



Primary Care Access: How General Practice Can Better Respond to the Needs of People Living with HIV

Executive Summary

Commissioned by:
NHS Kensington and Chelsea
NHS Westminster

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Introduction

- 1.1 The project aimed to develop options for care models to support patients living with HIV access primary care services was commissioned by NHS Kensington and Chelsea and NHS Westminster. The commissioned was given to Positively UK (then Positively Women).

Background / Policy / Literature Review

- 1.2 With the improved life expectancy of many patients living with HIV, HIV is now classified as a long-term medical condition. Within the NHS' long-term medical condition model GPs have a key role to play in supporting patient health.
- 1.3 NHS policy aims to move care closer to the community with increased diagnostics within primary care settings. This is accompanied by a drive to improve the uptake of GP services across the population and to increase outpatient care for long-term medical conditions in the community.
- 1.4 Previous research reports indicate that patients living with HIV (PLHIV) have reported instances of discrimination from healthcare services, and low trust in GPs resulting in low uptake of GP services. Previous consultations by Wharfside and Frontline Patients' Fora demonstrate this is particularly noticeable in those diagnosed long-term with HIV.

Models of Care

- 1.5 The current model of care for patients living with HIV has developed historically and evolved over 25 years; with people accessing acute clinics of their choice for HIV management. This is contrast to GP services which can only be accessed locally.

- 1.6 Brighton and Hove PCT introduced a Local Enhanced Service (LES) in 2008 for provision of primary care for patients living with HIV. GPs can voluntarily enter into the LES and are reimbursed for activities undertaken under the terms of this contract which includes compulsory attendance at HIV awareness training, registering a minimum number of patients living with HIV and monitoring a prescribed list of health concerns e.g. cardiovascular disease.
- 1.7 In 2008 Manchester PCT, in a move to support the uptake of GP services by patients living with HIV, introduced compulsory training for GPs and incorporated this into existing contracts. Guidelines for the management of patients were also produced which encompassed disclosure and confidentiality. This was complemented by a mentor programme to support patients living with HIV access GPs.
- 1.8 A key policy objective of the healthcare reform is the formation of one-stop shops; with a central hub and links to GP practices, these centres will provide increased scope for diagnostics and healthcare with the community setting.
- 1.9 A recommendation put forward by the Frontline and Wharfside Patient Fora, is to bring GPs into the HIV clinics. Bringing healthcare professionals on to one site would improve communication between GPs and HIV clinicians. It would also allow patients to access GPs and keep their healthcare within the acute centre which the fora considered supported confidentiality,

Consultations

- 1.10 For this project consultation was undertaken with three stakeholder groups: patients living with HIV, HIV clinicians, and General Practice staff (either practitioners or practice managers).
- 1.11 Clinic governance was the greatest area of concern for all groups consulted. The need for training for GPs to increase their awareness and knowledge of HIV and

confidence in managing the primary care health needs of patients was identified. Improving communication between GPs and HIV clinicians was also paramount.

- 1.12 Issues of quality of care firstly highlighted the needs of patients in understanding the role of the GP in supporting their healthcare and how to access the GPs. Secondly general practices could develop knowledge of HIV and improve standards of care by establishing a wider approach to HIV and by offering testing alongside primary care of patients' diagnosed HIV positive.
- 1.13 Confidentiality breaches are of high concern for PLHIV. Reported breaches are rare but there is evidence of some practices labelling the files of patients living with HIV differently to other patients and inappropriate questioning by reception staff in public waiting rooms. This highlights the need to agree protocols for handling patients files and information within primary care.
- 1.14 In reviewing accessibility there were noted incidents of discrimination and inappropriate behaviour and language of GPs, often when a patient disclosed their HIV status. This experience, or hearsay of such practice, discourages patients from disclosing their HIV status to GPs. Practices that displayed HIV material demonstrated a greater awareness and level of trust with HIV patients to disclose. This alongside trained staff who demonstrated knowledge of HIV instilled greater confidence in patients.
- 1.15 Stakeholders were consulted on the models of care outlined in sections 1.5-.1.9. No single model of care emerged as the favoured option by all groups. Patients with good experience of a GP favoured retaining the current system. There was support across all groups for provision of training and voluntary sign up introduced by Brighton and Hove PCT; not forcing GPs to sign up as adopted by Manchester PCT. The concept of one-stop shops and the ability to access a range of services in one location appealed to some patients, notably women.
- 1.16 Placing a GP in the HIV clinic received greatest support by patients and with some clinicians; however the latter group raised concerns over the sustainability of this

model when healthcare was moving to local provision. An alternative approach suggested was to place a GP in the HIV clinic for a limited period of time to support patients' make the transition from accessing all care at acute centres to accessing primary care with a GP locally.

Proposed Models

- 1.17 In reviewing and recommending options for care a key challenge to consider is the dispersed nature of how HIV care is accessed across London. Only a third of Westminster residents and half of Kensington and Chelsea residents access HIV care within their respective boroughs. There are also high numbers of patients at Wharfside and Kobler clinics who are not local residents, choosing to access HIV care away from home. Implications for PCTs arise in commissioning care that is locally based and addresses only the needs of local residents. Consideration needs to be given as to how, and to what extent, it can meet the needs of people accessing HIV care within the PCT, but not resident in that locality.
- 1.18 The **current system** while in line with healthcare policy of providing care locally is failing to meet the needs and concerns of most patients living with HIV; a new approach is therefore required to improve care and increase uptake of patients not only in accessing primary care services but in disclosing HIV status and thereby receiving effective healthcare.
- 1.19 Taking steps to **enhance the current system** through compulsory training for all GP practices would increase awareness across primary care. This approach alone would not guarantee changes within practices and improved quality of care. Implementing a LES with comprehensive training for practices and quality standards that GPs entered into voluntarily would better identify practices seeking to improve the care they provided. The LES could also allow GPs to register patients outside of their catchment area, thereby reaching patients who had no access to a GP working within the LES in their locality. Consideration needs to be given to including in the LES a list of conditions GPs should treat, as listed in the

Brighton and Hove contract. While not popular with many patients, the approach could be used to support GPs in identifying and addressing risk areas for patients living with HIV.

- 1.20 The concept of **one-stop shops** could provide scope for HIV clinicians to provide clinics locally, and within the community. However one-stop shops are in development, how they will operate and any remit for sexual health and HIV still undecided.
- 1.21 **Embedding a GP in the HIV clinic** would meet the needs of many patients living with HIV, in particular long-term diagnosed who are accustomed to accessing all healthcare at the acute centre. Benefits to this approach are the reassurances around confidentiality and increased scope for communication between the GP and clinician. However GPs are gateways to other local healthcare and social care services, and a GP in the clinic could not fulfil this role for patients drawn from such as wide geographical spread as found at HIV clinics. This approach is also in contrast to NHS policy of moving care closer to the community.
- 1.22 The **transition model of placing a GP in the clinic** could provide a means of supporting patients, accustomed to accessing all healthcare at the acute centre, make the adjustment to accessing primary care. This meets healthcare policy of establishing care within community settings and supporting under-represented groups access primary care. It also supports patient uptake of health and social care services that can only be accessed through referral from a local GP.
- 1.23 There are **financial implications** associated with all the proposed models and associated costs need to be identified for implementation of each approach. Two key considerations which will have significant impact are firstly identifying the commissioning body. Should commissioning rest with primary care who are responsible for GP contracts; HIV leads who commission acute services with HIV clinics; or is joint commissioning required? A second and related consideration is who will have access to the primary care services commissioned, and is it possible

to develop a tariff with other PCTs to give access to patients not resident in that locality.

1.24 It is crucial that in implementing any system that a structure be established to identify who has **responsibility for care**. No patient should be placed in a position where the HIV clinician and GP refer the patient to each other, without treating the patient. Increased and direct communication between HIV clinicians and GPs will address this to some extent. To fully address this concern there needs to be agreement as to which healthcare professional has ultimate responsibility, or a third party appointed to advocate when such issues arise.

1.25 The proposed models identified above address GP and clinical needs. Consultation identified that **training and information for patients** is required to raise awareness of how to access a GP, how to manage complaints and make informed choices particularly around disclosing HIV status in primary care settings.

Recommendations:

Recommendation 1: New models need to be implemented to increase take up and efficacy of primary care. The current provision of primary care to patients living with HIV does not provide sufficient support to patients or general practices.

Recommendation 2: Short training sessions delivered to all general practices raising awareness of HIV, patients' concerns and additional support for practices commissioned by PCTs.

Recommendation 3: Enhanced GP services are introduced to address provision of primary care to patients living with HIV through a 2-day training course and annual update training for practice clinical staff.

Recommendation 4: In GP surgeries offering enhanced services, all practice staff including receptionists attend HIV awareness training.

Recommendation 5: Quality standards be developed with basic information GPs should gather on patients' HIV health and medications; increasing standard length of appointments for patients living with HIV and agreeing protocols around patient confidentiality.

Recommendation 6: Incorporate the quality standards into the Quality Outcomes Framework, the reward and incentive programme for General Practices to support implementation and monitor progress.

Recommendation 7: GP's providing enhanced services to patients living with HIV open practice boundaries to provide primary care to patients outside their catchment area, where there no enhanced GP services provided in their catchment area.

Recommendation 8: General Practices currently operating within a sexual health LES and/or delivering HIV testing be targeted to deliver the enhanced services, as these practices already have an understanding of HIV, can provide continuity of care for patients and are more likely to generate trust in existing patients to disclose their HIV status.

Recommendation 9: PCTs review options for provision of healthcare for patients living with HIV within the 'one-stop shop' model as it is developed.

Recommendation 10: A GP be established at HIV clinics, to provide primary care to patients living with HIV for a limited period of time, providing a transition to patients accessing a GP locally in their community.

Recommendation 11: Operational and financial assessment are undertaken into providing the 'transition' GP to all patients at Kobler and Wharfside Clinics, where 85% of patients are non-residents of those PCTs.

Recommendation 12: A 'hotline' or dedicated telephone line is established at HIV clinics enabling GPs to call with questions to discuss concerns around care of a patient living with HIV.

Recommendation 13: The current CQUN standards are built upon to establish procedures for routine cross-posting of information between HIV clinics and General Practice where patients have consented to sharing information.

Recommendation 14: Building on recommendations from previous studies, a nurse specialist and community lead be appointed as 'champions' to promote good work practices and support advocacy of patients between General Practice and HIV Clinics.

Recommendation 15: Training and information be provided to patients living with HIV so address finding and accessing a GP, patient rights and disclosing HIV status to a GP.



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