NHS England

Best Practice in HIV Prescribing and Multidisciplinary Teams

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1 Introduction

This document sets out the HIV Clinical Reference Group's principles for providing clinical advice to NHS England on HIV prescribing, including the role, composition and operation of multidisciplinary team (MDT) meetings.

2 Principles of HIV Prescribing

1. The HIV Clinical Reference Group's guiding principle is that all patients living with HIV should have access to antiretroviral treatment (ART) that will result in viral suppression and immune reconstitution. This remains a priority, despite financial constraints, to prevent new HIV infections and help all people living with HIV to stay well.

2. The HIV Clinical Reference Group (CRG) will make recommendations with the involvement of patients and continuously assess the impact for patients of any proposed changes. We will promote, through the CRG and clinical services, the principles of informed choice, shared decision-making and supporting adherence to therapy.

3. The CRG will undertake regular 'horizon scanning', including liaison with pharmaceutical companies, to ensure early identification of new treatments. We will work with appropriate bodies to understand and plan for patent expiries to ensure the NHS has access to treatments at the best possible prices.

4. The CRG will suggest and support opportunities for savings. By promoting efficiency we will drive opportunities to consider new innovations, including those that cost more but offer significant clinical improvements over current treatment and care.

5. The CRG will promote a focus on high quality evidence in making commissioning decisions and recommendations.

6. The CRG support the principle that, where clinical effectiveness is equivalent, the lowest cost treatment option should be used first. It is the responsibility of all in the NHS to promote the cost-effective and efficient use of resources at all times.

7. With generic formulations, new drugs and new fixed dose combinations, the CRG anticipate that changing or switching treatments based on cost will be routine practice. Switching treatment requires input from patients, HIV clinical teams and commissioners. The HIV CRG will work collaboratively to support effective drug switches, including assessment of how switches will be undertaken, costs and potential savings. Factors considered when making recommendations will include supply, patient information, impact on uptake of VAT-free dispensing, changes in monitoring and safety issues.

8. Switching ART based on cost may yield concern from patients and clinicians. There are 3 main scenarios to consider:

    - **Replacement of a branded drug by its generic equivalent:** Licensed generics will usually be recommended over branded versions. It is the responsibility of each clinic to ensure patients aware of pending branded to generic switches since, as with other generic medicines in the NHS, this change is likely to be made automatically pharmacies or Home Care companies
    - **Complete or partial replacement of a branded fixed dose combination (FDC) tablet with generic components:** The NHS may be able to benefit from reduced costs either by switching patients from the FDC to component drugs. The HIV CRG will consider all options to ensure best outcomes for the lowest cost.
    - **Switching all patients to available generic drugs:** This option is not appropriate for HIV treatment due to the need to tailor treatment to the clinical needs of each individual. We would not expect anyone to switch to a clinically unsuitable drug based on cost alone. However, ART regimen should be reviewed at every visit with new evidence and cost changes in mind.

9. Patients may prefer fixed dose combinations (FDC), including single tablet regimens (STR). However, there is a lack of robust evidence to support improved virological outcomes through FDC use. Where there is no cost disadvantage we will support FDC use but will consider implementing a programme of switch from FDCs when cheaper treatments become available. Where treatments claim to improve adherence we will review available evidence and estimate the clinical benefit to patients. On an individual basis where there is clear, documented rationale for a more costly FDC this should be supported but reviewed on a regular basis.

10. The NHS is not obliged to offer routine access to all available antiretrovirals. More costly regimens, including FDC and STR options, will be restricted to patients with documented and (where required) MDT-approved indications for that regimen.

11. We expect Trusts to provide information to help people living with HIV to manage their medications and any changes made to them, including reassurance where a simple branded to generic substitution is undertaken, Other treatment switched may require additional information and discussion.

12. Commissioning policies based on evidence and affordability, will prioritise the patient groups that will benefit most from particular treatment options. However, individual patient characteristics should be taken into consideration when implementing policies.

13. We recommend that the following prescribing activities be subject to peer review:
    - prescribing decisions for ART initiation;
    - switches secondary to intolerability, toxicity, virological failure

or resistance; and
- the use of new agents.

14. We recommend that prescribing practice in individual clinics is based on regional prescribing guidance, including appropriate use of a multidisciplinary team (see Section 3 of this document).

15. We will work closely with the British HIV Association (BHIVA), the British Association of Sexual Health & HIV (BASHH), HIV Pharmacy Association (HIVPA), the National HIV Nurses Association (NHIVNA) and the Children HIV Association (CHIVA) and other organisations involved in assessing HIV treatments and care. The CRG will ensure that those bodies understand NHS England's focus on the quality of evidence and on affordability. We will implement any Technology Appraisal Guidance as required and consider other treatment guidelines in our recommendations.

16. All new HIV treatments, and new drug combinations, will be considered by NHS England through the mechanisms of specialised commissioning and the requirement for all new products to have a evidence-based commissioning policy in place for reimbursement. The processes of evidence review, impact assessment & stakeholder consultation, led by NHS England and supported by the HIV CRG, will ensure that all new treatments commissioned have been assessed in terms of clinical effectiveness, cost effectiveness and affordability. NHS England will decide if a commissioning policy is required, in which case the treatments be available for use and reimbursement only after this has been published.

17. The specific needs of children and adolescents living with HIV, cared for in paediatric services, will be considered as well as those of young people transitioning or following transition to adult services.

3 The Multidisciplinary Team (MDT)

3.1 Introduction

This section sets out the HIV CRG's principles for MDT-based case discussion, and review of prescribing decisions. Local MDT arrangements will vary according to service configuration but these recommendations will ensure consistency of approach.

3.2 Definition

A MDT comprises staff from a number of specialisms engaged in the treatment and management of people with HIV. In general terms, membership is outlined in the BHIVA Standards of care (www.bhiva.org).

HIV prescribing decisions should be subject to peer review, team discussion and audit. The MDT provides an opportunity to do this.

3.3 MDT operation

Although all HIV services are expected to engage in a network, the degree to which MDT discussions are networked will vary according to local geography, clinic set-up and expertise. All clinics must demonstrate local or networked access to an HIV MDT and network-agreed plans for the nature and frequency of wider network meetings as appropriate.

Each clinic should have terms of reference/standard operating procedures for their MDT arrangements to include:

- Participants (including minimum representation for quoracy)
- Prescribing algorithm outlining which treatment decisions require MDT discussion
    - To specify which decisions can be made locally (by 'mini MDT') and which require full/network MDT discussion
    - Local algorithms should be consistent with regional guidelines
- How decisions will be made where there is lack of consensus
- Meeting frequency
- How meetings will be conducted (site, teleconference, video conference, information governance arrangements)
- Mechanisms for referral
- Methods for documentation and communication of decisions, including between organisations
- Relationship with wider network
- Frequency of wider network meetings
- Pathways for access to clinical trials
- Audit process

Decisions should be:

- guided by regional prescribing policy and, where no clinical difference can be identified, cost;
- made as the result of debate and challenge with appropriate input from

clinical experts; and
- open to peer review.

3.4 MDT role in prescribing decision-making

The purpose of MDT involvement is to provide access to peer review and advice in achieving equitable prescribing in line with policy and guidelines. The role of the MDT is to provide assurance that local guidelines - linked to NHS England clinical commissioning policies and regional drug procurement framework agreements - are being followed.

To enable the MDT process to work efficiently and focus on the most complex cases, a hierarchy of how the MDT decisions are made will be set out in a treatment algorithm agreed for each area.

3.5 MDT composition

Full MDT membership should include representation from, or access to, the following:

- Clinicians with a minimum requirement of at least:
  a. Two HIV consultants
  b. Specialist HIV pharmacist
- Any of a range of other specialists involved in HIV care, routinely or to be co-opted as required, including:
  c. Specialist HIV nurse
  d. Virologist
  e. Psychologist
  f. Paediatrician
  g. In-patient medical staff
  h. Adherence specialist
  i. Social worker
  j. Occupational therapist
- Research representative or recruiting trials information with clear pathways for referral

Mini MDT membership should include at least two of the following:

- HIV consultant (at least one)
- HIV specialist pharmacist
- HIV specialist nurse

MDT for paediatric HIV should have a composition determined by the local specialist service provider, according to guidance provided in the CHIVA standards of care (available on the CHIVA website https://www.chiva.org.uk/). Local MDT should be supported by access to regional or national virtual clinics.