The main project for the year was an audit of 236 HIV-positive adults with active tuberculosis (TB), with accompanying surveys of how both TB and HIV services manage TB/HIV co-infection. Full results are available from the BHIVA website, but key findings and issues were that:

- Contrary to the 2008 national HIV testing guidelines, not all services routinely test TB patients for HIV on an opt-out basis. This is of concern because HIV infection is a major risk factor for developing active TB, and other data indicate that in 2003 about 8% of adult TB cases in the UK were in people with HIV. If an underlying HIV infection remains undiagnosed, the person will remain at high risk of potentially life-threatening complications even if the TB is cured. For 103 (44%) of the audited patients, active TB was the first sign of their HIV infection, illustrating the importance of such testing.

- Most patients (163, 69%) had advanced HIV disease with CD4 cell counts under 200 cells/mm³ when measured nearest to the time of their TB diagnosis (see Figure 1). This included 73 patients who had been diagnosed with HIV before they sought care for TB. This reflects existing concerns about people with known HIV infection who are not receiving or not benefitting from antiretroviral treatment.

- Among 60 sputum smear-positive TB cases, for 8 (13%) it took two days and for 17 (28%) it took three or more days to receive the result, whereas the national standard is within 24 hours on a six day/week service (see Figure 2). This is worrying in public health terms as well as for individual patient care, since sputum smear positivity is a marker of infectious TB.

- At some sites responsibility for statutory notification of TB cases among people with
HIV treatment failure and resistance

The committee also conducted a survey of arrangements for care of HIV patients experiencing failure of highly active antiretroviral therapy (defined as persistently detectable viral load on treatment) or drug resistance. This sought to explore the extent of clinical network engagement, in line with the 2007 Standards for HIV Clinical Care which recommend that networks develop protocols to ensure that outpatient HIV units can receive advice and input from HIV centre specialist units when assessing and managing such patients. Findings were that:

- HIV treatment failure is reassuringly rare, with most sites estimating five or fewer cases per year both of first failure with no or single class resistance and of second or subsequent failure. This shows the success of modern regimens.

- When failure does occur, it is managed locally more than through clinical networks. For example, 61 (87%) of participating sites had a regular arrangement for assessing patients with treatment failure/resistance and of these 38 were local to the site and 23 were network-based. About a quarter of outpatient HIV units would not routinely seek external advice even when assessing patients with second or subsequent line failure.

- Assessment of patients with failure/resistance is usually multidisciplinary; at least an HIV specialist physician and nurse would routinely be involved at most sites (see Figure 3). Unsurprisingly, specialist virologists are more involved, as are other specialists, such as pharmacists, in the assessment of patients with drug resistance.

- Completion of treatment is a key outcome for TB since it cures the patient and prevents TB transmission and drug resistance. The audited completion rate was 81% which did not meet the 85% national standard, although this standard is for all TB cases and not specifically those in people with HIV. A significant minority of patients were reported to attend irregularly and adhere poorly with treatment for TB, HIV or both, and not surprisingly this group were less likely to complete their treatment. In line with guidelines, some received directly observed therapy (DOT) for TB which is an important measure in supporting adherence.

- Information about HIV status had been passed on with the TB notification for about two-thirds of patients for whom data was available. The committee’s view is that this information should be passed on unless the patient refuses consent, as it is important when tracing and assessing close household contacts. Standard tests for TB may give misleading results if such contacts also have HIV.

- There was a high rate of extra-pulmonary TB with only 96 (41%) patients having pulmonary-only disease. This is consistent with previous studies involving people with HIV, but means that TB diagnosis and treatment is more complex for this patient group.

- Although not covered by guidelines or standards, completion of treatment is a key outcome for TB since it cures the patient and prevents TB transmission and drug resistance. The audited completion rate was 81% which did not meet the 85% national standard, although this standard is for all TB cases and not specifically those in people with HIV. A significant minority of patients were reported to attend irregularly and adhere poorly with treatment for TB, HIV or both, and not surprisingly this group were less likely to complete their treatment. In line with guidelines, some received directly observed therapy (DOT) for TB which is an important measure in supporting adherence.

- There was a high rate of extra-pulmonary TB with only 96 (41%) patients having pulmonary-only disease. This is consistent with previous studies involving people with HIV, but means that TB diagnosis and treatment is more complex for this patient group.

- Although not covered by guidelines or standards, information about HIV status had been passed on with the TB notification for about two-thirds of patients for whom data was available. The committee’s view is that this information should be passed on unless the patient refuses consent, as it is important when tracing and assessing close household contacts. Standard tests for TB may give misleading results if such contacts also have HIV.

- There was a high rate of extra-pulmonary TB with only 96 (41%) patients having pulmonary-only disease. This is consistent with previous studies involving people with HIV, but means that TB diagnosis and treatment is more complex for this patient group.

- Although not covered by guidelines or standards, information about HIV status had been passed on with the TB notification for about two-thirds of patients for whom data was available. The committee’s view is that this information should be passed on unless the patient refuses consent, as it is important when tracing and assessing close household contacts. Standard tests for TB may give misleading results if such contacts also have HIV.
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 clinic or department 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 at www.bhiva.org.

The committee also seeks to publish its major findings in appropriate peer-reviewed journals. Articles to date are as follows:


Future plans

Data collection started in autumn 2009 for an audit of HIV patients’ co-infection with hepatitis B and/or C. An accompanying survey is also looking at the role of adult HIV services in ensuring that their patients’ children are tested for HIV and supporting adolescent patients through the transition from paediatric to adult care. For 2010–11 the Committee is preparing to re-audit the new HIV diagnoses (audited in 2003) to assess the impact of the 2008 national HIV testing guidelines, and an audit of patients with advanced HIV disease not on treatment is provisionally planned for 2011–12.
Other activities

H1N1 pandemic influenza

The committee has initiated an appraisal of the impact of pandemic H1N1 influenza on HIV patients and services, which is to continue through winter 2009–10. Preliminary findings indicate that most services ask HIV-positive patients with flu-like symptoms to phone the clinic, probably reflecting concern that non-influenza disease may be mis-diagnosed if these patients are channelled solely via the national flu hotline.

Primary care

Following the 2007 Standards for HIV Clinical Services, a draft briefing paper has been prepared which expands on the role of primary and community care in relation to HIV. Consultation is continuing with external stakeholders with a view to finalising this.

The wider audit environment

The committee is in contact with the recently established Healthcare Quality Improvement Partnership, which seeks to promote better health services by supporting audit and similar quality improvement work, and has contributed to its discussions on criteria for best practice in clinical audit. There is also close liaison with the Audit and Outcomes Sub-Group of the London HIV Commissioners’ Consortium.

Financial details

BHIVA’s National Clinical Audit programme for 2008–9 has been funded by the Department of Health.

Costs are within budget, with any surplus being carried forward towards the audit programme for 2009–10 and other projects within the remit of the Association’s work.

Further information

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

Acknowledgements

BHIVA would like to thank all audit-participating centres, and to acknowledge the contribution of the Department of Health towards the funding of its audit programme.

Contact details

BHIVA Secretariat
Mediscript Ltd
1 Mountview Court
310 Friern Barnet Lane
London N20 0LD
Tel: 020 8369 5380
Fax: 020 8446 9194
Email: bhiva@bhiva.org
Web: www.bhiva.org

Audit Co-ordinator
Hilary Curtis PhD
39 Esmond Road
London NW6 7HF
Tel: 020 7624 2148
Email: hilary@regordane.net

Continued from front

Dr PC Gupta
Diana, Princess of Wales Hospital, Grimsby
(Midlands Representative)

Dr V Harindra
St Mary’s Hospital, Portsmouth

Dr M Lajeunesse
Children’s HIV Association
— to November 2008 —

Professor C Leen
Western General Hospital, Edinburgh

Dr N Lomax
Barts and the London Hospital

Ms G McCourt
Bexley Care Trust

Dr E Monteiro
Leeds Teaching Hospitals

Dr C O’Mahony
Countess of Chester Hospital

Dr ELC Ong
Newcastle General Hospital

Ms K Orton
Department of Health

Mr R Pebody
UK Community Advisory Board
— from January 2009 —

Dr FA Post
King’s College London

Dr A Rodger
Royal Free Hospital, London

Professor C Sabin
Royal Free and UCMS, London: Medical Statistician

Dr A Schwenk
North Middlesex University Hospital

Ms I Vaughan
London Specialised Commissioning Group Audit Information and Analysis Unit

Ms R Weston
HIV Pharmacy Association

Dr EGL Wilkins
North Manchester General Hospital

Dr D Wilson
CDC North East Protection Unit (Co Durham & Tees Valley Team)

Ms Maria Yeomans
London Specialised Commissioning Group Audit Information and Analysis Unit

More information about the work of the subcommittee is available at: www.bhiva-clinical-audit.org.uk