28th Annual Conference of the **National HIV Nurses Association**

Wed 17th - Fri 19th June

Leonardo Royal Hotel Southampton Grand Harbour,
Southampton

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Mind The Gap:

The role of the community CNS in managing complex caseloads across acute and community settings

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Guys and St. Thomas' NHS Foundation Trust

Conflict of Interest

In relation to this presentation, I declare that I have no conflict of interest

Speakers are required by the Federation of the Royal Colleges of Physicians to disclose conflicts of interest at the beginning of their presentation, with sufficient time for the information to be read by the audience. They should disclose financial relationships with manufacturers of any commercial product and/or providers of commercial services used on or produced for patients relating to the 36 months prior to the event. These include speaker fees, research grants, fees for other educational activities such as training of health professionals and consultation fees. Where a speaker owns shares or stocks directly in a company producing products or services for healthcare this should also be declared. Finally, other conflicts of interest including expert functions in health care or healthcare guidance processes should be declared (eg if the professional is a member of a health board). The Federation considers it good practice to also make speakers' disclosures available in digital format(s) relating to the educational event.

MIND THE GAP.

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The Role of the Community Clinical Nurse Specialist in Managing Complex Caseloads across Acute and Community Settings

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WHY THIS MATTERS

ACUTE

- Hospital Admissions
- Extended Inpatient Stays
- Discharge Planning

COMMUNITY CNS

- Case Management
- Coordination
- MDT Working
- Advocacy
- Earlier Community Intervention

COMMUNITY CARE

- Community Intervention
- Home Visits
- Social Care Liaison
- Adherence Support
- Safeguarding

Without effective coordination, patients can fall through the gaps between services, leading to poorer outcomes, avoidable admissions, and unmet health and social care needs.

SERVICE GAPS THAT REMAIN:

- Disengaged from care
- Homeless
- Highly stigmatized
- Migration-related barriers
- Complex mental and social care needs

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THE ROLE OF THE CNS

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The Clinical Nurse Specialist plays a vital role in bridging gaps in care as patients transition between acute services and wider multidisciplinary teams, ensuring continuity, coordination, and holistic patient support throughout their care journey.

We take the services to our patients wherever they are, bridging their care, coordinating and providing continuity for people living with HIV.

BACKGROUND

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Supports provided by CHCNS service.

EDUCATION & ADVOCACY

- Supporting patient at diagnosis and tackling stigma
- General health promotion
- Wider advocacy i.e. HIV testing week

OPTIMISING HIV CARE/ART ADHERENCE

- Clinical review, at home venepuncture
- Delivering and managing medications
- Monitoring adherence
- Supporting patient's lost to care back to services

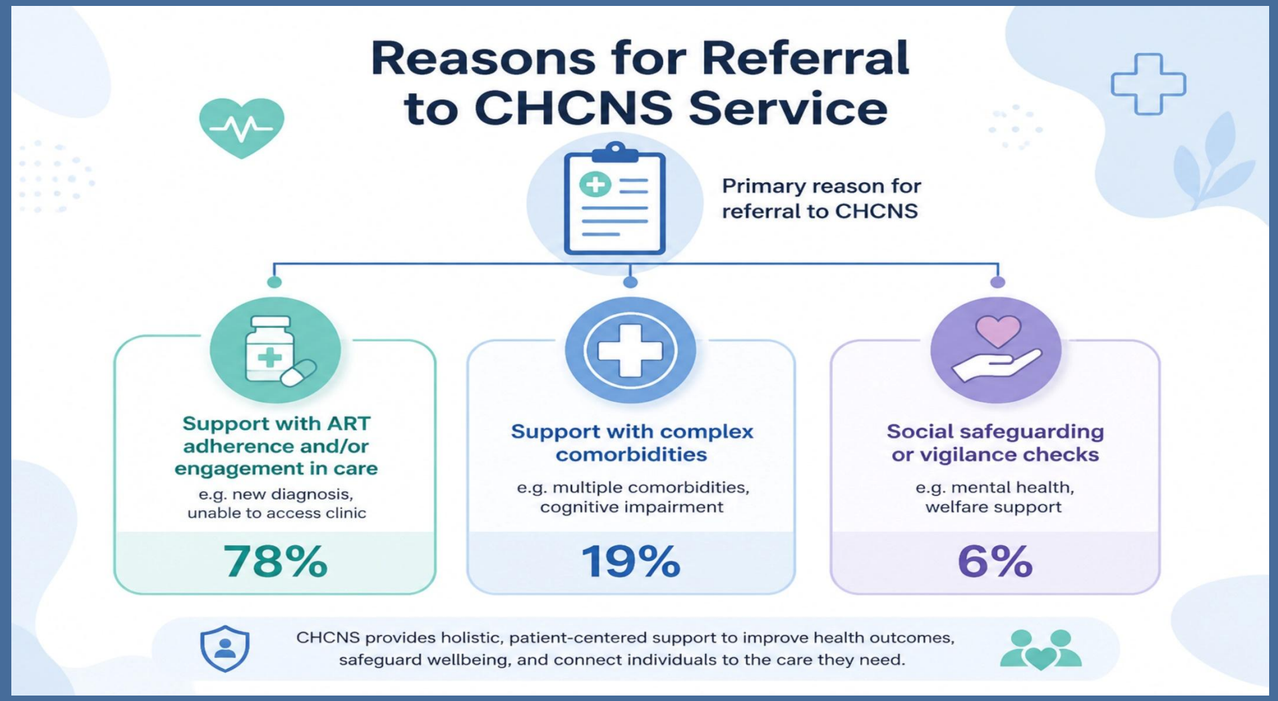
VIGILANCE CHECKS/ SOCIAL SUPPORT

- Support access to benefits, housing or immigration queries
- Support those with mental health concerns or substance misuse
- Support those with low health literacy
- Risk monitoring for deterioration and/or disengagement

COORDINATION OF CARE

- Including liasing with GP, district nurses, social workers, key workers, therapists and social prescribers.

The Community HIV CNS (CHCNS) team was invited by Dr. Ayoma Ratnappuli, of King's College Hospital, to participate in a case review of the patients that we support and the work that we do. The resulting findings demonstrated the wide-ranging impact of our service in improving engagement, adherence, safeguarding, and holistic patient care.



Data taken from case review: Behind the caseload: the role and reach of the Community HIV Clinical Nurse Specialist service. Author: Dr. Ayoma Ratnappuli

MORE THAN MEDICATION!

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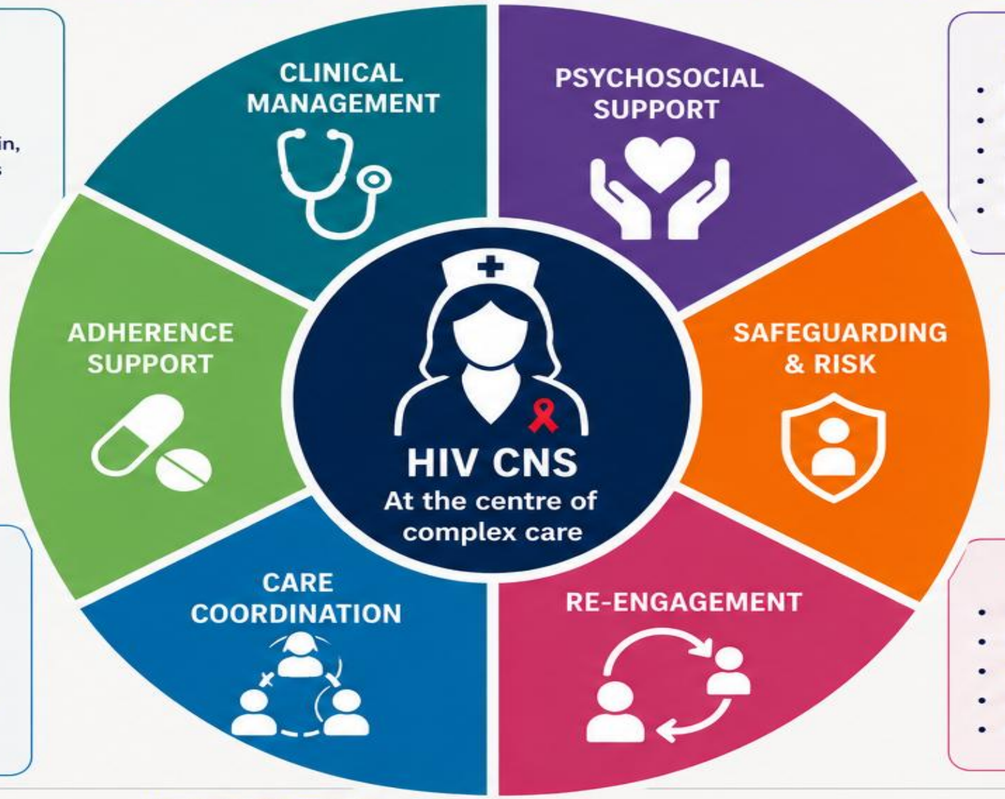
THE COMPLEXITIES OF THE HIV CNS ROLE

More than medication - holistic, person-centred, life-changing care

CLINICAL MANAGEMENT
- ART adherence management
- Polypharmacy reviews
- Managing co-morbidities
- Symptom management – e.g. pain, lethargy, weight gain, weight loss
- Monitoring bloods
- Medication reviews

ADHERENCE SUPPORT
- Adherence support – Dosette boxes
- Medication prompting
- Pharmacy liaison
- Stigma reduction
- Identifying barriers to adherence

CARE COORDINATION
- Case management
- MDT Meeting
- Liaison with other professionals (GP/Social Worker/Other teams/ Specialist nurses)
- Discharge planning for hospitalised patients
- Accompanying to appointments



PSYCHOSOCIAL SUPPORT
- Housing instability and support
- Benefits support & financial difficulties
- Advocacy
- Family support
- Stigma and disclosure

SAFEGUARDING & RISK
- Cognitive impairment
- Self-neglect
- Substance misuse
- Domestic violence

RE-ENGAGEMENT
- Disengaged patients
- DNA follow up
- Trust building
- MDT/Best Interests discussions
- Patients at risk of de-engagement

WHY IT MATTERS
- Prevents hospital admissions
- Improves ART adherence
- Reduces health inequalities
- Prevents safeguarding escalation
- Supports holistic wellbeing
- Improves outcomes & quality of life

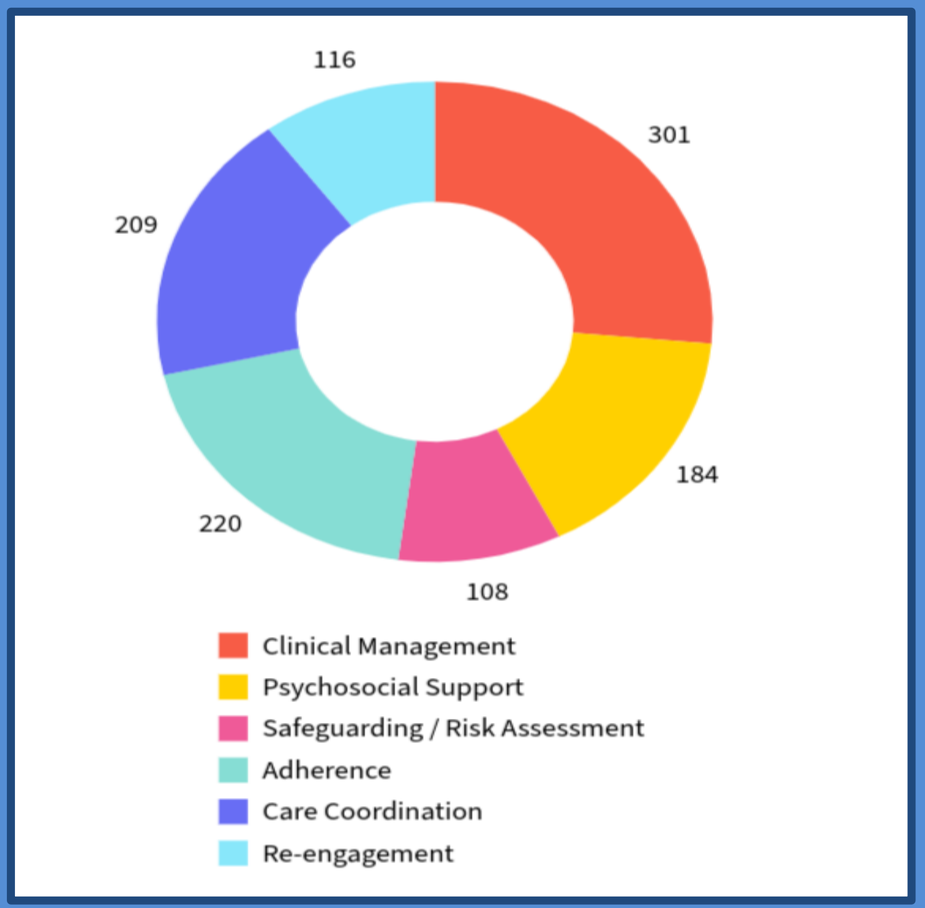
RELATIONSHIPS ARE AT THE HEART
Time, trust and continuity create the foundation for engagement, positive health outcomes and long-term wellbeing.

The HIV CNS role is diverse, dynamic and essential – supporting the whole person, not just the virus.

KEY FINDINGS:

OVERVIEW OF NURSING ACTIVITIES

Activity by Area of Practice	Activities completed/Total number of activities	Percentage
Clinical Management	301/360	84%
Adherence	220/300	73%
Care Coordination	209/300	70%
Psychosocial support	184/300	61%
Safeguarding/Risk	108/240	45%
Re-engagement	116/300	39%



CASE STUDY

1 Mary – Initial Visit by HIV CNS

Mary
- 73-year-old white Irish female

Health Concerns
- HIV (diagnosed 2010)
- COPD
- History of strokes
- Smoker (15 cigarettes/day)

Reason for Referral
- Multiple hospital admissions and lack of engagement

Assessment Findings
- Severe hoarding
- Old milk in fridge
- Self-neglect and poor personal care
- Medication boxes full

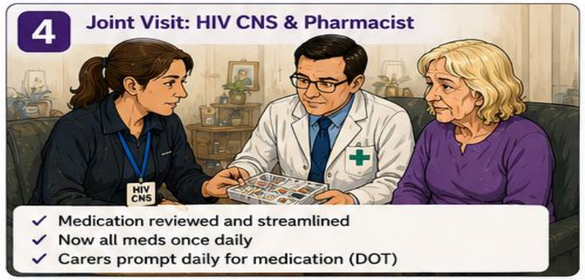
2 Safeguarding & Social Services

- ✓ Safeguarding referral completed due to self-neglect
- ✓ Query of financial abuse – benefits withdrawn
- ✓ Social worker assessment arranged

3 Care & Support at Home

- ✓ Twice daily carers – meals and basic tidying
- ✓ Mary is wary and only allows limited help

4 Joint Visit: HIV CNS & Pharmacist

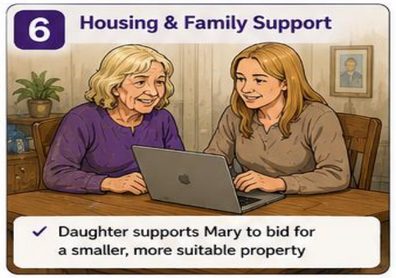


- ✓ Medication reviewed and streamlined
- ✓ Now all meds once daily
- ✓ Carers prompt daily for medication (DOT)

5 Additional Health Support

- ✓ Respiratory nurse visits at home
- ✓ Nebuliser provided
- ✓ Smoking cessation discussed – Mary declined

6 Housing & Family Support



- ✓ Daughter supports Mary to bid for a smaller, more suitable property

7 Ongoing Monitoring

- ✓ Reviewed every 6 months
- ✓ Bloods taken at home
- ✓ CNS coordinates care with all teams

8 Improving Outcomes

- ✓ Home environment improving
- ✓ Taking medication regularly
- ✓ Receiving twice daily care
- ✓ Health and safety improved
- ✓ Supported by team and family

SUMMARY

- Complex case with multiple health and social needs
- Multi-agency approach and strong coordination
- Building trust takes time but leads to better outcomes
- Mary is safer, better supported and slowly regaining independence

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CASE STUDY

The CNS acted as the bridge between health, social care and community services, reducing risk and helping Mary re-engage with care.

Outcomes for Mary have improved significantly, and she now has ongoing, long-term support from the CNS team.

Her care teams are now connected through the assessment, persistence, care coordination and trust-building provided by her CNS.

HIV ACTION PLAN FOR ENGLAND 2025 – 2030

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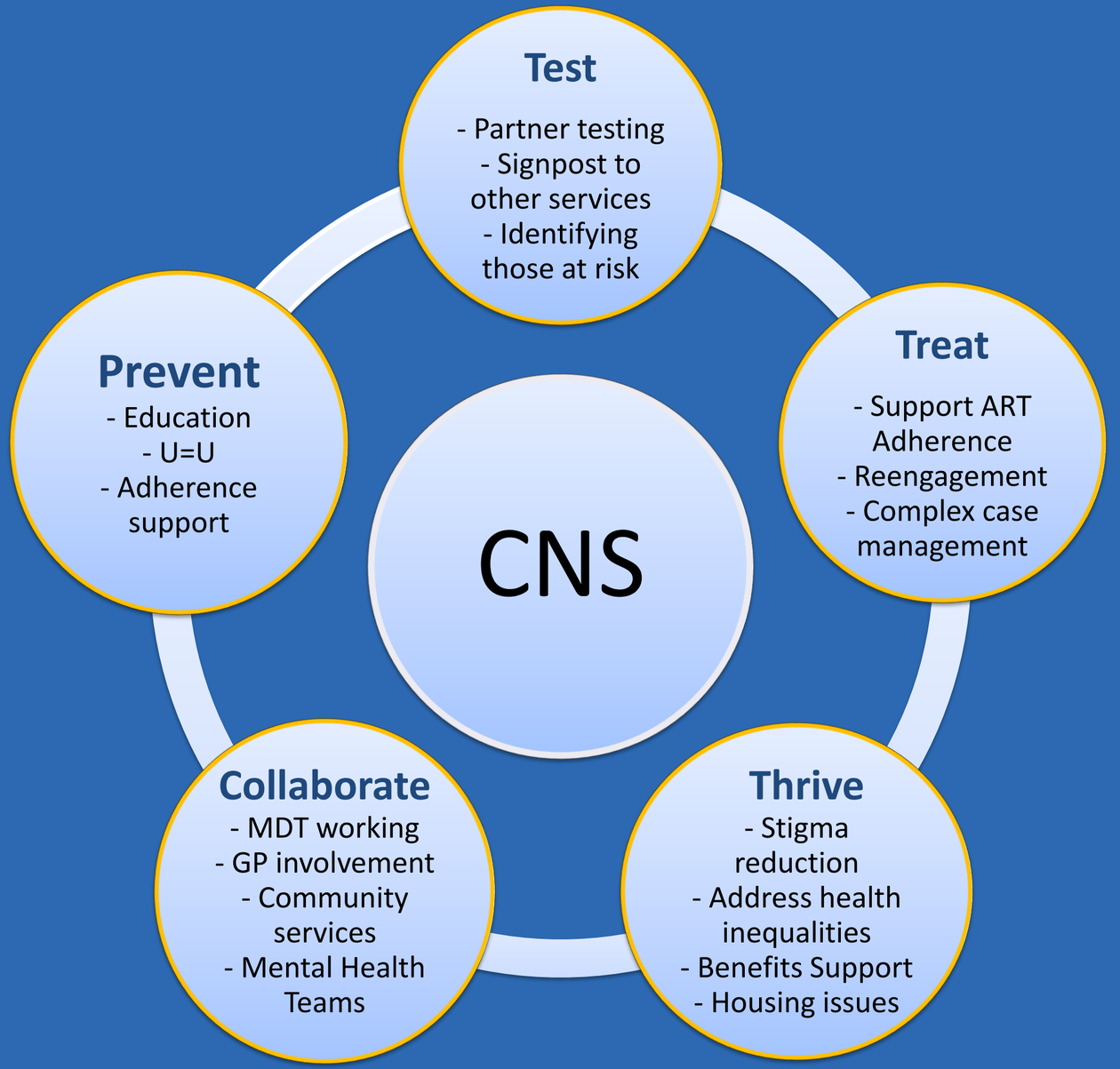
The Community HIV CNS Team is uniquely positioned to support and deliver the priorities of the HIV Action Plan.

The move towards community-based care places the Community CNS at the centre of service delivery, ensuring people living with HIV receive coordinated, person-centred care while supporting the goals of the national HIV Action Plan.

The Community CNS is not only supporting the shift from hospital to home, but also helping to shape the future of integrated HIV care

We are committed to achieving the goal of zero new HIV transmissions by 2030



USP OF THE CNS SERVICE

One Team.

Providing rapid access to specialist HIV care within 48 hours, with home phlebotomy, practical and emotional support, medication delivery, adherence support, and a dedicated point of contact for patients with complex needs.

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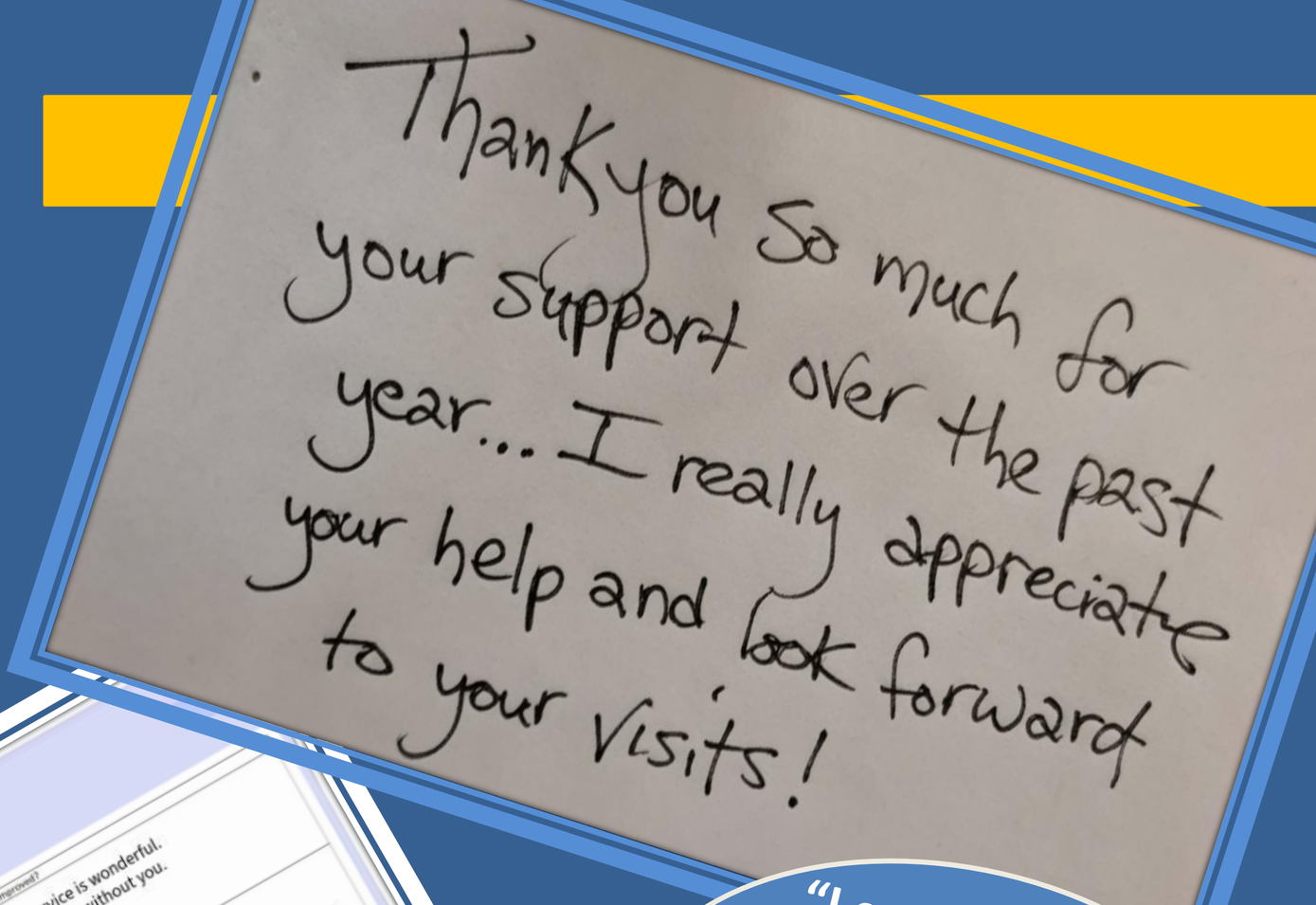
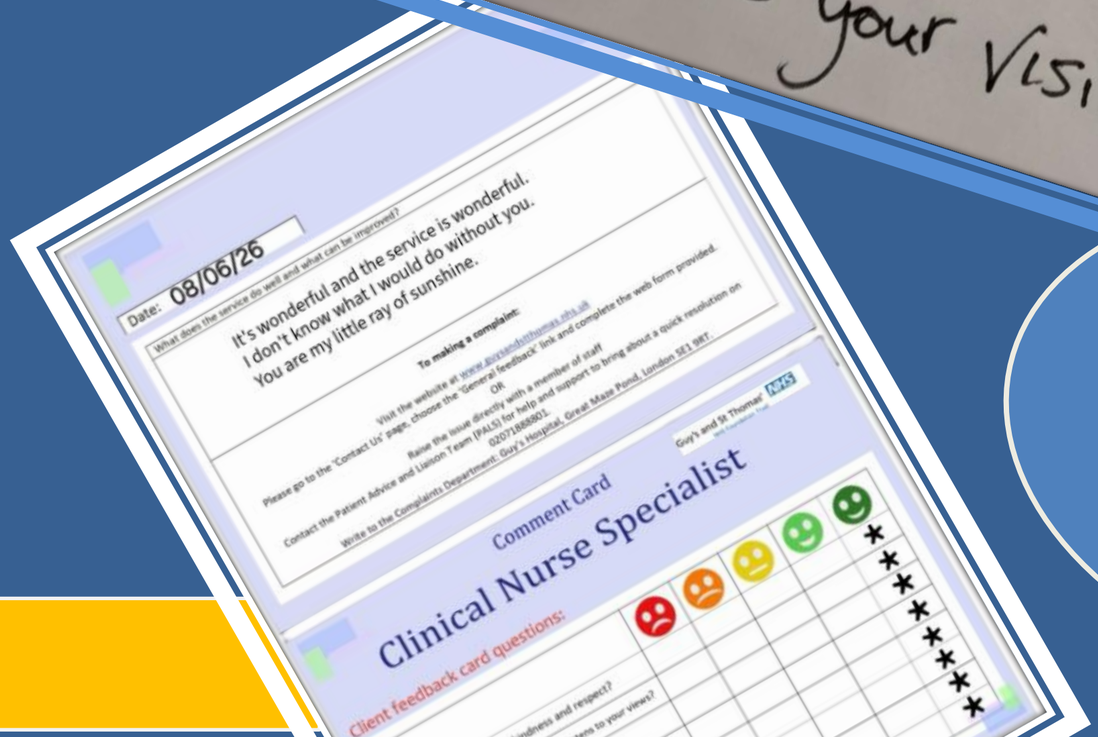
WHAT OUR SERVICE USERS SAY

For many patients, the Community CNS is more than a clinician.

We are their first port of call; a trusted source of support, advocacy, and continuity of care.





"I can call her for anything, and she knows what to do! I appreciate what you do for me. Thank you!"

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A FINAL NOTE

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PLEASE MIND THE GAP

BRIDGING GAPS

REDUCING RISKS

IMPROVING OUTCOMES

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THANK YOU.

Please feel free to ask any questions

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