TOWARDS 2025

How Do We Future Proof HIV Nursing

MONTH	DAY	YEAR
NOV	12	2015
JUN	30	2016
JUN	30	2025

TOWARDS 2025

How Do We Future Proof HIV Nursing

MONTH DAY YEAR
NOV 12 2015

MONTH DAY YEAR
JUN 30 2016

MONTH DAY YEAR
JUN 30 2025

BHIVA monitoring guideline's Audit

- 123 services took part in the audit
- Data was collected on 8258 people living with HIV.
- All patients were reviewed in clinic within the last 12 months (most were recent attenders)

Hepatitis B antibody titre

Guideline: Patients successfully immunised against HBV should have annual anti-HBs test.

3605 individuals were positive for anti-HBs and negative for HBsAg and anti-HBc:

- 2416 (67.0%) annual anti-HBs test done

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Calculation of CVD risk

Guideline: 10 year CVD risk should be calculated within 1 year of first presentation, and within past 3 years if on ART.

Target
70%

44.9% of those on ART, within past 3 years

32.3% of those not on ART, at any time

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BP, glucose, lipids

Guideline: BP, glucose and lipid profile should be assessed annually.

Target 90%

BP: 85.5%

Glucose: 77.0%

Lipids: 83.2%

Smoking

Guideline: Smoking history should be documented within past 2 years.

Target
90%

Documented within past 2 years: 65.9%

Of 34.1% not documented within past 2 years:

Never smoker: 13.7%

Current smoker: 3.7%

Ex-smoker: 2.4%

Smoking status not answered: 14.3%

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Smoking cessation

Guideline: People with HIV should be encouraged to stop smoking (cancer guidelines).

- 45.2% of current smokers had been offered a cessation service

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Sexual health screening

Guideline: Patients should be offered annual sexual health screen, and HIV notes should record outcome of offer, including whether declined.

Recorded as offered for:

- 65.7% all patients
- 72.7% of MSM
- 60.8% of heterosexuals

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Syphilis serology

Guideline: Syphilis serology should be documented at 3-monthly intervals as part of routine HIV blood set (unless indicated otherwise).

Done within 8 months (243 days) for:

- 63.0% all patients
- 73.4% of MSM
- 55.3% of heterosexuals

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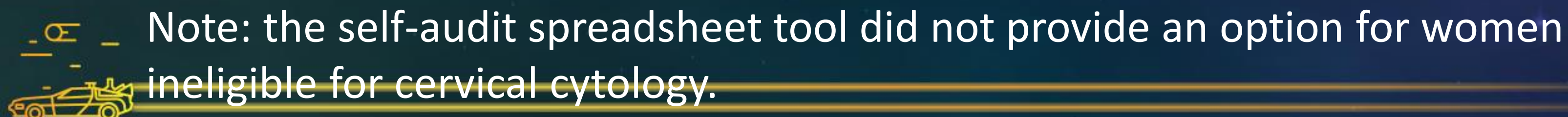
Cervical cytology

Guideline: Cervical cytology should be performed annually.

- 53.2% of women: done
- 21.9% of women: recorded that advised to obtain from GP or sexual health clinic



Note: the self-audit spreadsheet tool did not provide an option for women ineligible for cervical cytology.

Contraception

Guideline: Contraception and plans for conception should be discussed annually.

- Contraception was reported not relevant for 31.7% of women
- It had been discussed for 63.0% of women for whom it was relevant

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Fracture risk and BMD

Guideline: Fracture risk should be assessed every 3 years if aged >50.

- 16.7% done

Guideline: Among those on ART, bone mineral density should be measured in men >70 and women >65.

- 17.4% done for both sexes >70

Flu and pneumococcus vaccine

Guideline: People with HIV should be offered annual influenza vaccine.

Done: 21.1%

Target 95%

Advised obtain from GP: 36.2%

Guideline: Patients with CD4 >200 cells/mm^3 should receive pneumococcus vaccine.

- 26.4% done

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Psychological standard's audit

- 52 sites took part in the audit
- Data was collected on 1446 people living with HIV
- 768(53.1%) No reference to mental health status/history
- 91%(6.2%)documented brief or full cognitive assessment
- HIV Specialist nurse – not standard (37/52 sites)
- Almost half of the sites (48%) no access to psychological training

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Where do we go from here ?

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Eileen Nixon

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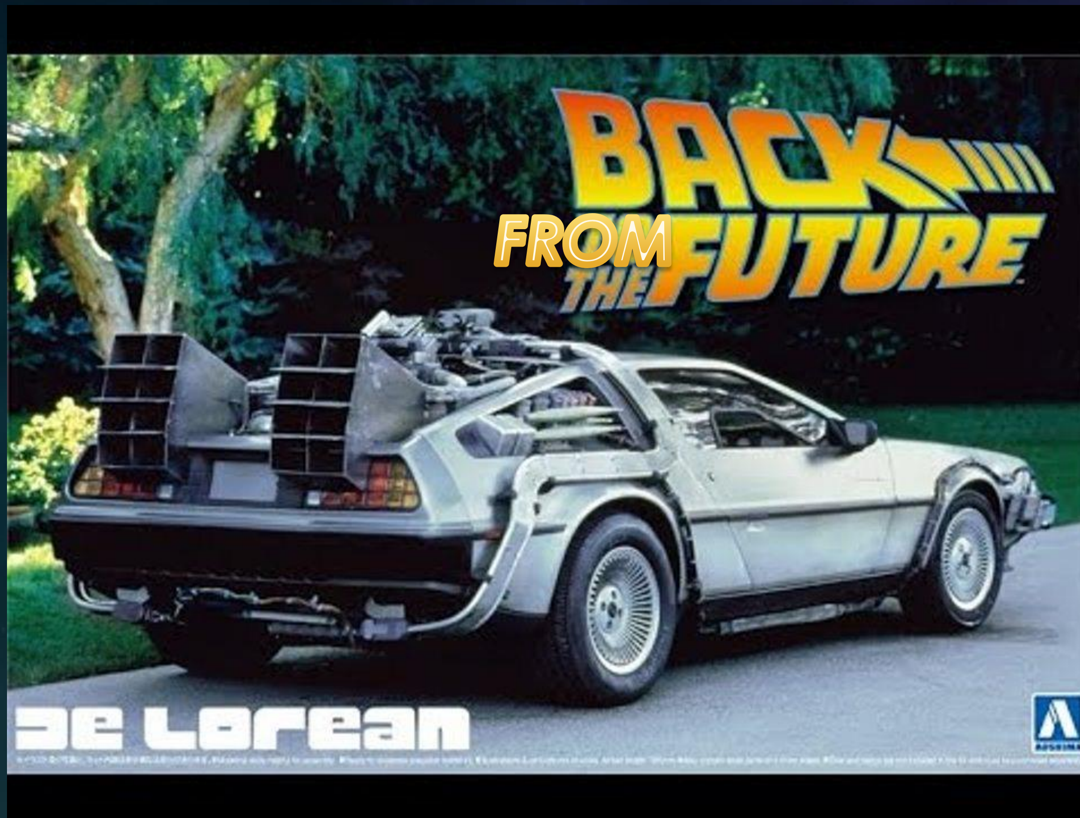

Eileen Nixon
Semi-retired and living in Scotland, European Union

Utopia or Dystopia?

How will our political leaders look?

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Aims of the session

To explore the context of care in 2025

Use case studies to illustrate future HIV nursing interventions

Highlight the education and training needs required to prepare nurses for the future

Context of care 2025

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ZERO New HIV infections

ZERO Deaths for AIDS related illness

ZERO Discrimination

Treatment target by 2020

THE TREATMENT TARGET

90%	90%	90%
diagnosed	on treatment	virally suppressed

90-90-90 An ambitious treatment target to help end the AIDS epidemic UNAIDS / JC2684 October 2014 http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf

Public Health England

Continuum of HIV care United Kingdom, 2011 vs 2014

Undetectable VL: VL<200 copies/ml

Delpech, V. Abstract 02: Quality of HIV care in the UK is excellent and improving. 22nd Annual Conference of the British HIV Association. 19th-22nd April 2016. Manchester. http://www.bhiva.org/Presentations160420.aspx

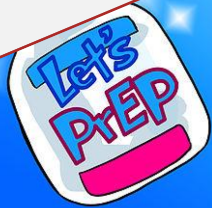
Getting to Zero

HALVE IT GOALS

Halve the proportion of pe
with HIV (CD4 count <3

Halve the proportion
undiagnosed H

We need to get the care and delivery of services right to support these goals.



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UK STIGMA INDEX 2015 SURVEY

BY US FOR US

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Case Studies

Audience Question 1

Do you think that in 2025 HIV outpatient services will still be hospital-led care under national specialised services?

YES – HOLD UP YOUR **GREEN CARD**

NO – HOLD UP YOUR **RED CARD**

Case 1

- David 25 years old, gay man
- Has a positive HIV test using home testing kit as he is thinking of taking PreP
- Contacts the local HIV clinic
- Has an appointment to see a nurse/ HA within 2 days for a confirmatory HIV test
- Baseline bloods CD4 550 v/l 20,472
- Wild type virus

Nursing Interventions – Case 1

- Discussed at MDT HIV treatment meeting
- Attend nurse-led new patient clinic
  - Full history taking (including sexual history)
  - Physical assessment and baseline measurements
  - Mental health assessment
  - Cognitive screening
  - Smoking history
  - Assessment tool for readiness to start ARVs
  - Assess social circumstances and personal support
  - Engagement in care tool

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http://www.bhiva.org/documents/Guidelines/Monitoring/160606-Monitoring-gl-draft-for-Consultation.pdf

Care Pathway – Case 1

- Shared HIV doctor/nurse for 6-12 months
- Registers with a GP
- Starts ARVs
- Treatment monitoring
  - v/l 1, 3 and 6 months, CD4 annually
  - Renal and liver profile and urinalysis 2-4 weeks, 3 and 6 months
  - Adherence support
- Patient self-management course / Peer mentor
- Review coping strategies at 3 and 6 months

http://www.bhiva.org/documents/Guidelines/Monitoring/160606-Monitoring-gl-draft-for-Consultati

Audience Question 2

Do you think in the year 2025 that routine stable HIV patients will be monitored in a community or general practice setting?

YES – HOLD UP YOUR **GREEN CARD**

NO – HOLD UP YOUR **RED CARD**

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Case 2

- Michael is a 40 year old gay man
- He has been HIV Positive for 7 years
- He has a CD4 of 942 last taken in the year 2022 and v/l <40 on ARVs
- He has previously been successfully treated for Hepatitis C
- He works full time as a graphic designer

Nursing Intervention – Case 2

- Bloods once a year taken by trained HCA outside of working hours
- Annual review by HIV nurse specialist in general practice / community clinic
  - Renal, liver and bone profile, FBC, urinalysis, HCV PCR
  - Metabolic assessment
  - CVD risk assessment
  - Adherence and medications
  - Mental Health
  - Sexual Health screen
  - Vaccinations
- Prescription for repeat ARVs

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http://www.bhiva.org/documents/Guidelines/Monitoring/160606-Monitoring-gl-draft-for-Consultation.pdf

Timelines for Devolvement to Primary Care

Diabetes – Chronic Disease Model

- Insulin produced 1922
- NSF Diabetes 2001
- Long-term conditions model - generalist/specialist 2005
- 15 Healthcare Essentials 2011
- State of the Nation Report 2012
  - 91% patients had 3 key annual health checks (50% had results followed up)
  - 6-60% had all 15 healthcare checks
  - 40% not referred to a specialist when required
  - 41% poor psychological well-being
  - 36% attended self-management course

HIV – Shared Care Model

- Combination ART 1996
- Sexual Health Strategy 2001
- BHIVA Standards 2007, 2013
- Position statement on engagement with primary care 2009
- Mixed study results on models of primary care and acceptability for patients, GPs and HIV physicians 2009-2015
- Some shared care models in place

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Variations in diabetes care and outcomes

Having the right care is essential for the wellbeing of everyone with diabetes, and can help reduce the risk, severity, and costs of complications.

An integral part of this is the receipt of the NICE-recommended care processes. These are the annual checks for the effectiveness of diabetes treatment (HbA1c), cardiovascular risk factors (blood pressure, serum cholesterol, BMI, smoking), and emergence of early complications (foot checks, eye screening, and two tests for kidney function).

Unfortunately, the 2012–2013 National Diabetes Audit showed that annual completion rates for eight[26] of these care processes continue to plateau – at 60 per cent. Moreover, there are worrying variations in the care and treatment received by some population groups, and in different parts of the country.

People with Type 1 diabetes receive poorer care than people with Type 2

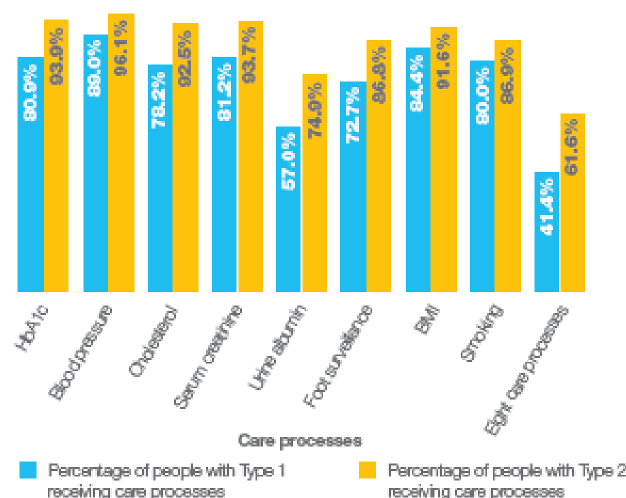
People with Type 1 diabetes – of all ages and ethnic groups – routinely receive worse care and treatment than people with Type 2 diabetes.

In 2012–2013, fewer people with Type 1 diabetes received each of the eight recommended care processes. Overall, only 41 per cent of people with Type 1 diabetes received all eight care processes, compared with 62 per cent of people with Type 2. People with Type 1 were also less likely to meet the recommended treatment targets for blood glucose (HbA1c) and cholesterol[15].

In 2012–13, very few people with Type 1 accessed structured education. This was offered to 2.4 per cent of people with Type 1 diabetes, compared with 6 per cent of those with Type 2. Only 1.1 per cent of people with Type 1 diabetes, and 1.6 per cent with Type 2, actually attended structured education[15].

> The outstanding message from this (audit) report is the need to address the **substantially worse routine care and treatment in younger people with Type 1 and Type 2 diabetes and in people with Type 1 diabetes at all ages.** Given the potential adverse consequences for these younger people of disability and premature mortality in middle life, designing better systems of care for them would yield considerable health benefits.
>
> Foreword, National Diabetes Audit 2012–13

People with Type 1 diabetes receive fewer checks than people with Type 2



Source: National Diabetes Audit 2012–13 (figures for England)

Non-routine care - Case 2

- Michael develops a chest infection and sees his GP who advises OTC medications
- He continues to get worse, coughing, temperature and SOB and is off work
- He rings the HIV Nurse Specialist for advice
- Following nurse assessment (and discussion with an HIV physician), Michael is prescribed antibiotics and reviewed by telephone 1 week later by the nurse

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Audience Question 3

Do you think that in 2025 that HIV specialist nurses will extend their skills to include other chronic disease areas?

YES – HOLD UP YOUR **GREEN CARD**

NO – HOLD UP YOUR **RED CARD**

Case 3

- Paula is a 57 year old woman
- She was diagnosed HIV positive in 2004
- She has a CD4 count of 180 and v/l 800 on ARVs
- She has COPD, diabetes, severe osteoporosis, hypertension and hyperlipidemia
- She has repeated hospital admissions for COPD
- Her mobility is impaired and she is low in mood

Care Pathway – Case 3

- Care provided in multi-specialty clinic in the community
- Care co-ordinated by HIV Specialist Nurse who works with other specialist teams
- 6 monthly visits from clinic based HIV Physician
- Blood tests co-ordinated through community clinic or at home
- Triage provided by HIV Specialist Nurse

Specialist / Generalist Practice Continuum

Expert Practice

Advanced Generalist

Specialist Practice

Generalist Practice

Junior Specialist

Novice Practice

Educational needs for 2025

Training in other chronic diseases

Motivational Interviewing

Nurse of the Future

Baseline HIV qualification / training

Advanced Practice skills

Physical Assessment / clinical skills

? Non-medical prescribing

Mental Health / psychological assessment

Nurse of the Future

Qualification in chronic disease management

Major in HIV disease management

Conclusion

- HIV treatment and care continues to evolve
- HIV Specialist nurses are key to future models of care provision

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Acknowledgements

- Ageing graphics – Owen Riseley
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- HIV medical and nursing teams in Brighton
- NHIVNA Competency Working Group

Marc Thompson

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Isolation
Stigma Sexual
Treatment
Polypharmacy mental Long Poor
services fatigue of
health
Loneliness Finances
GBV survivors Discrimination
term
Comorbidities side
effects Lack

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Age

Gender

HIV status

Race

Disability

Sexuality

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Technology Experience

Expert-Patients

Less-and-Easier-Drugs

Peer-Support LTCM

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Over to you …

- How do we future proof HIV nursing?
- What should nursing guidelines or standards of care include?
- What are the key educational issues for HIV nurses?

Thank you for listening

in the end
we only
REGRET
the chances
we didn't
TAKE

How Do We Future Proof HIV Nursing

- One
- Two
- Three

How Do We Future Proof HIV Nursing

- One
- Two
- Three