Improving Standards of Care in the UK

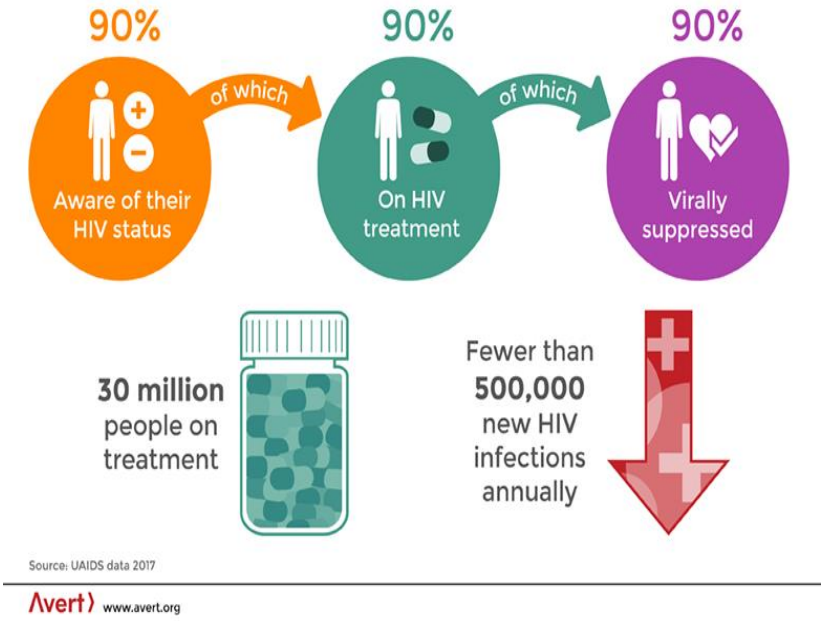
Professor Chloe Orkin,
Chair British HIV Association
Queen Mary University London

BHIVA
British HIV Association

Disclosures

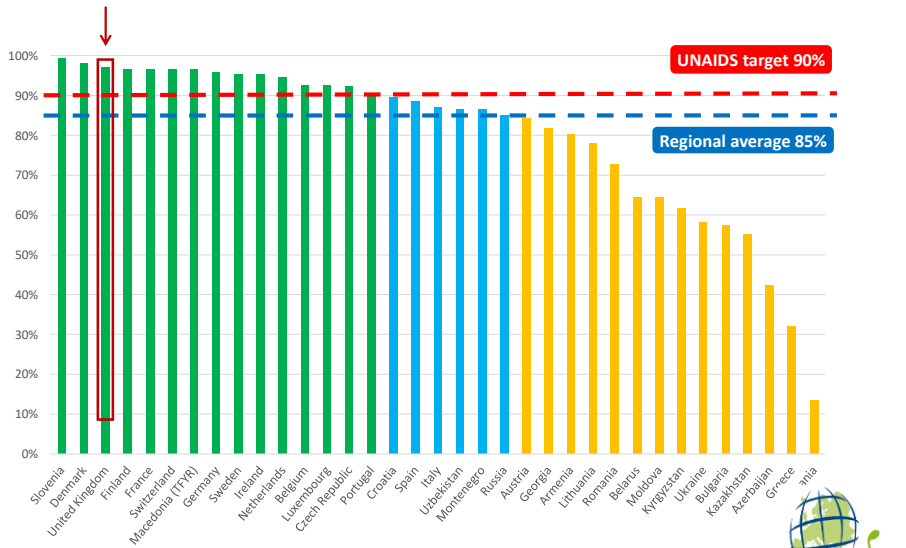
- Educational grants (HIV Unit): Merck Sharp & Dohme, Gilead Sciences, Janssen, ViiV Healthcare and Barts Charity
- Honoraria and travel sponsorship for lectures and advisory board contributions
- Member of the BHIVA Guidelines Subcommittee (2008–2017)
- Chair and executive trustee of BHIVA
- Not a patent holder or a shareholder
- No disclosures for spouse or family members

Key 2020 Fast Track Targets

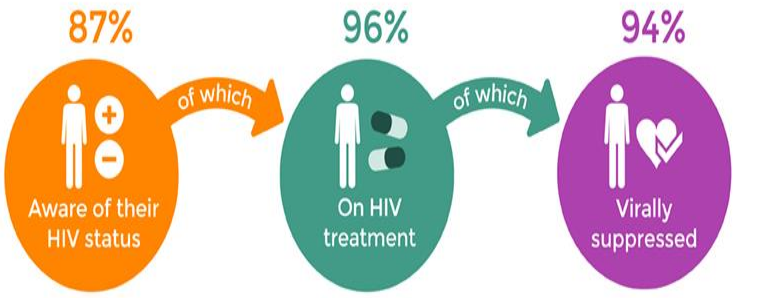


Progress toward achieving the third 90:

Target 3: 90% of those on ART virally suppressed (n=35)



UK progress toward 90/90/90 targets for 2020



Source: Public Health England (2016) 'HIV in the UK'

Avert www.avert.org

FAST-TRACK CITIES

London

90% Diagnosed

97% On treatment

97% Undetectable*

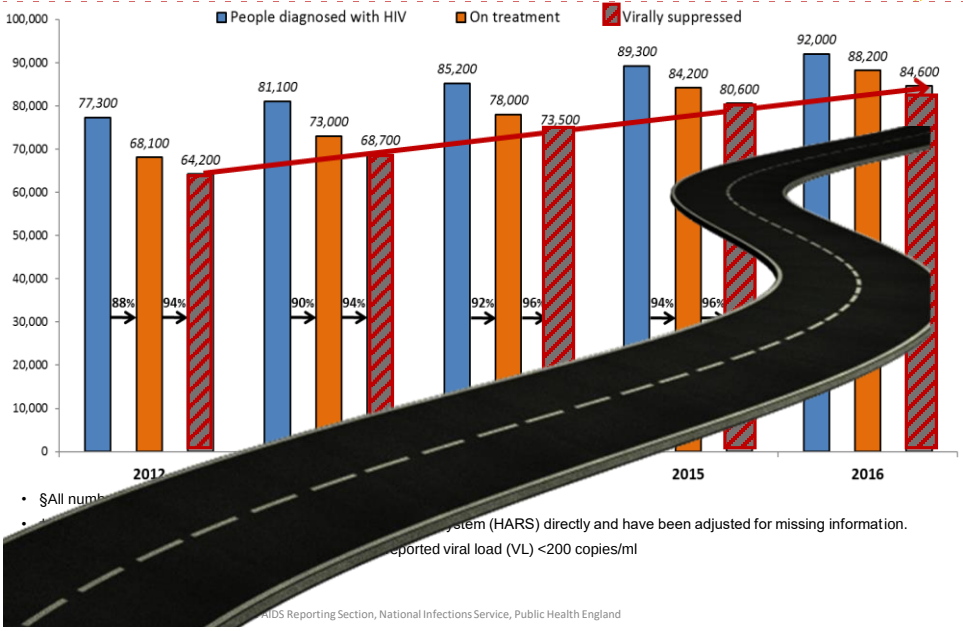
*VL <200 c/mL.
Public Health England, 2016.

Achieving success

=

+

Examining our journey to improve the cascade of care

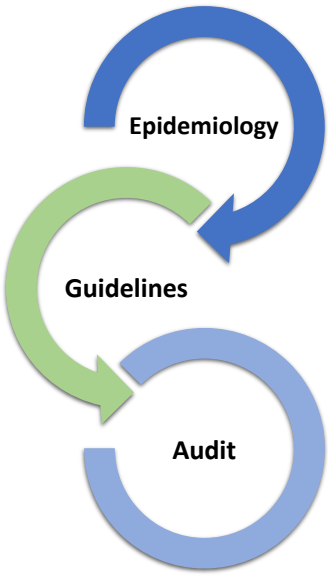


- §All numb
- ystem (HARS) directly and have been adjusted for missing information.

eported viral load (VL) <200 copies/ml

AIDS Reporting Section, National Infections Service, Public Health England

Assessing standards against guidelines



Data from national surveillance on HIV epidemic

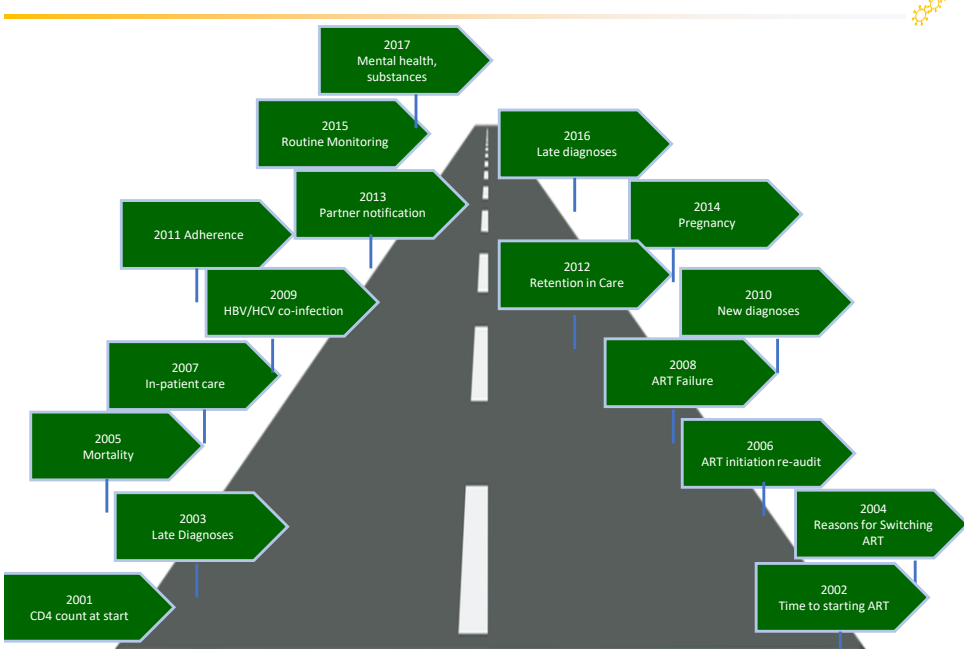
Auditable outcomes from guidelines

**What are our services delivering?
What should they be like?
How can we improve ?**

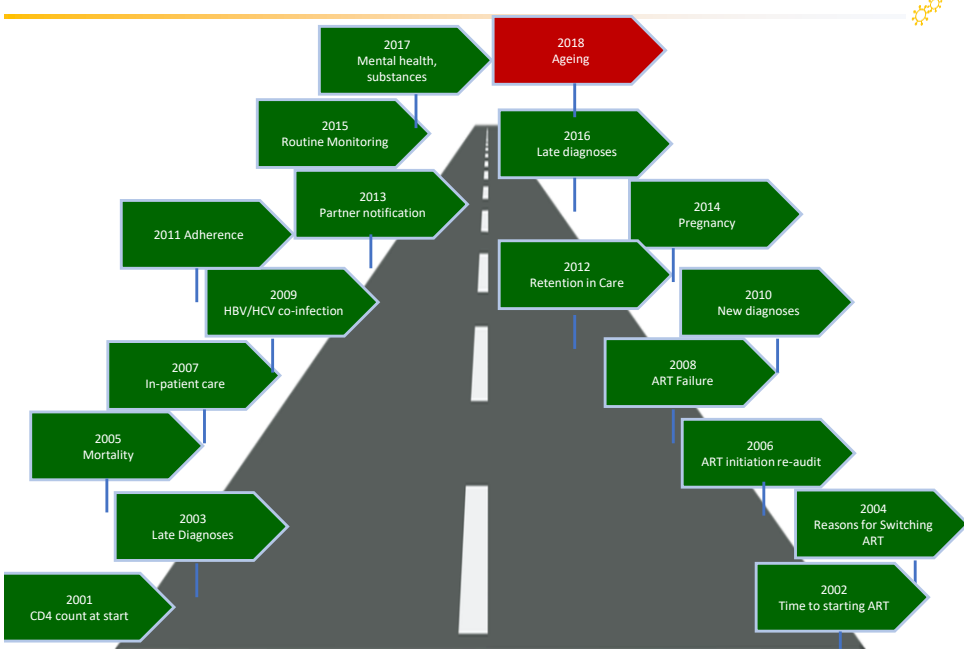
Improving care in the UK- two methods

1. BHIVA annual national audit
2. BHIVA Standards for HIV clinical care

BHIVA National Audit timeline 2001-2018



BHIVA National Audit timeline 2001-2018



Audit : evaluates a process not an outcome

- Audit : a snapshot in time
- Evaluates service delivery
- All clinics participate
- Not = national surveillance
- Voluntary
- Questions derived from guideline auditab issues
- Data collection feasible for clinics

Tools: Data collection

BHIVA: HIV monitoring and assessment self-audit tool		Patient 1	Patient 2	Patient 3	Patient 4
Instructions:	Date on which audit data was retrieved from patient's record (dd/mm/yy, required):				
Enter data for each patient in one column - the columns scroll across so you can align the one you are working on alongside the questions, which stay fixed and visible.	Date on which patient was last seen and reviewed by a clinician (ie, not just bloods taken):				
	Sex:				
	Age:				
	Ethnicity:				
	Exposure risk for HIV:				
	Latest CD4 in cells/mm^3:				
Only certain answers are allowed as calculation of your results depends on exact wording. Hence please select allowed answers using the drop-down menus and enter dates in dd/mm/yyyy format (if dd is missing, enter it as last day of the relevant month).	Does the patient have a current ART prescription?				
	Does current regimen include tenofovir?				
	Has HIV resistance testing ever been performed?				
	Stable on ART and long-term suppressed?				
	When was HIV viral load (VL) last measured (date sample was taken or leave blank if not recorded within past 2 years)?				
	When was ART adherence last assessed (give date or leave blank if not recorded within past 2 years)?				
You do not need to enter data in cells with a dark background, but this will change depending on data already entered.	Date list of all medication last recorded (or recorded that on no medication other than ART, (give date or leave blank if not recorded within past 2 years)?				
	Hepatitis A (HAV) status:				
	HBV surface antigen, HBsAg, status:				
	Hepatitis B (HBV) surface antibody, anti-HBs, status:				
	HBV core antibody, anti-HBc, status:				
	When was the patient's anti-HBs titre last measured (give date sample was taken)?				
	Hepatitis C (HCV) antibody status:				
	When was HCV antibody testing last done (give date sample was				
	When was HCV RNA last tested?				
	Date 10 year CVD risk last calculated (give date or leave blank if no				
	Select if obviously low risk or has established CVD:				
	When was smoking history last recorded (give date or leave blank if no record)?				
	Smoking status:				
	Has a smoking cessation service been offered?				
	When was the patient's blood pressure (BP) last recorded (give date or leave blank if no record)?				
	When was urinalysis last done or urine protein/creatinine ratio measured (give date or leave blank if no record)?				
	When was eGFR last measured (give date or leave blank if no record)?				
	When was liver function (LFT) last tested (give date or leave blank if				

Welcome | AboutYourService | PatientDataEntry | Results | RandomSorter | Lists

Confidential feedback to each clinic : compared with national figures

Scenario leading to death	All centres		Centre 752003	
Multi-drug resistant HIV - run out of treatment options	11	3%	0	0%
Being successfully treated for HIV but suffered a catastrophic event (eg adverse reaction)	7	2%	1	13%
Under care but had untreatable HIV-related complication	61	16%	1	13%
Under care but had chosen not to receive treatment	18	5%	0	0%
Under care but treatment ineffective due to poor adherence	26	7%	1	13%
Under care but unable to take treatment due to toxicity/intolerance	1	0%	0	0%
Not treated or had treatment delayed because of ineligibility for NHS care	0	0%	0	0%
Known to have HIV but not under care, re-presented too late for effective treatment	13	3%	0	0%
Diagnosed with HIV too late for effective treatment	93	24%	1	13%
Died in community without seeking care	1	0%	0	0%
Death not directly related to HIV	123	32%	3	38%
None of above	8	2%	0	0%
Not stated	25	6%	1	13%
Total	387	100%	8	100%

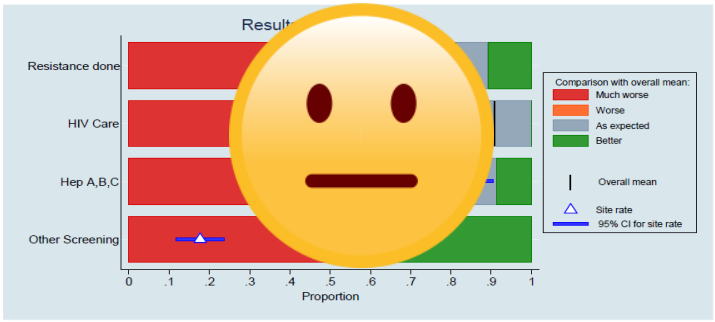
Post-mortem	All centres		Centre 752003	
Done, of which:	57	15%	1	13%
Coronial	*42*	*11%*	*0*	*0%*

Feedback : dashboard for grouped outcomes

Audit on Monitoring patients with HIV

Oh dear….

Audit on Monitoring patients with HIV



How do we improve our poor performance?

Audit on Monitoring patients with HIV

Audit Conclusions-sent to each centre

Main Conclusion and recommendations from MORTALITY audit:
Late diagnosis accounted for 24% of deaths overall and 35% of HIV related deaths
Causes not related to HIV accounted for 32% of deaths

National Dissemination

- National presentation
- Given by doctor in training
- Embedding standard of care approach

People with diagnosed HIV infection apparently not in care

BHIVA in collaboration with Health Protection Agency

Psychological well-being and support, and use of alcohol and recreational drugs

BHIVA National Clinical Audit 2017

Dr Sarah Parry
Trainee Doctor in HIV/GUM

On behalf of the BHIVA
Audit and Standards Sub-committee

BHIVA British HIV Association
BHIVA Autumn Conference 2017
16-17 November 2017, QEII Conference Centre, London

Aim

To assess adherence to standards and guidelines regarding psychological support and alcohol and recreational drug use, including chemsex.

Methods

1. Survey of HIV services' provision and care pathways relating to psychological support and substance use

2. Case-note review of 40 adult HIV patients per service covering:
   - Whether psychological well-being/mental health and substance use had been assessed within last 18 months
   - If problems identified, whether support was offered/provided

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Rapid Feedback

Participating sites were invited to request a rapid feedback report after submitting case note review data for 40 individuals:

- 48 out of 119 sites taking part in the case note review requested this
- Reports were sent within 1-2 working days

Case note review

4486 adults (16 or over) who attended for HIV care during 2016 and/or 2017

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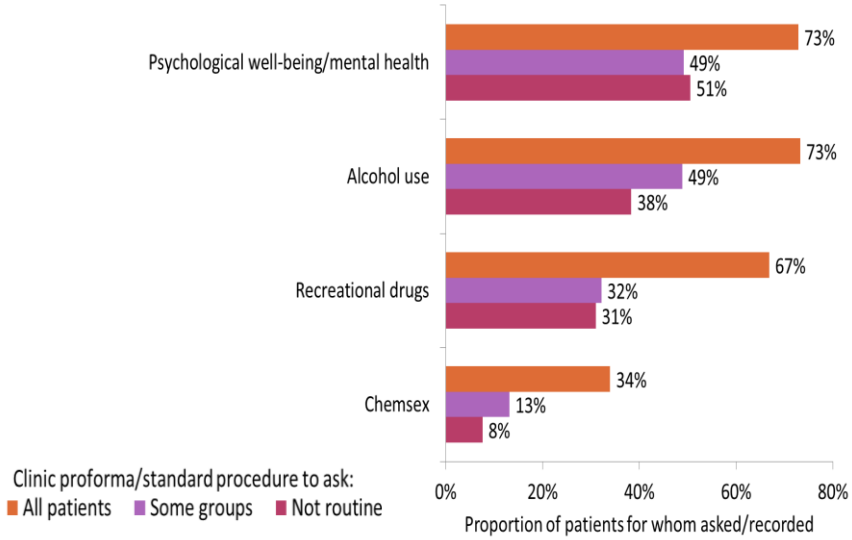
Assessment by clinic proforma/standard procedure



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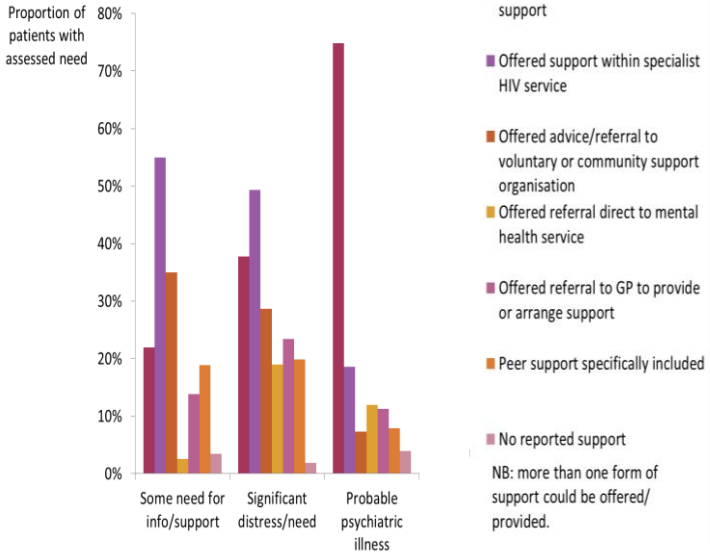
Provision of psychological support



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Summary of outcomes: service provision

- 49% of HIV services had an identified clinical lead for psychological support
- Documented care pathways for mental health, alcohol and drugs were reported by 53%, 38% and 36% of HIV services respectively, but more than 80% of services can refer patients directly

Summary of outcomes: assessment

- Rates of routine assessment within the previous 18 months were:
  - 66.0% of patients for psychological well-being/mental health
  - 68.0% for alcohol use
  - 58.4% for recreational drugs
  - 16.8% (26.5% of MSM) for chemsex
- These varied widely but were higher when included in the service's proforma/standard procedure

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Summary of outcomes: psychological status

Among individuals assessed:

- 59.4 were coping well
- 17.4% had some need for info/support
- 14.6% had significant distress or psychological support need
- 5.1% were likely to have a diagnosable psychiatric illness

This varied widely between services, but sites having a clinical lead or routinely using an assessment tool identified higher levels of need

Summary of outcomes: substance use

Among individuals assessed:

- The rate of problematic alcohol use was lower than expected in comparison with the general population
- Of individuals engaging in chemsex, 53% were identified as involved in problematic use
- A small number of individuals who injected drugs were not considered to have a problem

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Summary of outcomes: support provided

- Nearly all individuals identified with psychological problems were offered or already receiving support
- Around 90% of individuals identified with recreational drug/chemsex problems were offered or already receiving support
- For alcohol, this figure was only 69%
- *However these findings might be artefacts if provision was interpreted as evidence of documented need*

Recommendations to HIV services

HIV services should:

- Review their own results
- Identify a clinical lead for psychological support
- Develop agreed care pathways
- Prospectively look for possible psychological support needs on a routine basis, via a standard clinic proforma or procedure
- Adopt a systematic approach to alcohol and recreational drugs assessment and support, including chemsex

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Recommendations to BHIVA

BHIVA should explore the scope for guidance on methods for routine assessment of psychological support needs and substance use.

2016 monitoring guidelines suggest:

- The wellness thermometer can be useful as an aid to communication.
  Croston et al. National HIV Nurses Conference. June 2015. Leeds, UK. Abstract P11.

- Pre-consultation screening tools enable patients' agendas to shape the consultation and enable better communication of any concerns.

Recommendations to BHIVA

This might include recommending specific tools, e.g.

EACS two sentences:

- Have you often felt depressed, sad or without hope in the last few months?
- Have you lost interest in activities that you usually enjoy?

PHQ2:

Over the past 2 weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things
- Feeling down, depressed or hopeless

GAD2:

Over the last 2 weeks, how often have you been bothered by the following problems?

- Feeling nervous, anxious, or on edge
- Not being able to stop or control worrying

BHIVA Standards of Care

Contents

http://www.bhiva.org/standards-of-care-2018.aspx

Content of Standards

- 8 quality Standards, covering the care that any adult living with HIV in the UK should expect to receive.
- Each one presents a rationale, quality statements and measurable and auditable outcomes.
- Three new sections have been introduced looking at HIV prevention, stigma and well-being, and HIV across the life course.
- **HIV Prevention - Standard 1, Testing, diagnosis and prevention:**
- **Stigma and wellbeing - Standard 2, Person-centred care**
- **HIV across the life course - Standard 7**

http://www.bhiva.org/standards-of-care-2018.aspx

Press Release

- BHIVA **Standards Co-Chair**, Ann Sullivan :
- "**Patients** have had a **key role** in every stage ….actively involved in all writing groups; responding ….recommending, volunteering for ….organising the real representation seen in the Standards' imagery to deliver improved outcomes for people living with HIV in the areas **that are important to them**."
- **BHIVA Chair**, Chloe Orkin comments:
- "This third set of BHIVA Standards has been developed….with the **aim of delivering high quality services** to achieve the **best possible outcomes**.
- "……we are proud to say that **outcomes** for people living with **HIV in the UK are among the best in the world**.
- "…we **must manage** the **complex co-morbidities of an ageing HIV population** but on the other we welcome the very positive impact of effective medications on HIV transmission. Increased testing, alongside prevention interventions such as pre-exposure prophylaxis (PrEP)….
- "We hope that these new Standards will **provide a framework** to inform and support commissioning decisions both within and outside the NHS….**to inform people living with HIV,** and those who advocate for them, about the care they should expect to receive when they access HIV services."

http://www.bhiva.org/standards-of-care-2018.aspx

Response to public consultation

- Following the recent launch of the Standards of Care the use of the word 'negligible' on U=U was **replaced with more accessible phrases** to convey this important public health message and have included the full statement for ease of reference.
- ***"There should be no doubt that a person with sustained, undetectable levels of HIV virus in their blood cannot transmit HIV to their sexual partners," Chloe Orkin, BHIVA Chair.***

http://www.bhiva.org/standards-of-care-2018.aspx

Foster Engagement

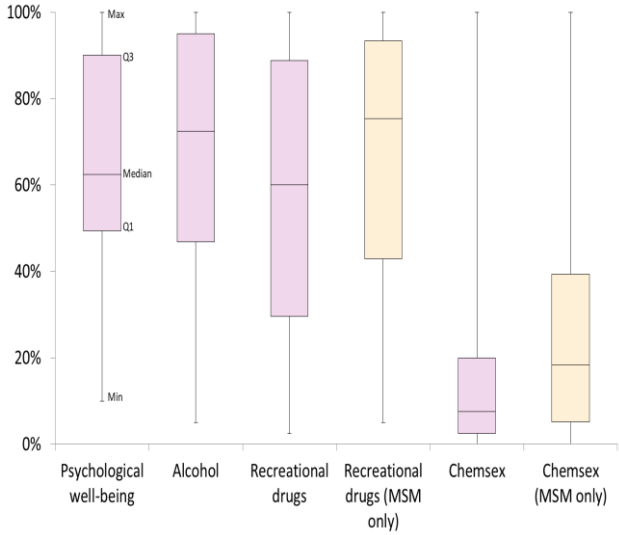
Questions?

@britishhivassoc

British HIV Association

Variation between services in assessment

Proportion of individuals for whom asked/recorded within each participating service



Psychological status by whether service has identified clinical lead