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Key findings and recommendations

BHIVA's main 2014 audit focused on HIV and pregnancy, in collaboration with the National Study of HIV in Pregnancy and Childhood. Prompt initiation of antiretroviral treatment (ART) is important both for a woman's own health and for prevention of mother-to-child transmission of HIV, so it is of concern that many women started treatment later than guidelines advise. BHIVA recommends that HIV, obstetric and paediatric services should review the results of this audit and work together closely especially to:

- ▶ Agree pathways to ensure swift assessment and prompt initiation of ART
- ▶ Encourage women to plan vaginal delivery unless obstetric factors or insufficient virological control of HIV provide a clear indication for caesarean section
- ▶ Ensure urgent HIV testing is always available in all delivery units for untested women who present in labour or who need immediate delivery – consider point-of-care testing if laboratory testing is not feasible
- ▶ Review obstetric practice in the light of current guidelines to ensure procedures are not avoided unnecessarily in women with well-controlled HIV
- ▶ Report ART in pregnancy consistently to the Antiretroviral Pregnancy Registry, so as to build up data and increase confidence in its use.

Following the 2013 partner notification (PN) audit conducted jointly with the British Association for Sexual Health and HIV (BASHH), BHIVA recommends clinical services to review their practice in line with the new standards for HIV PN.

Pregnancies in women with HIV

The main project was conducted in collaboration with the National Study of HIV in Pregnancy and Childhood (NSHPC), an active surveillance system that receives confidential reports on pregnancies in women with HIV. BHIVA asked HIV clinicians to complete a survey with input from their obstetric and paediatric colleagues, and analysed anonymised data provided by NSHPC on 1483 pregnancies in women with HIV with due-dates during 2013 or the first half of 2014. The aim was to assess outcomes against standards specified in BHIVA's 2012 guidelines for the management of HIV infection in pregnant women.

All but one of the 112 survey respondents said there was a local multidisciplinary team for management of HIV and pregnancy, but one team lacked an obstetrician, two lacked a paediatrician and eight lacked a midwife. Twenty-nine (25.9%) teams had neither a nurse nor a midwife who specialised in HIV.

Appropriate use of ART is important both for women's own health and to prevent mother-to-child transmission of HIV. Most audited

pregnancies were in women already known to have HIV who conceived on ART but 217 (14.6%) were new diagnoses during pregnancy (see Figure 1). Five hundred and fifty-two women started ART during pregnancy and while nearly all used recommended regimens, many started later than guidelines recommend:

- Of 104 newly diagnosed women who needed ART for their own health because of a CD4 cell count below 350 cells/mm³, only 30 (28.8%) started within 2 weeks of diagnosis. Referral delay may have been a factor in this. In the survey, 19 (17%) of respondents said it took more than a week for women diagnosed with HIV through routine antenatal screening to be seen for specialist HIV care.
- Of 402 women starting ART with low viral loads (<30,000 copies/mL), 318 (79.1%) started by week 24 of pregnancy as guidelines recommend. However, there was much poorer compliance with the recommendation that women with higher

viral loads should start ART by week 16 of pregnancy: only 47 (38.8%) of 121 did so. Most late treatment starts were not due to late booking for maternity care.

Guidelines recommend that women on combination ART with a viral load under 50 copies/mL after 36 weeks' pregnancy should plan for vaginal delivery, unless there are obstetric reasons otherwise. While most women had viral loads under 50 copies/mL at some point in pregnancy, data at or after 36 weeks was only reported for 540 women on combination ART of whom 148 (27.4%) planned for caesarean section. The overall caesarean section rate was 53.1% (719 of 1,354 live births with data available). This high rate may reflect obstetric factors that were not audited, recognising that many women with HIV have had previous caesarean deliveries. However, in the survey three (2.7%) respondents said local policy was to recommend caesarean section for women stable on ART with a viral load under 50 copies/mL, contrary to guidelines, and nine (8.0%) said this was a matter of

maternal choice. Of 50 women on ART with viral loads in the range 50–399 copies/mL after 36 weeks' pregnancy, 24 planned for vaginal delivery, consistent with guidelines that vaginal delivery can be considered in this circumstance, depending on individual factors.

Other findings from the survey were that:

- 21% of respondents said it takes over 2 hours to obtain an urgent HIV test result during working hours, and 50% outside working hours. This is of concern if women whose HIV status is unknown present in labour or needing immediate delivery.
- Many respondents said local practice was to avoid procedures such as fetal scalp monitoring, amniotomy or episiotomy in women on combination ART with a fully suppressed viral load under 50 copies/mL. Such avoidance is unnecessary and might contribute to the high caesarean section rate in women with HIV. ■

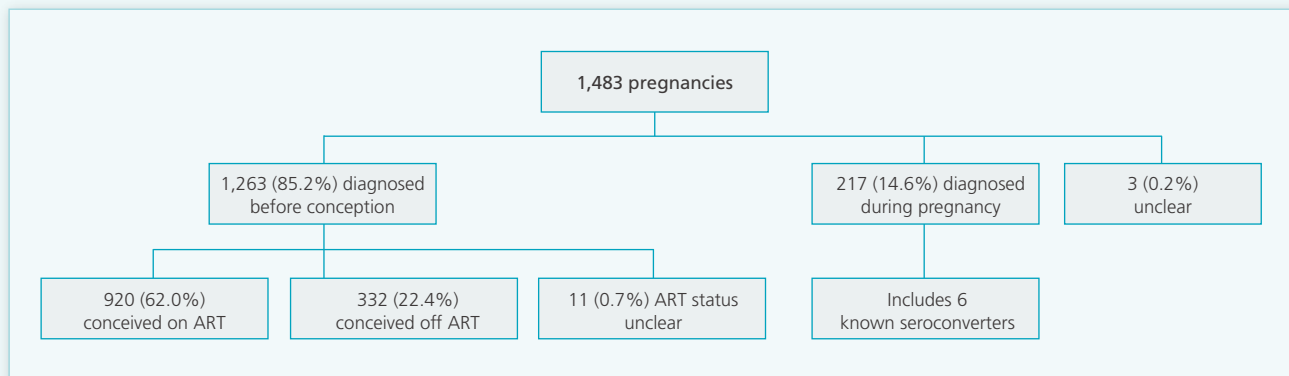


Figure 1: HIV diagnosis and ART status for 1,483 audited pregnancies in women with HIV.

Partner notification

Partner notification (PN) is defined by the World Health Organization as: ‘the process of informing the sexual partners of people with sexually transmitted infections, including HIV, of their potential exposure to infection, ensuring their evaluation and/or treatment, and providing advice about preventing future infection’. In 2013, BHIVA collaborated with BASHH to audit HIV PN. Clinical services provided data on 2964 individuals who were newly diagnosed with HIV during 2011 (index cases), and 3211 of their contacts. As shown in Figure 2, the main findings were that:

- 519 (16.2%) of audited contacts were not at risk of undiagnosed HIV, mostly because they were either already known to be infected or were deceased
- 1,399 (43.6%) were informed of their risk and tested as a result of PN
- 310 (9.7%) were informed of their risk but not known to have been tested
- 983 (30.6%) were not informed of their risk.

Of the 1399 who were tested, 293 (20.9%) tested positive – a very high proportion, which demonstrates the striking effectiveness of PN in identifying people with previously undiagnosed HIV. However, the audit showed considerable scope for improvement in PN. It was performed for only 87.5% of index cases, and was estimated to have been completed for fewer than half their total number of contacts.

Following the audit, the National AIDS Trust has drawn up standards for HIV PN in collaboration with BASHH, BHIVA and the Society of Sexual Health Advisors. These state that on average at least 0.6 contacts should be verified by a healthcare professional as having tested for HIV (including those already known positive) per index case, within 3 months of the latter’s diagnosis. When contacts reported by the index case to have been tested but not verified by a healthcare professional are included, this figure rises to 0.8. ■

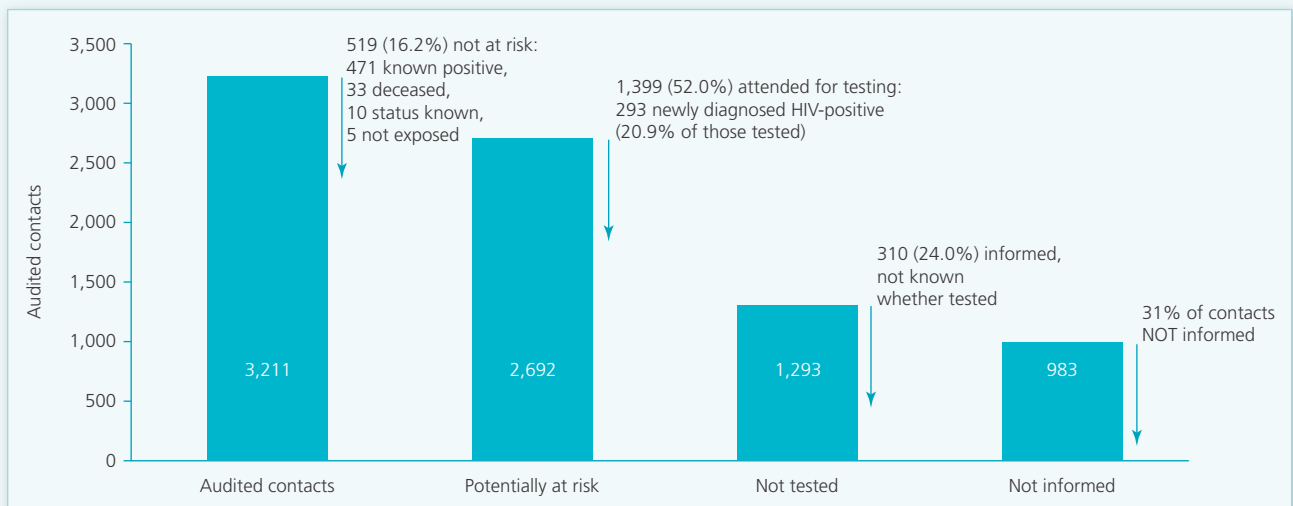


Figure 2: Partner notification outcomes for 3,211 audited contacts.

Other work

Monitoring audit 2015

During 2015, BHIVA plans to audit routine monitoring of adults with diagnosed HIV infection. In a new departure, this project will involve providing clinical services with a self-audit spreadsheet tool allowing immediate calculation of results as well as submission for national analysis and comparisons.

Late and missed diagnoses

Late diagnosis of HIV remains a major problem in the UK, and is associated with increased mortality, poorer response to treatment and higher healthcare costs. Following the 2010–2011 audit of newly diagnosed individuals, which found that a quarter had previous missed opportunities for diagnosis, the Audit and Standards subcommittee has undertaken two initiatives to improve adherence to HIV testing guidance:

- A publication, *Recording and investigation of late HIV diagnoses: good practice position statement*, has been produced to assist HIV specialist clinical services in reviewing previous use of healthcare services by newly diagnosed individuals to identify and share learning from earlier missed opportunities for testing. This is in line with BHIVA *Standards of Care for People Living with HIV 2013* that state that all HIV services should conduct such reviews.
- A group of specialist registrars convened by the committee reviewed clinical guidelines relating to HIV indicator conditions issued by other specialist organisations and the National Institute for Health and Care Excellence. They found that of 60 guidelines, only 26 mentioned HIV and only 20 recommended testing in accordance with national HIV testing guidelines. BHIVA is using this information to engage with guideline development groups and make the case for inclusion of HIV testing.

Retention in care: good practice position statement

Following the 2012–2013 audit of individuals with diagnosed HIV infection apparently not in care, the Audit and Standards subcommittee is working to produce a good practice statement on retention in care and follow-up of non-attendance.

Patient reported measures of care quality

BHIVA has led a stakeholder engagement exercise as a step towards developing patient-reported outcome and experience measures (PROMs and PREMs) for assessing quality of care for people living with HIV. This project involved a series of consultations with community organisations and patient groups, supported by the UK Community Advisory Board, African Health Policy Network, Positively UK and National AIDS Manual, and clinician consultation coordinated by BHIVA itself. Following this work BHIVA hopes to collaborate with an academically led project to develop and validate suitable patient-reported measures. This initiative has been supported by the MAC AIDS Fund.

National Clinical Audit and Outcomes Programme

Together with Public Health England and BASHH, BHIVA is collaborating with a one-year feasibility study led by MEDFASH and commissioned by the Healthcare Quality Improvement Partnership. This aims to explore and evaluate the design of a future national clinical audit of healthcare for HIV, chlamydia, gonorrhoea and syphilis, but excludes ongoing care for diagnosed HIV. The study report is expected to include recommendations as to whether an STI/HIV audit should be commissioned as part of the National Clinical Audit and Outcomes Programme. ■

Publications

Publication and feedback is an essential part of the audit cycle, to enable clinicians and others to reflect on findings and change practice if necessary. The subcommittee sends each clinical service a confidential summary of its own results with aggregated data for comparison, as well as presenting national results at conferences and on the BHIVA website (www.bhiva.org).

The subcommittee also seeks to publish its major findings in appropriate peer-reviewed journals. Articles to date include:

1. Curtis H, Yin Z, Clay K, Brown AE, Delpech VC, Ong E on behalf of BHIVA Audit and Standards Sub-committee. People with diagnosed HIV infection not attending for specialist clinical care: UK national review. *BMC Infect Dis*, 2015, **15**: 315.
2. Delpech VC, Curtis H, Brown AE, Ong E, Hughes G, Gill ON. Are migrant patients really a drain on European health systems? (letter) *BMJ*, 2013, **347**, f6444.
3. Ellis S, Curtis H, Ong ELC on behalf of the British HIV Association (BHIVA) and BHIVA Clinical Audit and Standards sub-committee. A survey of HIV care in the UK: results of British HIV Association (BHIVA) National Audit 2010. *Int J STD AIDS*, 2013, **24**, 329–331.
4. Ellis S, Curtis H, Ong ELC on behalf of the British HIV Association (BHIVA) and BHIVA Clinical Audit and Standards sub-committee. HIV diagnoses and missed opportunities: results of the British HIV Association (BHIVA) National Audit 2010. *Clin Med*, 2012, **12**, 430–434.
5. Garvey L, Curtis H, Brook G for BHIVA Audit and Standards Sub-Committee. The British HIV Association national audit on the management of subjects coinfected with HIV and hepatitis B/C. *Int J STD AIDS*, 2011, **22**, 173–176.
6. Backx M, Curtis H, Freedman A, Johnson M; BHIVA and BHIVA Clinical Audit Sub-Committee. British HIV Association national audit on the management of patients co-infected with tuberculosis and HIV. *Clin Med*, 2011, **11**, 222–226.
7. Rodger AJ, Curtis H, Sabin C, Johnson M; British HIV Association (BHIVA) and BHIVA Audit and Standards Subcommittee. Assessment of hospitalizations among HIV patients in the UK: a national cross-sectional survey. *Int J STD AIDS*, 2010, **21**, 752–754.
8. Street E, Curtis H, Sabin CA, Monteiro EF, Johnson MA, on behalf of the British HIV Association (BHIVA) and BHIVA Audit and Standards Sub-Committee. British HIV Association (BHIVA) national cohort outcomes audit of patients commencing antiretrovirals from naïve. *HIV Med*, 2009, **10**, 337–342.
9. Lomax N, Curtis H, Johnson M on behalf of the British HIV Association (BHIVA) and BHIVA Clinical Audit Subcommittee. A national review of assessment and monitoring of HIV patients. *HIV Med*, 2009, **10**, 125–128.
10. Lucas SB, Curtis H, Johnson MA, on behalf of the British HIV Association (BHIVA) and BHIVA Audit and Standards Subcommittee. National review of deaths among HIV infected adults. *Clin Med*, 2008, **8**, 250–252.
11. Hart E, Curtis H, Wilkins E, Johnson M. On behalf of the BHIVA Audit and Standards Subcommittee. National review of first treatment change after starting highly active antiretroviral therapy in antiretroviral-naïve patients. *HIV Med*, 2007, **8**, 186–191.
12. de Silva S, Brook MG, Curtis H, Johnson M. On behalf of the BHIVA Audit and Standards Subcommittee. Survey of HIV and hepatitis B or C co-infection management in the UK 2004. *Int J STD AIDS*, 2006, **17**, 799–801.
13. Curtis H, Johnson MA, Brook MG. Re-audit of patients initiating antiretroviral therapy. *HIV Med*, 2006, **7**, 486.
14. McDonald C, Curtis H, de Ruiter A, Johnson MA, Welch J on behalf of the British HIV Association and the BHIVA Audit and Standards Subcommittee. National review of maternity care for women with HIV infection. *HIV Med*, 2006, **7**, 275–280.
15. Sullivan AK, Curtis H, Sabin CA, Johnson MA. Newly diagnosed HIV infections: review in UK and Ireland. *BMJ*, 2005, **330**, 1301–1302.
16. Brook MG, Curtis H, Johnson MA. Findings from the British HIV Association's national clinical audit of first-line antiretroviral therapy and survey of treatment practice and maternity care, 2002. *HIV Med*, 2004; **5**, 415–420.
17. Curtis H, Sabin CA, Johnson MA. Findings from the first national clinical audit of treatment for people with HIV. *HIV Med*, 2003, **4**: 11–17.

Further information

Details of previous BHIVA audits together with specimen questionnaires, findings and reports, the list of articles, and further resources are available on the BHIVA website: www.bhiva.org/AuditandClinicalStandards.aspx

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