

National HIV Nurses Association

# ***FINAL PROGRAMME***

## ***14th Annual Conference of the National HIV Nurses Association (NHIVNA)***



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**14–15 June 2012**  
**Manchester Conference Centre**

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preceded by  
**NHIVNA Pre-Conference Study Day**  
**Wednesday 13 June**

*Supported by an educational grant from*



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National HIV Nurses Association

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**Badges must be worn at all times in order to gain access to lecture theatre and exhibition area**

## **Venues** *All venues at Manchester Conference Centre, unless stated otherwise*

Registration	Weston Foyer
Lecture Theatre	Weston Theatre
Exhibition	Weston Room 1
Posters	Weston Room 2/3
Lunch and Refreshments	Weston Room 1
Sponsors' Invited Lectures	Weston Theatre
Workshops	Weston Room 2
Speaker Preview	Syndicate Room F
Pre-Conference Study Day	Cockcroft Theatre
Gala Dinner	Manchester Town Hall

The 14th Annual Conference of NHIVNA  
is organised and administered by



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*Dear Colleague,*

Welcome to the **14 Annual Conference of NHIVNA**, which is being held at the Manchester Conference Centre.

The Conference Centre is located in the heart of Manchester city centre, close to Manchester Piccadilly Station. We have formally invited Local Hosts to assist the NHIVNA Committee in preparing the logistical aspects of the conference and to bring a local flavour to the programme. Jill Delaney and Ian Nixon from North Manchester General Hospital have kindly accepted our invitation to fulfil this role.

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

We are excited that the Annual Conference programme in 2012 will focus on a variety of important topics that will no doubt highlight some difficult issues in the management of HIV, as well as encourage some lively discussions and debate.


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 2012.

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.

The Gala Dinner will take place on the Thursday evening of the conference. This will be held at the elegant Town Hall in Manchester. In true tradition, we anticipate an evening of good food, followed by after-dinner entertainment – including 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 13 June 2012

Registration open from 1300–1730

**1300–1730**

### NHIVNA Pre-Conference Study Day

*supported by an educational grant from Gilead Sciences*

Cockcroft Theatre

### Implementing Treatment as Prevention (TasP) as a clinical standard in local practice

**1300–1400**

Lunch

**1400–1410**

### Introduction

Nathaniel Ault

*Chair, National HIV Nurses Association (NHIVNA)*

**1410–1450**

### BHIVA guidelines

Dr Ed Ong

*Royal Victoria Infirmary, Newcastle*

**1450–1520**

### TasP: the patient perspective

Mr Robert Fieldhouse

*BASELINE*

**1520–1540**

Afternoon tea

**1540–1625**

### Implementing TasP in a local setting

Juliet Bennett

*Freelance Nurse Consultant*

**1625–1700**

### Permission to speak

### Psychological therapies

Robert Palmer

*Newham General Hospital, London*

**1700–1725**

### Interactive case studies

Eileen Nixon

*University of Brighton*

**1725–1730**

### Evaluation and close

*The content of the presentations at this Study Day is the responsibility of the speakers. Gilead Sciences Ltd has no editorial control over the content of the presentations.*

**FINAL PROGRAMME**

**14th Annual Conference of NHIVNA** | Thursday 14 – Friday 15 June 2012 | Manchester Conference Centre

# Programme

**Thursday 14 June 2012**

Registration and exhibition open from 0815–1730

**0900–0910**

**Welcome address from the Chair of NHIVNA**

Nathaniel Ault

*Barts and The London NHS Trust*

**Welcome address from the Conference**

**Subcommittee Chair and Local Hosts**

Sam Mabey-Puttock

*Manchester Royal Infirmary*

Jill Delaney

*North Manchester General Hospital*

Ian Nixon

*North Manchester General Hospital*

**0910–0940**

**The Robert Pratt Lecture**

*Chairs: Nathaniel Ault*

*Barts and The London NHS Trust*

*Jill Delaney*

*North Manchester General Hospital*

**HIV in 2012: trends and developments**

Suzy Hargreaves

*Liverpool John Moores University*

**0940–1025**

**NHIVNA Plenary Session I: What the future holds for HIV testing**

*Chairs: Nathaniel Ault*

*Barts and The London NHS Trust*

*Jill Delaney*

*North Manchester General Hospital*

**Implications of changes in the NHS**

Deborah Jack

*National AIDS Trust*

**Halve It campaign update**

Dr Ed Wilkins

*North Manchester General Hospital*

**Panel discussion**

**1025–1045**

Morning coffee (First-time attendees meeting at the NHIVNA stand)

# Programme



## Thursday 14 June 2012

### 1045–1115

#### NHIVNA Invited Lecture I

*Chairs:* Jayne Churchill  
NHS Lothian, Edinburgh  
Catrin Evans  
University of Nottingham

#### Psychological models to promote behaviour change: what do HIV nurses need to know and why?

Dr Alex Margetts  
Central and North West London NHS Foundation Trust  
Dr Su Yin Yap  
Central and North West London NHS Foundation Trust

### 1115–1215

#### NHIVNA Oral Abstracts Session I

*Chairs:* Jayne Churchill  
NHS Lothian, Edinburgh  
Catrin Evans  
University of Nottingham

### 1115–1130

**Abstract O1** Psychological support study 'my brave face is false'  
Caroline Lovett, *The Sussex Beacon*

### 1130–1145

**Abstract O2** Evaluation of a patient satisfaction survey following screening for HIV related neurocognitive impairment (NC)  
Alice Nightingale, *Chelsea and Westminster Hospital, London*

### 1145–1200

**Abstract O3** Barebacking: opinions of HIV-positive men who have sex with men  
Matthew Grundy-Bowers, *City University, London*

### 1200–1215

**Abstract O4** Promoting user involvement through holistic nursing framework for the care and management of people with HIV/AIDS as a chronic condition  
Kemoh Rogers, *Anglia Ruskin University, Essex*

### 1215–1245

#### Janssen Invited Lecture

#### What are you trying to say?

Michelle Croston  
North Manchester General Hospital

### 1245–1345

Lunch, exhibition and posters

# Programme

**Thursday 14 June 2012**

**1345–1435**

## **NHIVNA Plenary Session 2: Faith and HIV**

*Chairs:* Kemoh Rogers

*Anglia Ruskin University, Essex*

Gina Rowlands

*Bevan House Primary Care Centre, Bradford*

### **An overview**

The Reverend Ijeoma Ajibade

*Diocese of London and Southwark Cathedral*

### **Engagement in the community**

Wellington Moyo

*Yorkshire Mesmac*

Brad Smith

*Yorkshire Mesmac*

**1435–1500**

## **NHIVNA projects update**

*Chair:* Nathaniel Ault

*Barts and The London NHS Trust*

## **NHIVNA Regional Audit and Research Initiative**

Michelle Croston

*North Manchester General Hospital*

Matthew Grundy-Bowers

*City University, London*

## **NHIVNA Study Day Programme**

Kemoh Rogers

*Anglia Ruskin University, Essex*

**1500–1530**

## **ViiV Healthcare Invited Lecture**

**The evolution of nurse prescribing: a tale from two cities**

Zoë Sheppard

*Chelsea and Westminster Hospital, London*

Fiona Wallis

*Monkgate Health Centre, York*

**1530–1600**

Afternoon tea

**1600–1700**

## **NHIVNA Oral Abstracts Session 2**

*Chairs:* Juliet Bennett

*Freelance Nurse Consultant*

Michelle Croston

*North Manchester General Hospital*

**1600–1615**

**Abstract O5** HIV healthcare in the future: where do nurses fit in?

*Eileen Nixon, University of Brighton*

# Programme



## Thursday 14 June 2012

1615–1630

**Abstract O6** The establishment of an annual health clinic

*Lorraine Lewis, Birmingham Heartlands Hospital*

1630–1645

**Abstract O7** Identification and management of patients who are newly diagnosed with HIV and subsequently lost to follow-up

*Breda Patterson, Chelsea and Westminster Hospital, London*

1645–1700

**Abstract O8** Improving nurses' knowledge about HIV: development and evaluation of an innovative online resource.

*Kirstie Weeks, University of Nottingham*

1700–1730

**NHIVNA Invited Lecture 2**

*Chairs: Juliet Bennett*

*Freelance Nurse Consultant*

*Michelle Croston*

*North Manchester General Hospital*

**Top 10 highlights in 2011–12 and their impact on HIV nursing**

*Katherine Bethell*

*Western General Hospital, Edinburgh*

1745–1835

**NHIVNA Workshop 1 (Weston Room 2)**

(Drinks and nibbles will be provided)

(please see page 12 for further details)

**Managing 'Did Not Attend' (DNAs)**

*Sam Mabey-Puttock*

*Manchester Royal Infirmary*

*Gina Rowlands*

*Bevan House Primary Care Centre, Bradford*

*This workshop has been supported by an educational grant from Bevan House Primary Care Centre, Bradford*

**From 2000**

**Drinks Reception followed by Gala Dinner**

**Manchester Town Hall**



# Programme

**Friday 15 June 2012**

Registration and exhibition open from 0745–1630

**0800–0850**

## **NHIVNA Workshop 2 (Weston Room 2)**

*Pastries, tea and coffee will be provided  
(please see page 12 for further details)*

### **HIV partner notification**

Steven Akehurst  
National AIDS Trust

Gary Barker  
St Helens and Knowsley Teaching Hospitals NHS Trust

*This workshop has been supported by an educational  
grant from Pasante Ltd*

**0900–0930**

## **NHIVNA Invited Lecture 3**

Chairs: Sam Mabey-Puttock  
Manchester Royal Infirmary

Ian Nixon  
North Manchester General Hospital

### **Antiretroviral drug update**

Dr Andy Ustianowski  
North Manchester General Hospital

**0930–1000**

## **NHIVNA Invited Lecture supported by a bursary grant from MSD Ltd**

Chairs: Sam Mabey-Puttock  
Manchester Royal Infirmary

Ian Nixon  
North Manchester General Hospital

### **HIV/hepatitis C co-infection update**

Sue Kidger  
North Manchester General Hospital

**1000–1100**

## **NHIVNA Oral Abstracts Session 3**

Chairs: Sam Mabey-Puttock  
Manchester Royal Infirmary

Ian Nixon  
North Manchester General Hospital

**1000–1015**

**Abstract O9** How does the changing role of the HIV  
nurse impact on job satisfaction?

*Michelle Croston, North Manchester General Hospital*

**1015–1030**

**Abstract O10** Lost to follow up – how can nurse  
specialists minimise this?

*Linda Panton, Western General Hospital, Edinburgh*

# Programme



## Friday 15 June 2012

Registration and exhibition open from 0830–1630

1030–1045

**Abstract O11** Clients' knowledge of PEP, criminalisation and safer sex

*Caroline Lovett, The Sussex Beacon*

1045–1100

**Abstract O12** Perpetual spirals of power and pleasure: Exploring the life experiences of gay men living long term with HIV into the twenty-first century

*Jim Stanford, University of Sussex*

1100–1130

Morning coffee

**1130–1230**

**NHIVNA Plenary Session 3: Three ages of women**

*Chairs: Jane Bruton*

*Chelsea and Westminster Hospital, London*

*Pauline Jelliman*

*Liverpool Community Health*

**Contraception and HIV**

*Julie Gallagher*

*Central Manchester University Hospitals NHS*

*Foundation Trust*

**Maternity**

*Sharon Wilson*

*Zion Community Health Resource Centre*

**Menopause**

*Breda Patterson*

*Chelsea and Westminster Hospital, London*

**Panel discussion**

**1230–1300**

**Gilead Sciences Invited Lecture**

**Simplified treatment approaches and the impact on quality of life**

*Sheila Morris*

*Western General Hospital, Edinburgh*

*Robert Fieldhouse*

*BASELINE*

**1300–1320**

**NHIVNA Annual General Meeting**

*(NHIVNA members only)*

1300–1400

Lunch, exhibition and posters

# Programme

**Friday 15 June 2012**

## 1400–1430

### European HIV Nursing Network (EHNN) Lecture

#### European HIV Nursing Network: the way forward

Nicky Perry

*Brighton and Sussex University Hospitals NHS Trust*

#### HIV in Europe from a nursing perspective

Iwona Wawer

*The National AIDS Center, Warsaw, Poland*

## 1430–1530

### NHIVNA Plenary Session 4: Social changes affecting HIV patients

*Chairs:* Catrin Evans

*University of Nottingham*

Andrew Thompson

*North Manchester General Hospital*

#### Immigration update

Mark Taylor

*The Taylor Partnership, Bradford*

#### Economics and changes in benefits affecting HIV patients

Ola Opoosun

*Terrence Higgins Trust*

## 1530–1615

### The Fourth NHIVNA Debate

#### For PrEP or not for PrEP?

*Chairs:* Joe Phillips

*Royal Liverpool University Hospital*

Shaun Watson

*Chelsea and Westminster Hospital, London*

#### The motion:

This house believes pre-exposure prophylaxis (PrEP) will have a major impact on the UK HIV epidemic

#### For the motion:

Dr Sheena McCormack

*MRC Clinical Trials Unit, London*

#### Against the motion:

Dr Martin Fisher

*Royal Sussex County Hospital, Brighton*

## 1615–1630

### NHIVNA Awards Ceremony and Close by the Chair of NHIVNA

Nathaniel Ault

*Barts and The London NHS Trust*

# Conference Information

## Manchester Conference Centre

Weston Building | Sackville Street | Manchester M1 3BB

Telephone: 0161 955 8063

Web: [www.manchesterconferencecentre.co.uk](http://www.manchesterconferencecentre.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 Gala Dinner on Thursday 14 June 2012 at Manchester Town Hall.

### 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 14 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 piloting a new 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 Weston Rooms 2/3 by 0930 on Thursday 14 June 2012. 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 1600–1615 on Friday 15 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 may make use of the Speaker Preview area (Syndicate Room F) to review their slides prior to presentation; however, a final version of their slides must be passed to the audio-visual technicians in the Speaker Preview area in good time for their session. The NHIVNA Best Oral, Krattinger Rennison and NHIVNA/Mediscrypt Clinical Practice Awards will be awarded at the Prizes and Awards Ceremony at 1600–1615 on Friday 15 June.

### Gala Dinner

The NHIVNA Gala Dinner will be held on Thursday 14 June 2012 at Manchester Town Hall and will commence at 2000 with a drinks reception followed by dinner and dancing until midnight. You will require a ticket to gain entry to the Gala Dinner and these need to be pre-booked in advance of conference, and the necessary contribution paid. If you have reserved a ticket but find you cannot attend, please let the Conference Organiser know and return the ticket to the Registration Desk at your earliest convenience.

### Cloakroom

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

### Exhibition

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

# Awards and Scholarships

## NHIVNA Best Oral Presentation Award

Awarded for the best oral presentation displayed at the NHIVNA Annual Conference. A NHIVNA-invited expert panel will judge the award and will be reviewing oral presentations based on the following criteria: quality of presentation; quality of research; impact on nursing practice; originality; considered ethical issues (if appropriate).

## 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 presentation; quality of research; impact on nursing practice; originality; considered ethical issues (if appropriate).

## 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: the principal investigator is a nurse; an original piece of research; demonstrates an understanding of the research process; has an impact on nursing-related HIV policy as well as patient care; research contains an explicit discussion of the relevance of the research to nursing practice/policy; considered ethical issues (if appropriate). 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: effective presentation; must have an impact on patient care; relate to nursing care; contain recommendations for future practice; considered ethical issues (if appropriate).

## NHIVNA/Gilead Sciences HIV Nursing Award 2012

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 2012/2013.

## NHIVNA Junior Nurse Scholarships

NHIVNA has awarded two [NHIVNA Junior Nurse Registration Concession Scholarships](#) to assist junior nurses to attend the NHIVNA Annual Conference 2012. To be eligible for a scholarship, applicants must be NHIVNA members for 2012 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 six [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 2012. 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 14 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 in collaboration with Gilead Sciences. [NHIVNA Pre-Conference Study Day Scholarships](#) have been made available for those who attend, in full, **both** the NHIVNA Annual Conference on 14–15 June, and the NHIVNA Pre-Conference Study Day on the afternoon of Wednesday 13 June. NHIVNA has awarded up to 50 scholarships that contribute a maximum of £75 towards travel expenses, and contribute a maximum of £125 towards accommodation costs (13 and 14 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.

## NHIVNA Travel and Accommodation Scholarships

NHIVNA has awarded up to 30 Travel Scholarships to assist delegates who are attending the 14th Annual Conference. To be eligible for a scholarship, applicants must be NHIVNA members for 2012 and be registered for the 14th Annual Conference. The scholarships will cover a contribution of a maximum of £150 which can be used towards accommodation costs (13 and 14 June only at a maximum £50 per night) and travel expenses (maximum £50). These scholarships have been supported by a grant awarded by the City of Manchester.

# Executive Committee

Chair	Nathaniel Ault	Barts and the London NHS Trust
Honorary Secretary	Sam Mabey-Puttock	Manchester Royal Infirmary
Honorary Treasurer	Catrin Evans	University of Nottingham
Journal Officer	Juliet Bennett	Freelance Nurse Consultant
Competencies Officer	Jane Bruton	Chelsea and Westminster Hospital NHS Foundation Trust, London
Newsletter Officer	Jayne Churchill	NHS Lothian, Edinburgh
Regional Research Officer	Michelle Croston	North Manchester General Hospital
Education Officer	Kemoh Rogers	Anglia Ruskin University, Essex
Primary Care Officer	Gina Rowlands	Bevan Primary Care Centre, Bradford
Marketing and Website Officer	Shaun Watson	Chelsea and Westminster Hospital NHS Foundation Trust, London



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.

## Judging Panels

### Krattinger Rennison Award and NHIVNA Best Poster Award Judging Panel

Catrin Evans (Chair)  
Juliet Bennett  
Jayne Churchill  
Gina Rowlands

### NHIVNA Best Oral Award and NHIVNA/Mediscript Clinical Practice Award Judging Panel

Jane Bruton (Chair)  
Michelle Croston  
Sam Mabey-Puttock  
Kemoh Rogers  
Shaun Watson

## Abstract O1

### Psychological support study 'my brave face is false'

C Lovett

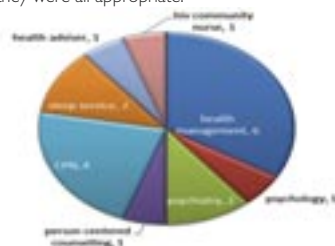
The Sussex Beacon, Brighton, UK

**Background:** The recently published MEDFASH 'standards for psychological support of adults living with HIV' states that the prevalence of psychological and psychiatric problems among people living with HIV is substantially higher than in the general public. People with HIV are about twice as likely to be diagnosed with depression as matched controls in the general public. Cognitive impairment is also higher amongst people living with HIV than in the general public, and is an early risk factor for early death, poor adherence, poorer functioning of daily life and loss of employment. With this in mind it was identified that patients being admitted to the in-patient unit presented an ideal opportunity to assess their psychological needs and their experiences of services/interventions and consider what may have helped them in the past and refer where necessary into the appropriate service.

**Methods:** 29 voluntary self-completed questionnaires were used to introduce the subject, followed by a structured interview. The interviews took part at a mid-point of their residential stay to allow for further support if required. Quantitative data was recorded by the number of referrals made and qualitative data measured by the client's responses.

**Results:** There was a broad range across the whole scale when asked if satisfied with how they are coping with their illness. Predominately clients reported they had accepted their illness, but a high proportion reported feeling sad. Surprisingly 81% clients reported feeling unsatisfied with their sex life's when this was explored in more depth, reasons given were, 'I worry about disclosure', 'I worry about passing on the infection', 'I don't deserve a partner', 'I have no sex drive'. 14 appropriate referrals were made into psychological services (48%). 11 patients felt their needs were being met already (38%). Referrals were made for all patients requesting them and agencies felt they were all appropriate.

#### Referrals made



**Conclusions:** This study resonates with issues raised in Standards for psychological support. There is a need for services to define mental health packages, screen regularly and involve patients in local service development. The relationship between sexual well-being and general well-being is strongly highlighted in this study. The screening tool operates as a therapeutic process within its own right and allows patients time to discuss their anxieties and have them acknowledged.

## Abstract O3

### Barebacking: opinions of HIV-positive men who have sex with men

M Grundy-Bowers<sup>1</sup> and A Black<sup>2</sup>

<sup>1</sup>City University, London, UK, <sup>2</sup>Imperial College Healthcare NHS Trust, London, UK

**Background:** Men who have sex with men (MSM) remain disproportionately affected by HIV and sexual infections, acquired predominantly through condomless anal sex (CAS). HIV positive MSM have higher rates of acute STIs than their heterosexual counterparts which increases the risk of HIV transmission in discordant sexual encounters. A better understanding of the influences that affect HIV positive MSM and their decisions to engage in CAS is required for more effective health promotion.

**Method:** MSM were targeted via gay press and leafleting, to complete an online questionnaire exploring issues around CAS. Following ethical approval data was collected from November 2010 to October 2011. Responses were reviewed thematically to explore opinions and motivations for CAS in HIV positive MSM.

**Results:** These data are drawn from a larger study. A total of 57 males met the criteria; the median age was 37 (range 23-58), with the majority being White British (n=38). All had engaged in unprotected anal sex, but only 24 identified themselves as barebackers. In the previous 12 months 21 were diagnosed with an STI, 9 with HIV. Barebacking was identified as contextual (e.g. in relationships); as an identity (e.g. I am a barebacker) and as a behaviour (e.g. I bareback). Participants opinions on CAS identified it was acceptable if consensual, it allowed better more natural sex and increased intimacy. However its associated risk, in particular Hepatitis C and acquisition of different HIV strains was acknowledged. The most common themes identified as personal reasons for engaging in CAS were: physical sensation, transgression and sero-concordance. Participants also reported engaging in sero-adaptive behaviours such as sero-sorting or condom sorting. Yet, on the last occasion of CAS discordant sex was reported by 13 participants with regular partners and 6 with casual partners. A further 15 reported CAS where the HIV status was presumed positive and 11 where the status was unknown.

**Conclusion:** This study has shown that there are a variety of reasons why this population engage in CAS, and remains a complex issue. HIV positive MSM are endeavouring to engage in concordant CAS and utilise sero-adaptive strategies. These decisions can be based on assumptions of status and an individual's responsibility, making discordant sex common. When tailoring risk reduction strategies with patients it is important to recognise this and the role that intimacy plays in CAS.

## Abstract O2

### Evaluation of a patient satisfaction survey following screening for HIV related neurocognitive impairment (NCI)

A Nightingale<sup>1</sup>, D Ratcliffe<sup>1</sup>, L Leonidou<sup>1</sup>, A Margetts<sup>1</sup>, D Asboe<sup>1</sup>, P Catalan<sup>1</sup>, B Gazzard<sup>1</sup> and T Barber<sup>1</sup>

<sup>1</sup>Chelsea and Westminster Hospital, London, UK

**Background:** Despite antiretroviral therapy, neurocognitive impairment (NCI) remains prevalent with asymptomatic neurocognitive impairment (ANI) the most common form of NCI seen at screening. However screening for ANI is controversial with concern over the anxiety caused either by screening or diagnosis and no clear management of the condition when identified. We offer a routine unselected screening service for those infected with HIV as well as a cohort study for 18-50 year old men who have sex with men (MSM). We distributed a post NCI screening service evaluation questionnaire to assess satisfaction and anxiety.

**Methods:** Subjects were HIV positive and aged 18-50. They were screened for NCI and anxiety/depression using the Brief Neurocognitive Score and International HIV Dementia Score as well as undergoing screening for anxiety (GAD7), depression (PHQ9) and memory (EMQ). On completion they were either reassured that the tests were normal or were referred for further investigation. Following assessment subjects were asked to complete an anonymous satisfaction survey.

**Results:** 101 neurocognitive screen surveys were analysed. Overall satisfaction was high with 50% saying they 'felt better' following screening. 43% said it 'made no difference' and only 6% stated it 'worried me'. On a scale of 0-10 of helpfulness, the mean score was 7.53. The strongest emerging theme was reassurance following assessment.

31 subjects indicated that they were referred for further investigation and 46 subjects that nothing else was needed; 8 reported they did not know and 16 did not respond. Satisfaction was not significantly different in these groups with those referred on, rating satisfaction out of 10 at a mean of 7.54, and those with normal screen as 7.09 (p=0.46).

Of the group that were referred for further investigation, only 6% said the test 'worried them' compared to 4% in the non-referred group. 49% said they 'felt better' despite an abnormal result compared to 50% in a normal screening result (p=0.76).

#### Conclusion:

Despite concerns around screening asymptomatic HIV positive patients for NCI, this service evaluation showed high satisfaction. The majority found it helpful and most felt better following screen. Very few commented that it 'worried me', even in the group that were given an abnormal result and referred on for further testing. The results suggest that screening for NCI by this method is acceptable and helpful to patients and concerns about creating undue anxiety by screening and referral are unfounded.

## Abstract O4

### Promoting user involvement through holistic nursing framework for the care and management of people with HIV/AIDS as a chronic condition

M K Rogers

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**Background:** Until recently, patient-client participation has played limited role in the assessment, planning and delivery of care in the National Health Service (NHS). Opportunities for patients' involvement in decision making within the NHS was provided by the formation of primary care groups (PCG). The PCGs core focus on health improvement required looking beyond traditional professional-client relationships and concentrated on forming partnerships with local populations. In this regard, PCGs and Primary Care Trusts (PCTs) were required to pursue initiatives for involving patients and the public. Other areas of healthcare including Genitourinary Medicine (GUM/HIV outpatient clinics followed this trend. Users, for the purpose of this research refer to HIV positive adults (18 years or older) that are registered and regularly use the GUM clinic as the main point of accessing HIV care and management.

**Aims:** The aims of this qualitative research are.

1. To identify the barriers to forming and maintaining HIV service users' involvement group from the perspectives of HIV positive patients
2. Ascertain the role of nurses working within HIV services in establishing and maintaining successful user involvement groups using holistic care framework for a chronic condition such as HIV

**Method:** A favourable ethics opinion was obtained from the local NHS Ethics Committee. A one and a half hour focus group interview was conducted and thematic analyses of data undertaken. Because the care and management of people living with HIV as a chronic manageable condition necessitates whole person care, the holistic perspective was used as theoretical framework to guide data collection and analyses.

**Results:** Four themes emerged from the analysis of the research data including Naming the group, involving the multidisciplinary team, peer support and developing the group. However, the overarching or all embracing theme here was power. This is attributed to the rationale that participants want their perspectives included to influence the way their HIV condition is managed as a 'whole'.

**Conclusion:** HIV has emerged as a chronic manageable condition. Hence neither a dominant medical model nor nursing interventions alone could address the diverse care needs of patients living with HIV. Hence a holistic framework, which also seeks to understand the perspectives of patients and family members, is appropriate for the nursing care and management of people living with and affected by HIV.



# Abstracts



National HIV Nurses Association

## Abstract O5

### HIV healthcare in the future: where do nurses fit in?

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**Background:** As HIV becomes a more manageable condition for many patients, new service models for stable and complex patients and for primary care are evolving. This research aims to explore current and future models of HIV healthcare to identify sustainable options for HIV service delivery including roles for HIV nurses.

**Method:** A grounded theory approach was utilised across 3 HIV service sites of different size, location and service specification. Following ethics and R&D approvals, data from semi-structured interviews with 13 HIV patients and 20 healthcare workers in HIV were transcribed and analysed using a constant comparative method and a dimensional analysis strategy.

**Results:** Overall, HIV healthcare services were perceived as different from other health services by all participants. This sense of 'special' identity influenced individual attitudes to service changes and the ability to adapt to new models of HIV healthcare. Relationships between patients and healthcare workers in HIV were highly valued and participation was a key factor in keeping patients engaged in care.

The majority of patients identified as being clinically stable but also described an all-pervading nature of HIV on their physical, psychological and social well-being that was irrespective of age, gender or length of diagnosis. There was a wide range of patient confidence in dealing with these fluctuating health issues and this to some extent determined HIV service utilisation. Expectations of non-HIV services were often based on the high standards of HIV healthcare reported by participants, although those who were younger and more recently diagnosed appeared more likely to consider new models of care.

Nursing roles and levels of practice were largely influenced by the numbers of doctor posts or volume of patients but there were high levels of support for nursing roles across all participants. Support, specialist advice and psychological care were the key elements of nursing roles irrespective of role description.

Further verification and data analysis will be undertaken.

**Conclusion:** As HIV services continue to evolve, some patients may require transitional support to access new services. Likewise, future models of care will need to incorporate the spectrum of needs for clinically stable patients and nurses may be key players in providing this.

## Abstract O6

### The establishment of an annual health clinic

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**Background:** The BHIVA guidelines state that specific investigations and assessments need to be carried out regularly to maintain the health of people living with HIV. Following a presentation at NHVNA regarding the set up of an Annual Health Clinic (AHC), a similar model was adapted for local use. Following the commencement of this clinic an audit was conducted against professional guidelines to determine whether this clinic was an effective intervention. The clinic is nurse-led, multi-disciplinary, and a "one stop shop" where the patient is aware they will be seeing various specialities for screening, which reduces missed opportunities to screen during routine standard care.

**Method:** The draft BHIVA guidelines "Routine Investigation and Monitoring of Adults with HIV-1" and the European AIDS Clinical Society Guidelines 2011 version 6 were used to establish the standards to set the audit against. A retrospective audit of case notes has been undertaken following the random selection of fifty patients who had attended AHC and fifty patients who had attended for standard care over the same time period.

**Findings:** The preliminary findings of this audit are that patients who have been seen in the AHC are much more likely to have had all routine annual screening completed than those who have attended for standard care. An example of this is of those women who attended AHC, 100% were offered cervical cytology compared to 43% of those who attended standard care over the same time period. EACS guidance recommends mood screening every 1-2 years and the AHC has enabled this with 98% completing the Hospital Anxiety and Depression Scale and being offered follow up for anxiety management and relaxation training where a need is identified. In comparison, the standard care group had no mood screens completed.

**Conclusion:** The pilot audit findings have shown that the AHC is successful at ensuring guidelines regarding patient care are met in one clinic visit. It has been instrumental in the diagnosis of significant cognitive deterioration and other conditions which would otherwise have gone undetected or taken longer to be recognised. This has allowed prompt treatment which should improve patient outcome.

## Abstract O7

### Identification and management of patients who are newly diagnosed with HIV and subsequently lost to follow-up

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**Background:** The provision of optimal HIV care and regular clinic review can help reduce the risk of HIV-related morbidity and mortality among persons living with HIV, as well as the risk of HIV transmission. Recently, the HPA has suggested monitoring rates of loss to follow-up (LFU) from HIV-services as a quality of care indicator. Our clinic does not currently have a uniform local policy on identifying newly diagnosed patients who are lost to follow therefore we present here the results of a local audit of all patients newly diagnosed with HIV in a 1 year period and management of patients who subsequently were lost to follow.

**Methods:** All patients who were diagnosed with HIV infection between January 2011 and January 2012 were retrospectively selected for the audit. Using electronic patient records, we assessed 1) the age of patients who were LFU within the 1st year of diagnosis 2) whether these patients were truly LFU or transferred to another centre 3) whether contact had been attempted 4) the outcome of this contact and 5) the CD4 count of patients who were LFU.

**Results:** 497 patients were newly diagnosed with HIV during the period studied. Of these, 91 (18%) patients were identified initially as potentially LFU as they had not been seen in the clinic since diagnosis or their 1st appointment with the HIV service. 26/91 (29%) had documented transfer of care letters to other centres in their records. 1 (1%) patient had died. 6/91 (6.6%) have since re-engaged with services. 5/91 (5%) were diagnosed with HIV in prison and no further follow up is documented however these patients activity is generally entered elsewhere. 3/91 (3%) are documented as currently overseas and have not been seen within the past 6 months with no follow-up booked. Median age of those who had been truly LFU was 31 (range 19-59); 2/51 (4%) were female. Median CD4 count was 483 (range 224-1006). 19/51 (37%) patients were contacted by the clinic either via letter, phone call or text message – this ranged from 1 voicemail left to - in 1 case – 3 phone calls, 2 recorded delivery letters, and 1 text sent. None of these 19 patients re-engaged.

**Conclusion:** Robust local protocols are essential to ensuring that patients who are lost to follow up are identified and contacted appropriately. However, ensuring that the patient's contact details and ideal mode of contact are correct is crucial. Nurses and health advisors are ideally placed to forge links with other centres to share information and concerns about patients who are lost to follow up.

## Abstract O8

### Improving nurses' knowledge about HIV: development and evaluation of an innovative online resource

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**Background:** Poor HIV-related knowledge is associated with discrimination towards people living with HIV/AIDS (PLWHA) in healthcare settings. The increasing prevalence of HIV in the UK and shift of HIV care into generalist settings means that more nurses will be caring for PLWHA. Therefore, improvement of nurses' HIV knowledge is important to ensure high quality care. Many nurses may not have been exposed to HIV patients and may not have had significant HIV-related training. This abstract reports on an educational research project that developed and evaluated an innovative e-learning approach to post-registration HIV education.

**Methods:** An evidence based Reusable Learning Object (RLO) was developed and delivered to 12 nurses as part of an undergraduate nursing research project. RLOs are short, multimedia, interactive educational tools valued for their flexibility and accessibility. The study aimed to investigate the RLOs' effectiveness by measuring changes in nurses' HIV-related knowledge scores through a pre/post-test design. Scores were compared with a non-RLO comparison group of nurses (n=12). Independent t-tests were used to establish if the change in knowledge score was significant.

**Results:** Prior to the intervention, all nurses' HIV knowledge was very poor, with a mean score of 9.11 (± 2.5) out of 20. The RLO group increased their score by an average of 6.5 (± 2.8) marks compared to the non-RLO group (mean increase 0.3±2.1). The RLO groups' increase in knowledge score was statistically significant (p).

**Conclusion:** Although small scale, this study is the first of its kind to provide quantitative evidence that RLOs can significantly improve nurses' knowledge. The findings suggest that, in light of nurses' poor HIV knowledge, post-registration HIV education must be a priority and can be easily delivered via a short RLO. In future, HIV nurse specialists will increasingly be called upon to educate generalist nurses in providing HIV care. This open-access RLO may prove to be a useful resource for this aspect of the HIV nurses' role. Further research is required to assess whether changes in knowledge and attitudes are sustained over time.



## Abstract O9

### How does the changing role of the HIV nurse impact on job satisfaction?

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**Introduction:** Since the introduction of antiretroviral therapy to treat HIV, the disease area has rapidly changed. HIV is now considered a long-term health condition in the UK, characterized by periods of illness. Increased cohort sizes, organizational changes and workforce configurations have lead to multiple changes to the HIV nurses role.

**Objective:** The aim of the survey was to gauge professional opinion regarding how nurses were feeling about their current role, how skilled they felt within their role and how they coped with work related pressures.

**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). 85.7% (N=42) felt their job had changed significantly within the past 2 years with 61.7% (N=29) stating there was no career progression within the organization where they worked.

42.6% (N=20) felt they had received a moderate amount of training for their current job, 21.3% (N=10) reporting receiving a lot of training, 21.3% (N=10) receiving a little, 4.3% (N=2) receiving no training, with surprisingly only 10.6% (N=5) stating that they received a great deal of training. The vast majority of respondents 77.1% (N=37) stated that they felt they had a good work life balance 56.3% (N=27) felt rested after their days off. In a typical week HIV nurses predominantly felt a moderate amount of stress 44.9% (N=22). Encouragingly, 59.2% (N=29) did not feel burnout by their work. Practitioners were asked about the level and type of support they had in relation to their job 52.1% (N=25) felt they received enough support. Types of support were varied with the majority of support coming through informal support and peer support (68.1 N=32). With only 31.9% (N=15) reporting that they had clinical supervision.

**Discussion:** A significant number of nurses felt that their job role had changed within the last 2 years. Nurses stated a variety of different reasons for these changes, common themes to emerge were increased emphasis being placed on value for money, increasing case loads, less patient contact and more paper work.

## Abstract O11

### Clients' knowledge of PEP, criminalisation and safer sex

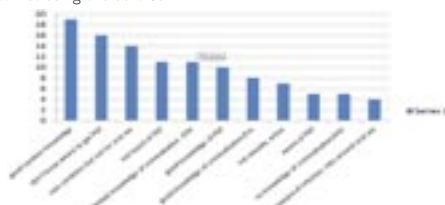
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**Background:** A large quantity of information is often offered to clients at the time of diagnosis and this study looked at what information is retained, updated, useful and meaningful. This is an important intervention in the reduction of onward transmission.

**Methods:** The method used was a voluntary semi-structured interview with 25 clients, followed by a client acceptability questionnaire. The interviews provided a platform to ascertain the knowledge and awareness clients had. Where there appeared to be a knowledge deficit, this was discussed and updated.

**Results:** There mean time of diagnosis was a high range of 1-21 years. The knowledge base was highly variable and interviews revealed many blocks enabling clients to have a good sex life. Clients expressed feelings of a low entitlement to a sex life, fear around disclosure and rejection, issues of low libido and a general poor self-worth. The client acceptability questionnaire was carried out to make sure that clients were comfortable discussing these issues. They were asked if the interview was relevant to them and if anything else should have been included. 81% stated the interview was useful and relevant. 100% reported it was appropriate to have the interview whilst using the service.



**Conclusion:** This study, although small, has identified there is a knowledge deficit in this cohort. The reduction in onward transmission is an important prevention strategy, and the focus has really shifted in terms of prevention, with a greater emphasis to work with HIV positive clients to enable them not to pass the virus on. Services need to find new ways of engagement with clients and perhaps screen for some of the more common problems, ie lack of libido, low entitlement.

This intervention

- Supports giving knowledge to clients to help them make informed choices
- Motivates – to behave in a certain way
- A chance to look at self-beliefs – a supportive environment is provided where ideas can be tested
- It allows clients to have power and opportunity.

As a result of this study we now have a named nurse for sexual health who ensures these areas form part of the care-planning. We have also started a 'virtual clinic' in terms of sexual health and are able to offer self-tests for *chlamydia trachomatis* and *Neisseria gonorrhoeae*.

## Abstract O10

### Lost to follow up – how can nurse specialists minimise this?

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**Background:** Long term follow up for HIV patients is crucial for good management of the condition. Regular clinic visits are not only necessary for the prevention of any complications, but to provide ongoing psychological support. For various reasons, every year a number of patients fail to attend specialist follow up to the long term detriment of their health.

**Method:** Our database highlighted patients who had not attended in the last nine months. Data was scrutinized by HPS, HPA, Health Records and unit staff. For patients identified as not having sought care elsewhere, their GP practices were notified. Several patients also received an invitation to re-engage. We then carried out a retrospective case note review to determine how to minimise future lost to follow up (LTFU).

**Results:** 204 patients were identified as being LTFU. Of these: 6 had died, 101 had moved abroad, 47 had transferred care, 7 had registered with a GP elsewhere, and 25 were untraceable. Of the remaining 18 still registered with a local GP, 1 re-engaged via the prison, 1 re-engaged as she was pregnant and 1 is a long term non-progressor therefore attends every 2 years. The GPs of the remaining fifteen were contacted. Eight patients received letters. Appointments were sent to seven at their request and four attended. Three have restarted therapy. Two of them had a CD4 less than 50, one has a CD4 less than 200. The three who did not attend were sent another appointment. We await contact from the remaining six. The average time from when a patient last attended was 30 months. On average they were offered 3.69 appointments each, missing a total of 48 appointments. Engagement following DNA's was analysed, illustrating that contact was successful following only 27% of the DNA's.

**Discussion:** The final number of patients genuinely LTFU was relatively low (2.45% of our total cohort). However, 75% of those who have returned to care have very low CD4 counts. Specialist nurses now call patients who DNA appointments, and further appointments without contact established will be limited. Reminders before appointments are also offered. Our database has been altered to clearly identify patients who are known to have left our care. It now also highlights those who are LTFU on a six monthly basis so that this can be reviewed regularly to continue to minimise numbers of missed appointments and ensure patients under our care remain well on therapy.

## Abstract O12

### Perpetual spirals of power and pleasure: exploring the life experiences of gay men living long term with HIV into the twenty first century

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The aim was to explore the life experiences of gay men living long-term with HIV.

**Methods:** This aim was achieved by means of an in depth analysis of a small number of life history interviews. 'Thick description' is used as a way of achieving external validity, providing context and meaning. The author's relationship with HIV forms one methodological issue, as does the continuum of involvement of relationships between the researcher and the researched. Narrative analysis of the narrative structures also identified which narrative models were employed.

**Results:** Themes which are analysed include coming out narratives in the context of sexuality and of being HIV positive. Coming out is shown as a process of moving to a positive or accepting sense of identity as being gay, or as being HIV positive. Coming out and other sexual life stories are shown to be part of the political process, embodied in the concept of intimate citizenship. The three generic elements of suffering that gives the plot tension, an epiphany, and transformation into a survivor, are identified. The epiphany leads on to another stage of life and involves a development of consciousness and of identity. It is suggested that sero-conversion for a person with AIDS/HIV can be seen in terms of a Giddensian "fateful moment" or a Denzinian "epiphany". These coming out narratives describe a circular life journey, ending in a finding of family or of coming home. The topics of identity and existential angst, linked to disconnection, self-esteem and mental health issues are examined, as is the creation of a positive identity and shift in consciousness. Power including abuse/ violence and other traumatic personal relationships, and sex and love are analysed in the light of the theories of Foucault and Plummer. As well as the power of one individual over another, also present are stories of personal empowerment. The power of sharing information, and the power that not telling can have, is a dominant theme in the narratives, as is the interconnection of power with sex.

**Conclusion:** This Life History Research dissertation paper is of significance to nurses working with HIV positive gay men. It tells of the traumas and struggles that many have been through and the long journeys of coming out and personal empowerment. Power, narrative, identity, self-esteem and mental health are key issues.

# Abstracts



## Abstract P1

### Survey of advanced practice roles in HIV nursing

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**Background:** The role of the nurse in HIV care has developed over the past few years, with nurses now having more extended roles. Recent debates have explored the role for advanced nursing practice in HIV but there remains little evidence of the breadth and extent of advanced practice in the United Kingdom (UK) within the HIV setting. The aim of this study was to gain further understanding of the variety of HIV nursing roles in the UK in relation to pay grades and level of nursing practice.

**Methods:** An anonymous online questionnaire using survey monkey was sent out to all NHVNA members. Data was analysed using Excel and benchmarked against the Royal College of Nursing (RCN) competencies for advanced practice.

**Results:** 67 responses were received from a variety of nursing roles clinical nurse specialist (CNS) 47.8%, nurse practitioner 7.5%, advanced nurse practitioner / advanced CNS 4.5%, health advisor 17.9%, staff nurse 3.0%, research nurse 6.0%, adherence nurse 1.5%, nurse consultant 3.0%, clinic manager 9.0%. Overall 88.1% of participants reported making health assessments using highly skilled knowledge and skills and 92.5% felt they had a supportive role in helping people to live with illness. 77.6% of all respondents reported making professional autonomous decisions and this function was more commonly reported in clinical nurse specialist roles, with all advanced practitioners and nurse consultants reporting this function. Just over half of respondents (56.7%) were making a differential diagnosis, this was reported more in clinical nurse specialist roles. Out of the 14 nurse prescribers, 9 were making a differential diagnosis. Almost all participants (98.5%) had a health education function to their role with 82.1% screening patients for disease risk factors although the level of practice was not specifically explored in relation to this. Under one third of respondents undertook the ordering of investigations (32.8%) and had the authority to admit or discharge patients and these activities were reported by all advanced practitioners and nurse consultants, whilst only 13 of 32 nurse specialist reported this activity.

**Conclusions:** This study has highlighted the variety of nursing roles in HIV across the UK. While many reported functioning at advanced practice levels, only 3 were advanced practitioners and there was apparent inconsistency between job roles and pay. The study found that despite RCN competencies and agenda for change guidance there is a lack of consistency between roles and pay.

## Abstract P2

### Audit of patients with HIV moving in and out of Lewes Prison

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**Background:** ESHT provides a CNS-led HIV service to HMP Lewes, a category B prison housing 742 men. The National AIDS Trust has produced standards for HIV care in prisons in the UK. People with HIV can be unexpectedly imprisoned, moved to different institutions or released at short notice. These can interrupt HIV care including adherence to antiretroviral therapy.

**Method:** an audit of 19 consecutive cases was performed reviewing the prison service healthcare electronic record (ER) and written notes.

**Results:** : 5 out of 13 patients on ART had a treatment interruption; 3 out of 19 waited more than one month to see the CNS; 13 patients' treatment centres sent a summary; 18 patients had a summary sent to their next treatment centre or the ER followed them; all those requiring it left prison with 30 or more days' ART.

**Conclusion:** Treatment interruption during admission to prison is common; there is scope to improve communication between HIV treatment centres and prison healthcare for people with HIV. HIV nurses are in a key position to improve this, possibly through the production of a communication tool. I would be willing to help to develop this with other HIV nurses working in prisons and NHVNA.

## Abstract P3

### Recovery of haematological markers in human immunodeficiency (HIV-1)-infected patients following treatment for hepatitis C (HCV)

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**Background:** Dual therapy with pegylated interferon alpha (PEG IFN $\alpha$ ) and ribavirin remains the gold standard treatment for HIV-positive patients infected with HCV. However, this treatment is more hazardous in HIV-infected individuals due to an increased risk of immunosuppression, bone marrow toxicity and interactions with highly active anti-retroviral therapy (HAART), potentially resulting in hepatotoxicity and decreased efficacy. While decreases in CD4 count, neutrophils count, haemoglobin (Hb) and platelets have been widely documented, time to recovery of haematological markers has been less well studied. Establishing the time to recovery of these haematological indices would provide clinical staff and patients with information and realistic expectations thus improving the patient experience. We aimed to review the time taken for haematological markers to resolve following treatment with PEG IFN $\alpha$  and ribavirin in a prospectively-followed cohort of HIV-positive individuals with predominantly early HCV infection.

**Methods:** 67 HIV-positive patients with HCV infection presenting to a single centre between January 2008 and December 2010 were treated with 24-48 weeks of pegylated IFN $\alpha$  and ribavirin and followed for up to 72 weeks. We analysed CD4 count, Hb, neutrophil count and platelets during the 6 month period after therapy.

**Results:** The overall SVR rate was 81%. All patients were male and the mean age was 38 years (95% CI: 37-40). 70% were treated within 1 year of HCV infection and 79% received HAART prior to HCV treatment.

The mean CD4 count decreased from 626mm<sup>3</sup> at baseline to 398mm<sup>3</sup> at the end of treatment (p3 (significantly higher than the 140mm<sup>3</sup> drop reported in the international Apricot study) This increased to 569 mm<sup>3</sup> at 3 months and 642 mm<sup>3</sup> 6 months following the end of therapy. Neutrophil, Hb and platelet levels recovered by 6 months of therapy.

**Conclusion:** Haematological markers, including CD4 count remain abnormal 3 months following treatment for HCV in an HIV-1 positive cohort but recover by 6 months.

## Abstract P4

### Recruiting patients with HIV to research studies in a London NHS clinic. Clinician perspective-motivating factors and barriers

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**Background:** A lot more is understood about HIV today due to the amount of research that has been done over the past 30 years but the changing epidemiology of HIV infection means that there is an increasing disconnect between those who have traditionally taken part in clinical research (mostly Caucasian men having sex with men) and those who carry an increasing burden of HIV (black Africans, women and heterosexual men). Clinical staffs are gatekeepers for research enrolment. This study explores service providers' perspectives of motivating factors and barriers for research participation of patients with HIV in an inner city UK HIV specialist clinic in which 55% of patients are women, of whom 72% are of Black African ethnicity.

**Methods:** Members of the multidisciplinary HIV clinical team were enrolled in a mixed methods study using structured questionnaires and focus groups.

**Results:** 19 staff members participated in focus groups and 20 completed questionnaires. Staff believed that patients participated in research for altruism, interest in research subject, gratitude and destitute patients were more likely to participate because of co-dependence. Reasons for not participating were time pressure, study commitments, life's demands (including work and childcare), poor literacy, confidentiality, disclosure and adjustment issues to HIV diagnosis. Burden of research and lack of feedback from previous studies to both participants and staff was given as a reason for declining future participation. All staff believed that incentives would increase research participation.

**Discussion:** Clinical staff carry the responsibility for the wellbeing of patients; their primary responsibility is key to research recruitment in healthcare settings. Their perspectives on factors for research participation may result in reduced participation in research studies.

**Conclusion:** Minimising inconvenience, together with careful planning to minimise overburdening patients with research may re-assure clinical staff. Staff and patients must have a sense of ownership and feedback to engage actively in research.

## Abstract P5

### UK students' knowledge and attitudes towards HIV

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**Background:** Both globally and within the UK, young people (aged 16-25) continue to be the group most affected by HIV/AIDS. In the UK, this is considered to be due to an increasingly sexualised culture, inconsistent sex education within schools and a decrease in drug and alcohol prices. There is a lack of up to date research on young people's HIV-related knowledge and understanding in the UK.

This research study aimed to address this gap, and comprised an exploration of university students' knowledge of HIV. The study also aimed to test the hypothesis that greater knowledge of HIV/AIDS would be associated with decreased discriminatory attitudes. The objectives were to establish the knowledge levels of first year university students on the topic of HIV, to establish attitudes held by these students towards HIV/HIV positive individuals, and to ascertain whether there is a relationship between knowledge levels and attitudes towards HIV positive individuals.

**Method:** A pre-validated questionnaire (developed by the National AIDS Trust and used by them in a large cross-sectional national survey in 2010) was administered to 422 first year university students in 2011. The questionnaire contained both knowledge and attitude questions. A specific scoring system was developed and piloted in order to establish a statistical relationship between students' knowledge and attitudes.

**Results:** Students from both arts and science subjects participated in the study. Knowledge levels were relatively high, however several misconceptions concerning transmission routes, testing and contemporary treatment scenarios were evident. Attitudes were mainly positive, yet some negative attitudes were present. The results showed that as knowledge of HIV increased, attitudes became more positive. However it was also found that some students held positive attitudes despite having poor knowledge on the subject. Students scored higher on most knowledge questions and more positively on the attitude questions than the national average.

**Conclusion:** Overall students' knowledge of HIV transmission was good, however there were still a worrying number of misconceptions. The continued existence of misconceptions and confusion around prognosis and testing suggest that HIV health promotion schemes and educational programs within schools and universities been to be improved. Such programmes need to highlight not only the transmission routes, testing options and treatments for HIV, but must also address the stigma currently surrounding the disease.

## Abstract P6

### Knowledge and attitudes to HIV/AIDS amongst registered nurses

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**Background:** Nurses need to be at the centre of reducing HIV stigma and not promoting it through ignorance or prejudice. HIV +ve patients should be cared for by those who will not judge them and have the knowledge to ensure they are treated properly. This study aims to evaluate the level of knowledge and attitudes of registered nurses and discover what factors are associated with these scores.

**Methods:** This cross sectional survey was conducted in a multicultural setting of one NHS Trust in London. A convenience sample of 144 nurses completed the questionnaire. The AIDS Study Questionnaire was distributed throughout the trust and self-administered. Modification was carried out with permission from the author. Sections included knowledge and attitudes to HIV/AIDS as well as HIV testing. Background variables were collected for associations with knowledge and attitude scores. These variables included HIV nursing experience, year of qualification, years working in the UK, country of training, gender, age, country of birth, marital status, job band, religion and ethnicity.

**Results:** The sample represented (predominately female) nurses from 22 countries and 25 ethnicities. White British nurses made up <0.0001. Small but statistically significant correlations were found between knowledge scores and years worked  $r=0.23$ , ( $p=0.007$ ) and between knowledge scores and years qualified  $r=0.23$ , ( $p=0.010$ ). Associations were found between several background variables and test scores including importance of religion, job band, and previous training.

**Conclusions:** Overall scores were good but individual knowledge questions indicated a lack of knowledge in some areas. Attitudes questions demonstrated a minority with negative attitudes to HIV. By evaluating the factors associated with poorer scores we can target training to reduce knowledge gaps and improve attitudes to patients with HIV.

## Abstract P7

### Circumcision as HIV prevention in MSM: A review of the literature

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**Background:** Men who have sex with men (MSM) are disproportionately affected by HIV, facilitated mainly though condomless anal sex (CAS). Since 2005 there has been growing interest in circumcision of MSM as a method of HIV prevention (CMHP). This follows 3 studies on circumcision in Africa which found up to 60% reduction in acquisition in heterosexual men with an estimated 3.7M HIV infections and 2.7M deaths prevented. Therefore the aim of this study is to explore the evidence for CMHP and the wider implications.

**Method:** Two platforms (hilo & OVID) were searched in November 2011 using specific search terms, restricted to full text in English. Erroneous and duplicates citations were removed, leaving 14 articles and 1 Cochrane review which were transferred to an Excel® database and analysed thematically.

**Results: The evidence** - While CMHP is biologically plausible to protect against HIV, STIs and some cancers, the evidence complicated, weak and inconsistent. No association between circumcision status and HIV infection was found. CMHP may reduce but not eliminate risk as the most effective mode of HIV transmission in MSM is receptive anal sex. CMHP offers most protection to insertive partners so relies on consistent sexual role, although there are issues with role consistency over time. CMHP alone would not prevent HIV transmission and is not recommended if already HIV positive.

**The wider considerations** - CMHP is socially sensitive, culturally controversial and raises human rights, legal and ethical issues. There are concerns about the re-pathologising of MSM, and that targeted circumcision could increase stigma. The removal of healthy skin is seen by some as genital mutilation and may be linked to increased sexual dysfunction and associated CAS. CMHP could actually increase HIV infections through risk compensation as circumcision status may influence an individual's risk assessment and leave some receptive partners feeling pressured to have CAS. While CMHP may be cost effective when compared to HIV treatment, funding it may impact on existing under resourced HIV prevention strategies.

**Conclusions:** CMHP would be adjunct to other prevention methods as alone it is not enough to prevent transmission and population level impact is unlikely. Some protection at individual level although dependant on being HIV negative, uncircumcised, anally insertive exclusively (and consistently) and willing to be circumcised. Further research is required, although unlikely.

## Abstract P8

### Adults newly referred to a third sector organisation demonstrate multiple complex factors that jeopardise health regardless of time since HIV diagnosis

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**Background:** People living with HIV may have complex social and personal factors that impact on their wellbeing and health promotion ability. The aim of this needs assessment is to identify time since diagnosis and presenting needs of adults newly referred to a third sector organization's services and to use those findings to inform service improvement and local HIV policy.

**Methods:** : During 2011, 218 adults were referred to a third sector organization by telephone. Upon referral a basic screening process identified factors relevant to individual need including: mental health, psychosocial wellbeing, family needs, physical health and practical needs. Initial screening also captured demographic information and time since diagnosis. This information was analysed to identify whether time since diagnosis influenced complex needs in newly referred patients.

**Results:** Amongst the 218 referrals, 31.3% presented with identified need in all factors (mental health, psychosocial, family, physical health, and practical needs). 11.5% presented with 4 out of 5 needs, 10.1% with 3 out of 5, 11.1% with 2 out of 5 and 19.3% with 1 out of 5. 16.6% either had zero presenting factors upon referral or were missing data. The most commonly presenting need was for psychosocial support (69.7%) followed by mental health (56.4%). While women consistently were more likely than men to present with greater need in all categories, the difference was not significant. Time since diagnosis was not a statistically significant predictor of individual need upon referral.

**Conclusions:** Adults newly referred to the third sector organization presented with multiple complex needs irrespective of time since diagnosis. Future research should examine clinicians' referral motivations and patterns, and the cost-effectiveness of earlier referral to third sector organizations in terms of preventing long-term barriers to wellbeing.

# Abstracts

## Abstract P9

### Every second counts – audit of waiting times for blood tests in an HIV outpatient service

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**Background:** Interventions which improve patient experience and satisfaction are key to service transformation. A common NHS complaint is time spent waiting for a blood test to be taken. Changes in nurse staff mix, with appointment of a nursing assistant team (Band 3), coupled with innovation in IT, with roll out of care record system (CRS) allowed introduction of patient held, pre-printed, request labels. Approximately 2400 HIV patients attend this inner city clinic.

Previously, serological requests were recorded in patient notes, which had to be pulled when the patient attended for bloods. Significant time was spent by reception staff finding notes that were not immediately available; with consequences of patients waiting and reception staff not able to perform their other duties.

**Methods:** A prospective audit of patients attending for blood tests was performed in June 2011. Data on visit date, time, minutes waiting, appointment type (walk in or booked clinic appointment) was recorded. Comments were also recorded if a patient was called but not in the waiting room.

**Results:** There were 466 patients attending for blood tests (20% cohort). The average (mode) wait was 2 minutes, with a mean of 3.9 minutes (range

**Conclusions:** The process of blood requests and waiting times has been transformed in several ways.

- 1) A system not reliant on finding patients notes has released receptionist time.
- 2) Clinicians pre-print future request labels which are brought by the patient and presented at phlebotomy. This ensures only necessary tests are performed and avoids unnecessary investigations. This has pathology cost savings.
- 3) The appointment of a dedicated nursing assistant team has streamlined nursing pathways, freeing qualified staff to deliver other duties.
- 4) Virtual outpatient clinics are popular for stable patients, and short waits for blood tests further improves patient experience.

## Abstract P10

### Mentoring nurse initiation and management of antiretroviral therapy (NIM-ART) in South Africa

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**Background:** An experienced HIV nurse from the UK was deployed for three months in 2011 to act as a mentor to nurses learning to initiate antiretroviral therapy in primary care clinics in a small town in the Eastern Cape, South Africa.

Previously, serological requests were recorded in patient notes, which had to be pulled when the patient attended for bloods. Significant time was spent by reception staff finding notes that were not immediately available; with consequences of patients waiting and reception staff not able to perform their other duties.

**Methods:** Mentoring was carried out using local resources. A review of existing pre-ART patient files was performed. Patients lost to HIV follow up were recalled to clinic.

**Results:** 286 files were reviewed. Only 24% patients had attended the clinics within the previous six months and 20% had not been seen for more than 2 years. Two lay counsellors visited 222 patients to encourage them to return to care. 65/286 (23%) were untraceable, 11/286 (4%) had moved away, 30/286 (10%) declined the invitation, and 8/286 (3%) had died. In the six weeks following the recall exercise, 51/286 patients (18%) returned to the clinics. All patients had repeat CD4 counts and were screened for TB and other opportunistic infections. 13/51 (25%) were started on ART, 1/51 (2%) patient was found to have TB and 23/51 (45%) others were put on INH prophylaxis.

**Conclusions:** Mentoring plays an important role in training and supporting professional nurses in their workplaces. By establishing accurate and robust management systems guided by tools such as the Adult Care Record, the pre-ART and ART registers, people identified with HIV infection can receive on-going comprehensive care and be started on ART at the appropriate time by nurses. Recall of lost to follow up patients is feasible in a small rural town. Such extended visits by experienced mentors could play a significant part in the future in raising the standard of HIV care in South African primary care clinics.

Please note: this work is being presented as a poster by Maryna Stander (author 3) at the 3rd South African TB Conference 2012 <http://www.tbconference.co.za/>

## Abstract P11

Abstract withdrawn

## Abstract P12

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

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**Background:** Changing dynamics within the consumer-led NHS has stretched resources. The governmental drive to encourage people to take more responsibility for their own health needs, challenges to professional patient dynamics in terms of dominance and power and the significant shift within the field of HIV, from a palliative to a chronic disease, have all influenced service provision. The lack of research, particularly in HIV, exploring patient perceptions of changing services and of empowerment models which promote self management of health needs was identified.

**Aim:** The study will explore whether people living with HIV (PLWH) have developed strategies to manage their healthcare over time. Also to capture the lived experience of people who are accessing healthcare services, focusing on aspects such as self confidence and ability to access and use health care services.

**Method:** Ethical approval was obtained for this qualitative study. Five focus groups are being conducted. Each focus group will have a maximum of 10 participants. Participants aged 18 or over who have been diagnosed for a minimum of 12 months are invited to participate by using posters in clinical and community settings. Patients can self refer. Prior written information is provided and participants consent obtained. The focus groups are facilitated by nurses from across the network but not within the geographical area they work in. This ensures the nurses are not in a dependent/caring relationship with any participants. A discussion guide, with ice-breaking advice, suggested open-ended questions and prompts, is provided to facilitators. Discussions are recorded, transcribed and then analysed using thematic analysis. This will produce patient identified themes important in the way they manage their changing relationship with NHS services.

**Results:** The study commenced on 3rd April. Results from 3 focus groups will be included in the presentation. The emergent themes will be outlined and the identification of the coding categories explained.



## Abstract P13

### Asymptomatic sexual health screening in HIV day ward leads to increased detection of sexually transmitted infections in asymptomatic HIV patients

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**Background:** In 2008 the British HIV Association (BHIVA) recommended that people living with HIV (PLHIV) under regular care should have an annual sexual health screen, regardless of risk. Prior to June 2009 this service was only provided using a pre-booked appointment system. If no appointment was available, patients would be given priority in the general walk in sexual health department. This resulted in the service not being as responsive to the patients' needs as the nursing team lacked the relevant skills to provide appropriate sexual health screening. Competency based training was implemented in order to achieve BHIVA national guidelines. A walk-in asymptomatic screening service subsequently went live on the 1st of June 2009.

**Method:** Data was extracted from the clinic's IT system of the entire patients that attended the asymptomatic screening clinic from June 2009 to May 2011 (22 months). The data showed how many patients attended, and which infections they were diagnosed with. The study also assessed frequency of sexual infections during that period.

**Inclusion:** All HIV patients who attended the asymptomatic clinic

**Exclusion:** PEP patients and HIV-negative partners

**Limitations:** 140 patients were not logged on the system as having attended, hence no data obtained.

**Results:** There were a total of 1553 patients seen during the 22 month period, of which 1035 were males and 518 were females. 50 (3.23%) patients were diagnosed with syphilis, 79 (5.09%) patients with gonorrhoea, 116 (7.47%) with chlamydia, 5 (0.32%) patients with hepatitis B, 2 (0.13%) with hepatitis C, 1 (0.064%) patient with *Trichomonas vaginalis* (TV) and 10 (0.64%) with urinary tract infection (UTI). A total of 30 (1.93%) patients had the same infection twice, 6 (0.86%) three times whilst 2 (0.128%) patients had more than two different infections in that period.

**Conclusions:** There has been an increased uptake of screening since the service was established. High rates of sexually transmitted infections (STI) in the asymptomatic cohort indicate the need to maintain and improve the provision of sexual health screening in this population. Further safer sex health promotion in this cohort regarding condom use and high risk behaviour could also benefit this group to prevent onward

## Abstract P14

### Process and psychological findings of implementing a behavioural change programme for adherence in young people with perinatally acquired HIV infection (PaHIV) using financial incentives and motivational interviewing

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**Background:** Evidence suggests when antiretroviral (ART) adherence is not established in childhood it reflects a range of self-management difficulties which impede intervention from the MDT to establish adherence in later adolescence. 20% of the transitioning cohort fell into this pattern, 2 of whom died aged 20 and 21. Consultation with clients suggested the potential importance of financial incentive (FI). This fits Behaviour Change theory which requires identification of concrete rewards for changing contingencies. Motivational Interviewing (MI) also has established credentials in this area, though study results are equivocal. An Incentive Scheme (IS) was developed with viral load (VL) endpoints combining FI and MI intervention.

**Methods:** Young people (16–24y) with PaHIV, low CD4 count and significant adherence problems were eligible. IS involved MI at 2 weekly follow up until a drop and then a VL<50 was achieved. Receiving FI was contingent on reaching each goal in the series and attending for MI. Further goals involved sustaining a VL<50 for increasing periods with further MI. An MI pro-forma recorded importance, confidence, adherence and stage of change at each visit, also identification of barriers and potential solutions. Outcome was measured (VL and CD4 count) at exit from IS. The max total FI was £200/patient (£25/£50 for specific goals). Exit interviews gathered additional qualitative data.

**Results:** 11 enrolled, 1 declined. Median age 19yr (range 16–23), 8 female. 9/11 reached VL<50 and 5/11 sustained to the IS endpoint (6 months VL<50). IS time range 3–20 months, MI range 2–13 sessions, VL<50 time range 0–13 months (10.2 completers, 1.3 noncompleters). There was a significant relationship between the number of MI sessions and success/failure of IS ( $P=.001$ ), months of VL<50 ( $P=.001$ ) and CD4 increment ( $P=.026$ ). These data and qualitative interviews suggest that the mediating factor in success is engagement via reward, rather than reward for adherence directly.

**Conclusion:** Following this novel intervention, 46% of this highly challenging cohort achieved sustained virological suppression as a result of behavioural changes. Rewards appeared to encourage attendance. This in turn allowed psychological intervention to identify emotional and logistical solutions for this vulnerable group. The nature of the intervention needs further tailoring in line with behaviour change theory and further directions will be outlined.

## Abstract P15

### Confidentiality: a continuing barrier to disclosure of HIV status to GPs? The experience and concerns of HIV patients in an integrated sexual health clinic

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**Background:** Existing data from large HIV centres exploring the relationship between HIV services and primary care demonstrate a high level of GP involvement. In 2008 we surveyed the patients attending our HIV service and found that a significant proportion had disclosed their status to their GP. Confidentiality was given as the commonest reason in those who had not. In 2011, following concerted efforts to encourage and support patients to disclose their status to their GPs, we repeated the survey with the aim of assessing ongoing barriers to communication with primary care. **Methods:** Patients attending our HIV outpatient centre between the end of March and July 2011 were asked to complete a form documenting their consent for communication between the clinic and their GP and to complete a questionnaire detailing their experience of Primary Care services.

**Results:** 102/120 (85%) questionnaires distributed were completed. 79% of patients gave consent for the clinic to contact their GP and 75% stated that their GP was already aware of their HIV status (compared with 76% who stated they had already informed their GP in 2008). 14% were registered with a GP but had not disclosed their status, of whom, 72% gave confidentiality as the main reason for their non-disclosure (compared to 50% stating confidentiality was the main reason they had not disclosed in 2008). Of all the patients who completed the questionnaire, 32% had concerns about attending their GP which related to their HIV status. Concerns expressed included confidentiality (39%), lack of GP HIV specialist knowledge (22%) and stigma (13%). 22% of those who completed the form stated they would be more confident in disclosing their status if they could be reassured that no one else in the practice beside their GP could access this information about their HIV status; however 10% stated that this would not dispel their concern.

**Conclusion:** This survey confirms that a continued high percentage of our HIV patients' GPs are involved in their care. However, despite concerted efforts, there remains a concerning proportion of patients who are reluctant to disclose their status to their GP and have ongoing concerns relating to confidentiality. Enhanced collaboration between patients, GPs and HIV centres in the form of working groups and patient forums could address these concerns.

## Abstract P16

### The TRxCare™ adherence support system: a pilot study of its acceptability to patients on virologically successful HAART

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**Background:** Adherence is key to the success of HAART, but there is little evidence that simple interventions can help. The TRxCare™ system is a pillbox that sends a mobile 'phone signal to a remote server when opened. It monitors dose events & texts reminders for missed doses & positive feedback on adherence. We assessed its acceptability in a pilot study.

**Methods:** Eligible patients had been stable on HAART for at least 90 days with a last HIV viral load <50 copies/ml & could read English. Subjects consented to use the modified pill-box for all their doses for the 24 week study. From weeks 13–24 only, text reminders were sent to the subject's own mobile 'phone if a dose was late; weekly text messages were sent to reinforce adherent behaviour. At weeks 12 & 24 subjects received verbal feedback on their adherence from the study team using data held on the system's server. Subjects completed an adherence questionnaire at baseline, 12 & 24 weeks. At 12 & 24 weeks they also completed questionnaires on the acceptability of the system.

**Results:** Fourteen patients participated in the pilot; all were male, median age 43 years (IQR 37–46); 11 were on once daily medication, 3 twice daily. At baseline reported adherence over the previous month was high at 99.5% & remained at 98% at week 24. The median number of reminders per patient was 14 (range 1–43). Dose times were later after reminders were switched on ( $p=0.017$ ), but overall the number of doses missed was low (4.8% wk 0–12; 6.3% wk 13–24) & did not change over time. On days when a dose was taken, 81% of doses were taken within 1 hour of the correct time in both phases. At week 24 64% were satisfied with the system but 36% were neither satisfied nor dissatisfied. 50% found the text reminders & overall system useful & 67% found the verbal feedback useful. However 54% found the pill-box inconvenient or that it made more difficult to take HAART regularly; 55% found reminders irritating.

**Conclusion:** This pilot found remarkably high, consistent adherence in patients on stable HAART. While open to possible bias towards those willing to be monitored, this suggests that future UK studies of adherence interventions may need to select patients at risk of low adherence e.g. based on virological failure. However given that even in this highly adherent group, TRxCare™ presented some barriers to adherence further study is required before it can be generally recommended. Adherence interventions should address individual needs.

# Abstracts



## Abstract P17

### Questionnaire-based evaluation of the contraceptive needs of HIV positive women at a south London HIV clinic

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**Background:** 331 HIV positive patients attend our service, of whom 557 (42%) are women. This study aimed to evaluate their contraceptive needs.

**Methods:** Questionnaires were distributed to HIV positive women >16 years presenting between 01.08.10–31.01.11. Data regarding age, ethnicity, HIV status, sexual activity, pregnancy history and contraceptive use were obtained. Data were analysed with Microsoft Excel 2007.

**Results:** 165 questionnaires were distributed; 109 were completed (response rate 66%). 61/97 (63%) women were of childbearing age (16–45 years) and 79% Black African. Median time since HIV diagnosis was 5–9 years. 67/97 (69%) reported contraceptive use: 51 (76%) condoms, 13 (19%) intrauterine device or system, 4 (6%) depo provera and 3 (4%) the oral contraceptive pill (OCP). Although 89/99 (90%) were taking antiretrovirals (ARVs), 29 (33%) women were unaware of potential interactions with certain methods of contraception. 3 women on ARVs were on the OCP; 2 of these prescribed by their GP. For those using condoms, only 32/51 (63%) reported consistent use. Contraception was accessed as follows: 32/51 (63%) during their HIV appointment, 11/51 'non-prescription' access, 6/51 GP, 5/51 family planning service at our clinic, 3/51 family planning clinic elsewhere and 2/51 young person's clinic. 77/102 (75%) had previously been pregnant and 36/91 (40%) reported unplanned pregnancies, with 18/36 citing the cause as 'no contraception used', 11/36 a 'failure of contraception', 2/36 cited both. 62 women reported pregnancies not ending in a live birth; 55% had terminations, 34% miscarriages and 11% still births. Frequency of contraceptive discussions varied: 30/77 (39%) had contraception discussed with them £ once a year, including 2 women who had never discussed contraception, 19/77 (25%) > once a year and 28/77 (36%) discussed it on every visit. 50/74 (67%) women discussed contraception with a doctor, often in conjunction with another healthcare professional. 57/76 (75%) of respondents stated preferring to access contraception at the same time as their HIV appointment; reasons included a wish to deal with issues in one appointment and a reluctance to disclose HIV status to other services.

**Conclusion:** An on-site service providing HIV positive women with effective, regular access to contraceptive information and prescription may increase appropriate contraceptive use, reducing the number of unplanned pregnancies and terminations.

## Abstract P19

### Meeting the psychological needs of people living with HIV: an evaluation of the HIV psychiatric liaison service in an urban area

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**Background:** In response to recent guidelines regarding psychological support for people living with HIV, the aim of the study was to evaluate current HIV psychiatric liaison service provision in an urban area.

**Methods:** A questionnaire-based psychiatric liaison service evaluation was conducted, supplemented with a qualitative study focussing on the psychological implications and individual experiences of people living with HIV. Questionnaires were distributed to all HIV positive patients seen in clinic between 13th October and 8th December 2011 who were current or previous users of the HIV psychiatric liaison service. Quantitative data from the questionnaires was collated and represented graphically. Qualitative data from free text boxes was classified into themes. Following this, semi-structured interviews were conducted with 20 HIV positive patients attending Consultant, Registrar or multidisciplinary team clinics between 14th and 23rd November 2011. Interviews focussed on experiences of general practitioner (GP) disclosure, coping mechanisms and relationships with family, friends and partners. Qualitative data from the semi-structured interviews was analysed thematically.

**Results:** 18 questionnaires were returned over the study period (43% response rate) and none were excluded from the study. Patient satisfaction scores were high for all criteria with mean scores ranging from 3.2 to 3.5 on a scale of 1–4. 79% of respondents stated that they would prefer to discuss their mental health issues with the HIV psychiatric liaison team rather than their GP. Identified themes included the desire for specialised care, greater confidentiality and less stigma felt in the integrated sexual health setting. Disclosure rates were: 85% (GPs), 80% (friends), and 60% (family and partners). Complex adjustment experiences and coping mechanisms were identified. The majority of participants reported positive lifestyle changes and a proactive approach to the management of the condition. Less positive experiences included struggles relating to negative self-perception, denial and substance abuse.

**Conclusion:** Given the well documented links between HIV and psychiatric comorbidities, responsive and high-quality service provision is crucial. The HIV psychiatric liaison service has been shown to be a valuable provision for people living with HIV, however additional funding is essential to expand the service and further meet their psychological needs.

## Abstract P18

### Following up persons 'lost to follow up': experiences of a medium-sized HIV centre

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**Background:** On average, 90% of adults attending HIV services in any one year attended the following year. The remainder become 'lost to follow up.' Some seek care elsewhere; others disengage from services and re-present late. We aimed to determine the rates of loss to follow up in our clinic population, and to identify subsequent presentation in alternative settings.

**Methods:** The hospital database was used to identify individuals who had not engaged in HIV care for more than 12 months during the period 2007–2010. Demographics, laboratory results and ARV experience at the last clinic visit were recorded. Medical records were reviewed to identify reasons for default. Where reasons were unclear, efforts were made to contact patients via telephone and by post. Finally, the HPA SOPHID database was interrogated to identify individuals who may have later presented for care elsewhere.

**Results:** Of 690 regular clinic attendees, 79 individuals (11%) were identified as being lost to follow-up. Of these, the majority (91%) were men. Three individuals (3.8%) had died, and 34 (43%) had formally transferred their care or returned to their countries of origin. For the remaining 42 individuals (53%) no documentation was available to explain why they had defaulted follow-up. In 7 cases (17%) there was evidence of attempted recall by clinicians. Following attempts to trace these individuals, two re-engaged in care. Attempts were limited by a lack of current contact information. Of the 40 truly lost to follow up (5.8% of total clinic caseload), the majority (70%) identified as white (with 20% identifying as black African). At the time of last visit, median CD4 count was 432 cells/mm<sup>3</sup> (range 7–823), and 18 patients (45%) were on antiretroviral therapy with 13 (72% of this group) having an undetectable viral load. The HPA SOPHID database revealed that three (7.5%) of these individuals have subsequently presented for care at alternative centres.

**Conclusion:** In our centre, a small fraction of attendees become lost to follow up. In fewer than half of cases, however, are reasons known. Attempts at recalling those patients truly lost were hampered by a lack of contact details. The use of the SOPHID dataset can be successfully employed to identify those still engaged in care in the UK. Maintaining contact details and improving communication with other healthcare providers (eg primary care) may improve recall exercises in the future.

## Abstract P20

### HIV-positive female patients – are we offering effective methods of contraception?

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**Background:** Antiretroviral drugs have the potential to either decrease or increase the bioavailability of steroid hormones in hormonal contraceptives. If a woman on antiretroviral treatment decides to initiate or continue hormonal contraceptive use, the consistent use of condom is recommended. This is for both preventing Human Immunodeficiency Virus (HIV) transmission and to compensate for any possible reduction in the effectiveness of the hormonal contraceptive.

**Objectives:** An audit was carried out to review the adherence to the 2008 United Kingdom (UK) National guidelines for the management of the Sexual and Reproductive health of people living with HIV infection. According to the guidelines consistent condom use should be encouraged in conjunction with an additional contraception method.

**Methodology:** Retrospective analysis of 144 cases was undertaken to ascertain compliance of documentation of offer of contraception. All HIV positive female patients attending the department in 2010 aged less than 50 were included in the audit. 74 women were excluded from the audit. The exclusion criterion was currently pregnant, previous hysterectomy and no sexual partner in last 12 months. 23% were not sexually active in 2010.

**Results:** Majority of patients (66%) were black African and 52% were aged 36–50. Condoms were offered in 83% of cases and contraception was discussed in 51%. Out of 36 patients using Contraception, 33 were on Highly Active Antiretroviral Therapy (HAART). Out of 14 patients using hormonal contraception, 4 were consistently using condoms. Use of condoms was not documented in rest of 10 patients.

**Conclusion:** The recommendations were made to discuss drug interactions and consistent use of condoms with patients using hormonal method of contraception and HAART. This will help to prevent HIV transmission as well as unwanted pregnancies. As Genitourinary Medicine (GUM) services are moving towards integration with contraceptive services, priority should be given to HIV positive women to seek contraceptive advice in order to enhance their overall care.

## Abstract P21

### Establishment of an annual health clinic for HIV-positive individuals

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**Background:** BHIVA guidelines for the routine investigation & monitoring of adult HIV-I-infected individuals 2011 and EACS version 6 guidelines advise on appropriate annual monitoring which maintains the health of people living with HIV. Standard care at our centre aims to fulfil these recommendations, however, it is identified that patients frequently do not stay or are reluctant to take these opportunities when offered. With this in mind the multi-disciplinary team (MDT) discussed new ways of working in order to meet this need. The outcome of this was the establishment of a new annual health clinic (AHC).

**Methods:** The AHC was set up fortnightly & overseen by Clinical Nurse Specialists (CNS). Screening was performed for sexual health; urine protein/ creatinine ratio; urinalysis; cytology; Hepatitis B/C serology; cardiovascular risk (CVR); fracture risk; neurocognitive and mood screens. Disclosure, child testing & PEPSE are discussed with the patient. Findings are recorded in an easily identifiable booklet, filed in the notes for medical review at the doctor appointment 2 weeks later. Band 5 nurses co-ordinate the clinic & an MDT of Dieticians, Occupational Therapists, Sexual Health Nurses, & Health Advisors deliver the care. The appointment is approximately one hour. An information leaflet explained the purpose and format of the clinic i.e. it replaces a routine blood test appointment; it is not an additional visit. This one-stop shop enables other appointments throughout the year to be less time consuming & complicated.

**Results:** To date 99 patients have attended with 69% male, 31% female with a mean age of 42yrs. The satisfaction survey in progress suggests it is highly acceptable to patients. 100% have had CVR, bone fracture risk, neurocognitive & mood screening carried out. 100% have been offered a sexual health screen & of those 70% have been screened. A benefit is to proactively provide advice & screening to prevent common conditions occurring or detect them early. Patients have an opportunity to meet the wider MDT to develop therapeutic relationships.

**Conclusion:** The aim of the AHC was to ensure guidelines regarding annual patient care are met. The clinic has been instrumental in the identification of problems which may otherwise have gone undetected or taken longer to be recognised. This has allowed prompt treatment. An audit comparing AHC to standard care will be completed in March 2012.

## Abstract P23

### The importance of social care support for people living with HIV: findings from a snapshot survey of healthcare professionals

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**Background:** Over the last two years there have been significant changes to the way in which social care for people living with HIV is funded. There is concern that the change from a ring-fenced grant (the AIDS Support Grant) to a non-ring fenced funding line in the Formula Grant for 'HIV/AIDS Support', combined with the wider Local Authority budget cuts, could threaten the provision of high-quality social care services for people living with HIV in England. As part of wider research into the importance of social care, we carried out a survey to find out what impact healthcare professionals working in HIV feel that social care support has on their patients' ability to manage their HIV and health more broadly.

**Methods:** In 2011 149 healthcare professionals working in HIV were surveyed to gather evidence on the value of HIV social care from a medical and public health perspective.

The survey was conducted online via Survey Monkey between 7 March and 15 April and was promoted to members of BHIVA, CHIVA, NHIVA and the Society of Sexual Health Advisors. The sample was opportunistic and is likely to overrepresent those with strong views on social care. Nevertheless the results offer an insight into the range of social care needs experienced by people living with HIV.

**Results:** Healthcare professionals frequently refer patients to social care services, the majority – 65% - referring at least once a month. The most frequently cited reasons for referrals were those associated with poverty. Psychological support needs were also frequently cited. The survey also showed significant number of patients had trouble accessing social care - 45% of respondents reported problems. Barriers cited included a lack of capacity in local services, high eligibility thresholds and the loss of specialised HIV social care support. However, the results also indicated that the vast majority of healthcare professionals – 77% - felt social care had a positive impact and helped their patients.

**Conclusion:** This survey illustrates the continuing need for social care support for people living with HIV, the positive impact that such support has on people's lives, and the value placed on it by HIV healthcare professionals.

## Abstract P22

### HIV-positive adolescents: bridging the gap between paediatric and adult HIV services

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**Background:** To characterise a cohort of HIV positive adolescents attending an outpatient transition service, for 18–24 year olds, at a SW London clinic.

**Methods:** A retrospective case notes review of all adolescents, currently or previously attending the transition service. Data was collected using a standardized database between 01/09/11–01/01/12 recording: demographics, HIV stage, anti-retroviral therapy (ART), psychosocial issues and sexual/ reproductive health data.

**Results:** 37 adolescents were identified. Median age 20, 19 (51%) male and 31 (87%) Black African. Most (97%) were vertically infected and 33 (89%) had transferred from paediatric services aged 18 years. 5 patients had already transferred to on-site adult HIV care, 3 had transferred elsewhere, 2 were lost to follow up and 2 had died. Of those vertically infected adolescents previously treated in paediatric services (n = 33), the median age at diagnosis was 5.5 years (range 1–16). The majority (79%) were symptomatic at diagnosis (CDC B/C). 27/33 (82%) had had an AIDS defining illness and 28/33 (85%) were taking ART; of whom, 15/ 28 (54%) had VL < 50c/ml. Median duration of ART was 11.5 years (range 2–20); only 4% were taking first line therapy. Side effects, simplification of the regimen and resistance (n = 7) were the commonest reasons for change. 43% self-reported poor adherence (2 or more missed doses over last 4 weeks). Most recent median CD4 count was 567 but in 20% was <200 cells/ll. 12 patients (33%) had missed ≥3 appointments in the preceding 12 months; none had been lost to follow up for >1 year. 9/33 (27%) had documented learning difficulties and 27% had mental health problems. Despite this 13/33 (45%) were undertaking university degrees. 21/33 (64%) report being sexually active, of whom 9 (43%) had a regular partner. Of those, 89% had disclosed their HIV status and 89% reported using barrier contraception. 38% of females had previously been pregnant and 25% had previously had a termination of pregnancy.

**Conclusion:** Characterisation of this cohort has highlighted the advanced stage of HIV at diagnosis, long duration of ART, high prevalence of side effects and poor ART adherence typical of this group. Encouragingly this vulnerable cohort, cared for in a dedicated service, displays a high level of educational attainment, and despite the frequency of missed appointments the service has maintained a high retention rate and low levels of loss to follow-up.

## Abstract P24

### Improvement in time taken to see newly diagnosed HIV patients following implementation of five key measures

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**Background:** British Association of Sexual Health & HIV (BASHH) guidelines stipulate that all patients with a new HIV diagnosis should be seen by a specialist ideally within 48 hours or, at the latest 14 days of being informed of a positive result. Two quality improvement projects (QIPs) were done at a large teaching hospital during 2006–2010. Changes in service provision in the GUM/HIV department were made to attain this accessibility standard for new patients testing HIV-positive in the 2 GUM clinics and were evaluated again in 2012.

**Method:** The components of these 2 key QIPs over the 5-year period comprised: An increase in clinic frequency; the number of weekly new patient HIV specialist nurse clinics was increased from 5 to 11 facilitating more rapid reviews (2008)

Creation of new patient slots within every consultant and registrar led general HIV clinic in the HIV outpatient slot where previously there had been just been one HIV new patient clinic weekly (2008) Training health advisors (HAs) to use the trust appointment system which allowed them to give new patients nurses or doctors appointments (2009) Creation of a new HIV patient database which signposted health advisors and nurses to expedite appointments for new patients for medical review (2010) Establishment of a dedicated HIV seroconversion clinic to fast-track patients experiencing HIV seroconversion (2009) The benefits of these changes were evaluated in 2012.

**Results:** Mean time for new HIV patients to be offered an HIV nurse appointment fell from 31 days in 2006 to 7 days in 2011 (P < 0.001) and time to doctors appointment fell from 59 days in 2006 to just 12 days in 2011 (P < 0.001). 12/39 (31%) of patients were offered a doctor appointment within 48 h of receiving an initial positive result in 2011 versus 3/44 (6.8%) of patients in 2009 (P < 0.01). For nurse appointments; 18/27 (66.6%) were offered an appointment within 48 hours in 2011 versus 7/38 (18.4%) in 2009 (P < 0.001)

**Conclusion:** There has been a consistent decrease in the time to see a HIV specialist over 5 years. These changes have been embedded, resulting in sustained improvement. The majority (66%) of new patients are now being offered nurse appointments within 48 hours. In addition to more appointments, an important factor contributing to this improvement has been the enhanced multidisciplinary team approach; streamlining of the HA roles and nurse and HA database usage to expedite appointments for patients with greatest medical need.

## Abstract P25

### To determine the influence of a home delivery service of HIV medicines on adherence to HIV therapy

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**Background:** Successful treatment of HIV requires a high level of patient adherence to anti-retroviral therapy. Home delivery of HIV medicines has expanded rapidly over the last two years in HIV units in London and these stable patients are receiving supplies of four to six months. Evaluating whether change in the mode of supply of medicines is associated with any change in adherence and patient outcomes needs to be reviewed.

**Methods:** Retrospective analysis of medical notes of one hundred patients who were started on home delivery (HD) and 100 patients who received supplies from the clinic based hospital HIV pharmacy (standard care) over a 3 month period (Jan–Mar 2011) were reviewed over a 6 month period. Patient demographics and type of HIV regimen were recorded. HIV viral load, CD4 (%) and adherence were analysed using SPSS for windows version 18, McNemar test, repeat measure ANOVA test and independent t-tests.

**Results:** No significant difference was found in the number of patients with a suppressed HIV viral load who were on home delivery versus the standard care patients ( $P = 0.650$ ). There was a general rise in CD4 (%) over time, but the average (mean) CD4 (%) was statistically similar between the two groups.

Adherence levels also remained statistically similar between home delivery and standard care patients ( $P = 0.350$ ). Over 50% of patients on HAART did not have adherence recorded over the 6 month period.

**Conclusion:** The average (mean) HIV viral load and CD4 (%) was not significantly different between the home delivery and standard care group indicating that the mode of supply did not affect adherence. Adherence documentation needs to be standardized and documented routinely.

## Abstract P27

### Baseline HIV knowledge of adolescents: a retrospective review of intake knowledge assessments

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**Background:** Illness related knowledge is associated with treatment perceptions and understanding in chronic illness. The purpose of this study is to examine HIV specific knowledge of adolescents (aged 13–19) upon registration at a community organisation for people living with and affected by HIV in London.

**Methods:** During 2011, all new adolescent registrants at a community organisation undertook a brief, 5-item screening process to measure baseline understanding of key concepts related to HIV, including: basic comprehension of the HIV diagnosis, CD4 count, viral load, transmission routes, and ways for a person living with HIV to stay healthy. 66 new registration charts containing assessment were retrospectively reviewed to evaluate knowledge trends.

**Results:** 66 total charts were reviewed; 50 of 66 belonged to HIV positive (HIV+) adolescents and the remaining 16 belonged to HIV affected (HIV-Af) adolescents. Items were scored 1–3: scores of 1 indicated little or no understanding, 2 indicated some understanding, and 3 indicated a satisfactory understanding of basic concepts. Maximum score for individual assessment was 15 and minimum score was 5. The mean score for registrants was 9.136, indicating some understanding of key concepts related to HIV. HIV+ adolescents demonstrated a slightly higher overall understanding (mean 9.52) than HIV-Af adolescents (mean 8.563), a trend that was consistent across all items. There were no significant differences in knowledge between male or female scores. Adolescents aged 13 had lower mean scores than adolescents aged 14–19 (8.421 versus 9.511 respectively). Adolescents scored higher on broader concepts (HIV, transmission routes, and ways for a person living with HIV to stay healthy) than on specific concepts (CD4 count and viral load). Overall scores for understanding specific concepts were low both before and after adjusting for potential factors such as age, HIV status, or gender (mean of 1.712 for CD4 count and 1.5 for viral load out of a potential 3 points each item).

**Conclusion:** Adolescents demonstrated some understanding of basic concepts related to HIV however there is substantial potential for improvement, especially around knowledge of specific concepts like CD4 count and viral load. There is need for additional research to identify factors contributing to individual differences in HIV knowledge. Adolescents require targeted programming aimed at building HIV knowledge.

## Abstract P26

### Testing children of HIV-positive parents: how a look back review of living and deceased patients and an MDT approach can result in increased testing of children, teenagers and young adults

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**Aims:** (i) To perform a review of all current HIV positive patients attending HIV services in one city, to determine whether they have children and if so have they been tested for HIV.

(ii) To determine the feasibility of a look back exercise on deceased patients.

To use a multi-disciplinary forum to elicit the best approach to families with untested children.

**Method:** A review was performed of all current HIV positive patients attending the Departments of Genitourinary Medicine and Infectious Diseases, and those who had died. Where children were identified who had not had a documented HIV test performed in the UK, a discussion was held by a multidisciplinary team including the paediatric HIV team, specialised HIV social worker and specialised HIV nurses. Various approaches were used to encourage testing including GP IT systems.

**Results:** The look back exercise identified 309 families with children. For 274 families (89%) testing of the children had been completed. Of the 35 families, where testing was incomplete, 5 were refusing testing, 9 were awaiting paediatric appointments and for 21 either further clarification was required or discussion was on-going.

After the look back exercise, 8 families who still refused testing were referred to a bi-monthly MDT meeting. This has resulted in 6 children being tested where parents had completely refused previously, including where a mother had died some years previously and the family were not in contact with services. One child has legal proceedings underway and 6 further children remain untested. The approaches used, including the use of GP IT systems will be discussed. The on-going need, to ensure testing for those children who may subsequently enter the UK, was identified.

**Conclusion:** Testing children of parents who initially refuse can be achieved through the use of an intensive MDT approach, including where parents have died. However there will still be some cases where recourse to legal action through child protection services may be required.

## Abstract P28

### An audit of the clinical outcomes and user satisfaction of an HIV virtual advice clinic

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**Background:** Our regional HIV care network operates a monthly virtual clinic. This service has not been assessed previously as to the clinical outcomes from the advice it issues (audit), or as to physician (user) satisfaction with the process.

**Methods:** Cases presented at the meeting between June 2009 and September 2010 were retrospectively reviewed for clinical data (casenote review) and a clinician satisfaction questionnaire sent to the physician in charge of the patient's care. We used the following audit standards: 1) After a change in HIV therapy (or intervention) a patient should be virologically suppressed (HIV Viral Load <50 copies/mL) by 6 months. 2) Physician is satisfied with advice they receive (Likert scale rating of 3 or above, 1 = bad 5 = excellent).

**Results:** Twenty-five questionnaires were returned. Of those that took advice ( $n = 22$ ), the mean Likert rating was 4.7 (range 5 to 4), in those that didn't take advice ( $n = 3$ ) the mean Likert rating was 4.7 (range 5–3).

Advice Category (Number of advice episodes)	Took advice $n$ (%)	If took advice, VL < 50 copies/mL at 6 months $n$ (% of those taking advice)	If took advice, Switched away from suggested regime by 6 months $n$ (% of those taking advice)	If took advice, Remaining on suggested regime 6 months after switch $n$ (% of those taking advice)
Viral load Rebound (18)	15 (83%)	6 (40%)	6 (40%)	9 (60%)
Drug-Drug Interaction (1)	1 (100%)	1 (100%)	0	1 (100%)
Co-Morbidities (8)	7 (87.5%)	7 (100%)	1 (14%)	6 (86%)
Previous cART treatment or resistance (10)	7 (70%)	4 (57%)	1 (14%)	6 (86%)
ARV side effects (10)	9 (90%)	8 (89%)	1 (11%)	8 (89%)
Total ARV advice episodes (47)	39 (83%)	26 (67%)	9 (23%)	30 (77%)

**Conclusion:** When advice was issued for patients with pre-existing resistance and cART treatment or viral load rebound, a higher than expected level of noncomplete HIV viral suppression at 6 months was seen. This potentially represents treatment compliance issues in a group of treatment experienced patients, as the aim of all advice issued was to achieve HIV viral suppression. Overall users of the meeting were satisfied with the process, even if clinical advice was not taken.



## Abstract P29

### A national survey of HIV testing practices within intensive care units: a need to standardise patient care?

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**Background:** There is a national trend to increase HIV testing in myriad healthcare settings with little mention of Intensive Care Units (ICUs). It is unknown how intensive care units are guided in testing for HIV in England.

**Methods:** A national enquiry examining HIV testing in ICUs was developed in collaboration with the Intensive Care Society (ICS). 120 ICUs were contacted by email and asked to complete an online, pre-piloted questionnaire at a dedicated website. Data was collected from 1st August to 31st October 2011.

**Results:** A 44% (53/120) response rate was achieved. 5/53 (9%) ICUs reported having written guidelines for HIV testing. Four incorporated the UK National Guidelines for HIV testing (UKNG). One based testing upon specialist advice only. Ten units without written guidelines had discussed introducing them with three intending to do so within the next 12 months. Of the centres without written guidelines, 7/48 (15%) reported using the UKNGs to guide testing but a further 4/48 (8%) stated they only tested on specialist advice.

The 48 ICUs without written guidelines were given a list of 8 indicator illnesses and asked to state for which units routinely tested for HIV. Eight gave no response. Three would not routinely test for HIV for any of the illnesses. Unexplained opportunistic infection was the most frequently tested (37/48; 77%). 27/48 (56%) routinely tested in the presence of pulmonary TB and 10/48 (21%) tested in the context of lymphoma. For each of the remaining indicator illnesses less than 10/48 (21%) ICUs routinely tested. No ICU performed HIV testing for all indicator illnesses listed.

Of the 7 units without formal written guidelines who were using UKNG as a basis for HIV testing, less than half reported a more than 25% testing compliance.

Qualitative data revealed some misinformed beliefs regarding HIV testing practices; perception of those 'at risk' of HIV infection and legislation for testing patients lacking mental capacity to consent.

**Conclusion:** Diverse HIV testing practices were observed across ICUs. The majority (91%) did not possess written guidelines for HIV testing. Some had discussed the need to introduce formal guidelines but only a minority had taken decisive action. Poor compliance with National Guidelines was widespread. This survey indicated a need for raising the profile of HIV testing nationally in ICUs. A consensus within the ICU community to standardise and increase appropriate testing will improve patient care.

## Abstract P31

### Predictors for delayed baseline assessment of newly diagnosed HIV-positive adults in the UK: variation across HIV diagnosis settings

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**Background:** To ensure optimal care after HIV diagnosis, BHIVA guidelines recommend baseline tests (CD4 counts and viral loads) are undertaken within two weeks of diagnosis. We use a national cohort of persons newly diagnosed with HIV to assess adherence to guidelines and examine predictors for delayed baseline assessment.

**Methods:** Adults ( $\geq 15$  years) diagnosed with HIV in 2010 reported to the national HIV database were linked to the CD4 laboratory data. Each adult's first CD4 count was used as a proxy for the baseline assessment date. Adults were defined as having a 'delayed baseline assessment' if their first CD4 test was  $> 1$  month after diagnosis. Predictors for delayed baseline assessment including age, sex, ethnicity, exposure category, and facility of diagnosis (antenatal clinics, general practitioner (GP), STI clinics, other medical settings, community, prison, and blood transfusion services) were examined in a multivariate analysis.

**Results:** In 2010, 6,125 adults were newly-diagnosed with HIV in the UK, of whom 3.0% (184) died in a year (as reported to June 2011). Of those surviving, 4,023 (68%) had a CD4 test within two weeks, 79% (4,683) within a month, 10% (574) after a month and 11% (684) were likely not assessed by the end of 2010 (42% of those 684 adults were diagnosed in the first half year). Where facility of diagnosis was reported, 69% (2,836/4,126) of adults were diagnosed in STI clinics (77% of 2,784 men and 52% of 1,342 women). Other diagnosis facilities included GP (6.8% of men and 9.6% of women), other medical settings (14% of men and 17% of women) and non-medical settings (2.2% of men and 0.9% of women). One-fifth (282/1,342) of women were diagnosed in antenatal clinics. Of adults diagnosed in STI clinics, about one in ten were transferred to another specialised clinic for HIV care.

Predictors for delayed baseline assessment included: persons who inject drugs (PWID) (adjusted odd ratio (aOR) = 2.78, 95%CI [1.52, 5.08], ref: men who have sex with men), adults diagnosed outside London (aOR = 1.49, [1.18, 1.90], ref: London) and those diagnosed at a GP (aOR = 2.77 [1.98, 3.88], ref: STI clinic) or other medical settings (aOR = 1.82, [1.36, 2.45], ref: STI clinic).

**Conclusion:** In the UK four in five patients are rapidly assessed following diagnosis. Clinical audits and a review of local referral pathways should be conducted to ensure prompt assessment and integration into HIV care after diagnosis.

## Abstract P30

### Financial Incentives and motivational interviewing for adolescents with advanced HIV disease: a pilot service

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**Background:** In the UK financial incentives (FIs) have been widely used in adolescent populations; from the Educational Maintenance Allowance to improving uptake of Chlamydia screening. Emerging evidence suggests FIs improve medication adherence in select populations. A small proportion of adolescents with perinatally acquired HIV (PaHIV) transfer to adult services with longstanding poor adherence and advanced disease, despite intensive MDT support in paediatrics, resulting in deaths due to end stage HIV despite a treatable virus. We describe a single centre experience combining FIs with motivational interviewing (MI) to improve adherence.

**Methods:** The deaths of 2 young adults due to poor adherence, prompted MDT development of the 'Incentive scheme (IS)' in consultation with service users demonstrating both poor and excellent adherence. Eligible patients (CD4 count  $\geq 200$ , off ART despite multiple attempts) received MI by psychologist/ CNS during clinic and gift vouchers dependent on VL of: £25 for each fall in VL at 2 and 4 wks, £50 VL  $< 50$  c/ml, £25 VL  $< 50$  at 3/12, 6/12 and £50 VL  $< 50$  at 1yr. Maximum FI £200/patient. From Jan 2010, IS was open to all aged 16–25yrs with; PaHIV, longstanding poor adherence despite MDT support, CD4  $\geq 200$  cells/ul, willing to start ART and to sign the patient agreement. IS was discussed with clinical and research ethics committees and designated a service intervention. IS was financed by donated MDT speaker fees and outcomes assessed by VL/CD4 count at 1yr.

**Results:** 11 young people enrolled, 1 declined. Median age 19 (range 16–23), 8 female. At start, median CD4 count 30 cells/ul (IQR 10–160), median VL 12,870 c/ml (IQR 2,382–26,300), previous ART regimens median 3 (range 2–9)

ART commenced: OD PI based (8), Atripla (1) BD darunavir/rvt, raltegravir, efavirine (2). 7 known to be sexually active; 4 partners ever tested, all negative. Outcomes: 9/11 ever achieved VL  $< 50$ , 5 sustained at 1yr. Median CD4 count at 1yr 140 cells/ul (IQR 60–200). Clinical outcomes: No deaths, 2 new AIDS diagnoses (PCP), 6 required admission and 1 pregnancy (delivery VL  $< 50$ ). Total FI expenditure £1,300: £76 per 50 CD4 cells at 1yr. Currently: median 6/12 post IS; CD4 160 (IQR 20–290), 5 VL  $< 50$  c/ml.

**Conclusion:** Adolescents represent a particularly vulnerable group living with HIV and many struggle to overturn poor ART adherence set up in childhood. In our experience some young people die with treatable disease and novel adherence interventions are urgently needed.

## Abstract P32

### Management of stable HIV patients in a community-based satellite outpatient HIV service: an appropriate model of care

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**Background:** The medical model of care for people living with HIV has changed over the past 30 years. Management has moved from an inpatient to an outpatient-based model, especially as the number of patients stable on treatment increases. The BHIVA guidance 'standards for HIV clinical care 2007' identified two distinct types of services required to meet the needs of HIV positive patients.

Firstly a HIV centre providing acute inpatient care and referral services for peripheral centers in networks and secondly HIV units providing outpatient care for the majority of patients with uncomplicated HIV infection. We aimed to evaluate this model of care in a North London community based satellite outpatient service against current best practice guidelines (BHIVA clinical standards 2007).

**Methods:** Data was collected retrospectively from electronic patient records and case notes. A pathology lab link was used to track if resistance tests were sent and for hepatitis serology. Data was collected and analyzed using excel.

**Results:** All HIV clinic attendances between 1/10/2010 to 31/12/2010 were included. This was a total of 106 patients. The average age was 40.6 years.

52% were male. The standards looked at were: (i) HIV testing & diagnosis: There were 14 new diagnoses with an average CD4 count of 540; two of the newly diagnosed had a CD4  $< 200$ .

(ii) Initiation and use of HAART: 71% were on HAART. Of the newly diagnosed four did not have a resistance test at baseline. For those starting HAART for the first time 9.4% did not have hepatitis B status checked in the previous year.

Four had a CD4 count of  $< 200$  and of these only one was not on HAART.

(iii) Failure of HAART: 79.3% achieved an undetectable VL within 6 months of starting HAART. 86.6% of patients were fully suppressed on HAART. One failed a 1st line regimen and was changed to 2nd line.

(iv) Acute Illness: One patient was transferred for inpatient care.

(v) Sexual Health: 62.3% had an STI screen in the previous 12 months, 82% of women had cervical cytology.

(vi) Mortality: There were no recorded deaths, 3 patients were lost to follow up.

**Conclusion:** Our findings suggest that management in a community based satellite HIV centre is in line with best practice guidelines, with an increasing trend in no of diagnoses, good average CD4 count at diagnosis and few with CD4  $< 200$ . HAART was used as per guidelines and sexual health screening was adequate. This supports the management of stable patients in satellite centers.

# Abstracts

## Abstract P33

### HIV testing in cancer: experience from a tertiary oncology hospital

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**Background:** HIV infection has been shown to increase the risk of malignancy. Non-Hodgkin's lymphoma, Kaposi's sarcoma and cervical cancer, in particular, are AIDS-defining conditions. Patients with these conditions should be routinely recommended to have an HIV test. The UK chief medical officer, in a letter in September 2007, emphasised increasing the detection and diagnosis of HIV.

**Methods:** Case notes and laboratory virology results of patients referred or initially diagnosed with Non-Hodgkin's lymphoma (NHL), Kaposi's sarcoma (KS) and cervical cancer from March 2007 to July 2011 were retrospectively reviewed.

**Results:** 1391 patients were diagnosed or referred with NHL, KS or cervical cancer within the study period. A sample of 229 case notes and laboratory evidence of testing were reviewed. Twenty one percent (34 of 158) patients with NHL were known to be tested for HIV; eighty-six percent (6 of 7) patients with KS were known to be tested for HIV; and one percent (1 of 64) patients with cervical cancer were known to be tested for HIV.

**Conclusion:** A significant number of patients presenting with HIV clinical indicators to this tertiary oncology hospital are not being offered a HIV test routinely. This represents a missed opportunity and increases the potential for late diagnosis and onward transmission of HIV. The lymphoma unit are in the process of incorporating universal testing for all new diagnoses and referrals.

A multidisciplinary team has been organised to negotiate testing within the colposcopy services in the region.

## Abstract P34

### HIV-positive adolescents: characteristics and treatment challenges

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**Background:** To characterise the population of HIV positive adolescents attending outpatient HIV services at a district general hospital in South London. At the time of study, there were no dedicated adolescent services within the department, the study was conducted to identify patient needs and inform service provision.

**Methods:** A retrospective case note review of all HIV positive patients aged 16–25.

**Results:** 46 patients were identified. Median age 23, 70% (32/46) were female and 52% (24/46) were of Black African origin. The most common HIV risk factor was unprotected heterosexual intercourse (57%). 10 patients (22%) were vertically infected and had been transitioned from paediatric services. 18 (39%) of the adolescents had lost either one or both of their parents. There was a high incidence of self-reported alcohol misuse (21 of 36), recreational drug use (10 of 37), mental health problems (18 of 41) and attempted suicide (6 of 46). 42% of patients were sexually active in the last 6 months, of whom 30% had a regular partner. Of those with a regular partner, 82% had disclosed their status but only 55% reported using condoms.

Characteristic		Number (%)
Currently on HAART	HAART	13 (40)
	PI	14 (52)
	RT	15
Length of time on treatment (months) n=27	Median	27
	(range)	(2–70)
CD4 count on Rx (n=27)	<350	10 (37)
	<350	17 (63)
Adherence (n=23)	Excellent	10 (43)
	Good	2 (9)
	Poor	5 (21)
DRAs in last 12 months (n=45)	0	9 (20)
	1–3	28 (63)
	>3	11 (24)

This patient cohort had advanced disease - 57% (26) of patients had CDC stage C disease. 59% of patients were currently on HAART therapy (table 1) and for 70% (19) this was their second regimen. Those patients who had transitioned from paediatric services were more likely to be symptomatic at diagnosis (50% vs 14%  $P = 0.014$ ), been exposed to multiple regimens (100% vs. 60%  $P = 0.046$ ), have poor adherence (71% vs. 0%  $P = 0.07 \times 10^{-6}$ ) and also more advanced disease (CDC stage C) (80% vs 44%  $P = 0.06$ ) compared to the behaviourally infected young people.

**Conclusion:** This study highlights the high prevalence of psychosocial problems and complex medical needs amongst HIV positive adolescents.

Patients who had transitioned from paediatric services had additional complexities. The endorsement of multidisciplinary 'one-stop' clinics providing HIV care, sexual and reproductive health and psychological support in a single visit may address some of the poor prognostic factors characteristic of this cohort.

## Abstract P35

### HIV and parenthood: clinicians and commissioners working together to make this a reality for our patients

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**Background:** In the past patients with HIV requiring sperm washing or fertility treatment often needed to travel long distances as such treatments were available only in one centre in the UK. In the absence of any clear referral pathways managing such patients proved extremely challenging to clinicians. Patients experienced long delays and significant inconvenience during this stressful period. With the development of additional centres offering such treatment we worked with colleagues in the Sexual Health Network and local PCTs to design clinical and commissioning guidelines and referral pathways for these couples. We audit how these guidelines have been implemented since their introduction and since the setting up of dedicated HIV fertility (complex) clinics in 2010. **Methods:** Retrospective case note review of all patients entered into the fertility database set up at the time of adoption of above guidelines in June 2010. Data including demographics, clinical characteristics and pathway referral times were collected.

**Results:** A total of 28 couples were reviewed between June 2010 and December 2011, in 12 of these both partners had HIV and in the other 16 only one (discordant) had HIV. Of all 56 patients a total of 17 women (average age 32 years) and 23 men (average age 36 years) were HIV positive. The majority of the couples attended for reproductive advice and with fertility problems but in at least 11 couples, sperm washing was also warranted to prevent transmission of HIV from a positive male partner to a negative female. The pathway of referrals were from standard HIV clinics to complex clinic (average time 82 days) then onto local gynaecology team for a decision regarding need for fertility treatment (average time 148 days). A specially designed form was then completed and submitted to the commissioning panel (average time to decision 47 days) and then an onward referral to the specialist fertility treatment centre (average time to review 61 days).

**Conclusion:** Even with our limited experience we feel that these guidelines and the subsequent introduction of fertility clinics have streamlined the previously complicated and haphazard referral process for couples where one or both partners might have HIV and who wish to start a family. During the process of writing up and subsequently putting these guidelines into practice clinicians from different specialities and commissioners have successfully worked together towards achieving a common goal.

## Abstract P36

### Contraceptive preferences following pregnancy among HIV-infected women: a study from a district general hospital in the UK

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**Background:** Safe and effective family planning practices are important among sexually active HIV infected women in reducing HIV transmission and to avoid unintended pregnancies. Concentrations of hormonal contraceptives can be altered when co administered with anti retroviral therapy (ART) and interactions are not always predictable.

The objective of this study was to determine patterns of contraceptive utilization among HIV positive women following a pregnancy.

**Methods:** It is a retrospective case notes review of all the women who had a pregnancy during the period of 2008–2011. A total of 87 women were included in the study. Data were collected from Genitourinary Medicine records using a structured questionnaire and analysed by using SPSS program.

**Results:** Mean age was 34 yrs ranging from 20–43 yrs. About a half were married (47) and a quarter (23%) were single and 87% sexually active.

Majority (91%) were of African origin; 67% had HIV subtype C; 26% resistant to one or more class of HIV drugs; 55% had a nadir CD4 fewer than 350; 44% diagnosed at an antenatal setting and 71% were living with HIV for more than a year. Of the partners, 38% have HIV and 73% were aware of their partner's HIV status.

In the past, 18% had a miscarriage and 16% reported a termination of pregnancy. Consistent condom use was reported as 18% and 7% never used a condom; two thirds of women are on ARTs. In 27% of women, the last pregnancy was not planned and 7% has a positive child.

Condoms were the most popular single method of contraception (49%) followed by Depo-Provera (14%), sub dermal implant (10%), combined oral contraceptives (8%), progesterone only method (4%) and tubal ligation (4%).

Intrauterine devices were the least popular method used by 1% of women and 8% was not using any form of contraception.

**Discussion:** Patients taking concomitant hormonal contraceptive and antiretrovirals are counseled to use an alternate method of birth control in addition to the hormonal agent. Despite changes in hormone concentrations, there are limited data on the effects of antiretroviral drugs when combined with hormonal contraceptives.

**Conclusion:** While condoms are the most popular method, Depo-Provera and Implant remain the preferred choice of hormonal contraceptive method among women after a pregnancy. Clear guidelines are needed as to the interaction between the ARTs and hormonal methods in order to prescribe them safely.

## Abstract P37

### The impact of courses for people with HIV on their knowledge, health and behaviour

K Alexander<sup>1</sup> and C Armstead<sup>2</sup>

<sup>1</sup>George House Trust, Manchester, UK, <sup>2</sup>Elton John AIDS Foundation, London, UK

**Background:** To assess the impact of its courses for people with HIV, funded by the Elton John AIDS Foundation (EJAF) George House Trust (GHT) operates a monitoring system based on the completion by clients of questionnaires at key stages.

**Methods:** Clients taking part in a GHT course for people newly diagnosed with HIV or a residential weekend for people living with HIV, were asked to complete a questionnaire at three key stages: before the course; at a recall meeting 5 to 6 weeks after the course and 12 months after the course. The questionnaires at each stage asked the same questions focusing on 3 broad areas: knowledge and understanding of HIV (for the newly diagnosed course only); emotional and physical health (including engagement with health services); sexual behaviour and substance use. The response rate for the recall questionnaires was 61% For the 12 month questionnaires, the response was 7%. Therefore, the results reported refer only to participants who completed an initial and recall questionnaire for the courses they attended. A focus group and 18 in-depth telephone interviews with course participants supplemented the questionnaire data.

**Results:** The newly diagnosed courses considerably increased participants' understanding of HIV. For example, there was an increase from 29 to 69 in the number of people who said they understood fully what CD4 count means.

While participants reported little change in their physical health, the courses gave them greater confidence in dealing with clinical staff and provided some with strategies to make their relationships with clinicians more productive.

The courses had a generally positive effect on participants' emotional health with respondents reporting less depression, improved self-esteem, greater self-confidence and reduced isolation. The results on sexual behaviour and substance misuse were more mixed, but there was evidence of increased thinking around disclosure and condom use. The courses also provided people with an opportunity to reflect on their substance use and information to support efforts to change behaviour.

**Conclusion:** GHT's courses are effective in increasing participants' knowledge of HIV. They also contribute to reduced isolation and improved emotional health among participants, and provide a forum for increasing thinking and discussion of sexual behaviour and substance misuse.

## Abstract P38

### A retrospective study of HIV testing in intensive care: significant numbers meet testing criteria according to national testing guidelines

M Dodd<sup>1</sup>, P Collini<sup>2</sup>, D Dockrell<sup>2</sup> and C Scott<sup>1</sup>

<sup>1</sup>Intensive Care Medicine, Northern General Hospital, Sheffield, UK, <sup>2</sup>Department of Infection and Immunity, University of Sheffield and Royal Hallamshire Hospital, Sheffield, UK

**Background:** HIV may first present as critical illness requiring general intensive care (GICU) management. Early recognition of HIV in such patients is key to their optimal management. However, in a recent national survey a majority of GICUs did not use any guidelines for HIV testing. The UK National Guidelines (UKNGs) were developed to improve early detection of HIV infected individuals, particularly when presenting with other illness. Testing is typically offered to patients with mental capacity to consent. In GICUs, testing rates may be low because of concerns over patients lacking capacity and nonadoption of formal testing guidelines. Adoption of UKNGs within this setting may help to raise HIV testing rates in line with national trends. This large cohort study assessed all GICU admissions for HIV testing using the UKNG criteria.

**Methods:** Over one calendar year all admissions to 2 GICUs within the same NHS Trust were retrospectively assessed against the UKNG criteria for HIV testing. 2 assessors (critical care registrar and infectious diseases registrar) reviewed the electronic records and independently placed patients into 3 study groups: 'Y' met UKNG criteria for HIV testing, 'N' did not and 'P' did not meet criteria but had a clinical picture that warranted testing on clinical suspicion.

Following this strict application of the criteria, a further analysis was undertaken using a pragmatic approach to the UKNG: those where testing could reasonably be delayed until the post ICU period or where a strong alternative factor had lead to the indicator illness (e.g. post operative, hospital acquired pneumonia) were excluded. When assessors' decisions differed, an adjudicator (HIV consultant) was asked to give a final decision on testing.

**Results:** Without the use of HIV testing guidelines, 4% of admissions were tested for HIV. With strict retrospective application of UKNGs 320 (30%) of GICU patients should have been tested for HIV. Using the pragmatic application of the UKNG 186 (18%) still would have been tested.

**Conclusion:** In the absence of formal guidelines in these GICUs HIV testing rates were low. A pragmatic application of the UKNG would lead to a fourfold increase in testing. Strict application of the guidance would result in a greater than seven fold increase. Although UKNGs are not specific to the critical care environment the adoption by GICUs in their present form is sufficient to markedly increase appropriate HIV testing rates.

## Abstract P39

### The economic hardship faced by families and children affected by HIV in the UK

P Bravo<sup>1</sup> and P Harrowing<sup>2</sup>

<sup>1</sup>Children With AIDS Charity, London, UK,

<sup>2</sup>Department of Primary Care and Public Health, Cardiff University, Cardiff, UK

**Background:** People living with HIV (PLHIV) are facing a long-term condition. Improvements in life expectancy have helped people to reframe their lives and many of them are deciding to make families and have children. Although parenthood has been identified as a positive process for PLHIV, HIV-affected families are facing difficulties to maintain economic stability and cover basic needs of their children. Fears of stigma and discrimination are still being described as one of the main reasons PLHIV do not seek help and support. As part of the only UK-wide fund, which provides financial support to families affected by HIV, this research aims to describe the social and economic needs of children affected by HIV.

**Methods:** Data was collected from application forms submitted to the fund from January 2010 to December 2011. Support workers completed the applications in collaboration with the families. Data retrieved was the weekly income, household structure, number of children within the family and the main need of the family/children by the time of the application. A descriptive analysis was conducted.

**Results:** During a period of 24 months a total of 1,065 applications were received and analysed. Over 1,700 children affected by HIV benefited from the fund. 80% of the children were living with only one parent. Most of the families have insecure immigration status and parents were not entitled to work in many cases. Parents were unable to cover basic needs of their children such as clothing, school items and living expenses. Interesting an increasing number of HIV-positive women who were expecting a new baby were in need of support to provide formula milk to their new child.

**Conclusion:** Children affected by HIV and their families are facing a difficult economic and social scenario. Families are unable to provide basic items to the children, which can make it harder to cope with other dimensions of HIV such as social isolation and fears of discrimination. Lacking clothing, basic items or food brings new worries and stressors to the family and the children. This research supports the call for further funding available to families living with HIV, as well as the need to systematically explore how the lack of economic stability is affecting the coping strategies children and family are using to overcome their HIV-affected condition.

# Plenary Speaker Biographies

**Ijeoma Ajibade** is a self-supporting priest and is a minister in the Diocese of London and at Southwark Cathedral. Ijeoma has worked on the issue of HIV for a number of years, developing a training course for diocesan clergy on theological and ethical perspectives of HIV. She is the Deputy Executive Director of the Kaleidoscope International Diversity Trust, a trustee for the Naz Project London and a trustee for Progressio.

**Steve Akehurst** is a Policy Officer at NAT (National AIDS Trust). He has responsibility for policy around HIV testing, prevention, public awareness and education. He has recently worked on NAT's Testing Action Plan and report on HIV Partner Notification. Before joining NAT, Steve worked at the University of Leeds.

**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 1st degree in Psychology and a Masters degree in Nursing (Advanced Practitioner) and is currently chair of the National HIV Nurses Association.

**Gary Barker** has been working in sexual health for the past 7 years. He currently works in an integrated service as senior health advisor working in GUM, contraception and HIV. He is currently Chair for the North West HIV Alliance, which is a group for nurses and pharmacist that meets four times a year for educational meetings.

**Katherine Bethell** is an HIV Specialist Nurse in the Regional Infectious Disease Unit in Edinburgh. She has worked in various Sexual Health clinics, and set up and managed HIV projects in Uganda. She is involved in the Scottish HIV Health Improvement Programme and sits on the Lothian HIV Strategy groups.

**Michelle Croston** has, since beginning her nursing career, worked at North Manchester's Infectious Diseases Research Department. During her time on the ward, she gained lots of experience from palliative care to treating HIV patients in a high-dependency setting. She experienced the challenges of complex patient care and witnessed the stigma associated with the condition. After undertaking health visitor training, she subsequently moved to North Manchester's HIV support team. She is currently undertaking a professional doctorate in which her research focuses on how HIV nurses elicit patients concerns. To compliment her research project, she has developed, along side the Maguire unit, a study day and workbook designed to facilitate patient's centred care by enhancing HIV nurses communication skills when dealing with complex situations.

**Jill Delaney** qualified in 1991 and is currently working as an HIV Specialist Nurse as part of the HIV support team at North Manchester General Hospital Regional Infectious Diseases Unit. She has been in post 4 years, working prior to this for 8 years as a sexual health nurse practitioner and as a gynaecology staff nurse for 9 years. During this time she has gained great knowledge and experience in dealing with the challenges that people face living with a stigmatising illness.

**Martin Fisher** is a Consultant in HIV at Brighton and Sussex University Hospitals NHS Trust. He is responsible for the outpatient and inpatient management of a large cohort of HIV-infected individuals, and leads an active research team, and has established an HIV/hepatitis co-infection clinic with local hepatologists. He is a member of the HIV Special Interest Group of the British Association for Sexual Health and HIV, and is the Convenor of the national Diploma in HIV Medicine. He is an author on over 100 articles on aspects of HIV infection and sexually transmitted infections, has recently been appointed joint Editor of the *International Journal for STD and AIDS* and is a frequent editor for *Current Opinion in Infectious Diseases*. His main clinical and research interests are in antiretroviral therapy, primary HIV infection, HIV and hepatitis co-infection, and the interplay between HIV and other sexually transmitted infections.

**Julie Gallagher** qualified as a nurse in 1988 and worked at both Withington and St Mary's Hospitals Manchester on the gynaecology units. Following completion of the old ENB Family Planning course in 1996 she worked in Bradford, West Yorkshire in the community as a Family Planning nurse leaving in 2001 to take up the Lead Nurse post at Brook Advisory Oldham. She came to work for the large citywide Manchester CaSH service in 2002, of which she is now the Clinical Nurse Manager.

**Matthew Grundy-Bowers** CNO/NHIR Clinical Doctoral Research Fellow/Consultant Nurse (HIV/Sexual Health) Qualifying in 1992 he moved into the field of HIV/Sexual Health in 1994, working in a variety of roles across London and including teaching both doctors and nurses in the field. He is currently on a 3-year sabbatical to undertake his PhD exploring gay and condom use. Matthew has presented widely, and continues to be actively involved in professional organisations at both regional and national levels.



# Plenary Speaker Biographies

**Suzy Hargreaves** is a public health researcher and analyst at the Centre for Public Health, based at Liverpool John Moores University. The HIV team gathers intelligence from clinics in the North West of England on HIV treatment and care through an enhanced monitoring system and contributes to the national Survey of Prevalent HIV Infections Diagnosed (SOPHID). These data are used locally in reports and interactive web-based tools to inform commissioning of services. Her background is in HIV and STI epidemiology and geography, with particular interest in the effect of deprivation on health.

**Deborah Jack** is the Chief Executive of NAT (National AIDS Trust) the UK's leading policy and campaigns charity on HIV. Deborah held senior marketing positions in both the public and commercial sectors, including 3 years as Marketing Director of St Mary's NHS Trust, before joining the voluntary sector in early 1993. Before joining NAT as Chief Executive in December 2003, Deborah worked at Brook, the sexual health charity for young people, as Head of Policy and Campaigns and Deputy Chief Executive.

**Sue Kidger** qualified in 1983 and worked in intensive care until 1999 when she became a Specialist Nurse for HIV in Oldham. She was a member of the NHVNA committee from 2000 to 2005 and treasurer from 2002 to 2005. Since 2005, she has been a Hepatitis Nurse Specialist and latterly, as The Lead Nurse. The HIV cohort at North Manchester is around 1800 with 10% co-infected with HIV and hepatitis C. On average, 25 patients are treated with co-infection each year.

**Sam Mabey-Puttock** worked at Chelsea and Westminster HIV and GUM unit for 7 years. In 1998 she took on the lead HIV nurse role in Manchester City's GUM clinic and has been central to building up an HIV service that now manages over 1000 patients. Since 1998 she has been secretary to a special interest group that she co-founded which meets quarterly and whose aim is to provide education and support to nurses working in HIV across the Northwest region.

**Alex Margetts** is a Clinical Psychologist working in sexual health and HIV, based at Chelsea and Westminster Hospital. Dr Margetts also works at the new NHS Club Drug Clinic ([www.clubdrugclinic.com](http://www.clubdrugclinic.com)), and is particularly interested in the link between mood, sex and drugs, and CBT approaches for difficulties in these areas.

**Sheena McCormack** is Senior Clinical Scientist, Co-principal Investigator, Microbicides Development Programme and a Clinical Epidemiologist who has been coordinating HIV prevention trials since 1994, when she joined what has subsequently become the MRC Clinical Trials Unit. She has been a Consultant in HIV/GU Medicine since 1991, now working at the Dean Street Clinic in Soho. She is working with colleagues to determine the role of PrEP in the UK HIV prevention strategy. She has been a Reader in Clinical Epidemiology at Imperial College since 2008.

**Wellington Moyo** is a community development worker for Our Project (Bradford) and Begin (Wakefield). He supports individuals and families living with, and affected by, HIV. He offers training to community organisations like churches, schools and sports clubs. He also does community testing. He believes in a society-driven-approach to HIV.

**Ian Nixon** began nursing as a student in September 1979 at Oldham School of Nursing. His first staff nurse job was working with the elderly in the hospital in which he trained. He moved out of the NHS briefly to work as the nurse in charge of a registered nursing home in the private sector. The opportunity to return to the NHS came in 1989 in the Department of Infectious Diseases in Monsall Hospital Manchester, moving from the wards to his current role of Liaison Nurse/HIV Specialist Nurse in 1999.

**Nicky Perry** has been a nurse in HIV care and management since 1988, she started as a nurse on the inpatient unit on Thomas Macauley ward now at the Chelsea and Westminster. Since then, she has worked as a HIV Clinical Research Nurse in London, Sydney and now Brighton where she has been for the last 16 years. Nicky was a founder member and Chair of the National HIV Nurses Association (NHVNA) for 10 years and is currently Chair of the European HIV Nursing Network (EHNN), which aims to provide support, education and training for nurses from across Europe.

**Breda Patterson** is Advanced HIV Nurse Practitioner at the Chelsea and Westminster Hospital. She independently manages a caseload of approximately 300 HIV patients both on and off antiretroviral therapy, and also co-leads the specialist HIV over-50s clinic. She teaches on the undergraduate and postgraduate HIV module at several London Universities. Her special interests include HIV and ageing, and developing advanced practice in HIV nursing.

# Plenary Speaker Biographies

**Kemoh Rogers** has worked in HIV/AIDS since 1999 both as an in- and outpatient nurse and, since 2002, as nurse specialist. In 2010, he took up the position of full-time Lecturer with the Faculty of Health, Social Care and Education at Anglia Ruskin University in Cambridge and Chelmsford. He has a strong preference for conducting qualitative research of those living with, and affected by, HIV.

**Gina Rowlands** is the managing director and practice nurse at Bevan Healthcare CIC. It is a city-wide general practice for the homeless, asylum seekers and refugees in Bradford. Bevan Healthcare is a responsive organisation promoting high-quality healthcare for the most vulnerable members of society. She has over 27 years of NHS experience both in primary and secondary care. She is passionate about the needs of patients and, along with the team, continues to be innovative and creative to provide the very best in health/social care.

**Bradley Smith** joined Yorkshire MESMAC group of services almost 4 years ago as a community development worker at the OUR Project, working with those living with, and affected by, HIV in the Bradford and Airedale District. He is Social Support co-ordinator for the Yorkshire MESMAC group of services and manages two support services, one in Bradford and one in Wakefield, both of which also offer rapid HIV testing. He also delivers training to medical professionals, schools, target communities. He strongly believes that the success of both projects is based upon the belief that there is no such thing as hard to reach service users but hard-to-reach services.

**Mark Taylor** is the Executive Director of The Taylor Partnership, which specialises in giving legal advice to asylum seekers throughout the UK. He has also developed support services for victims of torture in the Bradford District and assisted the resettlement of refugees via the Gateway Protection Programme.

**Andrew Ustianowski** is a consultant physician in Infectious Diseases and Tropical Medicine, and Clinical Director, at the Monsall Regional Infection Unit, North Manchester General Hospital, which has a cohort of just under 2000 HIV-positive patients. He has been part of guideline writing committees for BHIVA and other bodies, has given regional and national lectures on HIV, hepatitis and related topics, and is part of several educational steering groups.

**Iwona Wawer** is the Coordinator of the International Cooperation (IC) Department at the National AIDS Centre in Poland. Her work involves the coordination of work for people from the IC Department in cooperation with UNAIDS, WHO, ILO and other international project translations.

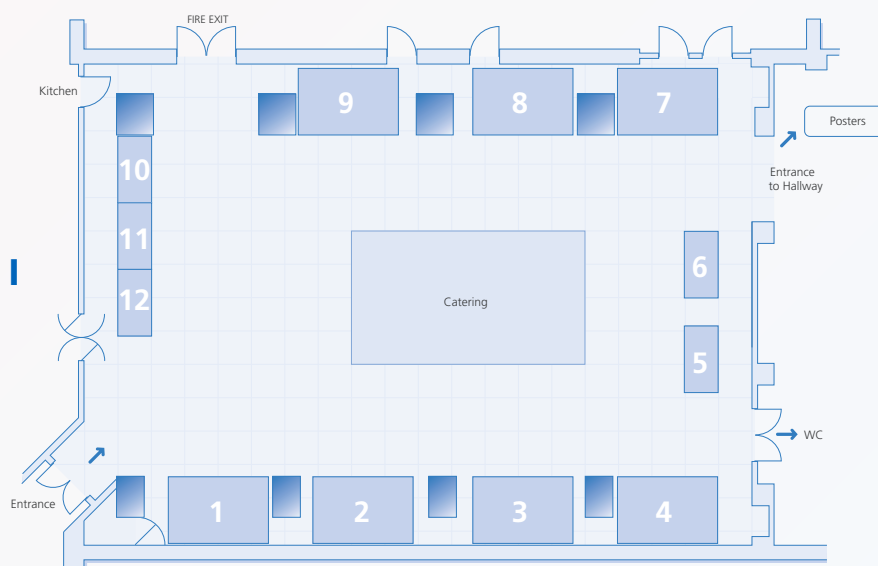
**Ed Wilkins** is a Consultant in Infectious Diseases and Director of the HIV Research Unit at North Manchester General Hospital. Prior to taking up his current position, he trained in Infectious Diseases in London and Liverpool, Tropical Medicine in Africa, and Medical Microbiology with the Health Protection Agency. He has been involved with HIV patient care and research since 1984 with interests in antiretroviral toxicity and hepatitis co-infection. He is heavily involved in clinical trials as well as many executive and advisory national committees, including BHIVA.

**Sharon Wilson** was appointed as Clinical Lead Midwife – HIV/Sexual Health in September 2001. Her key responsibilities include providing HIV training for allied health professionals, midwives, doctors and student midwives at Manchester and Salford University. She is developing services for maternal health and HIV, and manages a caseload of HIV-positive pregnant women from eight maternity hospitals within Greater Manchester.

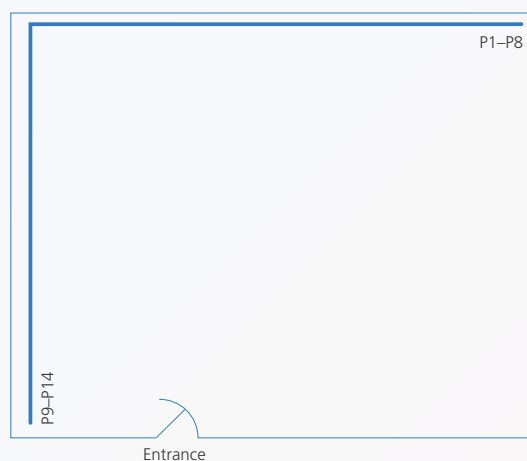
**Sue Yin Yap** is a Clinical Psychologist working in sexual health at the Chelsea and Westminster Hospital. She is interested in how motivational interviewing (MI) can be applied to sexual risk reduction and has set up a clinic, in conjunction with a health adviser, offering MI to HIV-positive and HIV-negative men for risk reduction.

# Exhibition and Poster Display Floor Plans

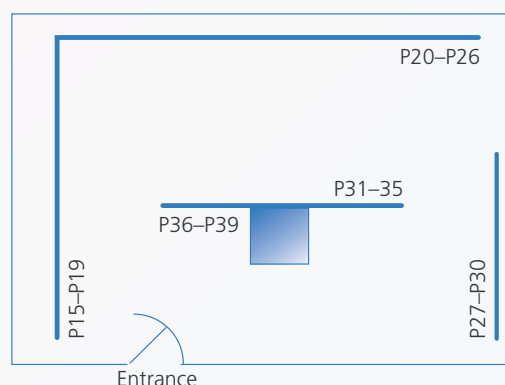
## Weston Room 1 Exhibition



## Weston Room 2 Posters



## Weston Room 3 Posters



## Key to exhibitors

- |  |                            |
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# Information on Manchester

There is more to Manchester than meets the eye. It is a city waiting to be discovered; from superb shopping areas and exciting nightlife to stunning countryside and a vibrant history. Manchester has everything. It is a city of immense variety, stunning architecture, fascinating museums, exciting attractions and plenty of bars and restaurants.

Manchester is a hot-bed of cultural activity; from the thriving and foremost music scene, which gave rise to sons as diverse as Oasis and the Hale Orchestra, to many world-class festivals and its rich sporting heritage. Throw into the mix an impressive range of galleries and museums (the majority of which offer free admission) and visitors are guaranteed to be stimulated and invigorated.

Manchester has a compact and accessible city centre. Most amenities are within walking distance of each other and are easily accessed from elsewhere. Or, if you want to save your energy, you can either hop onto the Metrolink tram or you may jump aboard the free Metroshuffle bus!

## Travel information

► **By air – Manchester Airport** A train to the city centre will take approximately 20 minutes. Or a bus will take approximately 40 minutes.

► **By train** Most major cities in the UK have direct train services into Manchester.

**From the south** Virgin Rail operates hourly direct services to Manchester. Journey times from London Euston to Manchester Piccadilly are approximately 2 hours.

**From the north** First TransPennine Express operates direct train services to Manchester Piccadilly Station. Journey times from Edinburgh to Manchester are approximately 3.5 hours. The Manchester Conference Centre is 5 minutes' walk from Manchester Piccadilly Station.

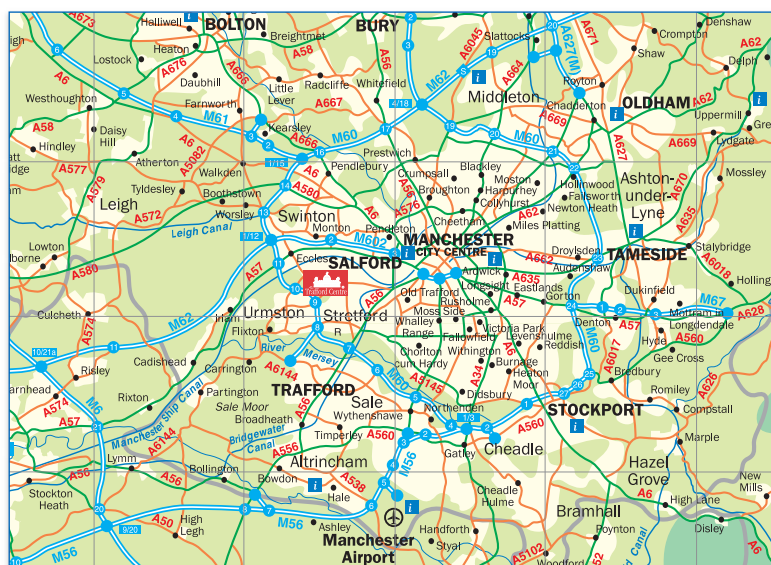
► **By coach** National Express operates regular services from all major towns and cities in Britain to Manchester.

► **By tram** Manchester's tram system, Metrolink, runs through the city centre connecting major railway stations and tourist attractions. Please contact Metrolink for more information regarding their services (see Useful Contacts).

► **By car** Half of Britain's motorway network passes through Manchester with approximate journey times of 2 hours to Birmingham, 3.5 hours to London and 4 hours to Edinburgh.

► **Parking** For information on car parks in Manchester please contact NCP (see Useful Contacts).

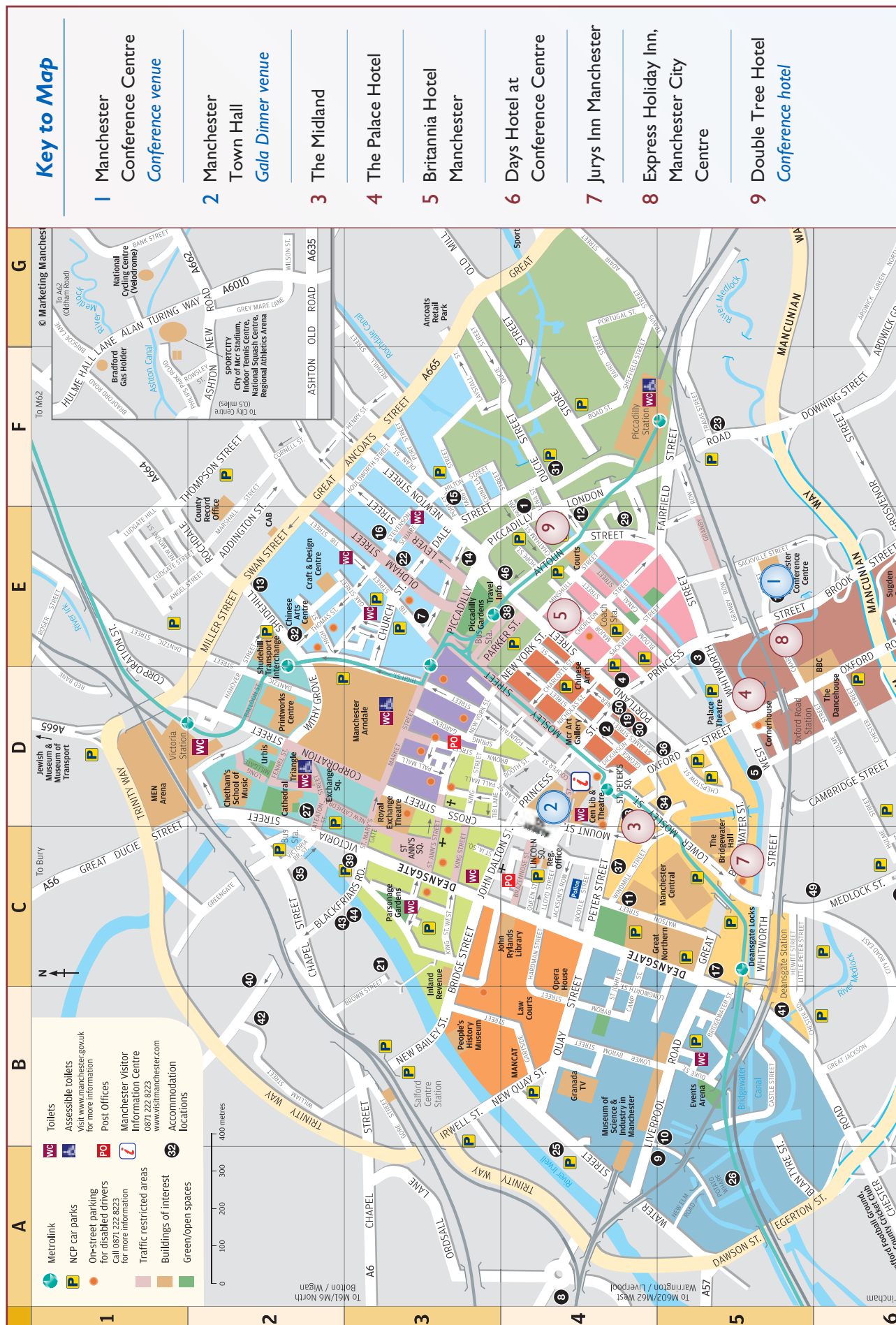
► **By taxi** Black cabs operate in the city centre.



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# Manchester City Centre



14th Annual Conference 2012

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# Future Events



National HIV Nurses Association

## 16th Annual Resistance and Antiviral Therapy Meeting

Thursday 20 September 2012  
Wellcome Collection Conference Centre  
London

## 5th Annual BHIVA Conference for the Management of HIV/Hepatitis Co-infection

Wednesday 3 October 2012  
One Great George Street Conference Centre  
London

## BHIVA Autumn Conference including CHIVA Parallel Sessions

4–5 October 2012  
Queen Elizabeth II Conference Centre, London

## NHIVNA Study Day Current issues in HIV: Promoting behaviour change

Wednesday 17 October 2012  
London

## 19th Annual Conference of the British HIV Association (BHIVA)

16–19 April 2013  
Manchester Central Convention Complex

## 7th Annual Conference of the Children's HIV Association (CHIVA)

Friday 24 May 2013  
Leeds

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

19–21 June 2013  
Birmingham

For further information on these events, please contact:

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Tablets containing 200 mg nevirapine, oral suspension containing 10 mg/ml.

**Action:** Non-nucleoside reverse transcriptase inhibitor (NNRTI) of HIV-1.

**Indication:** For use in combination with other anti-retroviral products for the treatment of HIV-1 infected adults, adolescents and children of any age. **Dose & administration:** **Adult:** 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. 8–16 years (suspension): 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 ULN. Recurrence of liver function abnormalities on re-administration after previous increases in ASAT or ALAT > 5 ULN. 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 2 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 ULN. Pre-existing increased ASAT or ALAT levels ≥ 2.5 ULN 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 evaluation 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 galactase intolerance should not take this product. **Interactions:** See SPC. Plasma levels of substances metabolised by CYP3A or 2B6 may be reduced. Plasma levels of Viramune may be reduced by strong CYP inducers. Concomitant 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 eg fever, arthralgia, myalgia, lymphadenopathy, plus visceral involvement such as hepatitis, eosinophilia, granulocytopenia and renal dysfunction. Very Common: rash (12.5%). Common: headache; vomiting, diarrhoea, abdominal pain, nausea; pyrexia, fatigue; hypersensitivity (including anaphylactic reaction, angioedema, 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 £39.67. 60 tablets £170.00. 240 ml suspension £50.40. **Legal category:** POM. **Marketing Authorisation holder:** Boehringer Ingelheim International GmbH, D-55216 Ingelheim am Rhein, Germany. **MA numbers:** Tablets 60 pack: EU/1/97/055/001. Tablets 14 pack: EU/1/97/055/004. Suspension: EU/1/97/055/002. Prescribers should consult the Summary of Product Characteristics for full prescribing information. Prepared in October 2011.

### 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 (freephone).

Date of preparation: May 2012. UK/NVP-121055



Boehringer  
Ingelheim

14th Annual Conference 2012

# New VIRAMUNE (nevirapine) prolonged-release



Similar efficacy and tolerability to Viramune IR<sup>1-3</sup>



Convenient once daily dosing<sup>1-3</sup>



Therapeutic drug level across 24 hours<sup>4</sup>

Switching to or initiating<sup>†</sup> VIRAMUNE prolonged-release would fit with a once daily therapy regimen, increasing potential for compliance and thus efficacy<sup>2</sup>

Once daily

**VIRAMUNE®**  
(nevirapine)  
prolonged-release tablets



**EXPERIENCE EVERY DAY**

A convenient **once daily** 400 mg tablet for the treatment of HIV-1<sup>1</sup>

<sup>†</sup> VIRAMUNE should not be initiated in adult females with CD4 cell counts greater than 250 cells/mm<sup>3</sup> or in adult males with CD4 cell counts greater than 400 cells/mm<sup>3</sup>, who have a detectable plasma HIV-1 RNA unless the benefit outweighs the risk.<sup>1</sup>

## Prescribing Information (UK)

### Prolonged-release tablets.

#### VIRAMUNE prolonged-release tablets

Prolonged-release tablets containing 50 mg, 100 mg or 400 mg nevirapine. **Action:** Non-nucleoside reverse transcriptase inhibitor (NNRTI) of HIV-1. **Indication:** 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 (400 mg strength) or adolescents and children three years and above and able to swallow tablets (50 mg and 100 mg strengths). **Dose & administration:** **Adults:** Initiation of therapy with nevirapine; 200 mg immediate-release tablet once daily for 14 days, then one 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/5 ml 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. The dosage must be strictly adhered to, especially 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 ULN. Recurrence of liver function abnormalities on re-administration after previous increases in ASAT or ALAT > 5 ULN. 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 2 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 ULN. Pre-existing increased ASAT or ALAT levels > 2.5 ULN 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 evaluation 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 tablet 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 CYP3A or 2B6 may be reduced. Plasma levels of Viramune may be reduced by strong CYP inducers.

Concomitant 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 eg fever, arthralgia, myalgia, lymphadenopathy, plus visceral involvement such as hepatitis, eosinophilia, granulocytopenia and renal dysfunction. The following undesirable effects were observed in the 1100.1486 trial in adults. Lead-in phase with Viramune immediate-release: Common: rash (6.7%); headache, diarrhoea, abdominal pain, nausea; pyrexia, fatigue; Maintenance phase 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 1100.1486 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 1100.1486. An inflammatory reaction to asymptomatic or residual opportunistic infections may arise on initiation of CART. Granulocytopenia more common in children than in adults. See SPC for other side effects. **Pack sizes and NHS price:** 180x50mg tablets £127.50; 90 x 100 mg tablets £127.50; 30 x 400 mg tablets £170.00. **Legal category:** POM. **Marketing Authorisation holder:** Boehringer Ingelheim International GmbH, D-55216 Ingelheim am Rhein, Germany. **MA numbers:** 50 mg EU/1/97/055/005, 100 mg EU/1/97/055/006, 400 mg EU/1/97/055/008. Prescribers should consult the Summary of Product Characteristics for full prescribing information. Prepared in October 2011.

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 (freephone).