Speaker Name	Statement
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The Royal Liverpool and Broadgreen University Hospitals NHS Trust

The changing faces of HIV and how to engage with difficult to reach patients

Elizabeth Foote

Introduction

- NHS aim was to ensure that everyone was entitled to equal and free care at point of access –effective health care should be available to everyone [1]

- Equity for all and engaging 'difficult to reach' groups
- NHS facing unprecedented pressures
- Crucial to develop innovative, cost effective, quality nursing practice

- 5 year forward view [2]-care closer to home
- BHIVA guidelines Standard of care 2 & 3[3]
- HIV & LTC agenda

Difficult to reach

- Defining the notion of the ‘difficult to reach' is not straight forward. It may be that certain groups resist engaging in treatment services and are deemed hard to reach by a particular service or from a societal stance.

- Difficult to reach groups commonly include drug users, PLWH, refugees, asylum seekers, LGBT, BEM, prisoners and homeless people [4]

Engagement

- Failure to engage with care is associated with poorer health outcomes and a higher risk of onward transmission.

- The need for innovative approaches to engage hard to reach populations cannot be overstated. ‘Ultimately, nursing interventions lead to new or improved resources that drive costs down and advance nursing care and optimal patient outcomes’ [5]

Reasons for non engagement

- Location,
- Opening times
- Lack of choice
- Stigma [6]
- Bad experiences
- Physical disability
- Social isolation
- Prisoner
- Deprivation
- Psychological issues
- Substance Misuse/Dependence issues

Deprivation

- Liverpool has five of the most deprived areas in the country

- People living in ‘Deprived Industrial Areas’ in England and Wales are more likely to be treated for depression and psychological issues than those living in any other type of area (DoH 2001)

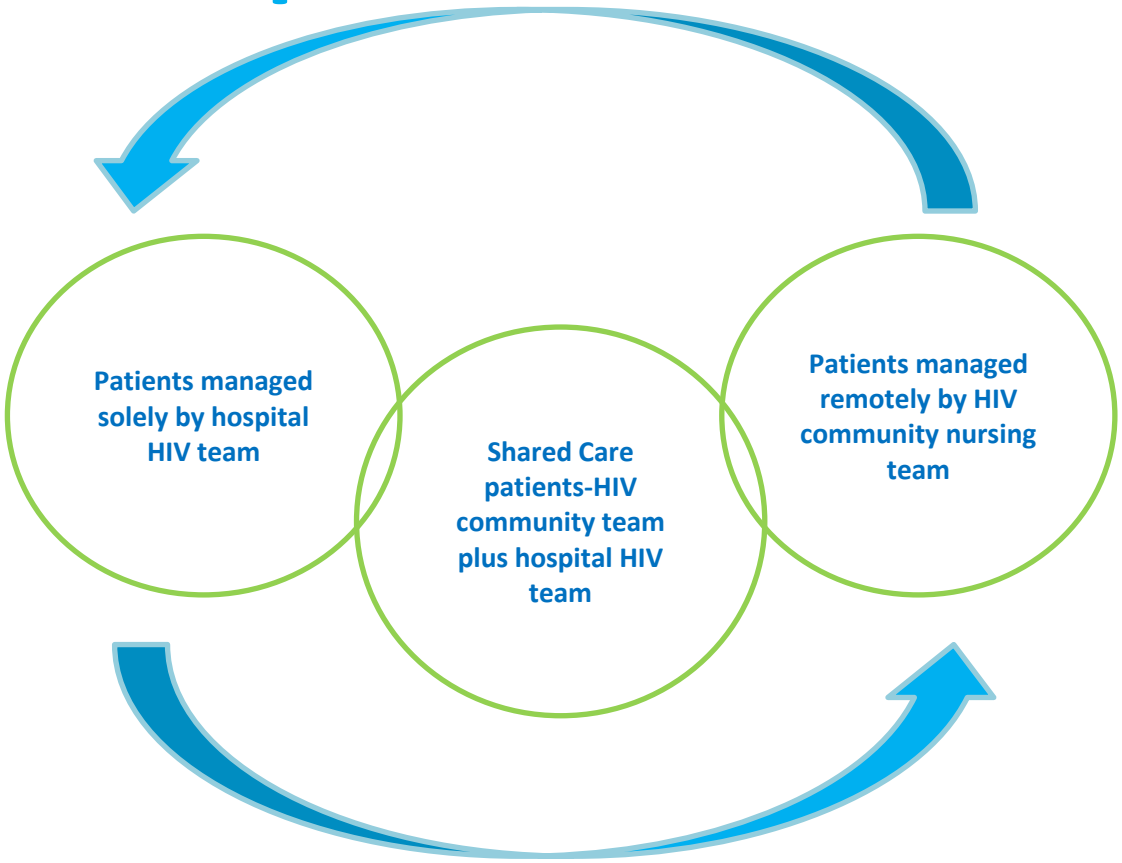
- The Liverpool Community Clinic (LCC) has been developed so that PLWH and who are difficult to reach receive timely, safe, appropriate care whilst being managed remotely by community HIV nurses delivering advanced practice in patients homes.

- This improves health, wellbeing and quality of life for those patients who are difficult to reach, aligning with BHIVA care standard 2 & 3 [3].

Aims

- To engage with difficult to reach patients
- To give the same care people would receive in the acute setting in their homes
- To reduce hospital admissions
- Prevent complications due to disease progression and comorbidities
- Guarantee medication and adherence review
- Facilitate a holistic MDT approach
- Enable retention in care

Liverpool Care Model



LCC Inclusion Criteria

- Poor clinic attender
- Physical disability
- Social isolation
- Prisoner
- Financial constraints
- Psychological issues

Care closer to home

- The NHS 5 year forward view [2]
- The model strongly promotes the value of home visits as an ongoing intervention linked in with existing community/primary care services involving non-medical prescribers.
- Meeting patients where they are.

Methodology

- Currently 23 patients are on the LCC.
- HIV consultant and HSCNT meet monthly to discuss existing and potential patients.
- Each patient is reviewed; individualised care plans are formulated and agreed with the patient at home.
- Once a year a patient will undertake an annual review.

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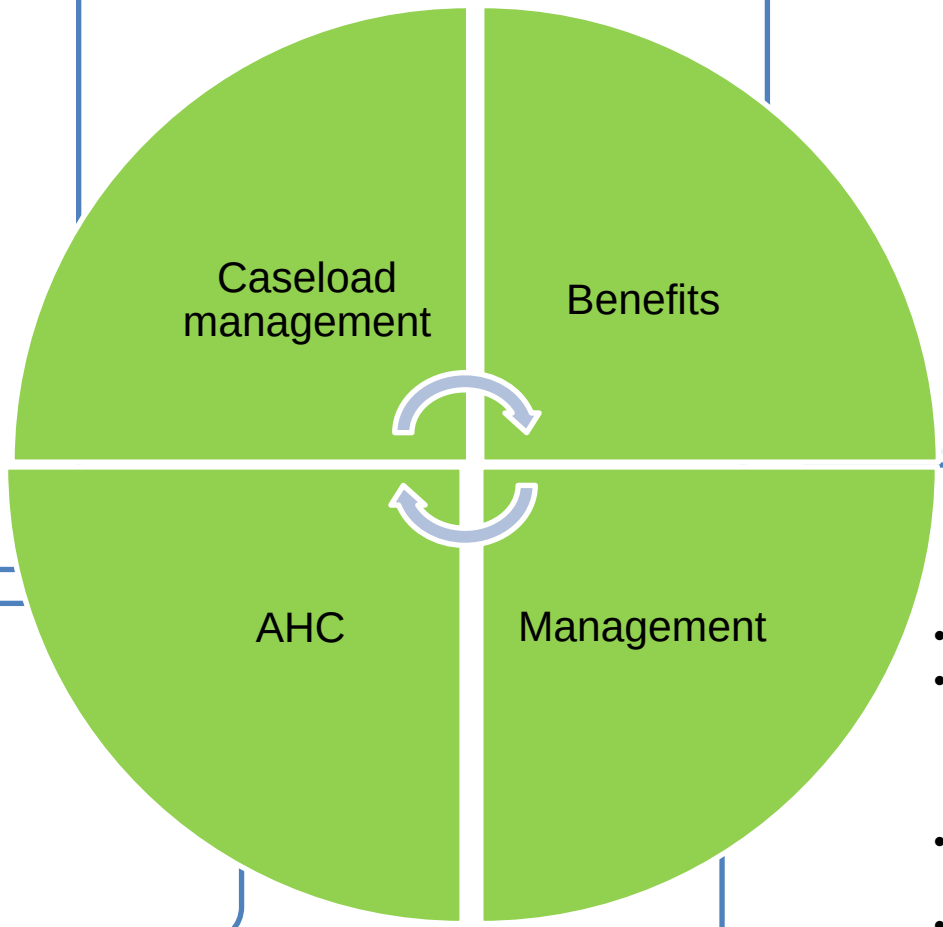
Elements of LCC

- Home visits
- Prescribing
- Medicines management
- Monitoring
- Documentation
- Advanced communication
- AHC
- Problem solving in non clinical settings
- Holistic care
- MDT approach

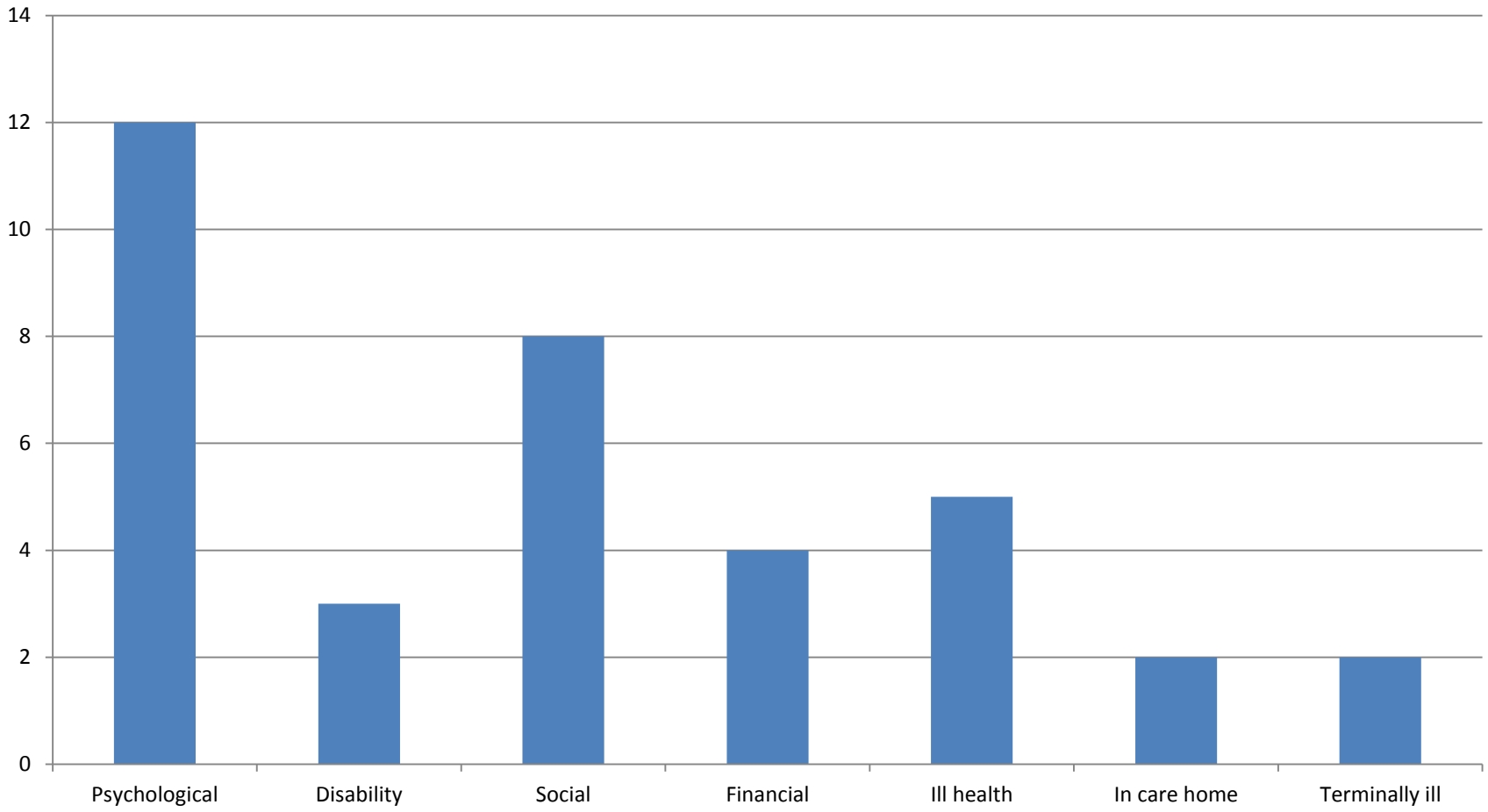


- ↓Hospital admissions
- Prevent complications
- Facilitate a holistic MDT approach
- To maintain meaningful engagement /retention in care
- Guarantee medication and adherence review
- Facilitate AHCs

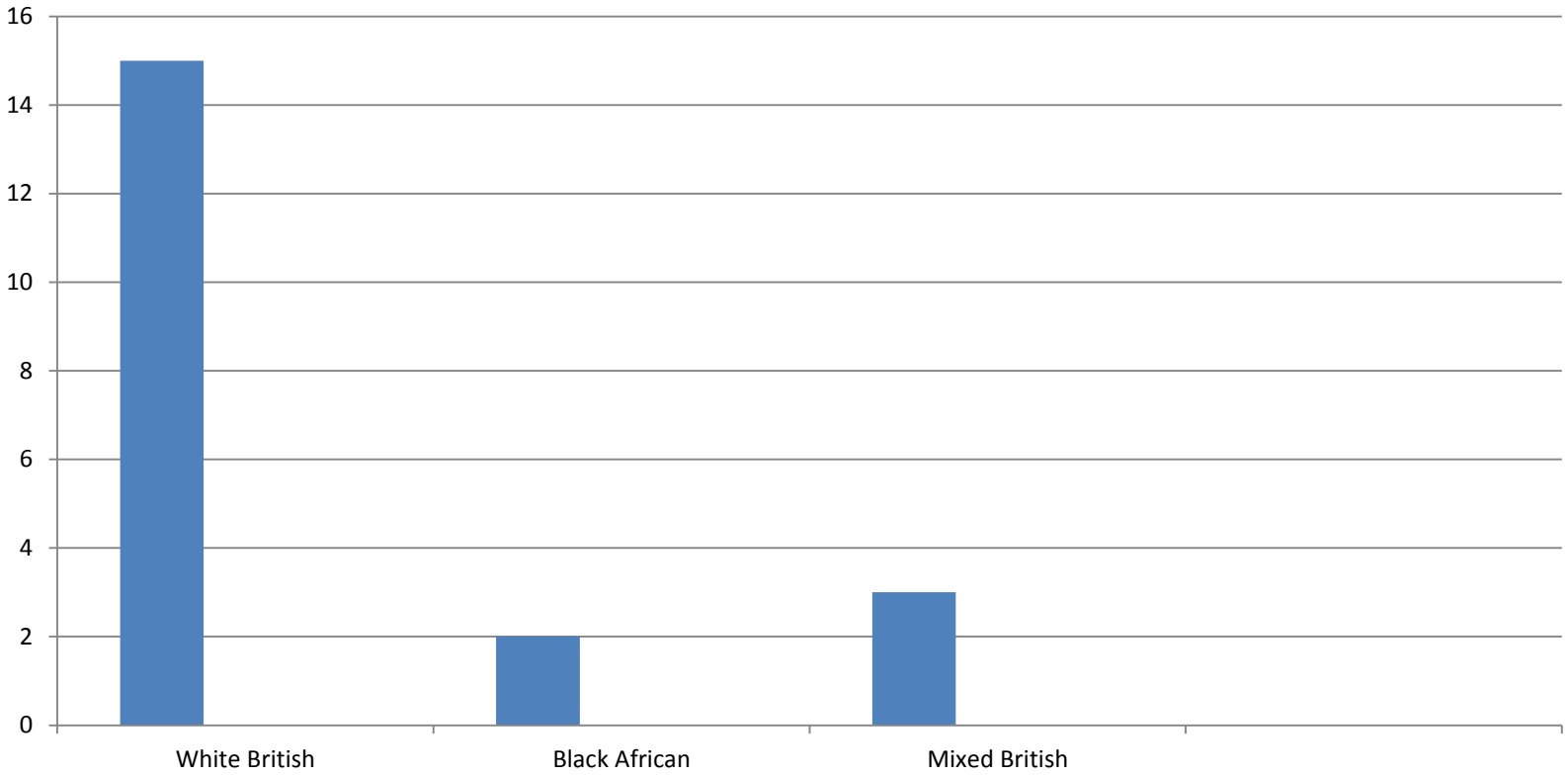
- Developing a AHC template
- Outcomes uploaded to HARS

- Monitor performance
- Monitor statistics (referrals /contacts/caseload throughput)
- Maintain competencies
- Audit
- Research potential

Reasons for being on LCC



Majority (75%) of patients managed via LCC are white British and local to Liverpool



Patient feedback

- *‘ I am on my medication and undetectable. Before I often had gaps in my medication’*
- *‘It has made my life easier to manage’*
- *‘It’s a lot less stressful, I used to miss appointments’*
- *‘If there are any problems they are there’*
- *‘Care, support and love’*
- *‘I would probably not be on my medication’*

Case study

- 33 year old female
- Diagnosed with HIV in 2007
- Complex psycho-social issues/non adherent/Stroke in 2011
- Left severely disabled-unable to attend clinic-isolated
- Two dependent children
- Closely monitored at home weekly by HIV CT for the last 6 years
- Dosette box, bloods
- Fully adherent and undetectable viral load

The LCC Model ensures

- Strong clinical governance
- Improved patient experience - Audit 2016
- Improved patient outcomes
- High quality and safe care
- More for less-cost effective

Recommendations

- To further develop the LCC model that supports patients who cannot attend conventional HIV clinics and are difficult to reach and reduce hospital admissions.
- Continue collaborative working /close communication with MDT to enable delivery of care closer to home/increase in primary care involvement.
- Offer responsive, flexible services which meet patients' needs.

Conclusion

'The drive for Innovation and creativity in delivering care for PLWH has never been greater to meet the need of an ageing population with unrelenting financial pressures on services' [7]

In order to reach the people in the defined groups means movement from where we are is essential.

Reference List

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