



National HIV Nurses Association

# ***FINAL PROGRAMME***



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

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**27–28 June 2013**  
**The ICC Birmingham**

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preceded by  
**NHIVNA Pre-Conference Study Day**  
**Wednesday 26 June 2013**

Sponsored by  
**janssen**  
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## Venues

*All venues at The ICC Birmingham, unless stated otherwise*

Registration .....	Hall 6 Foyer
Lecture Theatre .....	Hall 5
Exhibition .....	Hall 8
Posters .....	Hall 8 and Foyer
Lunch and Refreshments .....	Hall 8
Sponsors' Invited Lectures .....	Hall 5
Workshops .....	Hall 6
Pre-Conference Study Day .....	Hall 6
Gala Dinner .....	Crowne Plaza Birmingham City Centre

## 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*

# Programme

**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 I**

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



National HIV Nurses Association

## Thursday 27 June 2013

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*

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# Programme

**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**

Kenji 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*



# Programme

**Thursday 27 June 2013**

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**1745–1835**

**NHIVNA Workshop I** (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*

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**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

**0800–0850**

**NHIVNA Workshop 2** (Hall 6)

*(Pasties, tea and coffee will be provided)*

*(please see page 14 for further details)*

**Quantifying experiences: quantitative data collection and analysis within nursing research**

Dr Hilary Curtis

*Regordane Editorial and Design Services*

Michelle Croston

*North Manchester General Hospital*

**0900–1000**

**NHIVNA Plenary Session 2**

*Chairs: Jayne Churchill*

*NHS Lothian, Edinburgh*

*Maxine Owen*

*Birmingham Heartlands Hospital*

**Standard: Psychological care**

**Self-esteem building with vulnerable patients: the role of the nurse**

Ms Juliet Bennett

*Independent Nurse Specialist*

**Standard: Sexual health and identification of contacts at risk of infection**

**The impact of recreational drugs on sexual wellbeing**

David Stuart

*Antidote Substance Use Services, London*

**1000–1100**

**NHIVNA Oral Abstracts Session 3**

**Abstracts 9–12**

*Chairs: Jayne Churchill*

*NHS Lothian, Edinburgh*

*Maxine Owen*

*Birmingham Heartlands Hospital*

**1000–1015**

**Abstract O9** Evaluation of fitness for purpose in provision of an innovative, culturally sensitive, HIV counselling approach: an Interpretive Phenomenological Analysis (IPA)

*Agatha Benyera-Mararika, Canterbury Christ Church University, Medway*

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**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*

# Programme

**Friday 28 June 2013**

**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](http://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.

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# 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

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

## 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



National HIV Nurses Association

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](http://www.nhivna.org) | [nhivna@nhivna.org](mailto:nhivna@nhivna.org)

NHIVNA Registered Charity Number: 1099074

VAT Registration Number: 877 3182 89



# Abstracts

## Abstract O1

### To test or not to test, that is the question

A Waters<sup>1</sup> and E Pursell<sup>2</sup>

<sup>1</sup>North Middlesex Hospital, London, UK and <sup>2</sup>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 multicultural London hospital in a HIV 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.

Table 1	n(%)			n#
	Yes	No	Don't Know	
Every patient should be offered HIV testing when they are admitted to hospital.	54(38)	61(43)	27(19)	142
Patients should be offered HIV testing if they are from a country with high risk of HIV.	96(67)	23(16)	24(17)	143
Patients should be offered HIV testing if they are homosexual.	73(51)	38(27)	31(22)	142
I would like to be able to self-test anonymously for HIV using HIV rapid test kits.	53(37)	56(39)	33(24)	142
Hospitals should supply HIV rapid test kits to allow staff to self-test for HIV.	67(47)	47(33)	28(20)	142

**Conclusion:** 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.

Knowing one's HIV status is important for all including nurses. One third of the nurses agreed they would like to self-test anonymously. Further examination of this as a way to remove the stigma would be required to justify anonymous self-testing as a way to increase HIV testing amongst nurses.

## Abstract O3

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

M Owen, 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/deliver a telephone consultation service to reduce clinic visits and free up doctor appointments.

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 books an appointment slot on Tuesdays/Wednesdays 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 compiled 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 O2

### Missed opportunities

S Chidzomba 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 costs. The objective is to educate other health 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 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 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!



# Abstracts

## Abstract O5

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

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<sup>1</sup>Regional Infectious Disease Unit, Edinburgh, UK and <sup>2</sup>Chalmers Centre, Edinburgh, UK

**Introduction:** Health Improvement Scotland Standards for HIV Prevention, Treatment and Care (2011) require the development of an ICP for HIV care. The objectives of this project were to:

- Develop and pilot an ICP for the first three months of care following an HIV diagnosis in two units (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 2012. 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 of was high 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 GP 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 introduction of a paper-based ICP has been challenging. To avoid duplication of work the ID 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 O7

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

R. Bath, S Tillet, S Tariq and C Orkin

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 pressurised 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 (n/N (%)) in MAU is 1509/17652(7.7%). In IC the rate is 457/927(49.2%) 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)

MAU	IC
Average patients seen per month	1400
Time to Patient Report	1-2
Admission already covered in?	No other used in MAU test
Most tests taken by?	Doctor/physiotherapist
Average length of patient stay in?	2
How to obtain consent?	These patients are conscious
	Many patients are unconscious and require no consent to blood sampling

**Conclusion:** Both MAU and IC have seen an increase in rates 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 added to blood tests that are routinely 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 O6

### HIV Complex Case Audit

R. 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 O8

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

J. McLuskey, C Evans and P Callaghan

The University of Nottingham, Nottingham, UK

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; belief about sexual risk behaviours and previous sexual partners; or as part regular testing practice. They reported effective and negative experiences of receiving their diagnoses 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.

# Abstracts



## Abstract O9

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

A Benyera-Maranki<sup>1,2,3,4</sup>, P James<sup>4</sup>

<sup>1</sup>Canterbury Christ Church University, Medway, UK, <sup>2</sup>Middlesex University, London, UK, <sup>3</sup>Terrence Higgins Trust, London, UK and <sup>4</sup>New School of Counselling and Psychotherapy, London, UK

**Background:** African women are most represented service-users of HIV services, as most are diagnosed following routine antenatal screening. Although majority of them suffer from the psychological impact of being infected and accepting the diagnosis but are reported to be reluctant to access existing psychotherapy/counselling services, very little is known about their reasons. One service-user feedback survey shed some initial light. Cultural background has an impact. Although there is a plethora of literature advocating on the importance of culturally sensitive counselling services provision, still scant work relates to HIV-counselling. An award winning innovative culturally-appropriate counselling was set up. Therefore it is of paramount importance to gain enhanced understanding of those who access service more for planning and provision of fit for purpose services.

The study intent was to:

- Have an in-depth understanding through exploration of the lived experiences of HIV sero-positive African childbearing migrant women living in London.
- Evaluate and compare the efficacy of existing and alternative culturally sensitive models of counselling provisions to inform policy and practice.

**Methods:** A purposive sampling of a total of the 15 women participated in in-depth qualitative semi-structured tape-recorded interviews. IPA is used as the research methodology appropriate for the study population, research question sample size. Thematic data analysis method was undertaken for the verbatim interview transcription.

**Results:** Participants explored their experiences and the existence of barriers to effective helping by comparing the models. What emerged were the tension, links and paradoxes of the African philosophical sense of interdependent self as expressed against the existential anxiety and implications of isolation/aloneness in the context of the impact of HIV diagnosis and inherent stigma. Emphasis was on the significant positive impact of provision of situation-specific counselling by a counsellor from a similar cultural background whilst they felt more understood compared to counselling westernised approach with therapist of a different cultural background. Long term as opposed to time-limited counselling was preferred. Importance on African heritage and identity was flagged out as a distinct important counselling aspect.

## Abstract O11

### What are you trying to say?: pilot study results

M Croston

North Manchester General Hospital, Manchester, England

**Background:** Communication impacts on psychological distress and morbidity, adherence to treatment, quality of life, and satisfaction with care, complaints, litigation, and finally stress levels in healthcare professionals. A significant consequence of poor communication is the impact that it has on psychological morbidity. Research suggested patients do not disclose many of their concerns and healthcare professionals do not pick up all the things that they have been told. Communication skills training are designed to give healthcare professionals the skills and confidence needed to elicit patients concerns.

**Methods:** The participants (n=20) were asked to subjectively rate self-efficacy for 16 skills/situations using a modified version of the self-efficacy questionnaire. Participant's attitudes and beliefs towards the likely consequences of their communication behavior were assessed using a modified version of the outcome expectancy questionnaires. Participants were also asked to provide feedback on the course content, supportive material, perceived transferability of skills into practice and asked if they would recommend the course to a colleague. Participants were invited to provide feedback to the researcher anytime after the day by sharing any thoughts that may have come to mind as a result of their own personal reflection.

**Results:** Participant's self-efficacy scores increased significantly post study day. Participants self efficacy rating support anecdotal reports that participants feel they know how to establish patients feelings, but do not know how to manage these once elicited. Outcome expectancy results showed consistent improvements, which mirrored what is observed within the wider literature. The most predictable changes occurred in relation to participant's beliefs that patients would raise important concerns without being asked. Post study day participants felt less likely to feel responsibly for solving all their patients concerns. Participant's scores positively increased around their attitudes in relation to their own skills when responding to difficult questions. Participants felt the skills that they had learnt would be easily transferable to their clinical practice.

**Discussion:** The use of cue based assessment and interviewing approach has been shown to improve patient's outcomes, increase patient's satisfaction and compliance with treatment, reduce consultation times and complaints.

## Abstract O10

### Narratives of individuals and couples in relationships with one known HIV-positive partner (serodiscordant relationships)

K Rogers

Anglia Ruskin University, Cambridge and Chelmsford, UK

**Background:** Knowledge about how the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) affect individuals and couples is changing. In order to understand the complexities of relationships where one person is known to be HIV positive, new theoretical constructions are needed. Within this qualitative study, Strauss and Corbin's (1990, 1998) grounded theory methodology was used to construct a substantive theory of serodiscordant relationships. Symbolic interactionism provided a theoretical framework to understand these relationships from the perspectives of 'actors' for whom serodiscordance has symbolic meaning. This proposed oral presentation explores the interpersonal and social experiences of both the HIV-positive and negative partners in serodiscordant relationships.

The research aims to understand the experiences of individuals and couples in HIV serodiscordant relationships.

**Methods:** Through direct involvement in data generation, transcribing, analysis and theory construction, the researcher repeatedly interacted with and immersed in the data. Ethical approval was granted by the South East London Research Ethics Committee (REC) 1. Participants were purposively recruited from three NHS Genitourinary Medicines (GUM) clinics in North East London. Theoretical sampling focused on seeking to clarify concepts that emerged from data. 32 narratives were generated from 24 individuals and couples in current serodiscordant relationships. A qualitative data analysis software 'Maxqda' facilitated data management and analysis.

**Results:**

- Themes from the study include
- Surviving serodiscordance
- Supporting serodiscordance
- Disclosing serodiscordance
- Maintaining/staying in relationship

**Conclusion:** Albeit in different guise, HIV-positive individuals and couples are confronted with psychosocial experiences and HIV is still a stigmatising disease with no cure. In order to understand and explain 'how individuals and couples experience HIV serodiscordance', it is essential to discover the meanings from those who interpret the relationships through symbolic interactions and interpretations.

The research provides evidence that informs policy and develops interdisciplinary practice on HIV serodiscordant relationships.

## Abstract O12

### Masculinity, fatherhood and HIV: how has HIV impacted on experiences of fatherhood? A Foucauldian Discourse Analysis

S Highton<sup>1</sup> and A Smith Barnes<sup>2</sup>

<sup>1</sup>University of East London, London, UK and <sup>2</sup>Body & Soul, London, UK

**Background:** This study uses Foucauldian discourse analysis to better understand the experience of fathers living with HIV. Fathers have been largely ignored by studies of the family and HIV. In comparison to mothers there is also a lack of fathers affected by HIV in health and support services. There exists a stereotype of the absent father, particularly in families affected by HIV. However, up to 50% of HIV positive heterosexual men in the UK show a desire for fatherhood and 1 in 7 fathers in the UK are the primary carers for their children. Research on child development has emphasised the importance of fathers.

**Methods:** Six in depth semi-structured qualitative interviews were conducted with fathers living with HIV and analysed using Foucauldian discourse analysis. The participants were service users with a third sector charity organisation. Interview agenda included questions about fatherhood, parenting, masculinity, stigma, communicating about HIV and experiences of health care and support.

**Results:** Discursive constructions of fatherhood and HIV may enable and constrain certain behaviours within the family. These discourses suggest links between masculinity and responsibility for HIV. HIV is discussed as a positive force in some fathers' lives, encouraging men to take up new subject positions, namely that of the responsible father, which would not have been possible without HIV. Mainstream discourses on HIV are taken up and reworked by fathers as a means of coping with the effects of illness. These constructions interact and collide with wider hegemonic masculine ideals of fatherhood. The impact of HIV on parenting, communicating about HIV, co-parent relationships and health care and support are also discussed.

**Conclusion:** These findings have important implications for working with fathers and families affected by HIV. They highlight the importance of working with fathers in gender specific or gender sensitive contexts. They also suggest opportunities for building positive identities and relationships and coping with the psychological challenges of HIV for fathers. Further research into fathers affected by HIV is called for.

## 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 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 Heideggerian 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' 'risky/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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<sup>1</sup>Freelance Nurse Consultant, Nationwide, UK, <sup>2</sup>University of Nottingham, Nottingham, UK and <sup>3</sup>North 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) now 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 NHVNA members (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<sup>1</sup>. 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 wouldn't 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 'to talk openly about how I feel about HIV'. 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 those in need of support 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.

<sup>1</sup>HPA, 2012

## Abstract P4

### Between the Sheets: A qualitative review of issues faced by women living with HIV in relation to sexual activity

P Jelliman

Liverpool Community Health NHS Trust, Liverpool, UK

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 sensuality, perceptions of future celibacy, 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.
- Impart appropriate information via expert presentations /personal stories.
- Provide interactive workshops to address sensuality, 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, PEPSE, the effect of HIV on sexual relationships, link between violence abuse & HIV, Viral Load interpretation. This provided rich data demonstrating an unmet need. Excellent feedback was received from 67 attendees for presentations, workshops demonstrating appropriate content. Powerful, inspiring personal stories were presented by WLHIV. Evaluation identifies clear future support topics. 45% linked HIV and abuse. 23% disclosed Bi sexuality, posing inclusion issues. 50% identified as Black underrepresented on focus group 67% did not consider HIV a disability. Recently, the focus group have delivered a feedback event, attended by commissioning groups, doctors, patients and voluntary sector representatives. Evaluations were presented, and group work undertaken to identify progression. Future funding has been secured.

Fantastic event which should be repeated and expanded on. In a time of austerity, well done to funders and organisers for pulling off a powerful, innovative event the empowering impact of which has been felt by everybody I have spoken to today.

# Abstracts



## 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 effectivity 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 enjoying 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 P7

### Pain Management Group

R Downes

*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 and from the group was then formed with myself, a Community based Clinical Nurse Specialist in HIV, a Counsellor and a Therapist, both employed by local HIV voluntary support agency. This meets the recommendations of The Health and Social Care Act 2012, 'a greater voice for patients' and stresses the importance of the role of the specialist nurse in developing expert programmes of patient care and clinical outcomes.

The group meets monthly for a 2 hour session broken down into a clinical session and a therapy session. The first meeting was attended by 8 patients and was used to outline a mission statement, core values, aims and objectives along with identifying any professional input the group might like to invite as guest speakers. A program is outlined for 12 monthly meetings and clinical guest speakers include a pharmacist, physiotherapist, medicines management, chronic fatigue specialist and a pain specialist. Therapies include massage, art work, acupressure, reiki and meditation. There are also sessions exploring mindfulness, sleep and a session on pain and emotion in addition to what one might expect; the principles of pain management, assessment of pain and clinical investigation, anatomy and physiology of the pain process plus exercise and pain. A garden allotment has been secured for the group to access weekly. This provides benefits such as physical activity, peer support, comradery and increase in self-worth.

The group members are encouraged to keep a reflective diary. Results so far have been promising and the group are growing in confidence, ability and their understanding of pain as an individual experience, we plan to evaluate the project after 12 months to further develop the concept.

## Abstract P6

### Awareness of communication skills training within HIV nursing practice

M Croston

*North Manchester General Hospital, Manchester, England*

**Background:** The Department of Health published a 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.

British Psychological Standard (2011) 2 also aims to improve the psychological assessment and support to patients with HIV.

**Objective:** 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 NHVNA, 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) female.

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, 26.5% (n=13), 5-10 years 26.5% (n=13), 10-15 years 8.2% (n=4) 15-20 years 18.4% (n=9), 20+ years 20.4% (n=10). 53.2% (n=25) of respondents reported receiving formal training in communication skills. 51.0% (n=25) had received formal training in counseling skills with 47.95 (n=23) attending Motivational-interviewing training. Training in communication models that address emotional concerns of patients (SAGE and THYME) was heard of by 39.6% (n=19) of respondents with only 4.25 (n=2) receiving training in the model. 87% (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

1. Department of Health (2009) The NHS Consultation; Securing the NHS today for generations to come, Department of Health.
2. British Psychological Society (BPS), British HIV Association (BHIVA) and Medical Foundation for Aids and Sexual Health (Medfash) (2011) Standards for psychological support for adults living with HIV.

## Abstract P8

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

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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 reconcilable 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. 2 patients had a history of mental health problems predating their HIV diagnosis and 2 patients were diagnosed with depression during follow up.

The median CD4 count at diagnosis was 220 (IQR 78 to 399) and the median best CD4 on treatment was 509 (IQR 207 to 737) with the median lowest CD4 count off treatment being 49.5 (IQR 28 to 78). All patients took ART with the median time from diagnosis to stopping or declining 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 cryptococcal meningitis and a cerebral 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 bed days were also needed to address the complications of untreated 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 cohorts 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 P9

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

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**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 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 this film impacts on the way you feel about people living with HIV?' yielded desirable feedback in 142 out 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 treated equally and it's not fair', and 'I don't find them disgusting anymore'.

**Conclusion and Recommendations:** This pilot showed positive evidence from both open and closed questions that this intervention was effective in adolescent participants 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 P10

### A service improvement based needs assessment to identify the fears of young people of different age groups living with and affected by HIV

K Forbes and A Barnes

Body & Soul, London, UK

**Background:** By identifying specific fears of young people living with and affected by HIV (YPHIV), we better understand how to support this group of vulnerable individuals. Through comparing the fears of progressing age groups, we can prioritise the interventions and support provided at each stage using a lifecourse approach. This service improvement based needs assessment will influence programming and help tailor interventions to address HIV-related fears according to age.

**Methods:** On three occasions over 27 months (November 2010–February 2013) service users of a third sector support service for YPHIV aged 10–12, 13–19 and 20–29 attended workshops on Fears and HIV. In each workshop participants wrote down and anonymously submitted their fears. These fears were then categorised and an expert facilitated an immediate group discussion.

**Results:** The fears mentioned in each discussion were categorised according to themes as below. Each individual fear raised was recorded, even if it had been already mentioned by another member of the group.

Age Group	Number of participants	Total number of fears collected (average number per participant)	Medication (% of total)	Stigma & Disclosure (% of total)	Death (% of total)	The future and transmission (% of total)
10-12	8	8 (1)	0	1 (12.5)	2 (25%)	5 (62.5%)
13-19	53	101 (1.9)	12 (11.9%)	29 (27.7%)	25 (24.8%)	35 (35.6%)
20-29	15	47 (3.1)	6 (12%)	18 (38%)	7 (15%)	16 (34%)

Additional fears disclosed include:

- medication security by both the older age groups
- development of another chronic illness
- drug resistance

**Conclusion:** This small needs assessment revealed commonly experienced fears, across the ages (death, purposeful and accidental disclosure, adhering to medication) which clearly need addressing regularly, but also some less common yet valid and reasonable fears which will also influence future planning. The small sample size is a limitation when it comes to comparison, but from this initial assessment it appears that fears around medication, stigma and disclosure increase as YPHIV grow older; but fears around death decrease. Fears around the future and passing on of the virus were present across the ages.

## 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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At the end of 2011 there were an estimated 96,000 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-imagining of future life, which is influenced by personal experiences of the infection, information gathering and health professionals' responses.

## Abstract P12

### Opt-out HIV testing within intensive care in a large urban hospital: an innovative testing initiative

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**Background:** UK guidelines recommend increasing opt-out HIV testing in a range of medical settings in areas of high prevalence. Routine testing in acute medical settings is commonly practiced, however it remains rare within intensive care (IC) with evidence of missed opportunities for HIV diagnosis in IC patients. In this setting the consequences of a missed HIV diagnosis may be particularly critical as it may prevent appropriate immediate life-saving treatment.

**Methods:** We have started an opt-out HIV testing initiative within IC, in a hospital with an existing opt-out testing scheme in the acute medical admissions unit and a high local HIV prevalence of 5.95 per 1000. All patients admitted to IC or the high-dependency unit (HDU) non-electively are informed that they will be tested for HIV unless they opt-out. Those lacking capacity to consent are tested in their best interests based on high local prevalence. Our HIV-testing team, comprising an HIV consultant, registrar and nurse facilitator worked with IC staff to develop guidelines. The testing team also provided training, support and patient information material to IC staff to facilitate implementation of the intervention. We provide preliminary data from the first 3 months of the project.

**Results:** Of the 461 patients admitted to IC/HDU in October–December 2012, 59.7% (n=275) were tested for HIV. In the 3 months prior to opt-out testing the rate was (28/432; 6.9%; p3) and was instrumental in guiding investigation and treatment. He was successfully discharged from hospital having commenced treatment for HIV and B-cell lymphoma. One further patient had an equivocal HIV test result, but was negative on repeat testing.

**Conclusions:** We believe this service development to be the first of its kind in the UK to deliver routine opt-out HIV testing within an IC setting. It is a sustainable model with HIV staff providing training and support to IC staff, who deliver the testing. This strategy has resulted in a significant increase in HIV testing rates within an IC unit serving a high-prevalence local population, and will guide life-saving management in patients who test positive.



# 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 diagnosis, 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 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 with 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 with 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 P14

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

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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 (BHIVA testing guidelines, & NICE guidelines, both HIV & TB, & global (WHO CDCs, and UNAIDS). This guidance was therefore a driver 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 GANNT 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 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 health care 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

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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. NHVNA has championed nursing research and the concept of HIV nurses networks; the NHVNA 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:** A: An online survey sent to all members of the group with an invitation to participate in a focus group.

B: A focus group conducted after the results of the survey have been reviewed

**Results:** A: 39 nurses were sent an email invitation to participate; 23 (59%) nurses completed the online questionnaire, 70% of whom had attended at least half the previous year's meetings. 10 had attended sessions about the research process, all of whom found them helpful. 17/19 were aware of the research project and of these 7 played an active role in at least one aspect. 14 would have liked to play a more active role but were prevented from doing so by a variety of reasons including: insufficient time, skills and experience.

B: 5 had attended the focus group training; 3 of these had facilitated a focus group as had one other. The training was helpful to 2 but not the third and one suggested that holding the training just before facilitating a group would have helped.

Other findings included: not all nurses' participation is supported by their employers and logistics for attending after work meetings affects some; Several nurses made positive comments about participating in the network research project and 13/15 would be interested in future network research. There was also positive feedback about network meetings. 15/19 were on NHS pay bands 6 or 7. Median years as a HIV nurse was 10 (range

**Conclusion:** Conducting nursing research through a HIV nurses network is possible and can be fulfilling to nurses who participate.

## 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 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/mm<sup>3</sup> (Group 1) had an Interferon Gamma Release Assay (IGRA) (T-SPOT®.TB); those with a CD4 count ≤200 cells/mm<sup>3</sup> (Group 2) had an IGRA followed by a Mantoux test (TST) if this was negative. If any test was positive, a Chest Clinic 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, 1 had previously completed chemoprophylaxis for active TB and the other two were both commenced on chemoprophylaxis. In the non-diagnostic group, 1 had a subsequently positive QuantiFERON® IGRA test (QFT) and treatment for LTBI, 1 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 1 (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/mm<sup>3</sup>. Specimen transport issues and poor attendance has been a real limitation and has prevented all eligible subjects being appropriately screened.

## 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 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 among 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 eras. 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, 'HIV post-exposure prophylaxis', 'sexual behaviour', 'risk taking', '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 signalled 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 (55%) 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; infective(10), cardiology(4) dermatology(5) orthopaedic(2) gynaecology (3) renal(2) ophthalmology(1) endocrine(1) hepatology(2) nonsclerotic 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 admission; the definition of stable patient may differ for those who have lived with HIV from birth for more than 2 decades.

## Abstract P23

### Are generic antiretroviral drugs truly cost saving?

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**Background:** In 2010/2011, HIV Commissioners 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 £44k 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, PMTCT 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 £1742/yr.

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 £113); neither were statistically significant. Five patients (12%) reported problems with the switch; 1 felt unable to take the new tablets and switched back days later, wasting 3 months of drugs. One patient developed a rash and 3 contacted the clinic due to confusion about the doses or timings. One patient had a detectable VL (411 copies/uL) at 1 year post switch. He had a history of adherence issues and a VL of 71 copies/uL pre-switch.

**Discussion:** As further generic antiretroviral drugs become available, pressure may be placed on clinicians to switch from fixed dose combinations to components if the direct drug cost is less. Our work shows that the additional clinical costs involved in this may outweigh or negate the simple cost savings of the drugs. Additionally, 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 P22

### Are Health and Wellbeing Boards in higher HIV-prevalence areas prioritising HIV prevention?

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**Background:** The Health Protection Agency (HPA) identified 35 Local Authorities (LAs) with diagnosed HIV prevalence >2 per 1000 population aged 15–59 and with >50 individuals diagnosed late between 2008 and 2011. The HPA identified men who have sex with men (MSM) as the priority for prevention in 10 LAs; African communities the priority in 10 other LAs; and both the priority in 15 LAs. From April 2013, LAs are responsible for public health. In preparation, each LA has to identify clear public health priorities in a Health and Wellbeing Strategy (HWBS). The authors sought to establish whether HIV prevention is being prioritised in these higher prevalence areas.

**Methods:** Each LA's Joint Strategic Needs Assessment (JSNA) and HWBS were searched for the words HIV, sexual health, gay men (or MSM or LGBT) and African and the content assessed. The HWBSs indicate when HIV is a priority so subjective assessment was not necessary.

**Results:** 68% of JSNAs in higher HIV prevalence LAs included data on HIV and communities most at risk, 32% did not. More than half of LAs in higher HIV prevalence areas did not prioritise HIV. Only 20% of LAs prioritised HIV in both their JSNA and HWBS. 24 of 35 (68%) JSNAs included content about HIV, sexual health, gay men and African communities. Two JSNAs did not include any of the words searched for, including Manchester. 9 JSNAs did not include content on all the topics. Of those 9, 2 are LAs where both African people and MSM are priorities for HIV prevention; Birmingham included nothing about HIV and Brent no information about MSM. 5 of the 9 are LAs where MSM are considered in need of HIV prevention; 4 made no mention of MSM and 4 no mention of African people, including 3 which mentioned neither. No mention of MSM was made in 2 JSNAs for LAs where African communities are the priority.

7 of 35 HWBSs had not yet completed a HWBS. Of the remaining 28, 11 (39%) had prioritised HIV in their HWBS, 6 (21%) had not prioritised HIV but had addressed improving sexual health in general. 11 (39%) had no HIV priority: of these, Brighton and Hove, Camden, Hackney and Manchester have diagnosed HIV prevalence >5 per 1000.

**Conclusion:** HWBSs don't always reflect the data and recommendations in an LA's JSNA. Some LAs had understood the issue, e.g. setting targets to reduce late diagnosis in their HWBS. BHIVA and community organisations should contact HWB members in higher prevalence areas to present the case for HIV to be included as a priority in their HWBS.

## Abstract P24

### The importance attributed to religious belief plays an important role in the attitude of UK nurses towards people with HIV

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**Background:** The aim was to survey registered nurses for their level of knowledge of HIV, their self-reported attitudes towards HIV infected patients and determine associated factors. Lack of knowledge of HIV may lead to stigmatising attitudes by health care workers. Studies show stigma in health care settings lead to a decrease in uptake of HIV testing. National guidelines state that a nurse should have the competence to obtain consent and conduct an HIV test. There is little literature on the knowledge and attitude levels of registered nurses in the UK.

**Methods:** A cross-sectional study of a sample of nurses (n=144) in a large hospital from all clinical departments using self-completed structured anonymous questionnaires. Descriptive analysis using frequencies was used to examine demographic variables, knowledge and attitude scores and to describe the sample participants. Spearman's rho non-parametric test was used for all correlations as not all of the data was normally distributed. Non-parametric tests, Kruskal-Wallis and Mann-Whitney U, were used to look for associations between continuous dependent variables and the dichotomous background variables.

**Results:** Mean age was 43.3 years. 24 countries of birth were reported. The overall mean knowledge score was 19/25,77% (Median 80 IQR 68–84). The mean attitude score was 4.06 (SD 0.45, Minimum 2.64, maximum 5), the median was 4.08 (IQR 3.76–4.40), the higher the score the more positive the attitude with undecided (3) the neutral point. Nurses who felt religion was 'very important' to them had statistically significant worse attitude scores (Mdn 3.88) compared to other groups 'important' (Mdn 4.40, p<0.001), 'not so important' (Mdn 4.30, p<0.001), 'not at all important' (Mdn 4.36, p<0.001). A strong religious belief was associated with lower knowledge scores.

**Conclusion:** The importance attributed to religious belief appears to influence attitudes toward HIV-infected people. Although overall knowledge was good and attitudes were positive those who self-identified that religion was very important to them had lower knowledge attitude scores. On-going dialogue with religious communities is essential. In addition innovative ways need to be developed to get training to those who need it, for example short in-services on the wards, train the trainer and e-learning programs.

## Abstract P25

### Anal cancer screening in the United Kingdom: a national survey of perceptions and practices among sexual health clinics

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**Background:** The incidence of human papilloma virus (HPV) associated squamous cell anal carcinoma is increasing among HIV-infected individuals. In this population screening for anal intraepithelial neoplasia (AIN) could potentially prevent excess morbidity and mortality from anal cancer. The aim of this study was to assess the awareness and practices regarding anal cancer screening in a sample of Sexual Health Clinics in the United Kingdom.

**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 116 sexual health clinics from England, Wales, Scotland and Northern Ireland. Survey data was collected and analysed using a web-based data collection service (Survey Monkey™).

**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 (HRA). Only 4 (5%) clinics currently have an anal cancer screening service, consisting of screening predominantly HIV-infected MSM and those with history of multicentric HPV-genital disease using anal cytology and/or HRA for the identification of AIN. 15(21%) of clinics responding are planning to set up a screening service in the future, while other clinics 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 among a 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.

## Abstract P26

### As HIV moves towards a chronic disease, how involved are patients in their own care?

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**Background:** Service provision within the NHS has changed, with limited resources and a governmental drive to encourage people to take responsibility for their health. The Standards of Care for People Living with HIV state that HIV+ individuals should be enabled to maximise selfmanagement and should have opportunities to be actively involved in decisions about their health care (BHIVA, 2012). This study explored the lived experience of people with HIV accessing healthcare services and to what extent health needs are being met.

**Method:** Ethics approval was granted for this qualitative study. Participants aged 18 or over, diagnosed for more than 1 year were invited to participate. Recruitment was via posters in both clinical and community settings. Written information was provided prior to participant's consent being obtained. Focus groups were recorded, transcribed and analysed using thematic analysis.

**Results:** Five focus groups were conducted with a total of 16 participants, 9 female; 7 male. Length of diagnosis ranged from 18 months to 25 years. The emergent themes were: Managing own health: this is hard to achieve in reality and participants still wanted to rely on healthcare professionals. Stigma: is a significant issue within the general community and when accessing other healthcare services. Experience of using services: participants stressed the importance of continuity of care, building a relationship with their HIV doctor and barriers to accessing GP services. Changing/future service provision: attempts to 'normalise' HIV were felt to be unrealistic. The need to access different specialties led to concerns linked with stigma and being seen by non HIV specialists. Empowerment: a sense that those diagnosed longest felt more empowered and had a sense of knowledge and control over their condition. Coping with daily life: Chronic fatigue and uncertainty about living with a long term condition was a common concern.

**Conclusion:** Despite professionals viewing HIV as a manageable condition the majority of participants expressed concerns about changes in service provision and the impact on doctor-patient relationships. Participants diagnosed the longest felt more involved in decisions and were more likely to express their opinions. Those diagnosed for less time were more likely to accept the changes. Stigma in the workplace and across other healthcare settings was expressed by all as a concern.

## Abstract P27

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

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**Background:** Faith plays a vital role for many African people and communities - the 2001 UK census shows that approximately 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 claims by faith leaders of 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 of at least 5 cases. At least 15 separate cases were identified in the survey. In some of the reported cases treatment was restarted, but in others the health and mental health of clients declined, in some cases leading to death. The seminar uncovered similar findings, indicating the issue is widespread and being responded to at local levels but with a lack of overall response. The qualitative interviews are ongoing.

**Conclusion:** The findings from all three phases of the research indicate that 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 individuals affected. There is a lack of joined-up approaches or consensus in responding to the issue, which needs to be addressed.

## Abstract P28

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

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**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, 5 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 in Britain as a whole (10%). Respondents had 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 the 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 case management: an integrated care solution

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**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 NHS 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 care 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 non co-morbid outpatient 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 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 service provision. In addition, the ICP forms are designed to encourage primary care teams to support parts of the patient journey where specialist resource is not required. This group proposes that the HIV ICP offers a useful solution to structuring HIV case management within the challenging economic constraint faced by the NHS.

## Abstract P31

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

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**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 HIV positive African men/fathers. 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 medication 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 main issues affecting 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 integration, and employment. Many of the men have multiple partners and the project encourages them to be open about this in order to best manage these lifestyle choices. A key finding has been that group sessions on employment and setting up in business have been the best attended and this has been influential in how the project has developed whilst it retains its original focus on health and parenting. Sessions on domestic violence are also planned.

**Conclusions:** Calabash has been successful in engaging hard to reach and marginalised HIV positive 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 P30

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

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**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; and 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 (e.g. 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 practical support, 17% 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 vocalised 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 P32

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

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**Background:** To investigate the proportion of people who start ART with CD4 <100 cells/mm<sup>3</sup>, are subsequently regularly monitored with consistent viral load (VL) suppression (≤50 copies/mL), yet fail to achieve an adequate CD4 count response (>200 cells/mm<sup>3</sup>) 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 for 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/mm<sup>3</sup>, to predict the timing of reaching this value.

**Results:** From a total of 1,212 starting ART with pre-ART CD4 <100, 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/mm<sup>3</sup>. 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, 16.9), 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/mm<sup>3</sup> over observed follow-up would be 2.4 (1.4–4.5) years. When including those projected to reach 200 by 5 years, the predicted proportion of 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, we predict that only a small minority do not achieve an adequate CD4 count response after five years of ART. Inadequate CD4 response is associated with greater clinical consequences. Care should be taken over interpretation as the participants in the analyses were a select subgroup of people with HIV.



# Abstracts

## 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. We report the proportion of attendees to an 'Over-50 clinic' with previously undiagnosed skin cancer to inform the debate as to whether routine skin screening is necessary in this group.

**Methods:** 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. 32 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 [0–29] and mean duration of HAART was 12 years [0–25]. Two-thirds of participants were well controlled with normal CD4 counts and undetectable viral loads. Over 58% of the study participants had a history of previous or current cancerous 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 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, TB 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 health care workers (HCW). At inception, all patients in A&E were informed by poster, information sheet and verbally that an HIV test was routine for any person having blood taken unless specifically declined. Blood test orders are placed electronically. GUM Services provided oversight and results management.

**Results:** After 26 weeks of the programme 52% of eligible patients (3250) had an HIV test. Only 10% of patients actively declined a test. In 38% of instances, HCWs either did not offer or did not request an HIV test. 58% of attendees were of Non White Ethnicities. HIV testing rates were similar across ethnicities and by gender and age (range 15–103 yrs). Black Africans were most likely to have had a test (60% uptake rate overall), Black Caribbeans were least likely to decline a test if offered (8% decline rate). 9 new HIV positive patients were identified. 2.8/1000 compared to an estimated expected rate range of 1–2.3/1000. A further 9 patients tested HIV positive but transpired to have been previously diagnosed elsewhere. 4 of these 9 had left active care and have since been re-engaged in care and treatment. In total, 5.5/1000 tested HIV positive compared to an expected 4.7/1000 for our population, notwithstanding the partial testing rates observed. Testing rates have risen as the programme has become established and staffs have identified scenarios where test offer and performance was being omitted.

**Conclusion:** Opt Out HIV testing in the Accident and Emergency Department 'Majors' section is feasible and an effective strategy for HIV diagnosis. It is acceptable to patients and Health Care Workers.

## 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 (74/216, 34%) vs education alone (8/252, 3.1%);  $p < 0.001$  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 61/80 (76.3%) 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 P36

### Project 'Test the Hospital'

E Williams, R Bath, N Vaidh, S Tillett, G Mandersloot, N Poole, J Saunders, S Tariq, T Oliver, S Pereira, A Nori and C Orkin

Royal London Hospital, London, UK

**Background:** In areas where HIV prevalence exceeds 2 per 1000, BHIVA guidelines recommend opt-out testing for all general medical admissions in order to prevent late diagnosis and allow for optimal management. In response, opt-out testing is being introduced in Medical Admissions Units (MAU) and Emergency Departments (ED). Opt-out testing also occurs nationally in Antenatal Clinics (ANC) and Tuberculosis clinics (TB). These programmes are often initiated and managed vertically. Joining up the different initiatives within the hospital as part of a 'test the hospital' strategy may be helpful to improve coherence and implementation. In our inner London teaching hospital we combine Opt-out testing initiation with programme monitoring, to ensure efficient testing within relevant area.

**Methods:** Staggered introduction of routine opt-out testing has occurred in nine clinical areas within our hospital, which has a local HIV prevalence of 5.9/1000. We present the results of a series of snapshot audits on HIV testing from seven areas namely: MAU, ITU/HDU, Lymphoma, TB, Viral Hepatitis, Elderly Care Psychiatry (ECP) and ANC. Within MAU and ITU/HDU staff have been educated to incorporate opt-out testing as part of admission. Staff in ECP have been supported to test those with a clinical indicator of dementia. Here we report preliminary data from the first 3–12 months.

**Results:** Rates pre and post-intervention:

	HIV Tests Pre Intervention	HIV Tests post intervention	Positive results post intervention
MAU	50/4009 (1%) 6/12	848/6279 (12%) 8/12	10
ITU/HDU	28/432 (6.1%) 3/12	275/461 (59.7%) 3/12	1
ECP	0/15 (0%) 1/12	39/48 (82.9%) 3/12	0

# Abstracts

## Abstract P37

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

L Power and B McClelland

Terrence Higgins Trust, London, UK

**Background:** Late diagnosed HIV is a significant problem across the UK, with approximately 1 in 4 of all people with HIV currently untested. 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 news 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. NHS 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.

## Abstract P39

### Patient and physician preferences regarding medications for HIV treatment

A Lloyd<sup>1</sup>, D Collomb<sup>2</sup>, S Hearn<sup>1</sup>, S Ali<sup>1</sup> and F Mughal<sup>3</sup>

<sup>1</sup>Oxford Outcomes, Oxford, UK, <sup>2</sup>AstraZeneca, Luton, UK and <sup>3</sup>AbbVie Ltd, Maidenhead, UK

**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 rash, 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 on-line surveys and data were analysed using the conditional logit model whereby the odds ratios (ORs) indicated the likelihood of choosing a treatment. Utility values were calculated using a mapping function of the EQ-5D-5L.

**Results:** Patients placed most importance on treatment effectiveness (OR = 1.030 95% CI = 1.023–1.037) and long term safety profile (OR = 1.061 95% CI = 1.042–1.080). The avoidance of all side effects was valued, particularly risk of psychological consequences (OR = 0.978 95% CI = 0.974–0.982) and heart attack (OR = 0.977 95% CI = 0.973–0.980). Patients valued the avoidance of diarrhoea (OR = 0.991 95% CI = 0.985–0.996) to the same extent as the avoidance of jaundice (OR = 0.990 95% CI = 0.982–0.997). 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,  $p > 0.05$ ). Like patients, they preferred treatments which had a long established safety profile (OR = 1.061 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) ( $p < 0.01$ ).

**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 including rash, 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.

## Abstract P38

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

S Croxford, V Hope, Z Yin, K Cullen, F Ncube and V Delpech

Health Protection Agency, London, UK

**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  $\geq 15$ ) diagnosed with HIV in the UK to the end of 2011 were analysed to examine demographics, late diagnosis (CD4 count  $< 350$  cells/mm<sup>3</sup> 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 consistent 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 (aged 15–59; 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  $\geq 350$ .

The UA Survey shows the variation in HIV prevalence among PWID over time (0.61–1.8%), 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.

## Abstract P40

### Real-life clinical experience with Eviplera™

A Gothard, E Wilkins and A Ustianowski

Infectious Diseases Unit, North Manchester General Hospital, Manchester, UK

**Background:** Rilpivirine/tenofovir/emtricitabine (Eviplera™) is a once daily single tablet regimen (STR) option and is licensed for naïve 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 naïve 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, 70321 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-median 7  $\mu$ mol/L (range 1, 22  $\mu$ mol/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.

# Abstracts

## Abstract P41

### Five years of experience with raltegravir in a large HIV centre

C. van Halsema<sup>1</sup>, T. Whitfield<sup>1</sup>, N. Lin<sup>2</sup>, K. Millington<sup>1</sup>, A. Thompson<sup>1</sup>, A. Gothard<sup>1</sup> and A. Ustianowski<sup>1</sup>

<sup>1</sup>North Manchester General Hospital, Manchester, UK and <sup>2</sup>Manchester Medical School, Manchester, UK

**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); 155 (72%) Caucasian and 54 (25%) African/Caribbean. 189 (88%) were ART-experienced with median baseline CD4 count 324 cells/mm<sup>3</sup> and 26 naïve with median baseline CD4 54 cells/mm<sup>3</sup>. Of those not on ART immediately prior to RAL initiation (*n* = 52), median viral load (VL) was 66650 copies/mL. Doses other than 400 mg bd were used in 26: 16 (7%) individuals on 800 mg bd (15 of whom were on rifamycins) 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 C 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 started 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. 10/215 (5%) stopped RAL due to virological failure, of whom 2/4 with successful sequencing showed RAL resistance (one Y143R; one Q148R).

**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 adherence is good.

## 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

S. Dakshina, L. Foster, S. Limb and R. O'Connell

Barts Health NHS Trust, London, UK

**Background:** HIV-positive individuals with latent TB infection (LTBI) 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.

Risk category	Applicable for screening	No. screened	Positive T spot	Negative T spot	Active TB
High *	34/38	16/34	5/16	9/16	4/38
Medium**	15/23	9/15	3/9	6/9	1/23
Low	1/2	0	0	0	0

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:** BHIVA's 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.

## Abstract P42

### The emergence of new viral strains following treatment failure in an HIV-positive cohort infected with acute HCV

T. Abdelrahman<sup>1</sup>, J. Hughes<sup>1</sup>, J. Main<sup>2</sup>, J. McLauchlan<sup>1</sup> and E. Thomson<sup>1</sup>

<sup>1</sup>MRC Centre for Virus Research, University of Glasgow, Glasgow, UK and <sup>2</sup>Imperial 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 preant post-treatment samples taken from patients who failed standard of care therapy in a rare HIV/acute HCV 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 relapsers, 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 re-infection. 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.

# 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.

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**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.

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**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.

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**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.

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**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.

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**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.

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**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.

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**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.

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**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 NHVNA representative on the HIV Clinical Reference Group.

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# Plenary Speaker Biographies

**Maxine Owen** is a Clinical Nurse Specialist in HIV at Birmingham Heartlands Hospital, with 27 years' experience.

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**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.

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**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.

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**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 (Médicines 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).

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**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.

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**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

### The International Convention Centre (ICC)

Hall 5, Broad Street ■ Birmingham B1 2EA

Telephone: +44 (0)121 200 2000 ■ Facsimile: +44 (0)121 643 0388 ■ [www.theicc.co.uk](http://www.theicc.co.uk)

Conveniently located in the very heart of Birmingham, the International Convention Centre boasts 11 halls and 10 executive meeting rooms with dedicated registration and foyer areas. The ICC offers one of the UK's largest selections of conference facilities under one roof and all the key elements to deliver a successful event.

## Accommodation Information

### Birmingham Convention Bureau

Telephone: 0121 202 5151 Email: [bcb.accommodation@marketingbirmingham.com](mailto:bcb.accommodation@marketingbirmingham.com)

**Birmingham Convention Bureau** is the official hotel booking service for the 15th Annual Conference of NHIVNA. For full details of accommodation and to make a booking please visit the NHIVNA website at [www.nhivna.org](http://www.nhivna.org) and follow the appropriate links from the conference pages. Alternatively, please contact Birmingham Convention Bureau direct via the details below.

## Travel Information

- By air** 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 (1 hr 40mins), Edinburgh (4hrs 30mins), Cardiff (2hrs), and most other regional towns and cities throughout the UK.
- By road** Birmingham is at the hub of a comprehensive motorway network that connects to every corner of the country via the M5, M6, M40 and M42. Furthermore, the city benefits from having over 2,000 parking spaces for the International Conference Centre, and a further 5,000 spaces within walking distance.

## Useful travel contacts

24-hour Highways Agency Information Line	0845 750 4030	<a href="http://www.highways.gov.uk">www.highways.gov.uk</a>
Birmingham Airport	0844 576 6000	<a href="http://www.bhx.co.uk">www.bhx.co.uk</a>
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National Express coaches	08705 80 80 80	<a href="http://www.nationalexpress.com">www.nationalexpress.com</a>
Centro Coaches Hotline	0121 200 2700	<a href="http://www.centro.org.uk">www.centro.org.uk</a>
Taxis	0121 320 2409	



# Birmingham City Centre

### Birmingham City Centre

1	Adlon Bunk Hall	G2	Formula 1 (Birmingham)
2	Age Concern	E4	41 Hagley Court Hotel
3	AR	E2	42 Holiday Inn Birmingham City Centre
4	Ashton Hall	E4	43 Hotel Du Vin & Bistro (Birmingham)
5	Ashton Hall School	F4	44 HQT
6	Ashton Villa Conference & Banqueting	F4	45 HQT Regency Birmingham
7	Ashton Villa	F4	46 HQT Regency Birmingham
8	Ashton Villa	F4	47 HQT Regency Birmingham
9	Ashton Villa	F4	48 HQT Regency Birmingham
10	Ashton Villa	F4	49 HQT Regency Birmingham
11	Ashton Villa	F4	50 HQT Regency Birmingham
12	Ashton Villa	F4	51 The Jam House
13	Ashton Villa	F4	52 Jonathan's Hotel & Restaurant
14	Ashton Villa	F4	53 Jags Inn Birmingham (City Centre)
15	Ashton Villa	F4	54 Jags Inn Birmingham (City Centre)
16	Ashton Villa	F4	55 The Old Library
17	Ashton Villa	F4	56 The Old Library
18	Ashton Villa	F4	57 The Old Library
19	Ashton Villa	F4	58 The Old Library
20	Ashton Villa	F4	59 The Old Library
21	Ashton Villa	F4	60 The Old Library
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36	Ashton Villa	F4	75 The Old Library
37	Ashton Villa	F4	76 The Old Library
38	Ashton Villa	F4	77 The Old Library
39	Ashton Villa	F4	78 The Old Library

### Key to Map

1	International Convention Centre (ICC) Conference venue
2	Hilton Garden Inn Conference hotel
3	Crowne Plaza Birmingham City Centre Conference Social Event venue
4	Radisson SAS Birmingham
5	Ramada City Centre
6	Premier Inn, Brindley Place
7	Apollo Hotel Edgbaston
8	Hotel Ibis City Centre
9	Menzies Strachallan
10	Travelodge Central Broadway
11	Travelodge Broad Street

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## EXHIBITORS 2013

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The 15th Annual Conference of NHIVNA  
is organised and administered by



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# Future Events

## Future events for your diary

### Controlling the HIV Epidemic with Antiretrovirals: from Consensus to Implementation

sponsored by  
International Association of  
Providers of AIDS Care (IAPAC)  
in partnership with British HIV Association  
(BHIVA)

22–24 September 2013  
Queen Elizabeth II Conference Centre, London

### 17th Annual Resistance and Antiviral Therapy Meeting

Tuesday 1 October 2013  
Royal College of Physicians, London

### NHIVNA Study Day 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 British Association for the Study of the Liver (BASL) and British Viral Hepatitis Group (BVHG)

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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Email: nhivna@nhivna.org | Web: www.nhivna.org

#### Prescribing information (UK) Tablets & Suspension

##### VIRAMUNE

Tablets containing 200 mg nevirapine, oral suspension containing 10 mg/ml. **Action:** Non-nucleoside reverse transcriptase inhibitor (NNRTI) of HIV-1. **Indications:** For use in combination with other antiretroviral products for the treatment of HIV-1 infected adults, adolescents and children of any age. **Dose & administration:** **Adults:** 200 mg daily for 14 days, then 200 mg twice daily. **Paediatric:** by body surface area: 150 mg/m<sup>2</sup> once daily for 14 days, then 150 mg/m<sup>2</sup> twice daily, by body weight: below 8 years (suspension): 4 mg/kg once daily for 14 days, then 7 mg/kg twice daily; 8–14 years (tablets): 4 mg/kg once daily for 14 days, then 4 mg/kg twice daily. The dosage must be strictly adhered to, especially the 14-day lead-in period. The 200 mg once daily dosing regimen should not be continued beyond 28 days. If rash occurs during lead-in period do not increase dose until rash has resolved. Maximum daily dose 400 mg. Combine with at least two other antiretroviral agents to which the patient has not previously been exposed. After treatment interruption > 7 days start with lead-in dose for 14 days. **Contraindications:** Hypersensitivity to any component. Previous Viramune-associated severe rash, rash with constitutional symptoms, hypersensitivity reactions, or clinical hepatitis. Severe hepatic impairment (Child-Pugh C) or pre-treatment ASAT or ALAT > 5 U/LN. Recurrence of liver function abnormalities on re-administration after previous increases in ASAT or ALAT > 5 U/LN. Co-administration with St John's Wort. **Warnings & precautions:** Monitor for skin and/or hepatic reactions during the first 18 weeks. The greatest risk is in the first 6 weeks. Viramune should not be initiated in adult females with CD4 cell count > 250 cells/mm<sup>3</sup> or adult males with CD4 cell counts > 400 cells/mm<sup>3</sup> who have detectable plasma HIV-RNA unless the benefit outweighs the risk. The increased risk for toxicity based on CD4 count thresholds has not been detected in patients with undetectable (ie, < 50 copies/mL) plasma viral load. Monitor liver function every 5 weeks during the first 8 weeks of treatment, at 12 weeks, and then regularly. Perform LFTs if patients present with a Viramune-associated rash. Discontinue Viramune permanently if ASAT or ALAT > 5 U/LN. Pre-existing increased ASAT or ALAT levels > 2.5 U/LN and/or co-infection with hepatitis B or C increases risk of hepatic adverse reactions and require more frequent monitoring. Advise patients to promptly notify their physician of any rash; those developing signs or symptoms of hepatitis, severe skin reaction or hypersensitivity should discontinue Viramune immediately. Viramune must not be restarted following severe hepatic, skin or hypersensitivity reaction. Hormonal methods of birth control other than Depo-medroxyprogesterone acetate should not be used alone. Advise patients to seek medical advice if they experience joint aches and pain, joint stiffness or difficulty in movement; osteonecrosis has been reported, particularly in patients with advanced HIV-disease and/or long-term exposure to CART. Tablets contain lactose; patients with rare hereditary problems of galactose intolerance should not take this product. **Interactions:** See SPC. Plasma levels of substances metabolised by CYP4A or 2B6 may be reduced. Plasma levels of Viramune may be reduced by strong CYP inducers. Concurrent use of rifampicin not recommended. **Fertility, pregnancy and lactation:** Caution should be exercised when prescribing Viramune to pregnant women. There are insufficient data to determine whether risk thresholds for pregnant women are the same as those for non-pregnant women. Breastfeeding is not recommended. **Undesirable effects:** Most serious (rarely fatal) are SJS/TEN (0.2%) or serious hepatitis/hepatic failure, and drug rash with eosinophilia and systemic symptoms, characterized by rash with constitutional symptoms (fever, arthralgia, myalgia, lymphadenopathy, plus visceral involvement such as hepatitis, eosinophilia, granulocytopenia and renal dysfunction). Very common: rash (12.3%). Common: headache, vomiting, diarrhoea, abdominal pain, nausea, pyrexia, fatigue, hypersensitivity including angioedema, anaphylaxis, urticaria, hepatitis (1.9%), abnormal liver function tests, granulocytopenia. An inflammatory reaction to asymptomatic or residual opportunistic infections may arise on initiation of CART. Granulocytopenia more common in children than adults. See SPC for other side effects. **Pack sizes and NHS price:** 14 tablets (C9.47, 60 tablets (E170.00), 240 mg suspension (E50.40). **Legal category:** POM. **Marketing Authorisation holder:** Boehringer Ingelheim International GmbH, D-65216 Ingelheim am Rhein, Germany. **MA numbers:** Tablets 40 mg, E.U./197/055/001, Tablets 14 mg, E.U./197/055/004, Suspension, E.U./197/055/002. Prescribers should consult the Summary of Product Characteristics for full prescribing information. Prepared in December 2012.

#### Prescribing information (UK) Prolonged-release tablets

##### VIRAMUNE prolonged-release tablets

Prolonged-release tablets containing 100 mg or 400 mg nevirapine. **Action:** Non-nucleoside reverse transcriptase inhibitor (NNRTI) of HIV-1. **Indications:** For use in combination with other antiretroviral medicinal products for the treatment of HIV-1 infected adults, adolescents and children three years and above and able to swallow tablets (100 mg strength) or adolescents and children three years and above and able to swallow tablets (400 mg strength). **Dose & administration:** **Adults:** 100 mg or 400 mg prolonged-release tablet once daily, if already taking an immediate-release twice daily regimen a switch to 400 mg prolonged-release can be made without a lead-in period. **Children three years and above and adolescents:** Initiation of therapy with immediate-release tablets 200 mg or 50 mg/m<sup>2</sup> suspension, 150 mg/m<sup>2</sup> or 4 mg/kg bodyweight once daily for 14 days, then prolonged-release tablets once daily dosed according to body surface area or bodyweight. See SPC for full dosing details. Tablets should be taken with liquid with or without food and should not be broken or chewed. 15% dosage reduction should be used in the 14-day lead-in period. The lead-in dosing period should not be continued beyond 28 days. If rash occurs during lead-in period do not increase dose until rash has resolved. Maximum daily dose for all patients 400 mg. Combine with at least two other antiretroviral agents. After treatment interruption > 7 days start with lead-in dose for 14 days. Viramune prolonged-release tablets have not been studied in patients with renal dysfunction or hepatic impairment. Viramune immediate-release should be used. **Contraindications:** Hypersensitivity to any component. Previous Viramune-associated severe rash, rash with constitutional symptoms, hypersensitivity reactions, or clinical hepatitis. Severe hepatic impairment (Child-Pugh C) or pre-treatment ASAT or ALAT > 5 U/LN. Recurrence of liver function abnormalities on re-administration after previous increases in ASAT or ALAT > 5 U/LN. Co-administration with St John's Wort. **Warnings & precautions:** Monitor for skin and/or hepatic reactions during the first 18 weeks. The greatest risk is in the first 6 weeks. Viramune should not be initiated in adult females with CD4 cell count > 250 cells/mm<sup>3</sup> or adult males with CD4 cell counts > 400 cells/mm<sup>3</sup> who have detectable plasma HIV-RNA unless the benefit outweighs the risk. The increased risk for toxicity based on CD4 count thresholds has not been detected in patients with undetectable (ie, < 50 copies/mL) plasma viral load. Monitor liver function every 5 weeks during the first 8 weeks of treatment, at 12 weeks, and then regularly. Perform LFTs if patients present with a Viramune-associated rash. Discontinue Viramune permanently if ASAT or ALAT > 5 U/LN. Pre-existing increased ASAT or ALAT levels > 2.5 U/LN and/or co-infection with hepatitis B or C increases risk of hepatic adverse reactions and require more frequent monitoring. Advise patients to promptly notify their physician of any rash; those developing signs or symptoms of hepatitis, severe skin reaction or hypersensitivity should discontinue Viramune and seek medical advice immediately. Viramune must not be restarted following severe hepatic, skin or hypersensitivity reaction. Hormonal methods of birth control other than Depo-medroxyprogesterone acetate should not be used alone. Advise patients to seek medical advice if they experience joint aches and pain, joint stiffness or difficulty in movement; osteonecrosis has been reported, particularly in patients with advanced HIV-disease and/or long-term exposure to CART. There are no data on the interchangeability of the 50 mg or 100 mg tablets compared to the 400 mg tablets therefore neither the 50 mg nor the 100 mg tablets should be taken by adults. Contains lactose; patients with rare hereditary problems of galactose intolerance should not take this product. **Interactions:** See SPC. Plasma levels of substances metabolised by CYP4A or 2B6 may be reduced. Plasma levels of Viramune may be reduced by strong CYP inducers. Concurrent use of rifampicin not recommended. **Fertility, pregnancy and lactation:** Caution should be exercised when prescribing Viramune to pregnant women. There are insufficient data to determine whether risk thresholds for pregnant women are the same as those for non-pregnant women. Breastfeeding is not recommended. **Undesirable effects:** Most serious (rarely fatal) are SJS/TEN or serious hepatitis/hepatic failure, and drug rash with eosinophilia and systemic symptoms, characterized by rash with constitutional symptoms, granulocytopenia and renal dysfunction. The following undesirable effects were observed in the 1500 1448 trial in adults. Used in phase with Viramune immediate-release. Common: rash (5.7%), headache, diarrhoea, abdominal pain, nausea, pyrexia, fatigue. Maintenance plate with Viramune prolonged-release. Common: rash (5.9%), headache, abdominal pain, nausea, hepatitis (including severe and life-threatening hepatotoxicity) (1.6%), fatigue, abnormal liver function tests, blood phosphorus decreased, blood pressure increased, increased blood pressure while not observed in study 1500 1448 has been identified in other studies or post-marketing surveillance. The frequency is based on a calculation relating to the total number of patients exposed to the prolonged-release tablets in the maintenance phase of study 1500 1448. Granulocytopenia more common in children than in adults. See SPC for other side effects. **Pack sizes and NHS price:** 100 x 100 mg tablets (E127.50), 90 x 100 mg tablets (E127.50 x 400 mg tablets (E170.00). **Legal category:** POM. **Marketing Authorisation holder:** Boehringer Ingelheim International GmbH, D-65216 Ingelheim am Rhein, Germany. **MA numbers:** 50 mg E.U./197/055/006, 100 mg E.U./197/055/005, 400 mg E.U./197/055/008. Prescribers should consult the Summary of Product Characteristics for full prescribing information. Prepared in December 2012.

Adverse events should be reported. Reporting forms and information can be found at [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard). Adverse events should also be reported to Boehringer Ingelheim Drug Safety on 0800 328 1627 (toll-free).

#### References

1. Rodriguez-Arondo F et al. Current HIV Research 2009; 2(3): 524-532. 2. VIRAMUNE prolonged-release 400mg (Tablets) SPC, December 2012. 3. Soriano V et al. J Med Virol 2008; 81: 400-405. 4. Seday YS et al. AIDS Rev. Antiretrovir 2002; 19: 167-176. 5. Larder S et al. 16th Conference on Retroviruses and Opportunistic Infections 2009, Abstract 484B. 6. Ward DJ and Curtin J. AIDS PATIENT CARE and STDs 2006; 20(8): 542-548. 7. Pattemis A et al. Clin Infect Dis 2007; 45: 263-266. 8. Finkel C et al. AIDS 2005; 19: 917-925. 9. Van Leth F et al. AIDS 2004; 18(1): 67-70. 10. Soriano V et al. Presented at 5th IAS Congress, 2000; Cape Town, South Africa. Poster LBPE07.

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write VIRAMUNE prolonged-release\*

Because his  
**HEART**  
is vulnerable  
Because his life  
is just as full,  
Because he's  
**MORE**  
than **HIV**

Because her  
**MIND** is valuable,  
Because her life is just  
as full, Because she's  
**MORE** than **HIV**

Alongside excellent control rates, Viramune has demonstrated a favourable neuropsychiatric profile and beneficial effects on lipid metabolism; making it a key ART treatment for the last fifteen years.<sup>1-10</sup>

With the introduction of VIRAMUNE prolonged-release, you get all the benefits of Viramune in a once-daily pill.<sup>2</sup>

So, when you think Viramune, write VIRAMUNE prolonged-release.

  
**viramune**<sup>®</sup>  
nevirapine

Once daily  
**VIRAMUNE**<sup>®</sup>  
(nevirapine)  
prolonged-release tablets



\*If they're treatment naïve and have a CD4 count <400/mm<sup>3</sup> (him) or <250/mm<sup>3</sup> (her) or they're switching treatment and have an undetectable viral load

Prescribing information and references can be found overleaf





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