# HIVPA Bulletin | Winter 2023

HIVPA
HIV Pharmacy Association

## Welcome to the winter bulletin!

We both are very excited to take over from the fantastic Yemi, as the new HIVPA bulletin leads! With so much going on in the world of HIV, this issue is jam packed with exciting news and updates. We would like to thank all those that have contributed to this first issue and hope you enjoy the new look and content.
If you have any feedback or want us to include any of your amazing work in a future issue, please email: bhavna.halai@nhs.net and zoe.anorson@nhs.net.

## Meet the new co-authors:

### *Bhavna Halai*

Hello all, I am a highly specialist pharmacist in HIV and sexual health at Guy's and St Thomas' hospital. My interest in HIV ultimately pushed me to jump from my role as a medication safety officer to an HIV pharmacist! I love getting to know patients, as well as being involved in the clinical management of complex patients. As co-lead, I look forward to providing an educational spotlight on topics and sharing HIV news across the network!

### *Zoe Agyemang*

Hello, I am a Senior Specialist Pharmacist in HIV/ID based at the Royal Free Hospital. I consider myself a "people's person", getting the most out of serving others, and found that to be of most value within HIV. I enjoy pouring into our patients clinically and as people. My hope is that in this role, my co-lead and I will facilitate and inspire each of you in how you pour into your patients as well as showcase the incredible ways in which you are already doing this!

# News and events

## CVD update – REPRIEVE study

REPRIEVE, the largest randomised trial undertaken in people living with HIV, demonstrated a significant reduction in major adverse cardiovascular events in participants randomly assigned to pitavastatin 4 mg daily as compared to those receiving placebo.

**Key Recommendations from the study:**

Patient ≥40 years old should be offered a statin for primary prevention of CVD irrespective of lipid profile or estimated CVD risk. First line treatment, when available in the UK is pitavastatin 4 mg daily, alternatively atorvastatin 20 mg daily can be used. More information available on BHIVA.

## HIVPA communications lead

We would like to introduce Suki Leung the new HIVPA communications lead!

## Injectables update

Cabotegravir approved by the EMA for PrEP. In the UK however, the MHRA are still reviewing Cabotegravir use in this manner. Injectable cabotegravir has proceeded to go through the NICE Technology Appraisal Process.

## Inequity of Descovy PrEP in rural sexual health clinics

The HIV Clinical Reference Group recognises that some areas and services within the UK are struggling to implement the TAF/FTC PrEP policy. NHSE are working with various stakeholders to find solutions around challenges such as access to MDTs and Blueteq.

## PrEP Pharmacy Network

We are excited to announce the launch of the first HIV PrEP Pharmacy Network known as PrEP PharmConnect. This network aims to make a significant impact on those using PrEP and develop novel models of PrEP delivery. If you are involved in any aspect of HIV PrEP care, such as clinical practice, procurement, PGDs, research, or guideline development, please join us by contacting: stephanie.tyler@gstt.nhs.uk & kerry.street@nhs.net.

## Dates for your diary

**Conference on Retroviruses and Opportunistic Infections** – 3rd – 6th March 2024: Denver, Colorado, USA

**Chiva annual conference** – 15th March 2024: Birmingham, UK

**BHIVA Spring conference** – 29th April – 1st May 2024: Birmingham, UK

**BASHH annual conference** – 17th June 2024: Bournemouth, UK

## JCVI: meningococcal B vaccination for gonorrhoea prevention

JCVI have considered evidence for the use of 4CMenB in the prevention of gonorrhoea (off-label use). Real world studies have estimated the vaccine is between 32.7-42% effective against gonorrhoea. The department of Health and Social care are still **reviewing the evidence** put forward by JCVI. For further information click here.

## Chiva Conference 2024 - Registration & Abstract Submission open

The 18th annual Chiva conference, on 15 March 2024, will cover a range of vital issues and updates, from understanding HIV-related stigma, to engagement in care, youth involvement, and the latest HIV research. For more information click here.

# HIVPA November Study Day Summary – *Beth Ridsdill Smith*

HIV Pharmacy Association

**Introduction:**
Yemi Daramola, Highly Specialist Pharmacist at Chelsea and Westminster NHS Foundation Trust, and Dr Lucy Garvey Consultant in HIV and Sexual Health, Imperial College Healthcare NHS Trust co-chaired the event and introduced the focal point of the day - 'Managing Complex Cases.' This theme is especially pertinent with the aging HIV population and increasing co-morbidities.

**Dr Lucy Garvey**
HIV Lead Consultant a
Imperial College NHS Trust

## HIV & Viral hepatitis

Discussion around types of hepatitis and management of these

- Optimal ARV treatments for people living with both HIV and Hepatitis B in accordance with Alliance W96 trail.
- New treatment for hepatitis D- bulevirutide which has a 50% success rate (in comparison to pegylated interferon alpha which has a 20% success rate).

## Optimizing HIV management for Women living with HIV

*Industry Update: Merck, Sharp and Dohme (UK) Ltd- optimizing HIV management for Women Living with HIV- a case study.*

- Case study of a woman living with HIV experiencing menopause and taking HRT while on efavirenz
- Discussion around optimising ARVs to minimise interactions
- Discussion about relative low uptake of HRT among women living with HIV and the role of HIV specialists to discuss menopause and hormone replacement.

**Hassan Mohammed**
Lead Pharmacist GUM &
56 Dean Street
Chelsea & Westminster
NHS Foundation Trust

**Ross Hamilton-Shaw**
Senior Medical
Scientist - Gilead
Sciences

## Industry Update- Gilead Sciences

**Management of people with multidrug resistant HIV 1 for whom it is otherwise not possible to construct a suppressive anti-viral regimen.**

- Lencapavir as an add on treatment for people living with HIV who have resistance to multiple drug classes
- Dosing of lencapavir including oral lead in

# HIVPA November Study Day Summary – *Beth Ridsdill Smith*

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**Prof Sanjay Bhagani**
Infectious Disease Consultant
The Royal Free Hospital

## Opportunistic infections

- Co-trimoxazole as an alternative first line in the treatment of neurotoxoplasmosis in accordance with EACs guidelines.
- Opportunities to simplify TB treatment investigated in the TRUNCATE TB trial which suggested an alternative regimen using rifapentine (not available in the UK) to shorten TB treatment to 8 weeks.
- Less invasive ways of testing for infections including metagenomics next generation sequencing to test for PCP pneumonia, and urine LAM tests for TB.

## HIV and the kidney

- Case study discussing HIVAN and its management.
- Referral criteria for renal function decline
- Monitoring tenofovir disoproxil related renal function decline using UPCR tests over UACR tests to monitor tubular protein loss.

**Prof Jeremy Levy**
Consultant Renal Physician
Imperial College London

**Dr Tristan J. Barber**
Consultant Physician
The Royal Free

## HIV and ageing

- Explanation of the frailty service developed at the Royal Free
- Discussion around accelerated ageing and increased frailty in people living with HIV
- Thinking about not only the age of the person but the length of time living with HIV and the potential additional challenges faced by people diagnosed at the start of the epidemic.

**Jane Akodu**
Lead Pharmacist
The Royal Free Hospital

## Industry update- ViiV Healthcare: The Evolution of HIV.

- Discussion of evolution of treatment options since the start of the HIV epidemic
- Study data from Dovato studies including GEMINI, GEMINI 2, SALSA and TANGO showg Dovato as a robust first line treatment option
- Data from injectables trials

**Fiona Clarke**
Cardiff & Vale University Hospital Board

# *Spotlight Series*: Blood borne viruses – Hepatitis Delta

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## What is HDV?

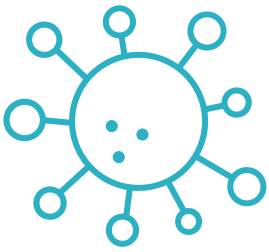
- HDV is an incomplete RNA virus that forms one of the five hepatitis viruses.
- The HDV requires Hepatitis B Virus (HBV) to replicate.
- HDV causes acute hepatitis in two ways, the first being co-infection with HBV when the two viruses infect the liver at the same time. The second being superinfection in which HDV infects a patient with chronic HBV.
- In superinfection, patients are more likely to develop hepatic encephalopathy and necrosis.

## How is HDV transmitted & prevented?

- HDV can transmit via contact with blood and other bodily fluids e.g., semen and vaginal fluid.
- In areas of high HBV endemicity, vertical/intra-familiar transmission is common.
- Vaccination against hepatitis B is the only means of preventing HDV infection.
- Avoiding high risk behaviour such as needle sharing can also assist in prevention.

## What are the signs & symptoms of HDV?

- Left untreated, chronic HBV with HDV results in cirrhosis.
- Symptoms of HDV are similar to that of HBV, including fever, muscle pain, jaundice, abdominal pain, loss of appetite, nausea and vomiting.



- Serological markers for HDV include: total HDV antibody, HDV IgM antibody and HDV RNA levels.
- BHIVA recommends all HBsAg-positive patients are tested for HDV antibody.

## How is HDV treated?

Whilst HDV suppresses HBV replication, chronic HDV enhances mortality and morbidity from cirrhosis and liver carcinomas in hepatitis B surface antigen carriers.

**Pegylated interferon alpha** has been mainstay treatment for many years.

- Treatment usually lasts for around 48 weeks, regardless of patient responses.
- Side effects can be severe, including cytopenia's, flu-like symptoms and depression.
- Avoided in decompensated liver disease.
- EACS guidelines: due to its anti-HBV activity, TDF/TAF should be added, as part of ART, to PEG-IFN to reduce HBV-DNA load.

**Bulevirtide**

- A competitive entry inhibitor that prevents HDV entering cells.
- NICE approved for chronic hepatitis D in patients with compensated liver disease only if there is both evidence of significant fibrosis and previous failure/contra-indication to pegylated interferon therapies.
- Optimal duration of this subcutaneous regimen is unclear.

**Want to find out more?**

Scan the QR code below to load up the WHO hepatitis A fact sheet:

# *Spotlight Series*: Blood borne viruses (BBV) specialty pharmacist

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To highlight more of the amazing work being carried out by pharmacy professionals across the globe within HIV, we have started the interview-styled Spotlight Series. These will be taking an in-depth look at the journey of an individual and how their role/service is impacting patient care. This edition we were honoured to get a look into the journey of Sarah Hulse!

## *Sarah Hulse*

MR Pharms (consultant) Blood Borne Virus Pharmacist at Betsi Cadwaladr University Health Board (BCUHB). All Wales HIV and Viral Hepatitis Pharmacists Group Chair and HIVPA Regional Representative for Wales.

### *Tell us about your current role and service*

I work in Betsi Cadwaladr University Health Board in North Wales (NW). I have a regional role across NW as the Lead Blood Borne Virus (BBV) Pharmacist covering HIV and viral hepatitis. Betsi Cadwaladr University Health Board consists of three integrated health communities (IHCs) - East IHC (Flintshire and Wrexham) includes Wrexham Maelor Hospital as the acute site and HMP Berwyn prison; Central IHC (Denbighshire and Conwy) includes Glan Clwyd Hospital and West IHC (Anglesey and Gwynedd) includes Ysbyty Gwynedd (Bangor Hospital). I work regionally across boundaries and across clinical teams, namely sexual health, and hepatology. The HIV service forms part of the Mersey, Cheshire, and North Wales Regional HIV Network as we are physically closer to NW England than we are to the Southern parts of Wales.

The pharmacy team I lead has a HIV Pharmacist and Viral hepatitis pharmacist for each IHC. We work in the HIV clinics consulting with patients, prescribing treatments, giving advice to the team, and writing local guidance for ART.

For hepatitis C, I run the community rapid test and treat service which operates across North Wales including in HMP Berwyn (largest single site prison in Europe). I run a weekly MDT, for community services run by pharmacist and BBV nurses. The pharmacists assess patients, prescribe, organise treatment and provide adherence support. We conduct both virtual and face to face consultations in the community e.g. in homeless hostels. Through this service we have gained a caseload of people living with HIV (PLWHIV) who struggle to engage in a clinical setting but are managed well within the community.

**Betsi Cadwaladr University Health Board**


Image edited from : https://www.bbc.co.uk/news/uk-wales-53365230

***Tell us about your pharmacy journey***

After my initial few years gaining general clinical pharmacy experience, I held a few short-term clinical roles in respiratory, rheumatology, palliative care and haematology before starting to specialise in critical care and hepatology whilst working in Oxford. I moved to London in 1999, where I would say I started my consultant pharmacist journey. I worked in a specialist role as Lead Pharmacist for Liver Services (1999-2006) and it was at this time when consultant pharmacist posts were first created. My role at Kings provided me with lots of experience in the four pillars of consultant pharmacist practice. Since then, I have continued practicing in hepatology and critical care, gaining more experience in leadership and management whilst widening my education and training, clinical and audit & research activities when working at West Hertfordshire and Wirral University Teaching Hospital NHS Trusts. I moved to my current role as Lead BBV Pharmacist in North Wales in 2018 as I wanted to move back to a more full-time clinical specialist role and it allowed me to pursue my interest in working in HIV medicine.

***How did you come into your consultant pharmacist role?***

BBV Lead Pharmacist in BCUHB was a newly created post when I started in 2018. I developed the BBV pharmacy service, establishing HIV Pharmacist and technician posts in the three IHCs. For viral hepatitis, one of my main achievements has been in transforming the hepatitis C testing and treatment pathway, enabling the most vulnerable patients, such as the homeless to engage in care via community services. It is very rewarding to see these patients being cured as some have been positive for up to 20 years, previously unable to access care via the traditional pathways. I submitted a successful business case last year for the service to be continued, following a pilot project and was successful in getting funding for three part-time pharmacists, a technician, and a consultant pharmacist post. The rapid test and treat service is now running across the three health economies in North Wales including in HMP Berwyn with over 200 patients having completed treatment.

I was also selected to be a part of a cohort of pharmacists from across Wales brought together into a community of practice by Health Education and Improvement Wales (HEIW) with the aim of 'fast tracking' the credentialing of several pharmacists. After successfully credentialling as a consultant pharmacist, I plan to submit the post to the RPS to have it credentialed as a consultant pharmacist post.

***What advice would you give to aspiring consultant pharmacists?***

Take advantage of any opportunities that come your way. Start your RPS portfolio now and collect evidence of your practice as you go along. Do not be afraid to put yourself forward for roles/opportunities if you wish to progress. Research and leadership are the domains that most pharmacists struggle with, so particularly look for any opportunities to get experience in these areas throughout your career. Consider getting a mentor through the RPS platform and try to expand your network – being part of groups like HIVPA is a good start!

**To find out more about consultant pharmacist credentialling, see the links below**

- *RPS Consultant Pharmacist*
- *RPS Collaborative supported e-Portfolio programme to advanced pharmacist practice in England*
- *RPS Core Advanced e-Portfolio*

***In your opinion, what do pharmacists in this field do very well and what can we improve upon?***

I think pharmacists are very good in becoming embedded within clinical teams and using their clinical expertise – prescribing, giving advice, writing guidelines, etc.

Areas we can improve on are developing services (leadership role) and getting involved in research/publishing work.

***What have been your biggest career challenges?***

One of the most challenging but rewarding things has been trying to find ways to provide BBV treatment for some of the most vulnerable groups such as those experiencing homelessness, people who inject drugs, refugees, and asylum seekers. Often traditional ways of delivering health care don't work for these patients and for hepatitis C, we have been able to successfully transform and simplify the pathway so that patients can be diagnosed and treated rapidly in the community using a non-judgemental, flexible approach with services tailored around the individual needs of patients.

COVID, as for everyone, was a very challenging time but I had the opportunity to use my leadership and previous critical care skills to lead the critical care pharmacy service across North Wales. It was challenging co-ordinating pharmacy, procurement, aseptic services, and the clinical service for critical care whilst not knowing how many patients we would be caring for during each of the different waves of the pandemic. I was also pharmacy lead for one of the COVID critical care trials which evolved rapidly, and it was difficult keeping up with new information/evidence and ensuring that it was quickly implemented into practice. Although challenging, it is also one of the most rewarding things that I have done in my career.

**What would you consider as current/future challenges in managing blood borne viruses?**

Finding those who are undiagnosed is one of the biggest challenges, but I am pleased to hear that there is going to be further roll out of opt-out BBV testing in emergency departments, and we need to find other ways to encourage testing.

We have such effective treatments now the challenge is overcoming barriers to patients accessing that treatment and providing services and support in a way that meet the needs of the populations we serve. We need to find new ways to break down the barriers that exist whether they be due to stigma, geographical (rural areas in North Wales mean patients have long travel times to access HIV care) or socio-economic status. I think it is important that we look to transform the way we deliver services going forward to ensure everyone has access to the care that they need.

## Want to learn more about hepatitis?

*Check out some of the resources below for further learning and CPDs!*

### Hepatitis B online modules

Free educational online lessons covering core modules about hepatitis B can be found **here**.

### Centre for disease control and prevention – Viral hepatitis

Free online chapters for Hepatitis A, B, C, D, and E can be found **here**.

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Free online chapters for Hepatitis A, B, C, D, and E can be found **here**.

### Free HIVPA talks/presentations

Recordings of educational events including presentations about hepatitis are available for members to watch online via eHIVE. Links can be found **here**.

# Thank you to our sponsors

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The HIVPA committee would like to extend a special thanks to all our sponsors for their continued support, especially over the past few years. The support of our sponsors is essential to how much of the work carried out by HIVPA including the return of the conference.

**Thank you.**

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# IDENTIFYING, ASSESSING & MANAGING FRAILTY IN PEOPLE LIVING WITH HIV

## A PRACTICAL GUIDE TO SUPPORT CLINICAL PRACTICE

**Introducing an online, practical guide, co-created by Gilead Sciences, healthcare professionals and HIV advocates.**

**Scan the QR code to access the guide or contact us for more information:**
**hivstandardssupport@gilead.com**

This guide has been developed and funded by Gilead Sciences Ltd.

GILEAD HIV STANDARDS SUPPORT TEAM

UK-UNB-4862
December 2023

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# Sharing our members work

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## UK Multi-centre Service Evaluation of Long-Acting Injectable CAB/RPV Pathways (SHARE LAI-net)

K. Ring[1,2], L. Okonta[1], M. Shongwe[1], M. Smuk[2], E. Hurn[3], G. White[3], W. Barchi[3], B. Halai[3], A. Ali[3], S. Darko[3], D. Chilton[3], F. Clark[4], B. Ali[4], S. Ayres[5], N.E. Mackie[5], B. Thornton[6], A. Umaipalan[6], J. Akodu[7], F. Ferro[7], T.J. Barber[7], G. Quinn[8], J. Arumainayagam[8], N. Naous[9], S. Leung[9], M. Boffito[9], R. Byrne[9], L. Waters[10], C. Orkin[2,1]

[1]Barts Health NHS Trust, Ambrose King Centre, London, United Kingdom, [2]Queen Mary University of London, SHARE Collaborative, Centre for Immunobiology, Blizard Institute, London, United Kingdom, [3]Guys and St Thomas' NHS Foundation Trust, London, United Kingdom, [4]Cardiff and Vale University Health Board, Cardiff, United Kingdom, [5]Imperial College Healthcare NHS Trust, London, United Kingdom, [6]Barking, Havering and Redbridge University Hospitals NHS Trust, London, United Kingdom, [7]Royal Free London NHS Foundation Trust, London, United Kingdom, [8]Walsall Healthcare NHS Trust, Walsall, United Kingdom, [9]Chelsea and Westminster Hospital NHS Foundation Trust, London, United Kingdom, [10]Central and North West London NHS Foundation Trust, London, United Kingdom

NHS Barts Health NHS Trust

### Background

Since NHS approval in 2021/22, UK HIV clinics have implemented long-acting injectable (LA-I) cabotegravir and rilpivirine (CAB/RPV) therapy. The impact on NHS HIV services has not been evaluated. This ongoing service evaluation will assess delivery of LA-I with CAB/RPV at 9 NHS clinics.

### Methods

We collected data on pre-defined spreadsheets based on electronic patient records in adults approved for LA-I between 02/2022-05/2023. We describe patient characteristics, reasons for referral, discontinuations and clinic processes (assessment criteria for suitability, time from approval to 1 injection, appointment duration, adherence to 7-day window, recall systems).

### Results

327 people were approved for LA-I. The median age was 46 (38-54), 47% (155/327) were White, 24.7% (81/327) were women, and 62.5% (202/327) were gay/bisexual men (Table 1). 80% switched due to inconvenience of oral medication (Figure 1). **Suitability:** 93.8% received LA-I according to EMEA licensing criteria, 71.9% met BHIVA guidance. 5 people had 2 predictors of virological failure. 13 people discontinued LAI (Figure 2). Median time on CAB/RPV was 140 days (IQR 57-223). 86% received an oral lead-in. 98.8% (847/857) of injections were received within the 7-day window. **Process:** screening tool criteria differed between clinics (Table 2). Appointment durations ranged from 30-60 minutes and injections were provided by senior nurses. Median time from approval to first injection was 43 days (IQR 18-101.5). HIV viral load testing was performed according to BHIVA guidelines for 93.8% (798/850) of injections.

**Figure 1: Recorded reason for switch according to Healthcare Professional**

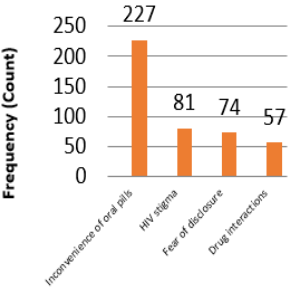
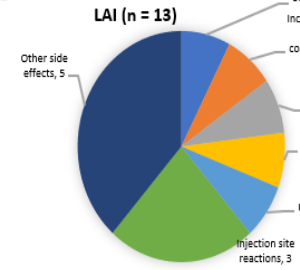



**Figure 2: Reasons for Discontinuation of LAI (n = 13)**




### Conclusion

Our service evaluation shows that female inclusion was lower than the country prevalence, highlighting potentially lower awareness and/or uptake in women which warrants further study. There were few discontinuations and 98% received on-time injections. 6% of people were prescribed LA-I outside of the EMEA license criteria despite rigorous screening processes. Gaps between approval and 1 injections were lengthy; appointment durations were longer than specified in national cost-effectiveness models.

**Table 1: Baseline characteristics**

| | |
|---|---|
| Total number of people approved for LA-I | N = 327 |
| Median number per site (IQR) | 21 (19-45) |
| Age (yrs) | 327 (100%) |
| Median (IQR) | 46 (38-54) |
| <50 | 196 (59.4) |
| 50-<60 | 95 (29.05) |
| ≥60 | 36 (11.01) |
| Race and Ethnicity | 327 (100%) |
| White | 155 (47.40) |
| Black or Black British | 115 (35.16) |
| Asian or Asian British | 28 (8.56) |
| Mixed | 8 (2.44) |
| Other Ethnic Groups | 15 (4.58) |
| Not recorded | 6 (1.83) |
| Gender | 327 (100%) |
| Cis-men | 244 (74.62) |
| Cis-women | 81 (24.77) |
| Non-binary people | 0 (0.00) |
| Trans-women | 2 (0.61) |
| Trans-men | 0 (0.00) |
| Sexuality | 324 (99.08%) |
| Homosexual | 194 (59.88) |
| Heterosexual | 120 (37.04) |
| Bisexual | 9 (2.78) |
| Other | 1 (0.31) |
| ART regimen prior to switch | 327 (100%) |
| 3-drug regimen | 276 (84.40) |
| Backbone | |
| TDF-based | 115 (41.67) |
| TAF-based | 95 (34.42) |
| ABC-based | 66 (23.91) |
| 3rd Agent | |
| 1st generation INSTI | 50 (18.12) |
| 2nd generation INSTI | 94 (34.06) |
| Non-RPV NNRTI | 54 (19.57) |
| RPV | 42 (15.22) |
| PI-based | 36 (13.04) |
| 2-drug regimen | 49 (14.98) |
| DTG/3TC | 42 (85.71) |
| DTG/RPV | 5 (10.2) |
| PI-based | 2 (4.08) |
| Non-standard regimen | 2 (0.61) |
| PI monotherapy | 2 (100) |
| Proportion with co-morbidities | 150 (45.87) |
| Number of co-morbidities | |
| 1 | 65 (43.33) |
| 2 | 34(22.67) |
| 3 | 28 (18.67) |
| 4 | 11 (7.33) |
| 5 | 3 (2.00) |
| >5 | 9 (6.00) |
| Proportion on Concomitant Medications | 95 (28.13%) |
| Number of drugs | |
| 1 | 32 (34.78) |
| 2 | 12 (13.04) |
| 3 | 19 (20.65) |
| 4 | 3 (3.26) |
| 5 | 5 (5.43) |
| >5 | 21 (22.83) |

TDF: Tenofovir disoproxil; TAF: Tenofovir alafenamide; ABC: Abacavir; INSTI: Integrase inhibitor; NNRTI: Non-nucleoside reverse transcriptase inhibitor; RPV: Rilpivirine; DTG: Dolutegravir; PI: Protease inhibitor; 3TC: Lamivudine

**Table 2: Clinic Processes**

| Site | Clinic 1 | Clinic 2 | Clinic 3 | Clinic 4 | Clinic 5 | Clinic 6 | Clinic 7 | Clinic 8 | Clinic 9 |
|---|---|---|---|---|---|---|---|---|---|
| Number of participants | (9) | (92) | (21) | (19) | (26) | (45) | (12) | (20) | (85) |
| **Screening Tool Criteria** | | | | | | | | | |
| **EMEA Licensing Criteria** | | | | | | | | | |
| HIV-1 RNA<50 | X | X | X | X | X | X | X | X | X |
| NNRTI/INSTI resistance | X | X | X | X | X | X | X | X | X |
| VF on NNRTI/INSTI | X | X | X | X | X | X | X | X | X |
| Hep B sAg | X | X | X | X | X | X | X | X | X |
| **Additional BHIVA Criteria:** | | | | | | | | | |
| Likelihood to attend | X | X | | | | | X | | X |
| BMI <30kg/m2 | X | X | | | | X | X | X | X |
| Non-A1/6 subtype | X | X | | | | X | X | X | X |
| **Other Criteria:** | | | | | | | | | |
| Hep B immunity | | | | | X | X | X | | X |
| Pregnancy +/- risk | | | | | X | | X | | X |
| Psychological issues | | | | | X | | | | |
| **Multidisciplinary Team (MDT)[a]** | | | | | | | | | |
| MDT approval required? | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Frequency of MDT meeting | 1x/week | 2x/month | 2x/week | 2x/month | 1x/month | 1x/week | 1x/week | 3x/month | 1x/month |
| SOP[b] in place? | Yes | Yes | Yes | Yes | Yes | In draft | In draft | Yes | Yes |
| Reminder system for appointments? | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes |
| Method of reminder | 2 x SMS | 2 x SMS | Call + 2 x SMS | E-mail or SMS | n/a | Mobile app | SMS | SMS | Call + SMS |
| Abnormal results system | Nurse worklist and clinic recall system | Nurse B6/7[c] + Consultant | MDT review | Consultant | Pharmacist | Clinic recall system | Nurse B7/8 recall | Nurse B7 recall | Nurse B6/7 recall |
| Staff delivering LAI | Nurse B6/7 | Nurse B5/6/7/8 | Nurse B7 | Nurse B6/7 | Nurse B6 | Nurse B6/7 | Nurse B6/7/8 | Nurse B7/8a | Nurse B6/7/8 |
| Appointment Length | 30 | 30 | 30 | 40 | 30 | 30 | 45 | 45-60 | 40 |
| No. of patients/session | 2-4 | 2-4 | 3-6 | 4 | n/a (OPAT) | 4-13 | 4 | 4 | 5-9 |
| Time from MDT approval to starting LAI (Median days, IQR) | 42 (12-83) | 35.5 (14-167) | 22 (18-28) | 58 (20-78) | 47.5 (19-82) | 29 (8-88) | 22 (8-93) | 49 (35-55) | 77 (31-134) |

[a]A multi-disciplinary team (MDT) is a group of healthcare staff with different professions (e.g. doctors, nurses, pharmacists), that work together to make decisions regarding the treatment of individual patients.
[b]A Standard Operating Procedure (SOP) is a set of written instructions describing the step-by-step process by which the long-acting injectable medications are stored, delivered and administered as well as providing detail on patient monitoring and management of missed doses.
[c] Nurses are placed in pay-scale bands based on experience and seniority. Band 5: newly qualified or staff nurse. Band 6: senior nurse or nursing specialist. Band 7: advanced nurse or nurse practitioner. Band 8: modern matron, chief or head nurse.

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