b) for treating severe refractory eosinophilic asthma. Reslizumab is an IL-5 inhibitor that reduces eosinophil numbers and activity by reducing the production and survival of eosinophils (www.ncbi.nlm.nih.gov/books/NBK476086/)
- Benralizumab was approved by NICE (2019) as a third biological treatment for severe eosinophilic asthma by targeting and depleting the immune cells in the blood that cause the condition. Benralizumab may have a more convenient dosing schedule than reslizumab and mepolizumab. The injection every four weeks for the first three doses and then every eight weeks thereafter is in contrast to mepolizumab, which is also injected, and reslizumab, an intravenous infusion, which are required every four weeks. Mepolizumab, reslizumab and benralizumab are all anti-IL-5 treatments targeting IL-5 or its receptor IL-5R (Farne et al, 2022)
- Dupilumab was approved by NICE (2021) for treating severe asthma with type 2 inflammation characterised by raised blood eosinophils and or FeNO. Dupilumab, a human monoclonal antibody, is designed to inhibit receptor signalling downstream by blocking IL-4/IL-13 receptors (Gade et al, 2024)
- Tezepelumab was approved by NICE (2023) as a human monoclonal antibody that blocks thymic stromal lymphopoietin (TSLP), an epithelial-cell-derived cytokine implicated in the pathogenesis of asthma (Menzies-Gow et al, 2021). Tezepelumab acts at the top of the inflammation cascade and has the potential to help address a broad population of severe asthma patients irrespective of biomarker levels (AstraZeneca, 2023). A systematic review concluded that tezepelumab is suitable for a broad patient population with

severe asthma of any phenotype (Menzies-Gow et al, 2022).

The criteria for accessing the different biologics include the number and severity of asthma exacerbations, sensitisation to inhaled allergens, biomarkers such as serum IgE, skin prick tests, eosinophil levels, use of oral steroids and age of patient (GINA, 2024a). Clinical assessment in a specialist centre will establish if the patient meets the specific criteria for a particular biologic to ensure that the most appropriate one is prescribed.

GINA (2024b) promotes a preferred track, which simplifies the pharmacological approach using a stepped approach from one to five. The sequential use of ICS-formoterol moving from anti-inflammatory reliever (AIR) to maintenance and reliever therapy (MART), including low dose and medium dose MART, confirms the ICS-formoterol as the reliever. Step five of the preferred track requires referral for specialist assessment, phenotyping and add-on treatment such as biologic therapy. This simplified approach is now aligned to the NICE/BTS/SIGN (2024) asthma guidelines.

CONCLUSION

Collectively, these advances in the identification, and management of people living with severe asthma have shifted existing paradigms in the approach to asthma with targeted therapy.

If the missing patients on the asthma register are identified, referral to secondary care can be expedited to enable access to targeted treatment and reduce the debilitating and potentially dangerous consequences of severe asthma. **GPN**

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Key points

- Asthma is now considered a heterogeneous disease rather than a single airways condition, with distinct endotypes defined by the immunological and inflammatory pathways.
- Emphasis should be placed on the necessity to confirm the probability of severe asthma to expedite referral to secondary care for treatment.
- There are currently six biologics approved in the UK and available on the NHS for severe asthma targeted treatment.
- Advances in the identification, and management of people living with severe asthma have shifted existing paradigms in the approach to asthma with targeted therapy.

Importance of trained paediatric clinicians in primary care

Children represent a significant proportion of primary care consultations in the UK, with up to 25% of general practice interactions involving young patients (Gill and Thompson, 2015). However, the nature of paediatric healthcare needs is evolving, while acute consultations for febrile illnesses remain common, serious bacterial infections are now rare (Wolfe et al 2013). Instead, there is a growing burden of non-communicable diseases, such as obesity and mental health disorders, which present new challenges for primary care providers (Di Cesare et al 2019; Fitzpatrick et al 2024). The changing spectrum of paediatric health issues demands, in the author's opinion, that general practitioners (GPs and nurses) receive adequate and specialised training to manage these complexities effectively. This article highlights why specialist paediatric care is such a needed area of care, and spotlights two practitioners who are leading the way in providing high quality paediatric care in the community.

KEY WORDS:

- Paediatric healthcare
- Training
- Diagnostic challenges
- Policy
- Resource gap

Judith Harford

Paediatric nurse practitioner, Adam Practice, Poole, Dorset

CHANGING LANDSCAPE OF PAEDIATRIC HEALTHCARE

Historically, primary care providers dealt mainly with acute paediatric illnesses, such as infections and injuries. However, modern paediatric practice in primary care is increasingly focused on managing chronic and lifestyle-related conditions (Gill and Thompson, 2015). Hospital admissions for acute illnesses has been rising significantly since the late 1990s (Neill et al, 2018), yet rates of obesity among children have also surged (Taylor, 2024; Zeng, 2024). This shift reflects a broader trend toward the need for preventive care and the management of long-term health conditions in children, which GPs and nurses are often not adequately trained to handle (Modi and Simon, 2016; Thomas et al, 2024).

Primary care clinicians face significant challenges in diagnosing and managing paediatric conditions

“Current child health quality markers in the UK focus on a narrow set of indicators (Gill et al, 2014), failing to capture the complexity of modern paediatric healthcare needs.

(Thomas et al, 2024). Early detection of serious illnesses, obesity, and mental health problems requires a nuanced understanding of child health that many GPs may not possess due to gaps in their training. Current child health quality markers in the UK focus on a narrow set of indicators (Gill et al, 2014), failing to capture the complexity of modern paediatric healthcare needs. In the author's clinical experience, this lack of comprehensive training and quality measures leaves many GPs ill-equipped to manage the evolving demands of paediatric practice.

Addressing health inequalities is another critical component of improving paediatric care. The Core20PLUS5 approach, introduced by NHS England, aims to reduce health disparities by focusing on the most deprived 20% of the population, with a particular emphasis on groups who experience poorer health outcomes (NHS England, 2023). For children, this includes tackling issues such as childhood obesity, mental health, and access to immunisations. Primary care has a vital role to play in delivering interventions aligned with this strategy, ensuring that vulnerable children receive timely and appropriate care.

The Core20PLUS5 framework highlights five key clinical areas of focus for reducing inequalities in children's health, namely:

- Improving maternity care
- Increasing childhood immunisation rates



Photograph: Ann in the UK/Shutterstock

- Managing asthma
- Addressing obesity
- Enhancing mental health support (NHS England, 2023).

By incorporating this approach into primary care, GPs and nurses can help address some of the root causes of health disparities. However, achieving these goals requires targeted training to equip primary care professionals with the skills to manage both acute and chronic paediatric conditions, while recognising and addressing the broader social determinants of health.

The significance of the Core20PLUS5 strategy for primary care cannot be overstated. It underscores the need for general practice to take a proactive role in preventing and managing health issues that disproportionately affect disadvantaged children. For example, GPs and other primary care staff working with children must be equipped to identify early signs of mental health issues, provide effective weight management support, and ensure that children from underserved communities receive necessary immunisations. Without adequate training in these areas, primary care providers may struggle to address these critical aspects of child health effectively.

The shift towards managing chronic conditions and reducing health inequalities places additional demands on primary care providers. GPs and nurses must not only diagnose and treat illnesses, but also act as advocates for their young patients, addressing social and environmental factors that contribute to poor health outcomes. This comprehensive approach to paediatric care requires a significant shift in how primary care practitioners are trained and supported in practice.

INADEQUATE PAEDIATRIC TRAINING IN GENERAL PRACTICE

The training of primary care professionals in paediatrics varies significantly across countries (Gill

and Thompson, 2015). In Canada, family doctors train for two years, with at least two months dedicated to child health in both general paediatric wards and emergency departments. Similarly, in the United States, family doctors complete three years of training, with a mandatory paediatric component. In contrast, UK GPs train for three years following a two-year foundation course, but there is no requirement

“A recurring theme in paediatric healthcare is the difficulty in making accurate diagnoses. GPs and ANPs/ACPs must be able to distinguish between minor illnesses and serious conditions that require urgent intervention.”

for dedicated paediatric training (Wolfe et al, 2013; O’Dowd, 2016). Similarly, there is no statutory requirement for nurses and allied practitioners working in primary care to have paediatric experience and, in the author’s experience, training courses rarely incorporate paediatric modules.

Calls to extend GP training in the UK have been ongoing for some time. The Royal College of General Practitioners (RCGP) has proposed lengthening GP training to four years, with an emphasis on specialist-led training in child health and mental health (O’Dowd, 2016). However, in the author’s clinical opinion, simply increasing the duration of training will not address the core issue. The content and structure of GP and advanced clinical practitioner (ACP) training must be adapted to reflect the current and future needs of paediatric practice. Without sufficient exposure to paediatric patients during training, it is challenging for GPs and ACPs to develop the skills necessary to

make accurate diagnoses and deliver effective interventions.

The need for specialised paediatric training for primary care professionals is happening in some areas. For example, Bournemouth University offers a course titled ‘Presenting Problems in Paediatrics in Urgent and Primary Care’, which aims to bridge the gap in paediatric training for healthcare providers such as advanced nurse practitioners (ANPs)/ ACPs, physician associates (PAs), paramedics, and NHS 111 staff. This course provides comprehensive training on recognising and managing a wide range of paediatric conditions safely and effectively. By covering both acute and chronic paediatric issues, the course equips participants with the skills needed to handle common and complex child health presentations in primary care settings.

The author has personally completed this course and now contributes to teaching it. The course’s practical focus on paediatric assessment and management is invaluable for healthcare professionals working in urgent and primary care settings. It emphasises the importance of accurate diagnosis, risk assessment, and communication with families — all critical aspects of providing safe and effective paediatric care. The course also addresses gaps in traditional GP and ANP training by offering hands-on experience and evidence-based guidelines for managing paediatric patients.

This targeted training approach is essential for improving paediatric care across different primary care roles. ANPs/ACPs, PAs, paramedics, and 111 staff are increasingly involved in frontline healthcare delivery, making it vital that they receive adequate paediatric training to ensure children receive high-quality care. By providing structured learning opportunities, courses like the one at Bournemouth University contribute significantly to addressing the gaps in paediatric training and improving child health outcomes in primary care.

ADDRESSING DIAGNOSTIC CHALLENGES IN PAEDIATRIC PRIMARY CARE

A recurring theme in paediatric healthcare is the difficulty in making accurate diagnoses. GPs and ANPs/ACPs must be able to distinguish between minor illnesses and serious conditions that require urgent intervention. However, the limited paediatric training that most primary care staff receive leaves them at a disadvantage when faced with these diagnostic challenges.

For example, recognising obesity in children is not always straightforward. Parents may not perceive that their child is overweight, and staff may lack the training to address weight management issues effectively (Gill and Thompson, 2015). Similarly, in the author's clinical experience, early markers of mental health problems can be subtle and easily missed without a thorough understanding of paediatric mental health.

Accurate diagnosis is essential for selecting appropriate interventions, yet primary care providers often have limited tools at their disposal. Children present with unique challenges due to the differences in anatomy, physiology, and symptom presentation between children and adults (Juarez-Hernandez and Carelton, 2022). GPs and ANPs should understand these differences to make accurate clinical decisions and provide safe, effective care for their young patients.

One critical diagnostic tool in paediatric care is the accurate recording of vital signs. Vital signs such as heart rate, respiratory rate, temperature, and oxygen saturation can vary significantly based on a child's age (Ramgopal et al, 2023). Understanding these age-related parameters is crucial, as failure to account for these differences can lead to misdiagnosis or inappropriate treatment.

GPs and ANPs must also have access to appropriate paediatric equipment. Standard adult-sized equipment, such as blood pressure

cuffs and oxygen masks, may not provide accurate readings or fit properly on a child. Ensuring that primary care settings are equipped with child-specific medical tools is crucial for accurate assessment and treatment.

“GPs are under constant pressure to balance the needs of both adult and paediatric patients, often with limited resources. This situation leaves little room for dedicated paediatric care, despite the increasing complexity of children's health needs.”

In addition to equipment and vital sign measurement, understanding the unique ways in which children present with illness is critical. Children may not exhibit the same symptoms as adults for the same condition. For example, a child with a respiratory infection may present with non-specific symptoms such as lethargy and poor feeding, rather than the classic cough and fever seen in adults. GPs and ANPs need to be aware of these variations to avoid missing serious illnesses (Brady et al, 1993; Chang, 2005).

Children's anatomy and physiology also play a role in how they respond to illness and injury. For example, their smaller airways make them more susceptible to respiratory distress, and their immature immune systems may respond differently to infections (Di Cicco et al, 2021). Recognising these anatomical and physiological differences is crucial for identifying early warning signs of serious conditions, such as sepsis or meningitis.

However, the lack of validated diagnostic tools specifically designed for paediatric use in primary care highlights a significant gap (Clark et al, 2024). Developing

and implementing paediatric-specific assessment tools, alongside targeted training in paediatric vital signs and symptom recognition, is important to improve diagnostic accuracy and ensure that young patients receive timely and appropriate care.

POLICY AND RESOURCE GAP IN PAEDIATRIC PRIMARY CARE

Child health has long been on the agenda for policymakers, but progress in improving paediatric primary care has been slow. GPs are under constant pressure to balance the needs of both adult and paediatric patients, often with limited resources. This situation leaves little room for dedicated paediatric care, despite the increasing complexity of children's health needs. However, with children under five years having the highest consultation rates of any age group in primary care in the UK, other than older people (Craven et al, 2024), it is difficult to understand the lack of paediatric specialty provision in primary care.

The Royal College of Paediatrics and Child Health (RCPCH, 2020) highlighted significant gaps in child health services in its 2020 'State of Child Health in England' report. The report pointed out that health outcomes for children in the UK lag behind those in many other high-income countries, particularly in areas such as obesity, mental health, and child mortality. It also emphasised the need for greater investment in child health services and more integrated care models to address these issues.

The report stressed that primary care services must be better equipped to handle the growing burden of chronic conditions and mental health disorders among children. It called for improved training for GPs to ensure that they can recognise and manage these conditions effectively. Additionally, the RCPCH recommended more targeted policies to address health inequalities that disproportionately affect children from disadvantaged backgrounds.

Despite these recommendations, progress has been slow and GPs continue to face significant challenges in meeting the needs of their youngest patients (Modi and Simon, 2016). High-quality research in child health continues to be conducted, but more investment is required to translate these findings into practical improvements in primary care. Resources should be directed toward developing comprehensive training programmes for GPs and nurses that address both acute and chronic paediatric care. Policymakers should also recognise the importance of child health and allocate appropriate funding to ensure that GPs and nurses are equipped to meet the needs of their youngest patients.

PRACTITIONER EXPERIENCE OF INNOVATIONS IN PAEDIATRIC PRACTICE IN PRIMARY CARE

Joanna Broderick, trainee paediatric advanced nurse practitioner

I qualified as a paediatric nurse from Southampton University in 1997 and have gained experience working in a variety of acute healthcare settings in the UK and internationally, and latterly as a children's community nurse in Exeter, Devon.

I am currently completing a Masters in Advancing Practice on the apprenticeship pathway with the University of Plymouth, and will complete my studies in July 2025. The role I now work in is part of an innovative pilot project funded jointly by the integrated care board (ICB) and primary care provider (PCP).

The aim of my role is to support the GP practice using my paediatric clinical expertise, to see children and young people (CYP) within their own community, in turn reducing the number of attendances to emergency departments (ED) and minor injury units (MIU). It is anticipated that by demonstrating an increase in same day primary care capacity for CYP under 16, it will be possible to establish whether providing additional targeted primary care capacity reduces the number of children accessing ED



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and MIU unnecessarily, allowing these departments to have capacity to deal more effectively with appropriate presentations.

In England, CYP make up a quarter of all attendances to emergency departments. This age group are most likely to be referred inappropriately or attend emergency services. A quarter to half of these young people could be seen in the community or managed by primary care teams (NHS England, 2019).

Parents and carers are inappropriately accessing care from the ED and MIU departments. It is possible that this is due to being unsure of the most appropriate way to access care quickly and effectively for their child, linked to a perception that there will be an excessive wait for primary care services. As a result, demand is growing on primary care teams to provide urgent same day appointments to children and young people.

The GP practice is a busy 22,000 patient cohort practice with an urgent care hub (UCH) where I work providing telephone triage and face-to-face appointments with CYP registered at the practice aged 0–16 years. My role involves proactive health assessment of acute and chronic health conditions, offering intervention and/or pharmacological treatment when

needed, and effectively modifying health outcomes. I am a registered independent non-medical prescriber.

The aim of my role is to prevent poor health outcomes, improve adherence to treatment and medication by offering support and having an improved understanding of their condition. In addition, there is an effective educational programme in place to allow for continuing professional and academic development alongside supporting training and educational opportunities wherever needed, for patients and clinicians alike. I have access to daily clinical support from a duty doctor working within the UCH, and regular clinical supervision. As part of the apprenticeship pathway, I am fortunate to have one day 'off the job training' each week to attend university education days, but this also allows me to explore other clinical areas or study days to support my clinical practice development.

Since my role was introduced, there has been strong evidence of a reduction in re-attenders, unnecessary referrals to secondary care and tertiary services, and an increase in on-site acute management. This has been achieved through the application of consistent evidence-based clinical assessments and treatment plans by myself as an experienced paediatric nurse and through consistent

evidence-based education being given to CYP and their families, and colleagues.

The feedback from families has been overwhelmingly positive, which has been retrieved through patient feedback forms being sent out after each consultation via ACCURX IT systems. Feedback from colleagues, the senior management team and the ICB is all positive. Evaluation of the role after 12 months has also been highly positive, although the investment into developing it further after the two-year pilot project ends is yet to be confirmed by the ICB and PCP. However, the need for a paediatric advanced nurse practitioner in the practice has been clear and the team would like my role to continue.

Future vision for this role includes collaborative working with schools in the area with a focus on obesity, health promotion and mental health, minor illness workshops targeting early years children and parents, education for colleagues working in MIUs, and supporting the work of the regional bladder and bowel service through education, training and clinical advice.

Paediatric advanced practice is on the cusp of looking very innovative, and I am proud and excited to be part of it. Every PCP should have a paediatric ANP to provide CYP with specialist support and advice, so my recommendation to paediatric nurses with an interest in primary care is that gaining an advanced practice qualification is going to be the best thing you can do.

Emma Harsum, paediatric advanced nurse practitioner locum

I have been working within primary care as a paediatric advanced nurse practitioner (PANP) since 2018.

When I first started, I was the only PANP in primary care in my area (Plymouth). The role helped bridge the gap between nursing and medicine, enhancing the quality, accessibility, and efficiency of care for children and their families.

Improved access to healthcare is one of the most immediate benefits of integrating PANPs into primary care. With rising demand and limited capacity within general practice, PANPs help reduce pressure on GPs by managing a wide range of paediatric presentations, from acute illnesses to chronic condition monitoring. This results in quicker access to timely, expert care — a key factor in preventing complications and reducing hospital admissions, both of which align with public health goals for early intervention and prevention. I can speak to parents quickly, usually the same day they make contact, provide advice over the phone or arrange face-to-face assessment in a timely manner.

A significant benefit of the role is our contribution to achieving national and local child health aims. These aims often include improving early years development, reducing health inequalities, supporting children with long-term conditions, promoting mental health, and safeguarding vulnerable children. PANPs are uniquely positioned to advance these goals through a holistic, family-centred approach to care. We provide a familiar face, can build rapport with patients and offer consistency in the care delivered. This continuous, proactive involvement helps meet developmental and safeguarding targets by ensuring that no child falls through the cracks of a busy healthcare system.

PANPs also support child health promotion through education and parental empowerment. A large part of my role is spending time educating families on nutrition, health, and managing minor illnesses at home. This helps build healthier communities, reducing health inequalities, and supports public health initiatives aimed at giving every child the best start in life.

Our advanced training allows us to assess, diagnose, prescribe, and monitor complex conditions, improving both health outcomes and quality of life for children living with chronic illnesses. This directly

supports health system goals around managing care closer to home and improving experiences for children with ongoing medical needs.

My working day is split between making triage calls, assessing health concerns over the phone, providing advice and booking those needing assessment into my afternoon clinics. My face-to-face clinic made up of 15-minute appointments is usually a mix of pre-booked (a few days in advance) and those booked on the day. My clinics are always full, and fill up very quickly. There is a high demand for children to be seen due to increasing health anxiety. I often feel like I don't have enough time in the day to see all the children I would like to see.

Paediatric advanced nurse practitioners are a key asset in meeting child health aims. Their expert, holistic care not only improves outcomes for individual children but also strengthens primary care's role in promoting health, preventing illness, and supporting families.

Despite the benefits the role can provide, it remains under-recognised in many areas. There is a pressing need for greater investment in paediatric-specific advanced practice roles within primary care. Expanding these roles would not only support existing health services, but also significantly enhance the care and outcomes for children across communities. Recognising and embedding these professionals more widely is a crucial step toward a stronger, more responsive child health system.

CONCLUSION

Properly trained paediatric healthcare providers are essential for delivering high-quality care in primary care settings. The changing landscape of paediatric health, characterised by a rise in non-communicable diseases and complex diagnostic challenges, in the author's opinion, necessitates a shift in how GPs and nurses/AHPs in primary care are trained to better equip future primary care providers to

manage the evolving needs of children.

To improve outcomes in paediatric primary care, training must be relevant, comprehensive, and focused on the specific challenges that GPs and nurses/AHPs face in practice. This includes gaining experience in acute paediatric medicine, mental health, and chronic illness management.

Investing in the training of primary care providers will have long-term benefits for child health outcomes and the broader healthcare system. Implementing specialist paediatric care in primary care with the necessary skilled workforce and tools, can ensure that children receive the early, high-quality care that they need to thrive and prevent problems escalating. **GPN**

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Key points

- Children represent a significant proportion of primary care consultations in the UK.
- There is a growing burden of non-communicable diseases, such as obesity and mental health disorders, which present new challenges for primary care providers.
- Without sufficient exposure to paediatric patients during training, it is challenging for GPs and ACPs to develop the skills necessary to make accurate diagnoses and deliver effective interventions.
- Implementing specialist paediatric care in primary care with the necessary skilled workforce and tools, can ensure that children receive the early, high-quality care that they need to thrive and prevent problems escalating.

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Revalidation Alert

Having read this article, reflect on:

- Why it is important to be trained in paediatric healthcare
- The additional demands that health inequalities place on your practice
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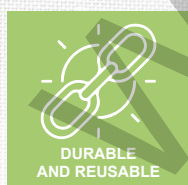
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