# BEST

Barnsley Education Support and Training

## Wednesday 16 July 2025

NHS South Yorkshire Integrated Care Board

Barnsley Healthcare Federation

- **Welcome** everyone. Please make sure you have signed in with Emma Smith, BEST Lead Administrator, outside
- **This session will be recorded** and will be available on the BEST website for future reference
- **Feedback –** please take time to complete the feedback form via the QR code on the back of the Agendas on your table. This feedback is shared with the speakers for their CPD. We also welcome detailed suggestions for future topics.

**HOUSEKEEPING**

- We're aware of the pressure on **car parking** spaces and apologise for this. If you have blocked someone in, please leave your details with Reception or Emma Smith
- There **no planned fire drills** today. In the event of an emergency or the alarm being raised, please vacate by the nearest clear exit, assemble at the fire point at the right-hand side rear of the car park and await instruction
- **A Quiet room** is available for anybody needing it today – it is the Maple Room just across the corridor
- **Toilets** are just out of the door and to the right
- **Mobile Phones** – please put on silent unless you are expecting an urgent call

BEST
Barnsley Education Support and Training

# Pharmaceutical Companies

Boehringer Ingelheim

Jardiance for Diabetes
CKD and Heart Failure

Chiesi

Fostair Nexthaler and
Trimbow Nexthaler

MAYOLY
Taking your care to heart

Simalivia, IBS medication

# Agenda

| | |
|---|---|
| **1.00pm** | **Practice Delivery Agreement 2025/26**<br>Dr Madhavi Guntamukkala, GP and Medical Director |
| **1.45 pm** | **Nephrology**<br>• **Kidney Function Risk Equation**<br>Daniel Fitzgerald, Prevention Programme Manager<br>Dr Pann Ei Hnynn Si, Consultant Nephrologist<br>Sheffield Kidney Institute |
| **2.15 pm** | **Radiology**<br>Dr Matt Kinsella, Consultant Radiologist, College Tutor and MSK Lead, BHNFT<br>Alison Lamb, Deputy Medical Imaging Manager, BHNFT |
| **3.00pm** | **Refreshment break** |
| **3.15pm** | **Sexual Health**<br>• **STIs**<br>• **HIV treatment**<br>• **HSV in pregnancy**<br>Dr Sylvia Bates, Consultant in Sexual Health and HIV Medicine, and Dr Bateman, Associate Specialist, Spectrum Sexual Health Service |
| **5.00 pm** | **Close** |

# Practice Delivery Agreement

Dr Madhavi Guntamukkala
GP and Medical Director

NHS
South Yorkshire
Integrated Care Board

# Practice Delivery Agreement 2025/26

# Barnsley Practice Delivery Agreement

**Purpose**

The aim of the PDA is to invest in the capacity needed to deliver a consistently high standard of General Practice across Barnsley. The PDA is reviewed and refreshed annually with consideration to the challenges for Primary Care and alignment with Barnsley place priorities.

The PDA has been established since 2014/15 changing each financial year to address variation and prioritise.

# PDA 2024/2025 Achievement

PDA breakdown 2024/25 -

- PDA Core - £1,691,206
- MMT - £1,518,429
- Eclipse - £68,135
- Shared Care - £357,698
- Anticoag - £218,079
- **Total £3,853,54**

| Achievement | No of practices |
|---|---|
| **100%** | 15 |
| **95% or more** | 11 |
| **87%** | 1 |
| **59 – 63%** | 3 |
| **19%** | 1 |

# High Level Outcomes

**1564** Patients had been reviewed for potential undiagnosed COPD & Asthma. From this **460** patients were diagnosed with Asthma, **162** with COPD, **10** patients with COPD & Asthma. **165** patients have been referred for onward investigation.

**672** Patients with COPD at high risk of admission have received a proactive review from their GP practice aimed to put proactive measures in place to avoid admission.

**972** COPD patients who had previously not received the PPV vaccine have been vaccinated as a preventative measure.

**1646** Aging well assessments were delivered

# High Level Outcomes

551 new patients diagnosed with hypertension

**1951 patients had a review of their** lipids and medication and were optimised as per NICE guidelines.

**1359** patients were screened for diabetes – **158** patients were diagnosed as having diabetes and **786** patients coded as pre-diabetes.

**78** Women with Gestational Diabetes who didn't have a HbA1c in 12 months now have a HbA1c completed - **10** women diagnosed with diabetes

# 2025/2026

- Scheme ideas were invited from all partners across the system on the key initiatives that could be undertaken in primary care to improve the health of Barnsley people.
- A PDA Working Group of GPs, Public Health and the ICB reviewed schemes and proposed 16 schemes to Barnsley SMT for approval.
- 16 Schemes in total were agreed, a breakdown is on each table.
- All approved schemes were sent out 01 April 2025.
- Since this time we have been working with ARDENS to develop the pathways in ARDENS Manager – practices now only need to add READ Codes into patients records which will automatically update ARDENS Manager on PDA progress.
- This work is complete and all practices can commence the 25/26 PDA work.

# 2025/26 Schemes

## Respiratory

**Scheme 1: Reduction of patients on 6 or more SABA inhalers with a diagnosis of Asthma.**

**Scheme 2: Review of all patients on 5 or more SABA with no diagnosis of COPD & Asthma.**

**Scheme 3: Achieve a reduction of Asthma Patients on SABA only and no ICS ever or within last 12 months**

**Scheme 4: Review of COPD & Asthma high risk patients to ensure that they are fully optimised to avoid the need for emergency care and offer an early intervention. All high risk COPD patients should be referred to BREATHE.**

**Scheme 5: Ensure that all newly diagnosed COPD & Asthma Patients are reviewed in practice within the first 3 months of diagnosis and have had their inhaler technique assessed and self-management plan completed.**

# 2025/26 Schemes

**CVD**

**Scheme 6: Hypertension case-finding: All patients with latest systolic BP > 160 and on anti-hypertension medication and no code of hypertension in deciles 1 & 2 and under 60.**

**Scheme 7: Increase the % of patients diagnosed with Hypertension treated to NICE guidelines**

**Scheme 8: Lipid Optimisation for patients with a QRISK over 20%, under 60 years, not on high intensity lipid lowering therapy.**

**Scheme 9: Heart Failure - Ensure every patient newly coded from 01 May 2025 with Health Failure has a review within 6-months.**

# 2025/26 Schemes

**DIABETES**

**Scheme 10: Ensure all patients coded Gestational Diabetes Meliltus (GDM) have annual bloods and referral to NDPP.**

**Scheme 11: Early onset diabetes - Increasing the completion of all the 8 key care processes through targeted intervention for each person with Early Onset Type 2 Diabetes age 18-39.**

**Scheme 12: Non-Diabetic Hyperglycaemia - Patients with HbA1c 42-47 who have not been coded as NDH to have a review.**

**Scheme 13: Diabetes Case Finding - Case finding potentially undiagnosed diabetes. ARDENS search for 2 or more HbA1c >=48mmol/mol in the last 12 months.**

**Scheme 14: Renal UACR – Practice to increase % diabetics and CkDG3a+ who have UACR done.**

# 2025/26 Schemes

**Scheme 15: Embed a direct referral process to Yorkshire Smokefree / Accurate recording of QUITS**
(for practices delivering the service in house the scheme aims to ensure that the number of QUITs are accurately recorded, for practice who use Yorkshire Smokefree they must embed a direct referral process rather than patient self referral).

**Scheme 16: Phlebotomy Provision**

- New Scheme to provide funding and consistent service specification for phlebotomy delivered in General Practice
- This scheme only covers phlebotomy generated by the practice and excludes phlebotomy requested externally
- The specification requires all practices to provide an urgent phlebotomy service to their registered patients within 5 days of need.
- Routine phlebotomy can be delivered within the practice or via the CDC

# 2025/26 PDA

| SCHEME | VALUE |
| --- | --- |
| Respiratory | £270k |
| CVD | £378k |
| Diabetes | £378K |
| Smoking | £55k |
| Phlebotomy | £650k |
| Total | £1.7m |

# 2026/2027

We are starting to work through a process for the developing the 26/27 PDA.

We need to reconigse early that the 26/27 PDA **may** look different as we start to move towards more neighbourhood health models and also as we work through a South Yorkshire review of locally commissioned services from Primary Care to get alignment across South Yorkshire.

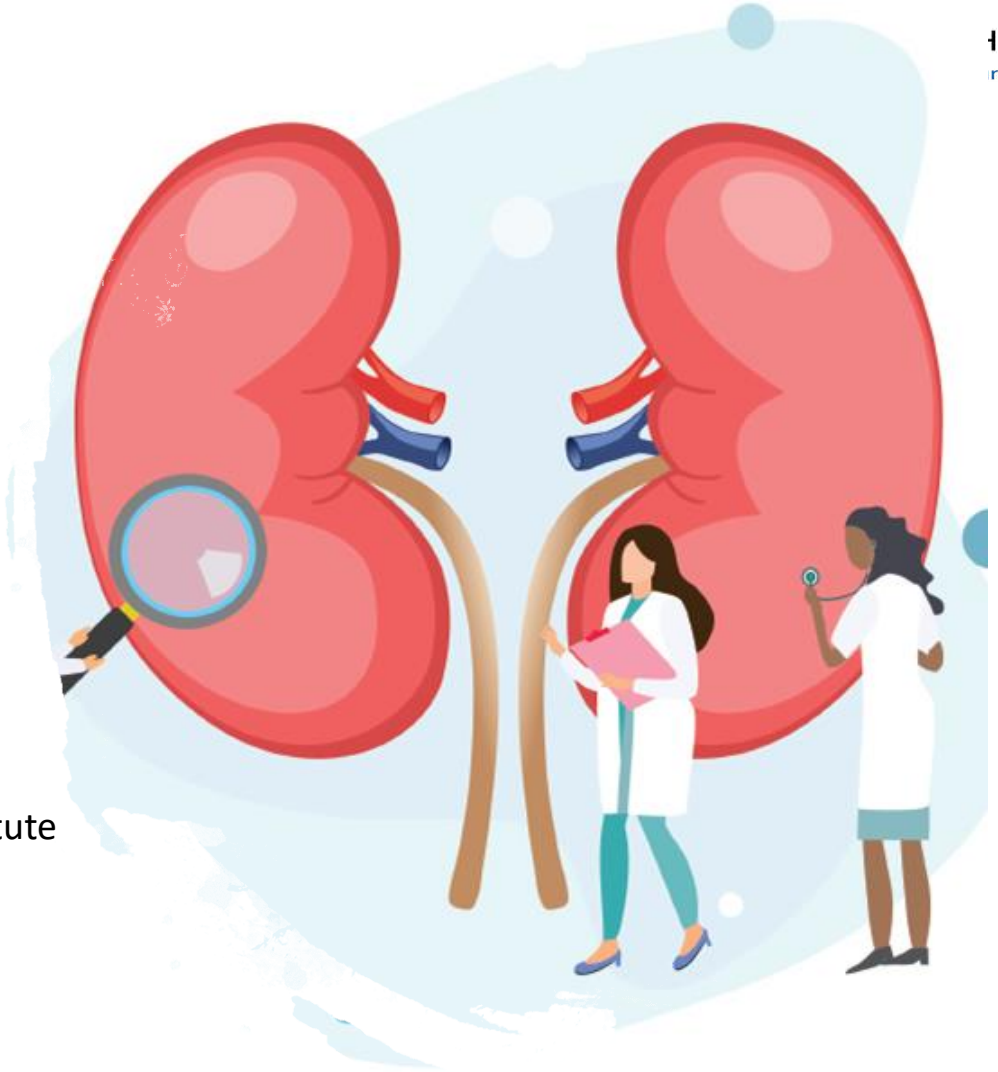
If anyone would like to be involved in the 2026/27 PDA development please contact Dr Guntamukkala.

# Nephrology: Kidney Function Risk Equation

Daniel Fitzgerald, Prevention Programme Manager
Daniel Clarke, XXXXXXXXXXXXXX
Dr Pann Ei Hnynn Si (MRCP, PhD)
Consultant Nephrologist
Sheffield Kidney Institute

BEST website Resources:
Diagnostic Tools – BEST  Local pathways and guidelines – BEST
Referral criteria, forms and investigations - BEST

# CKD – teaching update

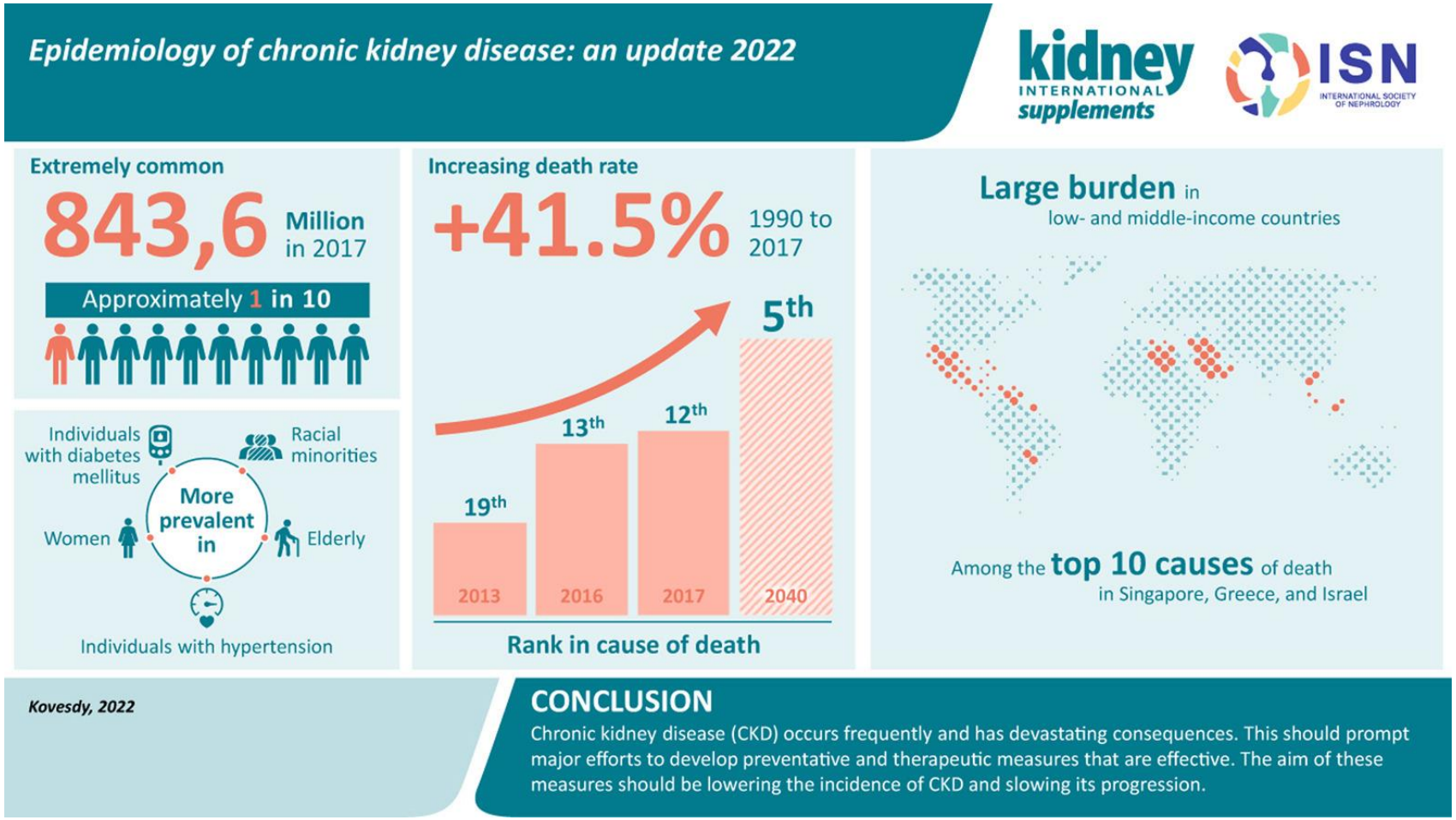


Dr Pann Ei Hnynn Si (MRCP, PhD)
Consultant Nephrologist, Sheffield Kidney Institute
Honorary Clinical Lecturer (SCHARR)
Pann-ei.hnynn-si@nhs.net

# Outline

- Why is CKD important
- CKD classification and how to approach patient
- KFRE
- CKD Management
- Cases

# Why is CKD important?

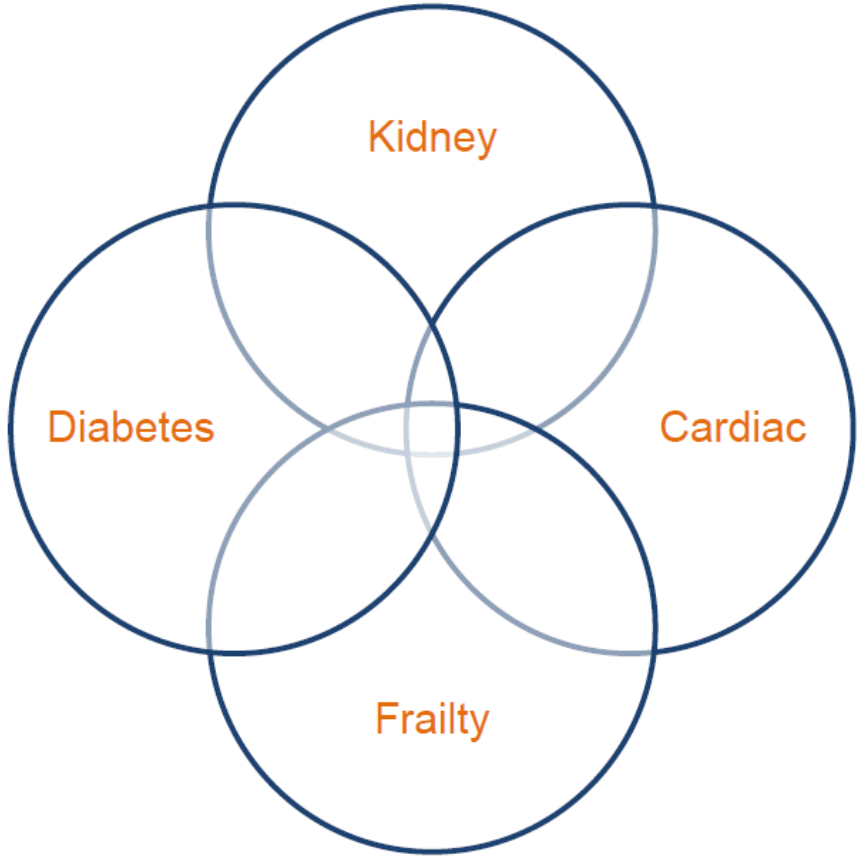


# CKD rarely in isolation

**6%** overall population prevalence with a focus on management, not prevention

Referrals outside of NICE guidelines and low discharge rates back to primary care

**80%** of patients have three or more significant co-morbid diagnoses



# How common is Renal Replacement Therapy in the UK?

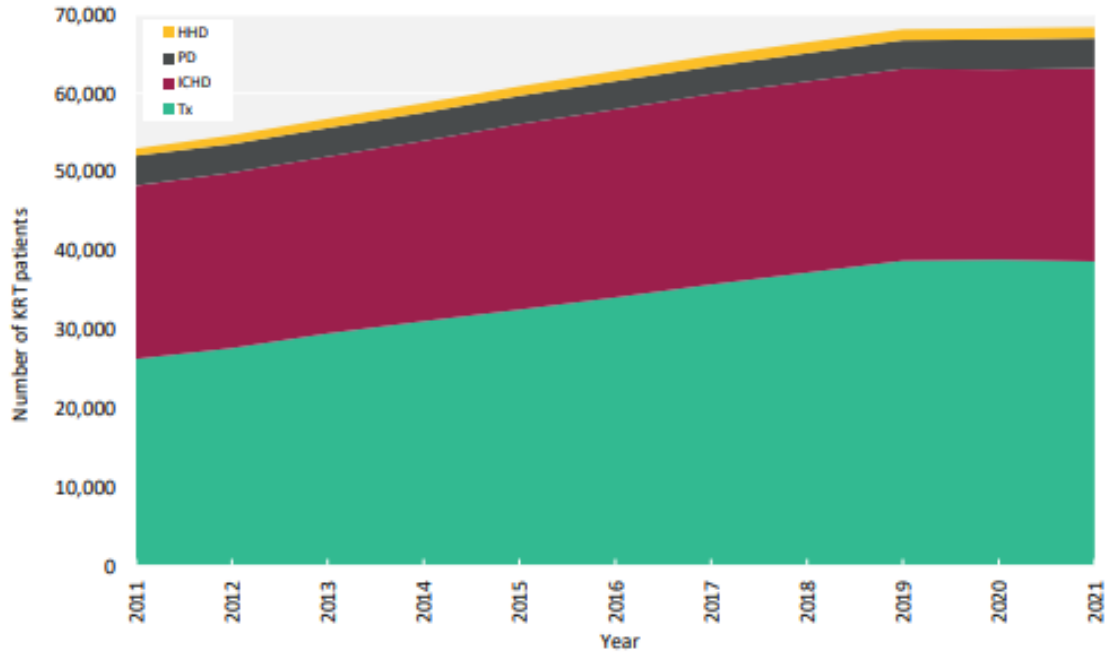
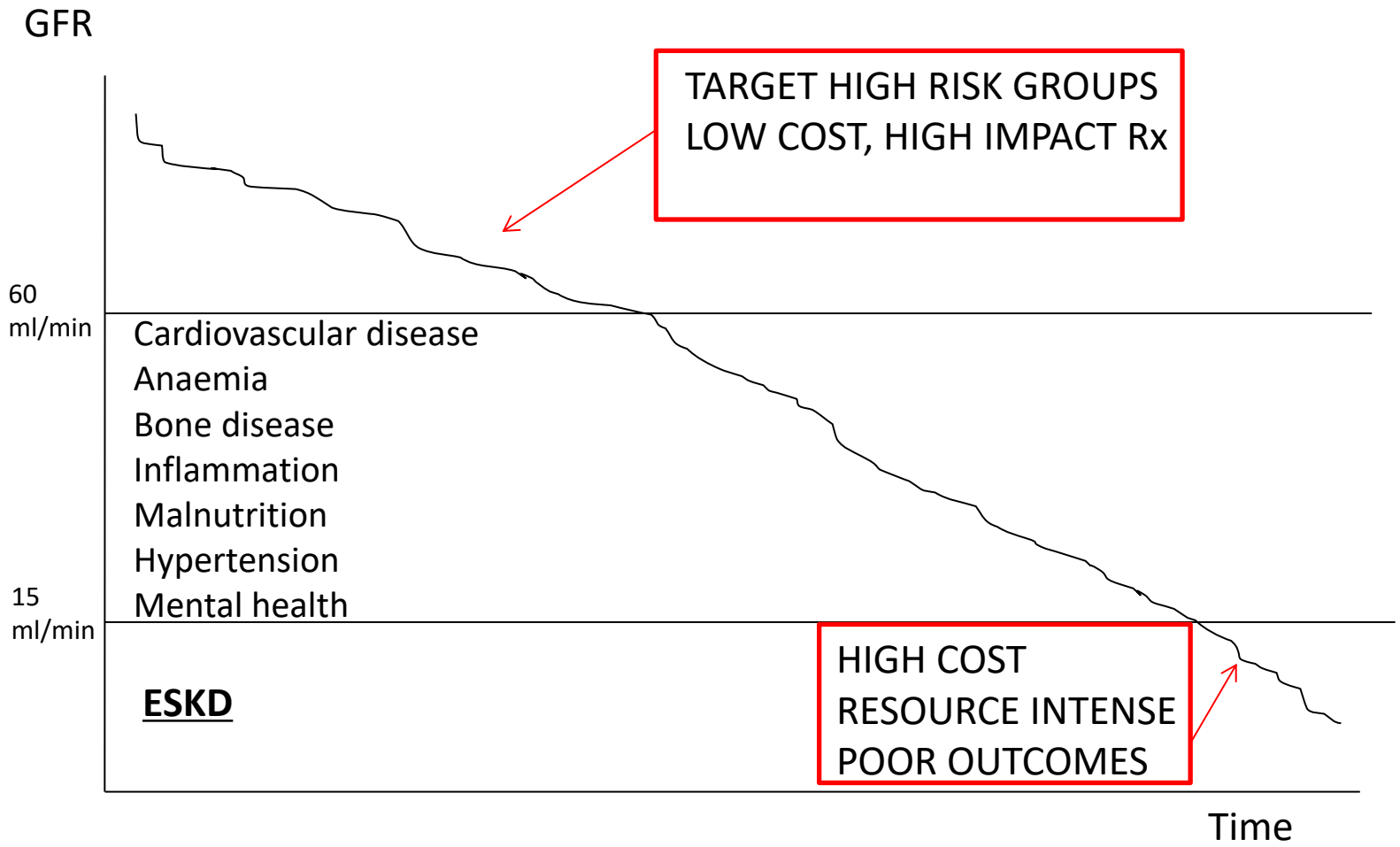
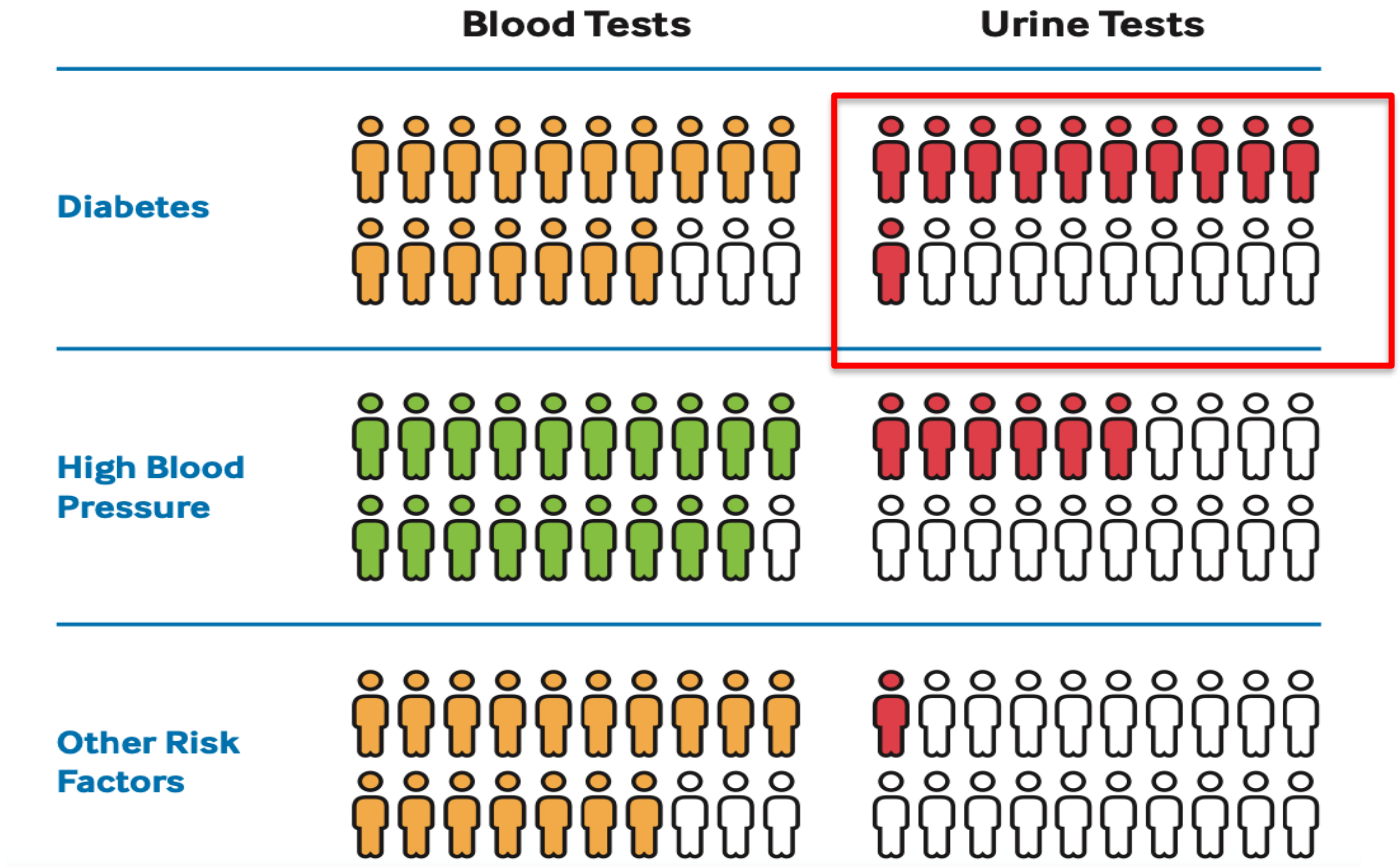



**Figure 3.7** Growth in numbers of prevalent adult KRT patients by treatment modality between 2011 and 2021

# Why intervene early in CKD?



# CKD diagnosis – missed opportunities




Need to embed urine ACR + KFRE in CKD monitoring

National CKD Audit Report 2017

# Outline

- Why is CKD important
- CKD classification and how to approach patient
- CKD Management
- Cases

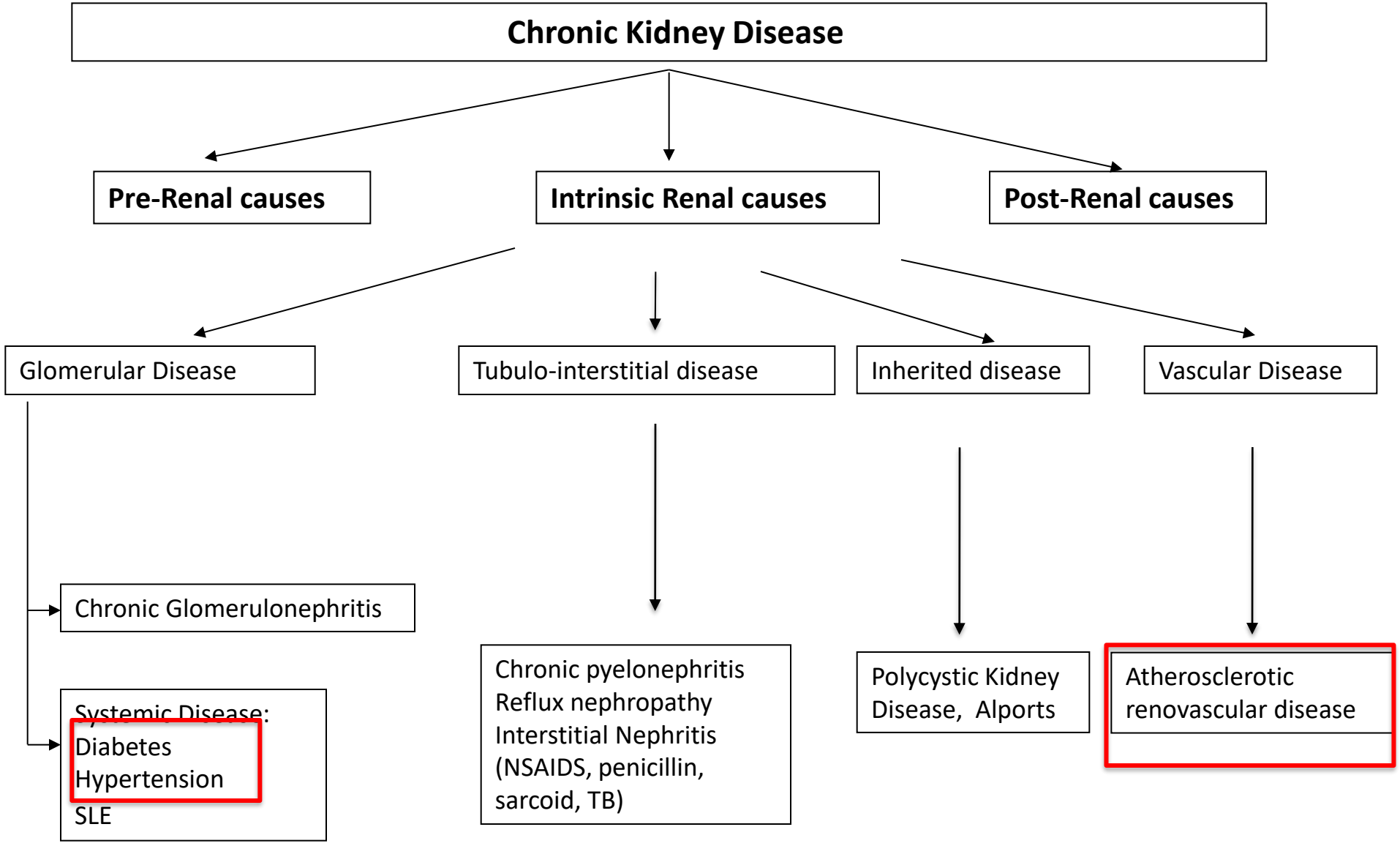
# Classification of CKD

**Prognosis of CKD by GFR and Albuminuria Categories: KDIGO 2012**

| GFR categories (ml/min/ 1.73m²) Description and range | | | | Persistent albuminuria categories Description and range | | |
|---|---|---|---|---|---|---|
| | | | | A1 | A2 | A3 |
| | | | | Normal to mildly increased | Moderately increased | Severely increased |
| | | | | <30 mg/g <3 mg/mmol | 30-300 mg/g 3-30 mg/mmol | >300 mg/g >30 mg/mmol |
| | G1 | Normal or high | ≥90 | | | |
| | G2 | Mildly decreased | 60-89 | | | |
| | G3a | Mildly to moderately decreased | 45-59 | | | |
| | G3b | Moderately to severely decreased | 30-44 | | | |
| | G4 | Severely decreased | 15-29 | | | |
| | G5 | Kidney failure | <15 | | | |

# What predicts progression to ESKD?

- BP
- Proteinuria
- eGFR at presentation
- Age
  - Young more likely to reach ESKD
  - Elderly more likely to die


Chronic Kidney Disease
Pre-Renal causes
Intrinsic Renal causes
Post-Renal causes
Glomerular Disease
Tubulo-interstitial disease
Inherited disease
Vascular Disease
Chronic Glomerulonephritis
Systemic Disease:
Diabetes
Hypertension
SLE
Chronic pyelonephritis
Reflux nephropathy
Interstitial Nephritis
(NSAIDS, penicillin, sarcoid, TB)
Polycystic Kidney Disease, Alports
Atherosclerotic renovascular disease

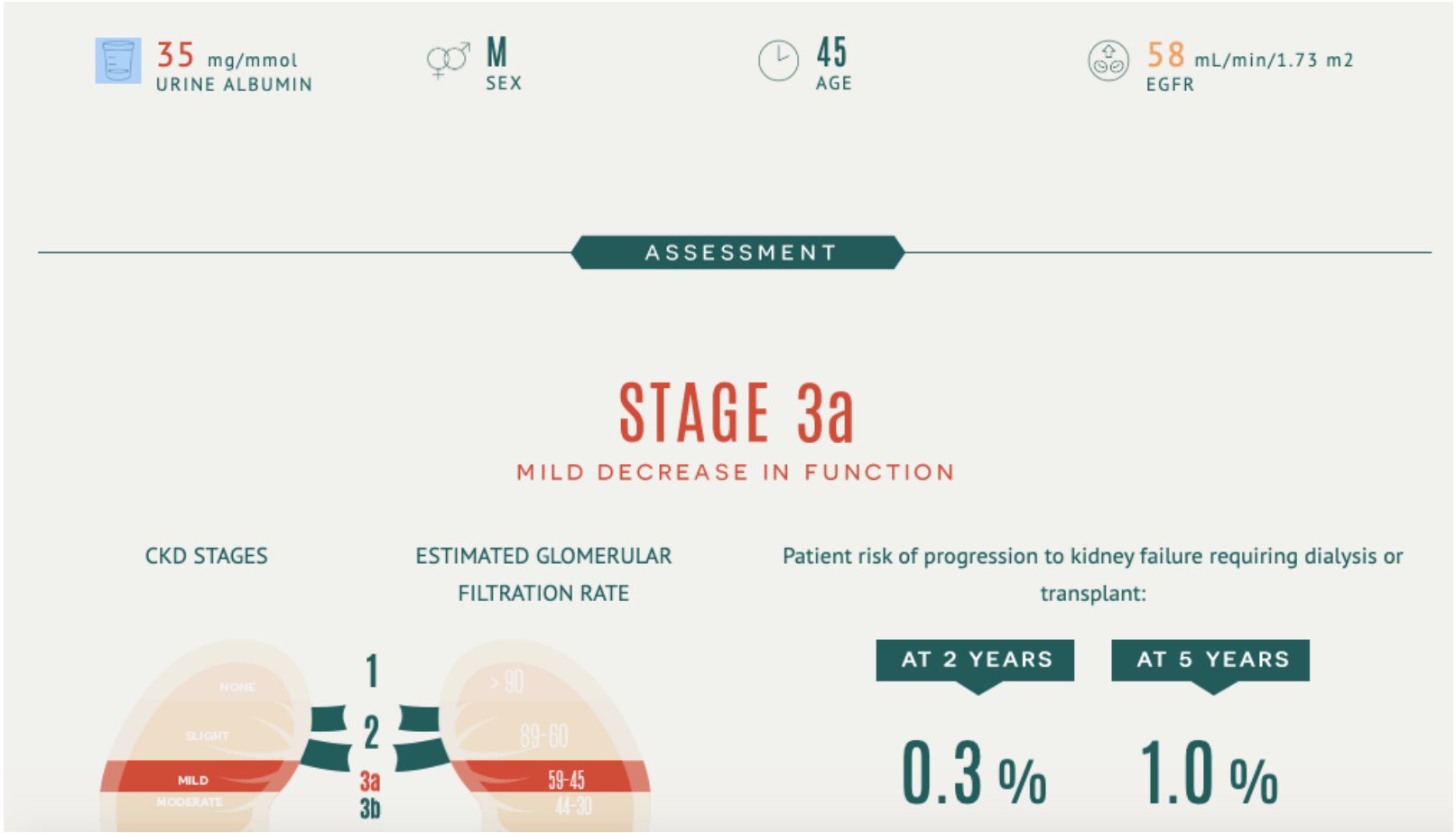
# How to screen?

- eGFR
- Urinalysis
- Albumin : Creatinine ratio – ACR*

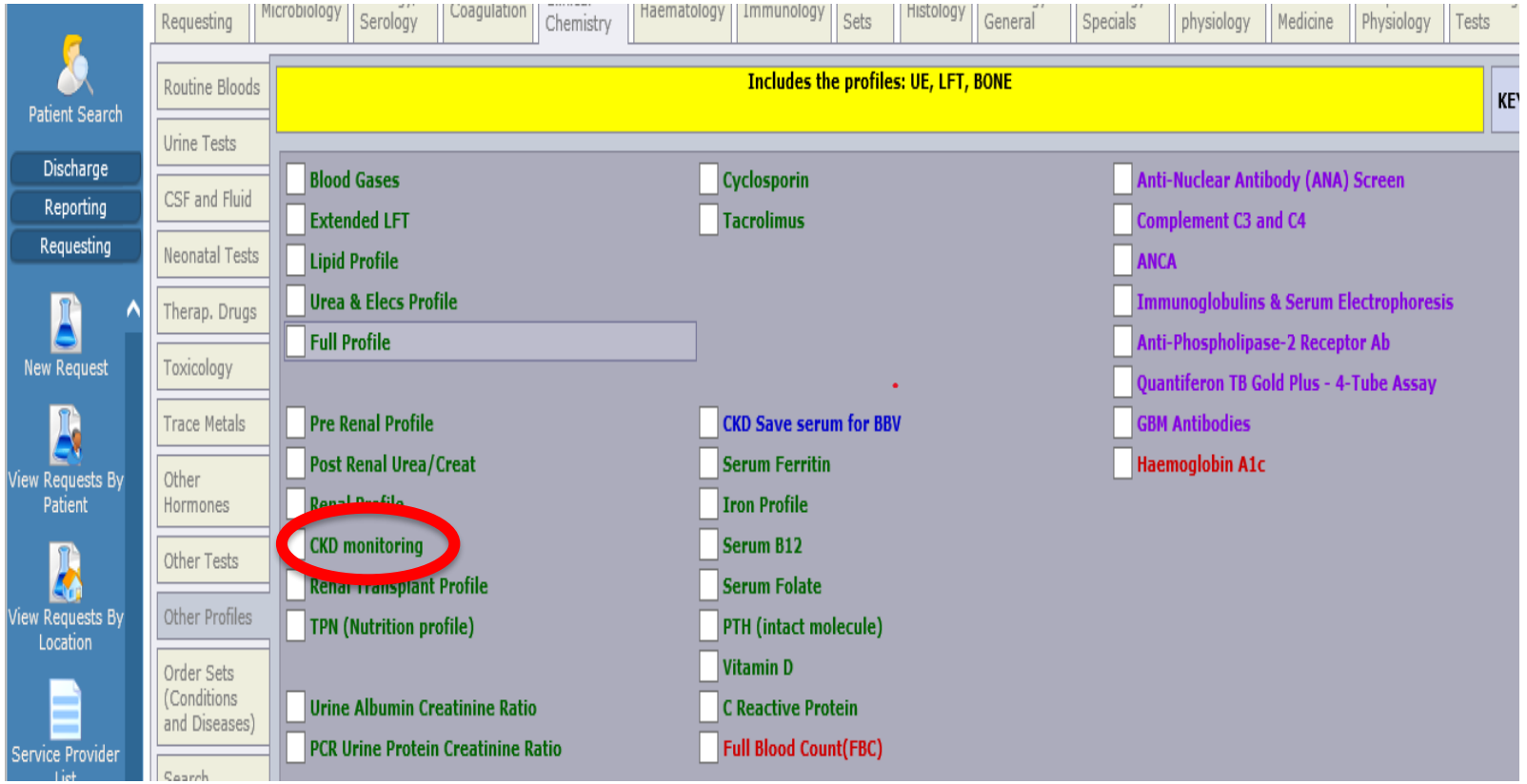
- **Kidney Failure Risk Equation**

- *NB ACR not valid on samples from a catheter, ileal conduit, with infection or pyuria

# What is the risk of kidney failure

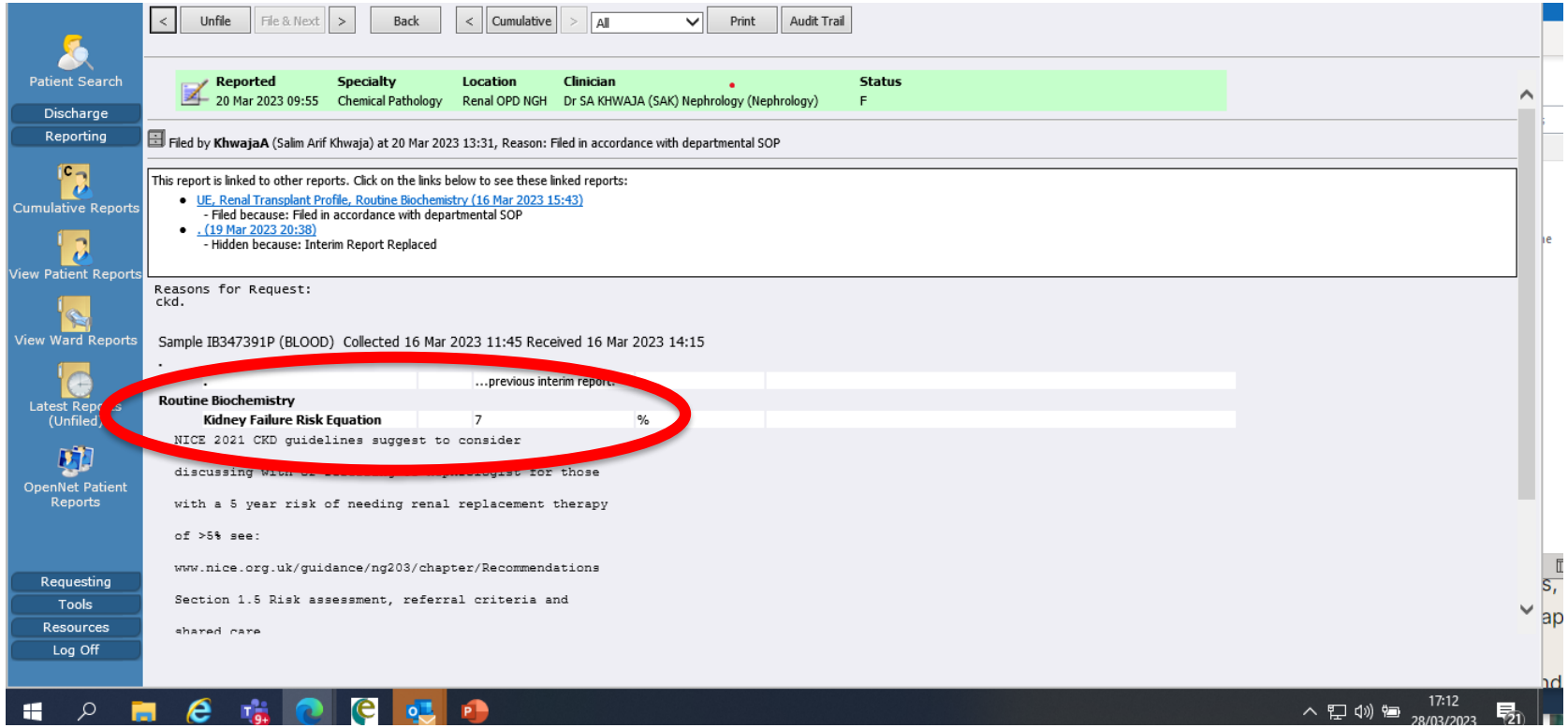


# Kidney Failure Risk Equation - ICE requesting




CKD Monitoring tab on ICE – renal profile and urine ACR; automatically reports a KFRE score

# Kidney Failure Risk Equation - ICE reporting



# CKD Management

# 4 pillars to save lives for adults with CKD

Pillar 1: RAAS Blockage and rapid titration

Pillar 2: SGLT2i

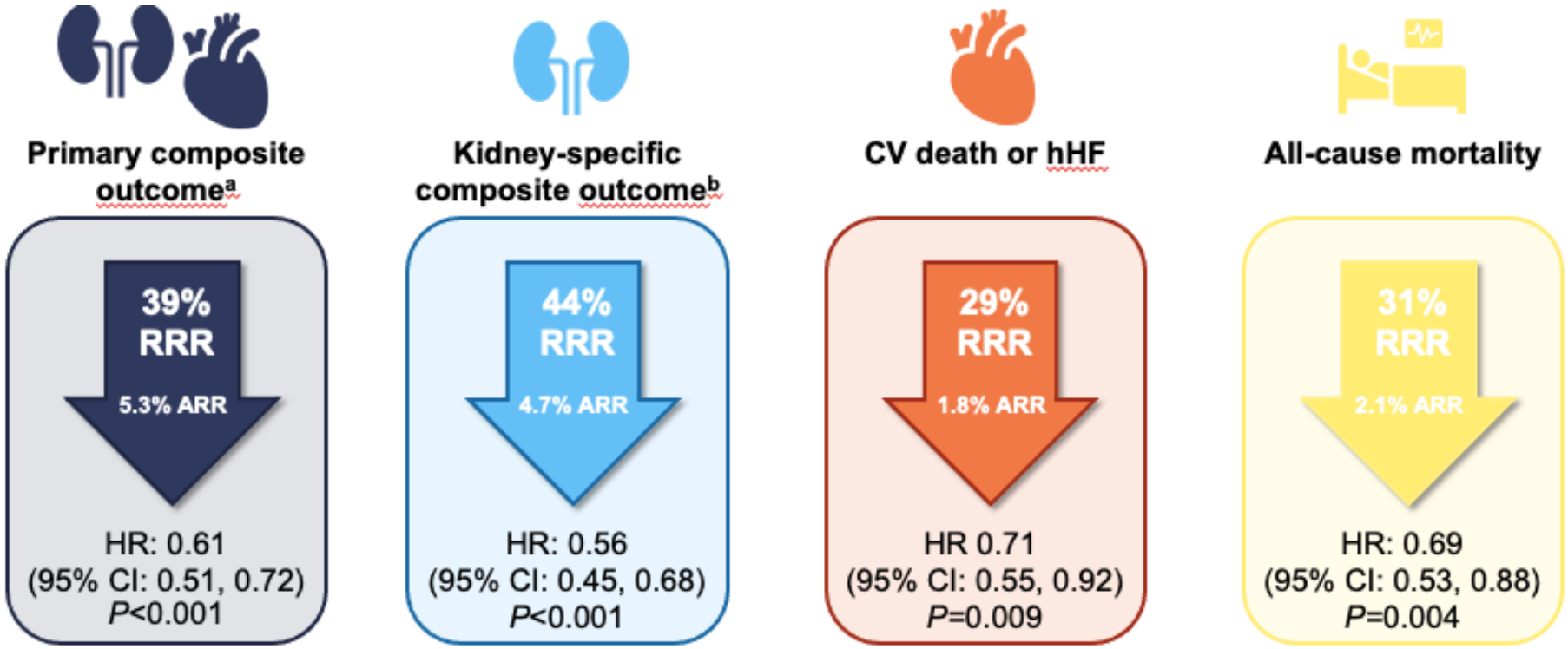
Pillar 3: Optimise BP and other cardiovascular risk factor

- Statin – Atorvastatin 20mg should be offered for primary prevention
- Aspirin
- Weight loss and smoking cessation

Pillar 4: Finerenone

GLP1a

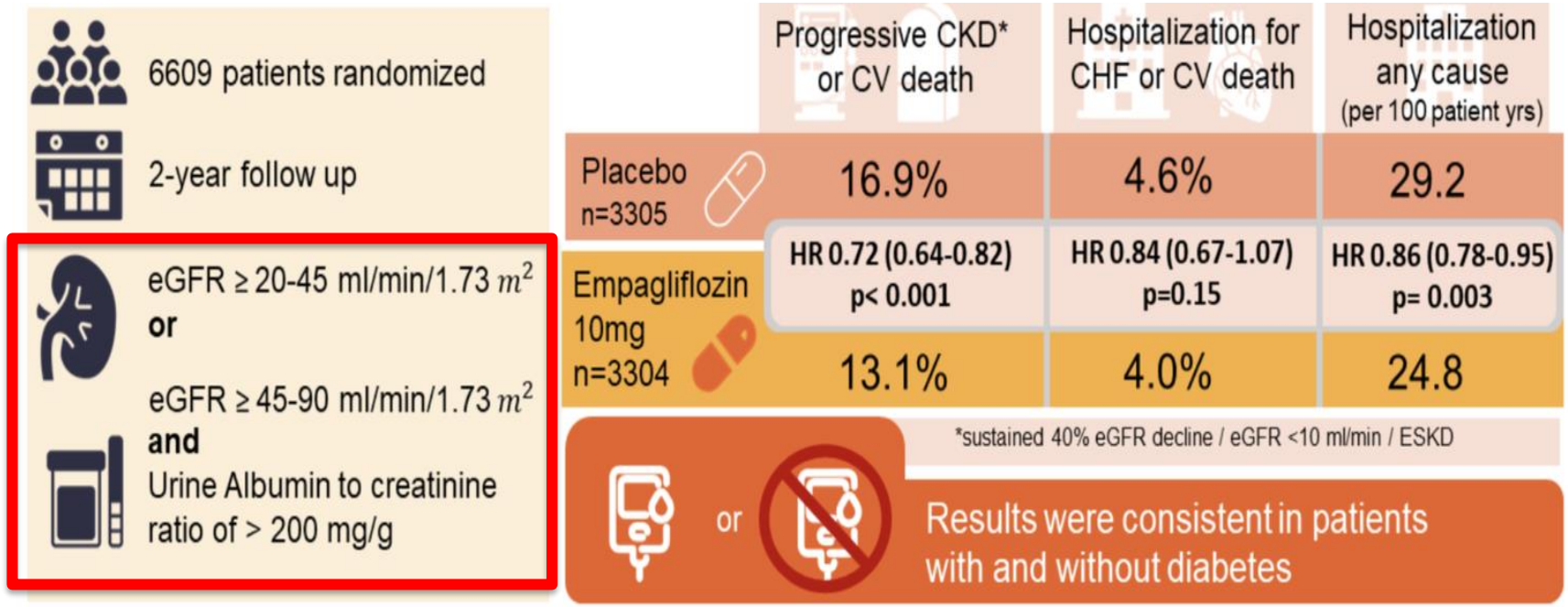
# Dapaglifozin and trial outcomes




Age 61+/-12

Heerspink HJL et al. Dapaglifozin in CKD. N Engl J Med 2020;383:1436-46.

# Empa-CKD Outcomes




Age 64+/-14

EMPA-Kidney Collaborative Group. N Engl J Med 2022 Nov 4 .

# CKD Management –SGLT2is

Dapagliflozin is recommended as an option for treating chronic kidney disease (CKD) in adults. It is recommended only if:

- it is an add-on to optimised standard care including the highest tolerated licensed dose of angiotensin-converting enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs), unless these are contraindicated, and
- people have an estimated glomerular filtration rate (eGFR) of 25 ml/min/1.73 $m^2$ to 75 ml/min/1.73 $m^2$ at the start of treatment and:
  - have type 2 diabetes or
  - have a urine albumin-to-creatinine ratio (uACR) of 22.6 mg/mmol or more.

Empagliflozin is recommended as an option for treating chronic kidney disease (CKD) in adults, only if:

- it is an add-on to optimised standard care including the highest tolerated licensed dose of angiotensin-converting enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs), unless these are contraindicated, and
- people have an estimated glomerular filtration rate of:
  - 20 ml/min/1.73 $m^2$ to less than 45 ml/min/1.73 $m^2$ or
  - 45 ml/min/1.73 $m^2$ to 90 ml/min/1.73 $m^2$ and either:
    - a urine albumin-to-creatinine ratio of 22.6 mg/mmol or more, or
    - type 2 diabetes.

| Low Risk<br>Prescribe SGLT2is | Moderate Risk<br>Prescribe with caution | High Risk<br>Do not prescribe SGLT2is |
|---|---|---|
| Monotherapy when metformin is contraindicated or not tolerated | History of PAD | **Diabetes contraindications:**<br>History of DKA |
| Dual therapy in combination with metformin or other oral agents | Osteoporosis or history of fractures | Rapid progression to insulin (within 1 year of diagnosis) |
| Triple therapy in combination with other oral agents | Frail/elderly (age> 75 years) | Latent autoimmune diabetes of adulthood (LADA) |
| Combination with insulin | History of foot ulceration | Ketosis-prone T2DM |
| Established CVD | CKD stage 3a (eGFR 45–60) or CKD stage 3b (eGFR 30–45) with ACR >30 mg/mmol† | Type 1 Diabetes (diagnosed or suspected) |
| Prior stroke | Receiving loop diuretics | Genetic diabetes |
| History of HF | High HbA1c levels (>86 mmol/mol or 10%) | Diabetes due to pancreatic disease |
| No history of LLA | Systemic steroid therapy | Existing/active diabetic foot ulcers |
| No history of PAD | Ketogenic diet (<5% carbohydrate content) | Previous LLA |
| Age < 75 years | BMI <25 kg/m$^2$ | **Non-diabetes contraindications:** |
| ACR <3 mg/mmol | Recurrent UTIs | Eating disorders |
| eGFR ≥60 mL/min/1.73 m$^2$* | Long-term catheter | Cognitive impairment |
| Overweight or obese (BMI >25 kg/m$^2$) | Men with benign prostatic hypertrophy | Acute illness |
| Vulnerable to the effects of hypoglycaemia | Mild to moderate liver impairment (Child-Pugh score A/B) | Alcoholism likely to increase the risk of falls and metabolic disturbances |
| No liver impairment | | Recent major surgery |
| | | Pregnancy, planning pregnancy or breastfeeding |
| | | History of Fournier's gangrene |
| | | Severe hepatic impairment (Child-Pugh score C) |

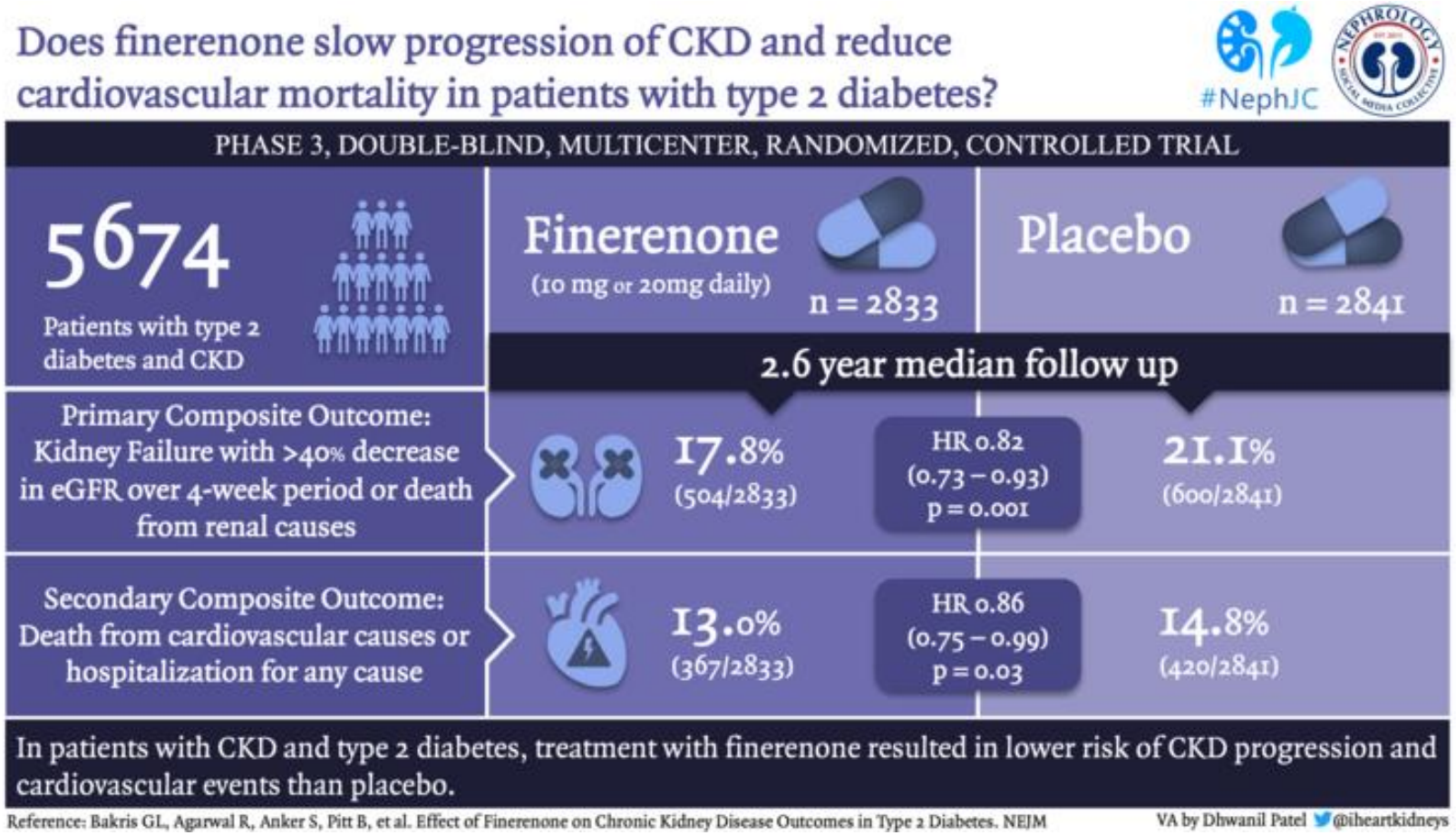
# CKD Management – Finerenone

## 1 Recommendations

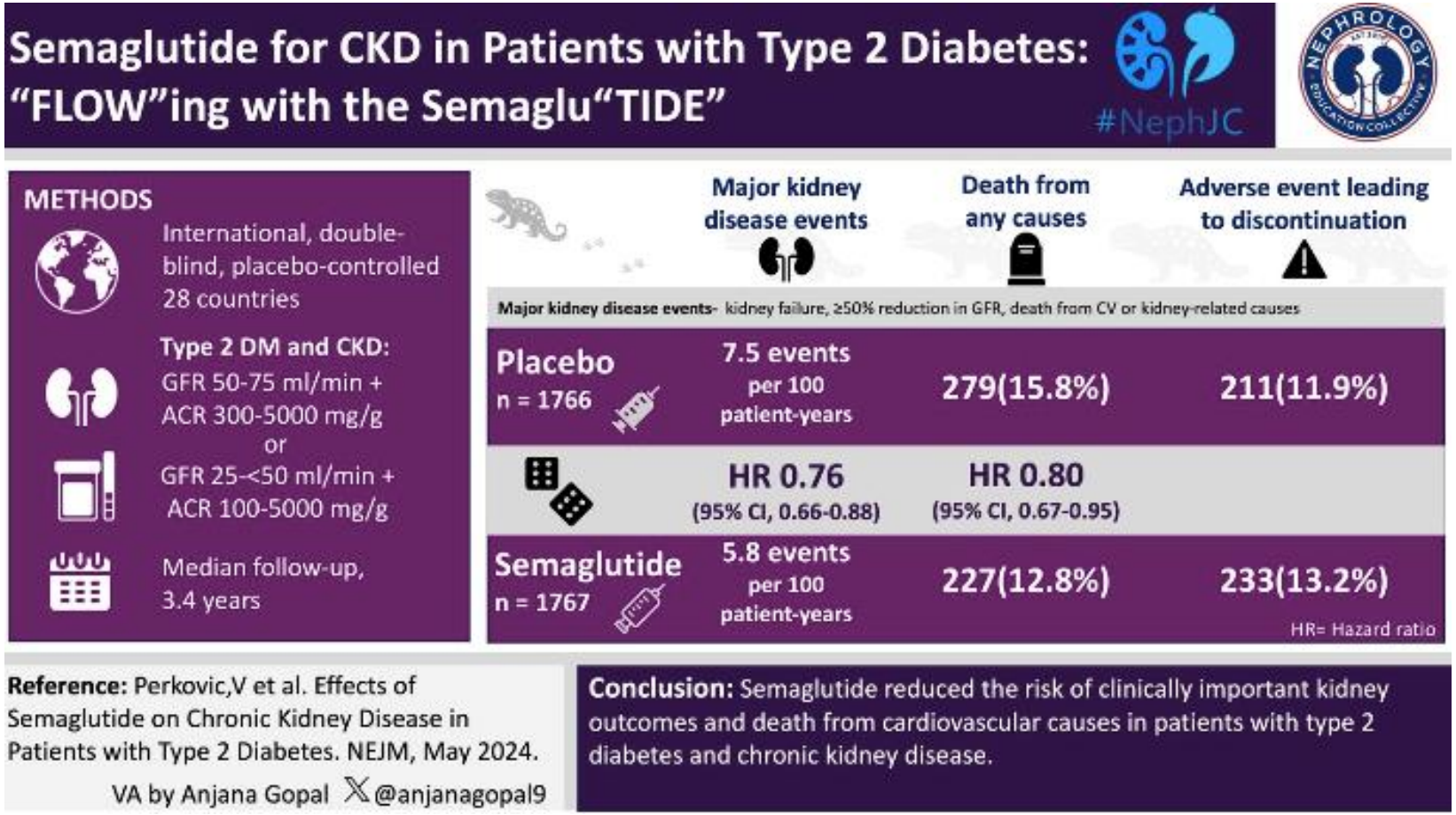
1.1 Finerenone is recommended as an option for treating stage 3 and 4 chronic kidney disease (with albuminuria, that is, an albumin to creatinine ratio that is persistently 3 mg/mmol [30 mg/g] or more) associated with type 2 diabetes in adults. It is recommended only if:

- it is an add-on to optimised standard care; this should include, unless they are unsuitable, the highest tolerated licensed doses of:
  - angiotensin-converting enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs) and
  - sodium–glucose cotransporter-2 (SGLT2) inhibitors and
- the person has an estimated glomerular filtration rate (eGFR) of 25 ml/min/1.73 $m^2$ or more.

# CKD Management – Finerenone



# CKD Management – Semaglutide



# Case Study

- 45 year old type 2 DM with hypertension and obesity
- eGFR 58 mls/min. ACR 35mg/umol. BP 142/78
- On Metformin 1g bd, ramipril 2.5mg, amlodipine 5mg aspirin and atorvastatin
- What are the next steps in management?
  - Optimise Ramipril
  - Add SGLT2i
  - Add finerenone
  - Liaise with diabetes re GLP1Ra

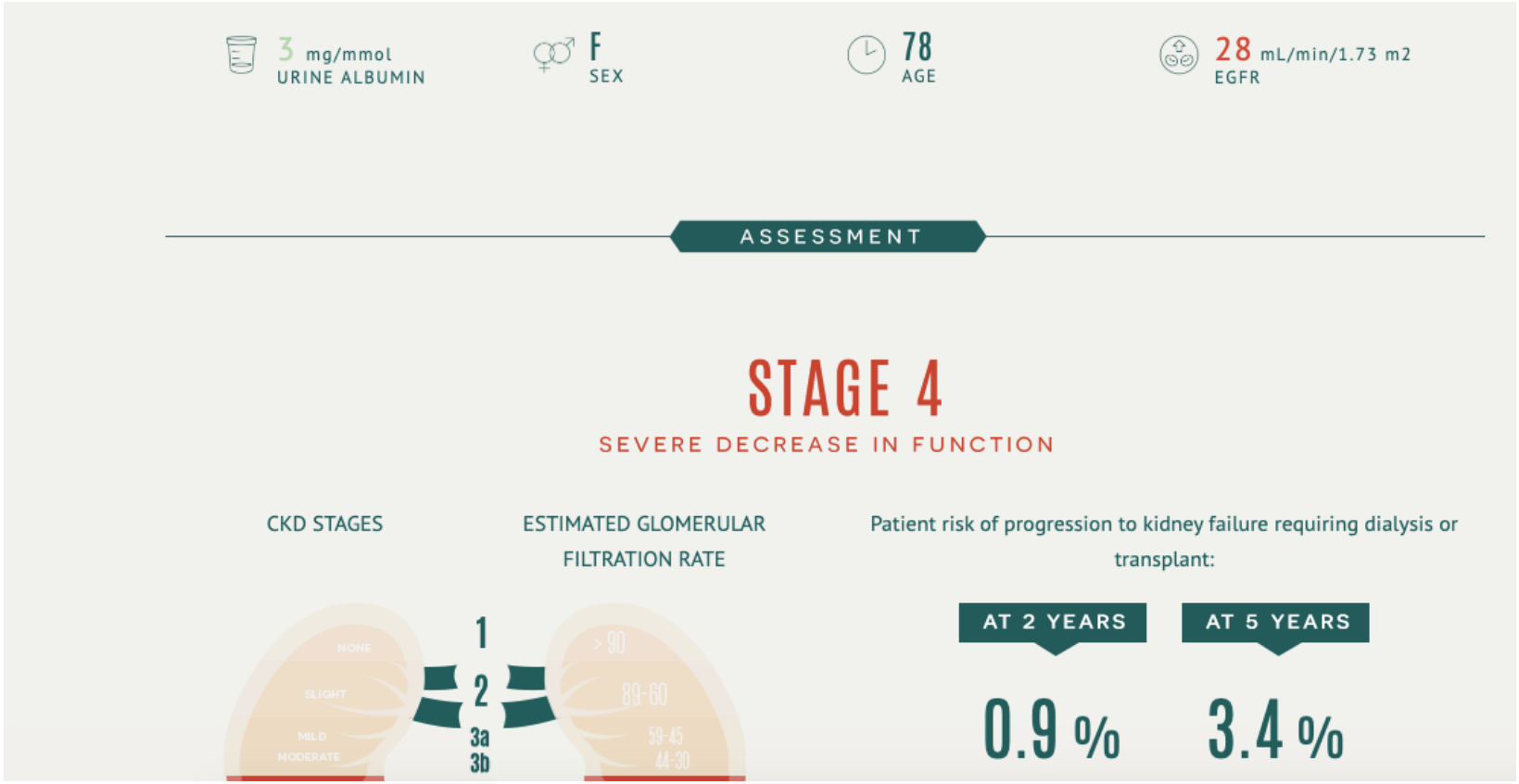
# Case Study

- 78 year old female, hypertensive with history of smoking and peripheral vascular disease. Urine dipstick was negative for protein and blood. BP=150/90. Last year eGFR 35mls/min.

- Now 28mls min. In view of progression of kidney disease please can you see. Rx: Aspirin, Simvastatin, Ramipril, Bendroflumethazide

  - What is the likely diagnosis?
  - How would you manage?
  - What is the risk of kidney failure?

# What is the risk of kidney failure



# Case Study- suggested management

- No nephrological indication for ACEI as no proteinuria and high risk of renovascular disease. Therefore trial stop ACEI
- High risk of cardiovascular death - already on aspirin/statin
- Add Empagliflozin 10mg day
- eGFR<30mlsmin – control BP <140 systolic – switch to loop diuretic

# CKD Management –SGLT2is

Dapagliflozin is recommended as an option for treating chronic kidney disease (CKD) in adults. It is recommended only if:

- it is an add-on to optimised standard care including the highest tolerated licensed dose of angiotensin-converting enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs), unless these are contraindicated, and
- people have an estimated glomerular filtration rate (eGFR) of 25 ml/min/1.73 $m^2$ to 75 ml/min/1.73 $m^2$ at the start of treatment and:
  - have type 2 diabetes or
  - have a urine albumin-to-creatinine ratio (uACR) of 22.6 mg/mmol or more.

Empagliflozin is recommended as an option for treating chronic kidney disease (CKD) in adults, only if:

- it is an add-on to optimised standard care including the highest tolerated licensed dose of angiotensin-converting enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs), unless these are contraindicated, and
- [illegible]
  - 20 ml/min/1.73 $m^2$ to less than 45 ml/min/1.73 $m^2$ or
  - 45 ml/min/1.73 $m^2$ to 90 ml/min/1.73 $m^2$ and either:
    - a urine albumin-to-creatinine ratio of 22.6 mg/mmol or more, or
    - type 2 diabetes.

# CKD – Case study

- 81 year old Type 2 diabetic, hypertensive. female recently moved to your practice. BP= 132/90. Routine bloods show creatinine 180 umol/l with eGFR 26. uACR = 5mg/umol. HbA1C = 52. Frail

- Creatinine = 150 in 2019.

- On Aspirin, atorvastatin, ramipril, Linagliptin
  - What is the risk of kidney failure?
  - Would you do anything else?

# CKD – Case study

- Tell the patient she has slowly progressive  CKD

- In theory may benefit from an SGLT2i (+/- finereone) – but perfectly acceptable to leave alone as risk of kidney failure alone

# Case Study

- 72 yr old female. History of type 2 diabetes, heart failure and diabetic retinopathy.
- eGFR = 35 mls/min. ACR=150.
- BP=158/88.

- Treatment: aspirin, atorvastatin, metformin, ramipril and doxazosin
  - Whats the likely diagnosis and risk of kidney failure?
  - What should you do?

# Case Study

- Likely diagnosis – diabetic nephropathy – in view of retinopathy
- High risk of progression to end-stage disease – proteinuria, diabetes, poor BP. Therefore tertiary referral appropriate
- Start SGLT2i – CKD and heart failure
- Ensure Metformin dose correct – lactic acidosis

150 mg/mmol
URINE ALBUMIN

F
SEX

72
AGE

35 mL/min/1.73 m2
EGFR

ASSESSMENT

# STAGE 3b

MODERATE DECREASE IN FUNCTION

CKD STAGES

ESTIMATED GLOMERULAR FILTRATION RATE


Patient risk of progression to kidney failure requiring dialysis or transplant:

| AT 2 YEARS | AT 5 YEARS |
| --- | --- |
| 2.9 % | 10.0 % |

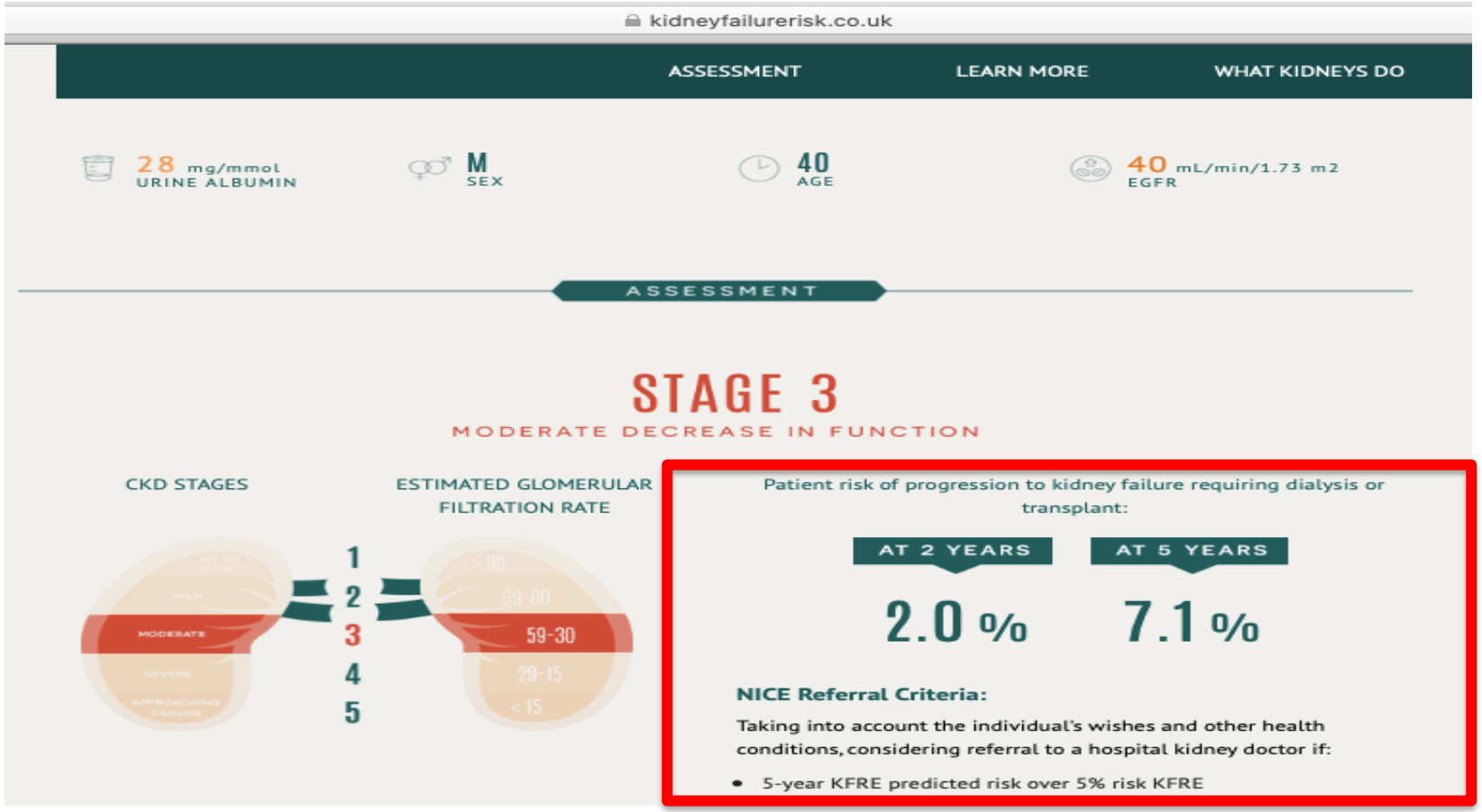
# CKD – Case study

- Very well 30 year old male comes to you as part of an insurance medical. On no medication. Urinalysis 1+ haematuria. ACR = 28mg/umol. eGFR = 40mls/min.

- No historical creatinines. BP =130/80

- What would you do next?

# Kidney Failure Risk Equation[1]




1. https://kidneyfailurerisk.co.uk/

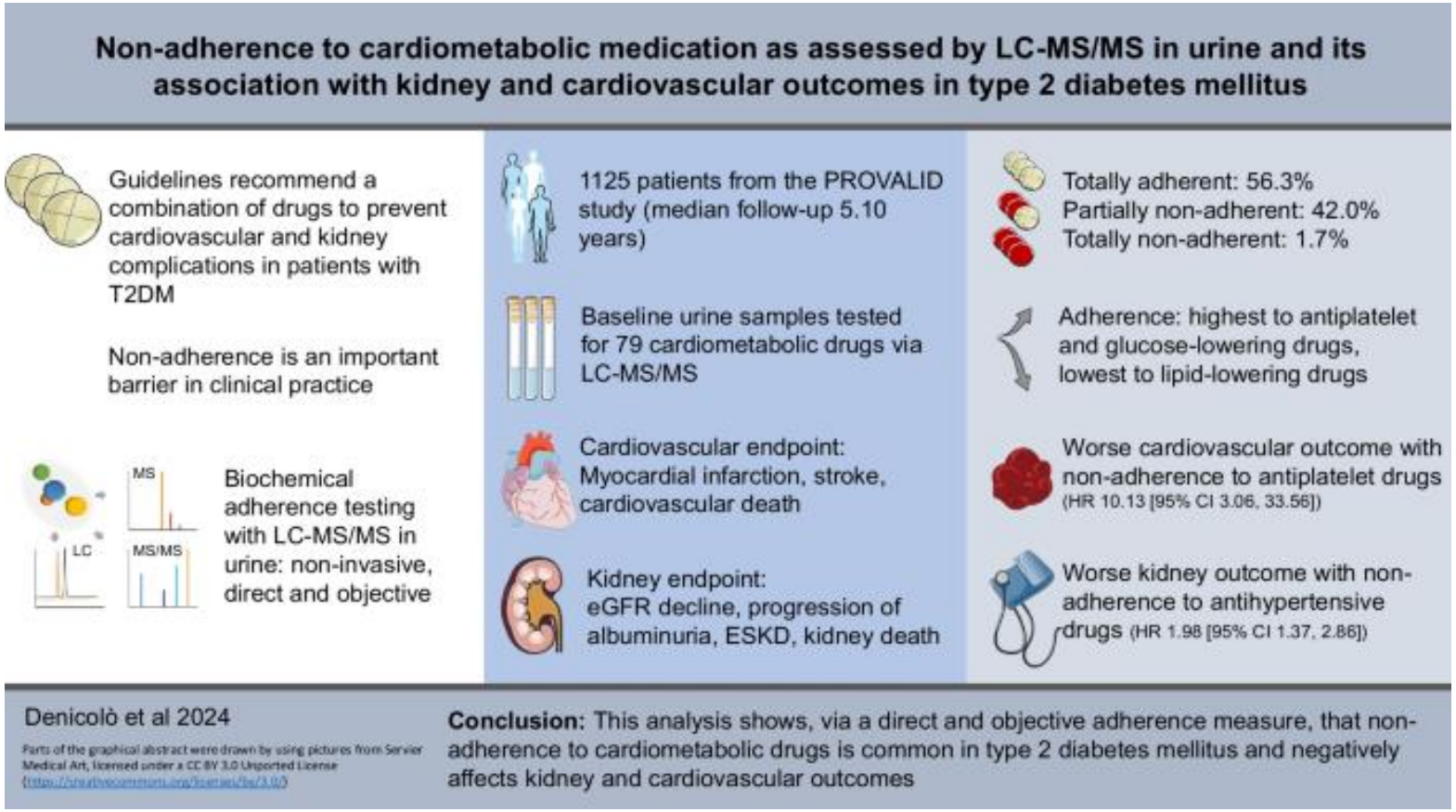
# CKD – Case study

- Repeat creatinine and dipstick within 7-10 days.
- Repeat bloods and urine unchanged
- Likely IgA nephropathy – start SGLT2i and refer to nephrology

# NICE referral criteria

- Patients with eGFR <30 ml/min , but if >30 ml/min, referral will depend on below criteria.
- 5-year KFRE >5% (5 year risk of needing RRT )
- UACR >70 mg/mmol
- UACR >30 with associated microscopic haematuria
- Sustained decline in eGFR >25% or more within 12 months
- Sustained decline in eGFR >15ml/min within 12 months
- Suspected RAS
- Poorly controlled HTN (>4 anti HTN)
- Suspected genetic cause of CKD

# We can't prescribe our way out of CKD



# Key messages

- **When monitoring CKD routinely use the 'CKD Monitoring' request on ICE**

- NICE recommend to discuss patients (with eGFR <60mls/min) with nephrology if  Kidney Failure Risk (Equation) >5% at 5 years

- SGLT2is are foundational treatments in both diabetic and non-diabetic kidney disease

# Key messages

- Finereone for T2DM with an eGFR between 25-60mls/min and ACR >3
- Think GLP1RAs for diabetics with CKD – especially for obese
- If you want to do virtual CKD MDTs , please contact us.

# Radiology

Dr Matt Kinsella
Consultant Radiologist
BHNFT

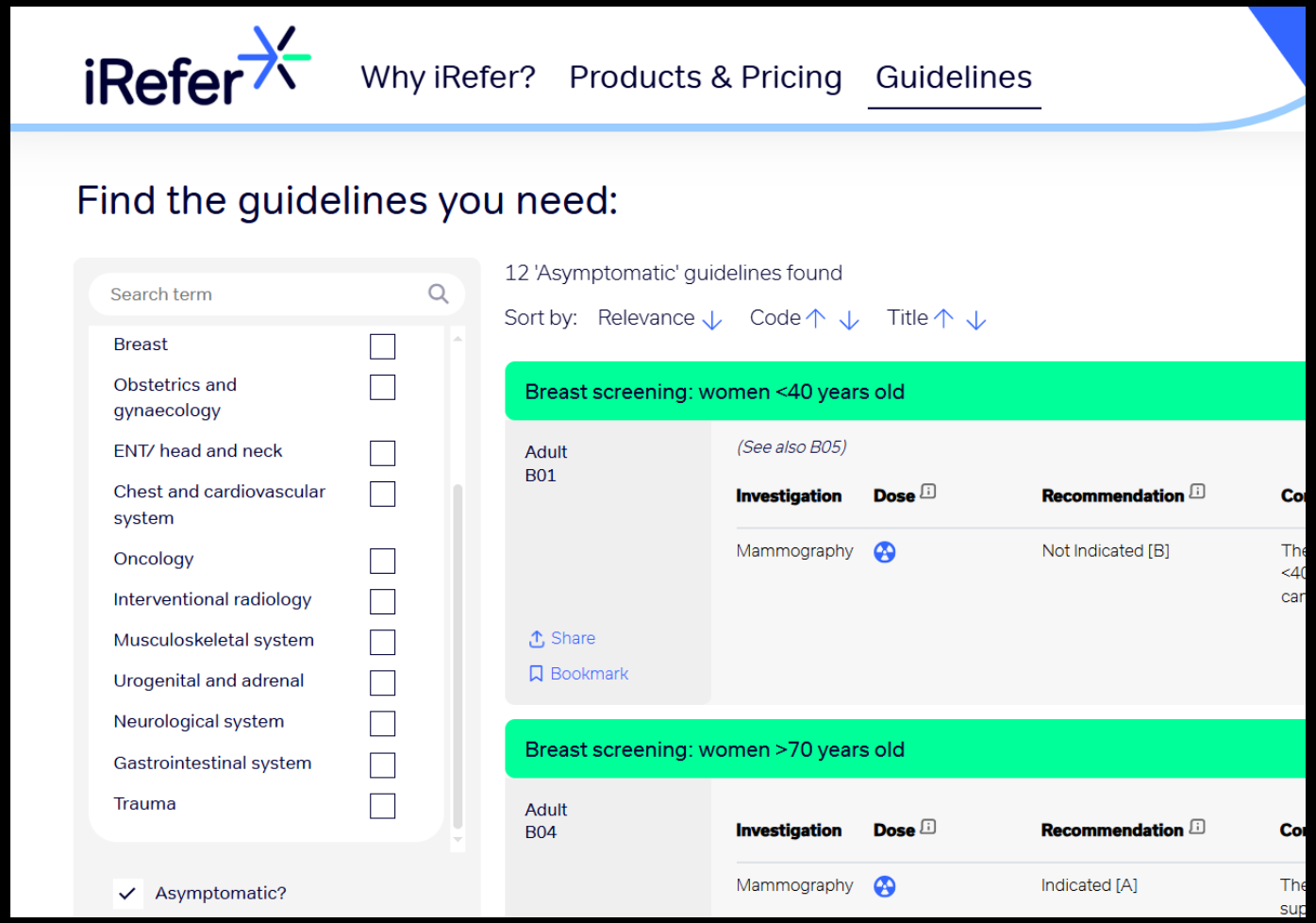
BEST website Resources:
Radiology - CT Scan - MRI - US - Xray - BEST
radiology-alerts-and-notification-of-imaging-reports-oct-2022.pdf

# GP meeting

Dr Matt Kinsella

Consultant Radiologist

# Do I dare ask.....

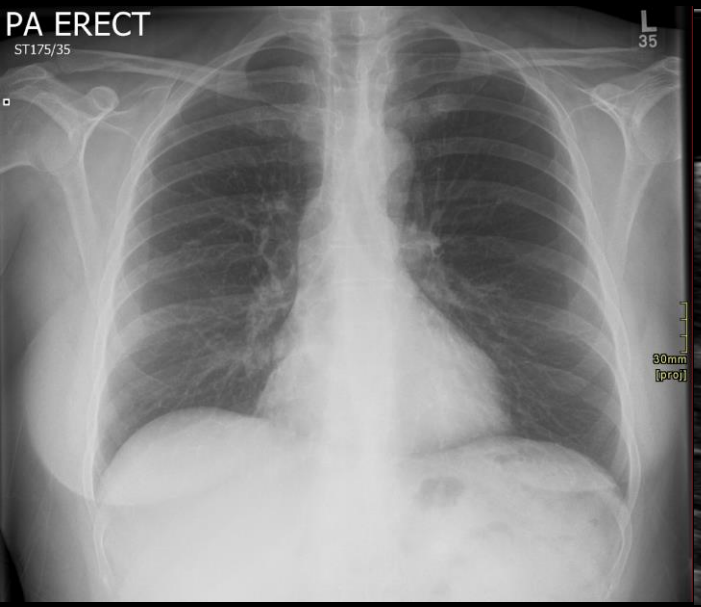



alison.lamb11@nhs.net

maxineharrison@nhs.net

# Plan

- Our service
- CDC
- Referrals
- Codes and alerts
- Q and A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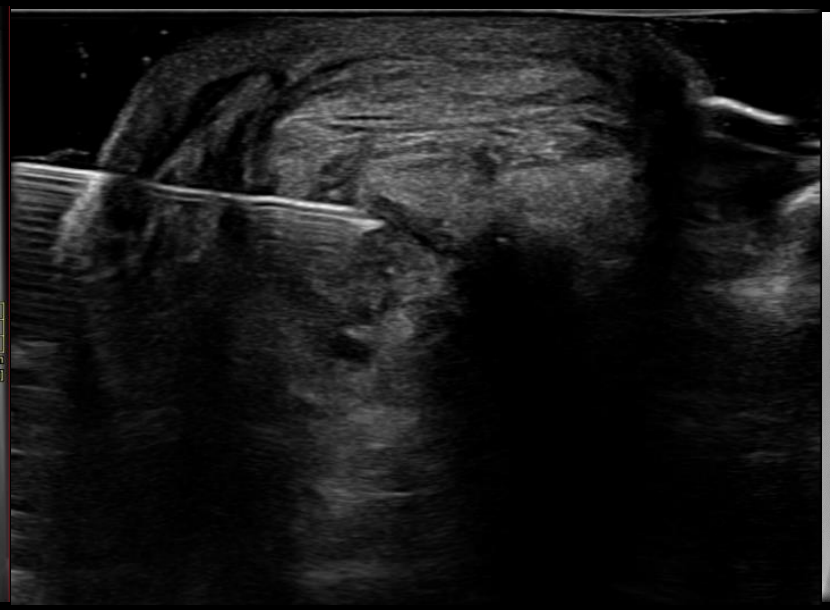
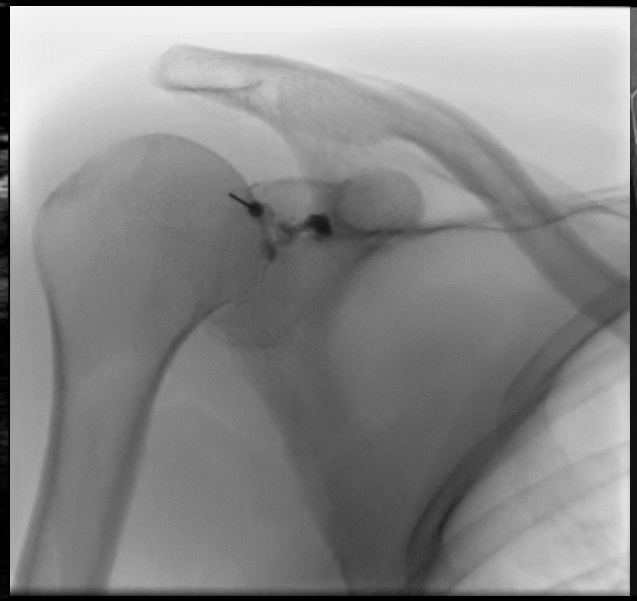
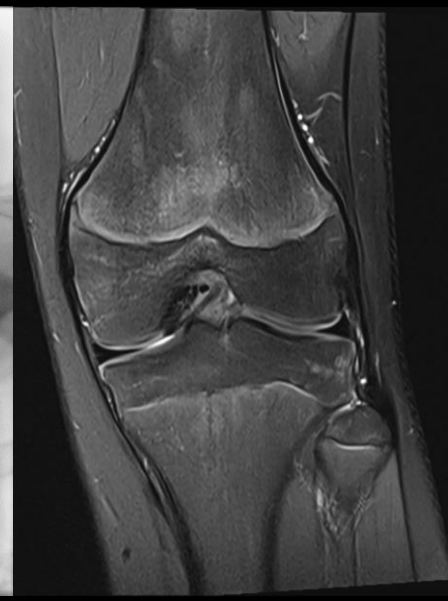
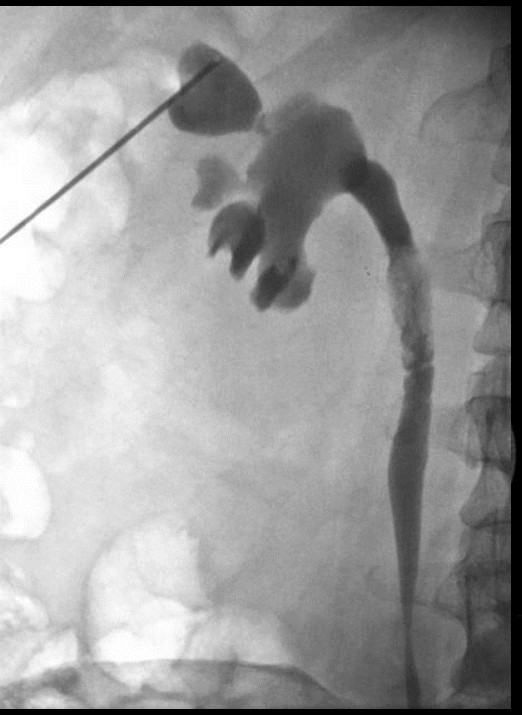
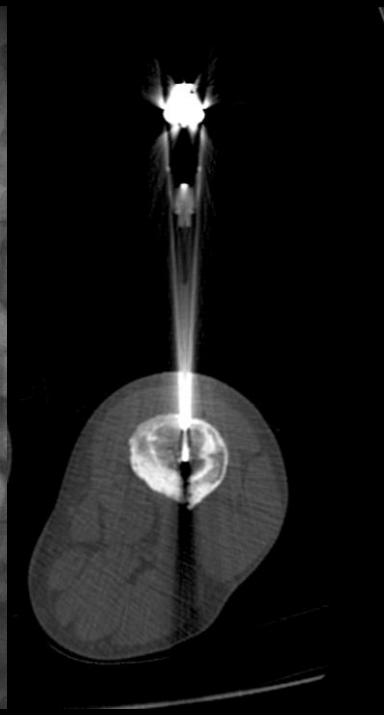
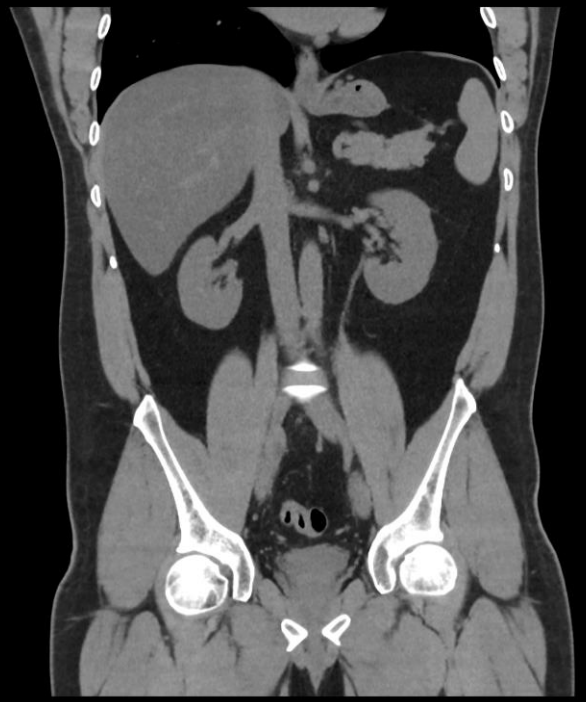


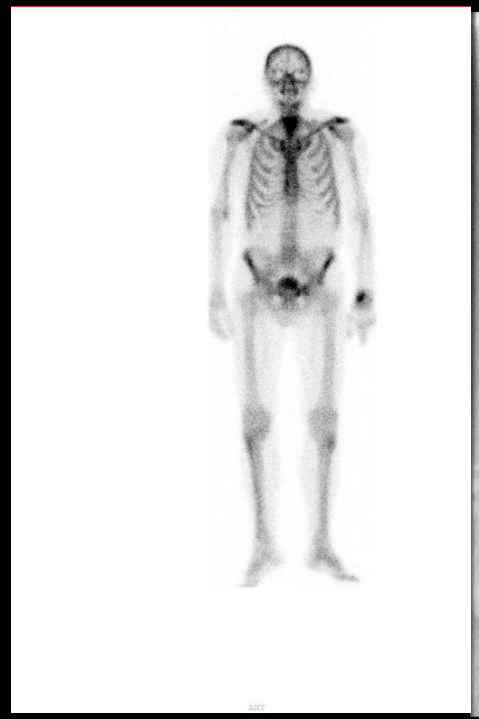


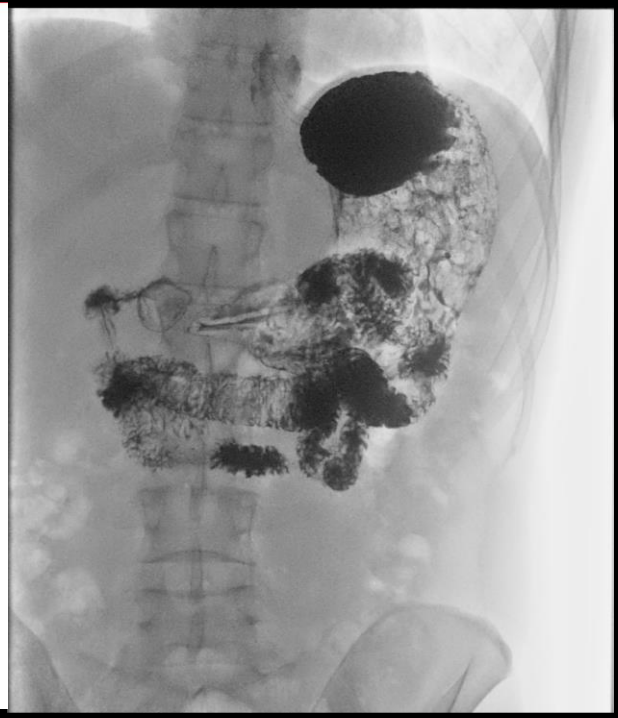













Welcome to the
Barnsley Community
Diagnostic Centre
Reception


NHS
Barnsley Hospital
NHS Foundation Trust
Community
Diagnostic
Centre


Breast Imaging Unit


Blood Tests


bdg-tr.pacsteam@nhs.net

Based on the chest radiograph appearances, your patient requires further imaging with CT. Cancer Services will alert the Cancer Nurse Specialist to this report and the nurse will contact your patient directly to arrange blood tests and a CT scan of the chest and upper abdomen.

**********

This report may contain an unexpected or important finding.
Further clinical and / or radiological investigation may be required.
Prompt urgent attention to the report is advised.
Please ensure and document that this report has been acted upon.

**********

Comment

Appearances may represent malignancy and or require further investigation on a 2ww pathway to exclude this.

Your patient now requires further imaging:

** delete as appropriate**
**Staging CT Thorax and abdomen
**Staging CT chest / abdomen/ pelvis
**MRI (BODY PART)
**Superficial / low risk Biopsy

A Cancer Specialist Nurse has been alerted to this report and will contact your patient directly to arrange blood tests and recommended tests.

**********

This report may contain an unexpected or important finding.
Further clinical and / or radiological investigation may be required.
Prompt urgent attention to the report is advised.
Please ensure and document that this report has been acted upon.

**********
**********
This report contains a non-critical finding.

Electronic notification has been sent automatically to the referrer.

Please ensure and document that this report has been acted upon.

**********
**********

**********
**********

This report contains a CRITICAL finding requiring prompt urgent attention and action.

The referring team has been contacted.

Please ensure and document that this report has been acted upon.

**********
**********

**********
**********
*Provisional new cancer diagnosis*
*Significant unexpected change in a known cancer*
*(Delete as appropriate)

Please discuss in xxxSPECIFY HERExxx MDT.
Please ensure and document that this report has been acted upon.

**********
**********


Q
?
A

# Time for a refreshment break

# Sexual Health

Dr Sylvia Bates and Dr Catherine Bateman
Spectrum Sexual Health Services

BEST website Resources:
National guidelines and pathways – BEST
Patient information sheets - BEST

# BEST meeting
# HSV in pregnancy, HIV and clinic services

*Dr Sylvia Bates*

# HSV in pregnancy

New BASHH guidance - Main changes:

Much more emphasis on reduction of acquisition of HSV in 3rd trimester

Change in thinking on ‘recurrence’ in pregnancy

Earlier suppression with aciclovir

# Stage of disease

- Initial (1/3 are asymptomatic)
  - Primary
  - Non primary
    - Prior infection with one type of HSV, now has the other.
- Recurrence

**Tests**

HSV 1+2 Antibody – serology

HSV PCR from lesion  (pink swab for genital, green swab for extra genital)

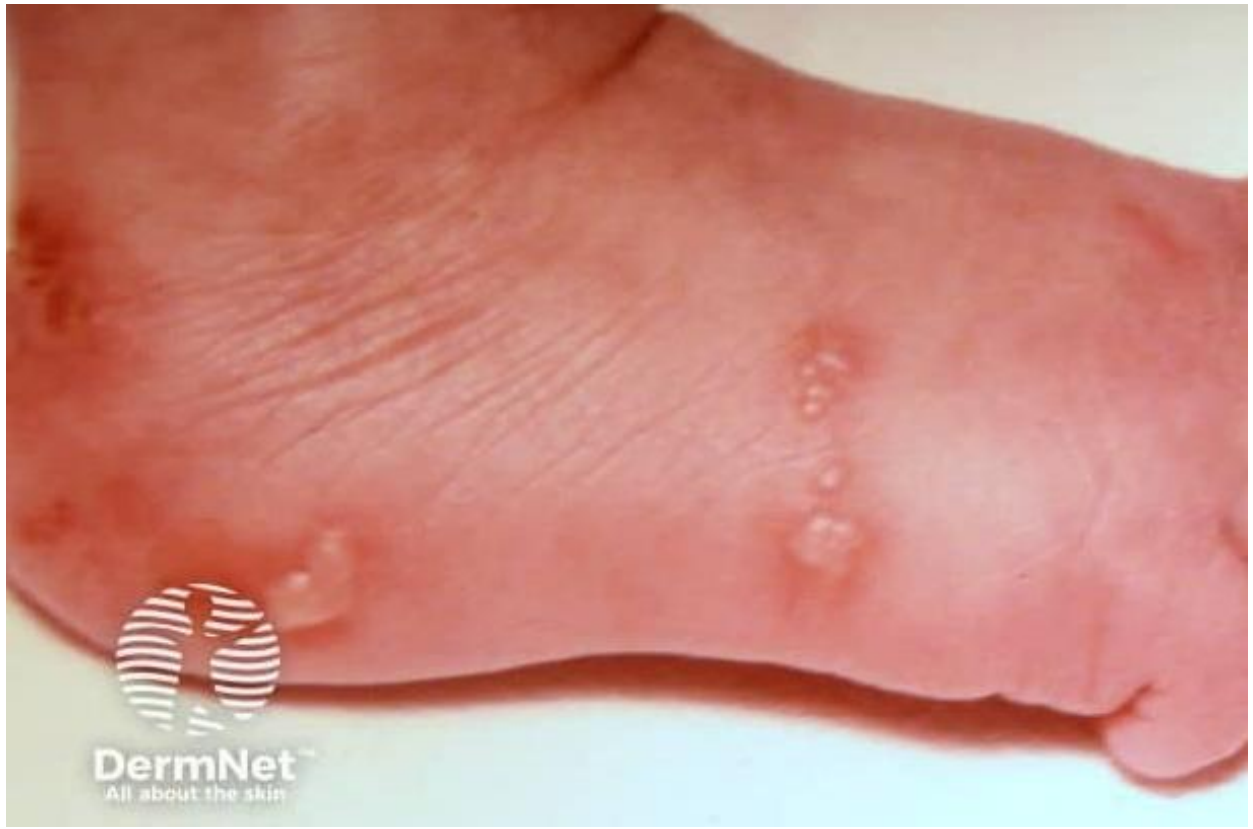
# Neonatal HSV

- 75-85% at birth
- 10-25% postnatal
- 5% in utero

- 52% HSV 1, 48% HSV 2

- Highest risk if :
  - initial episode within 6 weeks of delivery
  - absence of transplacentally-acquired maternal neutralising antibodies
  - Prolonged duration of rupture of membranes before delivery
  - mode of delivery - vaginal greater risk
  - use of assistance (vacuum, forceps or foetal scalp electrodes).

# Neonatal HSV




- 1/3 SEM – Skin eyes mouth
  - 0% mortality, 6% Morbidity (neurological, ocular)
- 1/3 CNS
  - 15% mortality, 64% morbidity (epilepsy, blindness, cognitive function, developmental delays)
- 1/3 disseminated
  - 66% mortality, 41% morbidity

# BASHH / RCOG guidance

At the first antenatal (booking) appointment all mothers and pregnant people should have a discussion and be given information on infections that can impact on the baby in pregnancy or during birth (including herpes simplex virus).

A careful history should be taken to identify any previous possible herpetic symptoms or diagnoses as per NICE guidance

Those with suspected genital herpes should be referred to genitourinary medicine (GUM)

Identification of women with partners who have HSV (**Discordant couples**)

# Advice in pregnancy

- to seek immediate medical advice if they develop genital ulcers during pregnancy.
- to avoid any sexual contact from 26 weeks gestation*
- about risk reduction post-delivery*
- to report symptoms in baby within the first 6 weeks immediately (Skin, eye and mucous membrane lesions, lethargy/irritability, poor feeding, fever).
- that suppression will be offered to those with confirmed HSV, usually from 32 weeks (22 weeks if risk of premature delivery). Advice should be sought if outbreaks occur whilst on suppression.
- If discordance, to seek immediate medical advice if they get genital ulcers for the first time within 4 weeks of delivery

# Risk reduction in pregnancy

## Risk reduction

- Abstinence from sexual activity (including vaginal, anal and oral sex, and mutual masturbation) in the third trimester and the 2 weeks prior to this – From 26 weeks

- If unacceptable
  - Selective abstinence during recurrences and prodromes.
  - Male condoms used consistently and correctly
  - Antiviral suppression of the sexual partner

- Undertaking serology in this situation may help guide the discussion.

# Risk reduction post delivery

- Everyone should wash their hands prior to touching the baby.
- The baby should not be kissed by people who are not very close family members or carers of the baby.
- Those kissing the baby should kiss the top of the baby's head and avoid kissing near the baby's mouth, nose and eyes (to avoid mucous membranes).
- People with current cold sores should never kiss the baby, and those with a history of cold sores should avoid kissing the baby.
- People with active herpes lesions at any site should avoid touching the baby unless they are very close family members or carers of the baby, and in this case, they should practice good hand hygiene.
- Health care professionals with current active lesions, or recurrent cold sores or herpetic whitlows who work on neonatal wards, other wards with babies should seek occupational health advice

# Assessment in pregnancy – presents with symptoms

- New lesions? Do a swab, start acyclovir  and refer urgently to GUM
- Signs disseminated HSV in mother – hepatitis, encephalitis, disseminated skin rash, viral sepsis – Admit to ward

- If recurrence, do a swab, refer to GUM and inform obstetric team of referral

Referrals by:

- Phoning us – 0800 055 6442
- Email - schcic.bishadmin@nhs.net

# Discordant partners

- Mother doesn’t have HSV – partner does
- Antibody testing of both partners MAY be helpful
  - Interpretation needs to be in context of clinical presentation
  - False negatives / loss of antibody response

- Partners may attend with a letter requesting HSV 1+2 antibody testing
- Please email BISH if antibody testing is done

# HIV Advances in care

# U=U*

# UNDETECTABLE
## viral load means HIV IS UNTRANSMITTABLE

www.i-Base.info/u-equals-u

Michelle Rees, clinic

Angelina Namiba, Salamander Trust

"A person with sustained undetectable levels of HIV in their blood cannot transmit HIV to their sexual partners."

Simon Collins, HIV i-Base

Chloe Orkin, Chair, British HIV Association (BHIVA)

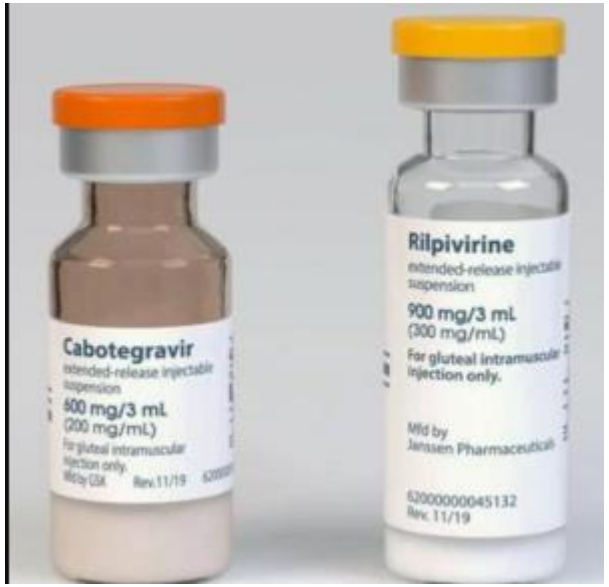
*** Undetectable = Untransmittable**

Poster produced by HIV i-Base for Kobler@CWH (July 2018)

# Injectable therapy

- Cabotegravir / rilpivirine
- Initial oral lead in
- Injections at 0,1 and then every 2 months

- Significant need
- No prior failure on NNRTI / INSTI
- Increased failure rates with some subtypes



# BHIVA advice on Statins

We recommend that all people living with HIV aged 40 years or older should be offered a statin for primary prevention of CVD irrespective of lipid profile or estimated CVD risk (Grade 1B)

We suggest that people living with HIV aged 40 years or older with an estimated 10-year CVD risk of 5% or greater are prioritised for primary prevention with a statin (GPP)

- We suggest that atorvastatin 20 mg daily can be used (pitavastatin 4mg used in REPRIEVE)

- We suggest that people on a low-intensity statin should switch to one of moderate intensity if clinically appropriate and tolerated (GPP).
- For people unable to tolerate a statin, we advise offering an alternative lipid-lowering agent in line with national guidelines (GPP). (eg *Ezetimibe / bempedoic acid*)
- It is best practice for statins for primary prevention to be prescribed and monitored in primary care (GPP)

# The 5-year number needed to treat to avoid one MACE

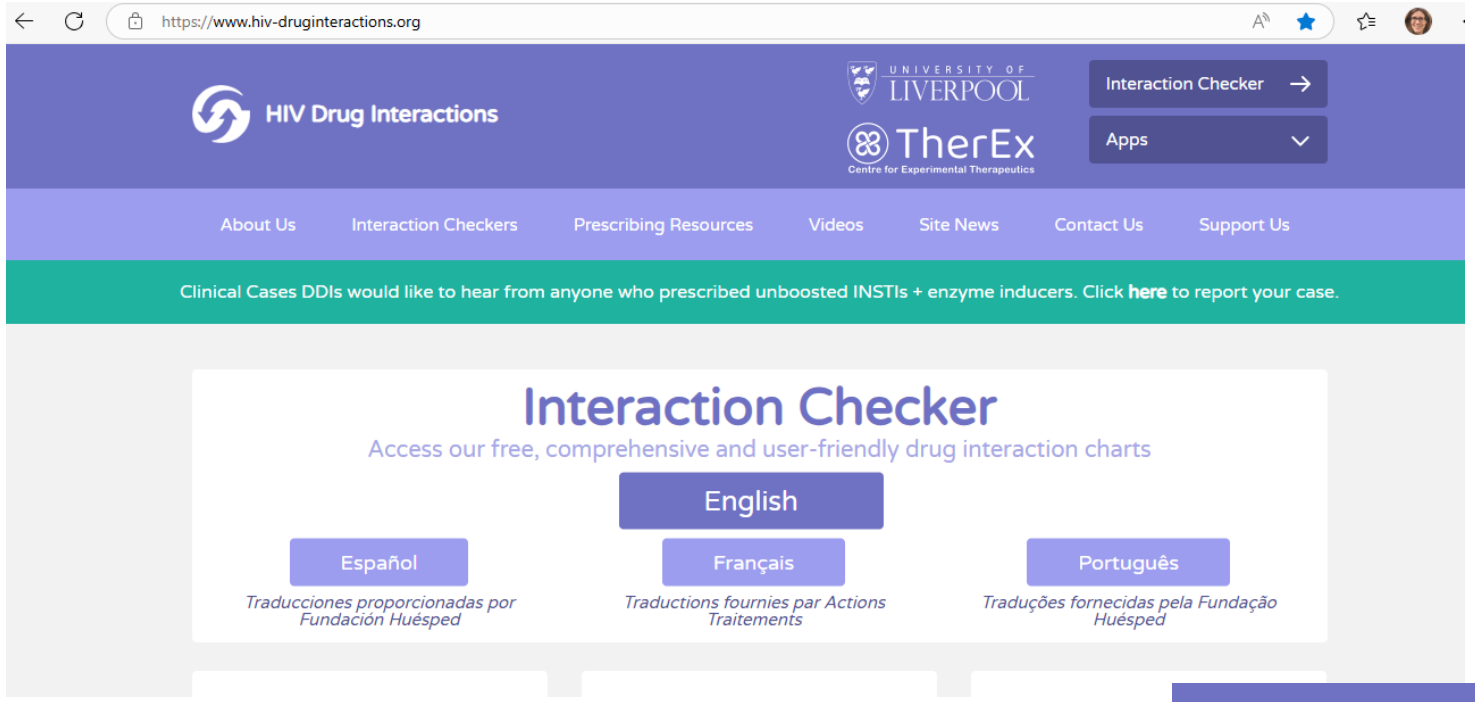
- risk score >10% 35
- 5–10% 53
- 2.5–5% 149
- 0-2.4% 199

- NICE advises to not rule out lipid modification therapy if a person's 10-year QRISK3 score is less than 10% if risk may be underestimated - as is the case for people living with HIV

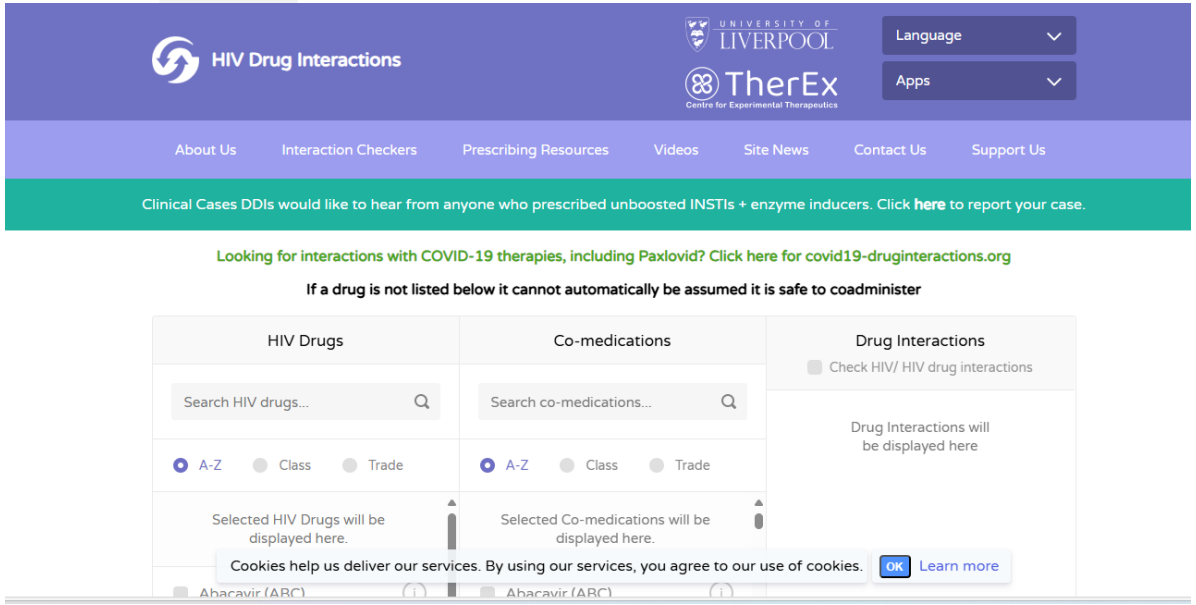
# Drug interactions

- Darunavir, atazanavir, ritonavir, cobicistat (CYP3A inhibitor), Elvitegravir
  - Increases levels of statins
- Efavirenz
  - Reduces levels of statins

- Co-administration of ritonavir- or cobicistat-boosted atazanavir with atorvastatin is not recommended
- Co-administration of ritonavir- or cobicistat-boosted darunavir or elvitegravir results - start at the lowest possible dose of atorvastatin, not exceeding 40 mg per day and careful safety monitoring.
- Co-administration of lopinavir/ritonavir, not exceeding 20 mg per day and careful safety monitoring.



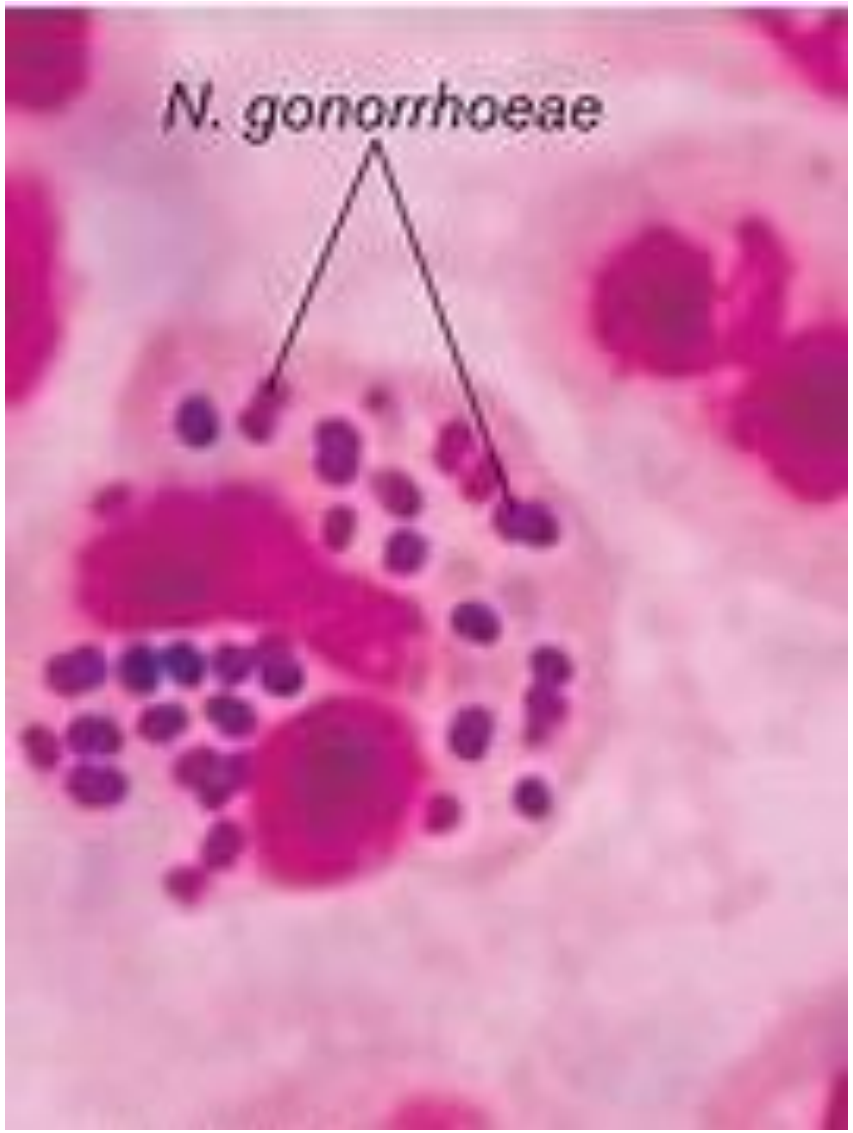

WWW.hiv-druginteractions.org

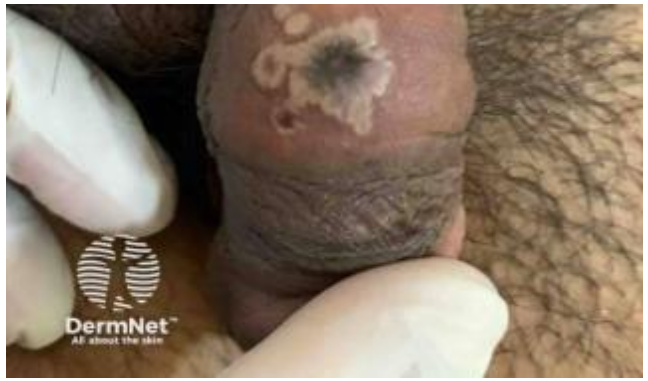


# Bexero 4CMenB

- 32-42% Effectiveness at protecting against gonorrhoea
- 80-90% sequence homology between N meningitidies and N. gonorrhoea
- 2 doses 1/12 apart

- Criteria:
- GBMSM with at least 5 parterns in last 3/12
- GBMSM with bacterial STI in last 12/12
- Others at equivalent risk





# Mpox

- Clade 1 – few cases UK, travel related, 10% fatality (First UK case Oct 2024)
- Clade 2 – Sexual transmission GBMSM, 3% fatality

- Vaccine approved for routine use for those at increased risk.

GBMSM with :

Multiple partners

Group sex

Bacterial STI in last year

And Sex on premises workers

# Services at Gateway Clinic

# Commissioned services at Gateway include:

- Management of STI's
- Delivery of HIV related care
  - Medication for HIV only
- Health promotion
  - Provision of PrEP, Vaccinations
  - MI
- Initiation of contraception
- Continuation of contraception for under 25's

# Not commissioned:

- Non STI causes of genital symptoms
  - UTI
  - Candida, BV
  - Genital dermatology
- Repeat contraception for over 25’s
- Coil fitting for any reason other than contraception eg HRT / Menorrhagia

# New services this year

- Doxy Prep
- GC vaccination
- Routine Mpox vaccination
- HSV in pregnancy management

- New commissioning guidance

- Moving to requesting tests under name
- Electronic prescribing

In recent years:
Small pox vaccination, Mpox management, PreP, HPV vaccination
EPR, greater move to home delivery of medication, Statins

# How can we help?

Spectrum Community Health CIC

# BEST 16th July 2025

www.spectrum-cic.org.uk

pr@spectrum-cic.nhs.uk


BASHH publishes UK-first guidelines on doxyPEP for the prevention of syphilis
The UK becomes one of the first countries in the world to issue a national evidence-based doxyPEP guideline.
The new guidelines offer clear direction for healthcare professionals and marks a landmark step in targeted STI prevention.
Read the guidelines over on the BASHH website
BASHH
British Association for Sexual Health and HIV

# DoxyPEP (Doxycycline post-exposure prophylaxis)

- New guideline published June 2025 (“informal use” before this, not being prescribed here yet)

- Aim is to reduce syphilis acquisition in those at increased risk:
  - Cisgender gay, bisexual and other men who have sex with men
  - Trans women
  - Case by case for people at risk of reproductive health sequelae from acquiring syphilis (e.g. trans men, sex workers, those with partners from higher risk groups)
  - People at increased risk of syphilis presenting within 72hours of sexual assault
  - Bacterial STI in last 12 months
  - Multiple new partners in last 3 months/group sex/chemsex

# Potential benefits?

- Reduction of infection acquisition – syphilis (chlamydia/?LGV)
- Improved quality of life
  - reduction of anxiety about acquiring/transmitting STIs
  - giving more control over sexual health
- Low cost, widely available medication

# What concerns might there be about this?

- Safety/tolerability
- Side effects – short/long term
- Antimicrobial resistance
- Effect on microbiome
- Reduction of other means to prevent STIs

# Data from 4 RCTs

- Efficacy ✓ for reducing syphilis + chlamydia in GBMSM and TGW
- Safety/tolerability ✓ safe and well tolerated, small numbers discontinued
- Side effects – short/long term ✓
  - nausea/vomiting/photosensitivity
  - benign intracranial hypertension/liver toxicity (rare)

- Antimicrobial resistance ✓? – not seen in STS/CT, “limited understanding”
- Effect on microbiome ✓? – “inconsistent findings”
- Reduction of other means to prevent STIs – part of a comprehensive approach

# What other approaches are there for STI risk reduction?

# What other approaches are there for STI risk reduction?

- condom use
- HIV prevention interventions (HIV PrEP)
- vaccinations
- STI testing, treatment and management
- appropriate risk reduction advice and psychological interventions

# What and how?

Single dose of 200mg (2x 100mg) doxycycline, within 24 hours and no later than 72 hours after sex.

Maximum of 200mg doxycycline in 24 hours.

If several episodes over 72hours can take at the end (may reduce side effects, no evidence)

# Pregnancy and lactation

- Use of doxyPEP supported up to 15 weeks gestation
- Contraindicated in breastfeeding in doxycycline SmPC but short term use unlikely to cause harm

# Baseline and follow up

- Testing/screening for asymptomatic STIs in line with current guidance
- Treatment/management of incident STIs in line with current guidance
- Offer epidemiological Rx to doxyPEP users who are contacts of syphilis
  - Although they may choose not to have Rx
- Encourage syphilis contacts to attend and have out of window screening

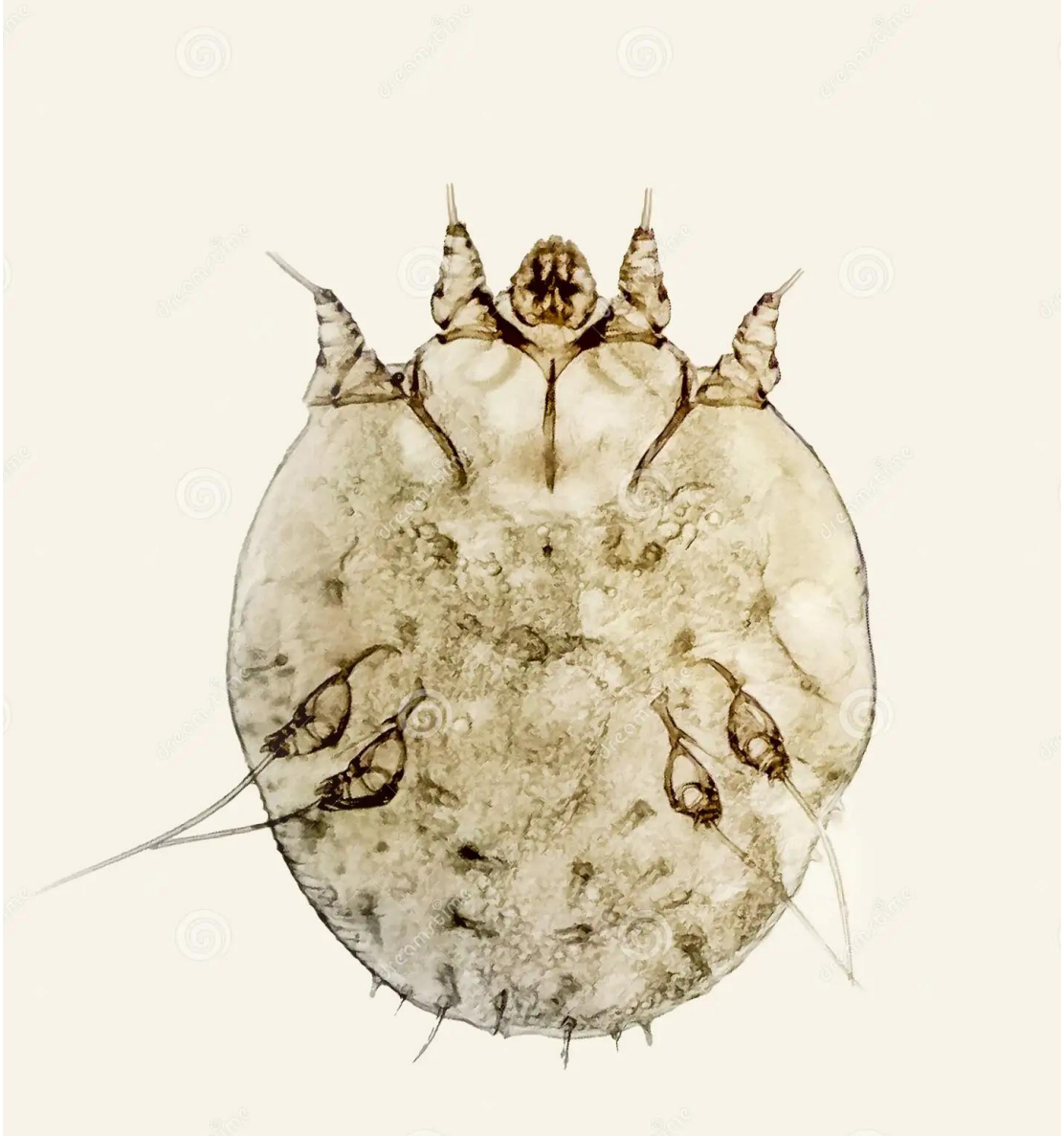
- Chlamydia contacts using doxy PEP do not need additional Rx (if correct dose taken within 72 hours)
- Report use for public health surveillance (GUMCAD)
- No additional monitoring required in DoxyPEP users

# Explain DoxyPEP

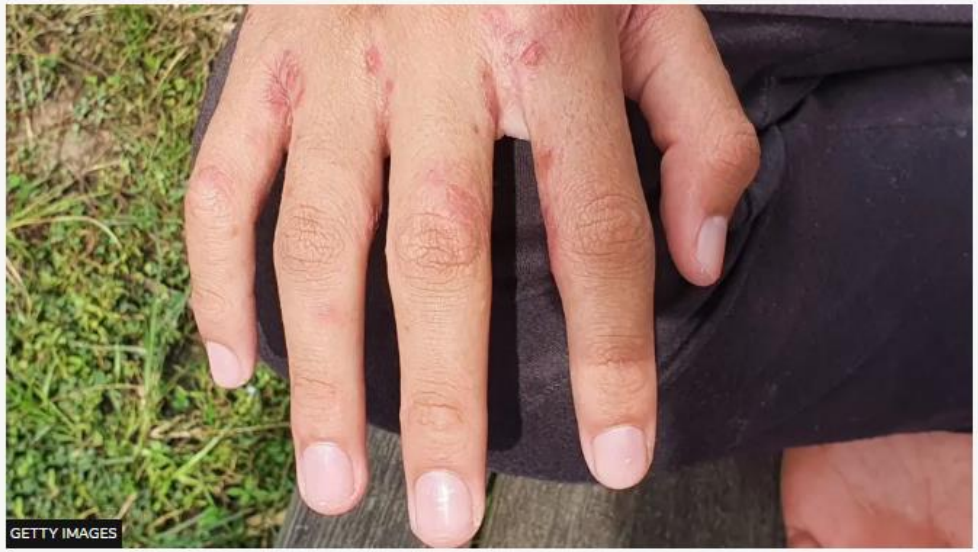
- not 100% effective at preventing bacterial STIs and should seek advice if signs/symptoms
- effective at reducing chlamydia and syphilis but unlikely to prevent gonorrhoea
- does not prevent HIV or non-bacterial infections e.g. HSV
- users may also benefit from HIV PrEP if not taking already
- users should share information with other healthcare providers

# Cautions

- Chronic/heavy alcohol consumption (may reduce effectiveness)
- Absorption problems
- Current long term use of tetracyclines
- Myasthenia gravis
- SLE
- Oesophagitis/oesophageal ulceration
- Porphyria
- Hepatic impairment
- Interacting medication e.g. antacids
- Allergies/intolerance to ingredients



# GPs advise not to ignore scabies symptoms




Scabies can lead to secondary skin infections, if not treated.

**Sharon Barbour**
Health correspondent

24 October 2024

**People are being told not to ignore an itchy rash, with GPs in England reporting a spike in scabies - the highly infectious skin infestation.**

- British Association for Sexual Health and HIV National Guideline on the Management of Scabies in adults 2025

- Intended for adults attending specialist sexual health services (but can be applied to other situations where appropriate and to children over 13 years old)

- Replaces 2016 guideline. Authors reviewed 64 articles (from 366)

- Updated information about biology/diagnosis
- 2 first line treatments (topical 5% permethrin/oral ivermectin)
- Evidence base for drug Rx and non-pharmacological interventions
- Malathion now alternative Rx (not first line)
- Management of follow up/contacts/ post-scabetic itch
- Management of suspected treatment failure

# Epidemiology

- Common, any age/socioeconomic status
- Risk increased in crowded conditions
- Prevalence estimates 0.2-71% worldwide
- Highest in Pacific region and Latin America
- Complex – depends on region. In UK mostly sporadic with occasional outbreaks in institutions

# Pathogen

- Scabies mite (females 0.3-0.4mm, 2 x size of males)
- Male dies after mating, female digs burrows (0.5-5mm/day for whole lifespan of 4-6 weeks, laying 1-3 eggs/day (about 25 total)

- Eggs hatch after 3-4 days
- Mature into adults after 10-15 days
- Fewer than 10% eggs become mature adults

- Initial infestation 10-15 mites on average  (can penetrate skin within 30 mins)

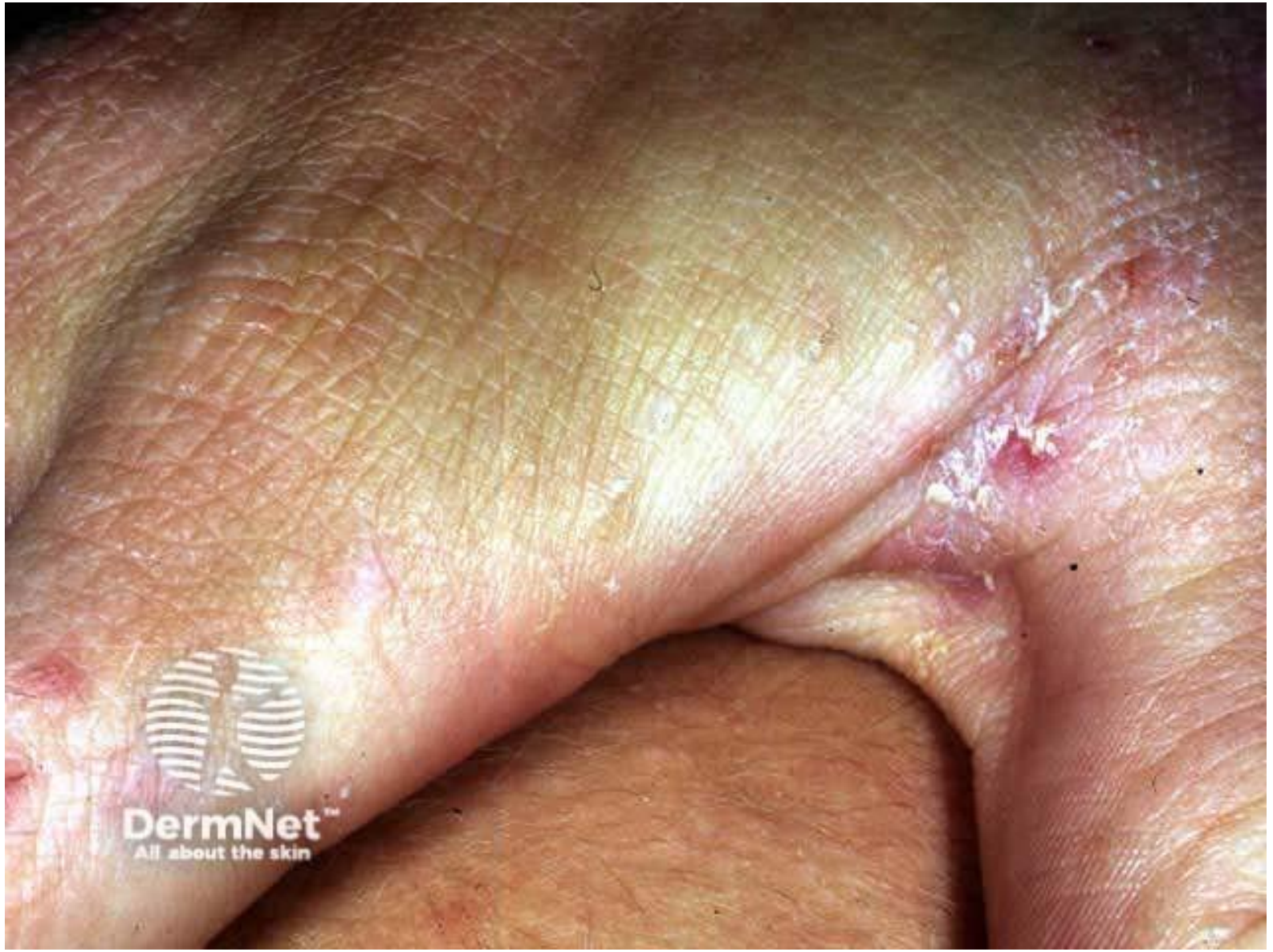
# Transmission

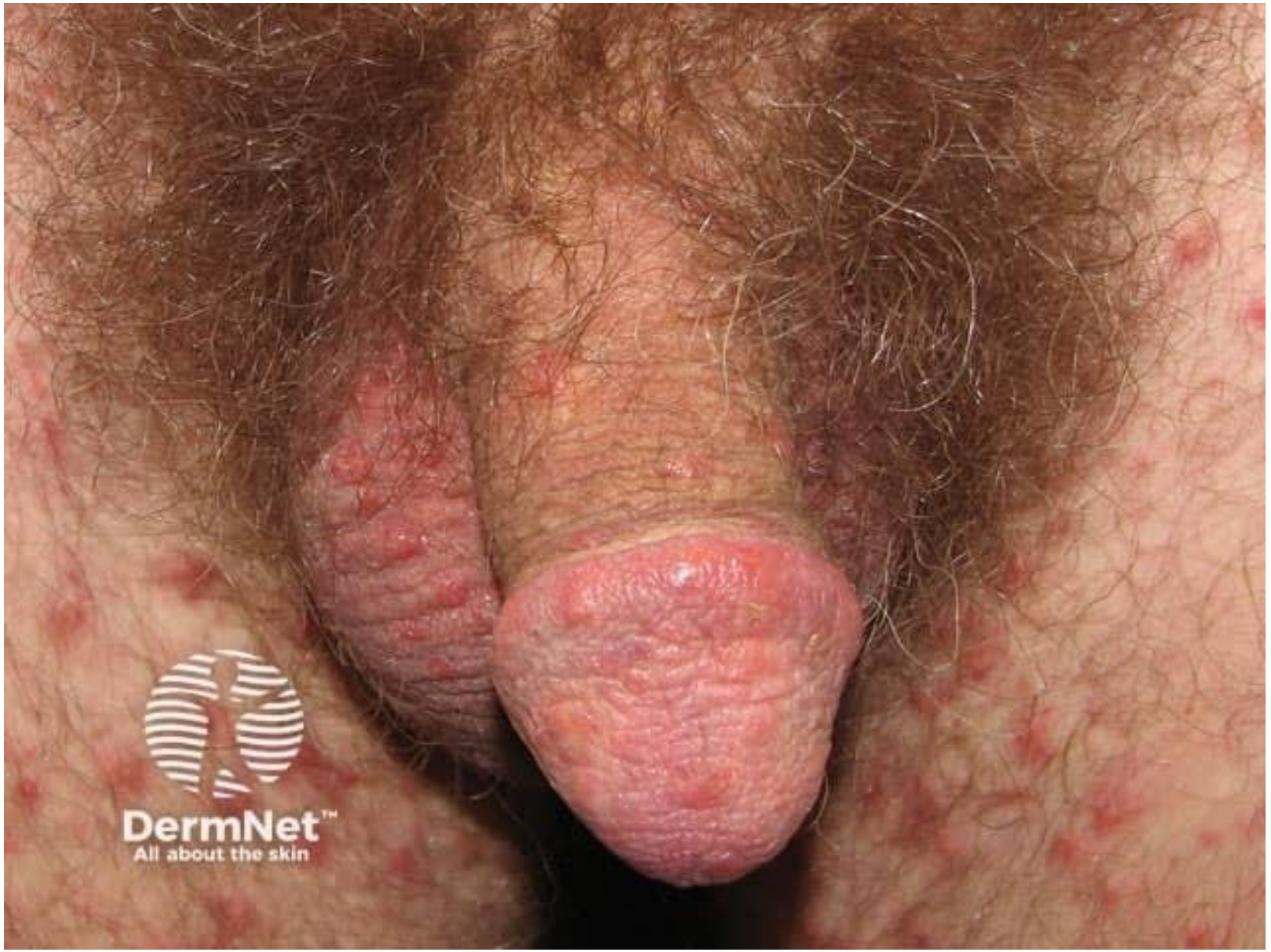
- Skin to skin contact – extended (unlikely through handshake etc)
- Heat and body odour attractive
- Can be sexually acquired
- Crowded conditions/malnutrition increase risk
- More common in first 4-6 weeks (before symptoms develop)
- Fomite transmission uncommon but can happen – sharing clothing/beds

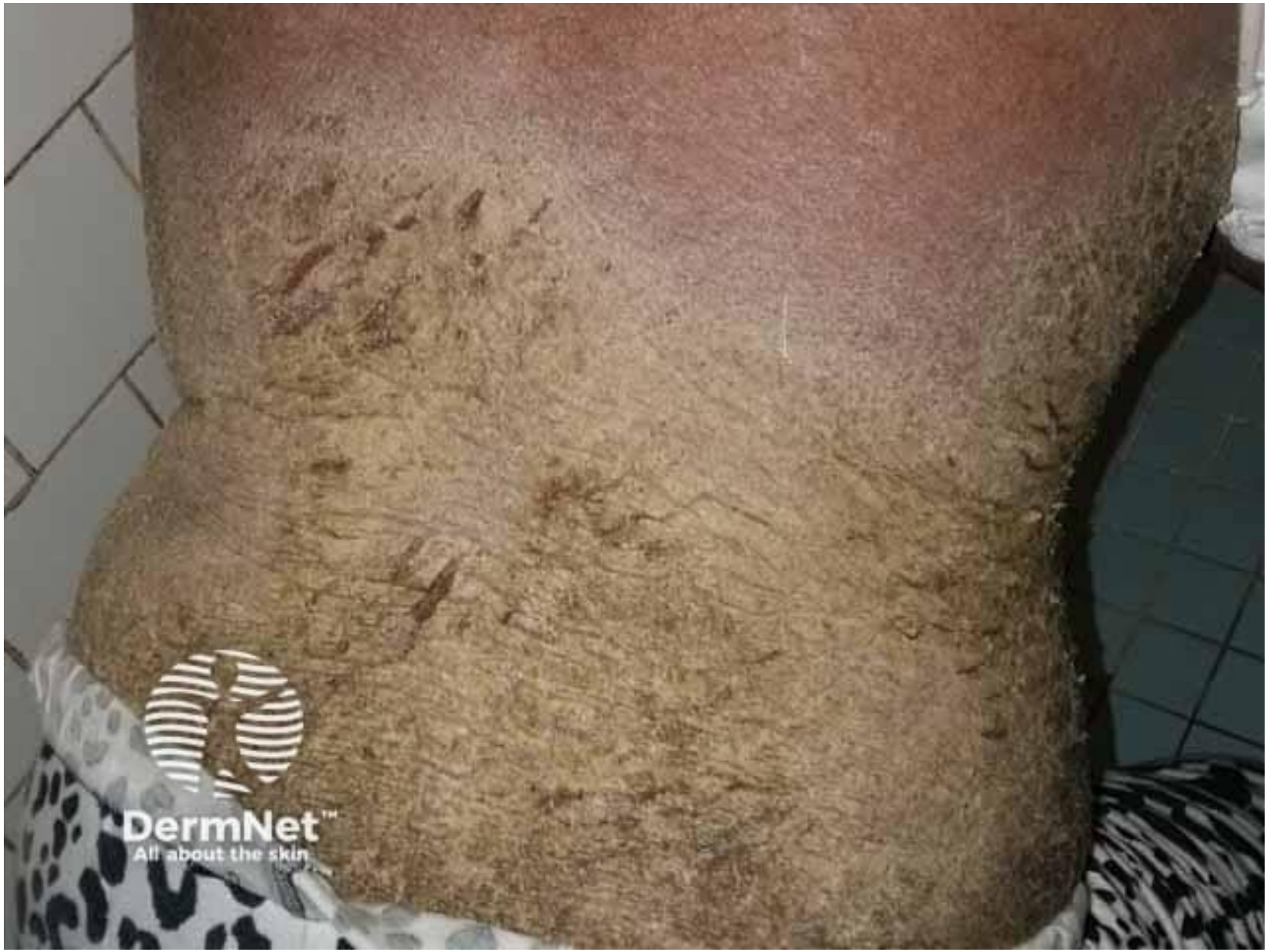
- Mite survival depends on temperature and humidity (24 hours – 19 days)

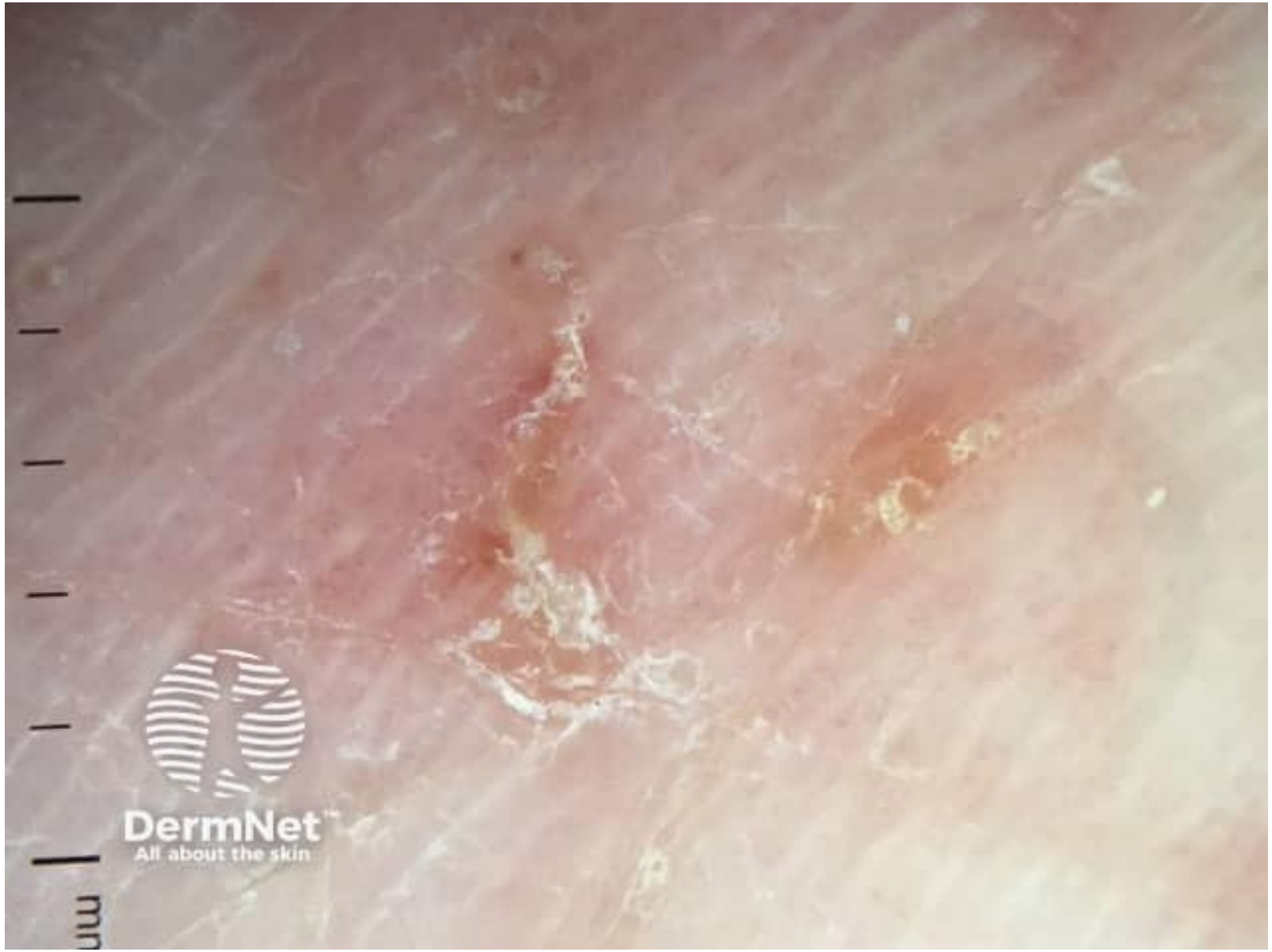
# Clinical Features

- Symptoms from 3-6 weeks after primary infestation
- Intense itch, worse at night (although lack of itch does not exclude it)
- Itchy household/family/sexual contacts
- ? Caused by host-mite interaction+/- delayed type IV hypersensitivity
- Scratching may allow strep/staph infection (causing other skin or systemic complications)
- Can have atypical presentations e.g. scabies incognito after steroid use


DermNet™
All about the skin


DermNet™
All about the skin


DermNet™
All about the skin


DermNet™
All about the skin

- Zoonotic scabies, self limiting, no burrows, sites of animal contact, cannot pass to other humans.

- Treat the animal only.

# Diagnosis

- Clinical – symptoms/signs/risk factors
- Excoriated papules/burrows/nodules at typical sites
- Needs visualisation of mites/eggs/faeces for diagnostic certainty

- Differentials for scabies: impetigo, folliculitis/urticarial reactions/dermatitis (atopic/contact/seborrhoeic), dermatitis herpetiformis/psoriasis/pityriasis rosea, secondary syphilis, lymphoma, pseudolymphoma

- Differential for crusted scabies: psoriasis/eczema/Darier's disease/pityriasis rubra pilaris/palmo-plantar keratoderma/cutaneous lymphoma

# Management

- Explain transmission route
- Coordinate treatment with contacts where possible (even if no symptoms)
- Offer screening for STIs, avoid sex (min 24 hrs after first dose completed)
- Decontamination of clothes/bedlinen/towels (on the 1st day of treatment)
  - Machine wash 35 mins at ≥50$^{o}$ (will kill eggs and mites)
  - And/or tumble dry on high (50-120$^{o}$ for 10-35 mins)
  - Or seal clothes in plastic bags for 4 days at room temperature
  - Or freeze at -10$^{o}$ for at least 5 hours
  - Crusted scabies may need more thorough cleaning – carpets/soft furnishings etc

# What is close contact?

- People who sleep in the same dwelling
- People who share a bed
- Sexual partners
- Children in the same classroom or who play closely together
- Adults with known skin to skin contact

# Treatment (1st options licensed for scabies)

- Permethrin 5% to whole body, wash off after 12 hours, repeat after 7-14 days.
  - Second dose increases success rate as may have missed some areas with first application

- Oral ivermectin 200µg/kg x 2 doses repeated after 7 days (or up to 15 days).
  - Second dose increases success rate as cream does not kill eggs
  - Discuss with pharmacy/microbiology if patient > 120kg

# Topical Rx

- Application of topical Rx must include ankles/under fingernails/between toes/sacral region (may need assistance)
- Skin should be clean, dry and cool
- Remove jewellery or apply underneath
- Include scalp and face, avoiding area around eyes
- Leave 10-15 mins before dressing and leave product on at least 12 hours
- Reapply to hands after washing
- Repeat treatment after 7 days and advise symptoms may last > 4 weeks
- Written advice: Scabies - BAD Patient Hub

| | Ivermectin | |
|---|---|---|
| Body weight (kg) | Single oral dose (mg) | Number of 3 mg tablet |
| 15 to 24 | 3 | 1 |
| 25 to 35 | 6 | 2 |
| 36 to 50 | 9 | 3 |
| 51 to 65 | 12 | 4 |
| 66 to 79 | 15 | 5 |
| 80 to 99 | 18 | 6 |
| ≥100 | 21 | 7 |

Discuss with pharmacy/microbiology if body weight >120 kg

# Alternative treatment options

- Malathion 0.5% liquid emulsion (licensed in UK for scabies but no RCTs)
- Benzyl benzoate 25% emulsion (not licensed in UK)
- Topical ivermectin 1% (not licensed or recommended by BASHH)
- Sulphur preparations may be used in other countries
- Spinosad cream, not recommended in UK
- Tea tree oil 5% (used as additional agent in parts of Australia)

- Involve dermatology/ID for treatment of crusted scabies, avoid admission

# Pregnancy/lactation

- Permethrin 5% cream
- Malathion 0.5% liquid if permethrin not suitable
- Not licensed but systemic exposure extremely low, no evidence of harm
- Oral ivermectin not recommended

# Side effects

- All topical treatments may cause skin reactions
- Paraesthesia recognised side effect of permethrin- usually mild
- Contact dermatitis from Rx or ongoing scabies??

# Side effects - Ivermectin

- Neurological symptoms reported
- Nausea
- Headache
- Slightly higher reported side effects compared to permethrin
- Likely to be lower risk than once thought

# Follow up

- Review at 4-6 weeks after last Rx may be helpful
- Itching >4 weeks after second dose can be a diagnostic challenge
- If new burrows > 7 days after second dose, need retreating
- If itch gets worse despite Rx consider re-infection/alternative diagnosis

# Post scabetic itch

- Expect improvement 2-4 weeks after Rx
- But 1/3 patients may itch for 1-3 months
- Psychological impact - can lead to excessive cleaning/overuse of Rx

- Can try crotamiton 10% cream bd/tds, emollients, steroid (if eczematous areas despite adequate treatment), antihistamines, treatment of bacterial infection

# Treatment failure

- Incorrect diagnosis
- Dermatitis
- Incorrect treatment use/prescription
- No repeat dose
- Immunosuppression
- Re-infestation from untreated contacts/fomites
- Drug resistance (?)

# Feedback Survey

Topics already confirmed:

Personality Disorders
Opiates In Primary Care
Safeguarding
Obstetrics
Obesity and Weight Loss Injections
Biochemistry
Cancer session

# Next Meeting

## Wednesday 17 September 2025

Agenda:

- Personality Disorders
- Opiates In Primary Care
- Safeguarding