Exploration of what enhanced management of HIV in primary care might look like

HIV Care should be at … because is…

- Primary care
  - Easy, just like diabetes
  - Cheaper but might provide further income
  - Larger numbers now
  - Familiarity with chronic conditions
  - Access to whole family
  - “Normalising”
  - But… already overworked, so many targets
- Secondary care
  - Complex, needs deep understanding of all issues
  - The way has always be done and works well
  - Many patients have long standing good relationships
  - Access to experts
  - GPs do not have the time
  - Our departments are sustained mostly by this income

What is this really about?

- **This is about patients.**
- “Care without borders”
- Integrated
- Designing best on existing strengths and services but also on patients needs
- Once that is done, sort out funding, commissioning, etc

- And patients come in many different versions…all with their own issues and needing individualised care within a standarised frame.

12 Standards of Care for People Living with HIV

Standard 1: HIV testing and diagnosis
Standard 2: Access to, and retention in, HIV treatment and care
Standard 3: Provision of outpatient treatment and care for HIV, and access to care for complex comorbidity
Standard 4: Safe ARV prescribing: Effective medicines management.
Standard 5: Inpatient care for people living with HIV.
Standard 6: Psychological care.
Standard 7: Sexual health and identification of contacts at risk of infection.
Standard 8: Reproductive health.
Standard 9: Self-management.
Standard 10: Participation of people with HIV in their care.
Standard 11: Competencies.
Standard 12: Information for public health surveillance, commissioning, audit and research.

Designing enhance care… let's see what the patients needs and primary care

Standard 1: HIV testing and diagnosis

- Most people in the UK have a GP. HIV service can do little other than support

Standard 2: Access to, and retention in, HIV treatment and care

- "lost to follow up patients" will eventually go to GP or the GP will get a request for previous records. A+E, other outpatients… will write to GP. GP surgery does not have the stigma of sexual health clinic or Infectious diseases.

Standard 3: Provision of outpatient treatment and care for HIV, and access to care for complex comorbidity

- GP's look after complex patients with multipathology. Excellent IT facilities to capture CV risk, fracture risk, smoking, etc.

Standard 4: Safe ARV prescribing: Effective medicines management.

- GP usually the one who has the full list of medications with IT to help with interactions
- However not familiar with side effects of drugs, when to start, what to choose and when to change

Standard 5: Inpatient care for people living with HIV.

Designing enhance care… let's see what the patients needs and primary care

Standard 6: Psychological care.

- Available from GPs but variable and not HIV specific

Standard 7: Sexual health and identification of contacts at risk of infection.

- Some GPs already involving on this but not all

Standard 8: Reproductive health.

- Part of GP Practice

Standard 9: Self-management.

- GPs already involve in this in many places

Standard 10: Participation of people with HIV in their care.

Standard 11: Competencies.

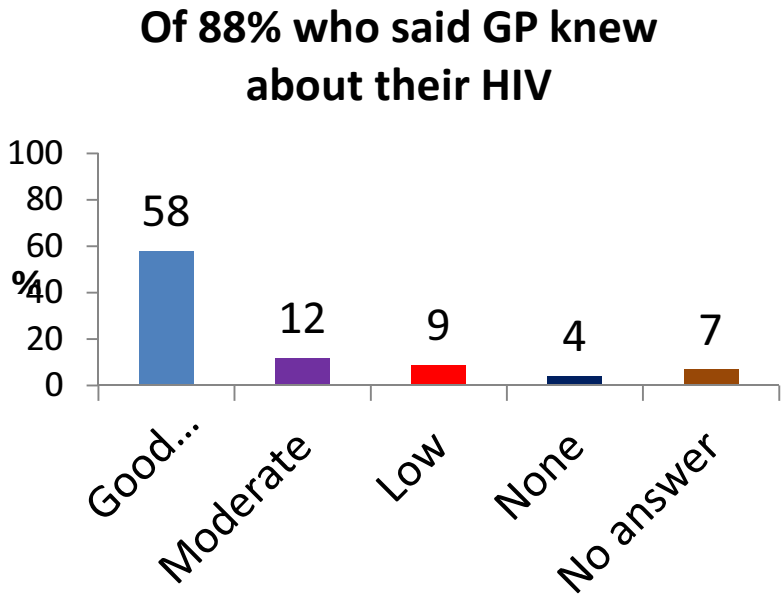
- Variable and needs updating

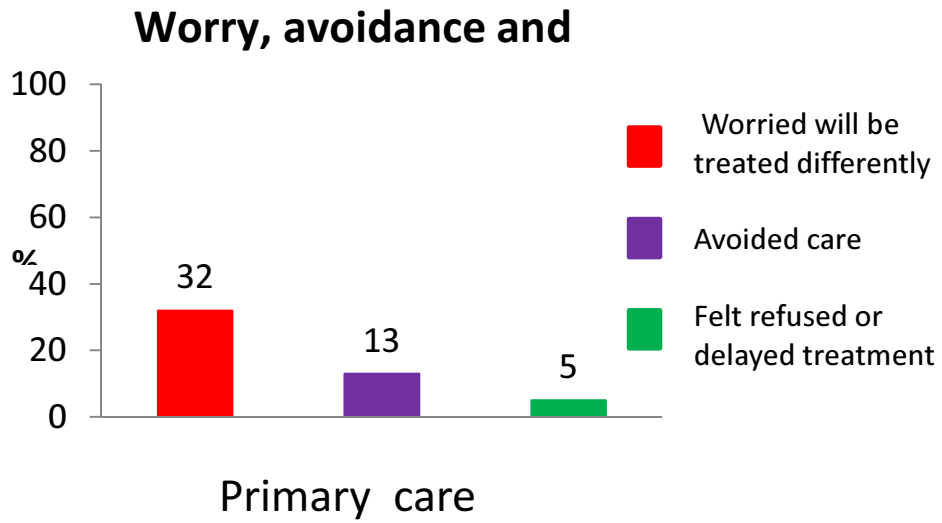
Standard 12: Information for public health surveillance, commissioning, audit and research.

BHIVA position statement

- Avoid fragmentation
- Good communication
- Every HIV patient should remain under a specialist
- Every HIV patient should be strongly encouraged to register with a GP
- Maintain choice
- Audit and monitor outcomes
- Clear accountability

UK stigma index 2015 – national survey of 1576 participants





http://www.stigmaindexuk.org/reports/2016/NationalReport.pdf

So how to start…

- It requires an interest from both primary and secondary care. Ie. *Not all GPs can/want to do it, not all secondary care wanted to supervise it and not all patients want this.*
- It should not be a “one size fits all”

Different levels

- Level 1- GP provides primary care and no HIV care at all.
- Level 2- GP provides help with monitoring (does some bloods, assess CV risk, smoking)
- Level 3- GP participates in integrated care- within this different ways but MDT, clinics in primary practice with secondary care, etc.
- Level 4- GP provides all care of uncomplicated patients with specialist review every 1-2 years and as needed

Who can do it?

- Primary care needs to have a significant volume of patients
- Minimal services: in house phlebotomy, person available to coordinate HIV care, sexual health provision, psychology/psychiatry access links, good links with social services, etc.
- A supportive secondary care backing them up and helping with training

Where to start?

- Level 1 and 2 just need a clear plan from secondary care
- Member of primary care comes to secondary care for training and experience
- Or member of secondary care goes to primary care for clinic and to train and provide experience

How to identify best practices?

- Self identification
- Volume of patients
- Willingness to take get involve in other services
- TALKING TO EACH OTHER

Difficult issues- mostly around money

- Workload pressures
  - Without commissioning at front many cannot get past level 2
- Funding- “if I train primary care, then I will lost my funding for my unit”
  - Commissioning must be done to pay for primary care work but to cost and pay properly for on-going training, MDT, yearly (or 2 yearly) secondary care reviews, urgent reviews, etc. Dismantling secondary care expertise is not good for patients
- Patients issues
  - Very close relationship with HIV Dr but not with GP can make it difficult

What do you do?
What do you want to do?
What stops you from doing it?
How can it be fixed?