SHORT COMMUNICATION

Covid-19 First Wave Impact National Survey for HIV Clinicians by Public Health England (PHE), the British HIV Association (BHIVA) and the Children’s HIV Association (CHIVA)

Gabriella Shanks1 | Ammi Shah2 | Amanda Williams3 | David Asboe4 | Jane Anderson5 | Valerie Delpech6 | Amanda Ely7 | Laura Waters8

1The Mortimer Market Centre, Central and North-West London NHS Trust, London, UK
2Blood Safety, Hepatitis, Sexually Transmitted Infections (STI) and HIV Division, National Infection Service, Public Health England, London, UK
3Children’s HIV Association (CHIVA), London North West University Healthcare NHS Trust, Harrow, UK
4British HIV Association (BHIVA), Chelsea and Westminster Hospital NHS Foundation Trust, London, UK
5British HIV Association (BHIVA), Homerton University Hospital NHS Trust, London, UK
6Division of Blood Safety, Hepatitis, STIs and HIV, Public Health England, London, UK
7Children’s HIV Association, CHIVA, Bristol, UK
8British HIV Association (BHIVA), Mortimer Market Centre, Central and North West London NHS Trust, London, UK

Correspondence
Gabriella Shanks, The Mortimer Market Centre, Central and North-West London NHS Trust, London, UK. Email: gabriella.shanks1@nhs.net

Abstract
Introduction: This short report describes the results of a survey that was developed by Public Health England (PHE), the British HIV Association (BHIVA) and the Children’s HIV Association (CHIVA) and circulated to all UK national health service HIV providers in the UK following the first wave of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2; coronavirus disease 2019 [COVID-19]) pandemic to assess the impact of the pandemic on HIV clinics.

Methods: The survey was created by BHIVA/CHIVA and PHE and was piloted prior to circulation to all HIV clinics within the UK on 3 July 2020. The survey questions were designed to assess the impact of the first wave of COVID-19 on HIV clinics and lead/senior HIV clinicians. Clinicians’ responses were collected between 3 July 2020 and 17 September 2020. The survey responses were collated, and non-statistical analysis was performed.

Results: The results of the survey confirmed that services had undergone substantial changes, including a shift from face-to-face consults to predominantly virtual consultations. Some clinicians’ responses suggested that the first wave had many negative effects on people living with HIV, including their ability to access mental health services.

Conclusion: The first wave of COVID-19 caused significant changes to HIV services within the UK. There was a shift toward the use of technology in healthcare, and results from subsequent clinician surveys carried out since the first wave of COVID-19 will reflect the ongoing transformation of care towards a more virtual service.

KEYWORDS
COVID-19, HIV, pandemic, services
INTRODUCTION

Following the rapid global spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2; coronavirus disease 2019 [COVID-19]) in early 2020, healthcare services worldwide had to rapidly adapt services to reduce transmission and accommodate the swiftly increasing inpatient burdens with widespread redeployment of staff.

This report describes the results of a survey that was circulated by Public Health England (PHE), the British HIV Association (BHIVA) and the Children’s HIV Association (CHIVA) to all national health service (NHS) HIV providers in the UK in July 2020 following the first wave, capturing clinicians’ experiences of the initial impact of COVID-19 on HIV services within the UK.

At the time of the survey circulation, the UK was recovering from the first wave of COVID-19, with data from the Office of National Statistics reporting fewer than 1000 new cases per day and an R rate of 0.7–0.9 [1]. The incumbent prime minister, Boris Johnson, announced on 17 July 2020 that the total lockdown was to be gradually lifted, with—for example—imminent permission to use public transport and the opening of gyms, pools and other sports facilities.

The aim of the survey was to describe how HIV services responded to the first wave of the pandemic and to evaluate the impact of these measures on people living with HIV and their families. HIV care is complex, and describing the experiences of HIV clinics during the first wave may provide useful information not only on how HIV services and other specialties could respond to future pandemics but also how they could deliver services in the future with an increased emphasis on remote care.

METHOD

The PHE, BHIVA and CHIVA online survey was sent out electronically to all HIV services within the UK on 3 July 2020. The survey questions, a mixture of pre-defined responses and free text, were written by committee members of BHIVA, CHIVA and PHE. The agreed survey questions were compiled in a Microsoft Word document and then developed using ‘Snap Survey’. The survey was piloted by everyone who was involved in the development of the questions prior to its circulation.

Either the lead consultant or a senior clinician was asked to respond to the survey.

Responses were collected between July and 21 August 2020, with some additional responses collected from paediatric centres up until 16 September 2020. Participants were requested to reflect on their experiences at the peak of the first wave of COVID-19, but exact dates were not specified in the survey. The results in this report represent the experiences of these clinicians at the peak of the first wave of COVID-19, not of all HIV services within the UK.

The responses from the survey were entered into a Microsoft Excel spreadsheet, and non-statistical analysis was performed.

RESULTS

Response rate

The survey was sent out to all HIV centres within the UK: 229 services, made up of 187 adult services and 42 paediatric/adolescent clinics. The overall clinic response rate to the survey was 35% (80 of 229 UK centres): 31% for adult clinics (58 of 187) and 52% for paediatric and adolescent clinics (22 of 42). In results presented as percentages rather than exact figures, 100% of the NHS institutions responded to all questions, unless stated otherwise.

The response rates for each PHE region are described in Table 1.

Routine services, urgent services and prescribing

In total, 53% and 46% of participants from adult and paediatric/adolescent services, respectively, stated that routine appointments continued as usual. Urgent assessments were less affected, with 87% of adult clinicians and 96% of paediatric/adolescent clinicians continuing with urgent physical assessments as usual. However, 53% of adult clinicians reported delaying routine monitoring to more than 9 monthly (usually every 6 months), and 43% of paediatric/adolescent clinicians reported delaying monitoring to every 6–9 months (usually every 3 months).

Within adult services, 90% and 100% of adult and paediatric/adolescent survey respondents, respectively, reported continuing routine prescribing as normal.

Comments suggested mixed reactions to telephone appointments, with positive attitudes toward improved convenience with patients not having to come into a clinic/hospital, improved DNA rates and the suitability of fewer reviews for patients with stable disease. Concerns included difficulties using an interpreter over the phone, inability to pick up on nonverbal cues and providing physical assessments. Other paediatric/adolescent concerns included difficulty in involving the multidisciplinary team, not being able to pick up on parent/child interactions and concerns about confidentiality, particularly when naming HIV and discussing sexual health and emotionally difficult topics. Uptake of internet platforms was minimal,
but comments did reflect its usefulness where it had been available Figure 1.

New innovations were introduced by some services to accommodate for restrictions, the most popular being “additional medication delivery or postal services” and “enhanced telephone support.” Other less popular suggestions included increased referral to network partners and enhanced mental health support.

**Negative effects: mental health, effects on services**

In total, 61% of adult clinicians and 39% of paediatric/adolescent clinicians reported continuing with urgent mental health assessments as usual. Comments from adult services reflected a reduced access to psychology services because of redeployments and a frequent signposting of patients to their general practitioner. Comments from paediatric clinicians also reflected a significantly reduced availability of psychology services.

In total, 77% of adult and 61% of paediatric/adolescent clinicians were aware of negative impacts on mental health because of the changes to HIV services.

Specifically, 81% of clinicians in adult services felt that the risk of patients experiencing avoidable harm because of the altered accessibility of HIV services was minimal, 13% considered the risk to be moderate and 5% considered there to be no risk. Although 18% of clinicians in paediatric/adolescent services considered there to be no risk of

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**TABLE 1** Response rates for adult HIV services per Public Health England centre

| PHE centres (total number of centres = 187) | Number of responding centres represented | Response rate (response/total no. of centres) |
|--------------------------------------------|------------------------------------------|---------------------------------------------|
| London (26)                                | 14                                       | 54%                                         |
| South East (24)                            | 8                                        | 33%                                         |
| South West (13)                            | 6                                        | 46%                                         |
| East of England (16)                       | 4                                        | 25%                                         |
| West Midlands (20)                         | 4                                        | 20%                                         |
| East Midlands (13)                         | 5                                        | 38%                                         |
| North West (25)                            | 4                                        | 16%                                         |
| Yorkshire & the Humber (18)                | 6                                        | 33%                                         |
| North East (9)                             | 2                                        | 22%                                         |
| Scotland (14)                              | 2                                        | 14%                                         |
| Northern Ireland (1)                       | 1                                        | 100%                                        |
| Wales (8)                                  | 2                                        | 25%                                         |

Abbreviation: PHE, Public Health England.

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**FIGURE 1** Problems that clinicians in adult HIV services encountered during remote consultations. NHS, UK national health service
avoidable harm. 43% considered the risk to be minimal and 32% considered it moderate. No clinicians felt the risk was high.

The availability of external services such as peer support, psychiatry/psychology and social care for both adult and paediatric/adolescent clinics reduced to varying degrees.

**Future planning**

Some common ideas included continuation of virtual appointments where convenient and appropriate, providing longer scripts and less frequent safety monitoring for patients with stable disease, and increasing the flexibility of services as needed, considering the success of several quickly implemented changes during the pandemic. A total of 95% of adult and 75% of paediatric/adolescent clinicians planned to ‘somewhat’ or ‘significantly’ change their delivery of HIV services in the future.

**Redeployment**

Pharmacy staff were the group least likely to be redeployed from adult and paediatric/adolescent services. More paediatric/adolescent consultants and nurses remained in their role than those in adult services. Junior doctors were the most likely to be redeployed within both adult and paediatric services.

**DISCUSSION**

Since the urgent reforms implemented at the start of the pandemic, ongoing progressive changes have been made to HIV services, with an emphasis on the use of technology and virtual encounters [2]. A viewpoint published in December 2020 highlighted the potential of combined face-to-face and telemedicine assessments for people living with HIV to enhance the whole spectrum of HIV care [3]. A framework published in the European AIDS Clinical Society guidelines outlined 13 procedures that can be done remotely and 13 that require face-to-face interactions, including consultation after initial diagnosis [4]. Using this framework should help progress toward the UNAIDS ‘90-90-90’ targets, with the fourth ‘90’ target being 90% of people having good health-related quality of life [3].

Many aspects of HIV care remained the same, including the continuation of urgent assessments and the delivery/collection of critical antiretroviral therapy using innovations such as drive-through collection. People living with HIV consider peer support to “improve a number of aspects of life,” according to a survey carried out by Positively UK, which highlights the importance of the continued use of health advisors and peer support workers throughout the pandemic [5].

Responses from clinicians in both adult and paediatric/adolescent services included a recurring theme of reduced accessibility of mental health assessments and services. Coupled with the widespread awareness of the pandemic’s negative impact on mental health, within the HIV cohort and beyond, this is concerning. A report published by the National Aids Trust in October 2020 highlighted a need for improved access to mental health services for people living with HIV and the importance of good mental health support for “wellbeing and long-term outcomes” [6].

Urgent services, including assessment of new diagnoses (which remained almost at standard for both paediatric/adolescent and adult services) or urgent physical assessments, were mostly continued during the first wave of COVID-19. However, access to urgent mental health assessments was inconsistent compared with access to physical health assessments. Although routine and urgent reviews of patients with HIV often involve a holistic approach that addresses mental health and socioeconomic issues alongside physical wellbeing, respondents specifically noted a discrepancy between the two.

There is a strong community network with an emphasis on peer support and engagement with health advisors. Different cohorts of people living with HIV have varying levels of vulnerabilities, which affects service needs; having persistent peer and health advisor support does improve accessibility for these at-risk groups. There was a degree of disruption of access to external services, such as psychiatry, psychology and social care.

In conclusion, the NHS is vulnerable to external events, and there will be future crises and hurdles to overcome. As a result of what we have learned from the clinicians’ responses in this survey based on initial changes made during the first wave of COVID-19, we have a better idea of what the HIV workforce looks like, what HIV services can achieve in crisis mode and where there is room for improvement. Learning from the experiences at this pivotal time is vital, and such insights can also be applied to other specialties, just as HIV services can draw out experiences and developments from other sectors of medicine. The ability of services to move to virtual consultations while striving to deliver the best patient care possible was not as flexible or adaptable as hoped. Preparations for possible continued disruption to services and for increased focus on virtual care should ensure these flaws are reviewed and resolved. At the time, it was not an easy transition, and
issues such as privacy during virtual consultations and lack of resources were common.

Survey effectiveness

The space to provide anecdotal evidence was invaluable in enabling us to appreciate the frontline experiences of healthcare workers and helped to add meaning to the tick box responses. The reach of the survey was wide, as it was sent to all HIV services in the UK. Despite the nationwide reach, the overall response rate was under 50%, with a lower response from adult clinics than from paediatric/adolescent clinics. As such, the findings do not represent all HIV clinicians and clinics within the UK. Responses were based on personal assessments rather than quantifiable measures, which will have introduced biases. The time period on which the participants were commenting (the peak of the first wave) was not specified, and this may have caused a time discrepancy between regions because different areas in the UK experienced their first wave ‘peak’ at different times. In addition, the open-text responses were limited to a certain character count, meaning that some comments were cut short.

CONCLUSION

The necessarily quick adaptation of services and the lessons learnt during the first wave of COVID-19 will help guide responses to future difficult situations, aid forward planning with flexibility and help overcome potential barriers to good patient care. Although the survey was circulated among only HIV clinicians, learning points can be extrapolated to other specialties and sectors within the UK, with implications for clinicians and policy makers. Participants’ responses suggested that, where logistically feasible, digital platforms were a success. The issues raised need addressing as NHS services increasingly use digital platforms for healthcare.

ACKNOWLEDGEMENTS

We thank Public Health England for their support with the survey and analysis of the results.

CONFLICT OF INTEREST

Dr David Asboe has received payment for attending advisory boards for Viiv. Dr Jane Anderson has received consultancy and speaker fees from Gilead Sciences and speaker fees from Viiv. Dr Laura Waters is an investigator on trials sponsored by Gilead, Viiv and Janssen and has received speaker/ advisory fees from Gilead, Viiv, Janssen, MSD, Theratech, Cipla and Mylan. Gabriella Shanks, Ammi Shah, Amanda Williams, Valerie Delpech and Amanda Ely have no conflicts of interest that are directly relevant to the content of this article.

AUTHOR CONTRIBUTIONS

Dr Gabriella Shanks: interpretation and analysis of data, drafting work, completing final draft and submission. Ammi Shah: analysis and presentation of data, revising content of work. Dr Amanda Williams, Dr Jane Anderson, Dr David Asboe, Amanda Ely, Dr Valerie Delpech and Dr Laura Waters: conception and design of work, interpretation of data for work, revising work critically prior to submission, approval of final draft.

ORCID

Valerie Delpech https://orcid.org/0000-0002-9952-8109
Laura Waters https://orcid.org/0000-0002-1379-1775

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How to cite this article: Shanks G, Shah A, Williams A, et al. Covid-19 First Wave Impact National Survey for HIV Clinicians by Public Health England (PHE), the British HIV Association (BHIVA) and the Children’s HIV Association (CHIVA). HIV Med. 2022;23(10):1098–1102. doi:10.1111/hiv.13307