

National HIV Nurses Association

FINAL PROGRAMME



13th Annual Conference of the National HIV Nurses Association (NHIVNA)

16–17 June 2011

**Arena and Convention Centre
Liverpool**

preceded by

NHIVNA Pre-Conference Study Day

Wednesday 15 June

Supported by an educational grant from



Bristol-Myers Squibb



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Contents



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 the Arena and Convention Centre, Liverpool unless stated otherwise*

Registration	Level 3 Foyer
Lecture Theatre	Hall 1C
Exhibition	Hall 3
Posters	Hall 3
Lunch and Refreshments	Hall 3
Satellite Symposia and Invited Lectures	Hall 1C
Speaker Preview	Room 10
Pre-Conference Study Day	Suites 3–5, Jurys Inn Liverpool Hotel
Gala Dinner	Town Hall, Liverpool

The 13th Annual Conference of NHIVNA
is organised and administered by



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Introduction

Dear Colleague,

Welcome to the **13th Annual Conference of NHIVNA** which is being held at the Arena and Convention Centre in Liverpool.



Liverpool was elected the European City of Culture in 2008, and has recently undergone a significant transformation through various regeneration projects. This included the opening of a new Convention Centre, a unique, purpose-built meetings facility combining the latest technology with innovative design. It is situated in the heart of Liverpool on the historic World Heritage waterfront and NHIVNA is delighted to be able to hold its Annual Conference at such a prestigious venue.

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. We are delighted that Jillian Williams from the Royal London University Hospital and Pauline Jelliman from Liverpool Community Health NHS Trust have kindly accepted our invitation to fulfil this role in collaboration with their respective teams.

I would like to thank all our speakers who have agreed to present their work at this 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 2011 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 no doubt be the presentation of the very latest research, education and clinical practice initiatives in HIV nursing during the oral presentation sessions. Following the success of last year's pilot, we are maintaining the arrangements for these to be presented as part of the main plenary sessions in 2011.

The NHIVNA AGM will be held prior to lunch on Friday and I would encourage all members to attend this meeting as it provides a forum to present any points which they may have 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 Liverpool. In true tradition, we anticipate an evening of good food, followed by after-dinner entertainment – including dancing.

I hope that you will enjoy the conference and find it of relevance to both your educational and your practical needs and look forward to welcoming you to Liverpool.

Best wishes,

Nathaniel Ault
Chair

Programme



Wednesday 15 June 2011

Registration and exhibition open from 1300–1700 at Jurys Inn Liverpool Hotel

1300–1400
Lunch

1400–1700

NHIVNA Pre-Conference Study Day

supported by an educational grant from **Bristol-Myers Squibb Pharmaceuticals**
and **Gilead Sciences**

Suites 3–5, Jurys Inn Liverpool Hotel

New approaches to Advanced Nurse Practice in HIV

Chair: Nathaniel Ault

Barts and The London NHS Trust

Forward thinking: the role of the HIV nurse in the changing NHS

Mr Gary Alessio

NHS Westminster, London

Advance Nurse Practice in HIV: what does this mean?

Eileen Nixon

Brighton and Sussex University Hospitals NHS Trust

The US experience

Robert Carroll

Association of Nurses in AIDS Care (ANAC), USA

A possible UK model?

Jane Bruton

Chelsea and Westminster Hospital, London

Thursday 16 June 2011

Registration and exhibition open from 0820–1730 at Arena and Convention Centre, Liverpool

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

Pauline Jelliman

Liverpool Community Health NHS Trust

Jillian Williams

Royal Liverpool University Hospital

0910–0940

The Robert Pratt Lecture

Chairs: Nathaniel Ault

Barts and The London NHS Trust

Pauline Jelliman

Liverpool Community Health NHS Trust

The future of HIV prevention

Dr Timothy Hallett

Imperial College London

Programme

Thursday 16 June 2011

0940–1040

NHIVNA Plenary Session I

Chairs: Nathaniel Ault
Barts and The London NHS Trust
Pauline Jelliman
Liverpool Community Health NHS Trust

HIV testing

0940–1005

HIV testing in non-traditional settings

Dr Michael Rayment
Chelsea and Westminster Hospital, London
Susan Ogden
Chelsea and Westminster Hospital, London

1005–1015

HIV testing in primary care settings

Gina Rowlands
Bevan House, Bradford

1015–1030

The 'Halve-It' campaign: where are we now?

Ruth Lowbury
Medical Foundation for AIDS and Sexual Health
(MedFASH)

1030–1040

Panel discussion

1040–1100

Morning coffee

1100–1130

NHIVNA Invited Lecture I

Chairs: Zoë Sheppard
Imperial College Healthcare NHS Trust, London
Jillian Williams
Royal Liverpool University Hospital

Ten key lessons from HIV research

Nicky Perry
Brighton and Sussex Hospitals NHS Trust

1130–1230

NHIVNA Oral Abstracts Session I

Chairs: Zoë Sheppard
Imperial College Healthcare NHS Trust, London
Jillian Williams
Royal Liverpool University Hospital

1130–1145

Abstract O1 An audit of HIV care provision for
Immigration Removal Centre (IRC) patients
Diane Reid, Hillingdon Hospital, Middlesex

Programme

Thursday 16 June 2011

1145–1200

Abstract O2 Young people and self-reported adherence to antiretroviral therapy: a HYPNet survey

Susan McDonald, Imperial College Healthcare NHS Trust, London

1200–1215

Abstract O3 The joint implementation of point-of-care HIV testing in hospital and community settings: a nursing perspective

Kathy Jones, Royal Liverpool & Broadgreen University Hospitals NHS Trust

1215–1230

Abstract O4 Sexual health screening in HIV-positive patients: why not DIY?

Tracey Buckingham, Brighton and Sussex University Hospitals NHS Trust

1230–1300

Gilead Sciences Invited Lecture

The modern woman, her reproductive years and HIV

Elly Bittleston

St Peter's Hospital, Surrey

1300–1400

Lunch, exhibition and posters

1400–1500

NHIVNA Plenary Session 2

Chairs: Jane Bruton

Chelsea and Westminster Hospital, London

Catherine O'Keeffe

London Deanery

Models of nursing care

1400–1425

What can we learn from nursing models in resource-poor settings?

Geraldine Main

Independent Nurse Consultant

(with additional thanks to Julianna Misore from Mildmay International, Kenya for her contribution to this lecture)

1425–1450

Models of nursing in UK primary care settings

Eileen Nixon

Brighton and Sussex Hospitals NHS Trust

1450–1500

Panel discussion

1500–1525

NHIVNA Initiatives

NHIVNA Regional Audit and Research Initiative

Catherine O'Keeffe

London Deanery

NHIVNA website redevelopment

Nathaniel Ault

Barts and The London NHS Trust

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Programme

Thursday 16 June 2011

1525–1545

Afternoon tea

1545–1700

NHIVNA Oral Abstracts Session 2

Chairs: Juliet Bennett

Freelance Nurse Consultant

Eimear Railton

Royal Liverpool University Hospital

1545–1600

Abstract O4A (Abstract O13 in Abstract pages [see page 17])

Facilitating nursing research within an HIV nursing network

Nicky Perry, *Brighton and Sussex University Hospitals NHS Trust*

1600–1615

Abstract O5 HIV PEP champions in accident and

emergency: can they improve the patient pathway?

Gary Seaton, *Brighton and Sussex University Hospitals NHS Trust*

1615–1630

Abstract O6 Community HIV support: future model and challenges

Anna Bamford, *Sussex Community NHS Trust*

1630–1645

Abstract O7 Introduction of a nurse-led asymptomatic sexual health screening clinic in HIV day ward leads to 225% increase in patients being offered an annual screen

Zoë Sheppard, *Imperial College Healthcare NHS Trust, London*

1645–1700

Abstract O8 The role of the nurse in co-ordinating pre-exposure prophylaxis as a method of conception in HIV-positive men with HIV-negative partners in the UK

Laura Charlwood, *Brighton and Sussex University Hospitals NHS Trust*

1700–1730

NHIVNA Invited Lecture 2

Chairs: Juliet Bennett

Freelance Nurse Consultant

Eimear Railton

Royal Liverpool University Hospital

Antiretroviral drug update

Professor Saye Khoo

University of Liverpool

2000–0000

Drinks Reception followed by Gala Dinner

Town Hall, Liverpool (see page 12 for further details)

Programme



Friday 17 June 2011

Registration and exhibition open from 0830–1630 at the Arena and Convention Centre, Liverpool

0900–0930

NHIVNA Invited Lecture 3

Chairs: Sam Mabey-Puttock
Manchester Royal Infirmary
Kemoh Rogers
Anglia Ruskin University, Essex

Standards for psychological support for people living with HIV: interactive case presentations

Dennis Dobbin
South London and Maudsley NHS Foundation Trust

0930–1030

NHIVNA Oral Abstracts Session 3

Chairs: Sam Mabey-Puttock
Manchester Royal Infirmary
Kemoh Rogers
Anglia Ruskin University, Essex

0930–0945

Abstract O9 Audit report: medical referrals to nurse-led HIV-maintenance clinics
Dr Gillian Fraser, Gartnavel General Hospital, Glasgow

0945–1000

Abstract O10 Urinalysis in HIV clinic: routine but necessary
Helen Webb, St George's Healthcare NHS Trust, London

1000–1015

Abstract O11 Six years on: a review of primary nurse clinics within a collaborative team approach to HIV care
Kevin McPeake, Chelsea and Westminster Hospital, London

1015–1030

Abstract O12 Improving complex patient outcomes with collaborative primary/secondary nursing intervention
Pauline Jelliman, Liverpool Community Health NHS Trust

1030–1100

Janssen Invited Lecture

Collaborative working to support transition

Susan McDonald
Imperial College Healthcare NHS Trust, London

1110–1130

Morning coffee

Programme

Friday 17 June 2011

1130–1230

NHIVNA Plenary Session 3

Chairs: Felicity Greenham
Body Positive North West
Helen Reynolds
Royal Liverpool University Hospital

Stigma and HIV: the global strategy and UK perspective

1130–1145

Setting the scene

Dr Ian Hodgson
International HIV/AIDS Alliance

1145–1200

The Stigma Index

Kevin Osborne
International Planned Parenthood Federation (IPPF)

1200–1215

The patient perspective

Sam de Croy
Body Positive North West

1215–1230

Panel discussion

1230–1300

ViiV Healthcare Invited Lecture

Confused but not forgotten: CNS management in HIV patients through the eyes of the Nurse Specialist

Michelle Croston
North Manchester General Hospital

1300–1315

NHIVNA Annual General Meeting (NHIVNA members only)

1300–1400

Lunch, exhibition and posters

1400–1410

NHIVNA Awards Ceremony

1410–1440

MSD Invited Lecture

Is it my HAART doctor? Treating CVD in HIV-positive patients

Dr Allan Gaw
Glasgow Clinical Research Facility

Programme



Friday 17 June 2011

1440–1540

NHIVNA Plenary Session 4

Chairs: Jayne Churchill

NHS Lothian, Edinburgh

Zoë Sheppard

Imperial College Healthcare NHS Trust, London

1440–1510

Criminalisation and HIV

Dr Matthew Weait

Birkbeck College, London

1510–1540

HIV and immigration

Sarah Radcliffe

National AIDS Trust

1540–1630

The Third NHIVNA Debate

Chairs: Jane Bruton

Chelsea and Westminster Hospital, London

Catrin Evans

University of Nottingham

Primary or secondary care-led services for HIV management?

The motion:

This house believes that the future of HIV care should be led by primary care services

For the motion:

Robert Downes

Liverpool Community Health NHS Trust

Dr Diane Exley

Brownlow Group Practice, Liverpool

Against the motion:

Helen Reynolds

Royal Liverpool University Hospital

Dr Maggie Edwards

University of Liverpool

1630

Summary and close by the Chair of NHIVNA

Nathaniel Ault

Barts and the London NHS Trust

Executive Committee

Chair	Nathaniel Ault	Barts and The London NHS Trust
Honorary Secretary	Zoë Sheppard	Imperial College Healthcare NHS Trust, London
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
Website Officer	Catherine Donoghue	City and Hackney Primary Care Trust, London
Regional Audit & Research Officer	Catherine O'Keeffe	London Deanery
Community Representative	Felicity Greenham	Body Positive North West
Conference Officer	Sam Mabey-Puttock	Manchester Royal Infirmary
Study Day Officer	Kemoh Rogers	Anglia Ruskin University, Essex



National HIV Nurses Association

NHIVNA aims to provide an academic and educational forum for the dissemination of original nursing research in the field of HIV/AIDS.

We also aim to address the communication and support needs of nurses working in this area.

We hope that these activities will assist in the promotion of good practice in the care of people with HIV.

www.nhivna.org

Registered Charity No: 1099074

Visit the new NHIVNA website

www.nhivna.org

Launch date

Thursday 16 June 2011

Arena and Convention Centre
Liverpool

Conference Information

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 16 June 2011 at Liverpool Town Hall.

Badges

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

Posters

Poster presentations should be in place in Hall 3 by 0930 on Thursday 16 June 2011. Poster presenters are encouraged to be beside their posters during the lunchtime sessions for discussion with delegates. A prize for the best poster will be awarded at the Prizes and Awards Ceremony at 1400–1410 on Friday 17 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 (Room 10) 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 Krattinger Rennison and NHIVNA/Mediscript Clinical Practice Awards will be awarded at the Prizes and Awards Ceremony at 1400–1410 on Friday 17 June.

Gala Dinner

The NHIVNA Gala Dinner will be held on Thursday 16 June 2011 at Liverpool 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.

Accommodation

Please note that the registration fee does not include accommodation. If you have not already done so, you can arrange accommodation by contacting the **Mersey Partnership** on 0151 237 3558 or by following the link on the conference website www.nhivna.org

Cloakroom

A manned cloakroom is available onsite on the ground floor of the Arena and Convention Centre, Liverpool (ACCL). All belongings are left at the owner's risk and there is a charge of £1 for each item deposited. 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

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

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 recommendation for future practice; considered ethical issues (if appropriate).

NHIVNA/BMS Best Poster 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 presentations based on the following criteria: quality of presentation; quality of research; impact on nursing practice; originality; considered ethical issues (if appropriate).

Junior Nurse Scholarships

NHIVNA has awarded up to ten [NHIVNA Junior Nurse Registration Concession Scholarships](#) to assist junior nurses to attend the NHIVNA Annual Conference 2011. To be eligible for a scholarship, applicants must be NHIVNA members for 2011 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.

First-time Attendee Scholarships

NHIVNA has awarded up to ten [First-time Attendee Registration Concession Scholarships](#) to assist delegates who are attending the NHIVNA conference for the first time. To be eligible for a scholarship, applicants must be NHIVNA members for 2011. 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.

Pre-Conference Study Day Scholarships

NHIVNA is to hold a Pre-Conference Study Day in collaboration with Bristol-Myers Squibb Pharmaceuticals and Gilead Sciences on the topic 'New approaches to Advanced Nurse Practice in HIV'. [NHIVNA Pre-Conference Study Day Scholarships](#) are available for those who attend, in full, **both** the NHIVNA Annual Conference on 16–17 June, and the NHIVNA Pre-Conference Study Day on the afternoon of Wednesday 15 June. NHIVNA has awarded 50 scholarships which will cover a contribution of a maximum of £75 towards travel expenses, and a contribution of a maximum of £125 towards accommodation costs (15 and 16 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.

Abstracts



National HIV Nurses Association

Abstract 01

An audit of HIV care provision for Immigration Removal Centre (IRC) patients

K Sabapathy, D Reid, L Rubinstein

The Tudor Centre, Hillingdon Hospital, Uxbridge, Middlesex, UK

Background: Detainees held in Immigration Removal Centres (IRC) should receive the same range and quality of services as the general public does from the National Health Service, and adequate provision should be made for onward care, according to published guidance from the British HIV Association and National AIDS Trust.

Method: An audit was done of all IRC patients seen at our sexual health centre to describe patient characteristics, and compare practice against recommended standards. Routine clinical data of patients seen at the centre between 2008 and 2010 was analysed using Stata statistical software (version 11).

Results: One hundred and sixteen new patients were seen for sexual health and HIV care in the study period. All patients were male (female IRC patients are referred elsewhere); median age 33y (IQR 28,41). Fifty-nine percent of patients were from Africa, 14% Asia, 12% West Indies, 9% Middle-East and 6% from another region. Most patients were referred for HIV care (N=61, 53%). 15% of those referred were removed from the detention centres before they could be seen (of whom half were HIV-positive). There was 1 new HIV diagnosis (in a partner of an HIV-positive patient). Of those with identifiable country of HIV diagnosis 93% (N=56) were diagnosed in the UK. Prior HIV care was provided by 36 different centres around the country, and 3 from abroad. Most patients (85%) were already on ART at presentation to us. The median number of visits at our centre was 5 (IQR 2, 6). Twenty-four (39%) of HIV patients were deported, 20 (33%) were released into the community, 11 (18%) were still detained and 6 (10%) had unknown outcomes. We were given prior notice of release/ deportation in 8 cases, with <1 weeks notice in 5 cases and 2 weeks in a further 2 cases. 1 patient died on release. For the 8 individuals where prior notice was given, none had the recommended 3 month contingency supply of medication provided, 5 received advice about care in the onward location, and 4 were provided with a medical summary letter to inform a subsequent care provider.

Conclusion: British HIV Association and National AIDS Trust standards of care for detainees are not being met. The majority of patients were removed from the IRCs without adequate notification. Greater commitment to meeting recommended standards is paramount to enable medical centres to uphold patient and public health interests.

Abstract 03

The joint implementation of point of care HIV testing in hospital and community settings: a nursing perspective

P Jelliman¹, K Jones², H Reynolds², M Taegtmeier³

¹Liverpool NHS Community Health Trust, Liverpool, UK, ²Royal Liverpool & Broadgreen University Hospitals NHS Trust, Liverpool, UK, ³Liverpool School of Tropical Medicine, Liverpool, UK

Background: Point of care HIV testing (POCT) is able to shorten wait times for results whilst increasing access to testing in hard to reach and at risk populations. HIV testing was traditionally offered locally using venous samples. We have successfully piloted POCT in a variety of settings with high levels of client acceptability.

Methods: Ethical approval was obtained for the study. POCT was offered in a GUM clinic and 6 community outreach venues. Fourth generation rapid tests were used which included P24 antigen testing. Joint POCT training was provided to community and GUM nurses. 25 nurses performing HIV POCT were invited to participate in three focus group discussions. Wait times were calculated for 135 patients using the initial consultation time to the time results were given. An evaluation and comparison between POCT in the community and GUM was made.

Results: In GUM, the 113 POCT increased the average time patients were in clinic for asymptomatic (n=58) and symptomatic (n=55) presentations by 36 min and 8 min respectively. This increase in time impacted on clinic flow and waiting times. Anecdotal feedback suggested that potential attendees declined services due to increased waiting times. Following this analysis POCT was only offered to patients assessed to be at high risk of HIV. This policy change improved clinic flow. POCT in community outreach settings saved time and proved invaluable in screening marginalised groups who would never have presented at traditional testing sites. The volume of patients is less in community outreach, providing more time to spend with patients and promote POCT. Focus group data showed that nurses find point of care HIV testing feasible and highly acceptable. It provides a direct level of patient contact and opportunity to explore risk and health promotion. Joint working enabled a standardised approach to education, quality assurance, support, supervision and robust pathways for referral and follow up of newly diagnosed HIV positive individuals.

Conclusion: This study has highlighted the effectiveness of close communication and joint working between nurses, specialist and non specialist, across different organisations, to optimise the planning, implementation, and outcomes of projects such as this. In line with BHIVA guidelines relating to normalising HIV testing, specialist HIV nurses are appropriately placed, in collaboration with each other, to promote POCT. Specialist nurses are also able to supervise and support other non specialist nurses to increase the uptake of testing, in line with DOH directives.

Abstract 02

Young people and self reported adherence to antiretroviral therapy: a HYPNet survey

S McDonald¹, J Griffiths¹, D Levitt¹, N Tanna¹, C Foster¹

¹Imperial College Healthcare NHS Trust, London, UK, ²Newham University Hospital Trust, London, UK, ³Royal Hampstead NHS Trust, London, UK, ⁴Body & Soul Charity, London, UK, ⁵Imperial College Healthcare Trust, London, UK

Background: Cohort studies have shown that young people (aged 12–24) living with HIV, infected either perinatally or sexually, have poorer adherence to highly active antiretroviral therapy (HAART), resulting in reduced rates of optimal viral suppression (VL <50 c/ml) when compared to either adults or younger children. As part of a wider collaborative approach to developing adolescent adherence guidelines on behalf of HYPNet, a self report questionnaire was designed to collect treatment adherence information from young people currently on HAART.

Methods: An adherence questionnaire designed by multidisciplinary health professionals and voluntary sector representatives was piloted by two HIV positive young people, gained ethical approval and was distributed to 28 hospitals and voluntary sector sites across the UK between September 2009 and March 2010. Participation was anonymous, voluntary and inclusion criteria included: age 12–24 yrs, HIV infected (any route of transmission), aware of status and currently on HAART. Completed forms were returned by post.

Results: 138 young people responded from 14 sites, median age 16 yrs (IQR 15–17). Of participants responding to each question: 67/111 (60%) were female, 50/96 (52%) were born abroad and 83% were living with family. 82/132 (62%) self reported good adherence defined as >95% HAART doses taken in the last month. 79/138 (57%) reported their latest VL result, 66% with a VL <50 c/ml. 72/138 (52%) reported a CD4 count, 47% with >350 cells/mm. Of HAART regimens taken: 66% once daily, 59/136 (43%) 4+ pills/day and 76/135 (56%) on HAART > 4 yrs. Factors identified as supporting adherence: reminders from family/carers (47%), memory aids (36%), regular routine (28%), health benefits (20%) and peer support 62/97 (64%). Barriers included: forgetting (48%), too busy with other activities (29%), keeping HAART secret from friends/family (18%), side effects (15%), pill fatigue (15%) and a daily reminder of HIV (10%). Reported views on what might further improve adherence were: once daily regimens (38%), less (34%) and smaller pills (26%), no side effects (23%), being able to share with friends (13%) and talking to someone else on HAART (9%).

Conclusion: Despite increasing independence associated with adolescence, the role of the family remains important in supporting adherence. Peers play a supportive role for many young people. Stigma and secrecy remains a barrier to adherence for one in five of the young people surveyed.

Abstract 04

Sexual Health Screening in HIV-positive patients: why not D.I.Y?

T Buckingham, S Soni, A Bannister, G Seaton, N Perry

Brighton Sussex University Hospitals Trust, Brighton, UK

Background: The National Strategy for Sexual Health and HIV 2001 laid the foundations to formally increase sexual health screening [SHS] in the HIV-positive population. HIV-positive individuals particularly men who have sex with men [MSM] are disproportionately affected by sexually transmitted infections [STIs] and the presence of an STI increases both the transmission and acquisition of HIV. National guidelines highlight the need for annual routine screening for all HIV-positive individuals.

In response to these guidelines the HIV outpatient department introduced a dedicated HIV/STI clinic offering 20 booked appointments per week. This was poorly attended and the 'did not attend' rates remain high and the uptake for SHS remains poor. An audit of attendances at the dedicated HIV/STI clinic undertaken from September to November 2010 demonstrated that patients at high risk of STIs are not accessing the service.

Newer sensitive nucleic acid amplification tests [NAAT] have been introduced in the clinic and has enabled us to diagnose more Chlamydia trachomatis and Gonorrhoea than previously.

Aim: To address the sexual health needs of our HIV positive cohort. To introduce self taken NAAT testing and monitor the acceptability as a simple and effective form of STI screening.

Methods: The introduction of self collected swabs for Chlamydia trachomatis and Neisseria gonorrhoeae GC for MSM attending the HIV/STI clinic. Patients provide a urine sample and self-swab the throat and rectum. We measured uptake of testing and assessed patient satisfaction with a questionnaire.

Results: The results suggest that we will diagnose and treat more STIs. The flexibility of self taken samples will create a more acceptable culture for patients. A recent study in Brighton demonstrated high acceptability and greater convenience of self-collected NAAT swabs.

Conclusions: The introduction of self taken samples offers a convenient and flexible approach to screening that can be incorporated into routine activity. The uptake is encouraging and has led to an improvement in diagnosis and treatment of STIs.

Abstract O5

HIV PEP Champions in Accident and Emergency: can they improve the patient pathway?

G Seaton¹, G Lawrenson¹, E Nixon², M Fisher¹

¹Brighton and Sussex University Hospitals NHS Trust, Brighton, UK,

²University of Brighton, Brighton, UK

Background: HIV Post Exposure Prophylaxis (PEP) plays a vital role in reducing the onward transmission of HIV following sexual and occupational exposure. Many Accident and Emergency (A+E) departments across the UK provide out-of-hours assessment and access for people requiring HIV PEP.

A local PEP pathway was established in 2005 to streamline access, initiation and referral of patients between A+E and Genito-Urinary Medicine (GUM) services. Feedback from staff and patients has highlighted problems in A&E with waiting times for PEP initiation; inappropriate prescribing; lack of PEP packs and baseline bloods; incorrect follow-up information and poor communication between A&E and GUM. In order to improve the patient pathway in A&E, two PEP Champion nursing roles were developed and were responsible for staff education and pathway maintenance. In addition, a rolling Multi-disciplinary Team (MDT) education program was established.

Aim: To undertake evaluation of the PEP patient pathway following introduction of PEP Champion roles and a rolling education program for A&E staff.

Methods: A retrospective review of GUM notes was undertaken on 20 sets of notes comparing pathway adherence pre and post development of PEP champion roles and training for staff in A+E. Specific aspects measured were the presence of fax documentation from A&E, baseline blood samples and appropriate PEP prescription according to national guidelines.

Results: At the time of abstract submission audit findings showed an improvement from 30% to 60% in the fax documentation received from A+E, an increase from 40% to 90% in correct baseline blood testing and a 90% pre champion to 100% post champion improvement in appropriate prescribing of PEP.

Further findings will be available for presentation.

Initial feedback from patients and staff involved in the PEP pathway suggests an improvement in adherence to the pathways, resulting in a more streamline and robust service delivery.

Conclusions: This initial evaluation of a nurse-led project introducing PEP Champion nursing roles and a rolling MDT education program in A&E has indicated improved adherence to a PEP patient pathway between A&E and GUM departments. This initiative may assist in maintaining standards for PEP provision in out of hours services.

Abstract O7

Introduction of a nurse led asymptomatic sexual health screening clinic in HIV day ward leads to 225% increase in patients being offered an annual screen

Z Sheppard

Imperial College Healthcare NHS Trust, London, UK

Background: In 2008, the British HIV Association (BHIVA) recommended that 'all HIV positive individuals under regular follow up should have an annual offer of a full sexual health screen (regardless of reported history) and the outcome documented in the HIV case notes, including whether declined'.

At this time our HIV service provided patients with access to a booked symptomatic screening clinic provided by Sexual Health Nurse Practitioners or 'fast tracking' to the sexual health clinic. The nurses working in the HIV clinic were unable to perform sexual health screening. We decided expand the access our patients had to sexual health screening & meet the National recommendations by training the HIV nurses to perform asymptomatic sexual health screening

Methods: All qualified nurses (8 in total) underwent the asymptomatic competency based training programme over a 4 week period which included a pre & post course exam, taught sessions, OSCEs, 1 week placement in the sexual health clinic followed by 10 observed assessments of male & female examinations. Upon successful completion of these; the nurse was deemed competent to see patients alone with 2 sets of their notes per week being audited. In parallel to this training, a patient self completion assessment form was developed. This would enable the patient to identify their risk & the nurse assess risk accurately & quickly. A nurse led clinic consisting of 20min appointments covering the opening hours of the service was established. Access was either through clinician or patient self referral, & appointments were either walk in or could be pre-booked. The clinic was also open to women to have their annual cervical cytology. Sexual history taking, acceptance & or decline of a sexual health screen were to be recorded on our stand alone electronic patient results system. This would be utilised alongside coding to monitor usage of the service & compliance with BHIVA (2008) recommendations. By May 2009, all nurses had undergone & passed the training. The clinic went live on the 1st June 2009.

Results: One month post commencing the service, initial figures reported that 24% of our patients had documented evidence of being offered an annual sexual health screen. Over the next few months, suggestions by patients on better wording of the assessment as well as greater awareness amongst patients & staff resulted in a month on month improvement in the number of patients offered a screen; so that in March 2011, the number was 78%.

Conclusion: The introduction of a sexual health screening service provided by the HIV nurses to our HIV patients enabled a 225% improvement in the numbers of patients being offered a screen in just over one year. Patients have found it acceptable to have the same nurses provide their sexual health care & the nurses enjoy the extension to their role in meeting this need.

Abstract O6

Community HIV support – future model and challenges

A Bamford

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Background: The evidence would suggest that there is now a shift of HIV from acute to chronic illness which will require a self-management model where patients assume an active and informed role in their healthcare. The community HIV team, successfully integrated in 2006, now faces the challenge of how to incorporate this paradigm shift in service provision.

A new model of support for people living with HIV in the community was successfully commissioned in the south of England in September 2010. Unlike other HIV community services this team includes HIV nurse specialists, mental health nurses, social care, psychology and health trainers. It also has a contract with a local voluntary organisation to provide inpatient beds.

Method: The team promotes self-management as a key theme for clients. This incorporates case management, full assessments; personalised care plans and defined timescales for the interventions. There is a clear patient pathway through the service through a tiered approach, by which the community nurse specialist or community psychiatric nurse contacts the patient, completes an assessment and identifies the appropriate team members for referral.

When the episodes of care are completed then the patient is discharged from the service, with the understanding if their needs change then they can refer back in.

Results: Covering a large geographical area in which staff have historically worked in isolation, our service is now clustered together into three localities. Subcontracting some of the elements to external agencies has given choice and flexibility to patients, but control is maintained by the main care provider. A service user group has been established to provide a forum for information sharing and to promote feedback on developments and ideas as the service becomes established.

Discussion: Cultural change for both workers and patients has begun with support around supervision, clear objectives and dealing with patient expectations. Patient pathways are starting to be developed as we try new avenues with partner organisations, for example, in helping patients with brain impairment. Data analysis for the Primary Care Trust now incorporates activity data, but will also include how many patients are in each tier of the model and, by using careplans and their evaluations, what outcomes have been achieved.

With the current political climate we must strive to maintain and develop HIV care in our community, enabling equal access across this newly constructed service while retaining the innovation and drive.

Abstract O8

The role of the nurse in co-ordinating pre-exposure prophylaxis as a method of conception in HIV-positive men with HIV-negative partners in the UK

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Background: The desire to have children is increasing in patients who are HIV positive. HIV-positive men with HIV-negative female partners have a number of conception options. The current gold standard is spermwashing which is expensive and involves significant inconvenience for patients living outside London. With Pre Exposure Prophylaxis for Conception (PrEP-C) the HIV negative female has unprotected sexual intercourse (UPSI) with her HIV positive partner (HIV VL <40 copies/ml, on treatment) using antiretroviral (ARV) cover. This has been reported as a safe method of conception however there is still a lack of safety data within the UK. As further evidence emerges on the safety and efficacy of PrEP-C, there is a role for nurses to develop robust patient PrEP-C pathways within an HIV outpatient setting.

Aim: To describe a formalised nursing patient care pathway for service users accessing PrEP-C.

Method: We have been running a dedicated HIV conception clinic since 2008 which is a multidisciplinary team involving HIV doctors and nurses, health advisors and a gynaecologist. My role as the HIV conception Nurse is to take referrals from the clinic and to make contact with the patients to coordinate investigations. The HIV negative women undergo a range of hormonal and radiological fertility investigations, regular HIV tests and sexual health screens. Their HIV positive male partners must have semen analysis, baseline seminal viral loads and regular sexual health screens.

Results: Five couples have been managed on the PrEP-C nursing pathway to date. The median duration from referral to completion of investigations was 60 days (range 30-90). The most difficult point in the investigation pathway was arrangement of Day 2-3 progesterone. Contact via the nursing pathway provided an additional opportunity for patients to discuss any questions or anxieties about the treatment. We have a developed formalised standard operating procedure and care pathway for patients on PrEP-C based on our experience and have implemented this within our clinic. This has demonstrated improved safety for managing and supporting patients, has increased the likelihood of appropriate and prompt follow-up and provided a tool for training and developing staff in the role of the PrEP-C nurse.

Conclusions: The provision of PrEP-C can be delivered safely and efficiently when managed within clear pathways. As more evidence supports the safety of PrEP-C in discordant couples hoping to conceive, further opportunities may develop for nurses to become more skilled in providing PrEP-C services.

Abstracts



Abstract O9

Audit report: medical referrals to nurse-led HIV-maintenance clinics

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Background: Current BHIVA guidance states that centres providing out-patient HIV care should develop their own clinical protocols and pathways for care.¹ At the Brownlee, patients who have been stable for more than six months, either on or off treatment, have the opportunity of referral to the 'specialist nurse-led HIV maintenance clinic'. This results in the patient alternating every three or four months between medical and nurse-led clinics.

There is evidence that care in a multi-disciplinary setting leads to better clinical outcomes² and the use of these clinics will become increasingly important as our cohort expands and people stay well for longer owing to HAART. We therefore performed a case-note audit to assess the proportion of eligible patients referred to nurse-clinicians and explore reasons for deviation from our clinic's protocol.

Methods: Clinical records were examined for all 133 patients who were booked to attend clinic in January 2010. Thirty-five patients were excluded leaving ninety-eight case notes eligible for audit.

Results: The results of this audit identified fifty out of ninety-eight (51%) of the patients attending in January were eligible for review at the nurse-led clinic. Thirty out of fifty (60%) of these eligible patients missed the opportunity for referral. Four out of thirty of these case notes had a documented discussion around referral to the nurse-led clinic. The non-referral group had more on-going medical, sexual and reproductive health issues and psychiatric issues compared to the referral group which may have been the barrier to referral.

Nine out of ninety-eight (9%) ineligible patients were referred contrary to our local guidance.

Conclusions: The inadequate documentation in clinical notes was a significant limitation to exploring doctors' and patients' reasons for both referral and non-referral. The findings also suggest that while many patients' HIV infection remains stable, clinic visits are spent dealing with problems often not directly related to control of their HIV infection. In order to increase uptake of this clinic, documentation needs to improve. A more qualitative exploration of physicians' attitudes to nurse-led clinics may also uncover what barriers exist to referrals.

Abstract O11

6 years on: a review of primary nurse clinics within a collaborative team approach to HIV care

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Background: A collaborative approach to care has been in place since 2005 in our HIV service. This was implemented in recognition of the changing needs of HIV outpatients. The approach included 3 teams, each with a primary and associate nurse. Referral criteria to the primary nurse clinics were as follows:

- consultant referral
- stable on antiretroviral therapy (ART) (viral load <40 for >6 months) or stable off ART (CD4 >350 for 12 months)
- no ongoing medical problems
- 3 month follow-up
- annual consultant review

A comparison of the original referral criteria and the current attendance for one of the primary nurse clinics has been carried out.

Methods: A case note and electronic note review for 50 patients in one primary nurse clinic over 3 months was carried out to review how many met the original criteria. Data collected also included age, medical/nurse co-consultation, new patients, starting/switching therapy, adherence issues, sexual health screening/advice, further referrals and if they required same day medical input.

Results: Of the 50 patients 20% were referred by a consultant. 98% were on ART, of these 37% did not have a viral load <40 for > 6 months. 2% were off treatment and had a CD4 >350 for 12 months. 28% had ongoing medical issues including hypertension and renal failure. 72% had >3 months between appointments. The mean age was 44.9. 2% of patients had a medical/nurse co-consultation. There were 0 new patients. 22% were starting/switching therapy. 16% had adherence issues. 46% offered a sexual health screen/advice. 28% had referrals made to specialties such as the renal clinic. 4% required same day medical input for problems such as ongoing rash and atypical chest pain.

Conclusion: Over half of those attending the primary nurse clinic had ongoing medical issues or were not stable on treatment. However adequate resources were in place in the nursing team to effectively manage these. With an ageing population ongoing medical issues are more likely to occur and these may not necessitate medical input on each visit. It is clear the role of the primary nurse has developed beyond the original specification and the criteria for the management stable patient is evolving and local policies are changing as a result.

Abstract O10

Urinalysis in HIV clinic: routine but necessary

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Background: The British HIV Association recommends that HIV patients have urinalysis performed yearly and at routine clinic visits for those taking Tenofovir. In our clinic routine urinalysis is performed by nurses who order laboratory tests, including midstream urine (MSU) and urine protein creatinine ratio (uPCR), based on the result. We wanted to explore the extent of abnormalities on urinalysis within our cohort and whether appropriate tests were ordered as a result.

Methods: As part of their annual health assessment, patients had a urinalysis performed using urine dipstick. Results were recorded on a database, and concurrently-requested urine laboratory tests were added retrospectively. Patient records were examined for those with significantly abnormal results to identify relevant medical history or subsequent treatment changes.

Results: • Urinalysis was performed on 1069 samples. 149 (14%) showed no abnormality; 694 (65%) had one abnormality; 226 (21%) two or more.

- The most common abnormality was proteinuria (875 (95%))
- 622 (90%) of samples with one abnormality had proteinuria. 253 (41%) trace; 265 (43%) one plus; 130 (20%) two plus; 14 (6%) three plus.
- uPCR was sent on 649 (74%) of the samples with proteinuria. 58 (9%) were reported as 'not applicable'. The rest ranged from 3.4–726 mg/mmol (median 11.5).
- 52 (8%) had uPCR >50 mg/mmol. 38 (70%) had an existing medical condition or infection that explained raised uPCR. Tenofovir was stopped in 4 patients and 3 referred to renal clinic. It was noted that abnormal uPCR results were found even on low levels of protein on dipstick.
- 577 (66%) of patients with proteinuria were on Tenofovir. 459 (80%) had uPCR ordered.
- 28 patients had glycosuria. 20 (70%) were diabetic or renal patients. Of the remainder 1 was subsequently diagnosed diabetic, 2 discontinued Tenofovir for suspected Fanconi's Syndrome and 4 investigated for renal toxicity.
- MSU was performed on 12% (135) samples. 18% (24) were identified as having urinary tract infections. Another 11 samples were identified as having signs of infection but no MSU sent.

Conclusions: Abnormalities on urine dipstick are common amongst our clinic cohort, many from patients with pre-existing medical conditions. However, potentially serious medical complications, drug toxicities and urinary tract infections were identified through routine urinalysis. Appropriate laboratory tests were ordered on most of the abnormal samples but uPCR should be considered even at low levels of proteinuria on dipstick.

Abstract O12

Improving complex patient outcomes with collaborative primary/secondary nursing intervention.

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Background: A reflective piece of work which ultimately demonstrates the importance of collaborative working between hospital and community based HIV specialist nursing teams. Early adoption of a multi disciplinary (MDT) approach improves outcomes for patients with complex needs. This case study focuses on the problems of a complex patient and the joint nursing interventions developed to meet these challenges. Nursing interventions within this study are linked to the DOH position statement on Advanced Level Nursing (2010), and NHVNA specialist competencies (2007). It is felt by the authors of this work that perseverance with the application of these competencies identified in the above documents, has made a significant impact on the health and well being of this individual.

Methodology: Anonymous information gathered from case notes and MDT meeting minutes from 2002 – present.

This case study is underpinned by graphs of CD4 counts and Viral load, which correspond to chaotic / stable periods, and the nursing interventions that were utilised during those periods.

Examples of Nursing Interventions highlighted within this case study

Structured MDT communication re medical/social issues

Tailored nursing interventions to support medical review and adherence

Specialist community assessment and on going interventions

Domiciliary support, use and management of dosing device

Results: Results show initial poor prognosis and generally hopeless outlook and progresses to improved social and medical circumstances. This is reflected in evidence presented.

Conclusion: A valuable lesson learned, is one around early lifestyle assessment, and appropriate support. If some of the chaotic aspects of a patient's life can be addressed as soon as possible, this may determine their outcome whenever they start HIV treatment. Although in this particular case, this patient was already ill and on treatment. This case study highlights the benefits of robust referral and communication systems between primary and secondary care services. This study also illustrates that HIV specialist nurses function at an advanced level and require the knowledge, skills and expertise illustrated in the competencies, to meet the challenges in complex cases which are undoubtedly compounded by an HIV diagnosis. Interventions underpinned by elements of advanced nursing practice have clearly had a major impact on the improved outcome for this patient. Attention to detail, close communication and a collaborative approach has not only improved quality of life but in all probability saved it.

Abstract O13

Facilitating nursing research within an HIV nursing network

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Background: In line with the BHIVA Standards for HIV Clinical Care (BHIVA 2007) a research nursing network was established to promote the continuing professional development of nurses across Surrey and Sussex. The Sussex and Surrey HIV Nurses Research Network (SSHNN) was set up in November 2007, with the aim of providing nurses with the opportunity to come together for education, research training and networking opportunities. In addition to the educational programme the group decided to focus on setting up a nurse led research project.

Methods: Network meetings are scheduled on a quarterly basis and are attended by nurses from HIV units across Surrey and Sussex and facilitated by a lead HIV research nurse. The attendees come from a range of backgrounds including in-patient, out-patient, research and community settings. Approximately 15 nurses attend the 3 hour meeting, which include relevant updates on HIV care and management and training in more generic research skills ranging from how to write a research proposal, research methodologies, focus group training, how to write an abstract and presentations skills. As the group became more established, they decided to undertake a nursing research project and were presented with two research questions and asked to vote for the project they wished to take forward as a group.

Results: The elected research question was 'As HIV moves towards a chronic disease, how active are patients in their own care?' Subsequently, a project management group was formed and a full research proposal was developed by clinical and research nurses. The group applied for a NHVNA research grant that was secured in October 2010. Since then a protocol and participant information has been developed and will be submitted for ethical approval in May. The SSHNN have been involved with all stages of the proposal to date. The protocol has been reviewed and comments taken on board. The project management group has engaged volunteers from the network group to assist with recruitment, facilitation of focus groups, data collection, and analysis and write up.

Conclusion: The formation of the SSHNN has led to the development of a research project that has been designed and implemented by nurses. It demonstrates how given appropriate education, training and support nurses who may not usually undertake research can be involved in the process and gain valuable research experience. The study will commence in July and the results will be presented at NHVNA conference 2012.

Abstract P2

Setting up a systematic annual health assessment programme in an HIV out patient clinic

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Background: BHIVA monitoring guidelines suggest annual health screening for people living with HIV, including cardiovascular risk, body mass index (BMI), waist circumference, urinalysis, sexual health screening and cervical cytology. Our inner-city clinic aimed to set up an annual screening programme which could be applied systematically across our cohort.

Methods: We designed a health assessment pro forma which looked at blood pressure, BMI, waist circumference, urinalysis, last cervical smear, patient and family cardiac history and smoking. All patients who attended the clinic for an appointment within a ten-month period were assessed by the nursing team. Exclusions were pregnant women, those who had given birth within the past 3 months and attendees of the young adult clinic. Ten-year Framingham coronary heart disease (CHD) risk was calculated for all patients. Results were stored on a database.

Results: Of the 1212 eligible patients, 1191 (98%) had an annual health assessment. 599 (49%) were Black African, 409 (34%) White British, 90 (7%) Black Caribbean and 114 (9%) 'other'. 701 (59%) were male, of whom 387 (55%) identified themselves as men who have sex with men.

312 (26%) of our cohort were smokers, 396 (33%) had raised systolic blood pressure (≥ 140), and 389 (32%) had raised total cholesterol (≥ 5.2). 714 (59%) of patients were overweight (BMI ≥ 25), of whom 285 (40%) were obese (BMI ≥ 30). Average waist circumference for men was 91cm, and for women 92cm. 279 (23%) had a waist circumference ≥ 100 cm. 351/499 (70%) of women assessed had a cervical smear in the last 12 months.

1158/1212 (96%) of patients assessed had full data collected for a Framingham ten-year CHD risk. Only 195 (17%) had a raised CHD risk ($\geq 10\%$), with 683 (59%) having a very low risk ($\leq 5\%$). Of those with raised CHD risk, only 13 (7%) had no modifiable risk factors.

Conclusion: By carrying out a standardised health assessment programme with minimal exclusion criteria, the nursing team were able to assess the majority of patients attending the clinic as part of routine care. Targeted and appropriate health promotion and medical interventions were implemented at assessment on an individual level. On a population level, analysis of the data has allowed us to identify universal health promotion needs. This has informed health promotion activities within the clinic and at PPI (Patient Public Involvement) events.

Abstract P1

Nurse led family clinic for parents and children with HIV infection and facilitation of rapid referral of sexually assaulted young people

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Our city is unusual in having general, paediatric and obstetric services on different sites. There are approximately 1200 patients attending adult services and 30 HIV positive children attending the children's hospital. Many parents are socially disadvantaged and psychosocial problems are common.

With access to antiretroviral treatment, children are surviving into adulthood and making the transition to adult services. A need for a family clinic was recognised. However, problems establishing a location for the clinic, medical staffing, confidentiality and recording of patient data seemed insurmountable.

An ad hoc service was started in 2005 when an adult specialist nurse (CNS) attended the children's hospital on a weekly basis to provide support to families. Initial problems arose because of staff shortages until funding was secured. Over the last 2 years the service has become firmly established. Currently an adult CNS attends the weekly children's clinic. The work includes:

- Facilitation of transition of HIV positive adolescents to adult services
- Rapid referral of sexually assaulted young people to GUM services
- Sex Education for HIV positive adolescents
- Psychological support, education and adherence support for parents
- Addressing treatment issues for parents
- Undertaking relevant blood tests for parents

A proforma was designed which is completed and filed in the adult patient's notes. Completed proformas were reviewed from a 10 month period. Over this time 39 consultations took place. 8 % of the consultations were with young adults. 92 % of the consultations were with adult patients. These 36 consultations consisted of adherence support (64 %), education (33 %), psychological support (79 %), social support (13 %), undertaking relevant blood tests (21 %) and prescriptions (5 %).

Prior to the involvement of our team there was no adult service provision at the children's clinic. The family clinic has provided a different environment for patients to access services outside of the adult clinic. This has improved communication with patients, some of whom did not regularly attend adult services. The family clinic has also reduced the number of clinic visits for parents some of whom have to travel long distances for appointments. The family clinic has assisted young adults in their transition into adult services with continuity of care. Feedback from HIV positive adolescents has been very encouraging.

Abstract P3

Testing Testing: Are men who have sex with men (MSM) that choose to test in community settings at higher risk of HIV?

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Background: 22,000 people are living with HIV in the UK and are unaware of their status. Despite concerted efforts from primary and voluntary HIV services this number has remained unchanged, suggesting that current HIV testing guidance and policies are not addressing this group. In 2010 the Halve It campaign was launched with a key aim to reduce the number of people living with HIV and unaware by 50% in the next five years. The UK National Guidelines for HIV testing 2008 reported that undiagnosed HIV can only be tackled if testing is performed in a wider range of settings than sexual health and antenatal clinics. Uptake of HIV testing reaching 93% among patients accessing traditional sexual health services in 2008 yet one in four people with HIV still remain undiagnosed. This brings to question, are those people that remain undiagnosed attending traditional GUM services? The 2011 National Institute of Clinical Excellence's guidance on increasing the uptake of HIV testing among men who have sex with men recommended increasing access to outreach schemes and providing rapid point-of-care tests. But are the men attending outreach services at higher risk of HIV?

Aim: To compare self reported HIV risk taking behaviour in men that have sex with men attending outreach testing services compared to traditional GUM services.

Methods: 135 MSM accepting community-based testing services over six months were compared to 135 MSM accessing traditional hospital-based GUM services between September 2009 and February 2010. Measures of risk of HIV infection included comparing lengths of time since last HIV test, rates of unprotected sexual intercourse and numbers of partners within the three months preceding screening.

Results: Of the 135 MSM that attended outreach services 28% reported having 5 or more sexual partners in the 3 months preceding testing compared to 13% of the 119 GUM clinic attendees ($P=0.149$). 12% of the outreach cohort reported having 2 or more episodes of unprotected anal intercourse compared to 4% of the GUM clinic cohort in the 3 months preceding testing ($P=0.069$). In the last year, 46% of the GUM clinic cohort had not had an HIV test compared to 61% of the outreach cohort ($P=0.189$).

Conclusions: MSM attending community-based testing report higher numbers of sexual partners, more episodes of unprotected sex and longer lengths of time since last HIV test. Although not statistically significant due to the sample size, findings show that outreach testing targets service users at higher risk of HIV.

Abstract P4

'We're all in this together' – Pre- and post-qualification HIV education a collaboration between service and university

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Nursing education has traditionally been divided between pre-and post-qualification provision, however, changes to the curriculum associated with the move to an all graduate profession allowed pre-qualification students to choose post-qualification modules as optional courses.

This, alongside changes in HIV epidemiology and treatment provided the opportunity for a re-evaluation of HIV educational provision. This paper describes the recent evolution of HIV education at a London University, and the developing partnership with a major NHS HIV treatment centre.

King's College London has provided HIV education for over 20 years. Three years ago, after informal discussion with senior staff at Chelsea and Westminster Hospital, the curriculum was reassessed, and provision extended to also include a summer school. The new curriculum, which was developed as a partnership between the two organisations, was based around the patient journey, from diagnosis through treatment and long-term care underpinned by the National NHVNA Nursing competencies. Alongside this, links were established with voluntary sector organisations, and a new level 7 Master's Course was validated. The emphasis is therefore on collaboration and 'togetherness', in uniting different types of student; and an academic institution and NHS Foundation Trust.

Moreover, there remain significant challenges, including the role that education plays in the changing NHS; the possible mainstreaming of NHS care in adult and care of the elderly settings; how to relate this to the work of the Academic Health Science Centre; and the role that UK health and educational institutions should play in the global response to HIV. This paper presents progress so far through an examination of the standard end of course evaluation plus innovative methods including a focus group and a questionnaire. This examines the success and challenges of this type of education and seeks consensus from those present on the future of educational provision.

Abstract P6

Psychological support for at-risk men who have sex with men

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New HIV diagnoses continue to include significant numbers of men who have sex with men (MSM). For some of these men there are repeated episodes of testing following risk taking behaviour.

In recognition of this a 'gap' between clinical services and psychological needs for some men attending MSM clinics was identified and a pilot project was proposed. The aim of this project was to provide tailored psychological support to clients to reduce onward transmission of HIV/STIs.

Clients who were at-risk or vulnerable within a sexual health context were identified and, following a risk assessment, they were given access to appropriate psychological services via a formal care pathway.

Referral criteria and a referral form were developed. Criteria included repeated at risk behaviours, mental health problems, past/present abuse issues, HIV positive clients and complex issues in relation to, for example, stigma and sexuality. The list was not exhaustive and discussion with the mental health team prior to referral was available.

Results showed that although numbers of referrals were small, clients who engaged made significant behavioural change, improved their mental health and well being and remained HIV negative. This was through comprehensive bio-psychosocial assessment and appropriate interventions based on this assessment. The focus of the interventions was motivational interviewing and included issues of health behaviour change as well as, for example, management of depression, anxiety and issues with low self-esteem.

However, some clients identified as at-risk accepted the referral but did not attend. This leaves the challenge of how to engage clients who repeatedly attend for testing and are recognised as having mental health/psychological issues but do not respond to the offer of additional support.

Abstract P5

Development of an HIV support campaign to meet identified patient communication needs

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Aims: To identify and understand any concerns and difficulties HIV+ patients have in communication with Health care professionals, and to develop materials to enhance communication, meet information needs and empower patients.

Methods: Interviews were conducted before and after a series of simulated patient-doctor consultations to identify perceived messaging and any unmet patient communication needs. Patient information materials available to HIV+ patients in the UK were collated and assessed for communication attributes. Materials were reviewed by 5 patient group leads. Patient support materials were developed to enhance currently available and address any identified unmet need.

Results: The key unmet communication needs identified were differences in perceived information needs and priorities between patients and their doctor. Patients wanted knowledge about treatment, the language to be able to understand and the questions that they can ask to check that everything is going as well as possible. Doctors tended to be in control of treatment decisions, despite sometimes being unaware of full impact of side effects as patients felt unable to disclose true impact on life to Doctors. Over 50 materials were reviewed. The majority (75%) provided solely written information and a quarter used pictures or diagrams. Only 20% of materials were printed in colour and 10% were specifically for women. New patient information leaflets and a website were developed with concise written information and pictorial representations of treatment scenarios to engage both patients and HCP.

Conclusions: It is important to identify and understand HIV+ patients concerns and difficulties in communication with health care professionals to ensure patients' needs are met. The use of concise written materials with pictorial representations may enhance communication and meet unmet information needs. We developed patient information materials and a website to support and empower patients.

Abstract P7

How should we be screening for proteinuria in an HIV positive population?

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Background: It has been suggested that approximately 17% of HIV positive patients have chronic kidney disease (CKD). Although HIV associated nephropathy is relatively rare in the UK, several commonly used antiretrovirals are associated with nephrotoxicity. With an ageing cohort, it is likely that an increasing proportion will go on to develop CKD. Hence, HIV-infected patients should be regularly screened for proteinuria. Proteinuria has been defined as \geq protein on urinalysis or a urine protein:creatinine ratio (uPCR) of $>30\text{mg/mmol}$. Currently, uPCR only is performed annually for all patients attending our service, and 3-4 monthly in those receiving tenofovir. We sought to evaluate this practice by correlating uPCR with conventional urinalysis. Methods: Since October 2010 data has been collected prospectively from patients undergoing uPCR as part of routine HIV care. Age, gender, ethnicity, antiretroviral therapy, CD4, viral load (VL), creatinine, co-morbidities, uPCR and urinalysis results were entered into excel for analysis. Results: 114 patients have been included so far: 51% male, 62% black; median age 46.1 (range 24-77), median CD4 533 (range 34-1071) and 66% VL <50 copies/ml. 64 patients had $<+$ proteinuria and uPCR ≤ 30 .

Protein on urinalysis	uPCR (mg/mmol)					Total
	<15	16-30	31-60	61-90	>90	
0	38	6	6	3	1	54
Trace	19	1	1	0	0	21
+	21	5	1	0	0	27
++	5	1	0	0	3	9
+++	1	1	1	0	0	3
Total	84	14	9	3	4	114

5/39 (13%) of patients with \geq proteinuria had a uPCR >30 . 5/16 (31%) of patients with a uPCR >30 had significant dipstick proteinuria. Conclusion: The majority of patients with $<+$ dipstick proteinuria had a correspondingly low uPCR (≤ 30). There was poor correlation between dipstick proteinuria and raised uPCR. Only 5/50 (10%) of patients with either dipstick proteinuria or a raised uPCR had concordant results. The significance of these discrepant results merits further investigation. Performing urinalysis alone would have missed 11 patients with a significantly raised uPCR and uPCR alone would have missed 34 patients with \geq proteinuria on urinalysis. Based on these results, performing urinalysis routinely, uPCR if \geq protein, plus an annual uPCR for those with \leq proteinuria, would overall detect more patients with significant proteinuria, and is likely to be a more time and cost effective strategy

Abstract P8

Point-of-care HIV testing in community based environment clinics

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Background: There is strong evidence that early diagnosis of HIV may lead to individuals starting medication in time to reduce incidence of AIDS and complications. There is also evidence that people diagnosed late have a slow response to treatment with chances of developing complications.

In addition, there are powerful Department of Health arguments for investing in early testing for HIV based in non clinical settings. There are clearly examples of excellent outcomes for early diagnosis. These include consistency in service use, positive self-management after early diagnosis, continuation with employment and consequently normalising HIV testing.

Aim of the study: Based on action learning, point-of-care HIV testing clinics were set up in the community. The aim was to provide testing at areas that minimise stigma, provide discussion on sexual health in a non threatening environment and allow individuals to observe the test take place to determine their HIV status. Hospital based HIV testing clinics may provoke, anxiety leading to failure to return for results a barrier to early diagnosis and subsequent treatment.

Methods: Trained nurses and counsellors under supervision of a clinical lead set up and ran the first clinic. Within eight months a second clinic was set up and others followed leading to the current five in operation. Persons with reactive results were first tracked for a confirmatory test within 48 hours based on World Health Organisation regulations.

Results: Strategically located community based clinics have been carrying out HIV testing since February 2008 to April 2011. Of 985 tests, 21 were reactive confirmed positive microbiology laboratories in hospitals and have commenced treatment. None of them has been lost to service. While one still has a CD4 cell count above 350 and is a regular attendee at his hospital monitoring clinics. Some of the clients maintain regular contact with the original testing clinic to discuss issues related to action to drugs, disclosure to spouses, family and employees.

Conclusion: Testing saves lives! The 21 individuals whose HIV status was confirmed can lead a near normal life contribute to family, community and society as the researcher waits to compare these result with hospital based testing clinics within similar testing periods.

Abstract P10

Ch@tspace – A novel HIV internet forum for a multi ethnic South London Clinic

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Background: HIV-related stigma is a key barrier to accessing practical and emotional support. Every HIV clinician will have experience of caring for patients with severe psychological distress who feel unable to access face-to-face support due to stigma. Stigma appears particularly severe in the Ethiopian/Eritrean community.

The Internet offers unparalleled opportunities to assist such patients. However, most online public HIV support groups do not touch on local concerns and do not have the potential for face-to-face interaction between users.

Methods: We have created 'ch@tspace' (www.mychatspace.net), an anonymous, internet support network for patients attending our South London HIV Clinic. Patients may choose to participate in online chatgroups for Africans (French/English), Caribbeans, MSM, straight men and women and Amharic speakers (Ethiopian/Eritrean). New groups can easily be created should the demand arise.

Unlike generic HIV internet forums, 'ch@tspace' is restricted to our HIV clinic patients. Patients choose a username to log onto the website and are able to post and receive anonymous messages with email alerts. The email addresses and identity of participants are highly protected. For discreet internet access in public places, the homepage does not contain any reference to HIV.

Patient volunteers will be trained as group moderators who will refer difficult or inappropriate postings to a Health Advisor.

Results: There has been huge enthusiasm for the project from patients and clinic staff. Although the registration process is quick, there are significant manpower and logistic challenges in registering over 2000 patients. Committed staff and patient champions have been essential for start-up.

Conclusion: Our vision is for our HIV clinic users to share experiences and information to create a supportive on-line clinic community. Ch@tspace also provides a forum for user involvement in our service and for dissemination of general clinic announcements e.g. changes in clinic times. The local clinic-based nature of ch@tspace and the possibility for one user to request to meet another is highly novel. This is also the first Amharic language HIV support group in the UK. There is potential to replicate this forum in other UK HIV clinics for the benefit of users and services.

Abstract P9

Nursing and the third sector: an opportunity for enhanced partnership

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Aims/Objectives: As funding cuts throughout the health and social sectors impact capacity, it is increasingly necessary for nurses to utilise onward referral opportunities to ensure patient needs are met in a timely and effective manner. The purpose of this study is to use several case studies of HIV+ persons accessing voluntary organisations to highlight the potential for these organizations to respond to common nursing diagnoses.

Methods: Four case studies were obtained from a voluntary organisation working with HIV infected and affected children, young people and families. The voluntary organisation obtained consent prior to sharing the studies, and all studies were anonymous. Case studies were analysed by a public health nurse familiar with NANDA-International and Nursing Intervention Classification taxonomies. The nurse classified the baseline case needs using nursing diagnoses, and then analyzed the applied voluntary organisation's interventions to determine to what extent they responded to the nursing diagnoses.

Results: The analysis of these case studies demonstrated several areas in which the voluntary organisation provided specific interventions that responded to nursing diagnoses. The nursing diagnoses most frequently addressed by the voluntary organisation were: ineffective coping, compromised family coping, knowledge deficit regarding HIV diagnosis, chronic low self esteem and social isolation.

Conclusions: This study highlights the need for further research into the role voluntary organisations could play in collaborating with nurses to respond to nursing diagnoses.

Abstract P11

Audit of assessment and management of patients commenced on post exposure prophylaxis following sexual exposure (PEPSE)

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Aims: 1. To audit our practice against the British Association for Sexual Health and HIV 2006 standards for management of patients commenced on PEPSE.

Methods: A retrospective case note review of patients seen in the sexual health clinic and commenced on PEPSE between January 2010 and January 2011.

Patients who were commenced on post exposure prophylaxis for other reasons were excluded.

10 patients were commenced on PEPSE.

Results: 100% (10/10) met the BASHH 2006 criteria for considering or recommending PEPSE.

90% (9/10) were commenced on PEPSE within 72 hours post exposure

One pregnant woman was commenced on PEPSE 96 hours post exposure following expert advice.

90% (9/10) commenced on Truvada and Kaletra.

90% (9/10) seen by health advisor.

100% (10/10) complete 28 days of PEPSE.

100 % (10/10) had baseline HIV test before commencing PEPSE.

60 % (6/10) reported nausea as the main side effects.

90% (9/10) had repeat HIV test 3 months post PEPSE (one patient tested HIV positive and one waiting for 3 months).

10/10 (100%) had sexual health screen week two post exposure to risk of infection. 8/10 (80%) had Hepatitis B and C screen on day 0 and 3 months post PEPSE and 50 % of women had pregnancy risk assessed.

Conclusion: Most patients were assessed and managed as per BASHH 2006 guidelines.

To improve on pregnancy risk assessment and screening for Hepatitis B and C.

One patient tested positive for HIV infection 3 months post PEPSE blood test- this emphasizes the need for proper counselling and following up of all patients.

Expert advice should be sought when assessing pregnant women for eligibility for PEPSE.

Re audit our practice against the BASHH 2011 guidelines.

Abstract P12

Is Kivexa as efficacious as Truvada for viral load suppression in HIV positive adults initiating antiretroviral therapy?

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Background: Both Truvada and Kivexa are first line drugs used in initiation of antiretroviral therapy. BHIVA cautions using Kivexa with patients with very high viral loads ($>100,000$ copies/mL). This was based the ACTG 5202 study conference abstract and an investigator letter relating to this study from February 2008. There are no Cochrane systematic reviews comparing Kivexa and Truvada directly HIV treatment. The US Department of Health and Human Services do not recommend Kivexa as a first line drug but as an alternate drug. The London Consortium has very recently decided Kivexa is to be considered first line due to drug costs.

Methods: A systematic literature search to identify studies comparing Kivexa to Truvada was undertaken on the MEDLINE and EMBASE databases. A mini review was conducted according to principals of NICE. A meta-analysis was not performed due to heterogeneity between the studies. A total of 615 published papers were found, of those 18 abstracts were reviewed for inclusion criteria and quality. 3 papers directly comparing both drugs are included in the review.

Results: The ACTG 5202 study (interim published results) showed a 2.1 fold increase in time to virologic failure at week 48 in the Kivexa arm in those with baseline viral loads $>100,000$. The HEAT study achieved non-inferiority of Kivexa to Truvada in all baseline viral loads with proportion of subjects achieving viral load <50 at week 48 with Kivexa arm 68% to Truvada arm 67%. The ASSERT study showed proportion of subjects achieving viral load <50 at week 48 with Kivexa arm 59% versus Truvada arm 71%.

Conclusion: Following the principals of GRADE, the overall quality of the body of evidence presented in order to make recommendations is low. Only weak recommendations from this review can be made according to the data presented here. These three studies cannot give us conclusive answers as to what drug is more efficacious overall and are inconclusive. However the following recommendations are made. For those with baseline viral loads $>100,000$ copies/mL it is recommended that they do not start on Kivexa. This is in agreement with BHIVA guidelines based on data from the ACTG 5202 study. For those with baseline viral loads $<100,000$ no specific recommendations can be made as there is not enough evidence to suggest difference in efficacy between Kivexa and Truvada.

Abstract P14

My body, my choice: an evaluation of performance arts-based HIV-prevention events for young people in London (UK)

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Background: London has higher than national rates of unplanned pregnancies, sexually transmitted infections and HIV in teenagers. Local World AIDS Day community education and prevention activities in Newham (London) specifically target young people, using a performance arts based approach underpinned by the Information-Motivation-Behavioural skills model of HIV prevention.

Methods: Young people participated in a school-based six week STI/HIV intervention culminating in a theatre production. Participants completed a pre- and post-intervention questionnaire covering HIV-related knowledge, and self-ratings of behavioural skills and motivation around condom use.

Results: Baseline data were collected for 101 participants: 48.5% male, 51.5% female; age range 15–20 years (mean = 17). The largest ethnic group was Black (55.4%), followed by White (19.8%) and Asian (8.9%); 41.6% of participants were sexually active. Post-intervention data has been collected for 44 participants to date: Gender, age and Black ethnic group figures are comparable with pre-intervention group, with smaller White (13.6%) and higher Asian (20.5%) ethnic groups and lower sexually active figure (36.4%). Initial between-group analyses indicate statistically significant higher levels of knowledge and self-rating of behaviour skills and motivation levels following intervention. Knowledge levels statistically significantly correlate with self-ratings of motivation and skill, and sexually active participants had statistically significantly higher scores on self-ratings of motivation and skill. Further analyses will be conducted when additional post-intervention data is collected, including a paired sample analysis.

Conclusions: Initial results suggest that participating in performancebased HIV-prevention activities has a positive impact on levels of HIV-related knowledge, behavioural skills and motivation to use condoms. On collection of final data, implications will be discussed in the light of relevant literature and implications for public health promotion approaches discussed.

Abstract P13

Complicated contexts: providing HIV care in London (UK) to children and families with multiple stressors

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Background: Research has indicated that family coping in the context of HIV reduces when the number of stressors increases. A case note review of families attending an HIV family clinic explored psychological status, social factors and medical concerns faced by families in order to identify factors likely to negatively affect coping.

Methods: A proforma was developed covering demographics, family composition, socio-economic context, disclosure, and parental and child physical and mental health. Medical/psychological files were reviewed. Missing data was identified and information obtained by asking relevant clinicians.

Results: 40/48 paediatric records were reviewed (21 female, 19 male). Age range was 2–18 years, with 72% aged 12+ years. 94% of families were of Black African ethnicity. 72.5% of children had no immigration issues. 67.5% lived with a lone parent (usually mother). Data regarding fathers was unavailable for 50%. Disclosure of HIV status occurred from ages 7–14 years, with the most common ages being 11 and 12 years. 50% of children on ARVs have had adherence difficulties (pill swallowing problems and treatment refusal). 80% of siblings resident in Africa were untested. 40% of parents had had mental health concerns, predominantly depression. 25% of children have had child protection concerns, usually relating to non-adherence and neglect. Over 50% of children had experienced an HIV-related death in their family.

Conclusions: The study highlighted the number and complexity of stressors including factors such as high levels of poor maternal mental health, absence of fathers and HIV related deaths within the family. Other factors such as child adherence difficulties, and family issues such as separation from siblings and children whose HIV status is unknown may also be stressors. Implications for clinical practice are that a more holistic approach to child and family functioning may be required to fully understand the capacity of families to respond effectively to the challenges of HIV management. Further research is indicated to investigate how such stressors interact and impact on young peoples' capacity to cope with their HIV status, adhere to medication and transition through adolescence into adulthood.

Abstract P15

Postexposure prophylaxis after sexual exposure to HIV in four accident and emergency departments in one region

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Background: The British Association of Sexual Health and HIV (BASHH) guidelines suggest that A&E departments should assume responsibility for provision of post-exposure prophylaxis for HIV following sexual exposure (PEPSE) in the UK. This study aimed to describe presentations for PEPSE and their management at four A&E departments in one region of the UK.

Methods: PEPSE presentations were identified by searching all A&E presentations during 2009 for key words or diagnosis categories. Demographic, exposure-related and management-related data were collected by retrospective review of clinical notes (casualty cards). Analysis was descriptive, concentrating on patient assessment and initial management.

Results: Out of a total 391,978 A&E presentations, 18 individuals seeking PEPSE were identified. Median age was 33 (IQR 23,42) years and 67% were male. High risk exposures included unprotected sexual intercourse with a) known HIV-positive partner (nine individuals), b) partner from a high-risk country (two individuals, and c) man who has sex with men (three individuals). Forty four percent (95%CI 19–70%) of individuals were fully assessed for PEPSE, and management was appropriate in 61% (95%CI 36–86%) of cases. PEPSE was overlooked in seven individuals. Overall, eight individuals were offered PEPSE, six of whom accepted treatment.

	All included	PEPSE offered	PEPSE not offered
Guideline: PEPSE recommended	5	4	1
Guideline: PEPSE not recommended	3	0	3
Insufficient history to assess eligibility for PEPSE	10	4	6
Total	18	8	10

Conclusion: Findings suggest low attendance at A&E for PEPSE and that some individuals are not managed appropriately in this setting. Suggestions for improving this service include training to improve staff awareness, development of local protocol, use of a pro forma and better promotion of PEPSE availability in A&E departments. Good communication between A&E departments and GUM services will be integral to guiding and implementing such changes.

Abstract P16

Communication with primary care in a genitourinary medicine clinic HIV cohort

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Background: HIV is unusual in being primarily managed in secondary care. This, along with concerns regarding confidentiality, means traditional communication links between General Practitioners (GPs) and Genitourinary (GU) clinics have not always been formed. Our aim was to assess communication with GPs in a GU clinic against the parameters outlined in the 2007 Standards for HIV Clinical Care.

Methods: A case record review of all HIV-infected patients seen in clinic in the previous 6 months was carried out during June–July 2010. Data was collected on year of diagnosis, HAART treatment status, known AIDS diagnosis, GP registration status, consent to communicate with GP, and communication with GP after last clinical episode. Data was analysed using SPSS v.18 and the Chi-squared test of association.

Results: 295 patients were eligible for inclusion. 63.6% were male, the median age was 43 years (IQR 37–50), and 54.5% of patients were of white ethnicity. 93.5% had a CD4 count of >200 cells/mm³, 88.1% were on HAART and 31% had a diagnosis of AIDS. 47.6% had been diagnosed for less than 5 years. 95.3% were registered with a GP and 82.9% of these had consented to their GP being informed of their diagnosis. Of these, the GP had been sent information on the latest clinical episode in 73.3% of cases. A diagnosis of AIDS and being on HAART were significantly associated with the GP having been informed of an HIV diagnosis ($p=0.02$, $p=0.026$ respectively) and having received correspondence on the most recent clinical episode ($p=0.026$, $p=0.033$ respectively). Females were significantly more likely to be registered with a GP ($p=0.054$). Older patients, those diagnosed for longer, and those with a CD4 count <200 cells/mm³ were more likely to have agreed to their GP being informed and to have had communication sent to their GP on the latest clinical episode. These were not significant. There were no differences in outcomes with ethnicity.

Conclusion: A high proportion of HIV-infected patients were registered with a GP but nearly 1 in 5 of these had not informed their GP of their diagnosis. Improvement can be made in terms of information being sent about latest clinical episode. An older population with a high proportion on HAART may account for good results. Further multi-regression analysis is required as the factors above may be interlinked. A standard letter template has been proposed along with qualitative studies focussing on patients who refuse consent to inform their GP.

Abstract P18

Evaluating HIV services: using focus groups to find out what matters to patients

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Background: The latest White Paper identifies the need for a transparent framework of outcomes in which care providers are required to produce measurable indicators of their activity. Two indicators are concerned with enhancing the quality of life for people with long term conditions and ensuring that patients have a positive experience of care. Within HIV services the latter has also been linked to higher levels of treatment adherence. A previous systematic review assessing patient satisfaction in HIV patients failed to locate a gold standard method of measuring satisfaction in this setting. Patient input and guidance is needed to develop appropriate and reliable measurements.

Methods: Using the themes derived from a previous systematic review as a guide, a qualitative research approach was taken. Patients were invited to take part in one of four focus groups. Face to face recruitment in the HIV clinic produced 32 volunteers, 25 of whom participated. The conversations were digitally recorded transcribed verbatim and analysed for content.

Findings: The rating of physician knowledge and expertise was high and the majority of the patients preferred to see the same consultant at each visit. In contrast the patients did not expect the clinic nurses to have specialist knowledge of HIV but did see them as kind and helpful in the clinic. The patients felt that it was important that they were treated with respect and that they were able to maintain their dignity. The level of perceived autonomy differed – MSM with professional backgrounds appeared to have more autonomy and were more likely to question treatment, whilst some of the Black African participants were more worried that they might be given inappropriate treatment. Communication between professionals and patients was highlighted as an important issue and generally satisfactory, but communication between professionals was seen as variable and sometimes led to inconvenience for patients. The organisation and operation of the clinic prompted mixed reactions.

Conclusions: The findings from the systematic review and focus groups provide common patient derived themes which can be used in the development of questionnaires which will reflect the areas of greatest concern to patients attending HIV services.

Abstract P17

Let's talk about sex: PEPSE and contraception methods – how well informed are our patients?

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Background: According to the 2008 BHIVA, BASHH and FSRH guidelines all HIV-positive individuals should be made aware of, and of how to access, post-exposure prophylaxis following sexual exposure (PEPSE). Additionally, there are recommendations regarding discussion and provision of contraceptive methods in addition to condom use for all HIV positive women. Our survey aimed to investigate how well informed patients are of these issues, and how effective we are as clinicians at providing appropriate information and services.

Methods: A survey was carried out of HIV positive individuals attending routine HIV clinic appointments in an Infectious Diseases unit. Between 12/10/10 to 31/12/10 a total of 306 people (105 women) were recruited, representing a capture rate of 70%. A questionnaire was completed in clinic by the care provider on direct consultation with the patient.

Results: Of all individuals surveyed, 52.9% were aware of PEPSE, of whom 62% had previously discussed it in the clinic, the others gaining their knowledge from other sources. Of those aware of PEPSE 76.5% knew how to access it. We had referred 12.3% partners for PEPSE elsewhere, and dispensed to only 6.8%. 157/306 (51.3%) of all had no current sexual partner, and 65/149 (43.6%) of the sexually active were in concordant relationships. Proportionally more of the discordant couples included in the survey were aware of PEPSE (84.5%), 73.2% of those having discussed in clinic, and 91.5% knowing how to access it. Of the sexually active women surveyed, 27.6% use no contraception other than condoms. Little over 20% had previously discussed contraception of any kind in clinic with only 12% having discussed emergency contraception (EC).

Conclusion: This survey has highlighted that there is very little discussion regarding contraception and EC with women, who are not using the best contraceptive options available, in terms of efficacy and undesirable drug interactions for those on HAART. Only half of the HIV individuals attending clinic in this period were aware of PEPSE, however level of knowledge was good in discordant couples. We have produced a PEPSE patient leaflet to increase awareness and aid discussion between patients and their partners. A dedicated PEPSE clinic may also improve access. It may be beneficial to provide written contraceptive guidance for HIV-positive women, to inform them of safe and effective contraceptive choices.

Abstract P19

Social care coordinator within an HIV clinic: an innovative and popular service

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Background: People living with HIV have complex medical, social, psychological and financial needs which are tightly interlinked and have both direct and indirect health consequences. Unresolved non-medical problems are frequently brought into the clinical environment by patients, many of whom may not have access to, or the wish to use other external sources of help. Since February 2010, a dedicated HIV Social Care Coordinator has been employed to provide integrated HIV social care provision from within an inner London HIV clinic, situated in an area of severe social deprivation.

Aims: 1. To evaluate the first 12 months of the Social Support Service from both service user and provider perspectives. 2. To evaluate service users perceived ability to cope with their social care issues before and after interventions from the service.

Methods: Two anonymous questionnaires were developed, one for health/social care providers (1) and the other for users of the service (2). Questionnaire 1 investigated the effect of the Social Care Support Coordinator on key aspects of their work. It was completed by email and fax. All patients using the service were invited to complete questionnaire 2 by post, telephone or in clinic over a four week period. Respondents were asked to rate the overall value of the social support service.

Results: Questionnaire 1 had an overall response rate of 85% (36/42). 97% (32/33) of respondents stated they were very satisfied with the service. Medical staff identified a reduction in their time now spent on social care needs. 4/4 (100%) Third sector providers reported an increase in uptake of services and in appropriateness of referrals. Initial results from the patient satisfaction questionnaire are positive. Patients report improved health management after accessing the Support Service. Interventions have had a positive impact on their overall needs, with faster, more effective resolution; ease of access and greater coordination of their overall care.

Conclusions: The introduction of the Social Care Coordinator post has had a positive impact for patients and professionals alike. The medical team now report less time being spent on social care, with consultations having a greater focus on the medical management of HIV. Third sector have reported more effective referrals and an increase in access to their services as a result of the new role. Patients report high levels of satisfaction with the service, with an improvement in their social needs as a result.

Abstracts



Abstract P20

Audit of adherence to BHIVA immunization guidelines

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Background: The British HIV Association published guidelines for immunisation of HIV patients. This study is to audit the uptake of immunisations for hepatitis A, B, pneumococcus and influenza vaccinations in our HIV cohort.

Methods: Retrospective case note review of 200 patient attendances in 2009. Information including demographics, CD4 count, and vaccination status were included.

Results: 127 patients were male (64%). The median age was 37 years (range 18–60) with median CD4 432 (range 1 to 1160). 151 (76%) were on antiretroviral therapy. Most patients not immune at baseline for hepatitis A (47/196) were vaccinated (87%). 151/200 (75%) had been vaccinated for pneumococcus with 5 declining and no documentation in 36 cases (18%). 144/200 (72%) had been vaccinated for influenza or advised to attend their GP, with 9 declining and no documentation in 47 (24%) cases. 114 (62%) patients were non immune to hepatitis B at HIV diagnosis and 93 (82%) had completed immunisation of which 65 (70%) were non responders. In the previous year 73/93 (80%) of those vaccinated had a surface antibody test but none had PCR measured. 23/86 (27%) of patients not immune to hepatitis B had yearly core and surface antibody checks with only 3 having PCR measured in the preceding year.

Discussion: Vaccination of hepatitis A, pneumococcus and influenza was nearly universal where it was clinically indicated. Although vaccination rates were high against hepatitis B, surveillance of hepatitis B status, in particular regular surface antibody and PCR testing were not universal. Departmental protocols should be changed to facilitate this.

Abstract P22

Rigorous outcomes evaluation can show impact of health trainers and usefulness of service to clinicians

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Background: Health trainers are non-clinical support staff, working in an increasing number of HIV clinics to support consultants and nurses in helping people self-manage their condition. However, very little solid outcome-focussed data exists to illustrate their usefulness. Working together, a provider NGO and a major HIV funder set out to provide outcomes evaluation to show their impact.

Methods: Health trainers were recruited to work in five regions across the UK with people with HIV (PWHIV) in collaboration with local clinics and using both clinic and self-referral of PWHIV who were newly diagnosed or having difficulties in self-management. A rigorous programme of evaluation was devised with the support of professional management consultants and academic researchers including collection of quantitative outcome data from service users and qualitative views of clinicians. PWHIV outcomes are assessed via a "Lifecheck", which measures progress in pre-defined areas and provides a score showing improvements in knowledge and self-management ability. Regular reports are shared with funders and an Advisory Group of researchers, clinicians and PWHIV. The Lifecheck is completed by the service user with the health trainer and acts initially as a learning tool as well as an evaluation mechanism. Demographic and other data is also collected to enable learning about specific target groups. The programme will be evaluated across three years in order to provide solid evidence of results.

Results: Initial analysis over the first year shows that service users broadly match HPA-provided demographics of the UK HIV population. The Lifecheck questionnaire has evolved to increase sensitivity and robustness. Early outcomes are that, of those showing an improved score, 86% demonstrate increased knowledge of HIV; 59% adopt healthier living practices (more exercise, healthier food, less smoking, alcohol and illegal drug use); 28% increase levels of disclosure to family, friends or professionals and 88% begin to share their experience of living with HIV with other PWHIV. Early indications suggest that baseline knowledge levels and behaviours may vary across the UK. An unplanned outcome of the programme has been a strong cultural shift within the provider organisation towards outcomes evaluation in other areas of work.

Conclusion: With appropriate support and collaboration between funders and providers, outcomes evaluation can be done and can show concrete improvements. However, it is neither short term nor simple and requires funding and commitment from all sides.

Abstract P21

Integral involvement of people with HIV throughout service design improves usefulness and acceptability

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Background: As part of a new programme of services, people with HIV (PWHIV) wanted comprehensive and interactive online information and services to manage HIV as a long term condition. Involvement of PWHIV and acceptability to them was agreed as a key feature for success. **Methods:** PWHIV were integrally involved in all stages and aspects of designing the website, including:

- * The original concept was led by PWHIV in both funding source and service provider
- * Consultation was undertaken with external groups of PWHIV on the concept
- * A national Expert Advisory Group was held including PWHIV to determine key content
- * Web design was managed by PWHIV, informed by focus groups in sites across the UK and reviewed by PWHIV in key user groups
- * Website content was user-edited, reviewed and piloted with key user groups
- * Video/other content was provided by a range of independent PWHIV
- * Of the 50 models used to illustrate issues, at least half were PWHIV and all were people affected by HIV
- * Discussion forums and message boards will be exclusively run and moderated by PWHIV for PWHIV

Result: Many features of the website were developed or changed in response to PWHIV input. These included:

- * Tools for self-management (CD4 tracker, journal for consultation notes)
- * Rigorous use of plain English instead of jargon
- * User-generated star system to evaluate services
- * Clearer explanation of confidentiality and data requirements for registration
- * Pages are tailored to "personas" for key user groups, without exclusion of other PWHIV
- * Evidence for all statements is cited on the page itself

Pre-launch evaluation by further PWHIV shows site contents and style to be highly acceptable. Comments from pilot users included "this is a whole new level of self-management" (white gay man) and "I feel like I've been to an African support group" (African heterosexual man). All information on the site is accredited under the Information Standard. **Conclusion:** Comprehensive user and target group involvement from concept to conclusion can substantially change a service to improve both quality and acceptability.

Abstract P23

Hopes, dreams and ambitions: a qualitative investigation into the views and concerns of older HIV-positive adolescents about their future challenges and support needs

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Background: HIV + young people are living longer and healthier lives. Previous research indicates that living with HIV presents many challenges about self-management at a time of rapid emotional and psychological change and in the context of rapidly changing educational and vocational experiences, the challenges of high adherence and the development of long-term emotional and sexual relationships. This small-scale qualitative study aimed to explore hopes and ambitions, anticipated challenges and support needs with regard to their transition to adulthood with a group of HIV+ young people in London. All participants were of Black African origin and had acquired HIV vertically. **Method:** 5 adolescents (4 female, 1 male; age range 17–19 years) attended a focus group. Questions focused on the impact of HIV status on; school and educational issues, romantic relationships/disclosure of HIV status, work and training. The focus group was facilitated by 2 clinical psychologists. The session was transcribed verbatim and data were compared and analysed for inter-rater reliability, commonly recurring themes and subjected to a thematic analysis. These themes were then collaboratively reviewed and refined in line with existing guidelines. **Results:** The over-arching theme was an increasing awareness and sometimes uncomfortable understanding by participants that HIV suffuses all areas of their lives in complex and unexpected ways. Key subthemes included; ambition for the future (e.g. wish to attend university and/or have a career but anticipating the burdensome aspect of keeping their HIV status secret); building life-skills (e.g. living alone but feeling ill-prepared to manage finances, bills etc); disclosure of status as a lifelong dilemma (e.g. delaying romantic/sexual relationships as a strategy for nondisclosure, anticipating discrimination in the workplace). Themes about support needs were; acknowledging need for on-going support (e.g. from peers, positive adults and professionals) and request for services to adapt to their changing needs (e.g. age-specific group support). **Conclusion:** This focus group had a small number of participants and representativeness of the population of HIV+ young people is not claimed. However, the data suggest that young HIV+ people slowly become aware of the complex implications of living with HIV infection as they grow older. Many of these implications are unwelcome and emphasize the need for them to be as equipped as possible with the skills and tools to self-manage effectively. Clinically, health professionals need to be aware that the personal meanings of HIV infection for this group may be changing very rapidly as they grow older. Professionals can help by being actively curious by enquiring about these changes in order to help their young patients make sense of their feelings and behaviours.

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Abstract P24

Don't forget the children – audit and service innovation

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Background: The consensus document "Don't forget the children" published in 2009 highlighted the issue of untested children at risk of HIV. In our hospital we had been referring children for testing on an individual basis but no formal referral pathways or policy existed. To streamline and improve the testing rates, a multidisciplinary steering group consisting of HIV physicians, paediatricians, health advisors and a HIV specialist nurse was formed. A "look back" exercise was performed to audit the existing testing rates in children and to determine the number of vulnerable untested children living in the UK. We report preliminary results from this project and our referral pathway.

Methods: Clinicians collected information prospectively during routine consultation on all children of HIV positive parents using a standardised proforma. The Children and Young Person's HIV Testing Pathway group devised the referral pathway. Parents who refused to test their children were referred to the health advisor and HIV specialist nurse for additional support and information. These parents were then followed up until the child was tested for HIV.

Results: From a cohort of 600 patients, data from 95 patients is available. 61 (64.2%) were black African, 27 (28.4%) were white, 4 (4.2%) were other and 3 (3.1%) unknown. 52 (54.7%) were women. Of the 43 (45.3%) male patients, 19 (20%) were men who have sex with men (MSM). 69 patients (72.6%) report having 149 children. We have data on 128 children. Overall 61 children (47.6%) are reported as being tested for HIV. 79 children (61.7%) are currently resident in the UK, 43 (33.6%) are abroad and there is no data on 6 children. Among the 79 children resident in the UK, 64 (81%) are less than 18 years old and among them 51 (64.6%) were tested. In this group there are 3 HIV positive children. 13 (16.5%) children in the UK <18yrs old have not been tested for HIV.

Conclusion: So far we have identified 13 untested children living in this country who need HIV testing and have tested 51 children. We have set up the Children and Young Person's HIV Testing pathway Group and developed robust referral pathways to ensure these children get tested and their families are supported through this difficult process.

Abstract P25

Safe conception: an audit of advice and methods used by HIV-positive women

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Introduction: HAART has greatly improved morbidity, mortality and quality of life for patients infected with HIV. Parenting has therefore become a realistic option for such individuals. BHIVA guidelines 2008 recommend that HIV services should provide clear pathways for advice and support around conception, pregnancy and fertility issues. Our centre offers a dedicated women's health clinic to provide pre-conception advice and contraception. An audit was performed to see whether HIV positive women were receiving pre-conception advice particularly in regard to safe conception.

Methods: Retrospective case note review of all new pregnancies referred to antenatal clinic (ANC) during 2009 and 2010.

Results: A total of 67 pregnancies in 64 women were identified. 56/64 women were known to be HIV-infected prior to conception, with 8 women diagnosed during antenatal screening. Of 59 pregnancies in 56 known positive women, 51 case notes were obtained. 77% of women were Black African, median age was 38. Partner status was documented in 47/51 cases. 18/51 (35%) had a positive partner. 17/51 (33%) had a negative partner and 12/51 (24%) had a partner of unknown HIV status. 25/51 (49%) pregnancies were planned; 14/51 (27%) were unplanned; in 12 cases this was unclear. In those with planned pregnancies, the majority (19/25, 76%) had received pre-conception advice. Of those women whose pregnancies were unplanned only 1/14 (7%) had received such advice. In concordant relationships, 11/18 (61%) conceived by regular unprotected intercourse (UPI). In discordant couples most (59%) conceive by self insemination. Where partner status is unknown, condom failure is the most common reported conception method (42%). In 16/51 (31%) case notes, method of conception was not documented.

Conclusion: The majority of women attending ANC are known to be HIV positive prior to conception which is a continued shift seen in the UK since 2005. The majority of women with HIV negative partners received advice and used self insemination to conceive. Those who do not know their partner's status are most likely to report condom failure. A significant proportion of pregnancies were unplanned suggesting we are not meeting these women's contraceptive needs. In many cases partner status and method of conception is not discussed and this represents a missed opportunity to identify at-risk partners.

Abstract P26

Efavirenz discontinuation in a UK HIV clinic cohort: later rather than sooner?

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Background: Current BHIVA guidelines recommend efavirenz (EFV) based regimens as first line therapy for HIV infected adults. Central nervous system (CNS) side effects on EFV are common and tend to resolve in 4–6 weeks of starting EFV; a minority of patients may have persistent symptoms resulting in switching off the drug. Patients also switch off EFV for other reasons including virological failure and non-CNS toxicity. This study aims to describe the timing and reasons for discontinuation of EFV in a clinical cohort.

Methods: Retrospective database analysis of all patients starting EFV as part of their first regimen from 1 Jan 1999 to 21 Dec 2010 was performed. Demographic details, HIV surrogate markers and information on EFV discontinuation were extracted from our prospectively collected database.

Results: 475 patients (425 male) started EFV as part of their first regimen; median CD4 count and viral load at starting ART were 265 cells/mm³ (IQR 243–278) and 16466 copies/ml, respectively. 186 (39%) discontinued EFV. The reasons were: CNS disturbances 74(40%) virological failure 27(15%) rash 5(3%), non-CNS toxicity 30(16%), clinical trial 14(7.5%), planned pregnancy 3(2%) and other reasons 33(17%). Median time to EFV discontinuation for all reasons was 365 days (IQR 134–729) and the discontinuation rate was highest between 0–12 weeks (41(22%) of all discontinuations) and between 1–2 years (62(33%) of all discontinuations). Most patients who experienced virological failure had been on EFV for at least 1 year. Five patients developed a rash and discontinued EFV within 14 days. The table below illustrates the rate of EFV switch due to CNS toxicity; 3% of these were after more than 4 years on EFV. There was no difference in discontinuation rates (overall or for CNS toxicity) across ethnic groups.

Time to switch	0–2 wks	>2–6 wks	>6–12 wks	>12wks – 1yr	>1–2 yrs	2–4 yrs	>4 yrs
Number (%)	4 (5%)	5 (7%)	8 (11%)	27 (36%)	15 (20%)	17 (18%)	2 (3%)

Conclusions: EFV discontinuation shows a bimodal distribution with the highest discontinuation rate in between 0–12 weeks and 1–2 years. Patients discontinue EFV for CNS toxicity up to 4 years after starting the drug. This highlights the importance of discussing CNS toxicity, even in patients established on EFV-based therapy.

Abstract P27

Gathering evidence for expanding HIV testing in England: an overview of eight pilot projects

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Background: Prevention of late diagnosis is key to improving health outcomes for HIV-infected individuals and may have an important public health impact. Therefore opportunities for individuals to test for HIV should be maximised. In 2008, the Department of Health funded eight pilot projects to assess the feasibility and acceptability of expanding HIV testing. We present an interim review of the results from these pilots.

Methods: Routine offer of an HIV test was piloted in hospital services (three projects, all included acute care units, one also included an emergency department, an outpatient service and a single general practice) and primary care (two projects involving 18 and 10 general practices respectively). Targeted HIV testing was piloted in community settings (three projects targeting either black African or gay communities). Standard indicators, including uptake of testing and seropositivity, were used to assess the success of pilots.

Results: Of 10,478 tests performed 50 individuals were newly diagnosed with HIV – a positivity rate of 0.5% (95% confidence interval 0.4–0.6%). In four of the five hospital settings, overall uptake of HIV testing was 71% (4,523/6,413), ranging from 61% to 91% in the different services. In primary care, uptake was estimated at 65% (4,310/6,664), ranging from 62% to 75% in the different projects. Fewer tests were conducted in the community (59–305). In hospital services seropositivity was 0.4% (ranging from 0 to 1%) and in primary care it was 0.5% (ranging from 0 to 0.7%). Higher seropositivity was seen in community settings: 1.2% overall, ranging from 0 to 2.1%. In one community setting, one primary care and one hospital setting (a dermatology service) no new diagnoses were made. Between 67% and 100% of newly diagnosed patients were successfully transferred to care. High levels of patient acceptability (>90%) were reported in all settings where measured.

Conclusions: The high number of tests offered and accepted indicate that routine HIV testing in healthcare settings is feasible and acceptable to staff and patients. This strategy was effective in diagnosing persons previously unaware of their HIV infection. The high seropositivity seen in community settings indicates that these testing in these should be further explored. Expanding HIV testing in healthcare settings should be prioritised in areas of high diagnosed prevalence.

Abstracts



Abstract P28

Routine HIV testing in the colposcopy clinic – acceptable and sustainable

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Background: The HIV in Europe initiative seeks to provide an evidence base for indicator disease-based HIV testing. Patients presenting with one of eight HIV indicator diseases are routinely offered an HIV test, measuring the point prevalence of previously undiagnosed HIV infection. As part of this multi-site survey, we established a service of routine HIV testing in the Colposcopy Clinic of a busy teaching hospital, offering an HIV test to all women presenting with any degree of cervical dysplasia. We report our experience to date.

Methods: All new and follow-up patients attending the Colposcopy service, not known to have HIV infection, were offered an oral-fluid based HIV test. The test was offered by medical staff, specialist nurses and healthcare assistants, all of whom had undergone focused training. Results governance was handled by the local GU service. All patients received their HIV test result, most commonly via SMS. Any patient with a reactive screening test was telephoned and asked to attend the local GU clinic for assessment.

Results: To date, there have been 528 attendances pertaining to 517 individuals. The mean age of attendees was 34 (range 21–70) and 61% of patients were white. There were 11 attendances from known HIVpositive patients. 418 patients were offered an HIV test (offer rate: 83%) and 298 accepted the offer (test uptake: 71%). All HIV test results to date have been negative. 91% of women accepting an HIV test had cytological or histological evidence of cervical dysplasia. Women offered a test did not vary significantly from women not offered a test by age, ethnicity or referral diagnosis. Women accepting an HIV test did not differ by age or ethnicity from those declining. The test offer rate between providers varied considerably (range: 48 – 100%) as did test uptake (46 – 82%).

Conclusion: HIV testing in the Colposcopy Clinic appears feasible and acceptable, with generally high overall offer and uptake rates. There is no evidence of targeted testing, but offer and uptake rates differ considerably between colposcopists. This may be due to underlying beliefs or anxieties about the merits or utility of routine HIV testing in this setting. Addressing this issue is central to the establishment of sustainable testing services. Feedback from the colposcopists, however, suggests that the addition of routine HIV testing has had a negligible impact upon the operation of clinics, and should be sustainable in the long term.

Abstract P30

Views on home testing for HIV from target audiences and people with HIV (PWHIV)

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Background: Home testing for HIV is currently illegal in the UK and kits illegally available on the internet are unregulated and often unreliable. Previous research suggests that 0.5% of gay men had used a home testing kit despite this and just under 6% would prefer to test in this way in future. Reliable home testing technology will shortly become available and approved in the US. An NGO in the UK solicited views from its membership and others with an existing interest in HIV about home testing.

Method: A Survey Monkey questionnaire was devised and piloted with key audiences. The survey was advertised via newsletters, Facebook, Twitter and other online media. Respondents were asked a small amount of demographic data and a range of questions about the acceptability and usefulness, or otherwise, of home testing for HIV. A comments section was included for free text responses. Data was analysed and a full analysis report is available.

Results: In all, 654 people responded of whom 337 (52%) were gay men and 167 (26%) were HIV positive. 64% of HIV positive respondents believed home testing should be legalised and regulated, compared to 77% of those whose last test was negative. 62% of negative respondents overall said they would consider using home testing kits if they were legally available and 51% of negative respondents said they thought they would test more often for HIV if home kits were legally available. 35% of people diagnosed with HIV thought they would have been diagnosed earlier if home testing had been available and this rose to 44% of those diagnosed with CD4 <350. Of the 47% of gay men who last tested negative or had never tested, 3% had used an illegal home testing kit, 65% would consider using home testing if it were legally available and 60% thought they would test more often. While a majority of comments supported legalisation of home testing, a considerable minority did not. These comments most commonly expressed concern about levels of support available with home testing and a strong desire for proper regulation should it occur. Those in favour cited patient choice, convenience and increased access but many also supported regulation.

Conclusion: If legalised in the UK, home testing could be an acceptable choice for many individuals and could increase testing behaviours and reduce late diagnosis. However, proper regulation is seen as vital by many.

Abstract P29

The UK national guidelines for HIV testing: lessons from one general practice

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Background: There is currently little evidence concerning the level to which the BHIVA UK national guidelines for HIV testing have been incorporated into primary care, or the practical barriers faced when attempting to increase HIV testing in this setting. This study aimed to assess the feasibility of implementing the BHIVA guidelines in one routine general practice, and to measure adherence.

Methods: Cases of indicator disease presentation in adults during sample period 1st Jan 2009 – 31st June 2009 were identified by searching read-codes on practice EMIS software. Data collection was by retrospective manual review of patient notes. Demographic and presentation-related variables were collected, with primary outcome 'HIV test considered or done within 3 months of presentation'. Feasibility of implementing the BHIVA guidelines was assessed by the primary researcher.

Results: 148 indicator disease presentations were identified, and estimated incidence was 32.54 per 1000 adult patients per year (95%CI = 27.30–37.79). The most common indicator diseases were 'any sexually transmitted infection' (40 individuals), and 'bacterial pneumonia' (35 individuals). Overall adherence to BHIVA guidelines was 16% (95%CI=11–23%), and this was lowest for indicator diseases diagnosed outside general practice.

Conclusion: Low adherence indicates missed opportunities for HIV testing in the practice studied. Potential difficulties in applying the guidelines in this setting include difficulty defining and identifying indicator disease presentations, lack of communication between primary and secondary care, and unawareness of local as well as national guidance on HIV testing among GPs. The BHIVA guidelines could be adapted or revised for use in primary care.

Abstract P31

Where do we diagnose HIV? Monitoring new diagnoses made in non-traditional settings

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Background: The 2008 BHIVA guidelines recommend that HIV testing should be routinely offered in a variety of medical settings in order to diagnose HIV infection early and to provide appropriate treatment. Little is known about diagnoses made in such settings in the UK and the impact of expanded testing on late diagnosis.

Methods: National surveillance data of newly HIV diagnosed adults (aged 15+ years) for the years 2006 – 2009 with a testing facility reported were analysed. Where available, CD4 count within 91 days of diagnosis was used to determine late diagnosis.

Results: From 2006 to 2009, 28,343 individuals were diagnosed with HIV, and 72% (20,645) had a place of diagnosis reported. 73% of new diagnoses were made in sexual health (STI) clinics, 6.5% in antenatal, 6.5% in GPs, 5.0% in medical admissions or A&E (MA/A&E), 4.7% in infectious disease units, and 2.1% in outpatient services (such as tuberculosis, TOP, haematology, and infertility). Late diagnosis (<350) ranged from 52% in STI clinics to 85% in MA/A&E. Very late diagnosis (CD4<200) was most common in MA/A&E (73%), followed by infectious disease units (51%), outpatient services (44%), GP (38%), GUM (29%) and antenatal (22%). Non-pregnant women were significantly more likely than men to be diagnosed by GP, outpatient services, or infectious disease units possibly reflecting health care seeking behaviour. Black Africans were significantly more likely to be diagnosed by GP or infectious disease units compared to other ethnicities. After STI clinics, older adults (>50 yrs) were most frequently diagnosed in MA/A&E (9.7%). Over the four years, STI clinics remained the main source of new HIV diagnoses. However, as a proportion, new diagnoses from STI clinics decreased, while diagnoses by GPs rose from 5.3% to 8.4% (p<0.001). From MA/A&E, diagnoses rose from 4.1% to 6.5% (p<0.001) and outpatient diagnoses rose from 1.7% to 2.9% (p<0.001). No significant variation was seen between rates of late diagnosis by setting over the time period.

Conclusion: HIV diagnoses made outside STI clinics has increased alongside changes in testing recommendations. Given high rates of late and very late diagnosis outside the STI clinic setting, efforts must be maintained to continue expanding testing outside traditional settings. Close monitoring and evaluation of where new HIV diagnoses are made will guide future recommendations and implementation.

Abstract P32

Are we routinely screening for mental health problems in HIV-infected people at baseline? A study from a district general hospital in the UK

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Background: The effect of mental health problems on the management of HIV is multifaceted; also, cellular and molecular changes that occur in depression are similar to the brain changes associated with HIV infection. We aimed a study to assess the prevalence of mental health problems in our HIV positive patients.

Methodology: All HIV positive patients who attended over a two week period, total of 110 were included in the study. A self administered, validated questionnaire was used to collect information and analysed by using SPSS statistical program.

Results: Prevalence of any mental health problem among HIV infected people attending for care is 63%; depression 40%; anxiety 49% and post traumatic stress disorder (PTSD) 35%. None of them were abusing substances. Prevalence of mental health problems were significantly higher in women 65.6% than in men 59% ($P < 0.05$) and women suffer with more complex mental health issues and PTSD than men. Mental health problems are more common among people with HIV at either end of the age spectrum. Of the 10% of the sample population < 25 yrs of age and > 56 years – 100% reported some sort of mental health problem.

Discussion: A high rate of co morbidity of mental health problems and HIV exists. In the United States, the prevalence of depression in the HIVinfected population is significantly higher 36%, compared to 7.6% in the general population, whereas in our study population 40% reported depressive symptoms. Maximizing the efficacy of HIV management in these individuals should start at the initial evaluation; regular evaluation of both the HIV and mental health treatment plans will provide patients with optimal care and enhance the quality of life.

Conclusion: Around two thirds of people living with HIV are experiencing mental health problems; particularly, women and people at either end of the age spectrum. We recommend that all newly diagnosed HIV patients should have a mental health assessment at baseline and yearly thereafter.

Abstract P33

Psychology service evaluation in a clinic for young people (over 16 years) living with HIV and transitioning to adult care

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Background: There is little published data on the psychological outcomes for young people with perinatally acquired HIV transitioning to adult services. The dedicated transition service established in 2005 is based on a multidisciplinary team approach with psychology integral to the service providing direct clinical work and contributing to patient management and research.

Methods: Psychology case notes for the years 2008–2010 were reviewed to determine the demographics, rates of referral, presenting problems and outcomes for the client group. These were checked against the clinic's database of all clients who attended clinic during that period.

Results: There were 63 perinatally infected young people attending the clinic during this period. Of these 40 were female and 23 male with ages ranging from 16 to 25 (median 18y). The ethnicity of the group comprised 84% black/african, 13% white/european and 3% asian. In this cohort, 54% were identified as having clinically significant psychological issues (22 female, 13 male). Of these, 18 female and 8 male clients have had direct psychology intervention and 9 more were referred but declined to take up the service. Males were more likely to decline psychology (38% vs 18%, $p < .01$). The most common primary presenting problems included; mood (58%), anxiety (21%), adherence (8%) and disclosure/ relationships (8%). However, the majority presented with multiple issues (e.g. mood and adherence problems) and a significant number reported body image concerns of whom 5 have been referred for plastic surgery to treat lipodystrophy. 17 clients (27%) were considered to have complex needs. This included 5 (3 female, 2 male) who have self-harmed, 4 of whom required hospital admission and 8 clients have been prescribed psychotropic medication (13%). Four clients were referred for neuropsychological testing due to concerns about the impact of neurocognitive impairment on their functioning.

Conclusion: This client population have a high level of psychological support needs due to the difficulties faced negotiating late adolescence in the context of HIV. As a result of the evaluation it was decided to implement an annual review of all clients attending the service using the SF-12v2 and CORE (with additional body image items) to improve monitoring and management of these needs.

Abstract P34

Sexual and reproductive health in adults perinatally infected with HIV: audit of a single centre cohort

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Background: Increasing numbers of adolescents with perinatally acquired HIV-1 (PaHIV) infection are entering adulthood but as yet there is little published UK data describing their sexual and reproductive health.

Methods: Retrospective case note audit of young adults aged 16–25 yrs with PaHIV attending a transition clinic from January 2005–11. Data collected: reported sexual behaviour; sexually transmitted infections (STIs); pregnancy; contraception; cervical cytology; hepatitis B vaccination and serological response.

Results: 51 patients, 31 (61%) female, 40 (78%) black African, median age at last consultation 20yrs (IQR 18–21) were identified. Median age transfer from paediatric services 17yrs. 24 (77%) female and 13 (62%) male patients had reported being sexually active. Median age coitarche was 16yrs (IQR 14–18) for females and 16yrs (IQR 15–17) for males. Median number of lifetime sexual partners was 3.5 (IQR 1.5–5.5, range 1–40). 5 reported non-consensual sex (4 females, 1 male). 13 (100%) and 20 (83%) sexually active males and females respectively had a STI screen (4 declined); median age 1st screen 18yrs. 7 STIs were diagnosed: human papilloma virus (HPV) (4); chlamydia trachomatis (2); genital herpes simplex (1). 11 pregnancies occurred in 8 patients, resulting in 6 live births, 4 elective terminations and 1 miscarriage. Median age of 1st pregnancy 18yrs (IQR 17–20). 1 male aged 20 fathered a child. 22/24 (92%) of females reported condom use at last sexual intercourse. Exceptions: non-consensual sex (1); patient with IUD, partner aware (1). 7 (29%) were using a long-acting form of contraception at the time of audit. 18/24 (75%) females had had a cervical smear. Median age of 1st smear 19.5 yrs (IQR 18–20), median interval from coitarche to 1st smear 2 yrs (IQR 1–5). 5 abnormalities: borderline cytological changes and HPV (4) and cervical intraepithelial neoplasia grade 1 (1). 51/51 patients had baseline hepatitis B serology: 3 had known hepatitis B co-infection. 38/51 (75%) accepted vaccination. 13/20 (65%) completing the vaccination course achieved satisfactory hepatitis B surface antibody titres > 100 mIU/ml.

Conclusion: Median age of coitarche occurred in paediatric care. The STIs and cervical smear abnormalities found in this cohort highlight the importance of sexual behaviour in the health of young adults with PaHIV. The hepatitis B vaccination response rate raises the possibility that those with PaHIV should be vaccinated whilst in paediatric care.

Abstract P35

Over 50 Clinic: how to assess for neurocognitive disorders?

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Background: A HIV older population is more likely to have comorbidities, polypharmacy, HIV-associated neurocognitive disorders, and social issues (such as isolation and financial difficulty) contributing to increased anxiety and depression. We introduced a clinical service dedicated to those aged over 50 two years ago, and have now introduced formal psychological and neurocognitive assessments to further assess symptomatic individuals and optimize referral pathways.

Methods: Following multi-disciplinary-team meetings with psychologists, psychiatrists, neurologists and HIV specialists, a FLOWCHART has been agreed. This involves: i) GAD7, a simple questionnaire (10 minute) used for screening and grading of generalised anxiety disorder; followed by referral to psychology with a score > 10 ; ii) PHQ9, a 10 minute questionnaire to score all DSM-IV criteria for depression. PHQ9 should be repeated six months later if scored > 5 , referrals psychology if > 10 and to psychiatry to consider pharmacotherapy if > 15 should follow; iii) questioning regarding concerns on memory, attention, cognition and whether others have noticed any changes in such functions; iv) in case of a positive answer, the "Everyday Memory Questionnaire" (EMQ) is then administered as a subjective measure of memory failure in daily life; v) International HIV Dementia Scale (IHDS). If either are abnormal, the patient is referred to psychology, however if both are abnormal, they receive a full neuropsychometric test (vi) that requires 4 to 6 hours to perform.

Results: Fourteen HIV-infected males were seen in the Over50 Clinic between September and December 2010. All were administered GAD7 and PHQ9 questionnaires and 11 were also administered EMQ and IHDS, as provided positive answers to having concerns regarding memory, attention, and cognition. Two had a > 10 score with GAD7 and were referred to psychology, 3 had a score > 10 with PHQ9 and were referred to psychology, 3 men with borderline scores between 5–10 were also referred to psychology. EMQ scores were impaired in 2 and IHDS scores were low (< 12) in 5. Two were referred for neuropsychometric testing and a brain MRI was requested in 3.

Conclusions: Excluding anxiety and depression when testing for HIV-associated neurocognitive disorders in individuals over 50 years of age is important, as mental slowing, memory loss, and motor disorders are common manifestation of these disturbances.

Abstract P36

Screening for mental health problems in HIV using the Client Diagnostic Questionnaire (CDQ)

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Background: HIV infection is associated with high rates of mental health problems that may go unrecognised resulting in increased morbidity. The Client Diagnostic Questionnaire (CDQ) screening tool has been validated in ethnically diverse HIV+ populations in the USA. It can be administered by staff who are not mental health specialists so could be a useful screening tool to identify mental health problems in those living with HIV. We describe the use of the CDQ in a busy, diverse inner-city HIV service.

Method: The CDQ was administered by a team of health advisors under supervision of a clinical psychologist. The sample population was all newly diagnosed HIV patients attending the HIV service in an inner city hospital between January 2010 and September 2010. Appropriate onward care was provided through a stepped-care model for mental health. Demographic data, CDQ results, onward referral patterns and diagnostic outcomes were collected prospectively.

Results: Between January and September 2010, 73 people (38 men, 35 women) diagnosed with HIV in the preceding 10 months attended the HIV clinic, of whom 36 (49%) were screened using the CDQ. 23 were men and 13 women, mean age 37 (range 19–56 years). 23 were of Black (or mixed race) ethnicity and 13 were White. 18 (23%) patients were not screened: lost to follow-up (6), transferred care to another centre (1), existing mental health service users (4), antenatal patients (5), DNA (2). For 19 (26%) the CDQ assessment is pending. 23/36 (64%) of those screened were identified as having one or more mental health problem while 13 (36%) screened negative. 13 patients screened positive for Major Depressive Disorder, 11 for Generalised Anxiety Disorder, 5 for Panic Disorder, 8 for alcohol misuse and 9 for drug misuse in the past 6 months. Of the 23 patients who screened positive, 17 (74%) were confirmed through assessment by psychiatrist or clinical psychologist, 4 are awaiting further assessment and 2 refused further assessment. There were no false positive screens.

Conclusion: In this newly diagnosed population the overall rate of positive screens was 64% with the majority confirmed as having mental illness. The CDQ is an accurate and appropriate screening tool for mental health problems in this population which facilitates speedy referral to mental health services. We postulate that this is likely to improve engagement with HIV related care. Minor modifications may make the CDQ more user-friendly and reliable.

Abstract P38

Testing for sexually transmissible infections in patients with HIV infection: what are we missing?

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Background: Sexually transmissible infections (STIs) are known to increase the transmission of HIV infection. Recent outbreaks of STIs among HIV infected groups led to the development of UK sexual health testing guidelines. These recommend 3-monthly syphilis and annual STI screening.

Methods: A retrospective chart review of two consultant cohorts was carried out to ascertain compliance with these guidelines. Data collected included: number of years diagnosed, probable mode of acquisition, current viral load, current use of antiretroviral medication, and frequency of testing for syphilis, hepatitis, chlamydia and gonorrhoea in the past 5 years or since diagnosis.

Results: 205 patients were included in the analysis: 165 (80%) male (of these 76% MSM). Median age was 41 yrs (range 17–71 yrs). 71% were diagnosed with HIV or transferred to our unit in the past 3 years. 65% are currently taking antiretroviral therapy. Rate of 3-monthly syphilis testing increased from 1.5% in 2006 to 14.5% in 2010. All infections diagnosed were in MSM. 12 had several episodes of infection.

STI	% of eligible patients tested at least annually					Incidence of infection
	2010	2009	2008	2007	2006	
Syphilis	75	63	53	37	18	5.5%
HBV	71	61	49	41	15	1.5%
HCV	72	61	50	42	13	1.3%
Chlamydia urethra/cervix	47	45	34	30	18	6.3%
Gonorrhoea urethra/cervix	36	35	30	23	19	3.2%
Chlamydia rectal	47	37	36	31	21	17.9%
Gonorrhoea rectal	43	33	32	24	2	3%

Discussion: Testing for STI has significantly increased in the past 5 years, but 3-monthly testing remains at a low level. Is this target relevant to all our patients? The incidence of STI in MSM with HIV infection is high in those who have been tested. We aim to set up a nurse-led clinic to improve routine screening in our cohort.

Abstract P37

The prevalence of vitamin D deficiency in HIV-positive patients in the West Midlands

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Background: Vitamin D has been shown to have immunoregulatory properties in addition to its role in bone metabolism. Therefore, identification and treatment of vitamin D deficiency may be an important aspect of HIV management. The predominant source of vitamin D is sun exposure, which depends on seasonal, geographical, social and cultural factors. The aim of this cross sectional study was to investigate the prevalence of Vitamin D deficiency amongst HIV positive patients in a West Midlands HIV centre during the summer of 2010.

Methods: All HIV patients who had their vitamin D level assessed for the first time between June 2010 and August 2010 were included. The following information was extracted: age, sex, ethnicity, duration of HIV, CD4 count, HIV viral load, calcium, phosphate, alkaline phosphatase, haemoglobin, eGFR and the duration of HAART where applicable. A normal vitamin D was defined as >50nmol/l. SPSS package was used for statistical analysis.

Results: 204 patients with median age of 38 (33–45) years had their vitamin D level assessed, 120 (59%) were female and 162 (79.5%) were non-white. They had a median CD4 count of 483 (37–613) cells/mm³. Their median duration of HIV diagnosis was 36 (16–60) months and 182 patients were on ART. Median vitamin D level was 37 (28.25–50) nmol/l. Sub-normal vitamin D levels were detected amongst 151 (74%). On linear regression analysis, non white ethnicity was significantly associated with sub-normal vitamin D levels [HR=0.505 (95%CI 0.062–0.948) P=0.026], whilst the duration of HIV was inversely correlated with subnormal vitamin D levels [HR=0.005 (95%CI 0.01 – 0.001) P=0.015]. There was no association found between sub-normal vitamin D levels and age, sex, CD4 count, alkaline phosphatase level, calcium, haemoglobin, eGFR, or use of ART.

Conclusion: A significant proportion of non-white ethnicity patients had sub-normal vitamin D levels even during the summer period. Additionally, vitamin D levels were found to be significantly lower at an early stage of the diagnosis. Routine screening of vitamin D may be helpful in all newly diagnosed non-white HIV patients.

Abstract P39

Research shows a majority of HIV-affected children in the UK live in poverty

B James¹, C Velasquez¹ and P Bravo²

¹Children with AIDS Charity, London, UK and ²Cardiff University, Cardiff, UK

Background: Children With AIDS Charity (CWAC) gives small grants to HIV affected families living under a certain financial threshold. The charity conducted a research study in order to obtain a profile of the situation of HIV affected children living today in the UK, with a specific focus on their economic circumstances. No comprehensive study has been done for 15 years and no reliable figures on HIV affected children were available.

Methods: CWAC collected data nationally from 75 of their referring agencies representing 3,200 HIV affected households and approximately 4,000 HIV affected children. A questionnaire survey mapped all aspects of the circumstances of families and children focusing on their material situations, such as income, accommodation, or the children's unfulfilled needs. CWAC was also able to draw from its annual client survey which informs on the purpose of the grants delivered.

Results: The research shows 92% of heads of households are unemployed, 70% of households live on benefits, 20% of these families have no income. This is due to more than 50% have insecure immigration status. Immigration status is the first reason these families encounter in accessing basic services, 14% of them have no access to healthcare and 44% have no access to childcare services. As a result, HIV affected families predominantly face difficult living conditions, with 9% of them being homeless and 22% living in an accommodation presenting hygiene issues.

Conclusion: Poverty has many trickledown effects on children. It affects in the short and long terms their physical and mental health conditions as well as their educational achievements. This research shows that funding available for families should be scaled up, as services on offer. Data on these children should be systematically collected to improve service delivery as well as public awareness and advocacy.

Abstract P40

Non-means-tested provision of formula feed to help prevent HIV transmission

M Dawson¹, H Green¹, C Gatford¹, J Moore² and A Apoola¹

¹Derby Hospitals NHS Foundation trust, Derby, UK and ²Derby Positive Support Group, Derby, UK

Introduction: Breast feeding is currently not recommended by the guidelines for HIV positive mothers delivering in the UK where formula feeds are easily available. No provision is made however for the financial capabilities of the families who are HIV infected to help with buying formula milk. HIV-positive women delivering babies in the 2 general hospitals in the county providing care were offered free formula milk funded by the local community support group for a period of 1 year. The milk provision was not means tested.

Methods: The uptake of free milk and the associated costs of this were assessed between October 2008 and January 2011. We also analysed whether free provision of milk from the local support group would be taken up by all mothers delivering within this time period. Results: There were 23 deliveries in the time period analysed with 21 women taking up the provision of formula feed. The average uptake of feed was 28 tins of milk (range 3–56). The mean cost per patient was £220 (range £43–£403). The 2 women refusing the free milk provision did this because of distance from the support group and stigma. There was no case of HIV transmission.

Conclusion: BHIVA/CHIVA continue to recommend that, in the UK, mothers known to be HIV infected, regardless of maternal viral load and antiretroviral therapy, refrain from breastfeeding from birth. Most of the mothers were on a low income and would have had some difficulty funding formula feed. Provision of formula feed in a non-means tested way may help to avoid partial breast feeding and the risk of HIV transmission.

Abstract P41

Patients' willingness to switch from a single-tablet regimen (STR) to individual drugs as part of a potential cost-saving strategy

L Baber, S Sonecha, S Mandalia, M Bower, B Gazzard and M Nelson
Chelsea and Westminster Hospital, London, UK

Background: Given the current economic climate methods to reduce costs whilst maintaining a high quality service must be developed. Lamivudine will soon become generic and one such strategy would be to switch patients taking Atripla as one pill once a day to three separate drugs, which could incur significant cost saving. We investigated patients' willingness to switch, the impact patients feel that a one pill once a day ARV regimen has on their adherence, and the variables that influence these two factors.

Method: Patients taking Atripla for at least three months with an undetectable viral load were asked to complete an anonymous survey recording the total number of pills and number of times a day they took them. They also marked on a non-hatched visual analogue scale their willingness to switch from a one pill once a day regimen to three pills once a day, and to rate the importance of having one pill once a day to their adherence. The investigator measured the mark on the line to the nearest 10mm increment to give a value from 0 to 10. A Mann-Whitney U test was used to determine any statistical difference.

Results: 154 patients completed the questionnaire, median age was 43, and 137 (89%) were Male. 93 (60.4%) were taking only Atripla and 127 patients (82.5%) were taking a once daily regimen. The median score for the importance of taking one pill once a day to patients adherence was 1 (0=very important, 10=not important) and this was not related to gender, age, total number of pills taken a day or the number of times a day they took medication. The median score for patients willingness to switch was 2 (0=unwilling, 10=very willing). Willingness to switch Atripla to three separate pills once a day was higher in Males (3.4 v 2.4 p=non-significant), in patients older than 43 (3.8 v 2.7 p=0.047), in patients taking two tablets or more a day as opposed to one tablet (4.1 v 2.7 p=0.016) and in those taking medication more than twice a day (4.1 v 3.1 p=non significant). Unwillingness to switch was strongly correlated with increased importance to the patient of one tablet once a day to aid adherence (p<0.001).

Conclusion: Atripla is the first choice treatment in many centres. A large proportion of patients receive medications other than Atripla. The majority of patients expressed an unwillingness to switch from Atripla and an individualized approach to such a strategy would appear to be needed.

Abstract P42

Pre-exposure prophylaxis: a risk-reduction strategy for serodiscordant couples wishing to conceive

E Rutland¹, A Blume² and R Mani²

¹Western Sussex Hospitals NHS Trust, Chichester, UK and
²Portsmouth Hospitals NHS Trust, Portsmouth, UK

Background: The most effective HIV transmission risk reduction strategy for HIV discordant couples wishing to conceive a child in the UK involves sperm washing. This method is however costly and funding is often refused by Primary Care Trusts. Many patients choose to conceive through timed unprotected sexual intercourse (UPSI) when the uninfected partner has an undetectable viral load. Increasingly pre-exposure prophylaxis (PrEP) is being used as a further risk reduction strategy in these patients, however large trial data on the safety and efficacy of intermittent PrEP is currently unavailable.

Methods: This HIV discordant couple (Mr & Mrs X) were referred for sperm washing but were refused funding. They decided to try timed UPSI and requested PrEP. Mr X was diagnosed with HIV infection in 2004 and remained asymptomatic with a CD4 count of 500 cells/ul. HIV genotyping demonstrated no resistance. To reduce the risk of transmission he started Truvada/Atazanavir/Ritonavir. Baseline fertility investigations in Mrs X were normal (follicular and luteal phase hormone profiles, pelvic ultrasound scan and hysterosalpingogram) as was full STI screening in both partners (microscopy, Chlamydia Trachomatis and Neisseria Gonorrhoea DNA). Once Mr X had an undetectable HIV serum viral load for over 3 months, they commenced timed UPSI. Mrs X used urine ovulation predictor tests twice daily to measure Luteinising Hormone (LH) peak and PrEP with 1 Truvada tablet at LH surge repeated 24 hours later (36 and 12 hours before intercourse). She also used topical vaginal oestrogen cream to reduce microtrauma during SI. A 4th generation HIV Ag/Ab test was performed prior to each cycle.

Summary of Results: Mrs X became pregnant on the 4th cycle and is negative for HIV infection (negative 4th generation Ag/Ab test at 3/12). They have been consistently using condoms for SI since the last PrEP cycle. She tolerated the medication without side effects and urinalysis and renal biochemistry remained normal throughout. The 20/40 detailed anomaly scan was normal.

Conclusions: Large phase III trial data on PrEP will not be available until 2012/13 and phase II data on intermittent PrEP is pending. In the interim serodiscordant couples wishing to conceive will continue to seek health professionals' advice about reducing the risk of UPSI. Establishment of a register and the collection of a wide case series may help develop a consensus opinion within the UK on the use of PrEP in this setting.

Abstract P43

How do patterns of antiretroviral adherence in childhood impact on adherence in adult life?

A Kent¹, C Foster² and S Fidler²

¹The Ipswich Hospital NHS Trust, Ipswich, UK and
²Imperial College Healthcare NHS Trust, London, UK

Background: Optimal treatment of HIV requires >90% adherence to antiretroviral medication (ART). Poorer adherence to medication in adolescence is well documented for many chronic diseases, with early data emerging for HIV. We investigated the relationship between ART adherence in childhood and subsequent adherence in early adult life.

Method: Case note review of perinatally HIV-infected young people (PaHIV-YP) aged 18–25 years attending an adult clinic before July 2010 who received ART in paediatric and adult care. Comparison was made between HIV plasma viral load (pVL), CD4 count, duration on ART and reported adherence between paediatric (ages 0–18) and adult services (ages 18–25). Optimal ART response was defined as time spent on ART with CD4 >200 cells/cc³ and pVL <50 c/ml. Self/carer reported missed doses of >10% was defined as poor adherence, with good adherence defined as >90% ART doses taken.

Results: 34 PaHIV-YP, 19 (56%) female, 25 (74%) black African, median age at last follow up 19.8 yrs (IQR 18.3–20.8). In paediatrics median age of starting ART was 9.2 yrs (IQR 7.0–11.5) with a median duration on ART of 8 yrs (IQR 2.9–8.6) prior to entering adult services. Median age at transition was 17.2 yrs. Post transition; the median time on ART was 2 yrs (IQR 0.5–3.5).

In paediatric care 15/34 (45%) were defined as good adherers, all maintained CD4 counts >200 cells/cc³ following transition and only 1/15 (6%) had virological rebound, with no deaths or new AIDS defining diagnoses in this group.

Of the poor adherers in paediatrics (19/34; 55%), only 17% of time on ART was spent with 'optimal ART response', compared to 71% in good adherers. Following transition, in poor adherers, the proportion of time on ART with 'optimal ART response' was 27%. Of this group 2/19 improved adherence in adult care achieving a CD4 >200 cells/cc³ and pVL <50 for more than 50% of time spent on ART. Clinical outcomes for poor paediatric adherers in adult care; 4 patients developed new AIDS defining illnesses, 2 of whom died and 9/17 (53%) survivors had a CD4 count <200 cells/cc³ at last follow up.

Conclusions: In this initial cohort of young adults with PaHIV patterns of adherence set in childhood, both good and bad, were difficult to change in early adult life, and influenced clinical outcomes. Supporting adherence within families at ART initiation in childhood is essential to promote long term adherence and survival in adult life.

Plenary Speaker Biographies

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

Sam de Croy has worked in Social Services for the best part of three decades. He is currently the Deputy CEO of Body Positive North West, a 26-year-old HIV charity. He has worked within the HIV field for over 25 years and was one of the first HIV pre/post test counsellors on the west coast of Scotland.

Dennis Dobbin I am the team manager for the CASCAID HIV Mental Health Team. I have been working in the HIV field for 16 years, initially as a community psychiatric nurse and then as team manager for the previous 10 years. I have witnessed a lot of change within that time. However, psychological input is as relevant today as it was 16 years ago. Within the current economic climate we will have to continually demonstrate that we are able to meet clients' psychological needs.

Robert Downes Community Clinical Nurse Specialist HIV/AIDS. I embarked on my journey through nursing in 1976, working in a wide variety of hospital clinical settings from staff nurse to ward manager. I became a generic community nurse in 1988 and moved into HIV nursing in 1996. I have a special interest in patients who present with high dependency or complex needs requiring community-based care.

Maggie Edwards qualified in 1975 from Manchester. She works as a GP Principal in Liverpool having spent several years in the Middle East. She has worked as a GU physician since 1989 and is also an accredited colposcopist and a family planning trainer.

Diane Exley Born in Bamsley. Qualified Glasgow 1989. After training in the Northwest and Lake District became one of Liverpool's first parachuting GPs (attracting young GPs to work in inner city Liverpool to improve practices). Became a GP partner in 1996 in inner city practice with 1,800 patients. Now the practice has 28,000 patients across four sites, including student health at Liverpool University. Medical Officer for Health for Liverpool University with special interest in student health, sexual health, obesity, substance misuse, homelessness, sex workers, hepatitis and HIV. Developed the first primary care treatment service for hepatitis C with the support of Royal Liverpool University Hospital.

Timothy Hallett is based at the Department of Infectious Disease Epidemiology at Imperial College London. His work centres on the development and application of mathematical models for interpreting HIV surveillance data, forecasting the effect of prevention interventions, and impact evaluation. The overall aim of this research is to come to conclusions about the optimal use of limited resources in the response to the HIV epidemic worldwide.

Ian Hodgson is a writer, researcher and educator focusing on health and international development. Ian has worked in South East Asia, Africa and Europe, and held teaching posts at the University of Sheffield and the University of Bradford. He recently worked as a senior research officer at the International HIV/AIDS Alliance, supervising studies in Uganda and Zambia. Ian has a special interest in the social and cultural impact of HIV, and the need to develop civil society networks to ensure health interventions are firmly rooted within a framework of human rights.

Plenary Speaker Biographies

Pauline Jelliman Clinical nurse specialist (community) HIV/AIDS. I commenced nurse training in 1981 in Liverpool. I then nursed in New York, staffed, and ward managed in general medicine, before undertaking district nurse training at Liverpool University, where I completed my first degree. I have held my current post since 1993, and so witnessed the pre-treatment era. Our team provides a city-wide service. I have special interests in developing testing, and adherence support in community settings.

Saye Khoo is Hon Consultant Physician in Infectious Diseases at the Royal Liverpool University Hospital, and Professor in the School of Biomedical Sciences at the University of Liverpool. Research focuses on the pharmacology of HIV treatment failure and how therapy may be improved through individualised care through understanding of why drug exposure varies markedly between individuals (and the role of individual characteristics such as weight, gender, host genetics and drug interactions), and identifying vulnerable groups who are at particular risk of failure, or toxicity. These studies span bench science, through translational research and into the clinic, and onwards to population-based modelling approaches.

Ruth Lowbury is Chief Executive of the Medical Foundation for AIDS & Sexual Health (MedFASH), a charity which works with health professionals and policy makers to promote excellence in the management of HIV and sexual health. Under Ruth's leadership MedFASH has reviewed national policy, developed standards and guidance, and published educational resources with a particular focus on improving rates of HIV diagnosis. Ruth is a member of the Expert Advisory Group on AIDS (EAGA) and a number of other national policy groups, including the Halve It campaign steering group.

Sam Mabey-Puttock I worked at Chelsea and Westminster HIV and GUM unit for 7 years at a time when AIDS deaths were at their peak. In 1998 I took on the Lead HIV Nurse role in Manchester City's GUM clinic and have been central to building up an HIV service that now manages over 1000 patients. Since 1998 I have been secretary to a special interest group that I co-founded that meets quarterly whose aim is to provide education and support to nurses working in HIV across the Northwest region.

Geraldine Main I have been a nurse and midwife. I spent most of my career in education. I had roles in the School of Nursing Midwifery and Social Work in the University of Manchester as Director of Teaching and Learning and Director, Quality and Practice Learning. I was Academic Advisor to an international HIV/AIDS charity Mildmay International when I supported them in their development of a diploma/degree programme in Training Trainers in HIV/AIDS in Home Based Care.

Eileen Nixon has been an HIV nurse consultant in Brighton since 2004. Her main interests in HIV nursing include competency and practice development, clinical pathways and international HIV nurse education. Eileen is currently seconded to the University of Brighton to undertake PhD research into models of HIV healthcare provision.

Catherine O'Keeffe is a nurse with a background in HIV care, both internationally and in London. Recently, she has taken up education posts with the London Deanery where she is involved in faculty development in secondary care and with the Institute of Education where she teaches on a Masters in Clinical Education.

Susan Ogden A registered nurse since 1996 and have worked mainly in women's health and family planning. Some short stints also in sexual health/infertility/medical nursing in New Zealand. Prior to nurse colposcopist training was a gynaecology ward manager but wanting to maintain clinical skills. Trained as a nurse colposcopist in 2005 and working at Chelsea and Westminster Hospital since January 2010 in this role and additionally as the Hospital-Based Programme Co-ordinator.

Plenary Speaker Biographies

Kevin Osborne is the Senior HIV Advisor at the International Planned Parenthood Federation (IPPF). Kevin has worked in HIV – at both a policy and programme level – for over 20 years and has worked in all regions of the world. Prior to joining IPPF, Kevin was the Director of HIV at the Futures Group International in Washington, DC where he worked extensively on the POLICY project, a global USAID initiative. He has also provided much needed technical support to regional programmes around the globe to address HIV policy issues. These have included the development of local response and capacity development initiatives through UNAIDS; the development of an advocacy agenda for the PLHIV community; supporting advocacy for key populations; and ensuring that the gender dimensions of HIV are adequately addressed.

Nicky Perry has been a nurse in HIV care and management since 1988. She started as a nurse on the in-patient unit on Thomas Macauley ward now at the Chelsea & Westminster. Since then she has worked as an 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 (EHN) which aims to provide support, education and training for nurses from across Europe.

Sarah Radcliffe is Senior Policy and Campaigns Officer with NAT (National AIDS Trust), where she has worked since 2009. She specialises in the areas of immigration and asylum, employment, benefits and poverty. Sarah has previously worked for the Australian Government in employment, welfare and workplace relations. She holds Masters qualifications in Public Policy from the University of York and Central European University, Budapest.

Michael Rayment is a specialist registrar in Sexual Health and HIV Medicine, at Chelsea and Westminster Hospital. For the last two years he has been pursuing his main research interest: how best to tackle the problem of undiagnosed HIV infection in the UK.

Helen Reynolds I currently work as a research nurse and clinical nurse specialist at the Royal Liverpool and Broadgreen University Hospitals NHS Trust and the Liverpool HIV Pharmacology Group at the University of Liverpool. My research is focused on HIV pharmacology and in particular, HIV drug interactions and HIV treatment failure, investigating how HIV drug resistance may be limited or prevented. The research is funded by the NIHR Biomedical Research Centre.

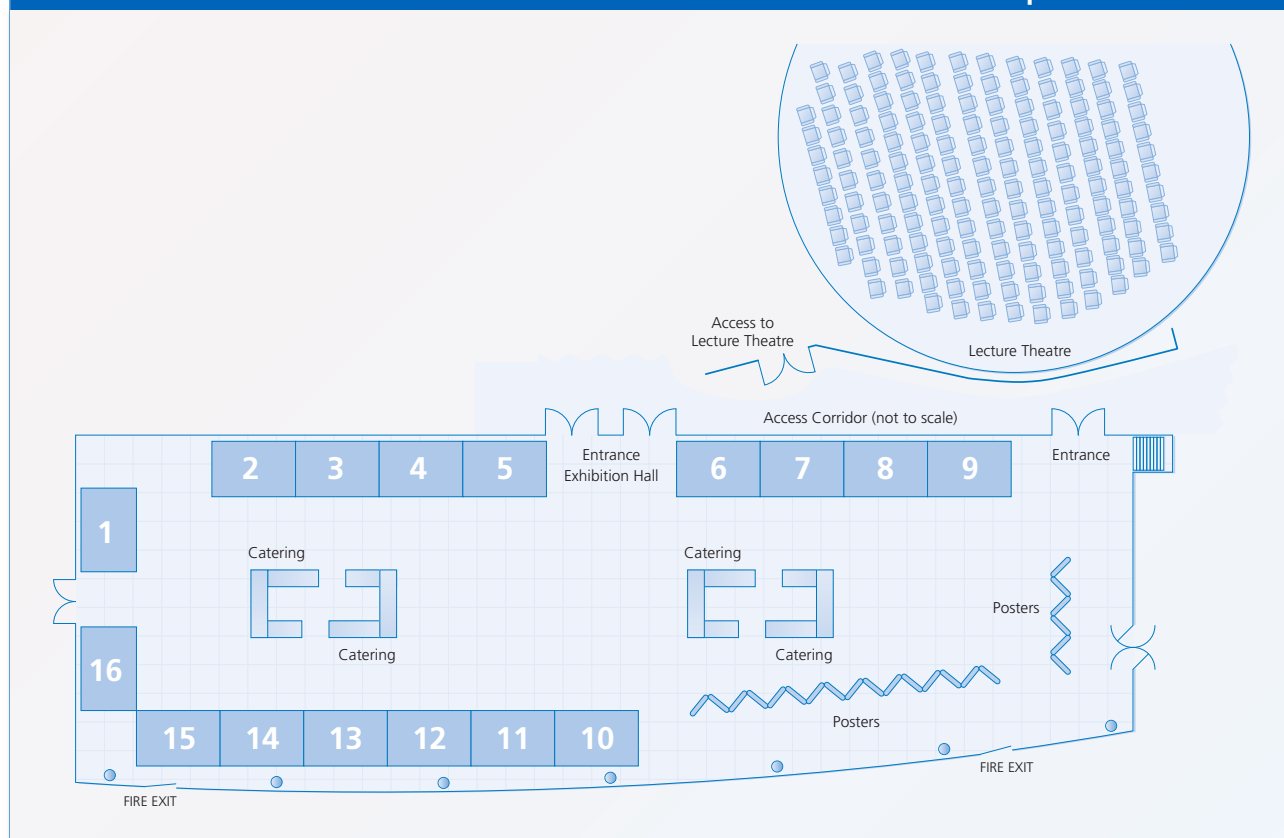
Gina Rowlands I am the managing director and practice nurse at Bevan Healthcare CIC. We are a city-wide general practice for the homeless, asylum seekers and refugees in Bradford. Bevan Healthcare is a responsive organisation promoting high quality health care for the most vulnerable members of society.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

Matthew Weait is Reader in Socio-Legal Studies at Birkbeck College, University of London. He is a member of the Advisory Group for the Global Commission on HIV and Law and has worked with UNAIDS and WHO on the criminalisation of HIV transmission and exposure, a subject on which he has written extensively.

Jillian Williams I joined the infectious diseases department as a staff nurse at the Royal Liverpool Hospital in 2002 progressing to become a specialist blood-borne virus nurse in 2004. My job encompasses a wide variety of roles and responsibilities, from supporting individuals infected with HIV and hepatitis to managing staff with needle-stick injuries that require PEP. I began my MSc in advanced nursing practice in 2008 and I am due to complete my dissertation in December of this year.

Exhibition Floor Plan

Hall 3 · Arena and Convention Centre · Liverpool



Key to exhibitors

- | | |
|---|-----------------------------|
| 1. Boehringer Ingelheim Ltd | 9. Body Positive North West |
| 2. BASELINE | 10. ViiV Healthcare UK Ltd |
| 3. Janssen Ltd | 11. NAM |
| 4. Centre for All Families Positive Health | 12. Terrence Higgins Trust |
| 5. Gilead Sciences Ltd | 13. MSD Ltd |
| 6. Bristol-Myers Squibb Pharmaceuticals Ltd | 14. The Sussex Beacon |
| 7. Astellas Pharmaceuticals Ltd | 15. Sahir House |
| 8. Abbott Ltd | 16. Therabel Pharma UK Ltd |



Information on Liverpool

Liverpool is famous the world over for its instantly recognisable waterfront, unique accent, and famous sons and daughters. The city centre is packed with magnificent buildings and splendid architecture including St George's Hall, which will host the BHIVA Gala Dinner, Liverpool Museum, Walker Art Gallery, and two cathedrals — the Anglican Cathedral and the Metropolitan Cathedral of Christ the King. In addition, Liverpool is home to a range of theatres and many tourists come to Liverpool just to taste its exciting nightlife.

Arena and Convention Centre Liverpool was the flagship project in Liverpool's year as European Capital of Culture and is the new jewel in Liverpool's crown. Located in the heart of the city on a World Heritage site, it is blessed by a wealth of surrounding amenities within 15 minutes' walk from the site; including the Albert Dock, Liverpool One shopping centre, hundreds of eating and drinking establishments, the famous Mersey Ferry and excellent hotels.

The Convention Centre is a unique, purpose-built meetings facility that combines the latest technology with innovative design. The Arena and Convention Centre was host to the opening ceremony of the 'Liverpool: European Capital of Culture' year in January 2008 and has subsequently hosted a number of national and international events.

Together, these unique attractions and facilities continue to boost Liverpool's image, and set it apart as one of Europe's finest cities.

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- By air** **John Lennon Airport:** A taxi to the city centre will take approximately 20 minutes, or a bus will take approximately 40 minutes.
- By train** **From the south:** Virgin Rail operates hourly direct services to Liverpool Lime Street Station. Journey times from London to Liverpool are approximately 2.5 hours.
From the north: Virgin Rail operates direct services to Wigan North Western Station. A local train can then be boarded to Liverpool Lime Street Station.
Arena and Convention Centre Liverpool is 15 minutes' walk from Liverpool Lime Street Station or a short taxi journey.
- By coach** National Express operates regular services from all major towns and cities in Britain to Norton Street Coach Station, Liverpool.
- By car** **From the north:** From the M6 junction 26, follow signs M58 Liverpool. At the end of the M58, follow signs for A59 Liverpool. Continue to follow A59 City Centre until picking up signs for the Albert Dock. This will take you off the A59 on to the A5053 heading towards Albert Dock.
From the south: From M6 junction 21, take the M62 to Liverpool. Continue to follow the signs for the city centre until picking up signs for the Albert Dock. This will take you via the A59 on to the A5053 heading for Albert Dock.
- Parking** The nearest car park to the Arena and Convention Centre Liverpool is onsite. Turn off at Queens Wharf where there is a 1600-space multi-storey car park.

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Air Travel			Avis	0800 200 888	www.avis.co.uk
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Future Events

15th Annual Resistance Meeting

Thursday 29 September 2011
Royal College of Physicians, London

London Study Day

Wednesday 12 October 2011
HIV Update Part II
London

4th Annual BHIVA Conference for the Management of HIV/Hepatitis Co-infection

1300-1730 Wednesday 16 November 2011
One Great George Street Conference Centre
London

British HIV Association (BHIVA) Autumn Conference

17-18 November 2011
Queen Elizabeth II Conference Centre, London

BHIVA World AIDS Day Event

Thursday 1 December 2011
London

18th Annual Conference of the British HIV Association (BHIVA)

17-20 April 2012
International Conference Centre, Birmingham

6th Annual Conference of the Children's HIV Association (CHIVA)

Friday 18 May 2012
Birmingham

For further information on these events, please contact:

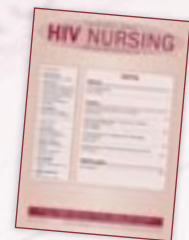
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See summary of product characteristics prior to prescribing

PRESENTATION: Hard capsules: 150mg, 200mg, 300mg atazanavir (as sulphate). **INDICATION:** Antiretroviral combination treatment of HIV-1 infected adults. **DOSAGE AND ADMINISTRATION:** Oral 300mg with ritonavir 100mg once-daily with food. If co-administered with didanosine, recommend didanosine be taken two hours after Reyataz with ritonavir with food. Hepatic impairment use caution in patients with mild hepatic insufficiency. Renal impairment: no dosage adjustment required. **CONTRAINDICATIONS:** Hypersensitivity to atazanavir or any excipient. Moderate to severe hepatic insufficiency. Do not use in combination with rifampicin or products that are substrates of CYP3A4 and have narrow therapeutic windows or products containing St. John's wort. Reyataz with ritonavir is contraindicated in patients undergoing haemodialysis. DPES inhibitor sildenafil is contraindicated when used for the treatment of pulmonary arterial hypertension (PAH) only. **SPECIAL WARNINGS AND PRECAUTIONS:** Patients with chronic hepatitis B or C treated with combination antiretroviral therapy are at increased risk for severe and potentially fatal hepatic adverse events. Patients with pre-existing liver dysfunction must be monitored according to practice. In worsening liver disease consider interruption or discontinuation of treatment. Reyataz may induce PPI prolongations. Caution with medicines that may increase QT interval. Caution in haemophilic patients. Combination antiretroviral therapy has been associated with lipodystrophy and metabolic abnormalities. Particular

caution is required when prescribing DPES-inhibitors (sildenafil, tadalafil, or vardenafil) for the treatment of erectile dysfunction in patients receiving Reyataz with concomitant low doses of ritonavir. Co-administration of salmeterol and Reyataz is not recommended. In clinical studies, Reyataz (with or without ritonavir) has been shown to induce dyslipidaemia to a lesser extent than comparators. Hyperbilirubinaemia has occurred in patients receiving Reyataz; no dose reduction is recommended. Nephrolithiasis has been reported in patients receiving Reyataz. If signs or symptoms occur, temporary interruption or discontinuation of treatment may be considered. On initiation of combination therapy immune reactivation syndrome may occur. **DRUG INTERACTIONS:** Co-administration of REYATAZ with the following agents is not recommended: simvastatin, lovastatin, nelfinavir, efavirenz, proton pump inhibitors or tenofovir & an H2-receptor antagonist. Oral contraceptives: ethinylestradiol 25µg & norgestimate co-administered with atazanavir 300mg with ritonavir 100mg QD: recommended minimum 30µg ethinylestradiol. Remind patient of strict compliance with dosing regimen. Co-administration with other hormonal or oral contraceptives has not been studied - therefore avoid. Alternate reliable methods of contraception recommended. Co-administration of Reyataz/ritonavir is not recommended for the following unless justified by the benefit/risk ratio: voriconazole, fluconazole or other glucocorticoids that are metabolised by CYP3A4. **PREGNANCY AND LACTATION:** Avoid use in pregnancy and lactation. **UNDESIRABLE EFFECTS:** Common: nausea, headache, ocular icterus, vomiting, diarrhoea, dyspepsia, abdominal pain, jaundice, insomnia, asthenia, peripheral neurologic symptoms, rash, fatigue and lipodystrophy. Serious:

pancreatitis, myopathy, hepatitis, nephrolithiasis. Consult SPC for other side effects. **LABORATORY ABNORMALITIES:** Elevated bilirubin, creatine kinase. **LEGAL STATUS:** POM. **PACKAGE QUANTITIES AND BASIC NHS PRICE:** Carton of 60 hard capsules, 150mg: £303.38, 200mg: £303.38, carton of 30 capsules, 300mg: £303.38. **MARKETING AUTHORISATION NUMBERS:** EU/1/03/267/003 - 150mg Bottle; EU/1/03/267/005 - 200mg Bottle; EU/1/03/267/008 - 300mg Bottle. **MARKETING AUTHORISATION HOLDER:** Bristol-Myers Squibb Pharma EEGL, BMS House, Uxbridge Business Park, Sanderson Road, Uxbridge, Middlesex, UB8 1DH. Telephone: 0800-731-1736. **DATE OF PI PREPARATION:** April 2011 687UK11PM022

Adverse events should be reported.
Reporting forms and information can be found at www.yellowcard.gov.uk.
Adverse events should also be reported to Bristol-Myers Squibb Pharmaceuticals Ltd
Medical Information on 0800 731 1736,
medical.information@bms.com



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