

<b>Speaker Name</b>	<b>Statement</b>
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<b>Date :</b>	<b>June 2016</b>



# Setting up a HIV outreach service

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Hathersage Integrated Contraception, Sexual Health and HIV services

Central Manchester University Hospitals NHS Foundation Trust

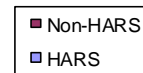
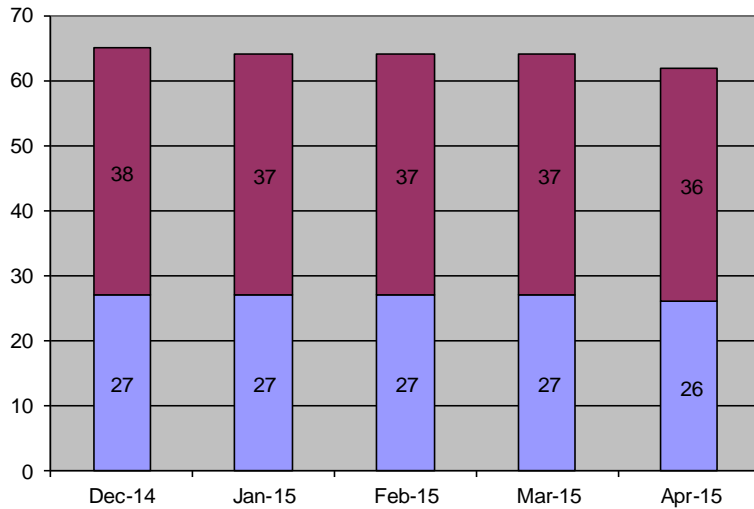




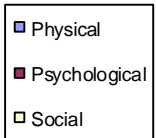
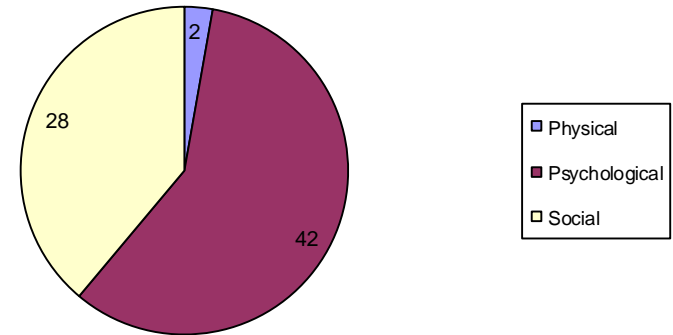
# Introduction

- Central Manchester University Hospitals NHS Foundation Trust – 6 hospitals, 1 community service
- Manchester Royal Infirmary - 4 CNS (2015)
- HIV Cohort 1800 approx
- Patients with complex needs requiring additional support
- No HIV community nursing service

# Patients with complex needs



Patients with complex needs - Total number = 64



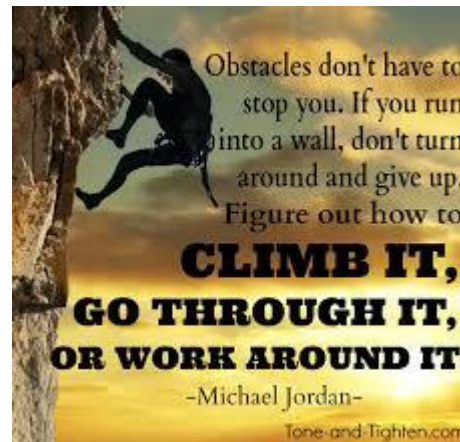
Psychological – mental health issues, personality disorders, disengagement, adherence

Social – housing, immigration, financial, drug/alcohol dependence, homeless, chemsex, isolation

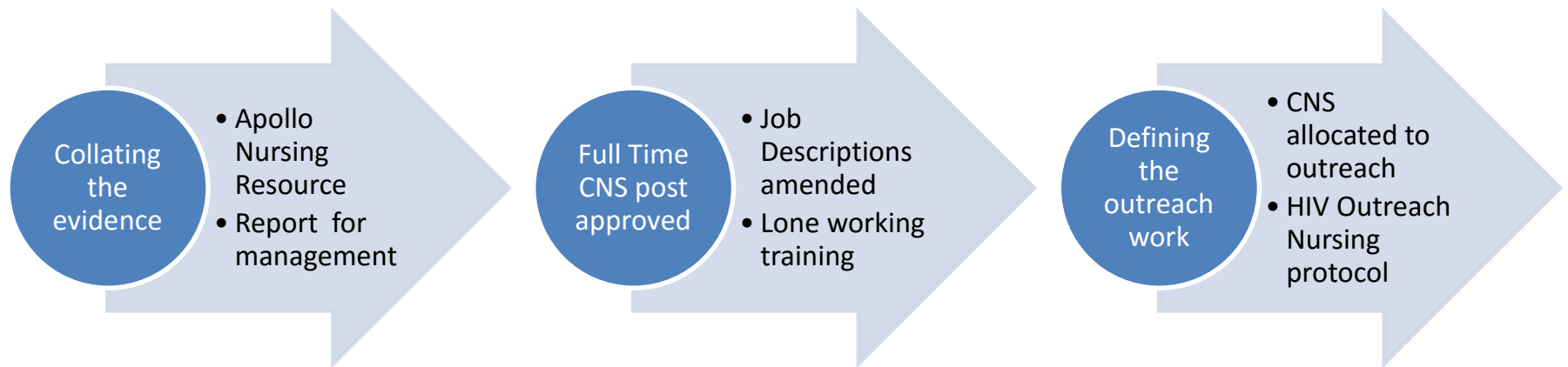
# Challenges

- Patients on database did not have any care management plans
- Time
- Busy CNS clinic lists /walk ins
- In patients referred but no CNS available
- Retention - >12 mths last attendance – 19 patients

CNS Team Vision



# The process





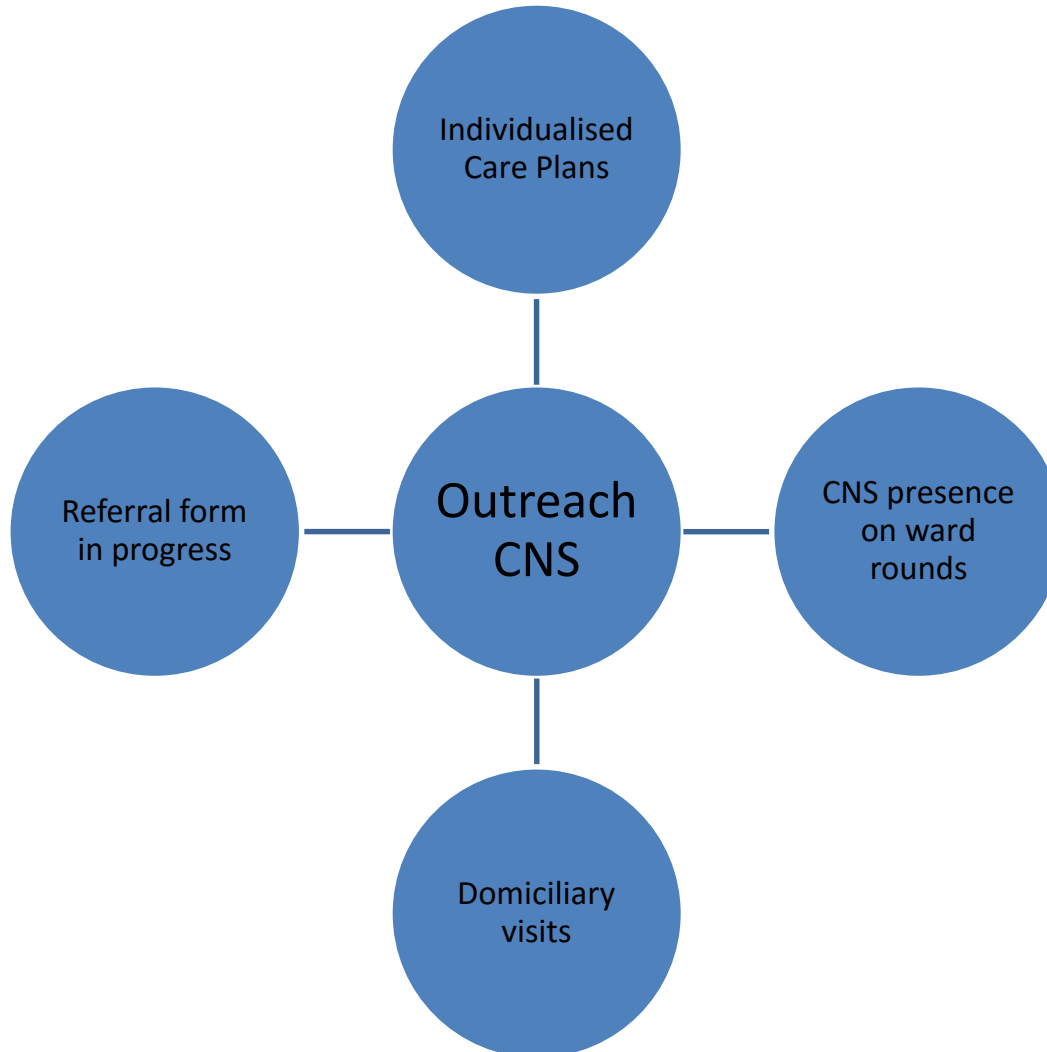
# Service gap analysis

Please enter your service title here...	
1. WTE posts	
2. Service summary	
3. Patient experience	
4. Current SWOT analysis	
5. GAP analysis	
6. Caseload & Evidence of activity	
7. Trust wide Leadership Activities	
8. Nursing Service Key Performance	
9. Best practice guidance	

Apollo Nursing Resource (Alison O'Leary)

<http://www.apollonursingresource.com/showing-how-i-spend-my-time/presentation>

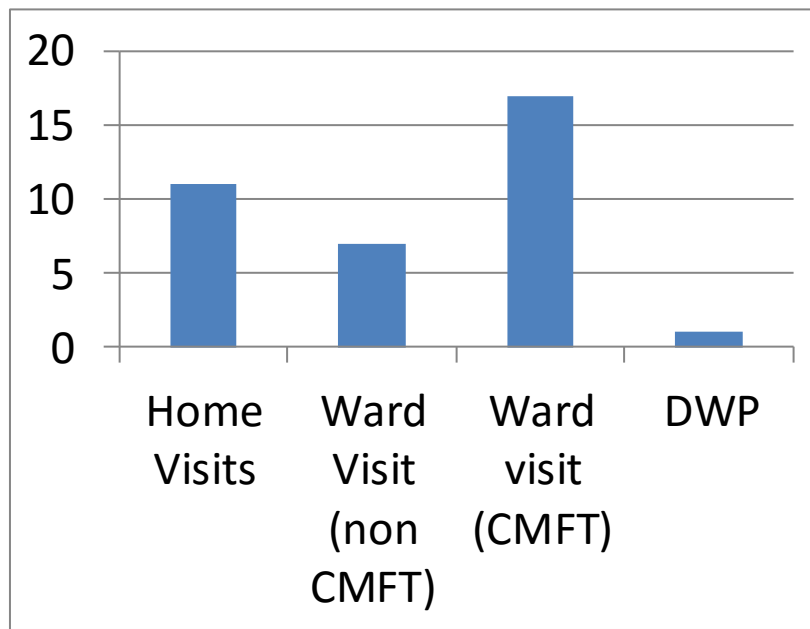
# Plan into practice





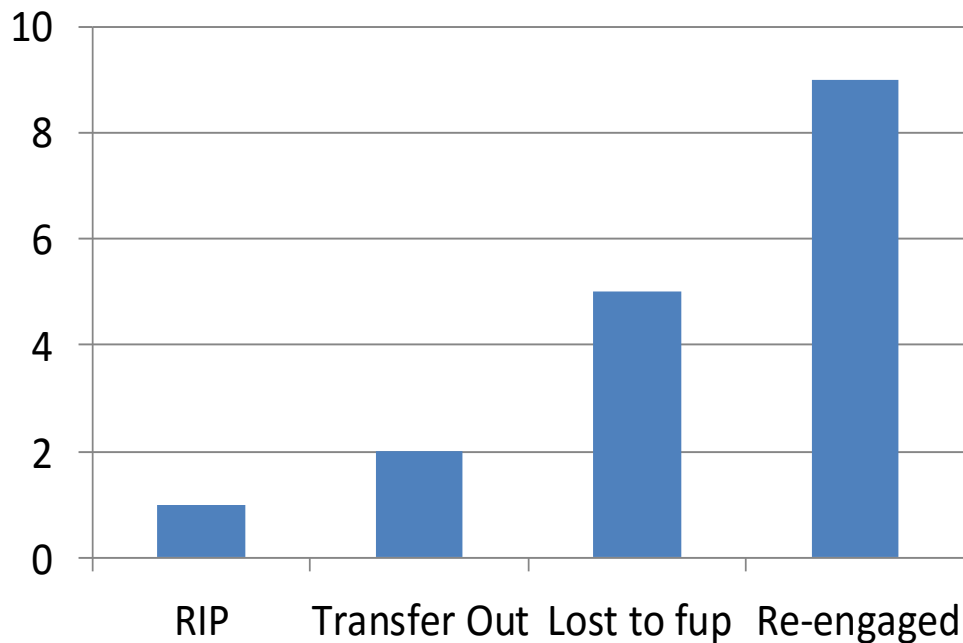
# Outcomes – May 2016

- Service commenced Jan 2016
- 100% patients have individualised care plans
- Complex pts n=52      Outreach pts n=9



# Retention in care

- End 2015 : 19 patients not seen >12 months
- End May 2016 : 2 patients not seen > 12months



9 (47.3%) re-engaged

6 on ARV

1 about to restart ARV

2 – remain frequent

DNA



# Example 1

- Male age 50 years
- Admitted A+E semi-conscious with drug overdose
- HIV test positive (3/3/2016)
- Discharged prior to result – no contact
- MDT discussion
- Home visit 4/5/16 diagnosis given
- Unaware tested - CD4 216 on ARV doing well



## Example 2

- Male age 43 years
- Admitted with groin abscess (IDU)
- New HIV/HCV diagnosis – refusing to engage with medical team
- Homeless, isolation, drug misuse
- CNS ward visits twice weekly – established relationship
- DNA 6 appointments following discharge
- CNS facilitated transfer of HIV care with GP/homeless team/HIV service at GP practice



# Conclusion

- CNS team work
- Identifying service gaps and developing service to meet patients needs
- Initial feedback - value of the HIV outreach CNS role
- Improve co-ordination and engagement in care
- Robust procedures including care planning
- Future developments – virtual clinic