AGEING&HIV

CHAIN UKI

CARE OF HIV AND AGEING IMPLEMENTATION NETWORK

Case Presentations

The Importance of Community Care for Older People Living with HIV

Speaker:

Dr Maggie Symonds

An MDT Home Visit

Speaker:

Peter Richards

ASK A QUESTION HERE

Royal Free London
NHS Foundation Trust

The Importance of Community Care for Older People Living with HIV: A Case Report

Dr Maggie Symonds

General Practice Specialty Training Year 1

Royal Free Hospital Trust

London, UK

Background

- People with HIV are living longer due to advancements in treatment
- Half of people receiving HIV care in the **UK** are over 50 years of age [1]
- **Key challenges:**
  - Frailty
  - Cognitive decline
  - Multi-morbidity
  - Polypharmacy

Why does this matter?

- Age-related conditions difficult to attend hospital appointments
- Hospital-based care not suitable for everyone
- Focus on community-based services

Frailty Hub

- Supports patients with frailty & complex health needs
- MDT approach
- Allows for hybrid care - links hospital and community services

Comprehensive Geriatric Assessment

Multidimensional MDT assessment of **medical, social** and **functional** needs

↓

Development of an **integrated** and **coordinated** care plan [2]

Case Report

- 77-year-old male living with HIV (diagnosed 1997)
- Non-engagement with health services
- Referred to community Frailty Hub assessment by HIV Geriatrician

Past Medical History

- Type 2 diabetes
- Peripheral vascular disease
- Cognitive impairment
- Recurrent falls
- Frailty

Drug History

1. **Atazanavir 300 mg PO OD**
2. **Ritonavir 100 mg PO OD**
3. **Nevirapine 200 mg PO BD**

4. Insulatard SC 12 units OM
5. Amlodipine 5 mg PO OD
6. Aspirin 75 mg PO OD
7. Atorvastatin 10 mg PO OD
8. Colecalciferol 1000 units PO OD
9. Ferrous fumarate 210mg PO OD
10. Metformin MR 500mg PO BD
11. Nizatidine 150 mg PO OD
12. Ramipril 1.25mg PO OD
13. Tamsulosin 400 micrograms PO OD
14. Paracetamol PRN

Social History

- Lives in a ground floor flat
- No carer support
- Walks with a stick
- Goes to church on a Sunday

Initial Community Assessment - Sep 24

REVIEW

- Not taking medication
- **No ART for 4 months**
- Polypharmacy (14 medications)
- Not engaged with HIV team
- Transport challenges
- No food, messy home environment

PLAN

☑ Bloods including HIV-VL

- **HIV-VL**: 5,370,318 copies/mL
- **CD4**: 366 cells/µL

☑ Nevirapine, darunavir and ritonavir

☑ Medications rationalised

☑ Advanced care planning

☑ Transport

☑ Referrals: Podiatry, District Nurses & Frailty Hub

Second Community Assessment - Sept 24

REVIEW

- New diagnosis of AF
- Using hospital transport
- Taking medications
- Engaged with services
- Memory decline

PLAN

☑ Bloods including HIV-VL

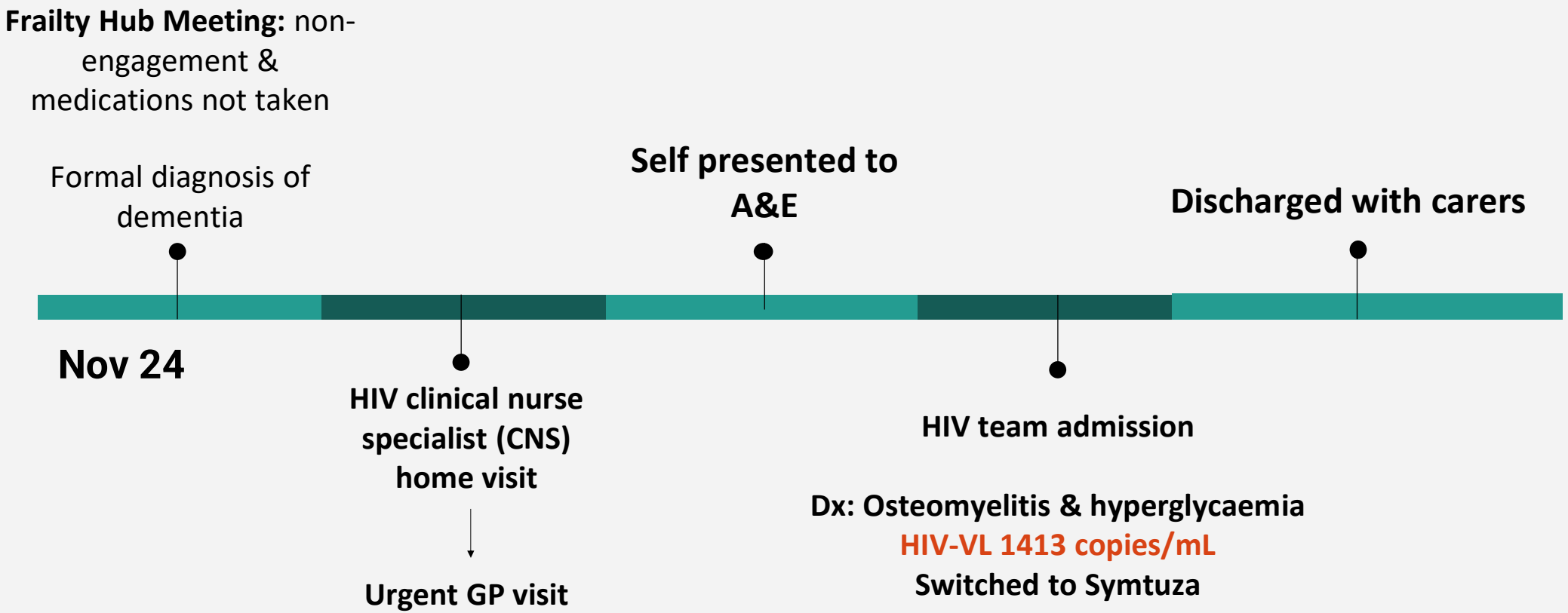
- **HIVVL 5012 copies/mL**

☑ Anticoagulation commenced

☑ Referral to memory clinic

☑ Frailty Hub MDT

Hospital Admission 1.



Third Community Assessment - Jan 2025

REVIEW

- Recurrent falls: 10-15x a day
- Carers cancelled
- Not taking antibiotics
- Is taking ART
- Self-neglect
- Declined admission to hospital

PLAN

☑ Bloods including HIV-VL

- **HIVVL 347 copies/mL**

☑ Food shopping

☑ MCA by social worker

☑ Urgent Frailty Hub discussion

Hospital Admission 2.

Admission under Health Services for Elderly People (HSEP)

- Right cerebellar stroke
- Postural hypotension
- Swallowing issues - Symtuza -> Biktarvy

Medications optimised:

Biktarvy
Insulin
Fludrocortisone
Edoxaban

Discharge


Independent Mental Capacity Advocate (IMCA)
Best Interests Meeting
Nursing Home
Community visits continued on discharge

Key Outcomes

- HIV-VL reduced from 5.3M in Sept 24 to undetectable by March 25
- Optimised from 14 to 4 medications
- Frequency of falls significantly reduced
- Nursing home ensured a safe living environment

Discussion

- Early CGA was key for identifying medical, social & functional issues
- Home visits identified unmet needs
- Frailty Hub enhanced MDT working
- Continuity led to trust which improved health outcomes

Conclusion

1.

Early CGA is important for older people living with HIV

2.

Home visits **reduce barriers** to healthcare

3.

MDT working between hospital & **community services (e.g. Frailty Hub)** is essential

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Thank you!

References

1. National AIDS Trust. *HIV statistics*. Available at: https://nat.org.uk/about-hiv/hiv-statistics/ (accessed 8 September 2025)

2. Parker SG, McCue P, Phelps K, et al. What is Comprehensive Geriatric Assessment (CGA)? An umbrella review. Age and Ageing 2018; 47: 149–155 doi: 10.1093/ageing/afx166

Case Study
An MDT Home Visit

Peter Richards, Advanced Nurse Practitioner

Harrison Wing

NHS
Guy's and St Thomas'
NHS Foundation Trust

HIV CONFIDENT

Background

- 62 yo male
- Diagnosed with HIV-1 2010
- Baseline CD4 41 (8%), VL 667K
- Presented with left lower limb weakness, MRI → PML
- IRIS PML, leading to partial cortical blindness & seizures
- CVA and osteoporosis
- Recurrent falls due to seizures/mobility/vision → **multiple fractures**
- Multiple IP episodes → progressive loss of independence
- Current ART: Descovy / NVP / Maraviroc

Pre visit – what we knew

- Home owner in receipt of private pension
- Mobilise with walker trolley / furniture walks
- Support: Community HIV CNS
  Dosette box
  Sister in Europe
  Friend helping with tech & cleaning
  Charity volunteer to read letters weekly
- Declined package of care **due to cost**
- **Polypharmacy**

- **Discussed and agreed a home MDT visit to reduce risk of falls and prevent readmission.**
  - Patient
  - Advanced Nurse Practitioner
  - Consultant Pharmacist
  - Community HIV CNS

Home visit – what we found

- Flat on 3rd floor (no lift)
- Spotless house
- Scored Clinical Frailty Score 6 = moderately frail
- Mood impacted by social isolation
- Poor eyesight, not had an eye test in over 10 years
- Uses supermarket delivery services
- Able to cook for himself and maintain personal hygiene
- Declined PoC due to cost (£147 per week)

Interventions – post visit

- Referral to Ophthalmology for eye test - booked
- Alternative mobility aides suggested - declined
- Total ACB calculated and a general medication review:
    - Lansoprazole switched to famotidine to reduce ACB
    - MRV stopped to reduce risk of postural hypotension
    - Montelukast stopped as not adding benefit
    - Reduced sodium valproate dose reduced → ammonia levels

Outcomes post visit

Ophthalmology review about to take place
Reduced polypharmacy
Reduced daytime drowsiness
Reduced admissions – 4 over previous year, 1 admission so far this year

Lessons Learned

Benefit in seeing home environment to assess
Clearer picture of current needs
Good rapport building leading to ?further interventions e.g. befriending