

NHIVNA Annual Conference 2023 abstract book

CP1 – CP4 – Case presentations

O01 – O06 – Oral abstracts

P01 – P27 – Poster abstracts

CP1

A case of vertical transmission of HIV: discussion of missed opportunities for safeguarding and multidisciplinary working in the perinatal period

Ms Karen Moir, Dr Selena Singh, Dr Subathira Dakshina, Mr Moses Shongwe

Barts Health NHS Trust, London, United Kingdom

Abstract

Background

Previous literature shows reduced engagement with HIV care postpartum may reduce the benefits of antiretrovirals for HIV transmission and maternal health. The infant was born at home via vaginal delivery and has subsequently acquired HIV infection; most likely through breast feeding there was a history of maternal disengagement with HIV services and previous refusal of antenatal HIV testing.

Methodology

The investigation was undertaken using root cause analysis methodologies. Data collect from computerised records system, staff interviews and reports. The mother was aware of the investigation and had a meeting with the Head of Clinical Governance.

Results

A brief outline of the background and timeline in Table 1. Events leading to the transmission were likely multifactorial, including:

Maternal:

Mother had 3 young children and told clinicians that she was struggling to attend due to lack of childcare. In retrospect she identified feelings of post-natal depression that she did not verbalize. She also had a history of disengagement with services. Mother reported lack of trust in clinical teams due to previous safeguarding referral with child 2 as a factor in non-disclosure of breastfeeding at the time.

COVID pandemic:

Move from face-to-face to telephone consultations in both secondary and primary care, with less opportunity for staff networking.

Operational issues:

- Lack of communication between adult and paediatric teams, primary and secondary care
- Separate note system for HIV service may have hampered information sharing

- Requests for confidentiality from mother impacted information sharing with primary care. Her HIV diagnosis and proposed screening for baby were not included in discharge summaries
- Staff changes between 2016-2021 including the lead paediatric consultant and sexual health/HIV consultants
- Missed opportunities with child safeguarding team around child “not brought to appointment”
- Lack of MDT working between clinical teams at different Trust sites

Table 1: A brief outline of the background and timeline

Dates	Events
March 2017	Mother diagnosed and disengaged in HIV care August 2017.
14/09/2017	Mum booked for antenatal care for second child.
3/04/2018	Viral load was undetectable and second son born in hospital with normal vaginal delivery.
08/04/2018	Post-delivery VL rises to 271 and mother advised to bottle feed but noticed breast feeding in clinic. Safeguarding triggered.
10/2018	Disengaged in HIV care since.
12/05/2019	Mum booked for antenatal for 3 rd child.
19/08/2019	Mum has a detectable HIV Viral load. HIV medication reviewed according to guidelines.
30/09/2019	Mother's Viral load was undetectable and booked for c/s on the 09/10/2019.
02/10/2019	Mum and the baby brought in by ambulance after home delivery. Baby was born before arrival vaginally with 2 nd degree tear. Baby breast fed x2 on demand. Discussion about bottle feeding held with mum and started bottle feed.
14/05/2020	Community Nurse Specialists contacted Mum about treatment and appointments. Last prescription in February for <u>antiretrovirals</u> and then 3 months from May 2020.
Jan to Sep 20	Did Not Attend x5 blood test and 4 doctor's appointments.
01/06/2021	Had an appointment and checked out – <u>paediatrics</u> department; initial HIV 1& 2 screening reactive, and Consultant Virologists informed the Pediatric team and HIV Health Advisor.

Conclusion

The root cause for this incident was that the mother and infant were being treated by different teams with little communication between them. There was no MDT arrangement to allow oversight of dyad as a whole which may have avoided missed opportunities for intervention at an earlier stage.

A cross site MDT has been established which discusses all HIV positive pregnant women being cared for by the Trust from first antenatal appointment to last HIV test for baby at 18 months. The MDT is attended by paediatrics, midwifery, HIV medicine and virology with input from health visiting. Mother and child are now both engaged in HIV care.

CP2

Challenges of supporting a complex patient without a community service.

Mrs Claire Chambers

NHS Lothian, Edinburgh, United Kingdom

Abstract

Introduction

Susan is a 46 year old cisgender woman. She came to Scotland in September 2020 and was diagnosed with HIV shortly after.

She is a sex worker living in an area of social deprivation and poor housing. She has a history of using drugs, mainly crack cocaine and heroin, but has never injected. Significant childhood trauma led to her drug use and poor mental health. She also been clinically diagnosed with schizophrenia and personality disorder.

Her GP tested due to severe lymphadenopathy and night sweats. She was fast tracked to clinic to start treatment. Susan's motivation to take therapy was her fear of onward transmission. Her community pharmacy agreed to dispense Biktarvy at the same time as methadone. Unfortunately multiple attempts to contact Susan after this initial appointment were unsuccessful.

The MDT agreed CNS to try to build a supportive relationship with Susan by attempting to meet her whilst attending pharmacy for methadone consumption.

Challenges

She had a lack of trust in health care professionals and did not want to attend a sexual health or hospital setting.

She was not taking ARV therapy reliably so concerns re sex work and onward transmission.

Severe needle phobia made blood monitoring difficult.

There were concerns regarding her own personal safety and not wanting to leave her local area.

Chaotic drug use prevented regular contact.

She did not access mental health services and remained isolated.

She was not willing to engage with third sector organisations.

There was a lack of time for clinic based CNS to attend pharmacy to wait for Susan to turn up.

Conclusion

This case study reflects taking care to the patient in the community is an invaluable way of keeping vulnerable patients engaged in care and treatment of HIV. She currently has an undetectable viral load. Susan is building a relationship with our 3rd sector organisation who now support her to attend clinic. Working in partnership has helped to improve attendance and engagement. Susan is now accessing addiction/mental health support services in her local community and is linked back with GP. Community pharmacy dispensing of HAART is not financially viable, however beneficial and effective for certain patients.

Individualised care is imperative to ensure both engagement and retention in care. Where community CNS services do not exist, it is imperative that clinic nurses roles enable the opportunity to do so when required.

CP3

High-Priority response resulting in improved patient and public health outcomes

Mrs Beth Freeborn, Ms Melanie Martin

SCFT, Brighton, United Kingdom

Abstract

Our case study is on a patient with HIV, mental health issues, chemsex use, self stigma, previous KS and multiple sexually transmitted infections. They have had repeated disengagement for multiple reasons.

With a social media presence stating they were HIV -ve and on Prep. In reality their VL was over 5,000,000 copies; this was only discovered when they presented to hospital with MPox and STI's. They self discharged before services could engage with them. They were also an index case for several new HIV infections. After MDT's and safeguarding's, Legal teams in both trusts and the BHIVA guidelines being reviewed; it was decided to involve the local Public Health England.

Bespoke MDT's were set up reviewing and prioritizing needs, making action plans and reviewing 4-6 weekly. The decision was made not to involve the Police until another attempt of contact was made. Multiple specialities were around the table but this number reduced as the case developed.

Our opportunity came when the GP informed us that they were returning for another appointment and so it was decided 2 of us would be at the GP surgery to offer our services.

I agreed to be the single point of contact and correlate all their care needs until they were in a stable place mentally and physically. This was only possible with the support and frequent reviews of the wider team. Then we would work on building confidence to do joint visits with external services. With open access to the Consultant and clinic we re started them on ARV's, and monitored bloods; sexual health screens and treatments. We then introduced weekly psychology still all from our base clinic as the known environment was a safe and stable space for them.

Several housing officers and countless forms later we got them into temporary accommodation. This was literally a life saver as they had a suicide plan in place. With unmanageable side effects we switch ARV's with a positive result. Within a 3 month window we had achieved our initial goals of stabilizing their mental health with medication and psychology, placing them in stable housing, concordance of ARV's and an undetectable viral load thus protecting the wider community.

We are tentatively positive and cautiously optimistic they will continue on this positive trajectory.

CP4

Injectables case study Compassionate access patient

Mrs Jill Williams

Liverpool University Hospital, Liverpool, United Kingdom

Abstract

The case discussion i would like to present is of a 40 year old gentleman who we obtained trust approval for injectable Rilpivirine and Cabotegravir on compassionate grounds. He had been lost to follow up, referred to the community team, refusing treatment and choosing to die. His reason for this was he has a tablet phobia . All previous HIV drug regimens were intolerable in the longer term. He would manage to take them for about a month and then stop. He felt tired of living with HIV and the difficulty of physically getting the medication into him orally and the side effects too much to continue. Injectable's his perfect answer.

1-Trust approval via the HIV resistance MDT and trust medicines management team for funding obtained (February 22)

2- Treatment with Injectable Rilpivirine and Cabotegravir started March 22.(base line resistance test - wild type)

Date	Dose	HIV Viral Load
01/03/22	1st Dose Injectables given	271, 546
29/03/22	2nd dose injectables given	7, 233
24/05/22	3rd dose injectables given	339
26/07/22	4th dose injectables given (MDT and resistance test	1,616
09/08/22	Commenced crushed Symtuza 1/12	343
06/09/22	Monthly HIV viral loads and MDT	<30
20/09/22	5th injectables dose given	43
18/10/22		45
18/11/22	6th injectables dose given	<30
19/12/22		<30

17/01/23	7th dose injectable given	44
15/02/23		<30
16/03/23	8th dose injectables given	37

Resistance test from July 22 - reported and actioned showing high level NNRTI and intermediate integrase resistance.

24/03/23 - HIV resistance MDT - injectable's stopped

31/03/23 - commenced dissolvable dolutegravir and liquid lamivudine/abacavir- Patient doing well so far awaiting bloods

Complex patient who did not fulfil BHIVA guidance for injectable ART approved on compassionate grounds. No oral lead in and detectable, sadly failed despite our best efforts. Highlights the difficulty and complexity of those you want to give injectable ART to in comparison to those who do fulfil the criteria.

This patient 1 of 3 currently receiving companionate use injectable's, the other 2 doing well.

001

Drag Queen for a day: 'DQ4ADAY' - using Drag to improve confidence and HIV related self-stigma

Mr Alan Spink¹, Tracey Buckingham², Mr Scott Davidson¹, Alex Allison²

¹The Sussex Beacon, Brighton, United Kingdom. ²None, Brighton, United Kingdom

Abstract

Background:

It is well documented that drag as an art form has been embraced by the LGBTQI+ community for many years. The flamboyant performances have created a space where individuals who have often felt stigmatised and isolated can feel their most authentic self, within the safety of a non-judgmental and welcoming space. Over the last decade the popularity of drag has exploded, gaining undeniable acceptance and popularity¹. Within our service we recorded a significant increase in the number of people living with HIV [PLWHIV] reporting issues such as self-stigma, isolation and lack of confidence to our specialist caseworker. HIV is one of the world's most highly stigmatised conditions and is linked to negative psychological, social, and physical health outcomes². The theory that Drag could have a positive impact on the negative self-imagery and self-stigma of PLWHIV led to the concept of a bespoke Drag workshop with the intention to improve self-confidence and reduce self-stigma.

Method:

A scoping exercise was conducted with service users and local Drag artists to assess the feasibility and acceptability of the workshop. A steering group developed the three day workshop. The event was shared with voluntary and secondary care organisations across the county. Criteria for the workshop included a history of self-stigma, lack of confidence or isolation. Pre and post workshop evaluation for both participants and queens were designed. Participants were asked to reflect on their emotional well-being, confidence, support and social networks and mood. The Drag queens were asked to highlight any learning around HIV and to reflect on anything that they had personally gained from the experience.

Results:

A total of 9 PLWHIV and 9 Drag queens were invited to attend the workshop. 7 participants completed all 3 days. Results from the evaluation forms showed a 47% improvement in participants emotional well-being, 45% improvement in participants confidence to manage their physical and psychological health needs and a 34% increase in how participants viewed their social networks. There was an overall 51% improvement in participants mood.

Conclusion: Bespoke Drag workshops are both feasible and acceptable. Drag has the ability to break down self-stigma, to give confidence to PLWHIV and to allow them to explore their own HIV identity in a safe, supportive and fun environment.

002

Opt-out routine hiv testing in an emergency department a 2 year retrospective analysis

Mrs S Potts¹, Mr C Hodgson², Mrs K Carroll³

¹Blackpool Teaching Hospital, Blackpool, United Kingdom. ²Blackpool Teaching Hospitals, Blackpool, United Kingdom. ³Gilead, London, United Kingdom

Abstract

Background

There is extensive evidence to support the effectiveness of opt-out routine HIV testing in Emergency Departments (ED) to identify people living with undiagnosed HIV (Human Immunodeficiency Virus) disease and People Living with HIV (PLWHIV) who have disengaged from services.

A previous successful project in the Acute Medical Unit highlighted a high prevalence of undiagnosed HIV in the locality, and audit recommendations indicated it would be beneficial to introduce routine HIV testing into the ED.

The project in ED was due to launch in October 2019 however was deferred due to the Covid pandemic and implemented in October 2020. The implementation is supported by the National HIV Action Plan 2021 to eliminate HIV transmission in the UK by 2030.

Method

A local policy, posters and patient information leaflets were developed, and a robust pathway designed to enable a seamless patient journey into Specialist HIV Services.

Currently all ED attendees over 16 years of age who require a venous blood sample, will be screened for HIV. Posters are displayed and patient information leaflets/QR link is made available to ensure assumed consent is obtained prior to testing. There is the option to decline the test and additionally staff must adhere to the exclusion criteria.

Monthly audits and data collection are submitted via an online portal to support the nationally developed Key Performance Indicators (KPI's).

To promote continued engagement to the project, ED staff receive monthly feedback of the testing statistics, and ongoing training/support is provided.

Results

In 2021 out of a potential 35 718 ED attendees, 10 171 (28%) venous samples were tested for HIV, with a total of 26 positive HIV tests, amounting to 7 new diagnoses and 19 previously diagnosed.

In 2022 out of a potential of 38 859 ED attendees, 11 201(29%) venous samples were tested for HIV with a total of 16 positive HIV tests, amounting to 6 new diagnoses (plus an additional positive result via partner notification) and 10 previously diagnosed.

Conclusion

The results support the feasibility and importance of an opt-out routine HIV screening programme within the ED setting. The benefits of integrating and normalising HIV testing improve health outcomes, access, re-engagement to specialist care and management of HIV disease, thereby supporting the “Towards Zero - An action plan towards ending HIV Transmission, AIDS and HIV related deaths in England.”

003

Klick – the use of mobile technology (app) in nurse-led clinics as a tool of empowerment (and development) for nurses and patients.

Ms Christina Antoniadis, Ms Yodit Fissahaye-Yimer, Dr Sara Day

Chelsea and Westminster Hospital, London, United Kingdom

Abstract

The presentation will cover the use of Klick as a tool for conducting nurse-led clinics under consultant supervision. The service is offered combining face to face components and over the phone/online ones. Features and characteristics such as access to blood results with interpretation and advice, request for emergency prescriptions, booking of appointments (including for injectable ARVs) has improved the patient experience and has had an empowering of patients. A development pathway has been implemented for nurses who conduct the Klick clinics leading to nurse practitioner and advanced practitioner status. The pathway improves knowledge levels, understanding, and builds on components of the compassionate and holistic care nurses provide.

The nursing development pathway will be presented covering local MDT trainings, knowledge building through collaborative working, supervision, the Klick competence pathway and the NHIVNA-STIF competences. 8 band 5/6 (staff/senior staff) nurses have participated in the trainings, in kobler clinic, achieving band 6/7 level (nurse practitioner) and are conducting the Klick clinics. Klick nursing staff is reviewing and releasing results with interpretation and advice (40 blood tests per week on average from a total of 80 appointments per week), conducts the annual reviews, writes to GPs when further support is needed to be coordinated in the community and manages the referrals to other MDT services, in-house mental health support (HIV mental health nurse and psychology service), peer support, social prescribing, etc.

The development of the Klick clinics has received very positive feedback from patients as it offers them a number of features (annual review, blood tests and injectable appointments, results review): 90% reported having a positive experience booking appointments, 70% use multiple features of the app, 77% prefer Klick to previous booking systems. Patients feel in control and appreciate the user-friendly technology.

Finally, consultant face to face appointments have become available within 2 weeks, half the time compared to 4 week-wait when the service started operating as the management of HIV-stable patients in Klick, including some with significant co-morbidities and polypharmacy, has freed-up the consultant appointments.

Project team: Christina Antoniadis, David Asboe, Marta Boffito, Ruth Byrne, Sara Day, Yodit Fissahaye-Yimer, Abeba Gebreselassie, James Hardie, Paul Holmes, Sam Ohene-Adomako, Olayinka Olaonipekun, Caroline Rae, Ryan Whyte, Rebecca Wilkins

004

Inside Out Health Project: how do people experience HIV healthcare in English prisons? An exploration of patient's experiences and opinions.

Ms Felicity Young

University of Portsmouth, Portsmouth, United Kingdom. Solent NHS Trust, Newport, United Kingdom

Abstract

Introduction

People living with HIV should receive high-quality, safe, and effective patient-centered care, and should have the opportunity to be involved in the development and delivery of services (BHIVA, 2018). Since 2006 people in prison are NHS patients entitled to the full range of services delivered to broadly the same standard as the wider community. However, the conditions of incarceration diverge from and impact on many aspects of the principles and practices of NHS care. And these conflicts can influence the delivery of HIV healthcare in prison. People living with HIV who have experienced prison more frequently encounter marginalisation, social disadvantage, and poorer health outcomes. Therefore, for people in prison, thoughtfully planned and delivered HIV healthcare is especially important. Understanding how people experience HIV healthcare whilst in prison and incorporating these opinions and views into all stages of care provision can contribute to this process.

Methods

This is a qualitative study, which explores the patient's experience. First-hand evidence has been gathered through one-to-one semi-structured interviews with people with lived experience of HIV healthcare in prison. Additionally, advocates for those in prison living with HIV, including health and social care and legal professionals, peer supporters and community representatives, and family and friends have also provided their reflections and testament. Data is being analysed using reflexive thematic analysis.

Results

Some of the early findings from this research project are presented and discussed. These findings outline both positive and negative aspects of receiving HIV healthcare whilst in prison. Some of the benefits appear to be related to the compassionate and respectful relationships with various professionals, and of access to HIV healthcare. Challenges are described regarding continuity of care, cultural, systemic, and structural conflicts, and related to stigma.

Discussion

A better understanding of the experience of people living with HIV, and of the context of healthcare delivery in prison, will inform improved and patient-focused care planning. Ultimately, these research findings will contribute to draft best practice recommendations for healthcare. Participants and those in the PPI group will then be invited to participate in a Delphi-style review of the draft recommendation to

co-produce the final output. Services need to be designed and delivered to ensure all patients, regardless of circumstance, can achieve the maximum benefit of HIV healthcare.

005

Immigration without information: an impending crisis?

Mrs Laura Hilton¹, Ms Lisa Walker², Ms Laura Wilson-Powell³, Ms Catherine Ormiston⁴, Ms Claire Bradbury⁵

¹Mid and South Essex NHS Foundation trust, Southend, United Kingdom. ²Royal Cornwall Hospitals NHS Trust, Cornwall, United Kingdom. ³Midlands Partnership NHS Foundation Trust, Stafford, United Kingdom. ⁴Midlands Partnership NHS Foundation Trust,, Stafford, United Kingdom. ⁵University Hospitals of Derby and Burton NHS Foundation Trust, Derby, United Kingdom

Abstract

The 5 authors noticed a rise in patient's transferring from overseas in the past 6-12 months. They decided to unite to do a joint piece of work.

The authors come from a diverse range of services across the United Kingdom (UK). These range from small rural clinics to larger City based services. All have a significantly increased rate of people living with HIV transferring from overseas recently with a nearly 300% increase in the past 6 months compared to the previous 6 month period. These people come from a diverse range of countries and are often moving to the UK for work purposes and many have been recruited by NHS Trusts or care agencies. All authors recount that the transferees often have limited HIV history available at presentation and few doses of Anti-retroviral drugs left, making it challenging to continue treatment uninterrupted.

Preliminary data from one of the services show that the majority of the individuals were very unsure about the HIV service provision in the UK and whether they had to pay anything towards care. Most had at least a week of medication left when they were seen in clinic, but a smaller proportion only made initial contact when they had a few days left. No transfer of care information was received for any individual.

The authors plan to use two tools to audit the data. The first will analyse data at a service level looking at the structure and set up of each service. It aims to identify whether location has an impact on the number of PLWHIV transferring care from overseas and to identify the impact on services. The second tool will be gathering anonymised retrospective data on the last twenty PLWHIV who have transferred to each service in the preceding 12 months.

The authors wish to publicise this planned national audit to other nurses across the UK and Ireland in order to ask multiple services to participate in gathering data. This will ensure that the results are truly representative of the national cohort and aid identification of whether this is a national issue or only being seen in pockets of the UK and Ireland. The authors will look at whether the increase in transferring individuals from overseas and the potential lack of relevant treatment information is impacting on participants ability to deliver safe care within their current staffing quota.

006

Barriers and facilitators to PrEP access for transgender women

Ms Jessica Clarke, John McLuskey

University of Nottingham, Nottingham, United Kingdom

Abstract

Background: HIV prevalence among transgender women is much higher than among the general population, but when research is conducted they are rarely separated from MSMs. Whilst there is no data on PrEP uptake among trans people for the UK, uptake is significantly lower among trans women compared with MSMs in other countries. Identifying and addressing barriers to PrEP access among trans women could drastically reduce transmission and prevent life-changing diagnoses.

Method: An extended literature review was conducted to examine barriers and facilitators to accessing PrEP for trans women. Searches were conducted across five databases: CINAHL, ASSIA, Web of Science, Embase and PubMed and all results were aggregated. Papers concerning access to PrEP were then refined using criteria including type of publication, publication date, location of studies, separation of trans women's data from that of other groups. Thematic analysis was applied to the remaining papers to identify key issues that need to be addressed in order to improve PrEP access for trans women.

Findings: Thematic analysis of the papers produced three main themes: adherence, training and education, and stigma and discrimination. Many participants in the studies cited unpredictable lifestyles and difficulty taking daily medication as a reason they avoided PrEP. These issues persisted even when adherence was defined as taking at least four tablets a week (the minimum required to maintain some protection). Training and education both for transgender women and the healthcare professionals interacting with them was a commonly cited barrier to PrEP. Among the trans women themselves there were many misconceptions about PrEP, its purpose, efficacy and safety; whilst healthcare professionals had very little knowledge of trans women, trans-specific health issues and knowledge of PrEP in general. Stigma and discrimination due to gender or association with HIV was found to be a serious barrier to PrEP in many of the studies. Many trans women feared being judged by their families, health professionals or members of their own community. This fear of microaggressions, being excluded from social groups or being treated poorly in healthcare environments often led to them avoiding healthcare altogether.

Conclusion: More efforts need to be made to provide accurate information on PrEP, its risks and benefits, to trans women. Healthcare professionals should be provided with training on transgender identities, trans-specific health needs and misconceptions surrounding trans women affected by HIV. Further research is needed to identify causes of difficulties with adherence specific to trans women.

P01

Thriving in the face of uncertainty: the changing face of specialist palliative care for those living with HIV in the post treatment era.

Mrs Emma Davey

Clatterbridge Cancer Centre, Liverpool, United Kingdom

Abstract

The role of Specialist Palliative Care (SPC) has always extended beyond malignancy to support those with complex, potentially life limiting disease including HIV. In the post treatment era of antiretroviral medication the role of SPC has changed from solely supporting end of life care for those affected by end stage disease.

As those living with HIV manage their illness as a chronic disease, the role of palliative care has changed. Supportive care addressing complex symptom/side effect management resulting from aging and multiple comorbidity is at the forefront, underpinned by a focus on the whole person rather than the disease process. As an example an HIV positive individual lives with a 44% increased chance of developing cancer in their lifetime. The complexities of dual diagnoses and treatments are multifactorial and SPC can offer solutions to support this.

Historically SPC nursed patients dying of late stage HIV. Pleasingly this is something rarely seen today. The specialism has changed significantly, the focus very much on 'living with' rather than 'dying from' incurable illness. 'Affirming life' but acknowledging death as normal in a life cycle; and ensuring the focus in 'not counting the days, but making the days count'.

For so many touched by HIV 'palliative care' elicits imagery of dying, largely because of individuals experiences of palliative care through the 80s and 90s.

Care of the dying remains an important part of palliative care, but the primary objective is helping people to thrive in the face of diagnosis, whilst planning ahead (advance care planning) for living with uncertainty IF it is what an individual wishes.

In the same way 'general medicine' struggles to keep up with advances in HIV care, potentially 'palliative care' needs a facelift within the support of individuals living with HIV. Doing so would highlight the benefits of multidisciplinary working between HIV specialist teams and SPC teams to enhance patients quality of life as opposed to involvement in care only when an individual is imminently dying.

SPC professionals have so much to bring to the care of those living with HIV in collaboration with HIV services. This subject seems pertinent given the focus on quality of life and wellbeing at this years conference. The opportunity to orally present the change in focus and service provision through a case study would be a wonderful opportunity to update and share expertise across specialisms.

Thank you for your consideration.

P02

Simulating Distress: A Case Based Discussion

Mrs Jen Kendrick

Manchester University NHS Foundation Trust, Manchester, United Kingdom

Abstract

Context:

HIV care is predominantly delivered by nurses working within the NHS. Over the past few years there has been a significant movement of nurses out of specialist areas or nursing altogether due to post-covid fatigue, burnout, retirement, or relocation. (Piercy et al 2018, Piercy and Wills 2022). Resulting in HIV services facing a significant lack of specialist experience and knowledge.

Background:

This exact situation occurred within my service, there were 4 band 6s and an experienced band 7. We have established a new team who have a vast nursing experience but very little HIV knowledge. We are a large clinic based within a multicultural and diverse population and have many teaching opportunities for new staff on HIV and common issues we face on a day-to-day basis.

However, one of the essential skills that HIV specialist nurses have is the ability to communicate effectively with our patients (Downes and Foote 2019). The nurse's ability to connect with patients and identify what matters to them is crucial in developing trust and understanding between nurse and patient. Nurses learn how to ask difficult questions or manage difficult consultations and they can do it with ease and compassion. (Croston and Gibson 2020) These skills can't be taught from a textbook; they must be acquired through experience and support to enhance these skills.

For staff who are new to HIV care when a person receives a new diagnosis it is important that we ensure that the therapeutic relationship is developed correctly at the start to ensure that care is developed collaboratively.

The challenge that comes within HIV care is how do nurses develop skills in a safe and supported way that do not impact of patient's experience or nurses' confidence? Based on these clinical observations and reflection on clinical practice I developed learning opportunities for staff whereby they are given a subject to look at such as low CD4 or new HIV diagnosis and then ask them to present to me their findings. Then the next step is to use simulated learning to put their knowledge into practice within a safe environment where we can go through areas for improvement and constructive feedback. Interestingly, there appears to be a gap in the literature surrounding HIV nursing and the use of simulated learning. The following case base presentation explores in a practical way the process involved in developing simulated learning in the context of HIV care to improve outcomes for people living with HIV.

Conclusion

Simulated learning is an effective way of developing nurses skills when exploring difficult patient consultations and managing distress in a proactive way.

P03

Do patients find virtual clinics acceptable? How a global pandemic accelerated change.

Mrs Laura Hilton

Southend University Hospital, Westcliff on Sea, United Kingdom

Abstract

The purpose of this study was to evaluate whether virtual clinics are acceptable to the people living with HIV (PLWHIV) within the cohort and whether missing a face to face consultation was likely to cause harm. COVID-19 put the clinic in the unprecedented situation of holding nearly all consultations by virtual means.

All PLWHIV who had a virtual consultation between March-September 2020 were asked to fill in a brief questionnaire. The clinician also completed a harm survey once all results were back. This assessed actual harm (viral load increase, deranged bloods, missed ARV doses) and psychological harm from missing a face to face appointment. 99% of virtual consultations were via telephone call, with <1% held via email (due to patient preference or hearing disability)

339 PLWHIV (nearly 50% of the cohort) completed the questionnaire with 96% finding their virtual consultation acceptable. Concerns included the absence of 6 monthly blood monitoring and feeling there was a lack of time to discuss issues. 68% of PLWHIV would definitely like the option of every other visit being virtual. Most of these would prefer telephone consultations, rather than email. Very little harm occurred as a result of missing a face to face appointment with only 3% of patients having detectable virus in their blood and less than 1% reporting psychological harm as a result of not being seen face to face.

As a result of this evaluation, virtual clinics were embedded into routine practice from June 2022. By offering a hybrid model of face to face and virtual consultations, PLWHIV will receive a tailored approach that meets their individual lifestyle, medical and psychological needs. So far, 116 virtual consultations have taken place, nearly all of them via telephone as it is easier to detect tone and nuances via this method of communication. Results discussed including metabolic markers, adherence and ART side-effects discussed, other medical conditions and medications, mood, cervical smears, and anything else the PLWHIV wishes to discuss.

Suitability is assessed by the clinician and documented on the bespoke computer software in use and the person can opt in or out. All PLWHIV have an annual face to face consultation with all annual bloods taken, weight, blood pressure and full review. PLWHIV on all classes of antiretrovirals (including NNRTI's) are offered virtual consultation, however many patients are moving across to Integrase Inhibitors. Patient satisfaction at this time is anecdotally high.

P04

Celebrating the African contribution to the UK HIV response: Our stories told by us.

Dr michelle Croston¹, Ms Angelina Namiba², ms Charity Nyirenda², ms Rebecca Mbewe², ms Memory Sachikonye², Ms Winnie Ssanyu Sseruma², mr Mark Santos³

¹University Of Nottingham, Nottingham, United Kingdom. ²4M Mothers, London, United Kingdom.

³Positive East, London, United Kingdom

Abstract

Background

HIV in the UK is concentrated in a few key populations, and Africans are among them.

And yet, there is no documented record/book to accompany the significant amount of epidemiological data on these communities. No record celebrating the contribution, resilience and lived experience of Africans living with HIV in the UK, their allies and their response to the epidemic.

The project's aim was to develop a book to showcase these experiences and shine a light on this community. The project was led by a steering group of African Women who are longstanding HIV activists and advocates, much respected for their leadership within the HIV community. The women have been involved in an informal collaborative, supporting, encouraging and mentoring one another in their work over the last ten years. Their experience spans the story of the African community's experience of HIV within the UK. The steering group felt that it was important that they captured and told these stories to ensure that they were accurately recorded in the history of HIV. The project aimed to showcase 40 stories to coincide with the 40th anniversary of HIV.

Method

The book was developed through the following process, the establishment of a steering group, made up of 5 African women living with HIV, one clinical academic and a project manager, who met monthly to prioritise and delegate project work. There were two face-to-face planning meetings and three poetry workshops alongside monthly meetings. The steering group were responsible for identifying contributors and then interviewing them. The stories were then edited, and decisions were made with regard to the ordering of stories, poetry, postcards, and photographs. The imagery of the book was carefully thought out, researched, designed and brought to life by a steering group member.

Conclusion

As the project developed, it revealed the significant need for this work as we were overwhelmed by the eagerness of people willing to contribute and the number of stories submitted which exceeded the target of 40 stories set by the steering group. It was apparent from the contributors' stories that they highlighted the often ignored (significantly missing) resilience, passion, advocacy, activism, leadership

and significant contribution of the African communities in their response to both the UK and global HIV response journey.

“It always seems impossible until it is done.”

Nelson Mandela

P05

HIV knowledge survey in a teaching hospital

Mr WL Htun¹, Mrs S Potts¹, Mr C Hodgson¹, Mrs K Carroll², Dr JN Sweeney¹

¹Blackpool Teaching Hospital, Blackpool, United Kingdom. ²Gilead, London, United Kingdom

Abstract

Background

The number of newly diagnosed HIV infections in England are decreasing in recent years, however undiagnosed HIV infection and late diagnosis remain a challenging issue.

To ensure early diagnosis of HIV, opt-out routine HIV testing has been implemented into the Emergency Department (ED) in October 2020.

A brief survey was conducted in December 2022 to assess the knowledge of HIV and the acceptability of opt-out routine HIV testing among the individuals attending the hospital and staff.

Methods

The authors developed an anonymous survey containing 12 questions and this was handed out to people attending the hospital at a World AIDS Day event on 01/12/22.

Data was collected via a Microsoft Teams Form and analysed in SPSS version 25.

Results

In total, 582 individuals participated in the survey via paper or an online form. Of the participants 72.5% identified as female, 26.8% as male and 0.2% as non – binary with their median age as 39 (IQR 23).

Only 21.3% of the participants correctly answered the correct modes of transmission of HIV.

Nearly 20% of participants thought HIV can be transmitted by kissing. 92.8% of participants chose condom for prevention of transmission however over half did not choose PEP or PrEP as a prevention method.

Expectedly 90% of participants are not aware of U=U message and approximately 50% of participants think HIV can be transmitted to a partner whilst taking HIV medication.

Almost 66% of participants agreed the life expectancy of people living with HIV was the same or longer than the normal population.

Only 37% of participants are aware of opt-out routine HIV testing in the teaching hospital and 84.7% agreed they would accept a HIV test if attending the ED.

Detailed of the survey can be provided.

Conclusion

The results identified the majority of individual's agreed to participate in the routine opt-out HIV testing in ED, and the survey supported the acceptability of HIV testing in ED setting.

The findings highlighted a significant HIV knowledge gap amongst participants in the locality, especially relating to new information such as U=U message and PrEP.

Future recommendations include improved access to access to education and a wider community survey incorporating a broader demographic of participants.

P06

Added value of nurse specialists carrying out annual health reviews

Ms Linda Panton, Mrs Claire Evans

NHS Lothian, Edinburgh, United Kingdom

Abstract

Introduction

BHIVA Standards of Care (2018) and the “fourth 90”, focusing on quality of life, help promote optimal health outcomes for people living with HIV. As well as ensuring good virological control, it is essential that we focus on maximising physical and mental health. An annual health review provides a holistic assessment and supports people to lead healthy and fulfilling lives.

Method

Clinic correspondence and annual review proformas from January to December 2022 were audited in 10% of our routine return patients (n=80). Ten were randomly chosen from each clinicians’ patient lists. Recordings for cardiovascular risk, osteoporotic risk, women’s health, mental health, sleep and vaccinations were reviewed, as well as health promotion and linkage to community supports.

Results

Data was analysed for 80 patients (male=47, female=33), with a median age of 52yrs (26-76years). Fifteen patients were under 40 years so required less monitoring. 58% (n=46) of this cohort did not see a clinical nurse specialist (CNS), and of them, 98% did not have a structured annual review performed. The table below illustrates the results of what was clearly documented.

	QRISK3	FRAX	SMEAR	MH	SLEEP	VACCINATIONS
DR %	35	88	53	24	4	33
CNS %	100	100	90	100	80	85

Discussion

Health prevention and promotion discussions are part of the annual review. This may not be included in the GP letter, however in 44% of cases there was evidence of patients receiving advice including weight management, exercise, smoking and alcohol. There was no documentation to evidence any discussion to promote engagement with community supports.

Nurse specialists ensure a high standard of holistic care is provided by carrying out annual reviews. In particular, cardiovascular risk scoring, mental health and sleep assessments, and administering appropriate vaccinations were implemented more effectively for patients who are seen by CNS.

Whilst patients are encouraged to lead conversations about their care, there are definite gaps for those not receiving an annual review.

Patients may well be having the necessary discussions but documentation is key to ensure good communication within our HIV service, as well as integrating care with other health professionals.

Conclusion

There are areas for improvement in health promotion and involving other support agencies, however these results highlight the benefits of nurse specialists in delivering HIV care, and adds weight to the provision of a completely nurse-led service for stable patients.

P07

Severe needle phobia - managing the challenges of a newly diagnosed individual

Miss J Harrison¹, Mrs K Carroll²

¹HCRG Caregroup, Chester, United Kingdom. ²Gilead Sciences Ltd, London, United Kingdom

Abstract

Background

Undiagnosed HIV among adults is a recognised problem in the UK, often associated with late presentation, increased morbidity and mortality. It is less understood in children. Challenges for healthcare professional's (HCP's) in diagnosing individual's with HIV include resistance to testing and needle phobia. Adam (pseudonym) was newly diagnosed with HIV and through partner notification, identified his current female partner (pseudonym Sarah) as someone needing HIV testing. Adam and Sarah attended the service together. During assessment it was identified that Sarah has significant needle phobia, had never undergone venepuncture in her lifetime and had 'opted out' of HIV testing during antenatal care for her two pregnancies. Sarah's initial HIV test was reported as positive, and further confirmatory testing was required, along with the necessary baseline investigations needed for a person newly diagnosed with HIV. Sarah's CD4 count returned at 9 cells/mm³ and viral load >500,000 c/ml clearly highlighting the need for immediate antiretroviral therapy (ART) initiation. Sarah was identified as the index individual and testing of HIV for her 2 children was urgently required. Obtaining venous blood samples was a significant challenge for Sarah and the HCP's involved in her care.

Methods

During the initial appointment, Sarah also identified a fear of examination and any words associated with venepuncture, HIV or physical examination. Sarah was given the positive HIV result, and a further appointment was made to acquire the necessary baseline investigations. The consultant made the decision to prescribe a low dose sedative and local numbing cream prior to attempting venepuncture. As there was no immediate access to psychological therapies and the need for full assessment and blood profile was urgent, it was discussed in the multi-disciplinary-team (MDT) the best approach to support Sarah in the need for ongoing venepuncture, examination, ART initiation and prophylactic treatments.

Techniques used to obtain samples were- longer appointments, distraction methods, partner support, low dose sedative and topical anaesthetic cream. Sessions were led by Sarah.

Conclusion

The service has been successful in venepuncture with Sarah; however, it does remain a challenge for the HCP's and Sarah, as services for needle phobia are limited. The specialist HIV psychology service has a long waiting list for new referrals and is some distance for Sarah to travel to. Time has been invested in techniques for managing phobias among the HCP's skill mix in order to provide Sarah's ongoing care.

P08

Quality missing: an audit of transfer letters for patients moving between HIV services in the UK.

Mr Michael Ward, Dr Emma Street

Calderdale and Huddersfield NHS Trust, Huddersfield, United Kingdom

Abstract

Aims

Patients who transfer care between providers are vulnerable to having poorer quality of care if the information provided is inadequate. After a serious case review within our clinic where resistance tests were not transferred between units, resulting in development of multidrug resistance, we want to see whether the quality of information provided in these letters was adequate.

BHIVA standards of care only mention “a full clinical summary should be provided within 2 weeks of a request” but do not specify what information should be included.

The HIV population of the UK is highly mobile, and many patients have had multiple previous care providers. Movement of patients between providers within the UK and internationally makes up a significant proportion of work.

Poor quality transfer documentation has the potential to result in future clinical errors and is potentially more costly with duplicate blood testing and vaccinations.

Methods

60 patient records were reviewed who transferred their care between 2015 and 2021. Patients diagnosed abroad with no previous UK care were excluded.

Results

96% had a referral letter in the record.

76% had a referral letter either prior to the patient attending the new clinic or within 14 days of request.

1/3rd of referral letters did not have the month and year of diagnosis to enable HARS to be complete.

Only 55% had documented where the patient had previously accessed care.

42% did not have a baseline CD4 count and 43% did not have a baseline viral load documented. In comparison 97% had the most recent viral load documented.

Only 70% mentioned resistance testing with results if applicable within the referral letter. 17% did not mention any relevant past ART use. 58% had the HLA B5701 status in the letter whilst only 65% mentioned hepatitis status and subsequent vaccinations.

In conclusion

A standard letter is essential for patients when transferring care. Poor quality transfer information ,as seen in this audit, means the potential for future clinical errors, duplicate testing with the additional costs necessary and difficulty completing HARS submissions.

P09

A qualitative exploration of how the multidisciplinary team members communicate with new mothers living with HIV about the current UK breastfeeding guidelines.

Mrs Siobhan Allison (nee Lynch), Ms Loraine Bacchus

London School of Hygiene and Tropical Medicine, London, United Kingdom

Abstract

Background

New mothers living with HIV in the UK are recommended by the BHIVA guidelines to formula-feed their babies to eliminate the risk of HIV transmission. In 2018 the guidelines were updated to include the caveat that if women want to breastfeed, “they should be supported to do so if they meet the criteria”(1). Infant feeding is complex, with many conflicting factors that influence mothers’ choice of how they feed their babies. This study aims to explore the views and experiences of participants from the MDT(multidisciplinary team) who support women who choose to breastfeed.

Methods

A qualitative interview methodology using semi-structured interviews was used to explore and understand the MDT’s experience. A purposive sampling method was used to recruit 9 participants. The participants were peer support, nurses, midwives, consultants, and breastfeeding specialists who had experience caring for mothers living with HIV who chose to breastfeed. The interviews were via zoom, they were recorded, then transcribed verbatim and analysed using reflexive thematic analysis.

Results

The results found that whilst participants supported mothers who chose to breastfeed, decision-making was a complex endeavour due to conflicting guidelines and public health messaging. Making sense of this required participants to draw upon their clinical expertise, peer support, personal experience of breastfeeding and knowledge accrued through providing breastfeeding advice to women living with HIV. Additionally, they were conscious of the need for women to be active in a shared decision-making process.

Conclusions

The interviews gave unique insights into how participants navigated uncertainty during their encounters with women by engaging them in open communication, building trust in the relationship, helping them to develop support networks, clear documentation, and the need to recognise and manage their own anxieties as well as those of the mothers. Finally, the study gives recommendations for practice, policy, and research.

P10

The Role of the Senior Support Worker in HIV Care

Madeline Brodie

Manchester University NHS Foundation Trust, Manchester, United Kingdom

Abstract

The Role of the Senior Support Worker in HIV Care

Introduction:

In 2017 I joined a team of HIV specialist nurses as a senior support worker. The job specification was vague and was predominantly based around helping the HIV team with phlebotomy and assisting with community visits. Over the last six years I have expanded the role and feel that senior support workers should be utilised to deliver HIV care more commonly and feel passionately that there should be more HIV specific training for people working at my level. I would like to share some elements of my role and some short case studies.

Re-engagement work:

My service cares for around 3000 people living with HIV and a large percentage of our cohort is chaotic and often hard to reach. I work together with other clinicians, both inside and outside of my organisation, charities and support services, service users and their families to ensure that people engage in HIV services and remain on effective treatment. I work inline with our re-engagement pathway and help to find patients who have been lost to follow up and support them to re-enter services.

Management of complex patients:

My service works across multiple different healthcare settings including outpatients clinics, inpatients, outreach clinics and the community. I work with the support of consultants and specialist nurses to manage a caseload of some of our most complex patients in the community and act as a liaison between our HIV service and their other specialities to ensure they are receiving holistic patient-centred care and empower them take control of their health.

Clinical support:

I have been a support worker for over 20 years in various roles and have developed a wide variety of clinical skills. My clinical assessment skills and confidence in difficult venepuncture mean that I am confident to attend home visits independently with the guidance from the wider team. I have been trained to discuss adherence to antiretrovirals and check many of the elements of the annual health review which allows me to support at multiple outreach clinics.

P11

Service Evaluation: Regional Pre-Exposure Prophylaxis pilot service.

Clinical Lead Nurse Yvonne Wilson, Dr Say Quah, Dr Carol Emerson

Belfast Health & Social Care Trust, Belfast, United Kingdom

Abstract

Service evaluation: Regional PrEP pilot project.

Introduction: Pre-Exposure Prophylaxis (PrEP) has been proven as an effective method of Human Immunodeficiency Virus (HIV) prevention. A tablet taken pre-emptively either daily or event based by people who are HIV negative to reduce the risk of HIV acquisition. In 2018, the Regional HIV Commissioning Group agreed funding of a pilot PrEP service in the Regional Genitourinary Medicine (GUM) Clinic to deliver interventions to reduce unsafe sex and provide PrEP. This study evaluates the outcomes of this service.

Methods: A quantitative, retrospective review of electronic case notes of patients prescribed PrEP between July 2018 and March 2020.

Results: For the duration of the pilot, there were 639 new attendances and 1215 review appointments with some patients having six appointments in total during the project. In the first three months of service, all appointments were for new patients. There was an overall attendance rate of 82%, age ranged between 18 to 73 years, average age being 35 years old. Overall, 531 opted for daily dosing and 83 event based dosing at first visit but switched between depending on how sexually active they were. In those referred, five patients tested positive for HIV at their baseline blood test, sixty-six declined the offer of an appointment due to changes in their personal circumstances, one patient was deceased and thirty-three were unable to be contacted / did not reply.

A high number of sexually transmitted infections (STIs) diagnosed and treated. Health Advisors counselled 437 (76%) regarding their high-risk sexual behaviour, three referrals to clinical psychology for further counselling, and two declined the offer.

Other reported risk factors

Risk	Number (%)
Chemsex	108 (17%)
Sauna use	94 (15%)
Group sex	13 (2%)
Commercial Sex Work (Giving or receiving payment / gifts)	7 (1%)

Injecting Drug Use	1 (0.1%)
Use of dating Apps	376 (59%)

Conclusion: PrEP has an important part to play in the ongoing fight against HIV transmission. Service provided was effective in reaching large numbers of high-risk patients. Figures show a 12% reduction in the number of new diagnosis in Gay Bisexual Men the year after implementation of the service; unfortunately, COVID-19 had a negative impact on service provision, with a 2% increase the following year.

Since this evaluation, funding has been made recurrent and available for all GUM clinics to provide the service; this is essential for accessibility, equity of care and future prevention.

P12

Review of annual cervical screening rates post Covid-19 pandemic

Clinical Lead Nurse Y Wilson, Sr C Johnson, SN F Perry

Belfast Health & Social Care Trust, Belfast, United Kingdom

Abstract

Introduction: The aim of this audit is to assess rates of annual cervical screening post Covid-19 pandemic. Cervical screening aims to detect and prevent cervical cancer from developing. British HIV Association guidelines recommend that women living with HIV (WLHIV) over the age of 25 up to 64 years old should have annual screening, locally this is performed mainly by the General practitioner.

Background: Regionally, approximately 83 women are diagnosed with cervical cancer, and around 21 die from the disease each year. Early detection and treatment can prevent eight out ten cases of this cancer. WLHIV are considered more likely to have HPV 16 or 18 and at higher risk of Cervical Intra-epithelial Neoplasia (CIN) than the general population. Many Gp services had suspension to cervical screening due to the COVID-19 pandemic, while screening has now resumed there remains quite a backlog of cases. Unfortunately, this may result in a high number of advanced disease diagnoses in the coming months.

Method: Up to the end of 2022, there were 337 women attending our service for HIV care, 272 of these were aged 25 – 64 years old. Data was collected by carrying out a retrospective case note review of the clinic charts and Gp Electronic Care Records of 60 women in this age bracket.

Results: Time since diagnosis ranged from five to thirty-two years, median twelve years. Ethnicity: White 29 (48.3%), African 27 (45%), Asian 2 (3.3%) and Other 2 (3.3%).

Further findings

Cervical cytology	timeframe	Number (%) N=60	Results of last screen	Number (%) N=60
Up to date		13 (21%)	Normal	45 (75%)
13 - 23 months overdue		20 (33.3%)	Borderline	9 (1.5%)
24 - 36 months overdue		13 (21.6%)	Mild	7 (11%)
37 - 60 months overdue		10 (16.6%)	CIN 3	1 (1.6%)
60+ months overdue		4 (6.6%)	Colposcopy referral	7 (11.6%)
CD4 count			HPV 16 or 18 present	3 (5%)
<350		1 (1.6%)		

351-499	6 (10%)		
500+	53 (88.3%)		

Conclusion: Prior to the Covid-19 pandemic approximately 33.3% of women were up to date with their cervical screening; this is now around 21.6%. This is a relatively quick and potentially lifesaving test. This audit suggest that high numbers of our patients are significantly overdue their annual screening. The clinic is due to introduce an annual health assessment clinic in the coming weeks; this will be an opportunity to send a reminder letter to the Gp in an effort to increase screening.

P13

Evaluation of a formula milk feeding project

HCSW Martine Madden, Clinical Lead Nurse Y Wilson, Social Worker R Hendron

Belfast Health & Social Care Trust, Belfast, United Kingdom

Abstract

Introduction: British HIV Association (BHIVA) guidelines continue to recommend exclusive formula milk feeding as the safest option for feeding infants born to women living with HIV. Women who are virologically suppressed; and choose to breastfeed are advised of the low on-going risk of transmission and are supported and closely monitored by clinic and community staff. Formula milk is expensive and this project was established to help support new mums, reduce risk of transmission and help reduce their financial burden.

Background: In 2019, the clinic set up a Formula Feeding Project to offer new mums free milk formula for the first six months following delivery. Funding was initially provided by a charity grant but has now been secured from the Trust. The project is based in the regional clinic but all antenatal screening coordinators are aware of the project, and identify and refer eligible expectant mums from across the North. The project can also offer assistance with sterilising equipment, bottles and baby clothes.

Method: Retrospective case note review of all WLHIV who have delivered a baby from 2019 to present day who have been referred to the project.

Results: Since 2019, 41 women and 45 babies have benefitted from this project; four of the women had more than one pregnancy. Data is available for 37 of the women. Age ranged from 19 to 43 years old with a median of 35 years old. Ethnicity: 14 white, 17 African, 2 Asian and 4 other ethnicity. Time since diagnosis ranged from antenatal booking in this pregnancy (4) to 24 years, one of the women was vertical transmission.

All of the women were on antiretroviral medication at delivery; thirty-six of the women were virally suppressed, one had a low-level viremia at time of delivery.

Conclusion: This project has been very successful in providing new mums with formula milk, it has also created more opportunities to engage and assess how they were managing postnatally. Feedback has been very positive reflecting the gratitude of the mums. With the current cost of living crisis, this is a valuable resource to those with no recourse to public funds, lone / unsupported mothers or families on low income. It is hoped that many more women and babies will benefit from this project in the future.

P14

Audit Monitoring Hepatitis B Co-Infected Individuals Against BHIVA Guidelines

Ms Nnenna Obi, Ms Margot Taylor, Ms Rebecca Wilkins

West Middlesex Hospital, part of Chelsea and Westminster NHS Trust, London, United Kingdom

Abstract

People living with HIV and chronic hepatitis B (PLWHIV/Hep B) have faster progression to cirrhosis and hepatocellular carcinoma (HCC).

BHIVA Hepatitis Guidelines recommend that people with co-infection should have baseline fibrosis screening, be on a tenofovir-based antiretroviral (ART) regimen, have hepatitis B DNA (HBV DNA) measurements every 3 - 6 months and have six-monthly hepatocellular carcinoma (HCC) monitoring (BHIVA, 2013). The guidelines talk of using alpha fetoprotein (AFP) blood tests as an HCC marker although gold-standard is liver ultrasound scan (LUSS).

We audited identified PLWHIV/Hep B against these recommendations.

Method

A retrospective audit of patient electronic records (EPR) from March 2020, when the present EPR system was introduced until 16th March 2023 looking for all patients who had had a hepatitis B DNA blood test. Once potential PLWHIV/Hep B were identified their notes were reviewed for

- HIV/Hep B co-infection
- Baseline fibrosis screen
- Date of last AFP
- Date of last LUSS
- Antiretroviral regime

Results

47 people were identified – 23 were HIV and Hepatitis B co-infected. (19 had HIV but no hepatitis B, 4 had hepatitis B but no HIV, 1 was treated at another clinic).

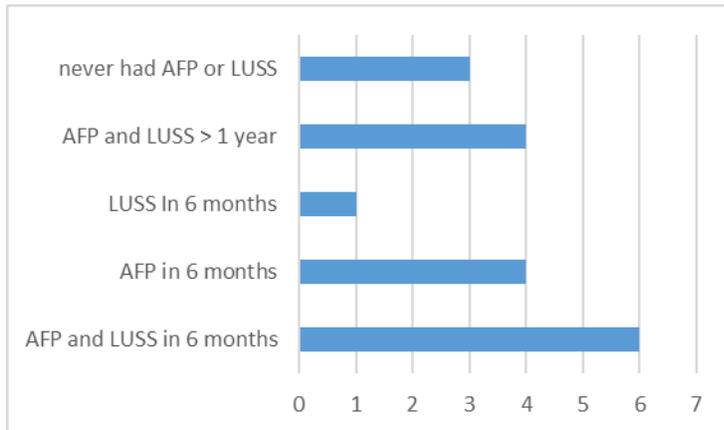
All patients were on a tenofovir-based antiretroviral regime.

Two of the 23 PLWHIV/hep B had a record of fibrosis screen in the new EPR, both were being seen by hepatology and this was recorded in their notes/correspondence. There was no record in the new EPR of fibrosis screening in the remaining 21 PLWHIV/hep B. It is not clear whether these had not been done or whether the information had been lost because of multiple forms of patient records and EPR systems over time.

Of the 23 identified PLWHIV/Hep B 6 (26%) had AFP and LUSS within the last 6 months.

3 patients had had neither LUSS or AFP since 2020 – 2 had understandable reasons for this absence, one

patient there was no clear reason why this had been missed. Some had had either AFP or LUSS within a year, 4 had had neither.



Discussion

There is a lack of clarity regarding adequate monitoring of PLWHIV/Hep B co-infection. BHIVA Hepatitis B guidelines are under review but, in the meantime, the clinic needs to come to an agreement of how we will ensure the liver health of this group is monitored.

It is worth considering completing a fibrosis screen on all PLWHIV/Hep B where this is not available.

P15

An audit of diversity in recruitment to clinical trials in a large HIV centre

Mr Tom Fernandez, Mr Tom Allan, Mr Jonathan Edwards, Ms Qayo Egeh, Ms Nargis Hemat, Dr Pedro Simoes, Ms Katie Spears

Royal Free, London, United Kingdom

Abstract

Background

Diversity is essential for research to be representative and the findings to be meaningful for a wider application. Literature highlights barriers to recruitment relating to language and communication, lack of invitation and trial design.

Aims

To explore how representative our recent recruitment into research studies has been, language barriers to recruitment and the diversity of our clinic team.

Methods

We undertook an audit of recruitment into research studies within the last 5 years; collecting data from our largest non-drug studies and our most recent drug studies. We matched these against the demographics of our total patient cohort of more than 3,000 patients with reference to age, gender and ethnicity. In addition, we audited the availability of Patient Information Sheets (PIS) in different languages and collated data on the language skills and ethnicity of our team.

Results

In two non-drug studies recruiting over 1,500 subjects, enrolment closely matched our clinic cohort ethnicity of 52% white, 32% black, 4% Asian and 9% mixed background. In these same studies, age and gender of subjects recruited closely matched our clinic cohort of 71% male, 29% female. However, data from drug studies showed a different picture. There was under-representation of black ethnicity (18% enrolled, 32% cohort) as well as women (14% enrolled, 29% cohort). The audit showed only 1/5 of PIS were available in languages other than English with sponsors citing different reasons for this. However, the clinic staff demographics illustrated a multiethnic workforce speaking a total of 18 different languages.

Discussion

This audit illustrated high levels of diversity in our recruitment to non-drug studies, aided by the research culture in the clinic and the staff diversity and language skills; factors identified as facilitating inclusion. However, under-representation in drug studies among black ethnicity and women warrant further exploration. Sponsor timelines may drive speedy recruitment leaving less time for inclusion of

people who need more time or investment to decide to take part. Sponsor inclusion criteria can make it difficult to include women of child bearing potential, people with complex co-morbidities and those finding the increased study attendance challenging; factors not uncommon in under-represented groups. Locally we are looking at some strategic changes to our approach to recruitment as well as ways to work with sponsors to make inclusion criteria and study schema more inclusive.

P16

Positive Voices 2022: methods and recruitment challenges

Dr J Sewell¹, Dr F Lampe¹, Dr M Kall², Dr V Martin², Dr A Aghaizu², Mrs C Kelly², Ms A Farah², Dr A Brown², Professor Alison Rodger¹

¹UCL, London, United Kingdom. ²UKHSA, London, United Kingdom

Abstract

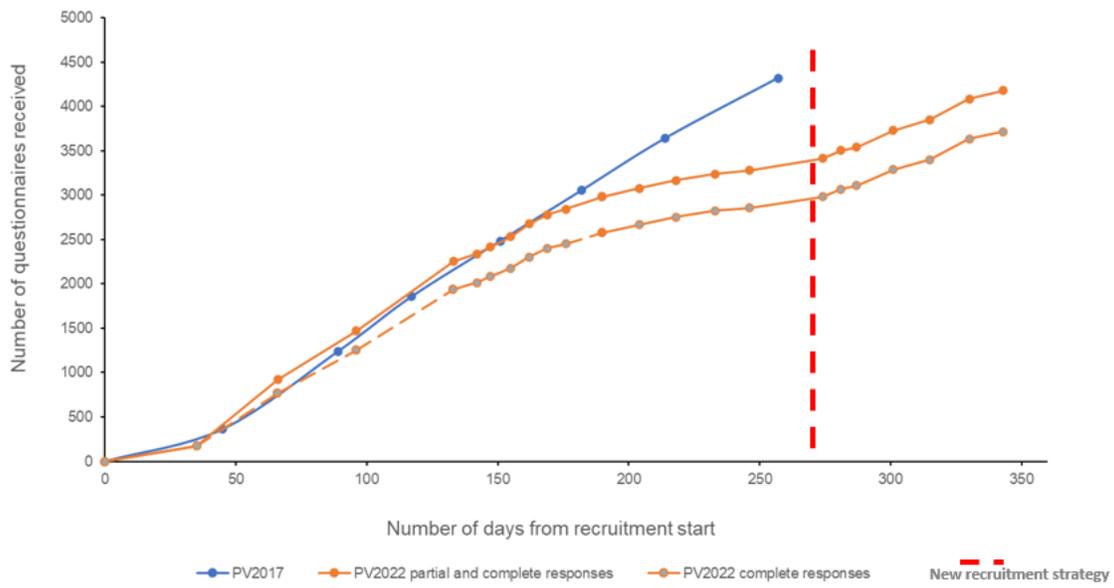
Background: The Positive Voices 2017 survey was the first UK nationally representative survey of people living with HIV (PLHIV). One in 20 people diagnosed with HIV in England and Wales were sampled and key findings demonstrated a high burden of poor mental health, other long-term conditions, and wider social and economic issues for PLHIV. A new round of the Positive Voices survey took place between April 2022 and March 2023.

Methods: The Positive Voices 2022 survey is a cross-sectional questionnaire study that recruited people living with HIV from 102 HIV clinics in England, Wales, and Scotland. A probabilistic sampling strategy was used to select a sample of PLHIV to complete either an online or paper questionnaire given out at each clinic. The questionnaires collected data on sociodemographic factors, HIV diagnosis and treatment, mental health and wellbeing, health service use and satisfaction, social care and support, needs, stigma, quality of life and the impact of COVID. For six NHS Trusts that were under-recruiting after six months of active recruitment, a sequential recruitment strategy was implemented to support them in achieving recruitment targets.

Results: By the end of March 2023, 3716 questionnaires were collected, of which 499 had been recruited through the new sequential recruitment strategy. In-person recruitment was the most frequent mode of recruitment (490 (49%)), followed by phone (723 (24%)), text message (552 (18%)), email (180 (6%)), and post (58 (2%)). Most respondents were men (2754 (74%)) and of white ethnicity (2422 (65%)), 22% (807) were of black African ethnicity. Responses increased after the switch to sequential recruitment (Figure 1), specifically in those 6 NHS trusts that implemented the change.

Conclusions: Despite logistical challenges to recruitment, the Positive Voices 2022 survey recruited a large sample of PLHIV from across clinics in the UK. The results of this survey will help to determine the impact of the COVID pandemic and associated changes to healthcare service provision on the health and wellbeing of PLHIV.

Figure 1: Number of questionnaires completed by days since the start of PV2022



P17

Real world experience of long acting injectable antiretroviral medication

Clinical Lead Nurse Yvonne Wilson, Dr Carol Emerson, Dr Leah McVeigh, Specialist Pharmacist Karen McMullan, Specialist Pharmacist Catherine Munn

Belfast Health & Social Care Trust, Belfast, United Kingdom

Abstract

Introduction: The FLAIR and ATLAS studies have demonstrated that long acting Cabotegravir and Rilpivirine (LA-CAB/RPV) injections administered two monthly is comparable with daily treatment and provides an alternative option for some patients. Following reopening of face to face services post Covid-19 pandemic, this treatment option available to our cohort of patients. This observational study is comprised of data collated within this group.

Methods: Eligibility for LAI was determined based on criteria as per BHIVA guidelines. Patients were referred by clinician or nurse specialist for further assessment regarding suitability and commitment to dosing schedule.

Results: At time of submission, 20 patients have been referred for consideration of LAI and 13 of these have accepted to switch. Two (15.3%) patients discontinued oral lead in medication (OLI) due to side effects. Both had previously been exposed to Rilpivirine. Two (15.3%) remain on OLI at present and 9 (69%) have commenced LAI. There have been no reported side effects or injection site reactions following commencement of injections. Eight (89%) patients who commenced LAI treatment maintained an undetectable HIV viral load (VL). One (11%) had a VL of 90 after second injection. This patient is subtype A (O1_AE) and with borderline BMI. Reasons for switching include tablet fatigue, frequent travellers / cabin crew / anxiety around others finding their tablets and dysphagia following tongue cancer.

Discussion: In our region, all patients are required to complete 28 days of OLI to identify potential side effects prior to LAI. While this is optional in the guidelines, given the high rate of side effects we feel this is best practice. The uptake from patients in our region has been encouraging. LAI treatment has been a highly anticipated option and patients feel it reduces stigma, other patients have registered interest should the interval dosing be extended or injections become self-administered in the future.

P18

The impact of the Wellness Thermometer tool in improving consultations for People living with HIV and Healthcare professionals.

Mrs Laura Hilton¹, Ms Deborah McCluskey¹, Mrs Susie Gyampo², Ms Kathryn Carroll², Ms Nicola Galbraith², Mr Joel Paparello²

¹Mid & South Essex NHS Foundation Trust, Southend, United Kingdom. ²Gilead Sciences, London, United Kingdom

Abstract

Background

With longer life expectancy among people living with HIV, health-related quality of life (HRQoL) is increasingly important.¹ HRQoL is mentioned in the UK Government's Zero Transmissions paper,² and a fourth '90'³ – to ensure that 90% of people with viral load suppression have good HRQoL – has been proposed.¹ We wanted to find a tool to help attendees at our predominantly nurse-led HIV service identify issues beyond viral load to discuss during consultations. The Wellness Thermometer, a user-friendly tool for healthcare professionals (HCPs) to monitor physical, psychological and social wellbeing of people living with HIV, has been shown to be beneficial.⁴ We piloted the tool in our HIV service, that supports 1,200 people across three locations.

Methods

We aimed to evaluate the experience of using the Wellness Thermometer, its effectiveness, and whether it added value and improved conversations in consultations. All attendees at our clinic over 1 month (n=79) were asked to complete the tool following a brief explanation. Anything noted was discussed in consultations. Attendees completed a survey about their views of the tool and its use in clinic.

Results

The Wellness Thermometer helped our attendees identify issues for discussion during consultations: 78% found the tool useful, 90% found it easy to understand, 56% noted something to discuss, 72% reported ≥ 1 physical symptom (23% reported ≥ 4 physical symptoms), 41% identified ≥ 1 emotional problem (6% reported ≥ 4 emotional problems), and 66% found the tool helpful to discuss issues in clinic. Most already felt comfortable discussing issues as they arose, but the tool encouraged them and those who do not usually open up to discuss more. However, some consultations overran because the tool prompted additional discussions and an extra HCP was needed to explain the tool. Using the tool was difficult when other research projects, audits or individual satisfaction questionnaires were being tested.

Conclusion

The Wellness Thermometer helped support identification of physical and psychological issues for discussion during consultations. Found to be effective the tool is planned to be embedded as part of the annual health review during this year.

References

1. Lazarus JV, Safree-Harmon K, Barton SE, et al. BMC Med 2016;14:94.
2. DHSC. Towards zero – an action plan towards ending HIV transmission, AIDS and HIV-related deaths in England – 2022 to 2025. <https://www.gov.uk/government/publications/towards-zero-the-hiv-action-plan-for-england-2022-to-2025/towards-zero-an-action-plan-towards-ending-hiv-transmission-aids-and-hiv-related-deaths-in-england-2022-to-2025>
3. UNAIDS. 90-90-90: an ambitious treatment target to help end the AIDS epidemic. 2014. <https://www.unaids.org/en/resources/909090>
4. Croston M, Petrak J, Ustianowski A. Nurs Stand 2017;31:46–53.

P19

Psychological wellbeing and sleep in human immunodeficiency virus (HIV)- a retrospective analysis of assessment and interventions within HIV services in the UK and Ireland (UKI). Final report.

Alice Brown, Kathryn Carroll, Susie Gyampo, Joel Papparello, [Nicola Galbraith](#)

Gilead Sciences, London, United Kingdom

Abstract

Background: People living with HIV are disproportionately affected by psychological wellbeing and sleep issues which can detrimentally impact their quality of life, adherence and health outcomes.

Despite monitoring and assessment being imperative to improve long-term health; evidence indicates a variation in incidence of this and absence in guidance for sleep issues.

To support generation of evidence in this field, a market research study was designed to gain insights into current interventions for psychological wellbeing and sleep assessment within HIV services in UKI.

Materials and Methods: The study was managed by a market research agency where an online survey link was disseminated to healthcare professionals (HCPs) in multiple HIV centres across UKI.

To ensure accuracy of data, HCPs randomly selected a maximum 20 patient notes reviewed between 2020 to 2022. No identifiable patient information was recorded or shared with resulting data presented at an aggregate level.

Results: 39 clinics participated contributing 665 patient notes with demographics reflective of UKI population.

Since Covid- 19 77% of HCPs perceived an increasing demand for mental health support with 64% stating they routinely assess mental health; however, the majority express issues with capacity and resourcing to sufficiently support these patients.

33% of patients included were identified as experiencing a decline in psychological wellbeing, the majority of which self-reported during face to face (F2F) routine appointments; 14% of these patients had a PHQ9. 78% received support with the majority signposted to external resources. For those who did not receive support, the primary driver was patient request.

46% of services state they do not routinely assess for sleep issues. A lower proportion of patients (17%) were identified as having such issues; however, of those identified the primary method was self-reporting during F2F routine appointments. 6% of these patients had a PSQI. Of those who did not receive sleep support, a lack of guidance was the main cited reason.

Conclusions: This study indicates high variation between local management of psychological wellbeing and sleep in HIV, in addition to key gaps in clinical guidance, identifying, managing and ongoing monitoring which is required to ensure long term health.

P20

Implementation of annual health review: case study

Miss Jodanna Thomas¹, Mrs Vincentia Akoto², Ms Adeola Stephens³, Ms Comfort Agyei¹, Ms Pearl Ahadzi³, Ms Grace Odonkor¹, Ms Marcia Barnaby¹, Ms Rosemary Burr ridge¹, Mr Lugard Ohen¹

¹Guy's and St. Thomas' NHS Trust, London, United Kingdom. ²Guys and St Thomas Hospital NHS Foundation Trust, London, United Kingdom. ³Guy's and St. Thomas', London, United Kingdom

Abstract

Our HIV Clinical Nurse Specialist Team (CNS) provides clinical support for patients in the community with complex care needs, encouraging adherence to medication regimens, maintaining patient engagement and retention in care, and reducing hospital admissions.

Due to the advances in HIV care, life expectancy for people living with HIV is equal to the general population. As a result, there is an increase in comorbidities and age-related diseases.

In our presentation; we will explore how the introduction of the annual health review, in the community setting, supports the CNS in managing the comorbidities of the over 50's.

The annual health review provided a framework to identify clinical needs and allowed the opportunity to involve other relevant healthcare professionals in delivering a holistic HIV care.

UKHSA (2022) state that approximately 48% of individuals accessing HIV care are over 50; however, around 70% of our caseload are individuals from this age group.

Since the introduction of the annual health review, in our community setting, all of our patients receive an annual health assessment as a standard of care.

This case study will highlight the work of the CNS team in addressing the health needs of Vanessa (pseudonym assigned), a 60-year-old female of African descent. Vanessa was referred to the team by her hospital consultant for ongoing clinical support. An initial assessment, utilising the annual health review, was carried out to identify the patient's health needs.

Initial findings:

- Adherence issues - due to cognitive impairment
- Alcohol misuse - impacting her frailty, memory, dietary intake
- Emotional health PTSD - depression, previous domestic violence and trauma
- Social health needs - hoarding behaviours
- Bone health concerns - bilateral avascular necrosis, osteoarthritis
- Renal impairment - CKD stage 3
- Frailty - history of falls
- Cardiovascular problems - Type 2 diabetes, hypertension

The above information will be explored in more detail in our presentation.

We will focus on how the CNS managed Vanessa's clinical issues with the use of the annual health review.

In conclusion, the annual health review was beneficial in identifying health needs and enabling the CNS to meet identified health requirements. It proved a useful tool and provided a framework to guide clinical practice and allow the team to focus on our patients, holistically. This included working collaboratively with other disciplines within the MDT team to ensure that care was individualised, patient-centred and provided positive patient outcomes.

P21

Annual health review in the HIV community setting

Mr Lugard Ohen¹, Ms Rosemary Burridge², Ms Adeola Stephens³, Ms Vincentia Akoto⁴, Ms Comfort Agyei⁵, Ms Pearl Ahadzi², Ms Marcia Barnaby², Miss Jodanna Thomas², Ms Grace Odonkor²

¹Guy's and St. Thomas' Trust, London, United Kingdom. ²Guy's and St. Thomas' NHS Trust, London, United Kingdom. ³Guy's and St. Thomas' NHS trust, London, United Kingdom. ⁴Guy's and St. Thomas' NHS, London, United Kingdom. ⁵Guy's & St. Thomas', London, United Kingdom

Abstract

Background

We are a HIV community team.

UKHSA (2022)¹ states that 48 % of individuals accessing HIV care are currently over the age of 50, in the UK. In recent years, the number of individuals accessing HIV care has decreased in all age groups with the exception of the over 50's. Although, the number of individuals living and accessing HIV care in our area have decreased from 8429(2017) to 8109 (2020); it still remains the region with the highest prevalence. Following a review of our caseload in 2019, in 2020 we launched a pilot of our Annual Health Review. The objective of this project is a follow on from our 2020 annual health review pilot project, and will focus on our over 50's cohort and their level of care delivered.

Method

In accordance with BHIVA Standards of Care², our clinical nurse specialist assessment form includes a more holistic assessment with the addition of bone, renal, cardiovascular, frailty and mental health screening tools. Our total cohort consists of 237 PLWHIV aged over 50; of these 50 (21%) were randomly selected for an in-depth analysis of the annual health review (see table 1 for breakdown of comorbidity profile). Data was obtained from patients seen between January 2022 to January 2023. Data was collected on an Excel spreadsheet and analysed using SPSS.

Results

Our sample consisted of n=50, with a median age of 62 [50-94], 62% were male and 57% were from a black ethnic background. We found that 70% of our cohort are over 50, which is 22% above the national average¹. After analysis, we found that there was an average of 3 comorbidities per person with 84% requiring level 3 care.

Analysis shows (n=50):

- 82% frailty issues
- 78% adherence issues
- 66% mental health issues
- 64% social health issues

- 60% cardiovascular issues with an average QRisk of 17.4 (69% had a QRisk >10)
- 54% bone health issues
- 30% men’s health assessment
- 24% women’s health assessment
- 26% smoking
- 22% alcohol

Table 1:

Table 1 - Comorbidities Profile		
Co-Morbidity	No patients	%
Brain Impairment	122	51
Cancer	24	10
Diabetes	60	25
Frailty	21	9
Heart Disease	52	22
Hypertension	105	44
Mental Health	73	31
Renal Impairment	27	11
Respiratory Disease	67	28
Smoking	16	7
	Totals	239

Conclusion

We recognise that we have an aging HIV population with complex needs and comorbidities. The annual health review is a useful tool, enabling us to deliver the same standard of care as in the acute setting.

Implications for Clinical Practice

We recognise that we have an aging cohort therefore, CNS’s must be competent in managing individuals with comorbidities in addition to their HIV needs.

P22

"Come back, come back.... wherever you are"

Ms Laura Wilson-Powell

MPFT, Stafford, United Kingdom

Abstract

Authors: Wilson-Powell, L (Poster).; Lightfoot, S.; and Dr Adams, R

Affiliations: Midlands Partnership NHS Foundation Trust

Purpose: Long-term regular follow up of ART is an important component of HIV care. Patients who are lost to follow-up (LTFU) while on treatment compromise their own health and the long-term success of ART.

Having lost touch with 80 individuals over a 2 year period, we wanted to know the reasons why they may have disengaged in their care, whether the changes in clinic due to the Covid pandemic had contributed to this and how to enable them to re-engage both for their own care and for that of other similar individuals going forward.

Methods: 80 individual's notes were reviewed using the electronic noting system. 30 individuals were identified as lost to care. Demographic data was collected and attempts were made to contact these patients as well as qualitative data about their reasons for disengagement and barriers to re engagement. For those who re-engaged we looked at whether they continued to stay in care and the impact of their disengagement on their CD4/VL and general health.

Results: Of the 30 patients lost to care 10 were successfully re engaged. 3 of these required Septrin due to drop in CD4 <200.

2 were in the care of HMP service

18 failed to answer or reply to SMS or voicemails left. The process is currently ongoing with attempting contact via GPs.

Reasons given for disengagement include:

- Difficulty getting through to service.
- Travel abroad
- 2 stated Post Covid related reasons
- Patients still had ARV's in possession
- Concerns about stigma and confidentiality.
- Had personal reasons and would not divulge.

Out of the 10 that successfully reengaged in care 4 Female, 6 Male. 4 white British and 6 Black African individuals.

Conclusions: Broadly speaking the reasons for disengagement fell into two categories- Personal and clinic related issues. Whilst we have limitations on patient's personal situations, we must ensure the clinic is accessible to all. Unfortunately, we must accept that whatever we do, there will still be some individuals who are lost to care.

In order to standardise practice across all sites we have implemented an SMS that is sent on the day that an individual fails to attend. This will hopefully reduce some lost to follow up's but it will be monitored to see if this is effective. We may also utilise email in the future.

P23

Annual Health Review – A Service Evaluation

Miss Maria Marabi Nkwe, Miss Phumuzile Dube, Miss Maria Mateyisi, Mr Benedict Lutaya, Miss Rushika Patel

Newham Barts Health NHS Trust, London, United Kingdom

Abstract

Background:

Due to the advances of HIV care, people living with HIV live longer. As a consequence, they are more likely to develop comorbidities. Assessments should be carried out as per BHIVA Standard of care recommendations in order to monitor co-morbidities which could affect clinical decision making. The objective of our service evaluation is to measure our current practice against the BHIVA standard of care 20181.

Methods:

Patient case notes were reviewed for several parameters which mark the presence of co-morbidities. The results were assessed against the BHIVA standard of care 2018 which outline the framework for identifying risk of co-morbidities 1. This includes their mental health, cardiovascular risk, adherence, FRAX and Frailty assessments. The data was retrospectively collected over a period of January 2020 to January 2023. Our total cohort includes 50 randomly selected patients age 40 and above. Data was collected and analysed using excel.

Results:

Our sample selection consisted of N=50 with an average age of 56, this consisted of 52% of females. The majority 74% were from Black ethnicity background.

Our analysis shows that:

- 86% of the patients adherence was assessed
- 66% had mental health assessment, a formal mental health assessment was not found on some of the case note review; though an informal assessment was always carried out
- 60% Cardiovascular assessment were performed, however only 10 patients had QRISK score recorded
- 51% had a bone assessment done which includes FRAX / Frailty

Conclusion

Our service evaluation highlights that patient's record documentation requires improvement to ensure that all assessments are recorded in real time. While cardiovascular risk and bone health have a standardized approach of assessment and documentation, further structure and guidance is required to

assess mental health, adherence, and frailty as various tools can be used to provide this assessment. It would be beneficial to scope out tools used frequently nationally and consolidate this in the form of guidance.

In order to provide such assessment through a structured approach, healthcare professionals need to be competently equipped. Supplementary mental health, cardiovascular, and bone health clinical education should be introduced within clinics to improve confidence and accuracy in undertaking annual health assessments.

Implications for clinical Practice

An introduction of Cardiovascular, FRAX, and Frailty assessment in the existing assessment proforma will ensure that all patients have a complete annual review regardless of which clinician/healthcare professional the patient is seen by.

Reference

1.- BHIVA standards of care 2018

P24

Introduction of HIV Triage nurse and management of telephone calls to improve patient care outcomes and experience in a HIV outpatient clinic

Mr Moses Shongwe, Mr John Howson, Ms Berna Mpungu

Barts Health NHS Trust, London, United Kingdom

Abstract

Background

Triage is a process of prioritization or assessment of patients in terms of their condition and ensure that no harmful delays occur on advice to treatment and support in care. The aim of introducing HIV triage nurse role by the service is to identifying patients who require urgent or rapid clinical review, give advice to limit deterioration until appropriate treatment available, provide advice to other healthcare professionals in a timely manner and finally reduce unnecessary footfall into the clinic, accident and emergency.

Methodology

The service received 844 answered calls from patients and other healthcare professionals over 92 days. The nurse was allocated a room and answer phone was set up to support the role.

Results

A total of 844 calls (n=757) from our patients and 87 from others see Table 1 of demographics. The common reasons for the calls are: prescriptions (21.2%), appointments (20.6%), concerns about medications (11.6%), blood results (10.7%), general advice (10.7%), Immunology (8.8%), unwell (8.8%), another healthcare professionals (3.7%), sexual health (2.5%), transfer of care (0.9%), and mental health concerns (0.6%), and research related enquiry (0.5%). Also, 40 people called with more than one reason.

The triage calls outcomes were as follows; reassured (73%), appointment for bloods booked (9.2%), booked in the emergency clinic (4.2%), referred to pharmacy (3.8%), referred to research team (3.3%), appointment booked for medical review (2.5%), advised to make GP appointment (0.6%), advised to attend ED (0.7%), advised to call 111 and virtual review booked (0.4%) and wrong department (1.2%). Most of the calls (82.1%) were managed by the triage nurse and some by the nurse in charge (3.3%). The mean is 7 minutes per call.

Table 1: Demographics (n = 757)	
Mean age: 49 (20 - 92) years old	
Gender (n = 757)	
• Male:	505 (67%)
• Female:	252 (33%)
Ethnicity (n = 757)	
• White UK/ Irish/other:	371 (49%)
• Mixed/ Other Ethnic Group:	34 (4%)
• Black:	287 (38%)
• Asian:	65 (9%)
NB: Other calls: Healthcare professionals, patient transferring care in and sexual health related: n = 87	

Limitation

Not all calls were answered and no headroom for annual leave cover as this was a new role introduced. Answer phone speakers not good and hard to hear sometimes messages. Patient who did not speak English would not understand the message on the phone to follow instructions. Training and competency framework not ready.

Conclusion

Successful triage will consistently recognise emergency and potential emergencies ensuring an immediate interventions are arranged. In order to encourage self-management patients are required to know about their condition and who to contact when needed.

Implication to clinical practice

To encourage development of triage competencies and a team development with educational program that ensure we have a team with appropriate skills.

P25

Are we meeting the needs of people living with HIV? An introduction of the wellness thermometer in the HIV/HCV co-infection clinic

Mr Moses Shongwe

Barts Health NHS Trust, London, United Kingdom

Abstract

Background

United Kingdom outpatient attendees perceived care does not address the issue of emerging physical, psychological and social wellbeing that is important to them. The aim is to introduce the wellness thermometer to address current emerging physical, psychological, social and spiritual concerns of people living with HIV and hepatitis C (HCV) co-Infection to improve their outcomes in our clinic.

Methodology

Wellness thermometer was introduced in the HIV/HCV co-infection clinic and used by 23 patients attending HIV/HCV clinic over 4 weeks. All patients completed the wellness thermometer questionnaire before the appointment and a feedback survey post appointment to measure how useful the tool was for medical consultation. Data was collected and analysed using excel.

Results

23 patients (demographics data Table 1) were on antiretroviral therapy with an undetectable HIV viral load.

The mean score is 7 (4-10) on the overall scale of how well they felt in the past 1-2 weeks on a scale of 1 - 10. The analysis also shows that: 21.7% feeling unwell (1-5 score), 30% feeling okay (6-7 score) and 48.3% feeling well.

When we asked, is there anything that affects your wellbeing, patients reported an average of 5 (1-11) health concerns discussed during the co-infection clinic consultations. These include: feeling tired (47.8%), drugs and alcohol use (39.1%), feeling worried (34.8%), weakness (30.4%), nervousness and personal relationships respectively (26.1%), with only 26.1% of patients having someone to talk to. Having the free text comment box on the tool was useful for some patients to add any other concerns not listed.

All patients strongly agree that the use of wellness thermometer tool is helpful to identify personal concerns that they can discuss with the clinician.

Table 1: Demographics (n = 23)

Mean age: 40 (26 - 55) years old

Gender (n = 23)

- Male: 21 (91.3%)
- Female: 2 (8.7%)

Ethnicity (n = 23)

- White: 16 (69.6%)
- Mixed: 4 (17.4%)
- Black: 2 (8.7%)
- Asian: 1 (4.3%)

Limitations

- Only available in English, excluding non-English speaking patients.
- Time and resources can be a preventative factor in wider service implementation.
- The timing of questionnaire administration.
- Follow-up with patients to see if all concerns were addressed and referred accordingly.

Conclusion and Implication

The use of the wellness thermometer tool is to enhance communication between patients and clinicians. It also supports the monitoring of patient's wellbeing and quality of life issues which can potentially impact on adherence to therapy leading to poorer outcomes and HIV transmission. Additionally it will enable patient to determine their priorities in order to help to facilitate person centred care and by encouraging referrals for additional support.

P26

Measuring what matters: How do we assess sleep in HIV Care?

Michelle Croston¹, Kathryn Bourne², Emily Hurt³, Nicola Galbraith⁴, Mark Hayter³

¹University of Nottingham, Nottingham, United Kingdom. ²Greater Manchester Mental Health NHS Foundation Trust, Manchester, United Kingdom. ³Manchester Metropolitan University, Manchester, United Kingdom. ⁴Gilead Sciences, HIV Standards Support Team, London, United Kingdom

Abstract

Background

Despite medical advances, people living with HIV experience significant issues affecting health-related quality of life; one such issue is sleep. Although poor sleep quality is common in this population, there remains a lack of understanding of how to identify sleep issues within clinical practice to improve outcomes for people living with HIV.

Materials and Methods

A scoping review was conducted searching Cinahl, Pubmed, Psycinfo and the grey literature. Inclusion and exclusion criteria were developed with data selection and charting undertaken by two reviewers using a qualitative content approach.

Results

Out of 2932 retrieved articles 60 met the inclusion criteria. Publication dates ranged from 1992 to 2021, a third of papers were published in 2020 and 2021 (n = 17). Over half the studies were conducted in the US (n = 35), and the majority were cross-sectional in design (n = 48). Across all studies there were 25,904 participants, of which 21,561 were people living with HIV. The following themes were identified when exploring how sleep was measured; range of methods available to assess, self-reported and objective.

The review found a number of different measures of sleep used, with the most favoured approach being the PSQI (N=48). Due to the variety of approaches used (n=18) there was a lack of consistency to what aspects of sleep were being explored, and in many cases why the measure was chosen.

Conclusions

Clinicians need more awareness of the different types of sleep difficulties and disorders there are, consider the aspect of sleep they are concerned about and choose a suitable assessment tool or tools. Future research should explore the effectiveness of different methods of assessing sleep to establish the best way to monitor sleep within clinical practice.

The results help healthcare professionals consider the multivariant nature of sleep to identify appropriate measures of sleep to be explored further, including potential alternatives to the PSQI such as the SATED questionnaire or a single question approach.

Despite all 60 studies highlighting sleep issues there was a lack of meaningful clinical recommendations on how findings could be used to improve outcomes for people living with HIV.

P27

Implementing menstruation and menopause assessment into the HIV nursing assessment for people living with HIV.

Miss Lena Paul¹, professor Yvonne Gilleece²

¹University Hospital Sussex, Brighton, United Kingdom. ²University Hospitals Sussex, Brighton, United Kingdom

Abstract

Introduction

Menstruation and menopause assessment are clearly defined in the BHIVA guidelines; however, little guidance is given to how these assessments are delivered locally.

This project was undertaken to support HIV nurses to better assess and understand women's health needs, including menstruation and menopause assessments and calculate Menopause Rating Scale (MRS) scores during an Annual health check.

Method

A survey was emailed to all HIV nursing staff, to assess knowledge and attitudes regarding menstruation and menopause to establish baseline knowledge and ability to discuss these topics and also current practice with a view to informing training needs. There were 9 questions ranging from patient scenarios to direct questions about knowledge and practice. Answers for scenarios and knowledge could be (Yes, no or maybe). Assessing and for practice focused on frequency of assessment (always, usually, sometimes, rarely).

Results

The survey was sent to 8 nurses & with 7 responses giving a response rate of 88%.

Only 1/7 nurse always discussed menopause, 2/7 'sometimes' and 3/7 responded that they 'rarely' discussed it. Discussion about periods was similar with 1/7 responding 'always', 2/7 "usually", 2/7 'sometimes' and 2/7 answered 'rarely'. When asked if they knew what to do when assessing and investigating amenorrhoea in a 35yr old cis women, 2/7 nurses answered "yes", 1/7 "no" and 4/7 "partially".

Discussion

The small single centre survey demonstrated that the HIV nursing team did not routinely discuss menstruation and menopause with women attending our clinic and knowledge was only partial in most nurses. This may lead to missed opportunities for signposting, health promotion and psychological support for women in preparation for and during this natural stage of ageing. Focused nursing education is vital in order to empower nurses to become more knowledge confident in having these discussions and is on-going in our department.