

ABSTRACTS

For the 19th NHIVNA Annual Conference held at Bristol Marriott Royal Hotel 22–23 June 2017

01

Patient and staff priorities for future models of care for people with HIV who have comorbid conditions

Eileen Nixon, Vanessa Cooper and Elaney Youseff
Brighton and Sussex University Hospitals, Brighton, UK

Aim: To explore the healthcare experiences of people with HIV who have comorbid health conditions and the staff involved in their care to identify areas for service development.

Background: As the numbers of people with HIV who have comorbid conditions increases, there is a need for evidence-based models of care to effectively address future healthcare needs. This research study was part of an NIHR Programme Development Grant to inform the development of HIV services to meet the needs of an ageing population.

Methods: Experience-based co-design methodology was used to explore the experiences of HIV patients accessing General Practice, HIV, Cardiology, Liver, Renal and Rheumatology services in one large urban HIV clinic. Patients were recruited from the HIV clinic and staff purposively sampled from the service areas. Experiences were gathered through observation, diaries, audio and filmed interviews. Thematic analysis was undertaken and filmed patient interviews analysed for emotional touchpoints. Staff and patient feedback events were utilised to validate data and identify areas for service improvement. A joint staff and patient co-design event was held to agree shared priorities for future healthcare services.

Results: 22 patients (with 110 comorbidities) participated in the diary study (5), paired observation of consultations (7), filmed interviews (10). A total of 18 healthcare workers were recruited from general practice (2), associated specialities (5) and HIV services (4) with a further 7 participating in paired consultation observations. A composite film was produced from the filmed patient interviews. Examples of patient touchpoints were: burden of appointments; telling their story again; quality of HIV care and repetition across services. Patients identified 6 areas for service improvement and staff identified 3. The joint co-design event was attended by 20 staff and 10 patients and agreed priorities for future service development were care co-ordination, shared medical records/results and systems to manage multiple appointments.

Conclusion: This pilot study was successful in capturing the healthcare service priorities of staff and HIV patients who have comorbid conditions in one HIV clinic using experience-based co-design methodology. Further research is required to identify if this is replicable elsewhere. However, this nurse-led research has contributed to the evidence base for future models of HIV care for this group of patients.

02

Are HIV support services being decommissioned?

Cheryl Gowar
National AIDS Trust, London, UK

Background: Evidence from people living with HIV and clinicians indicate that HIV support services which are usually provided by voluntary organisations or Clinical Nurse Specialists (CNS) – including self-management, sex and relationships support, emotional and psychological support, information and advocacy, and peer support – complement clinical services and are an essential part of the HIV care pathway. Both HIV standards of care and national health policy on long-term condition management including the Five Year Forward View establish an overwhelming case

for the commissioning of support services, but the Health and Social Care Act 2012 left HIV support services without a commissioning 'home'. Local authorities (LAs) have previously been the main funder of these services but have been subject to in-year and ongoing budget cuts. Anecdotal reports and evidence of ongoing contract reviews suggest that these essential services are starting to be decommissioned.

Methods: In May and June 2016, Freedom of Information (FOI) requests were sent to all LAs and Clinical Commissioning Groups (CCGs) in England, to establish expenditure on HIV support services in 2015/16 and 2016/17.

Results: Total expenditure known to be exclusively dedicated to HIV support services reported by LAs in England decreased by 28% between 2015/16 and 2016/17. Reports of further decommissioning since data collection indicates that this figure underestimates actual decline in provision. Two-thirds of LAs across England commissioned either no HIV support services in 2016/17 or at a lower value than in 2015/16. The change in contract values across LAs between 2015/16 and 2016/17 ranged from a 100% decrease to a 33.3% increase. There is only weak correlation between HIV prevalence and expenditure on HIV support services. Spending by CCGs showed very little decline over the two years, but the majority of CCGs reporting expenditure were unable to separate support service expenditure from clinical provision. Outside London there is very little CCG expenditure on HIV support services.

Conclusion: The data show decommissioning of HIV support services across England, unevenly distributed with complete loss of provision in some areas. To avoid further loss of essential services, clarity must be established around commissioning responsibility at the national scale, and local commissioners should ensure that adequate HIV related support is provided in their areas based on an assessment of local need. CCGs must familiarise themselves with the breadth of services required to support condition self-management.

03

Introducing the Patient Activation Measure in a UK HIV service: early results

Martin Jones
East Sussex Healthcare NHS Trust, UK

Background: Patient activation has been defined as 'an individual's knowledge, skill and confidence for managing their health and health care'. The NHS has invested in the introduction of the Patient Activation Measure (PAM) in services for managing long-term conditions. The only Pub Med reference that cites its use in an HIV clinic is from USA. The PAM uses a thirteen statement online survey whose outcome is a score that equates to one of four levels of patient activation:

- Level 1 Individuals tend to be passive and feel overwhelmed by managing their own health. They may not understand their role in the care process.
- Level 2 Individuals may lack the knowledge and confidence to manage their health.
- Level 3 Individuals appear to be taking action but may still lack the confidence and skill to support their behaviours.
- Level 4 Individuals have adopted many of the behaviours needed to support their health but may not be able to maintain them in the face of life stressors.

Methods: As part of its Commissioning for Quality and Innovation (CQUIN) contract for 2016–17, the NHS trust introduced the PAM in its HIV clinics. The PAM was to be applied to the entire cohort. Following a pilot the PAM was completed by patients during the course of their routine HIV clinic attendances, either directly on the consulting

room computer or with the healthcare professional reading the statements and entering the responses.

Results: In 2015 349 patients received HIV care in the trust's two clinics. 201 patients attended the service for HIV care between January 1st and March 21st. [I intend to update this data closer to conference.] 167 (83%) completed the PAM.

Level of patient activation	Total	%
Level 1	8	5
Level 2	25	15
Level 3	60	36
Level 4	74	44
	167	100

The median level of patient activation was Level 3 with 20% at the two lowest levels.

Conclusion: The PAM was successfully deployed in the clinics and was acceptable to patients. This is the first time that the use of the PAM in a UK HIV service has been described. The next part of the CQUIN process is to increase patient activation prioritising those patients at levels 1 and 2.

O4

Has HARS got it right for stable HIV patients?

Ami Patel, Stefan George, Yvonne Gilleece, Eileen Nixon and Duncan Churchill
Brighton and Sussex University Hospitals, Brighton, UK

Aim: To investigate the reasons for increased clinic attendance within the stable patient category.

Background: HARS, introduced in 2013, is intended to inform the commissioning of HIV Outpatient services and categorises patients into: 1. New, 2. Stable and 3. Complex with an estimated 80% of patients in the Stable category. Patient pathway mapping in one HIV clinic identified that many Stable patients attended more frequently than the BHIVA recommended 6 monthly reviews and a pilot study was undertaken to investigate the factors underpinning these clinic visits.

Methods: Stable patients in HARS Category 2 who attended between Aug 2015-Aug 2016 were identified from our HIV clinic database and divided into Group A (Gp A): <4 mths between clinic appointments; Group B (Gp B): 4–6 mths between appointments and Group C (Gp C): >6 monthly visits. 50 patients were randomly selected from Gp A and Gp B. Electronic and paper notes were used to collect patient demographic data, CD4+, HIV VL, duration of HIV infection and reason for attendance.

Results: There were 25 patients analysed in Gp A and Gp B. The majority were male 92% (Gp A) and 88% (Gp B). Mean age was 53 yrs and 47 yrs respectively. Mean time from diagnosis was 13 yrs (Gp A) v 15 yrs (Gp B). Almost all patients were on cART (100% Gp A and 96% Gp B) with 96% in both groups with HIV VL <40 copies/ml. Mental health was the main reasons for increased attendance in both groups with more frequent attenders in Gp A presenting with higher rates of mental health, new symptoms, drug and alcohol issues and co-morbidities.

REASON FOR ATTENDANCE	Group A (n=25)	Group B (n=25)
Mental health issues	15 (60%)	11 (44%)
New symptoms	15 (60%)	5 (20%)
Recreational drugs	10 (40%)	4 (16%)
Previous AIDS Defining Illness	9 (36%)	6 (24%)
Complex comorbidities	9 (36%)	2 (8%)
Recent hospital admission	9 (36%)	2 (8%)
Chem sex & STIs	9 (36%)	0 (0%)
Alcohol related	6 (24%)	4 (16%)
Virtual/Joint clinic	5 (20%)	1 (4%)
Domestic abuse/social needs	3/25 (12%)	6/25 (24%)

Conclusion: This pilot study indicates that Stable patients have a range of clinical needs that require additional support from HIV services to maintain patients within the Stable category and that commissioning mechanisms based on holistic needs are required to sustain high quality HIV care.

O5

Concurrent infections in pregnancies in women living with HIV in the UK and Ireland

Helen Peters, Kate Francis and Claire Thorne
University College London Great Ormond Street Institute of Child Health, UK

Background: Sexually acquired and blood-borne co-infections are frequent among people living with HIV. In pregnancy such co-infections may place women and their infants at increased risk for adverse outcomes, including vertical/congenital infection and have implications for management during pregnancy and beyond.

Methods: The National Study of HIV in Pregnancy & Childhood is a comprehensive surveillance study established in 1989 collecting data on pregnancies in women with HIV and their children in the UK and Ireland. Data on infections routinely screened for in pregnancy (hepatitis B virus (HBV), hepatitis C virus (HCV) and syphilis) and

other co-infections have been collected since 2008 alongside details on infant exposure to and/or confirmed congenital infection. We describe exposure to co-infections in 7758 livebirths to HIV diagnosed women 2010–2016, reported by end of 2016.

Results: Among infants born 2010–16 10% (764/7758) were exposed to a maternal co-infection. Main co-infections reported were HBV (4.6%, 350/764), HCV (1.9%, 148/764), herpes simplex virus (HSV) (1.5%, 114/764), and syphilis (1.3%, 97/764). Other infections reported were chlamydia (32), tuberculosis (24), cytomegalovirus (CMV) (14), toxoplasmosis (7) and gonorrhoea (4). 38/764 pregnancies had ≥1 concurrent infection of which 14 had HBV/HCV, 8 had HBV/syphilis.

Of co-infection exposed infants 20% (154/764) were born to a mother diagnosed with HIV during pregnancy vs 16% (1126/6994) of unexposed ($p < 0.05$). Most women were born abroad (85% (653/764)) with 75% (491/653) from Sub-Saharan Africa and 12% (78/653) from Eastern Europe (who accounted for 30% (44/148) of those with HCV co-infection). Injecting drug use was mode of maternal HIV-acquisition for 55/68 HCV co-infections (5/68 were HBV). Overall this was mode of acquisition for 9% (68/764) vs 0.6% (42/6994) in those without co-infection ($p < 0.001$); for the majority (78% (593/764)) maternal HIV-acquisition was heterosexual. Ireland and London accounted for >60% of HCV reports, and half of HBV and syphilis reports. Of infants exposed to co-infections 15% (117/764) were born preterm (<37 weeks gestation) compared to 10% (729/6996) in those unexposed ($p < 0.001$). A confirmed congenital infection was reported in 28/764 (3.7%) infants: CMV (12), syphilis (4), HBV (4), HCV (3), HSV (3), other (3) with one child having >1 congenital infection. Of infants with known HIV infection status, 5/624 (0.8%) were found to have HIV (1/5 had a congenital infection) compared to 0.41% overall.

Conclusions: One in ten infants born to women living with HIV in the UK/Ireland is exposed to co-infections. Findings underscore the need to follow recommendations for screening for sexually transmitted and blood-borne infections in pregnant women with HIV, to allow for appropriate management of mother and infant and to prevent congenital infection and/or other adverse pregnancy outcomes.

O6

Abstract withdrawn.

O7

HIV in prison – partnership for better HIV care in correctional facilities

Catarina Esteves, Inês Vaz Pinto and Mafalda Guimarães
Hospital de Cascais, Portugal

Background: Recent rearrangements in national policies in Portugal towards follow-up of HIV infected patients in correctional facilities have determined that hospitals closest to the prison facility be responsible for their care. Before, in the greater Lisbon metropolitan area, care of HIV infected inmates was centralized in one central Prison Hospital. Our HIV Unit and the two prison facilities in the area have established a clinical protocol whereby patients don't have to leave the prison for care: a clinical team composed by a physician and a nurse assures regular visits for blood collecting and clinical appointments instead of having the inmates transported to the hospital. The purpose of the protocol, from a continuum of care point of view, is to promote complete adherence to HIV care: blood tests, clinical visits and to antiretroviral (ARV) therapy.

Methods: This retrospective review looks back at the first year of protocol implementation between the HIV Unit of Cascais Hospital and the two prisons. The purpose of this study is to characterize the demographics of our inmate population; assess the number of inmates on ARV; describe ARV regimens; evaluate ARV efficacy and adherence.

Results: HIV infected populations shift frequently in and out of prisons and maintaining stability in their HIV care is a major challenge. Most of our patients were already on therapy at the beginning of follow-up; most were on once daily dosed regimens, which are easier to provide and are known to favour adherence. The higher number of protease inhibitors based regimens is due to two factors: HIV infected prisoners are mostly injection drug users and mentally unstable, whereby a regimen with higher generic barrier is felt to be the safest choice; frequent unavailability of past medical records and therapeutic history do not allow for a safe simplification strategy.

Conclusions: This protocol implementation between the hospital and the two prisons involved has benefited all parts: patients assure regular laboratory and clinical follow-up, and avoid constraint-full displacements to the hospital; prisons guarantee regular specialized assistance to their inmates and save on multiple trips to the hospital; the clinical team involved is rewarded with full adherence to visits and ARV, which is manifested by 97% viral load undetectability. The major constraint found was the difficulty in providing adequate discharge planning and linkage to care in the community due to frequent unannounced release and transfer of inmates.

O8

'How can you let someone live like that?' Hoarding and HIV: lessons learnt

Shaun Watson
Chelsea and Westminster NHS Foundation Trust, London, UK

Hoarding and self-neglect have been highlighted in the media and press over the past few years and as people live longer with HIV and become more complex we are now seeing more issues of self-neglect, poverty and hoarding tendencies either as a direct result of drug use, mental health/personality issues or an inability to cope. This is a case study of a 50-year old MSM who had disengaged from HIV services and was referred to the Community HIV Clinical Specialist Nurse for adherence

support' after a period in hospital. He had complained to nurses about 'infestations' and needing to 'deal with his flat', however the reality was much worse and the whole flat was filled with mattresses against the windows to block out noise and holes in the ceilings as the patient was convinced he was being listened to. It took over 18 months for a resolution to this case as there was no easy pathway to follow. There are now many organisations that can support those who hoard or self-neglect and this study will highlight the initial assessment and (attempted) follow-up, frustrations, discuss missed opportunities and lessons learned from this and similar cases. I will look at the 'clutter index' and discuss the role that environmental and fire services can play alongside housing and local authority support that may or may not be provided. As many areas do not have community HIV support how can nurses within other setting help patients that they feel are neglecting their self-care and may be at risk of further decline in their health?

09

Using creative writing to promote reflective practice in HIV nursing care

Sarah Barber and Beverley White
Bromley Healthcare, London, UK

Introduction: Writing creatively in healthcare has been shown to promote and foster feelings of empathy resulting in increased compassion for patients (Barber 2017). Writing stories and poems inspired by patient care helps us develop a heightened awareness to narrative such that we become more observant to details that may be otherwise missed in the clinical encounter (Charon 2006). Creative writing can help us reflect and remain connected to our professional values. The associated theory, 'narrative medicine' suggests that greater personal knowledge and growth is achieved through the power of writing.

Method: Following a literature review exploring whether creative writing can result in more compassionate care, two writing workshops were designed, delivered and evaluated by the HIV lead CNS. During the workshops fellow community clinicians from a variety of disciplines took part in creative writing exercises, exploring different techniques designed to encourage and foster writing. As a result of this project, both HIV nurses have begun to use creative writing in their clinical practice. It has proved a powerful way to reflect on patient care and profound poetry and short narratives have been written which encapsulate the challenges of nursing in HIV. The work has also been used to demonstrate reflective practice for NMC revalidation and CQC visits.

Discussion: We operate and deliver healthcare in a system that continues to be dominated by empiricism with narrative enquiry considered an 'art' and further down the hierarchy of evidence that informs practice (Muncey 2006). Evidenced based medicine fails to take account of the individual or interpersonal skills required to deliver care and therefore lacks humanity. Quality of care can suffer and the patient experience diminish. Narrative medicine recognises the importance of story telling in healthcare, exploring how close reading of literature and study of language can help us deliver more person centred compassionate care. 'Narrative competence' can be fostered through initiatives that explore literature, creative and reflective writing, storytelling and poetry (DasGupta and Charon 2004). Reflective practise should be personal not prescriptive, promoting reflexivity that empowers nurses. Creative writing can achieve this because it is a dynamic and liberating way of reflecting on nursing care.

Conclusion: We believe that building creative and reflective writing into our practice has encouraged us to question, challenge and make constructive changes within our professional lives. This enjoyable and creative process has offered us new insights into HIV nursing and helped foster compassion for our patients.

010

The role of the HIV clinical support nurse in an outpatient setting: the first year of an evolving role

Claire Bradbury and Lorraine Lewis
Hawthorn House, Birmingham, UK

After around 14 months of being employed in an outpatient HIV Centre and working within a role that is ever changing, now seemed like the right time to reflect upon the challenges and wisdom that my job had brought to me so that I could share my experience with others. Why is this so important? – Hopefully the rest will explain why.

As a constantly thriving and expanding HIV service which also incorporates caring for the sexual health needs of patient's, my role at the beginning of employment was initially defined as working with and supporting the HIV Clinical Nurse Specialist Team and this was a newly designed role for the service. As the talk goes on, you will see that during the time spent so far within the HIV Service, it has swayed into many areas some of which include Hepatitis and Sexual Health. It has been majorly shaped and adapted by both the demands of the Multi-Disciplinary Team and the need of the patient in having appropriate access to the service in a timely manner and I believe the role helps with this. This has made it an on-going learning process.

The text will discuss how the role of the Clinical Support Nurse has been adapted over the last 12–14 months to fit the needs of the service and the impact that the introduction of such a new role has had on fellow colleagues and the wider Multi-Disciplinary Team. Hopefully this will answer questions such as has the role been useful to the department, what benefits has the role brought to the team and how can my role be expanded to support the Multi-Disciplinary Team in the future.

To finalise the abstract, I will briefly discuss one of the NHIVNA initiatives I am currently involved in. My situation at present within the service has allowed me to devote

time to the Piloting of the STIF NHIVNA Core Competencies. This allows me to deal with some very complex and challenging situations and has given both me and my assessor protected time to reflect on areas where we think I can improve or need more guidance. It also gives me a rigid framework whereby I am achieving set competencies and this will hopefully enable my role to flourish in the setting I work.

011

How do I be an HIV nurse?

Michelle Croston

North Manchester General Hospital, UK

This interpretative phenomenological analysis explores HIV nurses' experiences of eliciting patients' concerns. It provides findings gathered from in depth interviews. The nurses' stories are central in understanding how HIV nurses elicit patients' concerns, how nurses respond to patients' concerns and the effect that these interactions have on patient centred care. Alongside these participants' stories I have also presented reflexive accounts from my own practice, which have helped with the development of the research.

The ten nurses who volunteered to be involved in the study were interviewed on a single occasion and encouraged to share stories from their own practice, which illuminated how they practiced patient centred care. Through these reflexive accounts from practice, a way of being was described with regards to HIV nursing practice.

Analysis of the interview revealed three superordinate themes, A way of being: HIV nurses experiences, The nurse patient relationship and factors that impact on authentic care. In addition I have considered the participants' narratives in terms of Heidegger's (1926/62) concept of being in order to inform the analysis and interpretation of the data to present a more insightful exploration of the HIV nurses' experiences.

The HIV nurses' stories offer an insight into how they provide patient centred care and describe a way of being which facilitates patient centred care.

012

Improving HIV education by developing a student nurse pathway in an infectious disease outpatient setting

Claire Gamble and Hayley Clifford

Heart of England Foundation Trust, Birmingham, UK

A lack of HIV education during nurse training is often noted and as a result, it is no coincidence that we have experienced poor care for HIV positive individuals from those with a lack of knowledge about HIV. Our outpatient facility which houses HIV, Immunology, Allergy, Infectious diseases and TB services, historically have not received student nurses on placement as it was thought that there wasn't enough opportunities available for a lengthy placement.

A working group consisting of senior specialist nurses who were keen to teach student nurses liaised with infectious diseases ward sisters and a pathway was established which allowed students on a week-long placement to access the entire HIV multidisciplinary team. The pathway also included time with the other specialist services within the department.

The pathway has been running for two years and has evaluated excellently. Students report that they have not only increased their knowledge significantly but feel confident to care for HIV positive patients moving forward. The pathway has been expanded to include all new staff inducted to the Infectious diseases directorate.

P1

Developing nursing practice through Work Based Learning

Ruth Burholt¹, Susanne Simmons², Mark Roche¹, Tracey Buckingham¹ and Eileen Nixon¹

¹Brighton and Sussex University Hospitals NHS Trust, Brighton, UK and ²University of Brighton, UK

Aim: The aim of this paper is to evaluate an HIV Work Based Learning (WBL) module in regard to the development of nursing skills and practice.

Background: Due to economic factors and increased demand in the workplace, there is a need to sustain HIV specialist nurse training that reflects the evolving needs of HIV patients, and that is also fit for purpose in training the future HIV nursing workforce. To address local educational needs, a tailored HIV WBL module was developed for nurses based on Level 3 skills of the National HIV Nursing Competencies. In 2014, a seven month 20 credit level 6 module was designed including HIV insight workbooks and taught lectures. Five key skills areas were defined with a further two learning outcomes chosen by the student which aligned with service audit or evaluation and aimed to change an area of practice.

Methods: Five students who successfully completed the WBL module in 2015 shared personal reflections of their overall experience. A thematic analysis was undertaken comparing the learner's initial self-assessment and their final reflective summary. Changes in service delivery were then collated. In addition, a survey on staff learning experience and development was undertaken.

Results: All students participated in the evaluation. Pre-and post-themes are as follows;

Themes of initial self-assessment		Themes of final reflective summary	
Strengths and Opportunities	Threats and Weaknesses	Strengths and Opportunities	Threats and Weaknesses
Supportive learning environment.	Challenging work environment	Increased confidence, HIV knowledge/ skills	Difficulty in containing projects
Desire to improve patient experience	Lack of self-confidence and academic ability	Positive practical and collaborative learning experience	Lack of mentor availability
Professional development	Time management	Personal / professional development	Time management
		Changes to nursing practice and patient care	Competing priorities

There were several changes to service delivery and nursing practice resulting from the individual's learning outcomes.

These included: re-organisation of the HIV Emergency Clinic; leaflet for New-Fill patients; redesign of the Annual Health Check; redefining the nursing role for newly diagnosed patients; development of Women's clinic; staff leaflet on re-feeding syndrome.

P2

Equality in accessing HIV care: the role of the community HIV nurse

Kirsi Connor, Luard Ohen, Rosemary Burridge, Marcia Barnaby, Sue Hunte, Grace Odonkor, Comfort Agyei and Camelia Carty

Guy's and St Thomas' NHS Trust, London, UK

This poster considers the role of the community HIV nurse specialist in managing patients who find it difficult to access HIV care. Equality to service is a priority for patients. The extent to which a population gains access to a service depends on financial, organisational and social or cultural barriers that can limit the utilisation of services. (Dept of Public Health Sciences; Kings College London 2002).

Within our community HIV specialist team we find there are many contributing factors to why patients do not attend the specialist clinic. These include physical disabilities and co-morbidities, cognitive impairment, mental health problems, stigma, denial, lack of insight and substance misuse. It is widely documented that consistent attendance at medical appointments plays a central role in both prolonging life and enhancing quality of life in people living with HIV. For example, non-attendance is particularly closely linked with medication non-adherence (Mitchell and Selmes 2007).

In this poster presentation we aim to cover how a community HIV specialist team can work closely with a patient and hospital clinic to provide equality of care. Depending on the patient's problems there may be a simple answer such as providing transport but in many cases there are a number of reasons why patients cannot or do not attend clinic. As community nurses we have the opportunity to work with the patient to overcome these problems and either engage them back into the clinic or manage the role of the clinic in a community setting, therefore providing equality of access to care.

P3

An evidence-based strategic approach to developing the specialist HIV nursing workforce

Hilary Piercy

Sheffield Hallam University, UK

Background: The changing needs of HIV care and increasing financial constraints highlight the need to maximise the contribution of HIV specialist nurses to service delivery. Achieving this will depend on developing a sustainable HIV specialist nursing workforce.

Identifying the problem: The 'Advanced Nursing contribution to HIV service in HIV' study was completed in 2014. It was a three part multi-method qualitative study comprising: (1) 19 stakeholders representing professional or service user groups; (2) 42 nurse/physician pairs from 21 purposively selected HIV services; (3) HIV teams during site visits to 5 services. The study identified:

- 1) Substantial challenges in developing a sustainable workforce to meet the expanding need for specialist nurse-led care.
- 2) The lack of a clearly defined career pathway and recognised professional qualification in HIV care which impacted adversely on role development.
- 3) The need for a strategic approach to workforce development supported by HIV specific educational opportunities and a clear career pathway.

A strategic response: The National HIV Nursing Association has led the development of two initiatives in response to the evidence.

1. The development of a national validated qualification in HIV care. The NHIVNA core and advanced level competency and work-based assessment programme has been developed in collaboration with the medical British Association of Sexual Health and HIV (BASSH) as part of an established training framework. The core competency programme is designed for nurses and midwives working in HIV across primary and secondary care settings. The advanced competency programme is designed to support advanced level practice in the specialist HIV nursing workforce.
2. A document which aims to provide national guidance on advanced practice in HIV nursing for clinical and managerial staff, provider organisations and commissioners.

The guidance situates advanced HIV nursing practice within the wider HIV care context and is structured around four key elements. These collectively offer a framework within which to develop and deliver high quality advanced HIV nursing practice across acute and community sectors.

P4

Trends in maternal characteristics of pregnancies in women living with HIV in the UK and Ireland: 2000–2015

Rebecca Sconza, Helen Peters and Claire Thorne

University College London Great Ormond Street Institute of Child Health, UK

Background: Since antenatal HIV screening became routine in the UK and Ireland, there have been major shifts in HIV management in pregnancy and a resulting decline in mother-to-child transmission (MTCT). We describe trends in maternal demographic and clinical characteristics for pregnancies in diagnosed HIV-infected women in the UK and Ireland in 2000–2015.

Methods: The National Study of HIV in Pregnancy and Childhood (NSHPC) undertakes comprehensive, population-based surveillance of pregnancies in women living with HIV in the UK and Ireland. Analyses were based on pregnancies in women diagnosed with HIV before delivery with estimated date of delivery (EDD) in 2000–2015, reported to the NSHPC by end of 2016.

Results: There were 18762 pregnancies reported among 12732 women, with the annual number increasing 3-fold from 385 in 2000 to 1116 in 2015 and peaking at 1532 in 2010. Sixty percent of pregnancies in 2000–03 were reported by London units compared to 37% in 2013–15. Median age at EDD increased from 29 (IQR 26–33) years in 2000–03 to 34 (30–37) in 2013–15. The proportion of pregnancies in women born in Sub-Saharan Africa (SSA) declined from 77% (2103/2732) in 2000–03 to 72% (2462/3405) in 2013–15 and that in women born in Europe but outside UK/Ireland increased from 2% (64/2732) to 7% (230/3405), respectively ($p < 0.001$). The number of pregnancies reported among women born in Eastern Europe (EE) increased 24-fold from 7 in 2000–03 to 169 in 2013–15. In 2000–03, 4% (99/2719) of pregnancies were in women who had reportedly acquired HIV through injecting drug use versus 2% (54/3206) in 2013–15 ($p < 0.001$). There were no pregnancies in mothers with perinatal HIV in 2000–03 compared to 51 (2%) in 2013–15. The proportion of pregnancies in women diagnosed before pregnancy increased from 41% (1120/2747) in 2000–03 to 86% (2990/3466) in 2013–15, with a corresponding rise in pregnancies conceived on ART from 19% (512/2717) to 65% (2193/3366) ($p < 0.001$). Median first antenatal CD4 count increased from 370 (245–528) cells/mm³ in 2000–03 to 490 (342–648) in 2013–15, with pregnancies with CD4 < 200 decreasing from 16% (330/2066) to 8% (223/2871). Of pregnancies with a viral load (VL) result provided within 30 days of delivery, 51% (570/1119) had VL < 50 c/ml in 2000–03 versus 90% (1674/1858) in 2013–15 ($p < 0.001$).

Conclusion: Most pregnancies continue to be in women born in SSA, but the increase in those in women from EE is noteworthy, reflecting the growing epidemic in EE and migration trends. Alongside the trend of older maternal age is the emergence of a new population of young pregnant women with perinatal HIV. Conception on ART, improved immune status, and delivery VL < 50 c/ml are now the norm, but there remain some groups at risk of MTCT.

P5

HIV testing week at Cascais Hospital in Portugal – are we efficacious at promoting awareness of healthcare professionals and outpatients for the need of increased HIV testing

Catarina Esteves, Inês Vaz Pinto, Mafalda Guimarães, Anabela Marques,

Vanda Castro, Sara Alves and Jana Zelinová

Hospital de Cascais, Portugal

Background: An estimated 30% of people infected with HIV in Europe are unaware of their HIV status. They will most probably present late for diagnosis, and are responsible for continued HIV transmission. Of the 173 new HIV diagnoses seen in our HIV Unit between 2013–2016, 51% presented late (< 350 CD4+ cells/mm³), and 10% presented with AIDS. HIV Testing Week is an initiative launched by HIV in Europe in 2013 to help more people to become aware of their HIV status. Cascais Hospital was the only hospital in Portugal to sign up in 2015 and continues participating since.

Methods: We used information and materials provided by the HIV Testing Week and marketing department of Cascais Hospital to launch campaigns to promote awareness of healthcare professionals and hospital patients to the need and benefits of increased HIV testing.

Our interventions involved key HIV testing messages that we wanted to spread:

'No doubt about it. Taking the test is easy. Difficult is to live in doubt.

Anonymous, free and confidential'

'UNAIDS wants and together we will be able to: 90% of people with HIV are diagnosed/ 90% of people with HIV diagnosed receive antiretroviral treatment/ 90% of people on treatment have undetectable viral load'

and included:

- Hanging of posters at key hospital spots: main entrance, emergency department (ED) and general clinic waiting rooms, employees' elevators;
- Distribution of pamphlets, pins and bracelets;
- Changing the food tray coverings at the canteen with ones containing HIV testing information;
- Exhibition at the main entrance of the hospital: 'Faces of Change';
- Exhibition of photographs of employees using the pin in the corridor of the canteen.

Results: HIV Testing Week 2015 was November 20–27th. We evaluated the number of HIV tests requested at the general ED during two different periods: 6 months before the interventions (June to November 2016) and 4 months after the interventions (December 2016 to March 2017). From June to November 2015, 401 HIV tests were done at the ED, of which 30 were positive and 3 led to the diagnosis of acute HIV infection.

Conclusions: After our hospital's first participation in HIV Testing Week 2015, we achieved a 17.7% increase in HIV testing done in the ED. The impact of our interventions in HIV tests done in other settings (pre-ops) was not evaluated. Results from HIV Testing Week 2016 are still pending.

P6

North West HIV Alliance re-audit of the routine monitoring of adults with HIV

Gary Barker

St Helens and Knowsley Teaching Hospitals, St Helens, UK

Background: The rationale for the British HIV Association, (BHIVA) National Audit conducted in 2015 was to evaluate improvements in care following the introduction of the BHIVA Routine Investigation and Monitoring Guidelines 2011. The outcomes of this audit highlighted several areas of poor adoption of the guidelines. The re-audit wanted to determine if any improvements in care had been achieved one year later; by repeating the original audit and using the original proforma, inclusion/exclusion criteria.

Method: Replicating the BHIVA audit proforma template (2015), all HIV Clinical Nurse Specialists from our database were invited to participate. Of the 19 units invited, 10 Units agreed, all of which were Sexual Health clinics. Each unit was asked to audit a random sample of 10 patients' care records of those who had attended for care within 2016. We noted that of the 10 units involved, 6 had a formalised annual review process.

Results: The results of the re-audit were compared against those of the original BHIVA Audit (2015). Within the North West, extensive improvements were observed in the screening and monitoring of cardiovascular disease (CVD) for adults living with HIV, with greater CVD risk assessments conducted: 68% v 45% in the BHIVA 2015 audit. Similarly, more of the patients with a CD4 >200 cells /mm³ had received a pneumococcal vaccine: 62% in the re-audit compared to 26% in the BHIVA 2015 audit. The majority of the patients within the re-audit that had received a vaccination, attended a formalised annual review (n=41 of 59 patients).

	Overall audit (n=100)	Clinics with formalised annual review (n=60)	Clinics with no annual review (n=40)
Non-HIV medication checked within 12 months	95%	98%	90%
Sexual Health screen offered within 12 months	79%	68%	95%
BP within 12 months	95%	97%	92%
Syphilis Serology	89%	97%	77%
Hepatitis B immunity (immune or Hep B positive)	79%	87%	67%
Hepatitis C test (or Hep C positive)	97%	98%	95%
Smoking Status recorded	94%	97%	90%

Conclusion: The re-audit demonstrated that the participating units had improved their standards of care across a wide variety of parameters when compared against the BHIVA National Audit, (2015), the results being even greater where a formalised annual review was in place. However, further improvements are needed despite formalised reviews. With the creation of various differing annual assessment forms throughout trusts, it would deem advantageous to develop a standardised annual review template to ensure equity of care for all PLWHIV.

P7

Treatment of hepatitis C in patients co-infected with HIV/HCV – real-life data from Hospital de Cascais

Catarina Esteves, Inês Vaz Pinto, Mafalda Guimarães, Vanda Castro, Anabela Marques and Sara Alves

Hospital de Cascais, Portugal

Background: In Portugal there has been a policy of universal access to the direct action antiviral (DAA) sofosbuvir and ledipasvir / sofosbuvir in combination for treatment of patients with chronic hepatitis due to HCV, with HIV co-infected patients being one of the defined groups as priorities for treatment. The HIV / AIDS Functional Unit (FU) of Cascais Hospital has a total of 1213 patients, 25% of whom are co-infected with HCV.

Objectives: Report data from HIV/HCV co-infected patients treated at FU HIV/AIDS Hospital of Cascais between May 2015 and March 2017.

Methods: Demographic data were collected from the 260 patients who obtained DAA leave in the referred period. About HCV infection, the genotype, the existence of previous treatments and the treatment performed are detailed. The therapeutic plan for the integration of patients with HCV and evaluation of nursing interventions is presented.

Data from patients with sustained virological response (SVR) at week 12, adherence data and nursing consults are presented.

Results: Of the total of 260 patients who were allowed to use DAAs, 249 started treatment and are analysed. Of these 249, 220 have SVR at week 12 post-treatment, 13 have finished treatment, and 7 are still on therapy. We recorded 9 therapeutic failures (2 death, 2 abandonment, 5 failures to S12 post treatment), which correspond to an efficacy rate of 96%, in line with that described in the literature. The mean age of the patients is 45 years, being 75% male. The degree of fibrosis of 94% of the patients was F2 or F3.

Conclusion: The results obtained in the real-life routine of a unit dealing exclusively with co-infected patients demonstrate that treatment of hepatitis C with the new DAA is associated with very high SVR rates, and similar to those described in the literature.

We believe that the routine operation of UF in the day hospital regime, based on a schedule outlined for DAA treatment, with consultations of permanent nursing support and a strict control of adherence and adverse effects played an important role in obtaining of these results.

P8

Constructing identities through selective disclosures of HIV to outsiders: the lived experiences of black African couples in serodiscordant relationships (SdRs) in the UK

Kemoh Rogers

Anglia Ruskin University, Chelmsford, UK

Aim: To examine and gain increased understanding of the lived experiences of Black African migrant couples in SdRs in the UK.

Background: Through effective use of Anti HIV medications, stable relationships containing one HIV positive partner (SdRs) have emerged and are increasing in number and significance. Black African heterosexual men and women are among the high HIV epidemic populations in the UK although some are unaware of their HIV positive status. Hence, a substantial number of people in the Black African community might have a partner with non-identical HIV status. However, limited studies have explored the lived experiences and support needs of Black African couples in known SdRs.

Methods: The emphases in this study are on the lived experiences of couples in SdRs and the phenomenon of SdRs themselves. Therefore, the research is located within the framework of Interpretive Phenomenology. Following multi-centre ethical approval, 19 heterosexual participants from Black African backgrounds in known SdRs were recruited for in-depth interviews from three London Genitourinary Medicines (GUM) clinics (25 interviews in total). The age range of participants was 30–58 years (12 females – 30–45, 7 males – 31–58). MAXQDA software was used for data storage and retrieval. Data was analysed through phenomenological reflection and writing.

Results: Following establishment of dissimilar serostatuses, significant themes emerged from this qualitative study including patterns of disclosure of HIV to outsiders. This proposed oral presentation shows that disclosing HIV within SdRs to family and friends is a complex process of constructing identities involving selective, tactical, disclosure to children and, gender and serostatus related disclosure.

Conclusion: The patterns of disclosing HIV within SdRs is understood in terms of constructing identities and appraising disclosure outcomes as means of coping with HIV as a stressor within SdRs. The implications for nursing and clinical practice, in terms of providing support and information for these couples are considered, particularly with potential benefits of greater engagement with the sero-negative partners.

P9

Clinical trial set-up expectation versus reality

Amy Shepherd, Sheila Morris and Linda Pantou

NHS Lothian, Edinburgh, UK

Background: There is a significant focus within the existing scientific literature on the role research nurses play in coordinating clinical trials, and in the management and care of trial participants. However, the role of the research nurse in the set-up of such clinical trials has received scant attention to date. This exploratory study examines this aspect of the research nurse role.

Methods: Prior to the initiation of a new clinical trial involving pre exposure prophylaxis, data were collected from the research nurse team exploring their expectations surrounding the trial set-up. Insights into the anticipated challenges, predicted strategies for managing these challenges, and expected timescales were gathered. Following the successful initiation of the trial, these expectations were then examined in relation to the actual challenges and obstacles encountered.

Results: Many of the predicted challenges foreseen by the nurse research team arose during the trial set-up. Experience and the utilisation of established protocols and operating procedures ensured these were successfully resolved in a timely manner. However, a number of unexpected difficulties also became evident which necessitated the development of new ways of working, and enhanced personal skills.

Conclusion: The importance of research nurses during the set-up of clinical trials has been clearly demonstrated within this study. The experience of the nurse research team allowed both expected and unforeseen challenges to be met; however, it also highlighted the lack of guidance available relating to the practical aspects of trial set-up for less experienced research nurses. As this is an exploratory study, further research is required to gain a more in-depth account of the vital role research nurses play in the set-up of clinical trials. Without this knowledge, this aspect of the research nurse role remains undervalued, reflected by the lack of reimbursement for trial set-up currently provided within the National template.

P10

Do we meet the criteria? Consideration for PrEP provision locally

Yvonne Wilson, Carol Emerson and Say Quah

Belfast Health and Social Care Trust, UK

Background: With various studies demonstrating Pre Exposure Prophylaxis (PrEP) as highly effective in reducing HIV transmission, Health Departments are under pressure to provide the treatment.

Method: Questionnaire feedback from 60 men who have sex with men (MSM) attending sexual health clinic, questions were based around the eligibility criteria for the PROUD study and some additional information we felt may be useful.

Results: 58 MSM & 2 trans women:

35 (58%) reported unprotected anal intercourse (UPAI) in the past 3 months, average number of partners 7.

6/35 had treatment for an infection in the past 6 months, all Gonorrhoea.

25 MSM (42%) reported no UPAI in past 3 months, average number of partners 2.

2 treated for infections, 1 GC and 1 had Syphilis and CT.

Overall 16 (27%) reported drug use, no IVDU. 43 (72%) used social media to meet partners, 16 (27%) used male only saunas.

56 (93%) would use PrEP if available.

24/60 was asked if using PrEP may encourage them to have UPAI, 5 (20%) responded yes.

6 (10%) had used Post Exposure Prophylaxis following Sexual Exposure (PEPSE). In the last 2 years we provided 216 MSM with PEPSE, 29 (14%) used it more than once, 5 (2%) are now HIV positive.

Conclusions: There appears to be high risk behaviour within our MSM cohort. PrEP has a role to play in prevention of HIV transmission, if funding became available for PrEP the service may need to find ways to target the higher risk individuals. 58% met the recommended criteria by BASHH/BHIVA.

P11

Contraceptive use in HIV-positive women: are effective methods being offered?

Yvonne Wilson, Laura Bell, Wallace Dinsmore, Emma McCarty, Clare Donnelly, Carol Emerson and Say Quah

Belfast Health and Social Care Trust, UK

Background: British HIV Association (BHIVA) guidelines recommend that consistent condom use should be encouraged along with additional methods of contraception for women living with HIV. Highly active antiretroviral therapy (HAART) may reduce the efficacy of hormonal contraceptive.

Methods: A retrospective chart review was carried out of all women under the age of 45 regularly attending the clinic (attended twice in the past year). Charts were reviewed to establish if the method of contraception used was discussed and documented within the past year; which method was being used and if there were any drug interactions.

Results: A total of 145 female patients were identified. The method of contraception used was documented in 75%, as shown in the table. Of the women reporting no contraceptive use 14 were not sexually active. 124 (86%) patients were prescribed

HAART. Of those patients who were prescribed HAART and hormonal methods of contraception, 2 potential drug interactions were identified of which 1 had been discussed with patient.

From 2014–2016 29 patients became pregnant (those diagnosed through antenatal services were excluded) of which 19 were prescribed HAART.

Method	Number	Method	Number
Condoms	46	COCP	4
None	36	POP	2
IUS	8	Implant	1
IUD	3	DMPA	2
Hysterectomy / Sterilised	6	Not documented	37

Conclusion: Contraceptive methods should be discussed with HIV positive patients along with advice on consistent use of condoms in patients using hormonal methods of contraception and HAART. This will help prevent unplanned pregnancies as well as HIV transmission.

P12

A patient taking antiretroviral therapy who was found to be HIV negative

Martin Jones

East Sussex Healthcare NHS Trust, UK

Two months after arrival in the United Kingdom (UK), a 52 year old black African health worker was referred to the HIV clinic by his GP. He required a prescription for tenofovir, lamivudine and efavirenz. He described feeling intoxicated, bad dreams and dizziness. He reported two missed doses in the previous three months, was switched to Atripla and baseline monitoring was performed.

When previously unknown patients taking antiretroviral therapy (ART) present to the clinic it is our practice to confirm HIV-positive serology. However there is no specific recommendation for transfers-in in the BHIVA monitoring guidelines.

The microbiology laboratory contacted the clinic when all HIV tests using two different fourth generation platforms showed HIV antibody/antigen (Ab/Ag) not detected. The patient returned to clinic for repeat sampling including testing for HIV proviral DNA. A third generation point of care test (POCT) showed HIV Ab not detected. Prior to marriage in 2001 he and his wife-to-be had HIV negative tests. In 2012 he and his wife attended a clinic where same-day-testing on venous samples resulted in both being diagnosed HIV positive. He reported that he did not have a confirmatory HIV test. He described no other sexual risks and had never had an occupational risk working in healthcare in Africa. The couple started ART shortly after diagnosis. We contacted his HIV physician Africa who checked the patient record. This showed baseline haematology, biochemistry and hepatitis B results but no record of an HIV test or of ART initiation.

HIV proviral DNA was not detected; a second POCT performed at the patient's request showed HIV Ab not detected and a HIV viral load (VL) test, recommended by the HIV Reference Laboratory four weeks after stopping ART showed VL <40. After four years living as if with HIV, the patient is adjusting to the news that he is HIV negative.