British HIV Association
BHIVA

November 2010

British HIV Association CLINICAL AUDIT REPORT 2009–10

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Action points from audit and survey 2009–10

The 2009–10 audit programme achieved record participation, with 145 clinic sites taking part overall. Based on the findings:

Commissioners should:

- Collaborate across geographical boundaries to support the continued development of managed clinical networks for HIV, including ensuring specialised care for patients with complex conditions such as liver disease and young people making the transition to adult care.
- If necessary clarify financial arrangements for vaccinating HIV patients against hepatitis A and B in accordance with guidelines.

HIV clinicians should:

- Review and discuss their audit findings within their own department and with relevant colleagues, e.g. gastroenterology/hepatology or infectious diseases, and develop an action plan to address any deficiencies.
- Ensure HIV patients are appropriately vaccinated against hepatitis A and B and re-tested for hepatitis co-infection annually in accordance with BHIVA guidelines.
- Ensure documented discussion with co-infected patients regarding alcohol avoidance and prevention of hepatitis transmission, including tracing contacts for testing/vaccination.
- Offer assessment of liver fibrosis to all HIV patients with chronic hepatitis co-infection, using validated non-invasive tests or biopsy.
- Ensure that patients with cirrhosis are managed jointly with a liver specialist and assessed regularly for hepatocellular carcinoma.
- Audit recording and testing of their adult HIV patients' children, and adhere to national guidance if parents refuse consent for such testing.
- Plan for an increase in young people with HIV making the transition from paediatric to adult care, through local multi-disciplinary liaison with support from the HIV In Young People Network and Children's HIV Association.

Note: BHIVA has sent each audit-participating site a report comparing its performance with national data, for use in action planning.

Hepatitis and HIV co-infection

The main project for the year was an audit of 973 adult HIV patients positive for hepatitis B surface antigen and/or hepatitis C antibody, with an accompanying survey of how HIV services manage hepatitis/HIV co-infection. Full results are available from the BHIVA website, but key findings and issues were that:

- Contrary to guidelines, 13% of hepatitis B/C co-infected HIV patients were neither vaccinated nor naturally immune to hepatitis A. Similarly, 5% of hepatitis C co-infected patients were unprotected from hepatitis B (Figure 1).
- Although previous audits have shown high rates of screening of newly diagnosed HIV patients for hepatitis B/C co-infection, almost a third of sites do not routinely re-test at least annually in accordance with guidelines.

- Discussion of alcohol avoidance and prevention of onward hepatitis B/C transmission were documented for only about half of patients. While this partly reflected availability of full records, documentation of this information is a clear standard in guidelines.
- Only 36% of co-infected patients had been assessed for fibrosis (liver disease), 21% by biopsy. This suggests under-use of the non-invasive methods recommended in recent guidelines.
- Some patients with significant liver disease were not under the care of a hepatologist or other liver specialist, and not all patients with cirrhosis had been assessed for hepatocellular carcinoma. ■

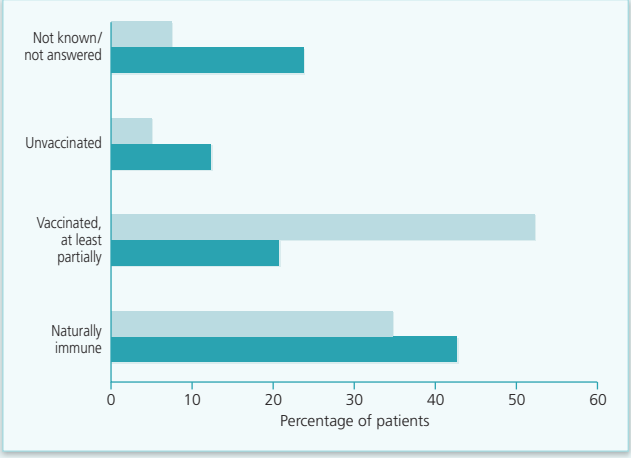

Figure 1: Immunisation status of HIV and hepatitis B/C co-infected patients against hepatitis A (■), and against hepatitis B (■) for hepatitis C co-infected patients only.

Testing children of HIV-positive adults

Late diagnosis of HIV is a significant cause of avoidable disease in both adults and children, so clinics should document the details of children of their adult patients who may have been exposed via mother-to-child transmission and ensure they have been tested (see *Don't forget the Children: guidance for the testing of children with HIV-positive parents*, 2009).

A survey was conducted to assess how well this is done:

- As shown in Figure 2, a third of sites do not routinely record details of children even of newly diagnosed adult patients. (Of those that do, some record this only for women.) Similarly a third of sites have no plans to do 'look back' identification of children of existing patients.
- Less than a quarter of sites say they have a reliable follow-up system for checking whether identified children have in fact been tested.
- Testing children is a sensitive issue and 71% of sites had experience of parents refusing consent at least initially. Most cases were resolved through discussion but two sites had needed to use child protection procedures.

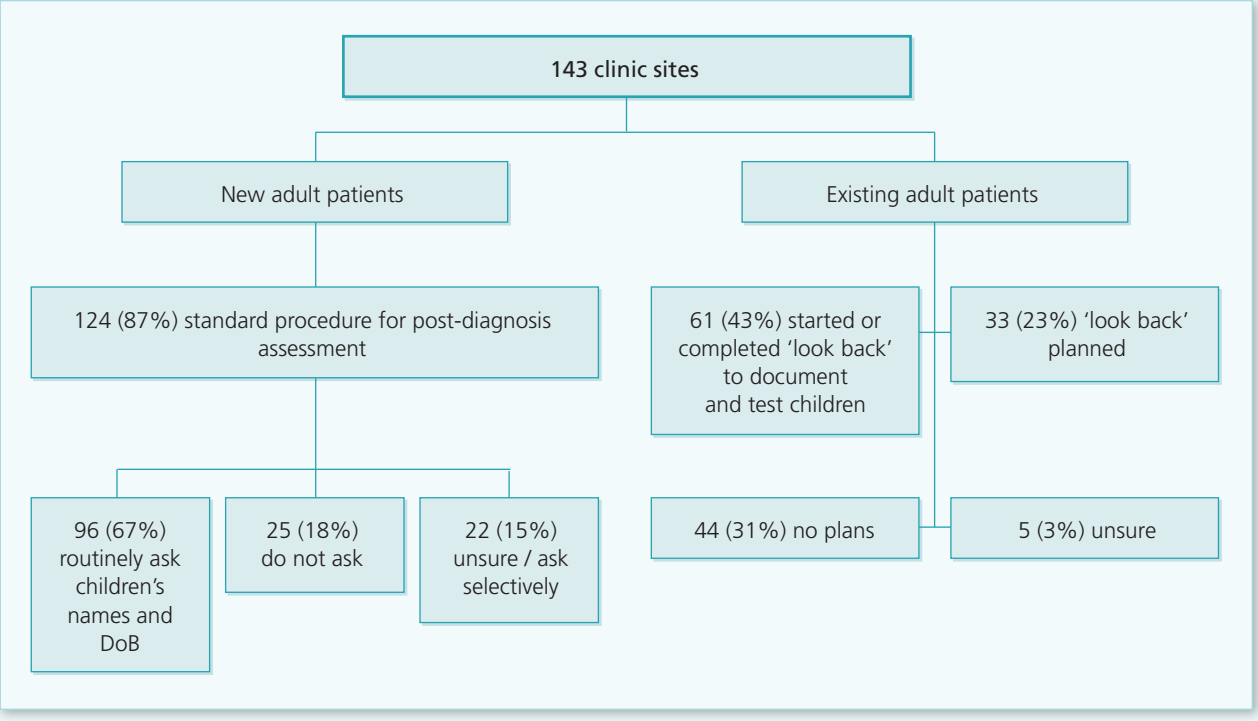

Figure 2: Clinic sites' practice for recording and testing children of known HIV-positive adult patients.

Adolescent transition from paediatric to adult care

More and more young people with HIV acquired via mother-to-child transmission are surviving into adulthood. According to Health Protection Agency data, 401 young people in this category aged 16–24 received care in 2009 – more than double the 2006 figure. While this is small compared to total adult HIV caseloads, these young people have exceptional medical and in some cases social needs as a result of their lifelong infection and complex treatment history. BHIVA's 2010 audit therefore included a survey of clinic arrangements for transition from paediatric into adult HIV care. This was mainly descriptive, but findings included observations that:

- Of 143 sites, 63 (44%) had experience of transition but a further 71 (50%) recognised they might do so in future. Only 22 had yet received more than three patients undergoing transition.
- In line with guidance, most sites do not have policies defining ages when transition should occur, but young people typically first attend an adolescent, transition or adult HIV clinic at about age 15–17 (perhaps accompanied by a member of the paediatric team).
- Models of care vary, but key workers and multi-disciplinary meetings were most often reported.
- Typically paediatric and adult care teams are both involved in planning transition but there was less input from patient/community representatives and very little from commissioners. ■

Other activities

H1N1 pandemic influenza

A brief appraisal concluded that H1N1 pandemic influenza did not have a significant impact on HIV patients in the UK, but it is noteworthy that only 54% of responding sites had facilities to separate potentially infectious patients from other outpatients. To avoid alternative diagnoses being missed, it is advisable for HIV patients with influenza symptoms to contact the HIV clinic. In accordance with BHIVA immunisation guidelines, people with HIV should be encouraged to accept annual influenza vaccination.

TB audit follow-up

Of 132 sites which took part in the 2008–9 audit of HIV and tuberculosis co-infection, 63 (48%) completed a short follow-up questionnaire in early 2010. This showed good awareness of the audit findings, although caution is needed in view of the low response rate. However, it was of concern that not all sites had discussed their reports internally and with TB colleagues. Some positive changes had occurred since the audit, but there were still problems in relation to TB services not testing routinely for HIV and delays in receiving sputum smear results. Commissioners and clinicians should continue to work to address BHIVA's 2009 audit recommendations to:

- Require routine, opt-out HIV testing of TB patients as a key quality indicator for all TB services.
- Ensure laboratory services meet standards for turn-around times for tests of public health importance such as sputum smear microscopy.

Primary care

Following the 2007 *Standards for HIV Clinical Services*, BHIVA has published a position statement on the role of primary and community care in relation to HIV. A working group has been set up with representatives from patients and from the Royal College of General Practitioners Sex Drugs and HIV Group, to develop relevant pathways, standards and educational resources. ■

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

1. Street E, Curtis H, Sabin CA, Monteiro EF, Johnson MA, on behalf of the British HIV Association (BHIVA) and BHIVA Audit and Standards Subcommittee. British HIV Association (BHIVA) national cohort outcomes audit of patients commencing antiretrovirals from naïve. *HIV Medicine*, 2009, **10**, 337–42.
2. 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-infected patients. *HIV Medicine*, 2009, **10**,125–8.
3. 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. *Clinical Medicine*, 2008, **8**, 250–2.
4. 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 Medicine*, 2007, **8**,186–91.
5. 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.

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6. Curtis H, Johnson MA, Brook G. Re-audit of patients initiating antiretroviral therapy. *HIV Medicine*, 2006, **7**, 486.
7. McDonald C, Curtis H, de Ruiter A, Johnson MA, Welch J, on behalf of the British HIV Association (BHIVA) and the BHIVA Audit and Standards Subcommittee. National review of maternity care for women with HIV infection. *HIV Medicine*, 2006, **7**, 275–80.
8. Sullivan AK, Curtis H, Sabin CA, Johnson MA. Newly diagnosed HIV infections: review in UK and Ireland. *BMJ*, 2005, **330**, 1301–2.
9. 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 Medicine*, 2004, **5**, 415–20.
10. Curtis H, Sabin CA, Johnson MA. Findings from the first national clinical audit of treatment for people with HIV. *HIV Medicine*, 2003, **4**, 11–7.

In the pipeline

During 2010–11 the Subcommittee plans to survey local HIV testing policy and practice and to re-audit patients seen for care for newly diagnosed HIV infection (audited in 2003). The aims will be to assess the impact of the 2008 national HIV testing guidelines, timeliness of diagnosis and referral into HIV specialist services, and whether earlier opportunities for testing may have been missed.

In 2011 unselected patients with established HIV infection will be audited to assess viral load outcomes of treatment, CD4 cell counts among those not on treatment and cardiovascular risk monitoring. A significant change in BHIVA's audit protocol is also planned for 2011; confidential reports to individual sites will include an overall score as well as feedback on individual outcomes. Clinician members of the Subcommittee will contact sites with lower scores to discuss in confidence whether this reflects factors other than clinical performance (e.g. case mix). Support towards improvement will be offered if quality of care issues are identified.

Financial details

BHIVA's National Clinical Audit programme for 2009–10 has been funded by the Department of Health.

Costs are within budget, with any surplus being carried forward towards the audit programme for 2010–11 and other projects within the remit of the Association's work.

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

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 at: **www.bhiva.org**

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