

BHIVA Standards of care online consultation comments

7 October 2012

Standard 5: Inpatient care for people living with HIV

12 September 2012

Florence Obadeyi sent the following message:

I agree with the standards. It is important that HIV positive people are able to access secondary care easily.

18 September 2012

John Evans-Jones sent the following message:

Would it be useful to make a clearer distinction between HIV patient in-patient admissions that do and do not require HIV in -patient until management ? e.g. opportunistic infection / advanced disease. Not appropriate for all Gen Med HIV patients to be transferred if admission is largely non-HIV related.

24 September 2012

Jane Bruton sent the following message:

Under care arrangements add:

A nursing team with HIV specialist nursing skills and expertise

2 October 2012

Allan Anderson from Positively UK sent the following message:

Positively UK welcome this recommendation and the recognition and value BHIVA has given to the range of psychological support mechanisms, with the inclusion of voluntary sector and peer support.

4 October 2012

Jan Clarke from Leeds Teaching Hospitals Trust sent the following message:

"Evidence that consultant physicians who have responsibility for the care of inpatients with HIV infection have up-to-date CPD in both HIV medicine and in general medicine, and a job plan with at least two PAs for inpatient care"

This standard does not reflect the reality of inpatient care capacity for most of the UK. It is appreciated that HIV specialist inpatient care needs to be given by clinicians with full CPD evidence of HIV medicine, but collaborative management with acute GIM physicians, with ID colleagues and with a wide range of other specialty clinicians who fulfill CPD in their own subspecialty, such as respiratory medicine is the model of care in moderate to large centres across UK. I would struggle to think of more than three or four units in the whole country that could provide 24 hour coverage with every physician meeting this dual accreditation standard. excellent care offered to inpatients by multispecialty consultant teams

4 October 2012

jan clarke from LTHT sent the following message:

"Evidence that consultant physicians who have responsibility for the care of inpatients with HIV infection have up-to-date CPD in both HIV medicine and in general medicine, and a job plan with at least two PAs for inpatient care"

Apologies- earlier posting sent prematurely.

To continue...

I would support a wording that expects full HIV CPD and evidenced updates in general medicine for inpatient service consultants, with evidence of collaborative working arrangements in place with other specialties. To specify specific time within job plans is also inappropriate, since many teams now work on monthly rotas where oncall teams vary their commitment to ward work on a weekly basis.

In general, it would be worrying to think even a dual accredited person was prepared or expected to manage all possible medical complications in an inpatient, since medical subspecialty work is becoming increasingly disparate; and nothing in this section recognises the patient safety benefit of cross referral to other subspecialties.

4 October 2012

Sarah Barber from Bromley Healthcare sent the following message:

admission to HIV in patient unit 24 hours after referral. If no bed then this can prove difficult - hospitals must be able to receive support from an HIV in patient unit if the patient is too ill to transfer and additionally until a bed is available.

4 October 2012

Lisa Haddon from department of sexual health RCHT sent the following message:

My consultant colleagues and I are very concerned about the fact that the number of PAs for in-patient care is prescribed in the guideline. Inpatient care should be lead or have adequate input from an HIV physician as part of a suitably experienced multidisciplinary team and with input from network tertiary centre as required. In units with smaller numbers of HIV patients, it is rare for in-patient care to take up a significant amount of a job plan on a regular basis. It is neither practical or desirable for all in-patient care to be channelled into larger units.

5 October 2012

David Ogden from HIV Pharmacy Association sent the following message:

Quality Statements

“Care arrangements..

- 24-hour availability of pharmacy services and timely access to specialist HIV pharmacist advice.”
 - Timely access to pharmacy-led medicines reconciliation
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5 October 2012

Karen Percy from Chelsea and Westminster hospital sent the following message:

HIV-positive people presenting with complications of HIV are often critically ill with life-threatening conditions and require complex care provided by an HIV specialist consultant-led multidisciplinary team,

Will regard to this statement it would be good to breakdown the MDT or define what staff members are meant in a specialised MDT (Dietitian, Occupational Therapist, physiotherapist)

5 October 2012

Dr Frances Keane from Royal Cornwall Hospital Trust sent the following message:

This applies only to large units with lots of in-patients. The standards need to address what is achievable in rural areas with relatively few admissions. Local HIV pts who are not critically ill will not want to be moved long distances from home for care, but neither is achievable to suggest local GU physicians should get 2pas in job plans to look after them and be available 24 hours a day

6 October 2012

Dr Ashini Jayasuriya from Nottingham University Hospitals Trust sent the following message:

Standard 5: Inpatient care for people living with HIV: Page 3, Measurable and Auditable Outcomes: 'Evidence that consultant physicians who have responsibility for the care of inpatients with HIV infection have up-to-date CPD in both HIV medicine and in general medicine and a job plan with at least two PAs for inpatient care'.

It seems unrealistic that all Trusts would be willing to designate clinicians with HIV inpatients, 2 PAs in their job plan. The question in my mind is why '2 PA's has been set as a standard. This can't be 'evidence based'. I assume it is either set simply in order to encourage Trusts to give clinicians more time in their job plans for HIV inpatient work, or to encourage HIV inpatient work to fall solely within the remit of clinicians with large inpatient cohorts, who can justify having 2 or more PAs designated for this. The latter seems unrealistic; given that HIV is predominantly managed on an outpatient basis, the numbers of inpatients - especially in centers outside London - with HIV may be relatively small. Any suggestion that only clinicians with 2 PAs of designated time can manage inpatients is also relatively discriminatory towards those who work part time, the majority of whom will be women, and many of whom are both highly skilled and committed to providing a high standard of inpatient HIV care. If quality of care is a concern, surely it is more accurate to monitor clinical outcomes rather than simply equate hours in job plan to quality of care.

I have discussed these standards with the Nottingham University Hospital HIV Strategy group of which I am Chair, and with my colleagues in the North Trent HIV Network, on whose behalf I am now responding: We fully agree (and welcome) the statement that consultant physicians who have responsibility for the care of inpatients with HIV infection have up-to-date CPD in both HIV medicine and in general medicine. We also fully agree with and welcome BHIVA's attempt to encourage Trusts to give these clinicians appropriate time in their job plans to do this work. Nevertheless, we feel that setting a specific number of hours to this, will be counterproductive. This should be locally negotiated according to the local inpatient care model and workload. Perhaps BHIVA would consider modifying this statement accordingly?

7 October 2012

Dr Olufunso Olarinde from South Yorkshire HIV Network sent the following message:

Standard 5

Evidence that consultant physicians who have responsibility for the care of inpatients with HIV infection have up-to-date CPD in both HIV medicine and in general medicine, and a job plan with at least two PAs for inpatient care.

Proportion of all patients discharged from hospital seen in HIV outpatient services within 1 month (target: 95%)

Proportion of all patients admitted with opportunistic infection/cancer alive 30 days after diagnosis

Comments:

- 2 PAs for inpatient care for clinicians would be difficult to achieve in a network setting such as the South Yorkshire HIV Network (SYHIVN) or for clinicians from smaller units
 - Auditable outcome states all patients should be seen back in out patients within a month of hospital admission – surely this depends on what they were admitted with and therefore should not form part of a generalised audit standard?
 - Whilst the need for audit to identify underperforming units is recognised, outcomes such as proportion alive at 30 days when admitted with an OI will only give an indication of performance in larger units. Many smaller units may only have one or two such admissions per year which would therefore generate 'skewed' figures.
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7 October 2012

Dr Eric Monteiro from Leeds Teaching Hospitals NHS Trust sent the following message:

Evidence that consultant physicians who have responsibility for the care of inpatients with HIV infection have up-to-date CPD in both HIV medicine and in general medicine, and a job plan with at least two PAs for inpatient care.

Comment from Eric Monteiro Network Clinical Lead on behalf of North and West Yorkshire Regional HIV Network MDT

We believe that this standard would severely restrict who would be able to provide inpatient care for HIV+ patients in the UK outside London in those geographical locations which have sparsely spread populations.

In our network, we provide care for around 2500 HIV+ individuals within a geographical area which in parts has a sparse population and where the distances between the largest centre (Leeds) and some of the peripheral units (York, Mid Yorkshire and Huddersfield) are considerable (up to 30 miles). In our network we have a weekly acute HIV ward round every Friday morning which is

videoconferenced with one other centre (York). This is a forum where all inpatients are presented and discussed amongst HIV physicians. As HIV patients who require hospital admission comprise a variety of grades of complexity, we believe that such arrangements ensure proper peer review of all cases and those with lower and intermediate levels of complexity can be managed safely at peripheral hospitals between Acute G(I)M Physicians and HIV Physicians, whereas those with higher levels of complexity can be transferred, if deemed appropriate, or if not safe to be transferred are able to benefit from expertise from peers within the network. Many HIV patients are also reluctant to be managed at considerable distances from where they live and their relatives live. We believe that in a geographical location such as ours the above networked arrangements where regular (weekly or more frequent) peer review provides high quality and safe management for HIV inpatients and allows patients to be managed closer to their homes which accords with many inpatients/service users wishes.

The requirement for 2 inpatient PAs for the HIV Physician would therefore preclude such an arrangement in areas such as ours where patients could be managed safely close to where they live by a General Physician eg with an interest in Chest Medicine with 24/7 input from an HIV Physician.

7 October 2012

Clare Stradling from DHIVA sent the following message:

Thank you for this welcome review of the HIV Standards, and for the time and energy this working group have contributed.

We realise that we are only a small part of the overall HIV journey but equally all the current evidence point to increasing numbers of people living with some metabolic and nutritional care needs secondary to HIV and if we are to ensure adequate access to nutritional assessment and specialist dietetic care for people living with HIV it will be key they are referenced in the standards. Therefore we recommend the following amendments.

Quality statements under Care arrangements, insert:

including specialist dietitian

timely access to dietetic services

'Arrangements for care in specialist HIV inpatient services must ensure there is:

- o appropriate and timely escalation of care to HDU and ITU when indicated
- o 24-hour availability of pharmacy services and advice
- o An HIV specialist consultant physician-led multidisciplinary team, including specialist dietitian
- o 24-hour availability of HIV specialist inpatient consultant advice and expertise

- o timely access to diagnostic investigations
 - o timely access to other medical and surgical specialists when required
 - o timely access to psychosocial and welfare advice and support
 - o timely access to peer support
 - o timely access to dietetic services'
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7 October 2012

Lindsay Short from Calderdale and Huddersfield NHS Foundation Trust sent the following message:

The measurable outcomes with respect to job plans and CPD is too proscriptive. The 2 PAs for in patient care would essentially rule out the majority of GUM physicians from being able to provide inpatient care and indeed a significant number of ID physicians. Any acute medical problem should be managed with the input of appropriate medical specialists e.g. cardiology, respiratory etc. I see no reason why in patient care cannot be adequately provided as a team approach between the HIV specialist and the acute physicians, with a forum for discussing cases in the forum of a local network of HIV specialist peers. Patients have difficulty travelling relatively short distances to hospitals and have been reluctant to travel 20+ miles with the costs for family etc and being cared for by an unfamiliar team.

Many of the acute admissions are late presentations who end up in ITU. ITU to ITU transfers do not occur very often - as very expensive and patient may not be stable enough for transfer. It is therefore essential to have local expertise to help support these admissions and has worked very well to date. It also ensures that the local physicians gain knowledge and understanding of HIV and it's complications

7 October 2012

Will Chegwiddden from Rehabilitation in HIV Association sent the following message:

RHIVA is the Rehabilitation in HIV Association and is the BHIVA affiliated organisation representing Occupational Therapists, Physiotherapists and Speech and Language Therapists working with people living with HIV. This includes representing the therapists working in specialist HIV inpatient settings and specialist HIV outpatient settings, as well as leading on policy, education and quality issues for therapists working with people living with HIV in non-specialist settings including but not limited to inpatient wards, community rehabilitation services, social services and outpatient clinics. As well as BHIVA affiliation, we maintain links to our relevant professional bodies and have been involved in

the overall development of these standards and the comments on this specific section are in addition to the general submission we have also made, where we also represent the specific comments below. Where we feel there is a small or simple change we have reproduced the original text, once without change, and once with our suggested change, for clarity, as well as giving a short rationale for our recommendation for change.

Change “People who are HIV positive who require admission to hospital should experience effective discharge planning to ensure timely length of stay, appropriate arrangements for ongoing care and safe discharge.” to “People who are HIV positive who require admission to hospital should experience effective discharge planning to ensure timely length of stay, appropriate arrangements for ongoing rehabilitation, care and safe discharge.”

Rationale: The term “care” does not generally indicate rehabilitation and current DH approaches to early supported discharge highlight rehabilitation as central to effective discharge processes; social care has also evolved so that care is no longer considered just a “package of care” but usually “reablement” which is a rehabilitation and care hybrid. Adding the term “rehabilitation” to this statement relating to discharge will reflect current good practice.

Change:

Arrangements for care in specialist HIV inpatient services must ensure there is:

- o appropriate and timely escalation of care to HDU and ITU when indicated
- o 24-hour availability of pharmacy services and advice
- o An HIV specialist consultant physician-led multidisciplinary team
- o 24-hour availability of HIV specialist inpatient consultant advice and expertise
- o timely access to diagnostic investigations
- o timely access to other medical and surgical specialists when required
- o timely access to psychosocial and welfare advice and support
- o timely access to peer support

To:

Arrangements for care in specialist HIV inpatient services must ensure there is:

- o appropriate and timely escalation of care to HDU and ITU when indicated
- o 24-hour availability of pharmacy services and advice
- o An HIV specialist consultant physician-led multidisciplinary team
- o 24-hour availability of HIV specialist inpatient consultant advice and expertise
- o timely access to diagnostic investigations

- o timely access to other medical and surgical specialists when required
- o timely access to assessment and provision of inpatient rehabilitation
- o timely access to psychosocial and welfare advice and support
- o timely access to peer support

Rationale: Early access to rehabilitation has been shown to improve clinical outcomes and reduce length of stay and is considered good practice in modern healthcare. Certain aspects of rehabilitation (such as physiotherapy input in to respiratory management, speech and language assessment of safe swallow, and occupational therapy/physiotherapy management of soft tissue shortening/contracture and pressure areas) are essential in avoiding potential life threatening or severely disabling conditions. Timely access to these services needs mention here.

7 October 2012

Jacqueline Stevenson from African Health Policy Network (Ffena) sent the following message:

As with our response to Standard 3, in terms of confidentiality, privacy and dignity, the full range of protected characteristics should be included, as should immigration status.

All outcomes, both clinical and related to patient experience, should have ethnicity and other equalities data recorded and reported against, to ensure equality of outcomes.

In addition to recording and investigating complaints, overall complaints should be reviewed to identify patterns, including disproportionate rates from different patient groups.