Final Programme

15th Annual Conference of the National HIV Nurses Association (NHIVNA)

27–28 June 2013
The ICC Birmingham

preceded by
NHIVNA Pre-Conference Study Day
Wednesday 26 June 2013
Sponsored by
Important considerations before prescribing STRIBILD®

- Patients who have previously discontinued treatment with TDF due to renal toxicity should not be treated with STRIBILD.
- Patients should have creatinine clearance calculated and urine glucose and urine protein determined prior to initiating STRIBILD therapy.
- STRIBILD should not be initiated in patients with creatinine clearance below 70 mL/min.
- Creatinine clearance, serum phosphate, urine glucose, and urine protein should be monitored every 4 weeks during the first year and then every 3 months.
- Concomitant use of a proton pump inhibitor (PPI) or a potassium-sparing diuretic may increase serum creatinine and cause modest increases in serum creatinine and blood urea nitrogen (BUN) concentrations. Patients should be carefully monitored for increased creatinine clearance. Patients with a history of chronic kidney disease may experience a decreased risk of renal adverse reactions with the TDF component in STRIBILD.
- Patients with chronic HIV or CD4 T-cell counts below 200 cells/mm³ are at an increased risk for adverse reactions with the TDF component in STRIBILD.
- Patients with chronic kidney disease may be at an increased risk for severe and potentially fatal hepatic adverse reactions.
- STRIBILD should not be administered concomitantly with other medications containing tenofovir disoproxil (as fumarate) or efavirenz or voriconazole.
- Discontinuation of STRIBILD therapy in patients with HIV and HBV may be associated with severe acute exacerbations of hepatitis B, leading to death. Treatment discontinuation should occur under close monitoring with both clinical and laboratory follow-up for at least 7 months after stopping treatment. If appropriate, discontinue treatment with STRIBILD if severe acute hepatitis B exacerbation occurs.
- Please refer to the relevant treatment guidelines and product information for the optimal management of co-infected patients.

Powerful performance in HIV¹–³

The first STR with an Integrase Inhibitor to combine high performance efficacy, tolerability, and dosing convenience with a guidelines-preferred Truvada backbone¹–⁶

Non-inferior virological suppression and tolerability in phase 3 clinical studies¹²

Indication: STRIBILD is indicated for the treatment of human immunodeficiency virus-1 (HIV-1) infection in adults aged 18 years and over who are antiretroviral-naive or who are antiretroviral treatment-naive or are infected with HIV-1 without known mutations associated with resistance to any of the three antiretroviral agents in STRIBILD.

As shown in these phase 3 clinical studies:

- Highly effective – robust and durable virologic response comparable to two guidelines-preferred regimens¹–⁶
  - 83% of subjects taking STRIBILD reached undetectable viral loads compared to 82% of subjects taking ATN+RTV + FTC/TDF at 96 weeks
  - 84% of subjects taking STRIBILD reached undetectable viral loads compared to 82% of subjects taking EFV/FTC/TDF at 96 weeks
- Generally well tolerated – as demonstrated by the low discontinuation rate <5% across both studies¹²
- Very convenient – one tablet once daily to assist adherence⁹

Abbreviations: ARV, antiretroviral; ATV, atazanavir; EFV, efavirenz; FTC, emtricitabine; HBV, hepatitis B; RTV, ritonavir; single-tablet regimen; TDF, tenofovir disoproxil fumarate.

Dear Colleague,

Welcome to the 15th Annual Conference of NHIVNA, which is being held at The ICC Birmingham. The Conference Centre is located on Broad Street, in the heart of Birmingham city centre. We have formally invited a Local Host to assist the NHIVNA Committee in preparing the logistical aspects of the conference and to bring a local flavour to the programme. Lorraine Lewis from Birmingham Heartlands Hospital has kindly accepted our invitation to fulfil this role.

NHIVNA would like to thank all our speakers who have agreed to present their work at the conference, and we are confident that their experience and expertise will benefit all who are in attendance.

We are excited that the Annual Conference programme in 2013 will be based around the recently launched Standards of Care for People Living with HIV. NHIVNA had a share in developing this important document in close collaboration with BHIVA, and we look forward to discussing how these standards will influence best practice in nursing care.

In addition, one of the highlights of the conference will be the presentation of the very latest research, education and clinical practice initiatives in HIV nursing during the oral presentation sessions. As in previous years, these will be presented as part of the main plenary sessions in 2013.

The NHIVNA AGM will be held prior to lunch on Friday and I encourage all members to attend this meeting as it provides a forum to present any points of view to the NHIVNA officers and members of the Executive Committee. In addition, it will provide us with an opportunity to update delegates of some of the exciting developments within NHIVNA over the past year.

The NHIVNA Conference Social Event will take place on the Thursday evening of the conference. This will be held at the Crowne Plaza, Birmingham City Centre. The evening will be less formal than previous years but, in true tradition, we anticipate an evening of good food, followed by after-dinner entertainment – including karaoke and dancing.

I hope that you enjoy the conference and find it of relevance to both your educational and your practical needs.

Best wishes,

Nathaniel Ault
Chair
Programme

Wednesday 26 June 2013

Registration open from 1300–1730

1300–1715
NHIVNA Pre-Conference Study Day
sponsored by Janssen
Hall 6
Identifying mental health issues in HIV

1300–1400
Lunch

1400–1415
Introduction
Nathaniel Ault
Chair, National HIV Nurses Association (NHIVNA)

1415–1515
Mental health issues in HIV-positive people
Lorraine Lewis
Birmingham Heartlands Hospital

1515–1535
Afternoon tea

1535–1620
Treating mental health problems in HIV-positive patients
Dr Anjum Tariq
New Cross Hospital, Wolverhampton

1620–1705
Providing patient-centred care: the impact on the nurse
Michelle Croston
North Manchester General Hospital

1705–1715
Evaluation and close
Nathaniel Ault
Barts Health NHS Trust, London
Thursday 27 June 2013

Registration open from 0815–1730

0900–0910
Welcome address from the Chair of NHIVNA
Nathaniel Ault
Barts Health NHS Trust, London

Welcome address from the Conference Subcommittee Chair and Local Host
Michelle Croston
North Manchester General Hospital
Lorraine Lewis
Birmingham Heartlands Hospital

0910–0940
The Robert Pratt Lecture
Chairs: Nathaniel Ault
Barts Health London NHS Trust, London
Lorraine Lewis
Birmingham Heartlands Hospital

Introduction to the Standards of Care for People Living with HIV
Professor Jane Anderson
Homerton University Hospital, London

0940–1040
NHIVNA Plenary Session 1
Chairs: Pauline Jelliman
Liverpool Community Health NHS Trust
Lorraine Lewis
Birmingham Heartlands Hospital

Standard: Information for public health surveillance, commissioning, audit and research

HIV in the UK: the story so far
Dr Alison Brown
Health Protection Agency, London

Standard: HIV testing and diagnosis

HIV testing in primary care: challenges and outcomes
Dr Richard Ma
The Village Practice, London

Panel discussion

1040–1100
Morning coffee
First-time attendees’ meeting at the NHIVNA stand
## Programme

### Thursday 27 June 2013

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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| 1100–1130 | NHIVNA Invited Lecture 1 | Chairs: Jane Bruton  
Chelsea and Westminster Hospital, London  
Kemoh Rogers  
Anglia Ruskin University, Essex  
**Standard:** Access to, and retention in, HIV treatment and care  
Lost to follow-up: identification of strategies to assist with patient engagement in service  
Emma MacFarlane  
Barking Community Hospital |
| 1130–1230 | NHIVNA Oral Abstracts Session 1  
Abstracts 1–4 | Chairs: Jane Bruton  
Chelsea and Westminster Hospital, London  
Kemoh Rogers  
Anglia Ruskin University, Essex  
1130–1145  
**Abstract O1** To test or not to test, that is the question  
Anele Waters, North Middlesex Hospital, London  
1145–1200  
**Abstract O2** Missed opportunities  
Sandra Chidzomba, Birmingham Heartlands Hospital  
1200–1215  
**Abstract O3** 'Virtually' satisfied: we've developed a virtual clinic service, but is it safe and does it meet the needs of patients?  
Maxine Owen, Birmingham Heartlands Hospital  
1215–1230  
**Abstract O4** Community HIV support: next steps?  
Anna Bamford, Sussex Community NHS Trust, Brighton |
| 1230–1300 | NHIVNA Invited Lecture 2 | Chairs: Jane Bruton  
Chelsea and Westminster Hospital, London  
Kemoh Rogers  
Anglia Ruskin University, Essex  
**Standard:** Provision of outpatient treatment and care for HIV and access to care for complex comorbidity  
Serving two masters – any willing provider  
Eileen Nixon  
Brighton & Sussex University Hospitals NHS Trust |
Thursday 27 June 2013

1300–1400
Lunch, exhibition and posters

1400–1440
NHIVNA Invited Lecture 3
supported by a bursary grant from MSD
Chairs: Michelle Croston
        North Manchester General Hospital
        Claire Gamble
        Birmingham Heartlands Hospital

Standard: Safe ARV prescribing:
Effective medicines management

The role of the nurse prescribing in a
resource-poor area
Keni Ramapepe
Médecins Sans Frontières, Lesotho

Panel discussion
Martin Jones
East Sussex Healthcare NHS Trust, Eastbourne

1440–1510
NHIVNA Invited Lecture 4
Chairs: Michelle Croston
        North Manchester General Hospital
        Claire Gamble
        Birmingham Heartlands Hospital

Standard: Inpatient care for people living with HIV

Complexities and challenges of providing inpatient
care in the era of ART
Linda Panton
Western General Hospital, Edinburgh

1510–1540
Janssen Invited Lecture
Chairs: Michelle Croston
        North Manchester General Hospital
        Claire Gamble
        Birmingham Heartlands Hospital

Commissioning and the impact on HIV nurses
Eileen Nixon
Brighton & Sussex University Hospital NHS Trust
Programme

**Thursday 27 June 2013**

1540–1600
Refreshments

**1600–1700**
NHIVNA Oral Abstracts Session 2
Abstracts 5–8

*Chairs:* Shaun Watson  
*Chelsea and Westminster Hospital, London*  
Juliet Bennett  
*Independent Nurse Specialist*

1600–1615
**Abstract O5** Development of an integrated care pathway (ICP) for HIV outpatient care in Scotland  
*Linda Panton, Western General Hospital, Edinburgh*

1615–1630
**Abstract O6** HIV Complex Case Audit  
*Robert Downes, Liverpool Community Health NHS Trust*

1630–1645
**Abstract O7** Operational barriers to the implementation of opt-out HIV testing in novel settings  
*Rachael Bath, Barts Health NHS Trust, London*

1645–1700
**Abstract O8** The experience of a recent diagnosis of HIV for men who have sex with men: an interpretative phenomenological analysis  
*John McLuskey, University of Nottingham*

1700–1730
NHIVNA Invited Lecture 5

*Chairs:* Shaun Watson  
*Chelsea and Westminster Hospital, London*  
Juliet Bennett  
*Independent Nurse Specialist*

**Top 10 highlights in 2012–13 and their impact on HIV nursing**

*Lorraine Lewis*
*Birmingham Heartlands Hospital*

*Maxine Owen*
*Birmingham Heartlands Hospital*
Thursday 27 June 2013

1745–1835
NHIVNA Workshop 1 (Hall 6)
(Drinks and nibbles will be provided)
(please see page 14 for further details)

Making sense of experiences: qualitative data collection and analysis within nursing research
Nathaniel Ault
Barts and the London NHS Trust
Michelle Croston
North Manchester General Hospital

From 2000
Conference Social Event
(please see page 14 for further details)
Crowne Plaza Birmingham City Centre
## Programme

### Friday 28 June 2013

Registration and exhibition open from 0745–1630

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<th>Time</th>
<th>Event</th>
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<tr>
<td>0800–0850</td>
<td>NHIVNA Workshop 2 (Hall 6)</td>
<td>(Pasties, tea and coffee will be provided) (please see page 14 for further details)</td>
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<tr>
<td></td>
<td><strong>Quantifying experiences: quantitative data collection and analysis within nursing research</strong></td>
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<td></td>
<td>Dr Hilary Curtis</td>
<td>Regordane Editorial and Design Services</td>
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<td>Michelle Croston</td>
<td>North Manchester General Hospital</td>
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<tr>
<td>0900–1000</td>
<td>NHIVNA Plenary Session 2</td>
<td>Chairs: Jayne Churchill, NHS Lothian, Edinburgh, Maxine Owen, Birmingham Heartlands Hospital</td>
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<td><strong>Standard: Psychological care</strong></td>
<td>Self-esteem building with vulnerable patients: the role of the nurse</td>
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<td>Ms Juliet Bennett</td>
<td>Independent Nurse Specialist</td>
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<td><strong>Standard: Sexual health and identification of contacts at risk of infection</strong></td>
<td>The impact of recreational drugs on sexual wellbeing</td>
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<td>David Stuart</td>
<td>Antidote Substance Use Services, London</td>
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<tr>
<td>1000–1100</td>
<td>NHIVNA Oral Abstracts Session 3</td>
<td>Abstracts 9–12</td>
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<td></td>
<td><strong>Chairs:</strong> Jayne Churchill, NHS Lothian, Edinburgh, Maxine Owen, Birmingham Heartlands Hospital</td>
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<td></td>
<td><strong>Abstract O9</strong> Evaluation of fitness for purpose in provision of an innovative, culturally sensitive, HIV counselling approach: an Interpretive Phenomenological Analysis (IPA)</td>
<td>Agatha Benyera-Mararike, Canterbury Christ Church University, Medway</td>
</tr>
</tbody>
</table>
Programme

Friday 28 June 2013

1015–1030
Abstract O10 Narratives of individuals and couples in relationships with one known HIV-positive partner (serodiscordant relationships)
Kemoh Rogers, Anglia Ruskin University, Essex

1030–1045
Abstract O11 What are you trying to say?: pilot study results
Michelle Croston, North Manchester General Hospital

1045–1100
Abstract O12 Masculinity, fatherhood and HIV: how has HIV impacted on experiences of fatherhood?
A Foucauldian Discourse Analysis
Sean Highton, University of East London

1100–1130
Morning coffee

1130–1245
NHIVNA Plenary Session 3
Chairs: Jane Bruton
Chelsea and Westminster Hospital, London
Angelina Namiba
Positively UK

Standard: Self-management
Health literacy: the role of patient empowerment and expert patient programmes in improving health outcomes for PLWHIV
Chris Sandford
Mortimer Market Centre, London

Standard: Participation of people with HIV in their care
No decision about me, without me: partnership working and ways to engage patients in services
Silvia Petretti
Positively UK

Why HIV policy matters
Dr Yusef Azad
National AIDS Trust

Panel discussion
Programme

Friday 28 June 2013

1245–1305
NHIVNA Annual General Meeting
(NHIVNA members only)

1245–1400
Lunch, exhibition and posters

1400–1430
European HIV Nurses Network (EHNN) Lecture
Chairs: Shaun Watson
Chelsea and Westminster Hospital, London
Sally Scott
Birmingham Heartlands Hospital
The role of nurses and stigma: a European perspective
Dr Ian Hodgson
Independent HIV Researcher and Advocate

1430–1530
NHIVNA Plenary Session 4
Chairs: Pauline Jelliman
Liverpool Community Health NHS Trust
Sally Scott
Birmingham Heartlands Hospital

Standard: Reproductive health
Decision-making and dilemma: the challenges of supporting discordant couples in practice
Dr Yvonne Gilleece
Royal Sussex County Hospital, Brighton

Standard: Competencies
NHIVNA activities and achievements
HIV nursing competencies
Jane Bruton
Chelsea and Westminster Hospital, London
TasP project and HIV Nursing journal
Juliet Bennett
Independent Nurse Specialist
NHIVNA e-learning initiative
Nathaniel Ault
Barts Health NHS Trust, London
1530–1615
The Fourth NHIVNA Debate
Is HIV a disability?

Chairs: Nathaniel Ault
Barts Health NHS Trust, London
Yvonne Vaughan-Gordon
Birmingham Heartlands Hospital

The motion:
This house believes that people living with HIV should not be considered disabled

For the motion:
Rebecca Mbewe  Positively UK

Against the motion:
Gordon Mundie  Independent Freelance
Trainer/Consultant

1615–1630
NHIVNA Awards Ceremony and Close by the
Chair of NHIVNA

Nathaniel Ault
Barts Health NHS Trust, London
Conference Information

The ICC Birmingham
Hall 11, Broad Street | Birmingham B1 2EA
Telephone: +44 (0)121 200 2000 | Facsimile: +44 (0)121 643 0388 | www.theicc.co.uk

Registration
The registration fee includes access to all conference sessions, the exhibition area, lunch and refreshments throughout the conference. In addition, all delegates who have reserved a ticket in advance and paid the necessary contribution are invited to the Conference Social Event on Thursday 27 June 2013 at Crowne Plaza, Birmingham City Centre.

Badges
Badges must be worn at all times to gain access to the conference facilities.

First-time attendees meeting
NHIVNA is inviting first-time attendees to meet members of the Executive Committee at the first refreshment break on Thursday 27 June at the NHIVNA stand. This will provide an opportunity for first-time attendees to engage with NHIVNA and network with others at conference.

NHIVNA workshops
NHIVNA are continuing the initiative of holding workshops on Thursday early evening and Friday morning, before sessions. Places are limited to the first 50 applicants. Please register only if you intend to come. If, subsequently, you realise you cannot attend, please let the Conference Organiser know at your earliest convenience. Each workshop will have refreshments available and will be interactive, encouraging discussion. Please note that you will need to arrive promptly for your workshop, and at least five minutes in advance, otherwise your place may be offered to someone else.

Posters
Poster presentations should be in place in Hall 8 and Foyer by 0930 on Thursday 27 June 2013. Poster presenters are encouraged to be beside their posters for part of the lunchtime sessions for discussion with delegates. A prize for the best poster will be awarded at the Prizes and Awards Ceremony at 1615–1630 on Friday 28 June.

Oral research presentations
Oral research presenters are reminded to ensure they bring along a copy of their oral research slides to the conference in addition to sending them to the Conference Organisers in advance. Oral research presenters need to ensure that a final version of their slides is passed to the audio-visual technicians in the Speaker Preview area (Hall 5 Control Room) in good time for their session. The NHIVNA Best Oral, Krattinger Rennison and NHIVNA/Mediscript Clinical Practice Awards will be awarded at the Prizes and Awards Ceremony at 1615–1630 on Friday 28 June.

Conference Social Event
The NHIVNA Conference Social Event will be held on Thursday 27 June 2013 at Crowne Plaza Birmingham City Centre and will commence at 2000 with a cocktail reception followed by a buffet, karaoke and dancing. It is intended that the event will be less formal than previous years and allow guests to network and relax and enjoy some fun entertainment. You will require a ticket to gain entry to the event and these need to be pre-booked in advance of conference, and the necessary contribution paid. If you have reserved a ticket but find you cannot attend, please let the Conference Organiser know and return the ticket to the Registration Desk at your earliest convenience.

Cloakroom
An unmanned cloakroom is available onsite on the ground floor of the Manchester Conference Centre. All belongings are left at the owner’s risk. The National HIV Nurses Association do not accept responsibility for the loss of, or damage to, delegates’ personal property stored in the cloakroom area.

Exhibition
The exhibition represents an integral element of the conference, providing participants with an excellent platform for networking as well as an opportunity to gain further insight into cutting-edge technology, the latest healthcare solutions, and services within the field of HIV and GU medicine. Entrance to the exhibition hall is free for all registered delegates.
Awards and Scholarships

**NHIVNA Best Oral Presentation Award**
Awarded for the best oral presentation displayed at the NHIVNA Annual Conference. A NHIVNA-invited expert panel will judge the award and will be reviewing oral presentations based on the following criteria: quality of presentation; quality of content; impact on nursing practice; and benefits to patients.

**NHIVNA Best Poster Presentation Award**
Awarded for the best poster presentation displayed at the NHIVNA Annual Conference. A NHIVNA-invited expert panel will judge the award and will be reviewing poster presentations based on the following criteria: quality of design/presentation; quality of content; impact on nursing practice; and benefits to patients.

**Krattinger Rennison Charitable Trust Nursing Research Award**
Awarded for an original piece of research presented at the NHIVNA Annual Conference either as an oral or poster presentation. A NHIVNA-invited expert panel will judge the award and will be reviewing presentations based on the following criteria: originality of the research; explanation of the research topic and its relevance to HIV nursing; justification and appropriateness of the research design; methodology; discussion of ethical approval; relevance of the research finding to HIV nursing policy, theory or practice; rigour and quality of research process. Winning presenters will be required to write up their research in the journal *HIV Nursing*.

**NHIVNA/Mediscript Clinical Practice Award**
Awarded for a clinical practice initiative that has made an impact on patient care presented at the NHIVNA Annual Conference either as an oral or poster presentation. A NHIVNA-invited expert panel will judge the award and will be reviewing presentations based on the following criteria: quality of presentation; impact on patient care; relevance to nursing care; recommendations for future practice.

**NHIVNA/Gilead Sciences HIV Nursing Award 2013**
The NHIVNA/Gilead Sciences HIV Nursing Award was set up in 2007 to recognise the outstanding achievements of nurses who have made a significant or unique contribution to the care and quality of life of people with HIV. The award will consist of a fully sponsored opportunity to attend a national or international medical conference in 2013/2014.

**NHIVNA Junior Nurse Scholarships**
NHIVNA has awarded up to ten NHIVNA Junior Nurse Registration Concession Scholarships to assist junior nurses to attend the NHIVNA Annual Conference 2013. To be eligible for a scholarship, applicants must be NHIVNA members for 2013 and have worked as a nurse in an acute or community setting, caring for people with HIV, for 2 years or less. These scholarships have enabled successful applicants to register for the conference at the reduced registration rate of £125. Applications were administered on a first-come, first-served basis.

**NHIVNA First-time Attendee Scholarships**
NHIVNA has awarded up to ten First-time Attendee Registration Concession Scholarships to assist delegates who are attending the NHIVNA conference for the first time. To be eligible for a scholarship, applicants must be NHIVNA members for 2013. These scholarships have enabled successful applicants to register for the conference at the reduced registration rate of £125. Applications were administered on a first-come, first-served basis.

**NHIVNA Community Registration Support**
NHIVNA has awarded 13 community registration places to delegates who work in community, voluntary or charitable organisations. Places have been allocated as fairly as possible, in principle on a first-come, first-served basis, with up to a maximum of two registrations per community group. The award covers registration for the conference only.

**NHIVNA Pre-Conference Study Day Scholarships**
NHIVNA is holding a Pre-Conference Study Day sponsored by Janssen. NHIVNA Pre-Conference Study Day Scholarships have been made available for those who attend, in full, both the NHIVNA Annual Conference on 27–28 June, and the NHIVNA Pre-Conference Study Day on the afternoon of Wednesday 26 June. NHIVNA has awarded up to 40 scholarships that contribute a maximum of £75 towards travel expenses, and contribute a maximum of £125 towards accommodation costs (26 and 27 June only). Applications were administered on a first-come, first-served basis. Original receipts are required post-conference, and within two weeks of the event, in order for NHIVNA to reimburse monies.
Executive Committee

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<th>Chair</th>
<th>Nathaniel Ault</th>
<th>Barts and the London NHS Trust</th>
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<td>Honorary Secretary</td>
<td>Jane Bruton</td>
<td>Chelsea and Westminster Hospital NHS Foundation Trust, London</td>
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<tr>
<td>Honorary Treasurer</td>
<td>Shaun Watson</td>
<td>Chelsea and Westminster Hospital NHS Foundation Trust, London</td>
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<tr>
<td>HIV Nursing Journal</td>
<td>Juliet Bennett</td>
<td>Freelance Nurse Consultant</td>
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<tr>
<td>Newsletter</td>
<td>Jayne Churchill</td>
<td>NHS Lothian, Edinburgh</td>
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<td>Audit and Research</td>
<td>Michelle Croston</td>
<td>North Manchester General Hospital</td>
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<td>Awards and Grants</td>
<td>Catrin Evans</td>
<td>University of Nottingham</td>
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<td>Community Representative</td>
<td>Angelina Namiba</td>
<td>Positively UK</td>
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<tr>
<td>Education</td>
<td>Kemoh Rogers</td>
<td>Anglia Ruskin University, Essex</td>
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<tr>
<td>Community Nursing</td>
<td>Pauline Jelliman</td>
<td>Liverpool Community Health NHS Trust</td>
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NHIVNA Judging Panels

**Krattinger Rennison Award and NHIVNA Best Poster Award Judging Panel**
- Juliet Bennett (Chair)
- Jayne Churchill
- Ian Hodgson
- Eileen Nixon

**NHIVNA Best Oral Award and NHIVNA/Mediscript Clinical Practice Award Judging Panel**
- Nathaniel Ault (Chair)
- Claire Gamble
- Pauline Jelliman
- Lorraine Lewis

NHIVNA aims to provide an academic and educational forum for the dissemination of original nursing research in the field of HIV/AIDS. We also aim to address the communication and support needs of nurses working in this area. We hope that these activities will assist in the promotion of good practice in the care of people with HIV.

www.nhivna.org  nhivna@nhivna.org
NHIVNA Registered Charity Number: 1099074
VAT Registration Number: 877 3182 89

FINAL PROGRAMME
15th Annual Conference of NHIVNA  26 – 28 June 2013  The ICC Birmingham
Exhibition and Poster Display Floor Plans

**Hall 8 Exhibition and Posters**

**Key to exhibitors**

1. ViiV Healthcare UK
2. Body & Soul
3. Janssen
4. National AIDS Trust
5. MSD
6. Gilead Sciences
7. Boehringer Ingelheim
8. AbbVie
Abstract O1

To test or not to test, that is the question

A Waters1 and E Pursell2

1 North Middlesex Hospital, London, UK and 2 King’s College London, London, UK

Background: Lack of knowledge of HIV may lead to stigmatising attitudes by health care workers. Stigma in health care settings can lead to a decrease in uptake of HIV testing. National guidelines state that it should be within the competency of a nurse to obtain consent and conduct an HIV test. HIV testing of NHS staff has not been widely studied however the fear of testing may be related to stigma.

Methods: A cross-sectional study of a sample of nurses (n=144) in a large, multi-cultural London hospital in a high prevalence area from all clinical departments using self-completed structured anonymous questionnaires. The aim of this study was to explore nurses’ attitudes towards HIV testing of patients and self-testing which was part of a larger survey of knowledge and attitudes to HIV.

Results: The mean age of the sample of nurses was 43.3 years with a range of 22–67 years. Respondents were born in 24 different countries with the two largest groups being 44% (n=57) born in the UK and 27%, (n=34) in Africa.

Conclusions: Nurses in this survey were more accepting of patients who were at higher risk of HIV to be tested rather than every patient. Implementing the recommendations for HIV testing emphasises the importance of decreasing stigma toward and improving knowledge of HIV testing. The goal of normalising HIV testing by offering an HIV test to everyone at admission however may be difficult due to financial restraints within trusts.

Abstract O2

Missed opportunities

S Chethana and V Ennis

Birmingham Heartlands Hospital, Birmingham, UK

Introduction: Early diagnosis and testing for HIV is paramount in preventing opportunistic infections and complications of late diagnosis. The problem identified is missed opportunities for early HIV testing. The aim is to identify the missed opportunities through education and avoid onward transmission of HIV and minimise cost. The objective is to educate other healthcare professionals the importance of testing and early diagnosis of HIV.

Method: A retrospective study of three patients diagnosed with advanced HIV was undertaken to identify any missed opportunities where an HIV test was clinically indicated in primary and secondary care. Past medical histories were analysed alongside the UK national clinical guidelines for HIV testing to identify opportunities where an HIV test would have been appropriate.

Results: The analysis revealed that over a period of time patients attending primary care with clinical indicator diseases should have prompted an offer of an HIV test. In one case the patient developed shingles twice and had weight loss over a two year period. Patients attending health care services such as primary, secondary and tertiary care should be offered a diagnostic test for HIV in accordance with current national guidelines. In addition to this patients who attended the walk in sexual health clinic with clinical indicator diseases for HIV infection are more likely to be offered an HIV test than those who attended the GP practice with similar symptoms. Late diagnosis is associated with increased HIV mortality, impaired response to HIV medication and increases costs to the health care service. The earlier HIV is detected, the more likely treatment will be successful.

Recommendations: The three cases exposed a wider issue of reluctance to test for HIV. This is in part due to lack of education regarding clinical indicator diseases. Education programmes at all levels of health care professionals should be established and continued efforts should be made to normalise and make HIV testing routine. This will also prompt health care professionals to offer an HIV test to all patients presenting with symptoms relating to the UK national guidelines HIV testing.

Abstract O3

‘Virtually’ satisfied: we’ve developed a virtual clinic service, but is it safe and does it meet the needs of patients?

M Oates, S Harris, J Barnes, C Cheung, K Gandhi, R Cook and G Hickinbottom

Birmingham Heartlands Hospital, Birmingham, UK

Background: Clinical Nurse Specialists assessing newly-diagnosed patients in ‘Nurse-Led Clinic’ were struggling to arrange appropriate doctor follow-up because of pressure on available appointments. The multidisciplinary team agreed that stable patients were attending for a doctor review more frequently than necessary. Was there potential to reduce these visits whilst still providing safe monitoring and care? Clinical Nurse Specialists and Pharmacists felt they could develop a telephone consultation service to reduce clinic visits and free up doctor appointments.

Methods: Many people are now truly ‘living’ with HIV, perhaps raising children, studying, working or all three! Patients felt clinic visits were difficult to schedule into busy lives and costly in terms of time and travel.

Methods: An eligibility criterion was agreed to encourage appropriate referrals. The patient booked an appointment slot on Tuesday/Wednesday and must be available when we call at that time. A patient information leaflet and clinic proforma were developed. The appointment includes a review of recent blood results, an assessment of well-being, adherence to medication, additional medication changes and if all is well, appropriate follow-up appointments are made, with a prescription arranged for collection.

A patient questionnaire was completed to assess satisfaction. HIV Consultants were asked to provide feedback, especially around patient safety.

Examples of results from 85 patient surveys returned:

92% of patients found virtual clinic more convenient than attending in person

99% found length of telephone appointment to be suitable

98% felt the appointment had met all of their needs

90% had remembered their appointment date and time

100% felt the staff member calling was organised and friendly/helpful

96% wish to continue having virtual clinic appointments

Conclusion: An increase in available doctor appointment slots enables newly-diagnosed patients to be seen promptly. Patients are extremely happy with the service, many wanting more virtual appointments. 5 HIV Consultants consider that the patients have received a high standard of care, with no evidence to suggest that patient safety has been compromised. Virtual Clinic will therefore continue to play a significant part in patient care.

Abstract O4

Community HIV support: next steps?

A Bamford

Sussex Community NHS Trust, Brighton, UK

Background: The shift of HIV care from acute to chronic illness requires a new approach – a self-management model for people living with HIV in the community, in which patients assume an active and informed role in their healthcare.

Such a model was commissioned in September 2010. The Community HIV Specialist Service includes HIV nurse specialists, mental health nurses, and access to social care, psychology and health trainers. We also have a contract with a local voluntary organisation to provide inpatient beds.

Method: The service’s key theme is self-management for clients. Management of a case would include full assessments; personalised care plans, and defined timescales for any interventions. There is a clear patient pathway through the service through a tiered approach, by which the community nurse specialist or community psychiatric nurse contacts the patient and completes an assessment. When the episodes of care are completed then the patient is discharged from the service. Access to inpatient beds is via eligibility criteria ensuring equity of use.

Results: It has taken time to embed the model into practice for both nurses and patients, and our service is now in the last year of its contract. Working with subcontractors has given increased choice and flexibility to patients, and regular contract meetings enable reviews and changes to be made. A service user group is now well established and provides patient feedback on developments and ideas. We’ve faced challenges, and we’ve discussed and shared our learning across the service. Working as part of a HIV network has encouraged us towards stronger partnership working. We also train GPs to raise awareness of the HIV community and to promote HIV testing in primary care.

Discussion: Our new model has meant a cultural change for both workers and patients, requiring support around supervision, clear objectives, and dealing with patient expectations.

With the current political and economic climate, and the new NHS commissioning regime, we all face uncertainty about the future of community HIV services. How do we develop HIV care in the community should be based on understanding local need, demonstrating clear outcomes, and cost effective services – so let’s get started!
Abstract O5

Development of an integrated care pathway (ICP) for HIV outpatient care in Scotland

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Introduction: Health Improvement Scotland Standards for HIV Prevention, Treatment and Care (2011) require the development of an ICP for HIV care. The objects of this project were to:
- Develop and pilot an ICP for the first three months of care following an HIV diagnosis for a genito-urinary medicine (GUM) clinic and an Infectious Diseases (ID) unit) providing very different models of care to a total of 1300 people
- Use the ICP to ensure consistency of care across the different care models.

Method: A multi disciplinary team of 20 volunteers from both units including patient representation and a local ICP expert met from April 2010. Process mapping was conducted leading to a draft version being pre piloted on 10 patients. After further extensive redrafting, an ICP document commenced a 1 year pilot in April 2011. Information is collected under five main headings - history, examination, investigations, screening and ongoing care. If care is not delivered as planned the reason (variance) is recorded. The Clinical Nurse Specialists introduce the ICP and co-ordinate the pathway of care depending on clinical need. ICP completion is reviewed at new patient meetings. Variance analysis highlights gaps in care provision.

Results: ICP was completed for a total of 55 of 63 newly diagnosed or transferring care patients. Of 24 essential components, a mean of 19.9 in GUM and 16.8 in ID were completed.
Completion was no different for sexual health in both units (53/55) and lowest for ‘plan for out of hours care’ (13/55). Variances were well recorded for consent to CP disclosure (not completed in 17, variance recorded in 12) but less well for cardiovascular risk assessment (not completed in 37, variance recorded in 15). Completion was not 100% even for components identified by the ICP group as essential (e.g. STI screening not completed in 15/55, variance only recorded in 9).

Conclusion: The development and implementation of a paper-based ICP in rates challenging. To avoid duplication of work the team made some alterations to the document. There were no consistent differences in completion of different components between units. The aggregate results for the 24 essential components will be fed back to a joint meeting in July 2013 to identify areas for quality improvement, and agree 5 priority areas aiming for 100% variance recording. The next phase will be to roll out the ICP in electronic form.

Abstract O6

HIV Complex Case Audit

P Downes

Liverpool Community Health NHS Trust, Liverpool, UK

Background: Complex cases command a huge investment both in terms of nursing time and resources. Often care outcomes can be disappointing, even following years of engagement. There is a service requirement for the team to access regular Clinical supervision, this is undertaken as a team and has proven to be invaluable in supporting the nursing team through some very difficult and often extremely challenging situations whilst managing complex cases.

A previous audit had highlighted that complex cases often have chaotic lifestyle usually involving substance misuse as a component; this is a continuing trend in some of the complex cases cared for by the HIV Nursing team.

Aims/Objectives: This audit was undertaken to identify possible gaps in care provision and seek out drivers for change. Highlighting areas of best practice by exploring both MDT involvement and improvement in CD4 counts and Viral load in response to intensive support were also areas for review.

Method: A sample of 14 patient records were audited against a proforma over a 3 month period. Completed forms were forwarded to trust research and audit team for analysis and reporting.

Conclusions: The results of this audit highlight that MDT working is crucial to care provision in complex case management. The quality of care is greatly enhanced by patients having access to a broad spectrum of AHP’s who engage and communicate with each other and ensure the patient is the focal point for decision making. Time spent on none face to face activity or patient related activity with patients and stakeholders in care is equal to or often greater than face to face patient contact. It is important this ‘Behind the scenes’ activity is recorded in any data collection used for any service commissioning purposes to portray a true reflection of service activity and patient demand. On-going engagement with complex cases over many years has had a major impact on patient mortality with 64% of cases audited achieving an undetectable viral load, effectively switching of HIV activity, promoting in most cases, immune reconstitution.

Recommendations: Late diagnosis continues to be a major problem for HIV services. This team is already proactive in community HIV testing: a way forward is to explore engagement strategies with local CCG’s, GPs & practices. Outreach testing in non-clinical settings, engaging with local communities and key stakeholders is crucial to promote HIV testing, to align with NICE Guidelines & BHIVA.

Abstract O7

Operational barriers to the implementation of opt-out HIV testing in novel settings

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Barts Health, London, UK

Background: National guidelines recommend routine HIV testing in medical admission units (MAUs) where local HIV prevalence exceeds 2 per 1000. Although HIV testing has been rolled out in MAUs across the UK, HIV testing remains rare in intensive care (IC) settings where patients may present with HIV indicator conditions. MAU and IC are highly pressured environments; patients have complex needs and require a range of medical interventions. The introduction of novel interventions such as HIV testing can therefore present challenges to staff.

Methods: Opt-out HIV testing was introduced in both MAU and IC in our hospital with a local HIV prevalence of 5.95 per 1000. We present testing rates in both settings, and explore differences in logistics in order to inform quality improvement in both programmes.

Results: Since opt-out HIV testing started 13 months ago, testing rate (rt) in MAU is 0.0552 (7.76%), in IC the rate is 0.457927 (49.25%) in 5 months. This difference is statistically significant (p

Operational differences exist in the 2 settings which impacted on how opt-out testing was conducted in MAU and IC. (See table 2)

Conclusion: Both MAU and IC have seen an increasing rate of HIV testing. Testing in IC has been a particular success with rates of 49%. In IC settings patient care is provided in a structured routine approach with a small staff to patient ratio. HIV tests can be administered during routine medical activities performed by nursing staff who have taken ownership of opt-out HIV testing in IC contributing to the high rates of testing. Challenges to testing have been identified within MAU. Most significantly, patients are referred from different locations with acute symptoms requiring attention. So there is no routine approach to admission into which HIV testing can be incorporated. Difficulties arise when patients have previously been bled, or care is taken over by another specialty. Opt-out testing in IC and MAU has been a success despite challenges in MAU. To improve the delivery of opt-out HIV testing within MAU, we must address operational challenges and learn from the many successes of IC.

Abstract O8

The experience of a recent diagnosis of HIV for men who have sex with men: an interpretative phenomenological analysis

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Despite HIV being present for over three decades, there is a dearth of qualitative evidence in relation to a recent diagnosis of HIV as experienced by men who have sex with men (MSM). Many studies have been undertaken using quantitative approaches and have relied on participants recalling their experiences of their diagnoses, with some studies undertaken as long as 23 years later. This study aims to explore the experience of MSM in the first three months of their diagnosis. It set out to elicit the feelings and emotions expressed by MSM who have been recently diagnosed with HIV; explain what an HIV diagnosis means to recently diagnosed MSM, and examine the experience of health and social care interventions during this time.

An interpretative phenomenological analysis (IPA) approach was utilised throughout this study. MSM who had received a diagnosis of HIV in the preceding three months were invited to participate. Charitable and voluntary organisations advertised the study through their Internet and social media pages. Nine men were recruited from across the United Kingdom. Semi-structured interviews lasting between one and two hours were undertaken and relied on the process of people making sense of their world and their experiences.

The men requested an HIV test for a variety of reasons including a period of continuous illness/belonging to a sexual role or relationship and previous sexual partners or as part routine testing practice. They reported effective and negative experiences of receiving their diagnosis from healthcare professionals and this impacted on where they chose to continue their care. Initial disclosure patterns were limited to a ‘need to know’ basis and many of the participants sought support from friends, partners and work colleagues during this time rather than family members. Some expressed a desire to move from where they were living to be able to identify themselves with others with HIV, but others were frustrated by the expertise of individuals who had been diagnosed for some time. All reported that they understood HIV to be a long term condition though a couple of men were not sure if they believed this. For those commenced on antiretroviral therapies, there was a challenge in getting to grips with the new regimes and how this made them feel, and coping with the side effects of the medication. These findings may help health professionals to identify further strategies of support in the initial weeks following diagnosis.
Abstract O9

Evaluation of fitness for purpose in provision of an innovative culturally sensitive HIV counselling approach: An Interpretive Phenomenological Analysis (IPA)

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1Gateshead Christ Church University, Medway, UK, 2Middlesex University, London, UK, 3Trent Hospit...
Abstract P1
Self-efficacy and communication skills
M Croston
North Manchester General Hospital, Manchester, England
Background: Self-efficacy has previously been studied within the scholarly literature in relation to the communication between healthcare professionals and patients. Highlighting that nurses who were uncertain about their abilities to talk openly with patient patients were less likely to use behaviours that facilitate patient’s disclosure of concerns. The literature suggests that self-efficacy contributes to the healthcare professionals communication patterns and should be considered in skills training programmes.
Methods: Using a heideggarian phenomenological approach, 10 members of the North West HIV Alliance were asked to answer the following two questions: ‘The conversations I find most difficult are’, and ‘I find these difficult because …’. The study aimed to establish what conversations nurses felt they had the most difficulties with in order to shape future research projects and form the content of an advance study day for HIV nurses.
The narrative accounts were analysed for common themes.
Results: Themes that emerged included initiating potentially embarrassing conversations or distressing conversation, challenging patients’ non-compliant behaviour, giving significant information, and addressing adherence issues with patients. The reasons why these conversations were challenging for nurses also shared common themes, lack of confidence and self-belief, perceived role boundaries (is this my job) and fear of consequences (what happens if).
Conclusion: Despite the small scale nature of this study it gives insight into the day to day challenges nurses face when providing patient care and provides opportunities to develop strategies to assist these expressed concerns. Although the consensus is that communication skills training is an important aspect of care. The content and method of skills training is still subject to much debate.

Abstract P2
A national evaluation of HIV nurses’ knowledge, attitudes and practices towards ‘treatment as prevention’ (TasP)
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1Freelance Nurse Consultant, Nationwide, UK; 2University of Nottingham, Nottingham, UK and 1North Manchester General Hospital, Manchester, UK
Background: There is now strong evidence indicating that a significant reduction in HIV transmission can be achieved when HAART is started early in the course of infection and an undetectable viral load is achieved and sustained in HIV positive individuals. The British HIV Association treatment guidelines (2012) recommend that clinicians should discuss the evidence for the effectiveness of antiretroviral treatment as prevention (TasP) with all patients with HIV.
Nurses are involved in all aspects of service delivery for people living with HIV and it is essential that they have the knowledge, skills and confidence to address the potentially complex issues that TasP may raise for patients. In the UK, there is a lack of information about HIV nurses’ views on TasP and on their related training and support needs. This is a gap that this project proposed to fill.
Aims: To evaluate self-perceived knowledge, attitudes, skills and practices of nurses working in the field of HIV in the UK in relation to TasP.
Methods: Ethical approval was obtained from the University of Nottingham, Faculty of Medicine and Health Sciences Ethics Committee. A concurrent mixed methodology is being used, consisting of an on-line survey and semi-structured interviews conducted by telephone. This paper will focus on the survey findings.
All NHS nurses (n=244) were sent an on-line questionnaire during April 2013. This consisted of approximately 20 questions to assess (1) knowledge, understanding, experience and confidence in discussing TasP in clinical settings, (2) the perceived impact of TasP on clinical practice, and (3) further education and training needs.
Data analysis will take place in May 2013. Data will be analysed in SPSS using descriptive statistics and correlation tests to determine the extent to which factors such as geographical region, clinical setting or years of experience influence experiences and perceptions around TasP.
Discussion: The discussion will identify areas for further research and will make recommendations for service innovation and development of educational resources.
Acknowledgements: This study has been conducted by NHVNA with support from a grant from Gilead Sciences.

Abstract P3
Determining effective practices of referring HIV positive teenagers to a third sector support service
K Forbes and A Barnes
Body & Soul, London, UK
Background: There are an estimated 3,258 people aged 24 years and under living with HIV in the UK. A third sector organisation based in London holds a weekly support service for 13-19 year olds living with and affected by HIV, with the aim to improve health, well-being and quality of life. It is vital that the service is easily accessible, approachable, useful and relevant to the group. Exploring service users’ experience of referral provides valuable information on referral practice and allows referrers and the supporting organisation to ensure pathways meet service user needs and preferences.
Methods: Questionnaires were verbally conducted either in person or over the telephone during March 2013 with a convenience sample of 20 service users aged 13–19 who had registered with the organisation during 2011/12. The questionnaire was composed of 4 open and 9 closed questions.
Results: Of the 20 respondents, 9 were male and the mean age was 15.1 years. 15/20 were referred from a health professional at their HIV clinic. 1/20 contacted the organisation directly, for 16/20 their referrer called for them (3/20 couldn’t remember). Of the 16 who did not call themselves, 10 said that they would have called if someone hadn’t done it for them. 10/20 attended for the first time with someone else, of whom 4/10 said they wouldn’t have come alone if that person couldn’t accompany them. On the first service visit, 20/20 attended a workshop and 7/20 saw a counsellor. 16/20 came back the next week. When asked ‘why do you access the service now?’ half or more of the participants responded: ‘to see my friends’, ‘to learn more about HIV’, ‘to be around other people who are affected by HIV’ and ‘I feel like I need help’. 20/20 respondents thought other people their age who are affected by HIV would like to know about the organisation and 20/20 could verbalise how they would describe and recommend the organisation to a peer.
Conclusion: This study highlights the critical importance of referrals by healthcare professionals, and specifically the action by the healthcare professional of arranging for the young person to access support services for the first time, without which only a small percentage of young people would access the service. Given that psychosocial support is highlighted in the CHIVA Standards of Care as a vital element of the package of care given to young people living with HIV, referral to support groups should be routine.

Abstract P4
Between the Sheets: A qualitative review of issues faced by women living with HIV in relation to sexual activity
P Kellman
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This is a patient engagement project influenced by Health and Social Care Act 2012 Greater Voice for Patients. Effective nurse / patient relationship enabled disclosures relating to issues faced by WLHIV & sex. The frustration conveyed was alarming and emotive. Common themes were, unmet need for women to explore and discuss sex, Confusion re undetectable viral load & infectivity, Disclosure, A loss of sexuality, perceptions of future cell damage, fear of rejection, violence or abuse within sexual relationships. Women who verbalised anxieties were encouraged to form a focus group to participate, contribute and facilitate the delivery of the Between the Sheets project.
Objectives: Provide a safe, inclusive female only event where WLHIV can explore issues relating to sex.
Import appropriate information via expert presentations (personal stories). Provide interactive workshops to address sexual health, empowerment and self esteem.
Facilitate networking opportunities & peer support.
Evaluate current experiences, & identify future support.
The project was awarded a Public Health Grant. A project group supplemented focus group, to support & ensure the event was delivered safely. Pre event Questionnaire examined issues such as stigma, disclosure, sex negotiation, confidence, support, safer sex, RESPE. The frustration conveyed was alarming and emotive. Common themes were, unmet need for women to explore and discuss sex, Confusion re undetectable viral load & infectivity, Disclosure, A loss of sexuality, perceptions of future cell damage, fear of rejection, violence or abuse within sexual relationships. Women who verbalised anxieties were encouraged to form a focus group to participate, contribute and facilitate the delivery of the Between the Sheets project.
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Import appropriate information via expert presentations (personal stories). Provide interactive workshops to address sexual health, empowerment and self esteem.
Facilitate networking opportunities & peer support.
Evaluate current experiences, & identify future support.
**Abstract P5**

Well-aware

N Mozagba and A Marie Tranter  
Infectious Disease Outpatients Unit, Birmingham Heartlands Hospital, Birmingham, UK

**Background:** The BHIVA guidelines state that specific investigations and assessments need to be carried out to maintain the health of people living with HIV. A year after setting up the Annual health clinic, an audit was conducted against professional guidelines to determine the effectiveness of the intervention. Alongside this a patient satisfaction survey ran to obtain a patient perspective in order to gather the whole picture.

**Method:** A questionnaire was handed out to patients who had attended AHC between June 2012 and April 2013. Patients were asked to complete questions about the clinic as a whole and specifics such as the time of the appointment and the information they received about the AHC prior to their attending appointment.

Questions generally required a 'yes' or 'no' answer and at the end of the questionnaire patients were asked to leave written comments regarding suggestions for improving the AHC and any additional comments they wished to add.

**Findings:** Overall feedback has been favourable with most enjoyed the experience of seeing different health professionals in a ‘one-stop shop’. There are a few remarks about the length of time spent at the appointment which has improved over time with a more co-ordinate approach. Patients found the service to show a high level of professionalism, they are also happy with the annual health check it helped them to find out how well they are doing. Also to identify issues they may have and act upon with the assistance of the correct professional.

**Conclusion:** The AHC is the only opportunity for stable HIV patients to get the opportunity to be fully assessed at least once a year as advised by the BHIVA guidelines. The absenteeism was marginally improved with a reminder text sent a few days before the appointment. Some patients reported being unsure about the nature of the clinic as appointments were sometimes made over the phone, this was resolved by giving the patient an information leaflet on arrival and the nurse verbally explaining the clinic, and giving the patient the opportunity to ask questions. The demand for the clinic has increased over time, thus the clinic moved from fortnightly to weekly. Patients suggested to be asked if they want to attend with a partner. Some others suggested having the clinic run on different days. To satisfy the raised demand for the clinic, we are planning to add more slots, resolve some logistic problems to concentrate the service in one place.

**Abstract P6**

Awareness of communication skills training within HIV nursing practice

M Croston  
North Manchester General Hospital, Manchester, England

**Background:** The Department of Health recommends that professionals take a comprehensive seven hour consultation for the NHS in 2009 [1] which places emphasis on respect, dignity, and the need to value each person as an individual finding the time to listen and talk when it is needed and make the effort to understand.

**Objectives:** The aim of the survey was to gauge professional opinion regarding communication skills training. Also to ascertain what training respondents were aware of or had attended.

**Methods:** A survey was sent to NHIVA, North West alliance members and nurses at North Manchester General Hospital who worked with HIV-positive patients.

**Results:** Out of the 49 surveys’ completed 22.4% (n=11) were male 77.6% (n=33) females.

The majority of the respondents had been qualified for 20+ years 57.1% (n=28) providing care for HIV patients for a variety of different time frames, 0–5 years, 5–10 years 26.5% (n=13), 10–15 years 8.2% (n=4) 15–20 years 18.4% (n=9), 20+ years 26.4% (n=10), 53.2% (n=23) of respondents reported receiving formal training in communication skills. 51.0% (n=25) had received formal training in counseling skills with 47.5% (n=23) attending Motivational-interviewing training. Training in communication models that address emotional concerns of patients (SAGE and THYMIE) was heard of by 39.6% (n=20) of respondents with only 4.25% (n=2) receiving training in the model. 87.4% (n=41) had not heard of cue-based communication as an approach to eliciting patients concerns.

**Discussion:** A significant number of nurses had received some form of communication skills training. With the majority of respondents expressing an interest in attending further communications skills training


2. British Psychological Society (BPS), British HIV Association (BHIVA) and Medical Foundation for Aids and Sexual Health (Medfash) (2011) Standards for psychosocial support for adults living with HIV.

**Abstract P7**

Pain Management Group

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Liverpool Community Health NHS Trust, Liverpool, UK

This exciting and innovative peer support group evolved following a lengthy consultation held with a patient who had a very late HIV diagnosis and as a consequence is quite disabled by peripheral neuropathy. The patient was asked what else I could do to improve her quality of life; she replied, ‘Enable me to meet others with the same problem’. A few embryonic ideas were emailed to R and the group was then formally convened.

The group meets monthly for a 2 hour session broken down into a clinical session with a nurse and a peer support session. The group has evolved from an opportunity for patients to ‘vent’, to an opportunity to share advice on various aspects of living with HIV and with specific interest in pain management and the use of alternative therapies.

**Conclusion:** We retrospectively identified 9 patients accessing care through our clinics in the last 10 years who had disengaged from ART for reasons that were not reconciliable with conventional medical thinking and assessed their outcomes. We excluded cases where the belief was felt to be secondary to a mental health diagnosis or the responsible clinical team felt the individual lacked capacity.

In this group there were 5 black African women, 1 black African man and 3 white men. Reasons for non-engagement were a religious belief in 5 patients, a belief in alternative therapies in 3 and a belief in a pharmaceutical industry conspiracy in 1. We excluded cases where the belief was felt to be inconsistent with conventional medical knowledge (e.g. faith healing or alternative therapies) little is known about the impact this has on patient outcomes. We retrospectively identified 9 patients accessing care through our clinics in the last 10 years who had disengaged from ART for reasons that were not reconciliable with conventional medical thinking and assessed their outcomes. We excluded cases where the belief was felt to be secondary to a mental health diagnosis or the responsible clinical team felt the individual lacked capacity.

In this group there were 5 black African women, 1 black African man and 3 white men. Reasons for non-engagement were a religious belief in 5 patients, a belief in alternative therapies in 3 and a belief in a pharmaceutical industry conspiracy in 1 patients took ART with the median time from diagnosis to stopping or deciding therapy was 21 months (IQR 18 to 64 months) although in 4 patients adherence was thought to be sporadic throughout their clinic history.

In addition to the significant fall in CD4 noted above all patients experienced AIDS defining illnesses after stopping ART, however as of date of submission only 1 patient has died. Illnesses included 2 cases of HIV encephalopathy, a CMV retinitis, a cryptosporidial enteritis and a central nervous system toxoplasmosis. Significant resources were utilised attempting to re-engage these individuals in therapy including an adherence nurse, a specialist HIV psychologist, Psychiatrists and multiple multi-disciplinary meetings. Significant hospital beds days were also needed to address the complications of unattended HIV.

Patients whose belief systems conflict with conventional medical knowledge and who do not engage with ART are a group who suffer a significant range of HIV related morbidities that would not be expected given the patient’s CD4 zenith and also consume a significant amount of medical resources. Identifying successful evidence based strategies that address this would save resources and most importantly improve the well being of our patients.

**Abstract P8**

Effect of antiretroviral treatment non engagement due to beliefs inconsistent with conventional medical knowledge

L Johnson, S Dartwaite and M Croston  
North Manchester General Hospital, Manchester, England

Although the national press and advocacy groups are aware anecdotally about individuals who disengage from Anti-Retroviral Therapy (ART) because of a belief that is inconsistent with conventional medical knowledge (e.g. faith healing or alternative therapies) little is known about the impact this has on patient outcomes. We retrospectively identified 9 patients accessing care through our clinics in the last 10 years who had disengaged from ART for reasons that were not reconciliable with conventional medical thinking and assessed their outcomes. We excluded cases where the belief was felt to be secondary to a mental health diagnosis or the responsible clinical team felt the individual lacked capacity.

In this group there were 5 black African women, 1 black African man and 3 white men. Reasons for non-engagement were a religious belief in 5 patients, a belief in alternative therapies in 3 and a belief in a pharmaceutical industry conspiracy in 1 patients took ART with the median time from diagnosis to stopping or deciding therapy was 21 months (IQR 18 to 64 months) although in 4 patients adherence was thought to be sporadic throughout their clinic history.

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Abstract P9

The effectiveness of a single intervention short film on adolescent perception of people living with HIV: a pilot study

A Barnes and K Forbes

Body & Soul, London, UK

Background: Adolescent HIV knowledge is not protective against HIV-related stigma; adolescents with high levels of HIV knowledge report stigmatising behaviours and attitudes towards people living with HIV. The purpose of this study is to show the effectiveness of a single-intervention short film (UNDEFEATED) on creating self-reported change in adolescent perception of people living with HIV and HIV-related stigma.

Methods: Approximately 150 young people participated in a Year 10 assembly that screened UNDEFEATED. After the film, young people answered a short questionnaire that combined closed and open-ended questions. Survey administrators collaborated with the Year 10 Head to ensure the survey and surveying methods were in line with institutional procedures. Students were advised that this questionnaire would help determine whether the utility of UNDEFEATED in a classroom setting, and that there would be no negative repercussions from providing feedback.

Results: 153 students completed feedback surveys. On the closed-ended questions, 65% felt that they learned more about stigma and discrimination from watching the film. 67% agreed that the film made them think differently about people living with HIV. Open-ended questions reinforced the aforementioned data. Open answers to the question, ‘How do you think the film impacts on the way you feel about people living with HIV?’ yielded desirable feedback in 142 of the 153 respondents. Qualitative feedback included, ‘It made me realise that just because the person has HIV you should never hate them or treat them horribly,’ ‘It made me understand that they suffer much more prejudice than I thought,’ ‘It makes me think that they’re not disgusting anymore.’

Conclusion and Recommendations: This pilot showed positive evidence from both open and closed questions, that this intervention was effective in adolescents participating in achieving short-term self-reported improvements in perception of people living with HIV. Given the intervention’s short length and ease of administration, this data is encouraging. To better demonstrate intervention effectiveness, it will be tested amongst a larger, more diverse sample. Additionally, more rigorous evaluation including pre and post testing and measurement of long-term change could help justify use of the intervention in classroom settings.

Abstract P11

The experience of men who have sex with men in responding to and coping with HIV in the first year following diagnosis: a systematic review of qualitative evidence

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The University of Nottingham, Nottingham, UK

At the end of 2011 there were an estimated 56,000 people living with HIV in the United Kingdom, with men who have sex with men (MSM) making up 47 per 1000. New diagnoses of HIV among MSM have been increasing since 2007 and in 2011 47% of these were late diagnoses. This is despite a slow and significant decline in late diagnoses among MSM over the last decade. The illness trajectory for many HIV-positive people has changed since the advent of widespread antiretroviral therapies in 1995. A diagnosis of HIV has many effects on the emotional and behavioural health of MSM. There is a body of evidence that has offered reflections on the HIV diagnosis experience for MSM. Whilst this evidence is useful in providing some understanding of the response and coping strategies employed by MSM following diagnosis, the main criticism is that the studies tend to be retrospective with participants being diagnosed for between 1 and 23 years. This can be problematic as some diagnoses were received prior to antiretroviral therapies being used more widespread. Therefore it was necessary to explore what is known of the experience of MSM in the first year following diagnosis.

A systematic review of qualitative evidence was undertaken utilising a three-step search strategy of common literature databases for published and unpublished evidence. Using PICO, evidence was included that focused on MSM and their experience of responding to and coping with HIV in the first year following diagnosis. Studies were excluded if they were published prior to the widespread use of antiretroviral therapies in 1995. Papers were retrieved and assessed by two reviewers using a standardised critical appraisal checklist from the Joanna Briggs Institute Qualitative Assessment and Review Instrument. 966 papers were identified initially but only 4 were included in the review following assessment of methodological quality.

Synthesis of findings from the included papers generated the identification of three categories which addressed a mix of emotions as an immediate response; thoughts on a disrupted life; and a re-imagined future. Meta-aggregation of these categories led to the production of a comprehensive statement that a diagnosis of HIV in MSM can be experienced along a continuum from disability to relief and leads to disruption in sense of self and re-imaging of future life, which is influenced by personal experiences of the infection, information gathering and health professionals’ responses.
Abstracts

Abstract P13

Breaking bad news in HIV – lessons to be learnt from other disease areas? ‘Teaching a new dog old tricks?’

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Background: Much of the literature/research regarding breaking bad news relates to delivering poor prognosis to palliative patients. However, clinicians often use guidelines set out for palliative patients when delivering bad news to patients who are not necessarily palliative, as the term ‘breaking bad news’ is often used for that moment when clinicians give a patient ‘negative information’ about a diagnoses, treatment options or prognosis. The aim of the study is to systematically review existing research on delivering bad news looking at the impact of this both from the patients and healthcare professionals’ perspective, and review how this is reflected in existing HIV guidelines and competency frameworks.

Method: A systematic review of the literature using variations on the term ‘breaking bad news’ was completed in both PubMed, Cinahl and Ovid. Only those articles which were original research, written in English and completed since 2005 were included in the review. The data from each of the articles reviewed was then analysed using a narrative synthesis approach, which allows for themes which are then sub-analysed into codes. These themes and codes are then to be further analysed using the same narrative synthesis approach to see to what extent they are reflected in guidelines and competency frameworks for delivering bad news to HIV patients. This part of the review is yet to be completed.

Results: The main themes which have emerged from the systematic review include, cultural and environmental issues, information withholding, communication issues (verbal versus non-verbal), treatment options, skill sets of healthcare professionals and, assessment and understanding of patient needs. The extent to which these are currently encompassed in guidelines and competency frameworks is being undertaken at the moment and the results will be available in advance of the NHIVNA conference.

Conclusions: As stated above the overall extent to which the themes from the research are reflected in current guidelines and competency frameworks is currently underway. However, the lack of research in this area specifically relating to HIV would indicate that the only lessons to be learnt are from other disease areas.

Abstract P14

The development of a competency based HIV testing guideline for TB nurses

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Background: Currently the community TB team refer all HIV tests into the community HIV team. This is not best practice as it does not align with employing NHS Trust strategic objectives, national guidelines (BHLVA testing guidelines, & NICE guidelines, both HIV & TB, & global (WHO CDGC & UNAIDS)). This guidance was therefore a drive for change in practice. Referrals increase the workload of the HIV team in respect of patient activity, paperwork & referral management. According to guidelines, there is a concept from local to global initiatives to normalise, and promote HIV testing, with an aim of early diagnosis. Patients with TB should be tested for HIV. TB team also administer BCG vaccine to eligible neonates, & there is a requirement to establish HIV status of the mother. Referral on hinders the patient journey into timely, appropriate, specialist care if they have HIV, and delays BCG vaccine for the baby. The tests therefore should be undertaken by the TB team at the point of contact.

Aim: To develop a competency based clinical guideline to enable TB nurses to undertake HIV tests in a safe, timely manner.

Method: Develop the guideline & competencies, review documentation, & submit for approval by NHS Trust clinical policy group.

Undertake a SWOT analysis to scope the need & impact of the project.

Develop a Gantt chart to manage the change in practice and provide a timeplan for implementation.

Action learning sets were developed to provide a 2 way communication opportunity between the teams, motivate & support TB nurses, & provide education relating to HIV.

Apply a theoretical change model to ensure an effective project plan.

Provide ongoing support to TB team especially if they have a positive test result.

Conclusion: Guideline is approved & available on staff intranet. By TB nurses undertaking HIV tests, they are increasing their knowledge, skills & expertise, promoting increased efficiency & enhancing the patient journey. This change in practice has released capacity within HIV team to enable them to support a caseload of complex patients, and provide support & education to GP practices & other community nurses in relation to HIV testing. This addresses the requirement to increase & normalise HIV testing. There is scope for any community nurse to refer to the guideline when a testing opportunities present. This change is sustainable as it has no cost implications, & staff have reassurance of ongoing support.

Abstract P15

The complexity of disclosure: positive mother to negative children

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As a community specialist team we have found we are working with increasingly complex families. The importance of a positive parent sharing her/his diagnosis with their children has been well documented and of course this comes the necessity to make sure those children have at sometime been tested themselves.

This case study discusses many of the problems raised when it is too late for the positive parent to take the lead to tell her children as she no longer has the mental capacity to do so, due to HIV related dementia.

The importance of long term case management where the client and children have a trusted health professional who works with them both at home and in clinics becomes very relevant when there are many professionals involved from community and hospital.

This case study involved coordinated multi professional work.

The family to be discussed include a mother who has had a positive diagnosis for over 10 years but has not engaged with treatment on a regular basis. She has three children aged 17, 15 and 12. The mother has always been clear that she does not want her children to know her diagnosis and informed professionals that the children had all been tested negative when younger.

Sadly, over the next few months, she continued to decline in health and is deemed to no longer have mental capacity. It is then recognised that the children have actually never been tested and remain unaware of their mother’s diagnosis.

This case study looks at how we dealt as a multi professional team with these complex issues involving case conferences to discuss ‘best practice’ for the mother and the children. The study looks at how we told the children their mother’s diagnosis, leading to the three children being able to be tested for HIV themselves.

The study discusses the outcomes for both the mother and the children and the lessons learnt by the professionals involved.

Abstract P16

‘Are we there yet?’: Raising the profile of HIV for non-HIV healthcare workers

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Background: The profile of HIV continues to evolve and the needs of people living with HIV remain complex and many need to access other services outside of the HIV setting. In addition, there sometimes appears to be anxiety amongst non-HIV specialist healthcare workers looking after people with HIV. The aim of this project was to measure the knowledge and attitudes of nursing staff in caring for people with HIV, to inform education strategies and to raise the profile of HIV care across the Trust.

Method: A steering group was established to explore promotional opportunities within the Trust.

Ten basic HIV questions were developed and using Survey Monkey were distributed over a three month period via the Trust info-net supported by the chief nurse. A specific World AIDS Day [WAD] 2012 event was planned to disseminate the results and to promote HIV awareness amongst healthcare professionals.

Results: There were 348 respondents of which 5% looked after patients on a regular basis. 63% reported having some knowledge of HIV and 90% were aware that antiretrovirals need to be given at the same time every day. However, 30% of respondents thought personal protective equipment was required for looking after people with HIV. 40% felt there should be an alert on patient notes. In addition 67% replied that HIV testing should only be carried out by a specialist.

Following the WAD event the project team were invited to run two workshops at a local conference for healthcare assistants and to present at an additional conference for nurses and midwives. There have been further requests for HIV awareness training and some work is currently being undertaken to increase HIV training in the undergraduate nursing curriculum.

Conclusion: While it is reassuring that nursing staff perceive they have some knowledge around HIV and treatment, this project indicates that ongoing education and training is required in non-HIV settings even in high prevalence areas. This also demonstrates that raising the awareness of HIV through Trust communication networks can promote further training opportunities. This is particularly significant as people with HIV increasingly come in to contact with other healthcare workers outside of the HIV setting.
Abstract P17
The experiences of HIV nurses conducting research in a HIV nurses network
M Jones1, J Bennett2, RJames3, J Roberts1, N Pertey1, N Perry3
On behalf of the Sussex and Surrey HIV Nurses Network (SSHNN).
Background: The Sussex and Surrey HIV Nurses Network meets four times a year providing an educational programme including clinical updates, conference feedback and research processes. NIVHVA has championed nurse research and the concept of HIV nurses networks; the NIHIVNA Conference Best Poster Award 2012 recognised research carried out by nurses across the HIV network.
Aims: Part A: The aim of this project was to evaluate the views of nurses who attend the network meetings and to assess their involvement in the research project Part B: To further explore the nurses views on participation in the research project.
Methods: An online survey sent to all members of the group with an invitation to participate in a focus group.
Results: A focus group conducted after the results of the survey have been reviewed.
Conclusion: Conducting nurse research through a HIV nurses network is possible and can be fulfilling to nurses who participate.

Abstract P18
The role of the community HIV CNS in complex case-management of HIV positive individuals
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Case-management is a concept that is widely used among several care providers in the UK and worldwide. It is however, a concept that is ill-defined and poorly understood.
Looking at literature and practice, it appears that the interpretation of what case-management means depends on the service setting and the person providing the case-management.
This paper aims to clarify the term ‘case-management’ as it is used in literature and by the Community HIV CNS team.

Within our area there is a high HIV prevalence ranging from 13.9 per 1000 population to 7.5 per 1000. The London average is 5.4 per 1000 in comparison to the UK average of 1.9 per 1000.
The three boroughs we cover also have a high rate of late HIV diagnoses (late presenters) and have marked deprivation and social inequalities. We have large ethnic minority communities whose residents are mainly Sub-Saharan African descendants. Health Protection Agency data of our area in 2010 also identifies significant rates of new HIV diagnoses amongst MSM (men who have sex with men).
Our caseloads consist of clients with very complex needs. These clients represent approximately 5-10% of the total HIV cohort in this area.
This paper will explain the case-management criteria used by the HIV CNS Team and spell out why we use this approach for our client group. The paper will also explore the desired outcomes of case-management. We intend to describe and define what it entails to case manage and give an example of the case-management pathway used.
We will also look at the limitations and difficulties we face as community CNS case managers.

Abstract P19
Does the dual testing strategy under-diagnose latent TB infection in HIV-infected individuals?: A 1 year experience in a TB high incidence Area in the UK
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Background: HIV patients with latent TB infection (LTBI) have an 8% annual risk of developing active TB compared with a 5–10% lifetime risk in HIV-negative individuals. NICE recommends screening HIV-positive patients for LTBI and giving chemoprophylaxis if positive. We introduced a screening service in July 2011 and report our first year’s experience.
Methods: From July 2011, newly diagnosed and established HIV-positive patients identified at our HIV clinic were screened for LTBI as per NICE guidance (CG117, 2011): patients with CD4 counts >200 cells/mm3 (Group 1) had an Interferon Gamma Release Assay (IGRA) (T-SPOT®TB); those with a CD4 count ≤200 cells/mm3 (Group 2) had an IGRA followed by a Mantoux test (TST) if this was negative. If any test was positive, a Chest Clinician referral was made to exclude active TB and provide chemoprophylaxis.
Results: Forty four patients that attended the clinic at times suitable for sample transportation were screened.
Within Group 1 (n=33), the IGRA was positive in 3 patients (9%), negative in 26 (79%) and non-diagnostic in 4 (12%). Of the 3 positive patients, I had previously completed chemoprophylaxis for active TB and the other two were both commenced on chemoprophylaxis. In the non-diagnostic group, I had a subsequently positive QuantIFERON® IGRA test (QFT) and treatment for LTBI. I had a negative QFT and TST and no treatment was commenced. Two patients were lost to follow-up.
Within Group 2 (n=11), no cases of LTBI were detected. The IGRA was negative in 10 patients (91%) and non-diagnostic in I (9%). Subsequent TST screening has been negative in all 6 patients that have attended to date. The patient with the non-diagnostic test deferred follow-up.
Conclusions: Screening for LTBI using the NICE guidelines is successful in the less-immunocompromised HIV population, but may under-diagnose LTBI when the CD4 count is ≤200 cells/mm3. Specimen transport issues and poor attendance has remained one. Frontline practitioners should be aware of the potential pitfalls of over-reliance on medication, and should reflect on how research based evidence is generated, how it is implemented, and to what extent it informs clinical practice.

Abstract P20
PEPSE as prevention: an oxymoron?
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Background: There is an overall reduction in HIV infection rates amongst heterosexual men and women, while infection rates among men who have sex with men (MSM) continues to rise. There is therefore, an observed discrepancy between the role and purpose of PEPSE as a risk reduction strategy vis-à-vis the evidence of a persistent increase in the HIV incidence rate worldwide, particularly amongst MSM.
Aims: To identify the role of PEPSE as prevention strategy and its influence on sexual behaviour in MSM.
Method: A literature review was undertaken using different electronic databases, to look at the impact of PEPSE on sexual choices in MSM, both in the pre- and post-ART era. A total of 54 papers were examined. The review was undertaken through a variety of online databases, including CINAHL, Cochrane, British Nursing Index (BNI), PubMed, Athens, Google. Only peer-reviewed journals were included in the search. Search words included, 1-HIV post-exposure prophylaxis; "sexual behaviour; risk taking," 2 men who have sex with men.
Results: The search revealed a vast body of literature on the observed changes in risk taking behaviour in MSM since the introduction of PEPSE, with many researchers arguing that PEPSE does influence sexual behaviour in MSM, by engendering over-reliance on medications and by reducing interest in safer sex practices and others affirming it does not. There was considerable paucity of qualitative research. Of the 54 papers examined, 13 were qualitative research, based on phenomenological or ethnographical approach to explore sexual behaviour in MSM. Quantitative research on this subject usually combines mathematical modeling and surveys to quantify behaviour.
Conclusion: Whilst there is circumstantial evidence to support the case that the availability of PEPSE has signaled a paradigm shift in the choice of sexual behaviour in MSM This literature review has also highlighted the importance of adopting comprehensive strategies to reduce onward transmission of HIV, of which PEPSE remains one.
Frontline practitioners should be aware of the potential pitfalls of over-reliance on medication, and should reflect on how research based evidence is generated, how it is implemented, and to what extent it informs clinical practice.
Abstracts

**Abstract P21**

Applicability of stable patient HIV service provision for young adults

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**Background:** The 2011 BHIVA Guidelines on routine investigation and monitoring of adult HIV-1-infected individuals propose that stable patients (VL <50 c/ml, CD4 count >350 cells/µl) adherent to antiretroviral therapy (ART), may only require 6-monthly outpatient follow-up. This audit assesses whether this service model is applicable to young adults attending a designated young persons’ service.

**Method:** Single centre retrospective case note audit of all young adults attending a young person’s HIV clinic for >1 year with an undetectable viral load (VL <<50 c/ml) for >6 months and CD4 count >350 cells/µl. Reasons for attending clinic between October 2011—October 2012, and the resulting services provided were recorded.

**Results:** Of a cohort of 91 young people; 38 (42%) met stable patient criteria; median age 21 years (range 17–28), 21 (53%) female, 78% black African origin and 36 (95%) acquired HIV perinatally. The median outpatient attendances in the 1 year was 4 (IQR 3–5), 31 (82%) patients had a new medical diagnosis requiring treatment or referral; infectious (10), cardiology (4), dermatology (5), orthopaedics (2), gynaecology (3), renal (2), ophthalmology (1), endocrine (1), hepatology (2), non-infectious portal hypertension (1). 4 (10%) patients required inpatient care during the year; 29/35 (83%) individuals known to be sexually active had at least one sexual health screen, 15/18 (83%) sexually active females had a cervical smear and 11 (61%) were provided with a long-acting contraceptive. 2/38 patients required partner post exposure prophylaxis and 8/38 had documented partner disclosure issues. 71% of patients received hepatitis B vaccination. Drug/alcohol misuse requiring intervention was documented in 6 (16%) patients. 13% of patients’ social, financial or housing issues were addressed at the clinic. A psychological issue requiring ongoing intervention was documented for 13 (34%), 92% of patients saw more than 1 member of the multidisciplinary team within the audit period.

**Conclusion:** This audit highlights the varied and complex needs of this young adult population. Despite patients being stable on ART and at least 1 year post transition from paediatric to adult services, patients required high levels of multidisciplinary support to maximize physical, sexual and psychological health. Surprisingly, 10% of designated “stable patients” required admissions; the definition of stable patient may differ for those who have lived with HIV from birth for more than 2 decades.

**Abstract P22**

Are generic antiretroviral drugs truly cost saving?

R Taylor1, E Carin1, A Ahmad2, A Darley1, L Taylor1, Z Saddique1 and E Adams2

1Nottingham University Hospitals NHT Trust, Nottingham, UK and 2Aquarius Population Health, London, UK.

**Background:** In 2010/2011, HIV Commissions in our region withdrew payment for the fixed drug combination Combivir, forcing a switch to individual components. This was deemed clinically acceptable and annual savings of £46k were expected. Preliminary work on drug costs alone estimated a much smaller saving.

**Aims:** We estimated the true costs of switching Combivir to its component drugs and patient outcomes with the new regime.

**Methods:** 65 patients used Combivir during the study period, 22 were excluded (temporary patients, lost to follow up, PHTCT only), leaving 43 patients. We used case notes to document each clinic visit or phone call in the 12 m pre- and 12 m post-switch, including clinician seen, pathology tests, and ARVs prescribed. We compared costs in these time periods using local pathology and drug costs. We also recorded viral load (VL) at 1 year post switch, and any patient-reported problem during the switch period.

**Results:** The difference in cost between pre- and post- switch is not significant. Post-switch care is more expensive by £40 per patient annually (95% CI £672 to £753) giving a total increase in costs post-switch in our 43 patients of £1,743/y.

Patients had more clinician contact post-switch (mean = 7.2 visits) compared to pre-switch (mean = 4.9 visits), leading to £60 additional cost per patient post-switch (95% CI £29–£92). Mean drug costs per patient were slightly less post-switch (£7,093 vs £7,140) and pathology test costs per patient were slightly more post-switch (£140 vs £13); neither were statistically significant. Five patients (12%) reported problems with the switch; 1 felt unable to take the new tablets and switched back to Combivir, 1 was switched from 3 months of drug “A” to a 7 month supply, 1 patient developed a rash and 3 contacted the clinic due to confusion about the dosages or timings. One patient had a detectable VL (411 copies/µl) at 1 year post switch. He had a history of adherence issues and a VL of 71 copies/µl pre-switch.

**Discussion:** The overall economic impact of the switch was therefore small. In addition, a switch may cause confusion or new side effects for some patients, risking loss of adherence. Hence caution needs to be exercised when considering the utility of generic antiretroviral drugs on cost grounds alone.

**Abstract P23**

Are generic antiretroviral drugs truly cost saving?

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**Discussion:** The overall economic impact of the switch was therefore small. In addition, a switch may cause confusion or new side effects for some patients, risking loss of adherence. Hence caution needs to be exercised when considering the utility of generic antiretroviral drugs on cost grounds alone.
The findings from all three phases of the research indicate that cases levels but with a lack of overall response. The qualitative interviews are ongoing. The case of faith ‘healing’ claims and pressure to stop taking medication with one knowing taking medication by faith leaders. Most respondents were aware of more than one cases of people being told they had been ‘healed’ and being told or pressured to stop to the service users of their organisations. Of the respondents, 7 were aware of

Methods: Between August and December 2012, we conducted a national survey of anal cancer-screening. The web-based survey was sent to the Lead Consultants of 11.6 sexual health clinics from England, Wales, Scotland and Northern Ireland. Survey data was collected and analysed using a web-based data collection service (SurveyMonkey). Results: We obtained responses from 73 (62%) sexual health clinics, of which the majority 69 (95%) also provide care for HIV-infected individuals. From these clinics 52 (72%) have a HIV cohort of more than 100 patients (range = 50 to >1000), with a proportion of men that have sex with men (MSM) of 46% (range = 10% to 82%). Regarding knowledge of anal cancer risk factors and screening approaches, 67 (96%) are aware of the increased risk of HPV-associated anal cancer in HIV-infected individuals and 65 (93%) have an understanding of screening methods for prevention of anal cancer such as digital rectal examination, anal cytology and high resolution anoscopy (HR-A). Only 4 (5%) clinics currently have an anal cancer screening service, consisting of screening predominantly HIV-infected MSM and those with histories of multcentre HIV genital disease using anal cytology and/or HR-A for the identification of AIN. 15 (21%) of clinicians responding are planning to set up a screening service in the future, while other clinicians are waiting for national guidelines. Interestingly, 21 (30%) of respondents do not consider screening for anal cancer to be effective in the prevention of HPV-associated anal cancer among high-risk groups.

Conclusion: Awareness of risk factors and screening methods for HPV-associated anal cancer are a major priority. Sample of Sexual Health Clinics in the United Kingdom is high. Despite the increasing risk of HPV-associated anal cancer in high-risk groups such as those with HIV infection, only a minority of Sexual Health Clinics are offering anal cancer screening at present, although more clinics are planning to do so in the future.

Results: The survey recruited 14 organisations, including 8 community organisations, and asked them to respond to a series of questions about faith healing with reference to the service users of their organisations. Of the respondents, 7 were aware of cases of people being told they had been ‘healed’ and being told or pressured to stop taking medication by faith leaders. Most respondents were aware of more than one case of faith ‘healing’ claims and pressure to stop taking medication with one knowing that at least 5 cases. At least 15 separate cases were identified in the survey. In some of the reported cases treatment was not offered, but in others the health and mental health of clients declined, in some cases leading to death. The survey uncovered similar findings, indicating the issue is widespread and being reported to local levels but with lack of overall response. The qualitative interviews are ongoing.

Conclusion: The findings from all three phases of the research indicate cases of faith ‘healing’ claims are widespread across the UK, and becoming more common. The nature and impact of these claims varies, but in all cases pose a risk to the health and wellbeing of affected. There is a lack of joined-up approaches or consensus in responding to the issue, which needs to be addressed.

Abstract P27

The impact of faith-based ‘healing’ and ‘cure’ claims on Africans living with HIV in the UK

Stevenson, O Browne, I Otoro and A Duffy

African Health Policy Network, London, UK

Background: Faith plays a vital role for many African people and communities - the 2011 Census in the UK estimates that 69% of Africans living in the UK identify as Christian, and 20% as Muslim. In terms of health, faith and prayer can be a source of strength and support for people living with HIV, however there can be negative consequences of the interaction between faith and HIV. There are increasing reports of faith-based and faith healer’s faith ‘healing’ and ‘cures’, where people living with HIV are influenced to stop taking their treatment and rely instead on prayer. Over the past 18 months we have carried out a programme of research to investigate the impact of these claims.

Methods: The research was conducted in three stages:

1) An online-based survey of community-based and other service provider organisations working with Africans living with HIV.
2) An expert seminar, which brought together a multi-sector group of individuals with representatives from statutory, voluntary, academic and clinical sectors.
3) Qualitative interviews conducted with members of the African community, including people living with HIV who had been affected by ‘healing’ claims.

Results: The survey recruited 14 organisations, including 8 community organisations, and asked them to respond to a series of questions about faith healing with reference to the service users of their organisations. Of the respondents, 7 were aware of cases of people being told they had been ‘healed’ and being told or pressured to stop taking medication by faith leaders. Most respondents were aware of more than one case of faith ‘healing’ claims and pressure to stop taking medication with one knowing that at least 5 cases. At least 15 separate cases were identified in the survey. In some of the reported cases treatment was not offered, but in others the health and mental health of clients declined, in some cases leading to death. The survey uncovered similar findings, indicating the issue is widespread and being reported to local levels but with lack of overall response. The qualitative interviews are ongoing.

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Abstract P28

HIV and psychological support: a psychological needs assessment of adults living with HIV

A Ray1, C Anderton1, SY Teo2, A Evans2 and G Latchford3
1School of Medicine, University of Leeds, Leeds, UK; 2Centre for Sexual Health, Leeds Teaching Hospitals Trust, Leeds, UK and 3Leeds Institute for Health Sciences, University of Leeds, Leeds, UK

Background: The link between HIV and poor mental health is well established, with significant individual and public health implications. Recent publication of Standards of Care for People living with HIV in 2013 has drawn attention to the unmet need for psychological support among the HIV-positive population in the UK and advocated for change. Providing services requires support from commissioning bodies however, and context-specific evidence of need. We aimed to gain an understanding of the psychological needs of adults attending a HIV clinic, to explore current support, and to establish the need for further services.

Methods: We designed a screening tool to establish baseline psychological need. This included the Hospital Anxiety and Depression Scale (HADS), the Distress Thermometer (DT), and questions regarding current support and future need. This was distributed to adults attending a regional HIV centre based in genitourinary medicine.

Results: 80 completed questionnaires were received (53% male; 47% female; mean age 39 years). HADS scores revealed 40% of respondents had clinical anxiety (12.7% severe) and 31% had clinical depression (17.7% moderate/severe). The DT identified 28.8% as having poorly controlled distress with 62.5% of these directly attributing their distress to HIV. Only 9 participants (11%) reported receiving any type of formal psychosocial support at the time of assessment, from their GP and 4 from a psychiatrist or psychologist. Those who requested mental health support all had clinical levels of anxiety or depression. No participants scoring in the normal range requested support.

Conclusion: There is a high level of unmet mental health need in this population. A point prevalence of anxiety and depression of 40% and 31% respectively in this population is far greater than the population in the UK. This is supported by the DT which revealed 28.8% as having poorly controlled distress which they often attributed to HIV. Those in the clinical ranges for anxiety and depression were appropriately indicating a need for psychological support. Appropriate psychological services specifically addressing these distressing impact of HIV, including stepped care for the range of severity should be made available to this population, as suggested by the 2013 Standards of Care and 2011 Standards for Psychological Support. Our evidence suggests that services would be used efficiently by those with a real mental health need, and resources not wasted by those without need.
Abstracts

**Abstract P29**
Ensuring implementation of BHIVA guidelines and pathways in HIV care management: an integrated care solution


1Royal Victoria Hospital, Newcastle, UK, 2King's College Hospital NHS Foundation Trust, London, UK, 3Guy's & St Thomas' NHS Foundation Trust, London, UK, 4Chelsea and Westminster NHS Foundation Trust, London, UK, 5Imperial College Healthcare NHS Trust, London, UK, 6Royal Surrey County Hospital, Brighton, UK, 7London School of Hygiene & Tropical Medicine, London, UK, 8South Manchester University Hospitals NHS Foundation Trust, Manchester, UK, 9Cardiff & Vale NHS Trust, Cardiff, UK, 10Vauxhall Chelsea & Westminster NHS Foundation Trust, London, UK, 11West Midlands Strategic Commissioning Group, Birmingham, UK, 12Trinity, London, UK.

Background: Integrated care pathways (ICPs) are structured multidisciplinary care plans which detail essential steps in the care of patients. The development of ICP methodology has been supported by the NHIS since the late 1990s and processes such as the ICP Assessment Tool (ICPAT) have made the implementation of robust ICPs possible. Systematic review of the implementation of ICPs has shown that ICPs can effectively support proactive care management, adherence to guidelines, improve physicians' agreement with treatment options and support decisionmaking. A multidisciplinary team applied this process to health care of people with HIV across the UK to adopt a defined standard of case management based on BHIVA guidance, which provides robust definition for both standards of care and model pathways for service delivery which has not been undertaken previously.

Methods: Using a proprietary process of facilitation and iterative development, this multidisciplinary working group of HIV specialists comprising representation from around the UK has developed an ICP for core co-morbid patient HIV care in accordance with ICPAT standards and current best-practice thinking.

Results: The ICP forms comprise a streamlined and easy to implement solution for structuring each consultation along the patient pathway. The forms ensure that the full HARS dataset is collected for each patient as they progress along the pathway. The HIV ICP comprises:
- A process map defining the consultation flow along the patient journey
- A set of forms for use at each consultation, ensuring that appropriate assessments and interventions are performed according to BHIVA guidance
- A comprehensive support booklet, containing the full evidence base for HIV management with instruction for managing implementation of the ICP This ICP is available in a Word format so that it may be easily modified and implemented by HIV teams across the UK.

Conclusion: Adoption of the ICP by HIV teams across the UK may facilitate implementation of BHIVA guidelines, collation of the HARS dataset and equity of care across the UK.

**Abstract P30**
Description of new referral data gathered by phone from a third sector support service for adults living with and affected by HIV, 2012

S Forbes and A Barnes.

Body & Soul, London, UK.

Background: People living with HIV may have multiple factors impacting their wellbeing. This needs assessment for service improvement summarises the baseline information gathered during the telephone referral process of 254 adults (age >20) to a third-sector organisation during 2012.

Methods: When a new referral contacts the organisation basic demographic information and the individual's urgent needs are recorded: age, gender, whether or not the individual has a child/children; whether the individual was presenting with any of the following immediate needs: problems with physical health; any mental health problems; need for psychosocial support; need for practical support (eg, legal help, help regarding immigration status, but excluding support around hardship grants, benefits or housing/homelessness), support in applying for a hardship grant, help in understanding/applying for benefits and problems regarding housing or homelessness.

Results: Of 254 adults who were referred by telephone, basic information was taken from 252. Information on immediate needs was taken from 186 individuals. 23% presented with problems with physical health, 12% with mental health issues and 45% were in need of psychosocial support. 29% needed help with applying for a hardship grant, 11% needed assistance with benefits and 21% had an immediate housing situation. 50% of females and 42% of males presented with 2 or more immediate needs. 54% of females and 40% of males had children. 58% of the females and 37% of males with children presented with multiple immediate needs.

Conclusion: A significant proportion (73%) of individuals approaching the organisation voiced an urgent need for help during the initial telephone referral. Females are more likely to present with an urgent need and multiple urgent needs compared to males. Women with children are more likely to present with multiple immediate needs compared to women without children. This data provides a singular snapshot of the need profile presented upon telephone referral. It is likely that these results are underreporting the true situation. In order to have a clearer picture of the complex needs of this population, further research is advised.

**Abstract P31**
Calabash at George House Trust: innovating to support HIV-positive African men in the North West

C Armstrong

George House Trust, Manchester, UK.

Background: In September 2011, George House Trust (GHT) received a two-year grant from the Henry Smith Charitable Trust to provide a highly innovative service focussed on a population of African men. The Calabash project is an extension of previous work by GHT to support families, which had revealed specific issues for African men: a group that is often stereotyped and marginalised.

Methods: Calabash uses a combination of group work and one to one sessions to support HIV-positive African men on a range of issues such as: HIV diagnosis; immigration; poverty and destitution; disclosure; employment advice; adherence to medications and so on. The project is led by an African man, supported by a group of HIV-positive male African volunteers.

Results: To date, Calabash has supported 55 HIV-positive African men. The service has held over 150 one-to-one sessions; hosted 10 workshops sessions, attended by between 8 and 17 men, and held a reflective residential weekend, attended by 8 men. The men are affected men who attend the service are understanding HIV and health management; stigma and discrimination; immigration issues; family issues; relationships problems and long distance families; poverty and destitution; difficulties in integrating into local community. Many of the men have multiple partners and the project encourages them to be open about this in order to best manage these issues. A key finding has been that group sessions on employment and health management have: held over 150 one-to-one sessions; hosted 10 workshops sessions, attended by 150 African men on a range of issues such as: HIV diagnosis; immigration; poverty and destitution; disclosure; employment advice; adherence to medications.

Conclusion: Calabash has been successful in engaging hard to reach and marginalised populations of African men. It is a ground breaking and highly innovative project. It accepts their lifestyle choices and encourages them to be open about them in order to improve health outcomes. Key to its success has been its willingness to adapt and innovate to reach those whose experience of stigma makes them unwilling to approach HIV services.

**Abstract P32**
Failure to achieve an adequate CD4 count response despite regular engagement in HIV care and consistent viral suppression


Background: To investigate the proportion of people who start ART with CD4 <100 cells/mm³, are subsequently regularly monitored with consistent viral load (VL) suppression (<50 copies/ml), yet fail to achieve an adequate CD4 count response (>200 cells/mm³) in the first five years on ART.

Methods: Eligible participants started ART after 1st January 2000, with at least one year of follow-up on ART. Participants were further required to have achieved VL suppression by nine months after starting ART and to have maintained this up to five years of follow up. Participants were required to be regularly engaged with care (≥6 months between each consecutive VL assessment). Linear regression was used to estimate a CD4 count trajectory for each participant who did not achieve a CD4 count >200 cells/mm³, to predict the timing of reaching this value.

Results: From a total of 1,212 starting ART with pre-ART CD4 <100 cells/mm³, only 168 (14%) participants met the stringent criteria and were included in analyses. Median (IQR) follow-up was 2.9 (1.7–4.7) years, participants were 26% men who have sex with men, 18% black heterosexual men, 29% black heterosexual women, 2% injecting drug user, 24% other + unknown, median age 39 years at start of ART. Of these, 45 (27%) did not achieve a CD4 count >200 cells/mm³. The median follow-up on ART for those who did and did not achieve an adequate CD4 count was 3.4 and 2.0 years, respectively. Among those who did achieve CD4 >200, median time to this was 1.4 years. Morbidity/mortality rates for those who did and did not achieve an adequate CD4 count were 2.7/100 person-years (95% CI 1.3, 4.8) and 9.2/100 person-years (4.4, 16.5), respectively. Using the individual estimates of CD4 count trajectories, we predicted that the median (IQR) time to an adequate CD4 count response in people who did not achieve a CD4 count >200 cells/mm³ was 2.4 (1.4–4.5) years. When including those projected to die between 200 and 5 years, the predicted median time to CD4 count response for people who do not achieve a CD4 count >200 after 5 years of ART is 12/168 (7.1%).

Conclusions: In a strictly defined group of people with regular monitoring and consistent VL suppression, our African cohort, we predict that only a small minority of people do not achieve an adequate CD4 count response after five years of ART. Inadequate CD4 count response is associated with greater clinical consequences. Care should be taken over interpretation of the conclusions in the analyses we select subgroup of people with HIV.
Abstract P33

Skin cancer in aging HIV-positive patients

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Background: Cutaneous cancers are the most common malignancies. Multiple studies have shown an increased risk of skin cancer for immunosuppressed transplant recipients. National Institute for Health and Clinical Excellence (NICE) guidelines recommend these patients receive regular skin checks for timely detection and management of cutaneous malignancies. Human immunodeficiency virus (HIV) patients are also at increased risk of cancers, such as Kaposi sarcoma and lymphoma; however, since the advent of highly active anti-retroviral therapy (HAART) the incidence of these acquired immunodeficiency syndrome (AIDS) defining malignancies has declined. Unfortunately, the incidence of non-AIDS defining cutaneous malignancies continues to increase with the increasing life expectancy of HIV patients and presently accounts for most cancers in this group. Currently, there is limited data about the rate of skin cancer among older and long-term HIV patients.

Conclusion: We undertook a prospective observational service evaluation to establish the prevalence of skin cancer in HIV patients over the age of 50 years. Patients attending the ‘Over-50 clinic’ were invited for a skin examination. A full medical history was taken from each patient before proceeding to a full skin check including the oral mucosa and perianal area. Management recommendations for detected skin cancers were provided accordingly.

Results: Forty patients were invited and accepted screening over a 3-month period. 33 participants were white, men who have sex with men with an average age of 59 years [50–78]. The mean duration of HIV diagnosis was 15 years [0–27] and mean duration of HAART was 12 years [0–25]. Two-thirds of participants were well controlled with normal CD4 counts and undetectable viral load. Over 58% of the study participants had a history of previous or current noncancerous or precancerous lesions of the skin. Ten (25%) had a previously undetected skin cancer identified during the study, mostly basal cell carcinomas.

Conclusion: We have identified a high rate of previously undetected skin cancer amongst HIV patients older than 50 years. Routine skin examination will allow older HIV patients to benefit from early detection of skin cancer, decrease morbidity and perhaps mortality in this high risk group of patients.

Abstract P34

HIV testing in clinical indicator diseases in outpatient settings: offer and uptake rates and impact of educational and active interventions

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Background: Approximately 50% of patients with late HIV diagnosis have accessed healthcare in the prior 2–3 years. HIV associated clinical indicator diseases (CID) seen in outpatient clinics (OPD) are proposed as an opportunity for earlier diagnosis in multiple testing guidelines. Expanded testing pilots show that whilst testing is acceptable to patients, offer rate by clinicians is low. Strategies to increase offer rate are needed. This study assessed the impact of a targeted OPD educational programme with and without additional individual case note prompts for patients with a CID as a strategy to increase HIV testing.

Methods: A 2 stage prospective study over a 12 week period during 2012 in Dermatology (D), Gastroenterology (G) and Haematology (H) OPD at 2 University hospitals. Clinicians received an education programme about significance of late HIV diagnosis, highlighting CID relevant to their field (as per national testing guidelines). For D OPD, stage 1 (6 weeks) consisted of preidentification of CID and insertion of a prompt to offer HIV testing. Stage 2 (6 weeks) relied on clinician identification of a CID only (no prompt). For G and H OPD, stages were reversed. The option of testing using serum or oral sampling was given. Test offer and uptake rate was compared with/without prompts and across age, gender and ethnic groups.

Results: 4191 patients were eligible. 608 (14.5%) were identified with a CID (D 8.9%, G 18.3%, H 22.7%) of whom 25 (4.1%) were known to be HIV positive, and 115 did not attend. 468 evaluable subjects were male (251, 54%), of white UK ethnicity (302, 65%) and with median age 51 years. Overall test offer rate was 82/468 (17.5%) and was significantly higher during the prompt stage (74/16, 34%) vs education alone (82/35, 23%) (p<0.001) for total population and for each of D, G and H. There was no difference in offer rate by age, gender or ethnic group. Uptake was 61/180 (34%) and similar across OPD demographic group, and prompt usage. Of those testing, 28/61 (46%) used oral sampling. No new cases of HIV infection were identified.

Conclusion: Test offer rates by OPD clinicians is low despite the high rate of HIV infection in OPD attendees with CID, national recommendation for testing in this setting and targeted educational intervention. Novel strategies to prevent missed diagnosis are urgently needed. Individual case note prompts significantly increase test offer rates, and this effect is lost if the strategy is withdrawn.

Abstract P35

Opt-out HIV testing in the accident and emergency department ‘majors’ is effective and acceptable to patients and health care workers

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Background: HIV positive patients continue to be diagnosed with late stage disease. Many have previously sought healthcare outside of traditional HIV testing settings and opportunities to diagnose HIV infection earlier may have been missed. Strategies to reduce the rate of undiagnosed and late diagnosis of HIV are recommended especially for areas where the local prevalence of diagnosed HIV is greater than 2 in 1000. In our area the estimated rate is 4.7 per 1000. Experience in Antenatal, Tuberculosis and Genito-Urinary Medicine (GUM) Services demonstrates that Opt-Out testing is most effective. We introduced Opt Out HIV testing in the Accident and Emergency (A&E) Department ‘majors’ section of a District General Hospital serving an ethnically diverse population.

Methods: The HIV Testing in A&E working group initiated a teaching and advertising programme among care health workers (HCW). At inception, all patients in A&E were informed by poster, all patients had verbally that an HIV test was routine for any person having blood taken unless specifically declined. Blood test orders are incorporated opt-out testing as part of admission. Staff in ECP have been supported with a CID only (no prompt). For G and H OPD, stages were reversed. The option of testing using serum or oral sampling was given. Test offer and uptake rate was compared with/without prompts and across age, gender and ethnic groups.

Results: 4191 patients were eligible. 608 (14.5%) were identified with a CID (D 8.9%, G 18.3%, H 22.7%) of whom 25 (4.1%) were known to be HIV positive, and 115 did not attend. 468 evaluable subjects were male (251, 54%), of white UK ethnicity (302, 65%) and with median age 51 years. Overall test offer rate was 82/468 (17.5%) and was significantly higher during the prompt stage (74/16, 34%) vs education alone (82/35, 23%) (p<0.001) for total population and for each of D, G and H. There was no difference in offer rate by age, gender or ethnic group. Uptake was 61/180 (34%) and similar across OPD demographic group, and prompt usage. Of those testing, 28/61 (46%) used oral sampling. No new cases of HIV infection were identified.

Conclusion: Test offer rates by OPD clinicians is low despite the high rate of HIV infection in OPD attendees with CID, national recommendation for testing in this setting and targeted educational intervention. Novel strategies to prevent missed diagnosis are urgently needed. Individual case note prompts significantly increase test offer rates, and this effect is lost if the strategy is withdrawn.
Abstracts

National HIV Testing Week: An intervention for raising awareness and encouraging HIV testing

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Background: Late diagnosis and HIV is a significant problem across the UK, with approximately 1 in 4 of all people with HIV currently undiagnosed. HIV testing remains stigmatised and underutilised. As part of HIV Prevention England (HPE), Terrence Higgins Trust coordinated the first National HIV Testing Week (NHTW) to encourage awareness, provision and uptake of HIV testing among gay men and African people.

Method: NHTW was delivered through partnership working with HPE local delivery partners, clinics and other services who were encouraged to participate. A wide range of events including increased testing hours and venues were supported. A ‘flash logo’ for the week was made available for use by all on existing materials and posters distributed to HIV clinics. Additional clinic hours were promoted on an online clinic finder and in local media, and an online risk assessment tool promoted which directed users to the clinic finder if the result indicated testing. A full risk assessment report was offered via email to users who provided their email address. Regional testing opportunities and awareness raising events were advertised through a dedicated NHTW Facebook page and a Twitter hashtag. Press releases about the week were sent to appropriate media.

Results: NHTW delivered over 800 additional hours of HIV tests across the country. An average of 575 people per day used the online clinic finder with a peak of 2,766 on the first day of NHTW. A total of 118 new items were placed in digital, print and broadcast media, with an audience reach of nearly 10 million. The NHTW Facebook page attracted 2,582 likes and reached 151,590 at its peak. More than 55 organisations working in HIV and sexual health provided support, HIV testing and related events. BHIVA supported NHTW extensively. NHIS Medical Director Sir Bruce Keogh included NHTW and the importance of reducing late diagnosis of HIV in a circular for doctors in England. The Health Protection Agency will analyse testing numbers and diagnoses to evaluate further impact. In feedback, the most common concern was a desire for more time to plan for 2013.

Conclusion: NHTW was a highly acceptable and popular intervention which energised testing initiatives and awareness across England and the target groups. It achieved good coverage across social and traditional media and amongst key health influencers. Dependent on final evaluation, it is likely to be repeated in 2013 with better notice.

Patient and physician preferences regarding medications for HIV treatment

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Background: The range of antiretroviral drugs available has increased considerably over the past 10 years. NICE guidelines (2009) state the importance of understanding patient preferences regarding treatment to optimize adherence. The present study was designed to elicit patient and physician preferences for HIV treatment options using stated preference survey.

Methods: Two stated preference surveys were developed from published literature and from interviews with patients (n = 5) and physicians (n = 2). Eight key attributes were identified: Treatment benefit, Risk of death, Risk of kidney stones, Risk of jaundice, Risk of diarrhoea, Risk of psychological effect, Risk of heart attack, and Long term safety profile. Two hundred HIV patients and 125 NHS based physicians completed the stated preference survey.

Results: Patients placed most importance on treatment effectiveness (OR=1.030 95% CI = 1.023–1.037) and long term safety profile (OR = 1.016 95% CI = 1.002–1.028). The avoidance of all side effects was valued, particularly risk of psychological consequences (OR = 0.985 95% CI = 0.974–0.982) and heart attack (OR = 0.987 95% CI = 0.973–0.980). Patients valued the avoidance of diarrhoea (OR = 0.991 95% CI = 0.985–0.990) to the same extent as the avoidance of jaundice (OR = 0.990 95% CI = 0.985–0.992). Physician results were similar, although they were more influenced by treatment effectiveness than patients (OR = 1.110 95% CI = 1.093–1.126) and risk of serious side effects (OR = 0.971–0.988, p<0.005). Like patients, they preferred treatments which had a long established safety profile (OR = 1.016 95% CI = 1.040–1.082). Patients with detectable viral load had lower utility values (mean = 0.483) than patients with non-detectable viral load (mean = 0.641) (p<0.001).

Conclusions: Treatment effectiveness and long-term safety profile were the most important drivers of treatment choice for both patients and physicians. Patients valued the avoidance of certain side effects, diarrhoea and jaundice which were of equal importance. Physicians placed more value on treatment effectiveness but placed no value on avoiding some side effects (e.g. diarrhoea, rash). Considering the perspective of patients when making treatment decisions may result in improved adherence and better treatment outcomes in HIV.

HIV and risk behaviours among people who inject drugs in the UK: 30 years on

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Background: People who inject drugs (PWID) are known to be at high-risk of HIV. We report on the epidemiology of HIV among PWID in the UK over the past 30 years.

Methods: Data on PWID (aged ≥15) diagnosed with HIV in the UK to the end of 2011 were analysed to examine demographics, late diagnosis (CD4 count <350 cells/mm³ within 3 months of diagnosis) and mortality. Quality of HIV care of PWID in 2011 was assessed, alongside HIV prevalence and risk behaviours of PWID participating in the 2011 Unlinked Anonymous (UA) Survey.

Results: Over the past three decades, 5600 PWID were diagnosed with HIV. New diagnoses peaked at 417 in 1986, decreasing to 132 in 2011. The male to female ratio has remained relatively constant at 2:1, while median age at diagnosis has increased gradually from 29 in 1984 to 36 in 2011. The majority of diagnoses have been among white PWID born in the UK and Europe. Late diagnosis has remained high: 52% in 2011; 39% of PWID were also diagnosed with AIDS. The 2011 mortality rate of PWID diagnosed with HIV was 26 per 1000, 5 times higher than that of the total diagnosed HIV population (England and Wales). Of the 132 PWID newly diagnosed in 2011, 86% were linked to care within a month of diagnosis and 88% were retained in care 1 year after diagnosis. Among 1610 PWID seen for care in 2010 94% were retained in care in 2011; 87% were receiving antiretroviral therapy (ART) as per BHIVA guidelines, and 86% had a viral load <50 copies/ml after a year of receiving ART. After a year in care, 69% had a CD4 count ≥350.

The UA Survey shows the variation in HIV prevalence among PWID over time (0.61–1.86%), with prevalence 1.0% in 2011. In 2011, 77% of survey participants reported ever being tested for HIV, 71% ever imprisoned, 77% ever homeless and only 19% reported consistent condom use with multiple partners. In the last month, 37% had shared injecting equipment, 32% injected crack, and 35% injected into their groin.

Conclusion: The HIV epidemic among PWID in the UK has remained relatively contained compared to other European countries, most likely due to prompt implementation of an effective national harm reduction programme. However, reported risk behaviours among PWID indicate the potential for HIV prevalence to increase if high quality services for PWID and HIV testing uptake are not maintained. Though quality of HIV care among PWID is excellent, this population appears to have poorer outcomes than other people living with HIV.

Real-life clinical experience with Eviplera™

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Background: Tenofovir/emtricitabine/efavirenz (Eviplera™) is a once daily single tablet regimen (STR) option and is licensed for naive patients. Emerging data supports its use in Protease Inhibitors (PI) and efavirenz switch where it is an attractive option because of the STR formulation. This is a descriptive analysis of Eviplera™ use in a large cohort.

Methods: Pharmacy and laboratory databases were interrogated and clinical records reviewed; trial patients were excluded.

Results: 79 patients in total received Eviplera™ with 25.5 patient-years (PYs) of experience; median age 44 years (IQR 37, 50), male 75%. 16% were naive to ART. For those who were Antiretroviral Therapy (ART) experienced switching occurred for regimen simplification in 39%, CNS side effects of Efavirenz in 29%, and gastrointestinal toxicity with existing ART in 12%: 20% had other reasons for switching including lipid elevation and abnormal Liver Function Tests (LFTs). 52% were switched from PI-based regimens and 41% from Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)-based regimens. Of the 37 patients who were switched whilst undetectable and had follow up viral load, 97% remained undetectable over a median follow-up of 4 months; the 1 patient who became detectable had a viral load of 59. Of the 17 patients who were not undetectable at switch (median viral load of 292 copies/ml (range 44, 707,321 copies/ml) all remained undetectable at the end of follow up (median 4 months). 68 patients had baseline and follow up renal monitoring data. All had baseline estimated Glomerular Filtration Rate eGFR of >60 ml/min. 2 patients had a reduction in eGFR to below 60 ml/min (From 60 to 56 ml/min at 3 months and from 69 to 58 ml/min at 4 months). 63% had an increase in serum creatinine 17 µmol/l (range 1, 22 µmol/l) after median 3 months follow-up.

Conclusions: Although cohort analyses have inherent limitations, our patient series supports that Eviplera is an effective regimen for patients wishing to switch therapy. The small increase in serum creatinine reinforces the importance of regular renal monitoring.
Abstract P41

Five years of experience with raltegravir in a large HIV centre
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Background: Raltegravir (RAL), the first integrase inhibitor, was licensed by the European Medicines Agency in December 2007 as a component of antiretroviral therapy (ART). Real-life antiretroviral experience is informative and complements trial data, so we evaluated our RAL use in naïve and experienced patients, including those with hepatitis and mycobacterial coinfection, and off-licence use.

Methods: Pharmacy and HIV database records were used to identify all adults who had taken at least one RAL dose outside of clinical trials. Demographic, clinical and laboratory data were collected from patient records using a standardised form.

Results: Data from 215 individuals provided 502 patient-years (PYs) of RAL use. Median duration of use was 2.6 years (interquartile range [IQR] 0.8, 3.5). 166/215 (77%) were male, median age 43 (IQR 37, 49); 153 (72%) Caucasian and 54 (25%) African/Caribbean. 189 (88%) were ART-experienced with median baseline CD4 count 324 cells/mm3 and 26 naïve with median baseline CD4 54 cells/mm3. Of those not on ART immediately prior to RAL initiation (n = 52), median viral load (VL) was 6650 copies/mL. Doses other than 400 mg bd were used in 26: 16 (7%) individuals on 800 mg bd (15 of whom were on rifampicin) and 10 (5%) on 800 mg od. On 800 mg od, 5 had reported very poor adherence whilst the other 5 remained virologically suppressed after median 2.4 years. RAL was used in hepatitis B and co-infection in 35 individuals (92 PYs), none of whom stopped RAL for hepatotoxicity. 22 individuals had mycobacterial co-infection; one of whom stopped RAL for potential toxicity (peripheral neuropathy). RAL was started during an inpatient stay in 40/215 (19%), of whom 18 were naïve. Overall, 18 individuals stopped RAL due to ART-related side effects, 13 of whom (6% of total) were judged probably related to RAL. Six females RAL in pregnancy, 5/6 as treatment intensification (at median 32 weeks gestation) and one switch from protease inhibitors for tolerability reasons (at 35 weeks). All had VL <40 at delivery and HIV-negative infants with no complications. 10/115 (5%) stopped RAL due to virological failure, of whom 2/4 with successful sequencing showed RAL resistance (one Y143R, one Q48R).

Conclusions: RAL appears safe in clinical practice, with no evidence of excess toxicity above that indicated by clinical trials. It has been used safely and effectively in pregnancy and with co-infections. Once daily dosing seems effective where toxicity above that indicated by clinical trials. It has been used safely and effectively in pregnancy and with co-infections. Once daily dosing seems effective where adherence is good.

Abstract P42

The emergence of new viral strains following treatment failure in an HIV-positive cohort infected with acute HCV
T Abdelrahman1, J Hughes1, J Man1, J McLauchlan1 and E Thomson1
1MRC Centre for Virus Research, University of Glasgow, Glasgow, UK and 2Imperial College NHS Trust, London, UK.

Background: In hepatitis C virus (HCV)-infected patients, the virus circulates as a mixture of closely related but distinct genomes called quasispecies. The hypervariable region-1 (HVR-1) is the most heterogeneous region of the HCV genome and is an excellent target for sequence analysis to distinguish between different variants. We studied the dynamics of quasispecies in pread post-treatment samples taken from patients who failed standard of care therapy in a rare HIV/HCV co-infected cohort of 160 patients.

Methods: A group of 16 patients failed to respond to treatment. A 220 bp region of the E2 envelope gene including (HVR-1) was amplified using nested RT-PCR using a combination of genotype-specific primers. PCR products were sequenced by direct sequencing (DS), clonal analysis (CA) and next generation sequencing using a pyrosequencing approach (NGS). Phylogenetic trees were constructed using the maximum likelihood (ML) method.

Results: Using DS, in the 16 patients that failed treatment (6 relapers, 6 null responders and 4 partial responders), 60% of patients had evidence of a ‘new variant’ post-treatment. However, CA and NGS results revealed that 66% of such ‘new variants’ were present in pre-treatment samples, representing new dominance of a pre-existing minority strain that was not detected by DS. Only 3 patients had completely new strains, which were presumed to represent reinfection. NGS was superior to CA in detecting the dominance of pre-existing minority strains in 25% of patients. Both techniques detected multiple strains in 50% of patients that were missed by routine diagnostic methods (DS).

Conclusion: In HCV treatment failure, the emergence of new viral strains may most commonly be attributed to new dominance of pre-existing minority variants rather than reinfection. NGS could become an important screening tool at baseline for decision making when treating HCV-infected patients to identify mixed infection, particularly in the context of treatment decisions involving genotype-specific direct-acting antiviral agents.

Abstract P43

Reviewing BHIVA guidelines on screening for latent TB infection in HIV-positive patients in a high TB and HIV prevalence area in the UK
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Barts Health NHS Trust, London, UK.

Background: HIV-positive individuals with latent TB infection (LTB) are more likely to develop rapidly progressive active TB with reactivation rates of ~10% per annum or ~50% cumulative lifetime risk. BHIVA recommends the use of interferon release gamma assay (IGRA) for screening LTBI according to: TB risk in the country of origin ARV duration and CD4 count. The aims of this project were i) to audit new BHIVA LTBI screening guidelines in a busy clinic; ii) to investigate retention in HIV care prior to a TB diagnosis.

Method: We performed a review of patients using paper and electronic records. i) All new HIV diagnoses attending during 10/2011–10/2012 were reviewed according to BHIVA guidance. ii) All TB diagnoses in the same period were reviewed for prior HIV care.

Results: 63 new diagnoses of which 38 (60%) were females; 60% Black Africans, 17% Black British/Caribbean/Black other, 8% Indian subcontinent, 6% East European, 3% South Americans and 3% UK Caucasians.

<table>
<thead>
<tr>
<th>Risk category</th>
<th>Applicable for screening</th>
<th>Positive T spot</th>
<th>Negative T spot</th>
<th>Active TB</th>
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<td>12/348</td>
<td>3/12</td>
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<tr>
<td>Medium**</td>
<td>4/152</td>
<td>2/4</td>
<td>0/2</td>
<td>4/152</td>
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<tr>
<td>Low</td>
<td>2/34</td>
<td>1/2</td>
<td>0/2</td>
<td>2/34</td>
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</tbody>
</table>

Reviewing our entire patient cohort during the study period eight patients had active TB. 5/8 (62%) patients were diagnosed with active TB and HIV simultaneously; 3/8 (38%) patients were lost to follow up and presented with advanced HIV disease and active TB (all extra-pulmonary TB).

Conclusion: BHIVAs stratified approach to screening for LTBI means targeting high-risk groups to avoid unnecessary tests and cost. Testing can be improved in our clinic. We found it is essential to ensure adequate infrastructure is in place to best perform the tests. In addition to screening, to prevent TB in our clinic, consideration for retention in care services are important.
Plenary Speaker Biographies

Jane Anderson (Homerton University Hospital NHS Foundation Trust). Involved in the care of people with HIV since the beginning of the epidemic my clinical practice and research focus on migrant and ethnic minority populations in the UK. I hold honorary professorial appointments at Queen Mary, University of London and University College London. I co-chaired the 2013 Standards of Care for people with HIV, and am immediate past Chair of the British HIV Association.

Nathaniel Ault is the Consultant HIV Nurse at Barts and The London Trust. He has worked in HIV for over 20 years in various posts across the community, acute, palliative and voluntary sectors. He has a first degree in Psychology and a Masters degree in Nursing (Advanced Practitioner) and is currently chair of the National HIV Nurses Association.

Yusef Azad is Director of Policy and Campaigns at NAT (National AIDS Trust) which he joined in 2004. His work has covered all areas of HIV policy in the UK including HIV testing and prevention, migration issues, criminalisation of transmission and NHS reorganisation. From 2008 to 2011 he was co-Chair of the European Union’s HIV/AIDS Civil Society Forum. He was previously a House of Commons Clerk, supporting the work of the parliamentary select committees.

Juliet Bennett has 25 years’ HIV nursing experience in a variety of settings and a special interest in medicines-related behaviours. Specialising in HIV from 1992 she was responsible for leading the development of adherence support services at Chelsea & Westminster Hospital. For the last 7 years Juliet has worked independently as a consultant to the NHS, pharmaceutical industry and in healthcare-related education. In this capacity she has trained, presented and written widely for nurses and professionals allied to medicine. Juliet currently sits on the National HIV Nurses Association Executive Committee for her second term, as Journal Officer with additional roles on the Education Subcommittee and Competencies Working Group.

Alison Brown is the principal HIV scientist at Public Health England (formerly the Health Protection Agency), where she co-ordinates HIV-surveillance activities. Alison has led the development of the new national HIV dataset, the HIV and AIDS Reporting System (HARS), which integrates current surveillance systems and will be rolled out during 2013. As well as enhancing public health information, HARS will monitor the level of HIV care and audit patient outcomes, in addition to informing the commissioning of HIV services. Her main research interest lies in evaluating HIV treatment as prevention. This involves examining why HIV transmission has not declined among gay men in the UK despite widespread treatment coverage and subsequent viral suppression among the diagnosed population.

Jane Bruton is the Nurse Consultant for HIV at Chelsea and Westminster NHS Foundation Trust. She has worked in HIV since 1987 and has an MA in Medical Anthropology. She is on the NHIVNA Executive Committee and co-authored the National HIV Nursing Association Competencies.

Michelle Croston Since beginning my nursing career, I have worked at North Manchester’s Infectious Diseases Research Department. During my time on the ward, I gained lots of experience – from palliative care to treating HIV patients in a high-dependency setting. I experienced the challenges of complex patient care and witnessed the stigma associated with the condition. After undertaking health visitor training, I subsequently moved to North Manchester’s HIV support team. As part of my professional development, I am undertaking a professional doctorate, and my research focuses on how HIV nurses elicit patients’ concerns in order for them to provide patient-centred care. Alongside the duties that I will be assigned within the Executive Committee, I hope to work on developing evidence-based strategies aimed at improving standards of care for patients, with a specific interest in developing strategies and resources to help nurses provide psychological support for PLWHIV.
Plenary Speaker Biographies

**Hilary Curtis** trained as a scientist and is an independent consultant on health and policy. She has managed BHIVA’s clinical audit programme since its inception.

**Yvonne Gilleece** is a Consultant in HIV & Genitourinary Medicine at Brighton & Sussex University Hospitals NHS Trust and an Honorary Senior Lecturer at Sussex University. She is the Lead for HIV in Pregnancy and Hepatitis B as well as a clinical supervisor for a PhD on HIV and Bone. She is a member of the BASHH HIV SIG and is an author on the BHIVA guidelines for Hepatitis, HIV-2 and the most recent guidelines on HIV in Pregnancy.

**Ian Hodgson** is a consultant researcher, educator and advocate, involved for 15 years in the HIV sector. Areas of interest include: HIV stigma; cultural determinants of HIV prevention; HIV treatment access; adolescents living with HIV; HIV advocacy; and project evaluation. He has worked in a range of locations in Southeast Asia, Africa, and Europe, and most recently was Senior Research Officer at the International HIV/AIDS Alliance. He is currently PhD supervisor for students at Bradford and Huddersfield Universities, and delivers sessions on HIV advocacy for Trinity College, Dublin, Ireland.

**Lorraine Lewis** is a Clinical Nurse Specialist at Birmingham Heartlands Hospital. She began working in Infectious Diseases in 1994 as an inpatient nurse and has worked for the HIV team in an outpatient setting since 2000, the last 8 years as a CNS. She has qualified as a Clinical Hypnotherapist and uses this within her practice.

**Richard Ma** is a GP principal in London. He trained in GUM/Sexual & Reproductive Health at King’s College Hospital, Margaret Pyke Centre and Mortimer Market Centre. He has contributed to sexual health policy and implementation at local, regional and national levels through working with organisations such as: RCGP, Faculty of Sexual & Reproductive Healthcare, Department of Health and National Chlamydia Screening Programme. He is currently a part-time doctoral student at the London School of Hygiene & Tropical Medicine.

**Emma Macfarlane** has worked in HIV for 15 years, including in-patient and outpatient care, community nursing and research, and currently works as a nurse practitioner at Barking, Havering and Redbridge University Hospitals NHS Trust. She has a B.Sc (Hons) in Nursing, an Advanced Nurse Practitioner M.Sc, and is due to undertake a PhD in Sociology later this year.

**Rebecca Mbewe** has a degree in Psychology. Her current role is as Senior Caseworker at Positively UK. She also sits on the Board of a national charity.

**Gordon Mundie** is a leading expert in engaging and empowering PLWHIV, hepatitis C and other long-term health conditions to build and strengthen the determinants of good health and wellbeing especially within those communities disproportionately affected by HIV and poor sexual health: men who have sex with men and Africans. Gordon set up and managed the Groupwork Programme funded by the Pan London HIV Prevention Programme at the Terrence Higgins Trust, project managed the Community Champions Project in INWL PCTs and works as a freelance consultant, group work facilitator and trainer.

**Eileen Nixon** has been an HIV Nurse Consultant in Brighton since 2004. Her main interests in HIV nursing include competency and practice development, clinical pathways and international HIV nursing education. Eileen is in the final stages of completing her PhD into models of HIV healthcare provision. Eileen is currently the NHIVNA representative on the HIV Clinical Reference Group.
Maxine Owen is a Clinical Nurse Specialist in HIV at Birmingham Heartlands Hospital, with 27 years’ experience.

Linda Panton is an HIV clinical nurse specialist in Edinburgh. She has worked in RIDU (Regional Infectious Disease Unit) for 20 years gaining a lot of experience working with drug users. She has a Masters in Nursing and Education and has an interest in ensuring HIV education continues to be delivered to student nurses.

Silvia Petretti is an HIV-positive woman and advocate for the rights of people living with HIV. Since 2005 she has been openly living with HIV, believing that it is a powerful tool to challenge the stigma and prejudices directed towards women living with HIV. Silvia is a co-founder of PozFEM-UK which acts as a network and voice of Women Living with HIV in the UK. Silvia is Deputy CEO at Positively UK and works to ensure HIV-positive people around the UK are able to influence policy. Silvia is an experienced advocate and has spoken on behalf of the community of people living with HIV at the House of Lords and at the High Level Meeting on HIV/AIDS at the United Nations. Silvia sits on the board of trustees of the Sophia Forum, the Steering Committee of the UK Community Advisory Board, and was community representative on the BHIVA Board of Directors between 2009 and 2012.

Makeneiloe Ramapepe has been a Registered Nurse Midwife since 1982 and gained a Diploma in Nurse Clinician Practice and Primary Health Care in 1993. Currently working with MSF (Médecines Sans Frontières) as a Field Nurse Mentor, TB and HIV Focal Person and TB Infection Control Responsible for 5 years (Morija and now Roma project).

Chris Sandford A patient representative at the Mortimer Market Centre in central London – one of the largest HIV clinics in the UK with over 4250 patients. He also administers the Bloomsbury Patients Network. Last year the patient representatives engaged 1500 patients in one-to-one peer-support sessions, motivational workshops, educational forums, social events and newly diagnosed courses. Involvement includes: British HIV Association (BHIVA), BASHH, National Aids Trust, NAM, Positively UK, Living Well, Terrence Higgins Trust, University College London, UCL Partnership, London School of Hygiene & Tropical Medicine, New York University, UK Consortium, African Health Policy Network, MEDFASH and the Royal College of GPs. Contributor to the new edition of The ABC of HIV, a member of the London Specialised Commissioning Group (Audit & Outcomes Committee and PPE Subgroup), the working parties for the Standards for Psychological Support for PLWH and the BHIVA Standards.

David Stuart has spent the last seven years monitoring the epidemiology of the HIV/HCV/Methamphetamine-use syndemic amongst MSM in London, managing the LGB&T substance misuse service, Antidote. He has pioneered appropriate treatments and care pathways, raised awareness, and educated healthcare professionals; while bringing this expertise to the innovative CODE clinic at 56 Dean St, for MSM who use drugs for sex, and managing the Antidote partnership at CNWL’s Club Drug Clinic.
Information on Birmingham

Conference Venue

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Birmingham Convention Bureau

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Travel Information

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More than 20 scheduled airlines serve Birmingham International Airport, linking it to over 60 business destinations throughout Europe, North America and the Middle East. Conveniently located next to the National Exhibition Centre, and adjacent to Birmingham International Rail Station, travellers can access the city centre and the ICC quickly and conveniently.

By rail

The International Conference Centre is minutes away from Birmingham New Street Station, the UK’s largest interchange station. Regular services connect to London (1hr 40mins), Edinburgh (4hrs 30mins), Cardiff (2hrs), and most other regional towns and cities throughout the UK.

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Current Issues in HIV
Social issues affecting people living with HIV
Wednesday 16 October 2013
National Council for Voluntary Organisations, London

6th Annual BHIVA Conference for the Management of HIV/Hepatitis Co-infection
in collaboration with
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Wednesday 13 November 2013
Queen Elizabeth II Conference Centre, London

BHIVA Autumn Conference
including CHIVA Parallel Sessions

14–15 November 2013
Queen Elizabeth II Conference Centre, London

For further information on these events, please contact:
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