

ABSTRACTS

For the
17th NHIVNA Annual Conference
held at
Royal Armouries International, Leeds
17-19 June 2015

Abstract O1

An exploration of the health and social care concerns of HIV-positive gay men aged over 65: a qualitative study using photo elicitation and framework analysis

L Kerr¹ and R Bartlett²¹Brighton and Sussex University Hospitals NHS Trust, Brighton, UK and ²University of Southampton, Southampton, UK

Background: The number of HIV-positive adults aged over 50 in the UK has tripled in the past decade: the majority are gay men. Research indicates these individuals experience increased physiological, psychological and social difficulties relative to their younger peers. Thus far, little is known about HIV-positive adults of older ages, defined here as over 65, who are among the first generation to age with HIV-disease. This study begins to address this gap by exploring the health and social care concerns of HIV-positive gay men aged over 65.

Methods: An in-depth qualitative study with six HIV-positive gay men. Data was generated from one-to-one semi-structured interviews and photo-elicitation. A framework analysis approach was used to analyse both the interview transcripts and the references made by the men to the photographs in order to identify relevant themes and concepts. Thus, two sources of data were used to generate an explanatory account of the men's health and social care concerns.

Results: The men's concerns were found to be diverse and to broadly relate to four distinct typologies: personal health; gay identity; service provision; and social well-being. Whilst similar in some respects to those of other HIV-positive and older people, the men's concerns were simultaneously distinct and inextricably linked to their identities as 'older gay men' and 'the first generation of people ageing with HIV'. Most fundamental was a sense of great uncertainty that framed their experiences of ageing with HIV (often compounded by other socially and medically mediated disadvantages), that leads to increased anxiety and distress.

Despite these challenges, the men also exhibited a number of beneficial adaptive responses that facilitated quality of life in older age: a highly-developed sense of agency in relation to optimising health and well-being; a perception of the care/relationships within HIV services to be of an exceptionally high standard; and other beneficent aspects of belonging to the broader gay and HIV communities.

Conclusions: This study suggests the health and social care concerns of HIV-positive gay men aged over 65 reflect very particular underlying needs. The nature of these men's needs and circumstances are such that current generic older people's services would appear to be under prepared and unable to provide adequate care. Given the unique positioning of older HIV-positive individuals and age associated increasing need for involvement with multiple non-HIV services, further investigation of this group is warranted and necessary, if appropriate care is to be provided.

Abstract O2

Experiences of HIV-positive patients accessing a one-stop clinic

J Mellor

Manchester Centre for Sexual Health, Central Manchester University Hospitals NHS Foundation Trust, Manchester, UK

Background: With advancements in antiretroviral therapy, the life expectancy of many HIV-positive patients has improved with minimal complications. Historically many clinics require patients to attend for blood tests followed by medical review after. The one stop project aims to combine the blood and medical appointments together whilst offering patients a complete holistic assessment and review in a single clinic visit. We aim to offer patients an alternative model not only to improve patient's experience but also to reduce the DNA rate.

Clinic proformas and protocols were developed in accordance with national guidelines. Patients who were suitable were offered this clinic as an alternative. A senior HIV Clinical Nurse Specialist and a HIV clinician work in parallel with a nursing assistant providing phlebotomy and chaperone if needed.

Methods: Information include demographics, treatment history, HIV parameters, and DNA rate were included. An on-line patient satisfaction questionnaire was designed for patients to provide feedback on the service.

Results: 36 patients were booked into this service since February 2015. 5 patients DNA'd (13%). 31 patients attended, 29 males (94%) and 2 females (6%). The median age was 39 (range 28–59). 29 patients (94%) were on treatment and 22 (71%) had other co-morbidities. Demographics and feedback can be seen in the below table.

Comorbidities	number (%)
Diabetes	1 (0.03%)
Hypertension	5 (16.1%)
Hyperlipidaemia	20 (64.5%)
CVD Risk >10%	3 (0.1%)
HBV infection	1 (0.03%)
HCV infection	0 (0.0%)
Smoking	13 (41.9%)
STI Screen performed	18 (58.1%)
STI infection	5 (27.7%)
Questionnaire – Sent (n=31), Returned via online link (n=13, 41.9%)	
Result received within 7 days	11 (84.6%)
Results received within 14 days	13 (100.0%)
Confidence in care delivered by nurse	13 (100.0%)
Convenience of the new service	
Excellent	12 (92.3%)
Neutral	1 (0.8%)
Poor	0 (0.0%)
Delivery of Care	
Excellent	11 (84.6%)
Good	2 (15.4%)
Poor	0 (0.0%)

Conclusions: The majority of the patients are highly satisfied with this service. The number of clinic visits have reduced yet patients continue to receive a complete holistic care. Having a non-medical nurse prescriber working independently with an HIV clinician improves the clinic capacity by 67% without increasing patient waiting time. We are currently planning to increase the number of one stop clinics at different times, and train more HIV nurse specialists to meet the national competency and become non-medical prescribers. This will improve our clinic efficiency and patient experience with limited resources.

Abstract O3

Patient perspectives on the treatment cascade

J Bruton and T Rai

Imperial College London, London, UK

Methods: We conducted semi-structured, face-to-face interviews with 48 HIV-positive adults recruited from two HIV clinics, and observed patient consultations. Interview participants were purposively selected from the four HIV 'generations', based on availability and effectiveness of ART – those diagnosed pre-1996, 1997–2005, 2006–2012, and new diagnoses since 2013. Framework was used to analyse the data.

Results: *Diagnosis:* Participants from the pre-treatment era were diagnosed on the development of AIDS-defining conditions, or following a partner's diagnosis. Late diagnosis of recently diagnosed was either because they underestimated their own risk, or the failure of healthcare professionals to spot indicator conditions.

Linkage with care: The earlier generations sometimes chose to disengage with care for a period because of dismay at the lack of treatment or toxicities. In contrast, those diagnosed since 2005 were linked to care promptly and generally felt they received appropriate medical support and counselling.

Retention in care: Once linked to care, participants reported continuous engagement and a commitment to attending appointments and taking their medications. Occasional lapses were explained by issues; such as, drug misuse, household disruption and economic insecurity rather than their relationship with the clinic. Some participants reported feeling uncomfortable with reduced frequency of clinic appointments; in these cases their emotional dependence on the clinic was evident, and they worried about the impact of reduced contact on their lives.

Viral suppression among those on ART: Most participants were undetectable on ART. Actual or anticipated co-morbidities were a greater concern than HIV, however, wider discussions about NHS cost cutting have raised patient anxiety about the availability of the 'best' treatments, participants had varied interpretations of the drivers for the changes in service delivery.

Conclusion: The high standard of the HIV treatment cascade in the UK should be maintained and improved. Being sensitive to how patients experience the stages of decision-making and the wider influences that impact on their behaviour is vital towards achieving this.

Abstract O4

Indicators of complex social needs in a small cohort of HIV-positive adults

A Barnes

Body & Soul, London, UK

Background: Adults living with HIV may have complex practical needs that contribute to their overall wellbeing and productivity. Recent changes in social services provision in the UK due to austerity measures may have impacted the social wellbeing of this population. The purpose of this service-related needs assessment is to utilize several factors to explore complex needs of adults aged 20+ living with HIV.

Methods: A survey comprising multiple choice and short-answer questions was administered to a convenience sample of 107 adults aged 20+ whilst they accessed a third-sector support service. Questions were structured to capture basic indicators around social wellbeing, and participants were able to opt out of the survey or specific survey questions. 100 participants met inclusion criteria. Results were then analysed and used to inform service improvements.

Results: 52% of respondents were female. 19% of respondents were aged 20–29 years, 19% aged 30–39, 28% aged 40–49, and 29% aged 50+ (5% no response). The majority of respondents self-identified as Black-African ethnicity. 50% of respondents reported not being able to work due to health, immigration, or other factors. Older adults aged 50+ were more likely to report an employment barrier than adults younger than 40 (75.9% versus 27%). Younger adults were the group most likely to be looking for work, and also most likely to be concurrently enrolled in education programmes. 26% currently had a social worker, 24% previously had a social worker, and 12% have never had a social worker but their children either currently or previously have been under social care. Only 1/3rd reported that it was easy to access support services like benefits advice, counselling, or other advocacy, in their local area. Amongst respondents, 34% have been homeless, 45% regularly do not have enough money for food, 25% do not feel safe in their neighbourhoods, and 76% report being worried about their future. 51% feel like people treat them differently because of their HIV status.

Conclusions: Adults living with HIV may have practical barriers to wellbeing and productivity. This service-improvement related needs-assessment highlights several practical challenges faced by this cohort. Social support services in the UK need to recognize and respond to the complex needs of this group. Further, better-powered research is needed to identify factors that contribute to these needs.

Abstract O5

Peer Navigators – can patient-led support contribute to clinical and well-being outcomes?

A Anderson¹, J Anderson², M Fadojutimi², I Reeves² and M Wills²

¹Positively UK, London, UK and ²Homerton University Hospital, NHS Foundation Trust, London, UK

Background: HUH is in a high HIV prevalence area with a diagnosed prevalence of 8.11 per 1000 (London average 5.8/1000).

- Approximately 1,100 adults receive HIV care at HUH
- 75% women and 75% from ethnic minority communities
- Approximately 100 new diagnoses are made annually
- Approximately 50 women living with HIV give birth in the hospital.
- Significant numbers are within the immigration system, compromising their eligibility for statutory support and increasing their vulnerability
- Poverty, housing and food security are common problems, exacerbated by welfare reforms

We wanted to increase capacity to meet growing support needs by appointing 'Peer Navigators' (PNs): patients trained and employed to provide peer support.

Methods: Working in partnership with Positively UK, 3 patients were appointed through a competitive selection process. They were trained and accredited, receiving an NVQ Level 2 in Peer Mentoring from the Open College Network. Supervision was provided by the clinic's Social Care Co-ordinator and Positively UK's Peer Case Worker. Support was provided during all HIV clinics. PNs worked with patients to identify needs and priorities, set action plans, work towards agreed goals and undertake advocacy with third party agencies. The service was evaluated internally using an outcome star, with patients self-assessing on a 10-point Likert scale upon registration, with reviews throughout, and upon completion of the support programme. Exit interviews with patients assessed to what extent needs had been met.

Results: 40 patients with high level needs were supported through 200 hours of one-to-one support; 70% had increased uptake of services ranging from benefits advice to immigration and hardship support. 6% reported an increase in disclosure and talking to others about HIV; 53% reported being in a better financial position. Adherence to HIV medications was generally high across the cohort, nevertheless just under half said their understanding and adherence had improved. 23% reported a significant improvement. One Peer Navigator has since gained further employment as a result of the project.

Conclusion: Embedding peer support within the clinic is an effective way of skilling up patients and providing essential peer support, information and advocacy. Collaboration and harnessing the skills of the clinic and voluntary sector were crucial to the success of the project. The Peer Navigator model is replicable and could be rolled out to other centres.

Abstract O7

The Wellness Thermometer: the experiences of patients with human immunodeficiency virus with a new wellbeing monitoring tool

M Croston¹, T Whitehead², A Ustianowski¹, D Lindsay², P Benn², A Dunne³, M Jones⁴, S Walker⁵, D Sheedy² and J Petrak⁶

¹North Manchester General Hospital, Greater Manchester, UK; ²Gilead Sciences Ltd, Cambridge, UK, ³Freelance Medical Writer, Greater Manchester, UK; ⁴East Sussex Healthcare NHS Trust, East Sussex, UK; ⁵Milton Keynes Hospital, Buckinghamshire, UK and ⁶Homerton University Hospital, London, UK

Background: Patients with HIV do not always feel comfortable or able to discuss some topics with their care team. Elsewhere we have reported on the development of the Wellness Thermometer to facilitate such communication. Here we report on the experiences of patients who have used the Wellness Thermometer.

Methods: The Wellness Thermometer was trialled in three HIV clinics across the UK for eight weeks. Patients completed anonymous surveys, evaluating their view of the Wellness Thermometer by giving a rating ranging from 'strongly agree' to 'strongly disagree' to the following:

1. The Wellness Thermometer helped me identify my concerns
2. The Wellness Thermometer improved my conversation with my doctor/nurse
3. The Wellness Thermometer helped me bring up my concerns with my doctor/nurse
4. The Wellness Thermometer will help me record my concerns between appointments
5. I would recommend the Wellness Thermometer to a friend or family with a health problem
6. I would recommend the Wellness Thermometer to other people with my condition

Patients were asked to rate the usefulness of being able to record overall wellbeing, specific issues regarding wellbeing and being able to write down what they wanted to discuss in their consultation.

Results: In total, 231 surveys were completed. Responses are reported in Table 1.

'Ability to record overall wellbeing' and 'ability to record specific aspects of wellbeing' were both rated as 'most useful' or 'useful' by 90% of patients. 'Ability to write down what the patient wanted to discuss in the consultation' was rated as 'most useful' or 'useful' by 85% of patients.

Conclusion: Participating patients overwhelmingly reported positive experiences with, and impressions of, the Wellness Thermometer. The results reported here strongly suggest that the Wellness Thermometer was well received by patients with HIV and that it greatly enhanced patients' ability to communicate their concerns with their care team. The Wellness Thermometer could be a highly valued tool for patients to enhance patient relationships with their care teams and facilitate communication of any concerns.

Statement	Strongly agree, %	Agree, %	Neutral, %	Disagree, %	Strongly disagree, %	Missing, %
1	29.4	50.6	15.6	1.3	3.0	0.0
2	28.6	50.2	14.7	3.0	3.5	0.0
3	35.1	46.3	12.1	2.6	3.5	0.4
4	30.3	45.9	17.3	2.2	3.0	1.3
5	36.1	45.5	13.0	2.6	3.5	0.4
6	35.9	47.2	10.4	2.6	3.5	0.4

Abstract O6

Perceptions of support amongst adolescents living with and affected by HIV

A Barnes

Body & Soul, London, UK

Background: Adolescents living with and affected by HIV are disproportionately vulnerable to poor health and social outcomes. The purpose of this service-improvement related needs assessment was to identify factors that the adolescents (herein referred to as participants) view as risky or protective in their lives, with a focus on factors that bring confidence or strength. This abstract specifically focuses on participants' relationship with key individuals. Results from this assessment were used to shape third-sector support services.

Methods: A survey comprising multiple choice and short-answer questions was administered to a convenience sample of 24 adolescents between the ages of 13–20. Survey questions were developed along with HIV-positive peer mentors. The survey focused largely on relationships and relationship quality, as it was an area that peer mentors identified as essential to young people's lives.

Results: Half the participants were female. All identified as Black-African or Black-British. 1/6 lived alone or with siblings, and 5/6 lived with at least one parent, of whom 1/5 lived with both parents. 2 respondents talk about HIV with friends outside of charities. Participants inconsistently discussed HIV with family members. 7 never had discussed HIV directly with family members, 5 only ever discussed HIV with family during naming of HIV, 5 only talked to certain people in their family about HIV, 5 felt they could talk to someone in their family about HIV whenever they wanted to, and only 1 participant stated that their family was open about HIV. Despite inconsistently discussing HIV in the home, participants rated their overall quality of communication with parents as good (mean 7.29/10). All HIV positive participants felt more confident communicating with their HIV consultant than with their friends (means 6.31 and 5.79 respectively), a result which should be explored in greater depth.

Conclusions: Reliable support improves health outcomes of people living with long-term conditions. Social support and acceptance is especially important in stigmatised conditions like HIV. This assessment provides initial evidence that the degree of connection between adolescents living with HIV and key persons around them is highly variable and dependent on the individual. This information could help improve service provision, especially as it relates to transition. Further, better powered research is needed.

Abstract O8

Being positive about being positive – staff stories to increase HIV awareness

T Buckingham

Brighton and Sussex University Hospitals, Brighton, UK

Aim of project: In spite of the advances in HIV treatment and care in the UK over the past 30 years, there continue to be reports of HIV related stigma in both healthcare and community settings. The aim of this project was to utilise the personal stories of HIV positive healthcare workers (HCW) to increase HIV awareness across an NHS Trust.

Method: 7 HIV positive HCW who attended the HIV clinic in the NHS Trust were approached and asked to write an account of their experiences of testing; living and working with HIV and disclosure of HIV status at work. These stories were circulated during HIV Testing Week (24th–1st December 2014) with one story published on the Trust info net daily for one week. The number of info net visits were subsequently analysed by day and story and further thematic analysis of the stories was undertaken with permission of the contributors.

Results: 6/7 healthcare workers agreed to participate in writing. All were on ART and engaged in care. While all 6 HCW had previously disclosed their status to some of their work colleagues, only one staff member chose to divulge their name in the published stories.

Key themes from the stories included impact of diagnosis, taking control and selected disclosure. Disclosure to work colleagues was largely based on perceptions of being judged and how other healthcare workers were seen to react towards HIV positive patients. During HIV Testing week, there were 2,574 recorded hits on the Trust info net for the staff stories. The range was 150–738 (Mean 429, Median 380) hits per day with the higher number occurring at the beginning of the project when the HIV testing campaign was launched by the Chief Executive. Independent feedback from Trust staff was positive and supportive but acknowledged ongoing issues with HIV stigma. The stories were also published in one of the local newspapers at the request of the sexual health commissioner.

Conclusion: This project has demonstrated a successful approach to using staff stories as a means of increasing HIV awareness and highlights the importance of challenging negative or judgemental attitudes towards people with HIV in healthcare settings.

Abstract O9

Text messaging to encourage uptake of HIV testing amongst African communities: findings from a theory-based feasibility study

C Evans¹, A Juma², H Blake¹ and K Turner¹

¹University of Nottingham, Nottingham, UK and

²African Institute of Social Development, Nottingham, UK

Background: There is a public health need to tackle high levels of undiagnosed (or late diagnosed) HIV amongst the UK's African communities. This research aimed to assess the feasibility and acceptability of using a text messaging intervention to encourage uptake of HIV testing amongst this population in Nottingham.

Methods: Participatory research adopting a mixed-methods design. Four distinct stages included:

[1] Formative Research: Six focus group discussions (FGDs) (*n*=48) were conducted with diverse sections of the African community to assess perceptions about HIV and to inform message development. The Health Belief Model (HBM) was used as an organising framework for data analysis and interpretation.

[2] Message Development: SMS messages were developed based on HBM constructs, existing HIV campaigns and FGD findings, and tailored according to language, gender and religion. 12 HIV-related and 12 generic health-related text messages were developed and piloted using elicitation interview processes.

[3] Intervention and outcomes: 172 participants were recruited. They received 2 messages per week for 12 weeks. Data was collected in pre and post questionnaire surveys assessing uptake of HIV testing, HIV-related attitudes and knowledge and perceived general health.

[4] Evaluation: Acceptability and meaningfulness of the intervention were explored via semi-structured telephone interviews (*n*=21). Data were analysed using thematic content analysis.

Results: Follow up data was collected for 76 of the participants (44%). Of these, 10.5% (*n*=8) reported having had an HIV test during/after the intervention. Risk perception remained low at pre and post-test. Non-significant improvements were observed in HIV-related knowledge (testing procedures and treatment availability) and attitudes towards HIV. Qualitative evaluation (*n*=21) showed that messages were perceived to be highly acceptable, useful and appropriately targeted. The majority of those interviewed had shared the messages with others and reported intentions to test in future.

Conclusions: SMS text messaging is an acceptable and feasible method of promoting HIV testing in African communities, with widespread appeal. Rate of testing uptake is comparable to other community-based strategies in this population. More research is needed to fully understand outcomes and impact on testing uptake, and methods of improving response to follow-up.

Abstract O11

Developing collaborative care between community and hospital HIV services

P Davies¹, E Foote², H Reynolds¹, T Mannix², S Caddick¹ and P Jelliman²

¹Royal Liverpool & Broadgreen University Hospitals NHS Trust, Liverpool, UK and

²Liverpool Community Health NHS Trust, Liverpool, UK

Background: The BHIVA standards of care recommended the establishment of clear protocols and pathways for care between both primary and secondary care for safe delivery of care, and strongly recommended regular communication unless the patient specifically refused consent. In our city we have both an acute hospital based specialist nursing team (CNS) and a community based specialist nursing team providing care to our HIV cohort. Development of improved patient care between hospital and community settings was improved by HIV community nurses attending a weekly hospital MDT meeting. An awareness of a gap within our communication between acute and community CNS teams was central to the development of a monthly nursing meeting so as to fully support our patient cohort.

Methods: A community HIV audit performed in 2014 prior to the development of joint meetings looked at communication between the community CNS and the acute CNS teams. The majority of communication was verbal via the telephone, however, communication in written format was minimal. Audit results showed that in 1 year 21 letters were sent from the community CNS to acute team and 32 letters were sent from acute team to community CNS from a caseload of 52 patients. Audit recommendations were to set up regular monthly MDT meetings between HIV CNS and HIV CNS teams to discuss complex patients and shared patients; for written correspondence from the MDT to be filed in patient's notes; to create and regularly update a spread sheet of all community supported patients.

Results: Community and acute CNS teams collaborated and developed a monthly forum essentially to improve our review process of mutual patients from a cohort of 1000 registered in acute services. Terms of reference were agreed along with a regular monthly meeting time. Evolution of the meeting format now includes administration support and development of a proforma for each patient discussed that is filed in both community and acute medical records.

Conclusion: We now have an integrated community and acute HIV nursing team which is fit for purpose and have created a close, seamless nursing network. The joint meetings allow us to share best practice with improved communication in a formalised written process. Shared information is secure and will result in better care for patients. The development of this collaborative care has allowed us to work at level 4 of the NHIVNA competencies (G4).

Abstract O10

Survey of nurse prescribing in HIV care

G Barker

St Helens and Knowsley Teaching Hospitals, Merseyside, UK

Background: Non-medical prescribing (NMP) for nurses has grown significantly in recent years with over 19000 NMP's in the United Kingdom. The extent to which nurses are using this qualification can vary within the same specialty. The aim of this survey is to identify how the NMP is being used within HIV and the support received by nurses.

Methods: An anonymous online survey was distributed to all National HIV Nurses Association (NHIVNA) and British HIV Association (BHIVA) members in December 2014. Inclusion criteria was: Registered Nurse with a valid NMP qualification registered with the Nursing and Midwifery Council.

Results: 22 responses were received, however, 3 of these had not completed the course, thus their responses were removed. 18 responders prescribed repeat antiretroviral therapy (ART). Of these 9 prescribed new ART regimes for naive patients where they made the treatment decisions, with 12 also prescribing when switching regimes. In addition, 12 also reported prescribing medication for other ongoing medical conditions such as hypertension or cholesterol. 1 responder did not state what they were prescribing. 16 responders felt that their skills as an NMP were being used effectively. The table below shows how having an NMP qualification has affected their role.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Improved job satisfaction	0	0	2	6	11
Increased workload	0	4	6	4	5
Saved time during working day	0	0	3	8	13
Allowed me to deal with patients more effectively	0	0	0	6	13
Improved relationship with patients	0	0	3	10	6
Allowed me to manage more complex patients independently	0	1	2	10	6
Allowed the doctors to spend more time with complex patients	0	2	4	5	8

Respondents were asked about barriers that they had faced after gaining their NMP qualification. Reluctance from medical staff, limited training opportunities, being used only for repeat prescriptions and only being allowed to prescribe new regimes after discussing with a doctor first were identified. One respondent reported sitting an internal exam to prove competence in prescribing when transferring to a new Trust. A lack of education was identified with the majority of responders only having training relevant to their role as NMP once a year. This was provided in a variety of ways with the majority being by the Trust or Employer. Few responders reported training through local HIV networks, NHIVNA or BHIVA. When asked about support the two main themes were training specific to NMP in the form of case studies and workshops and a forum for NMP's in HIV care.

Conclusion: This survey has identified that overall being an NMP has had a positive impact on nurses roles and that the majority of nurses are supported by medical colleagues. There is a need for further training and support network for NMP's in HIV care

Abstract O12

An audit using Draft Outcomes for HIV Specialist Outpatient and Community Nurses

S Attridge

Cardiff Royal Infirmary, Cardiff, UK

Background: The need to provide evidence of the need for HIV Specialist Nurses has been an enigma within the discipline. Commissioners require measurable outcomes to evaluate HIV services; therefore a proof of concept audit was developed to evaluate Draft Outcomes for HIV Specialist Nurses (DOHS).

Methods: An audit pro-forma was created using the DOHS. The pro-forma required documented evidence of HIV Nurses discussing specific items relating to the four of the five themes within the outcomes (dying prematurely, quality of life, recovery and maintaining a safe environment). Ethical Approval was not required, audit approval was granted by the UHB. The pro-forma was verified by discussions with medical and pharmaceutical colleagues. To examine the patient perspective of the DOHS a self administered questionnaire asking patients if they happy talking about the issues mentioned in the audit pro-forma. The patient questionnaire was completed by a small sample of patients (*n*=18).

A total of 50 patients who had been reviewed by a CNS were audited. The criteria for inclusion required generation of medication script for patients on ARVs, blood results requested and the appointment was not a recall.

Results: Sexual health was documented in all patient notes audited. Documented evidence of switching ARVs was found in 10% of notes. Half of the notes audited had evidence of vaccinations being given at the appointment with the CNS. Blood pressure was documented in all but 4 patients. Sadly cardiovascular disease (score) was only documented in 24% of notes. The use of recreational drugs was documented in 90% of patient's notes.

The patient questionnaire revealed some interesting findings. Only 16% of patients felt illicit/recreational drugs should be discussed during their consultations. However 100% of patients who completed the questionnaire felt blood pressure should be discussed in their consultations. Patients do not seem to know the wider context of their blood pressure, only 55% of patients feel cardiovascular disease should be discussed in the consultation.

Conclusions: Whilst auditing it became apparent that further criteria's could be added to the audit pro forma. The audit pro-forma functions as a proof of concept. Documenting is essential to prove clinical worth. Patients have different expectations what should be discussed in consultations.

Abstract P1

Developing a nurse-led post-exposure prophylaxis service: creating an expert nurse

B Thomson¹, R O'Connell¹, M Fields² and A Hartley¹¹Barts Health NHS Trust, London, UK and ²Royal Free London NHS Foundation Trust, London, UK

Background: The risk of seroconversion after exposure to the human immunodeficiency virus (HIV) can be reduced by taking post exposure prophylaxis (PEP), preferably as soon as possible after the event, but within 72 hours. Robust and widely disseminated clinical pathways are needed for access to PEP. Effective assessment, follow up and support for patients while taking PEP is required, including support for future sexual health and well-being. We describe how a PEP service was developed following audit of a pre-existing service, along with a quality review of the new PEP service.

Methods: The development team included a clinical nurse specialist (CNS), 2 consultants, specialist registrar and sexual health adviser. The plan-do-study-act cycle was used as a basis for the service improvement and continual review. The team agreed that a nurse-led service was desirable. The development of the CNS as an expert practitioner became a core component of the project. The different stages of developing a nurse-led service are described. We maintained a flexible approach to development, including adjusting components of the service following reflection.

Results: The CNS completed a programme of training and supervision by 2 consultants to gain skills around evaluation of HIV and hepatitis exposure risks, managing clinical and psychological aspects of patients taking PEP, and managing sexually transmitted infections.

A 2011 audit of the PEP service, undertaken before the redesign, showed that 1 out of 4 auditable outcomes had been achieved. Audit of the redesigned PEP service showed that 6 out of 7 auditable outcomes were achieved.

The CNS found that patients presenting for PEP following 'chemsex' and attendance at sex parties was an emerging trend.

Abstract P2

BHIVA Standards 2013: how relevant are they for HIV nurses?

M Roche¹, M Martin¹, M Croston² and E Nixon¹¹Brighton & Sussex University Hospitals Trust, Brighton, UK and²North Manchester General Hospital, Manchester, UK

Background: The BHIVA standards for Patients Living with HIV were first launched in 2013 with the initial aim of ensuring that those providing care for patients with HIV had clear goals on what was expected and required of them together with ensuring 'ways of auditing and performance.'

Methods: Against a back drop of existing research showing that 'considerable effort' is required to engage people in clinical governance arrangements at local level, an online survey was sent to members of two regional HIV nurses networks. Ethical approval was not required. The aim of this project was to undertake a survey of the impact of the BHIVA standards on nurses working in HIV to identify the following:

1. How engaged nurses are with the standards
2. Whether engagement differed across the standards
3. Impact on nursing practice and how the standards influenced or changed nurses practice.

Results: 44 nurses responded of which; Staff Nurse = 10, Junior Sister/Charge Nurse = 6, Clinical Nurse Specialist = 16, Research Nurse = 4, Nurse Manager/Nurse Consultant = 5, Other = 3. The vast majority of respondents were hospital based working in a GUM/HIV/ID outpatient setting or an inpatient setting.

The majority of respondents (63.64%, $n=28$) either agreed or strongly agreed that the standards had influenced their practice. 40.9%, $n=17$, agreed that their practice had changed since the launch of the standards. 45.46%, $n=20$ either agreed/strongly agreed that they regularly reference the standards to ensure high quality of care. Most of the respondents felt that either or all of the standards was either relevant or extremely relevant to their practice.

The responses to qualitative questions looking at influence of the standards on practice have been grouped into themes.

Theme	
Utility of Standards	Not Visible enough Often difficult to engage service users as a result
Competencies	Should be more about competencies for the wider MDT Too medical orientated Not enough about the role of nurses in competencies
Benchmarking	Standards are useful to audit against Often too long Unenforceable to drive service change

Conclusions: The survey suggests that nurses find the BHIVA standards useful and are overall engaged with them. Future development of the standards should look at competencies which reflect the role and utility nurses have in achieving the standards of care, and linking those competencies to further postgraduate education. The standards could be linked to improving service specification and making those improvements enforceable.

Abstract P3

Using social networking sites in the prevention of HIV: a systematic literature review

E Boddye and J McLuskey

Nottingham University School of Health Science, Nottingham, UK

Background: Over the past decade social networking sites have become increasing popular. Sites such as Facebook now have over a billion members and every second about 8,000 tweets are sent via twitter. Social Networking sites offer new and exciting way for people all over the world to communicate with each other 24 hours a day all year round. The aim of this systematic review is to explore how useful social networking sites can be for HIV prevention. It is estimated that worldwide currently there are 35 million people living with HIV, this shows that more preventative measures should be considered to prevent the infection. Social networking offers a great platform due to its reach and availability.

Methods: A systematic approach to literature reviewing was used to compile evidence for this paper. A range of databases were utilised to conduct the search strategy, including ASSIA, Medline and Scopus. Key words such as 'HIV prevention', 'Social Networking' and 'Social Media' enabled data collection that was appropriately focused. Also social networking is such a current trend, the search was restricted to papers published from 2007 onwards. Other inclusion and exclusion criteria involved research undertaken on adults (18+) and research which was performed in developed societies. This focused inclusion criteria produced 12 papers which were appraised critically using an analytical framework.

Results: The results generally show that social networking can have a positive influence on HIV prevention and testing. Many of the results show that 'real-time' social networking, such as instant messaging and interactive Facebook posts offer an effective platform for discussion and influence in terms of HIV prevention. Also the use of peer leaders and cyber health professionals offered an effective method of communicating, especially with those in communities which in the past have been harder to reach.

Conclusion: To conclude, using social networks in HIV prevention does hold promise and some research has been undertaken which indicates the potential benefits of using it. However, more research will be needed in order to gather a greater understanding of how best social networking can be used in HIV prevention outside of the developed world.

Abstract P4

Understanding non-attendance at routine HIV outpatient clinics

L Spowage

Nottingham University Hospital, Nottingham, UK

Background: People living with HIV need to attend routine HIV outpatient clinics and be reviewed by specialists. In our cohort 'did not attend' data from March 2013 to May 2014 was analysed. An average of 26% of appointments were not attended each month.

Method: In order to understand this did not attend rate, service users were invited to comment on what prevented them attending their appointment and if any change to our service would make clinic more accessible.

A telephone survey was designed and peer reviewed within the local HIV specialist multi-disciplinary team. All service users that did not attend their appointment between 1st July and 1st September 2014 were contacted by telephone. Consent was obtained from participants who were informed their responses to the survey would be anonymous and used to inform future service redesign.

Results: We attempted to contact 53 service users. In total we successfully contacted 25 service users. We were unable to contact 28 people due to incorrect contact details. One person declined to take part in the survey.

16/24 (67%) of the participants were female. The majority of the participants were black African (63%). Most were aged between 31–45 years old (58%).

The most common reason for not attending the outpatient appointment was because service users forgot (43%). Other reasons for not attending included perceived stigma, long clinic waits and no continuity with clinicians.

Only 9 (38%) reported receiving a text message to remind them of their appointment. 11 of the surveyed service users (46%) were satisfied with current clinic provision. There was some interest in telephone 'virtual' follow up clinics, evening and weekend clinics.

Conclusion: It is essential that service users have an opportunity to comment on the services they receive and how these can be improved. This telephone survey highlighted that the most common reason that people missed their outpatient appointment was because they forgot. The use of text message reminders should be promoted. Service user contact details should be checked at each visit to ensure text messages are sent to the correct number. Good communication, continuity and trust between service users and specialists is essential in addressing perceived or actual stigma related to clinic attendance.

Abstract P5

Who wants to learn about HIV?

Rebekah Shaw¹ and John McLuskey²

¹Nottingham CityCare Partnership, UK and ²University of Nottingham, UK

HIV has been identified for the past three decades. Even so, knowledge of HIV care amongst some health care professionals remains poor. As an Infection Control Team we have received questions from health care professionals regarding double gloving and the need for special precautions.

It was decided to raise awareness and knowledge by exploring a different approach. Through a review of the evidence it was identified that games can be an effective way to raise awareness amongst more inexperienced staff. Whilst games have been used previously they tended to be based on board games and so it was decided to utilise an approach based on 'who wants to be a millionaire'.

Gaming education has been used to educate patients, teenagers and to test people's assumptions of people with HIV. The 'who wants to be a millionaire' approach has been developed previously to educate first year medical students about pulmonary physiology, hormonal changes in puberty and to raise awareness of HIV amongst pre sixteen year old school pupils. It has not been used to educate health care professionals in this way. This approach utilises formative assessment strategies that can be fun as well as educational.

The questions included universal infection prevention and control precautions as well as knowledge of the HIV virus and how it is transmitted. As questions were answered participants gained a word which will form part of the end word puzzle. It was trialled with twelve participants who were link infection prevention and control clinicians. A pre questionnaire was given to all participants to assess their current knowledge and whether they had previous learning. It showed that they felt confident about their knowledge. However on reflection the questions were too broad and would be adapted for future use. The post questionnaire found that participants had gained knowledge and were positive about the novel approach used.

In conclusion using games to enable learning and bring post results. However, it is important to ensure that the game and questions are appropriate for the audience.

Abstract P7

Implementation of a latent TB screening policy in HIV-positive patients in a low TB-prevalent area

L Bell, Y Wilson, W Dinsmore, C Emerson, S Quah, E McCarty, S Todd and C Donnelly

Belfast Health & Social Care Trust, Belfast, UK

Background: HIV positive individuals with latent TB infection are more likely to reactivate. Treating latent TB in patients co-infected with HIV reduces reactivation. NICE and BHIVA have recommended different criteria for screening latent TB in these patients. A regional TB screening policy was developed incorporating BHIVA and NICE guidelines for our low prevalence population.

Method: Patients from low incidence countries, with a CD4 count <500 cells/mm³ and on ARVs for <2 years were screened. Patients from high incidence countries were screened regardless of CD4 count if they had been on ARVs for <2 years. Patients with prior or active TB were excluded. Patients underwent IGRA testing ± CXR.

Results: 297 patients fulfilled criteria for screening. Of those 72 have so far had IGRA. Of those screened, 1.38% were from sub-Saharan Africa, 15.27% from medium incidence countries and 83.33% from low incidence countries. One IGRA was positive; however this patient previously had TB and did not fulfil the criteria. 71 were negative. Of the 11 patients diagnosed with active TB, 8 presented with TB at HIV diagnosis, 2 were from sub-Saharan Africa but did not fulfil criteria as they were on treatment for >2 years and CD4 count was >500 cells/mm³.

Conclusions: Over the last 5 years only one patient who developed TB would have fulfilled criteria for screening. The majority of HIV positive patients in our cohort who developed TB were from high incidence countries and TB and HIV was diagnosed concurrently. Earlier HIV diagnosis and identifying those at risk of TB will be necessary for TB screening to be effective.

Abstract P6

Healthy eating and nutrition course

J Stanford

Sussex Beacon, Brighton, UK

Background: It has been acknowledged that healthy eating and a healthy lifestyle can help prevent ill health. Also that dietary intake and a healthy lifestyle may be particularly important for people living with HIV, who may have a higher risk of ill health compared to people who are HIV negative. Research has shown that Cardiovascular and bone health are two of the comorbidities which can affect people living with HIV. These were the main area of focus of a course run at an HIV unit.

Methods: The principles of healthy eating and balancing the diet were introduced in the first session along with how to read and interpret nutrition labelling. Cardio-vascular and bone health were covered in the second and third sessions. A portion of the final session was left free for the participants to choose a subject that they would like to learn more about. They chose to learn about food additives. SMART (Specific, Measurable, Achievable, Realistic and Timely) goals were used to achieve a sustainable change in one's diet and how to achieve those goals, along with the concept of the cycle of change.

Results: Participants mentioned that they learnt more by being able to discuss the topics with each other. Interaction with each other was described as assisting the learning process.

Using a numerical Likert-type scale (0–10), participants reported that their knowledge of cardio- protective diet had increased by an average of 3.35 points. The range was from 1 to 7 points. They could all cite a variety of practical changes which they might make to their diets to improve their cardiovascular health. These included reducing the amount of processed food, meat-intake and saturated fats, to increasing exercise, low-fat foods and reading the labels on foods to increase awareness. Knowing the difference between various forms of fats and the issue of portions size and labelling were also cited as positive learning outcomes. Knowledge of bone health and diet increased by an average of 4.25 points. The range was from 2 to 8 points.

Participants reported that their confidence in reading nutrition labels had increased by an average of 4.625 points. The range was from 3 to 6 points.

Conclusion: When looking back at the whole course, finding out about the different food types, the varieties of fats and the use of sugar in foods were seen as being some of the most interesting topics covered. Learning how to read food labels was mentioned as being particularly interesting. 'It helps you shop more accurately'. This feedback implies that the course empowered HIV positive participants to make informed choices about healthy food and nutrition.

Learning from these first two series of the Healthy Eating and Nutrition course and from an informal scoping exercise has shown that education on the topic informs people to make appropriate changes and choices regarding healthy nutrition in the context of living with a long-term condition.

Abstract P8

Recent Infection Testing Algorithm positive rates in men who have sex with men on the increase – 6 month review of new cases

Y Wilson¹, S Quah¹, N Irvine², E McCarty¹, C Emerson¹, W Dinsmore¹, C Donnelly¹ and L Patterson²

¹Belfast Health & Social Care Trust, Belfast, UK and ²Public Health Agency, Belfast, UK

Background: Recent Infection Testing Algorithm (RITA) allows us to measure the incidence of recent HIV infection occurring within the preceding 4–5 months. Since July 2014, there has been an increase in the number of RITA positives within our cohort when compared to numbers observed in previous years. The aim of this project was to identify the feasibility of a targeted intervention to reduce the acquisition of HIV.

Method: All new HIV diagnoses between July 2014 and January 2015 with a positive RITA were identified. An enhanced surveillance questionnaire which collected demographic, clinical and risk factor information was completed with a member of medical / nursing staff in an attempt to identify any common themes.

Results: 16 individuals had a positive RITA, 14 were MSM and were included in the analysis. The median age was 27.5 years, 13/14 were NI residents, all 14 were Caucasian

Location of first presentation	n	%
GUM	12	85.7
Gp	1	7.1
Hospital	1	7.1
Reason for presenting		
Seroconversion illness	1	7.1
Routine STI screen	7	50
Gp referral	1	7.1
Other symptoms	2	14.3
Other	3	21.4
Previous negative test		
Yes	13	92.3
No	1	7.1
Approximate time since last negative test		
0 – 6 months	8	61.5
6 – 12 months	1	7.7
12 – 24 months	2	15.4
>24 months	2	15.4
Co-infections		
Chlamydia	2	15.4
Gonorrhoea	4	30.8
Herpes	1	7.7
Other	1	7.7
None	6	46.2

Social/sexual networks were a common theme in meeting partners 57.1% reported using Apps, 21.4% used Dating websites, only 7.1% reported sauna use and the remainder bars/nightclubs.

Conclusion: Increased numbers of RITA positive infection may be an indication that our efforts to increase awareness and accessibility to testing have been successful particularly in the context of the proportion of individuals who had a recent test. However the safer sex message may not be effective. Accessibility to PEPSE outside of specialist services could be improved. Other strategies to reduce transmission include the use of PrEP; however this is not currently available on the NHS. RITA is a valuable tool which allows us to evaluate our local need for targeted services.

Abstract P9

From city lights to the rural fields

S Chidzomba¹ and C Ormiston²

¹Birmingham Heartlands Hospital, Birmingham, UK and

²Stafford Central Clinic, Stafford, UK

Introduction: The BHIVA guidelines of standards of care for people living with HIV (2013) state no HIV service provider large or small should deliver service in isolation. The service provider's aim is to create a positive patient experience that promotes all aspects of health – physical, psychological, social and spiritual, including support with disclosure thus requiring a complex multifaceted approach.

Method: Using the BHIVA guidelines on shared patient care to manage the complexity of a patient's multiple health conditions two neighbouring areas – one City centre, one urban rural, examine the challenges of sharing care. Centrally is the patient's choice of their treatment and delivery locations, requiring continual update between health care professionals involved in that individual's care; City and rural clinical nurse input such as home visits, co-ordination of patient transport for appointments, inpatient follow up including discharge planning and outpatient follow up. Additional support, practical as well as psychological through the third sector where there is an expressed need. The family and wider social network that are significant in a persons' wellbeing interlink care throughout.

Results: This model of care promotes high standards of medical and nursing care whilst prioritizing patient choice and control to create holistic outcomes that are empowering, self-managing and enduring. Thus conforms to the BHIVA standards of care for people living with HIV and emphasizes the essence of nursing.

Recommendations/Discussion: BHIVA guidelines (standard 9&10) state 'participation in decisions about all aspects of treatment and care, service design and delivery' promotes optimum shared patient care. This shared care in action presents a multi healthcare professional patient model that requires continual reflection, review, adaptation and evaluation to maintain its patient centre and achieve real meaningful care.

Abstract P11

The Wellness Thermometer: healthcare professionals' experiences of using the tool in practice

M Croston¹, T Whitehead², A Ustianowski¹, D Lindsay², P Benn², A Dunne³, M Jones⁴, S Walker⁵, D Sheedy⁵ and J Petrak⁶

¹North Manchester General Hospital, Greater Manchester, UK; ²Gilead Sciences Ltd, Cambridge, UK; ³Freelance Medical Writer, Greater Manchester, UK; ⁴East Sussex Healthcare NHS Trust, East Sussex, UK; ⁵Milton Keynes Hospital, Buckinghamshire, UK and ⁶Homerton University Hospital, London, UK

Background: Treatment and management of patients with HIV has evolved enormously over the previous few decades, from caring for patients with an infectious disease and poor prognosis, to long-term chronic infection treatment. This includes monitoring patients' wellbeing and quality of life as these can impact adherence to therapy. Effective communication between patients and HCPs is essential and all efforts should be made to overcome any communication barriers that exist. Here we report HCPs' experience with the Wellness Thermometer – a tool to facilitate patient-HCP communication.

Methods: The Wellness Thermometer was offered to all patients attending three UK HIV clinics over eight weeks. Participating HCPs were invited to complete a short anonymous survey giving their opinion and experience of the Wellness Thermometer. Ratings from 'strongly agree' to 'strongly disagree' were collected for the following:

1. The Wellness Thermometer helped my patients identify their concerns
2. The Wellness Thermometer improved consultations with my patients
3. The Wellness Thermometer was easy to use and understand
4. The Wellness Thermometer resulted in longer consultations with my patients
5. I think the Wellness Thermometer is a useful tool
6. I would like to introduce the Wellness Thermometer for ALL my patients
7. I would like to introduce the wellness for SELECTED patients for all my patients

HCPs were asked to rate the usefulness of patients being able to write down discussion points ahead of the consultation and the ability to record overall wellbeing and specific concerns.

Results: To date, 12 HCPs have evaluated the Wellness Thermometer. Responses are given in Table 1.

Table 1

Statement	Strongly agree, %	Agree, %	Neutral, %	Disagree, %	Strongly disagree, %
1	25.0	66.7	8.3	0.0	0.0
2	25.0	33.3	33.3	8.3	0.0
3	25.0	66.7	0.0	8.3	0.0
4	16.7	16.7	33.3	33.3	0.0
5	33.3	58.3	8.3	0.0	0.0
6	25.0	25.0	33.3	16.7	0.0
7	25.0	50.0	8.3	16.7	0.0

'Most useful' or 'useful' ratings were given by most HCPs for 'ability to record wellbeing' (82%), 'ability to record specific concerns' (100%) and 'ability to write down what the patient wanted to discuss in the consultation' (91%).

Conclusion: HCPs' experiences of using the Wellness Thermometer were extremely positive. HCPs indicated that the Wellness Thermometer enabled patients' agendas to shape the consultation and enable better communication of any concerns. We envision that the Wellness Thermometer could become a useful tool for establishing open communication between patients and HCPs.

Abstract P10

The Wellness Thermometer: development of a tool to facilitate monitoring of the holistic wellbeing of patients with human immunodeficiency virus

M Croston¹, A Ustianowski¹, T Whitehead², D Lindsay², A Dunne³, I Reeves⁴, C Scott⁵ and J Petrak⁴

¹North Manchester General Hospital, Greater Manchester, UK; ²Gilead Sciences Ltd, Cambridge, UK; ³Freelance Medical Writer, Greater Manchester, UK; ⁴Homerton University Hospital, London, UK and ⁵Chelsea and Westminster Hospital, London, UK

Background: The care paradigm for patients with HIV has changed from managing an infectious condition with a poor prognosis to managing a long-term chronic disease, bringing new challenges to the long-term management of patients with HIV. Effective communication between patients and HCPs is vital for monitoring wellbeing. Wellbeing applies to assessing disease progression, adherence to treatment, adverse events arising from treatment and, importantly, psychological wellbeing. Depression and other psychosocial problems are more common in patients with HIV and can contribute to poor adherence. It is important that patients feel able to communicate with HCPs in order to mitigate these issues. Facilitation of communication is an important, but often challenging aspect of long-term care.

Methods: A survey of HCPs about holistic assessment was conducted in order to assess the perception of wellbeing-monitoring for patients. Following this, a multidisciplinary team (MDT) of HCPs and patient representatives met to analyse and optimise the existing Distress Thermometer, a wellness monitoring tool used in oncology, for patients with HIV. Multiple meetings were held to create and review early drafts of the Wellness Thermometer, in order to make it appropriate for the HIV-care setting.

Results: The survey of HCPs showed that 96% of respondents agreed that patient's needs should be addressed holistically (Table 1) The Wellness Thermometer was developed with the involvement of the MDT to assist monitoring of wellbeing in a quick, convenient and easy manner.

Question	Response		
	Yes, n (%)	No, n (%)	Unsure, n (%)
Do you think as practitioners we should assess patients' needs holistically?	54 (96.4)	0 (0.0)	2 (3.6)
Are you familiar with any particular holistic assessment tool?	16 (28.6)	40 (71.4)	0 (0.0)
Do you use holistic assessment tools to assess HIV positive patients?	9 (16.1)	47 (83.9)	0 (0.0)

Conclusion: The disparity between the numbers of HCPs who felt that patients should be holistically monitored and those who were aware of, and used, holistic assessment tools suggests that there is an unmet need for tools to facilitate monitoring. Here we present the Wellness Thermometer, a tool that will be freely available for use by all and has been designed to facilitate discussions about the wellbeing of patients with HIV in an easy and convenient way. Patient wellbeing improves adherence, leading to improved clinical outcomes such as morbidity and mortality. We believe that the Wellness Thermometer allows for routine and recordable monitoring of wellbeing.

Abstract P12

Could serosorting be used as a sexual risk-reduction strategy amongst men who have sex with men to prevent HIV infection? – a literature review using a systematic approach

RE Gorton and J McLuskey

The University of Nottingham, Nottingham, UK

Background: Anecdotal evidence in practice suggests men who have sex with men (MSM) use Serosorting (A strategy where MSM select sexual partners of the same HIV-status) to reduce potential risk of HIV-acquisition. Recent evidence is limited exploring this behaviour. An existing systematic review focused on all sexually transmitted infections; however specificity to MSM and HIV-acquisition is not direct; therefore the present study reviews the available literature surrounding MSM using Serosorting as a HIV risk-reduction strategy to determine whether the practice could be recommended safe.

Method: A literature review using a systematic approach reviewed empirical literature relating to the topic. A research question was developed where explicit inclusion and exclusion criteria assisted to identify appropriate papers. Bibliographical databases, encompassing a variety of health and social care disciplines, were searched. Papers were evaluated for methodological strength using a critical appraisal tool. A literature-matrix enabled thematic analysis, revealing the current situation regarding the use of Serosorting by MSM.

Results: Serosorting is culturally influenced. White MSM populations are more confident in the protective value of Serosorting compared to Black MSM populations; where prevalence of Serosorting is much higher in White MSM than Black MSM. This said; serosorting appears to be increasing within all MSM population sub-types. Many MSM do not know their own or partner's accurate HIV-status. This is multifactorial as assumptions and trust underpin HIV knowledge and increasing casual relationships coincide with this. Misconceptions, miscommunication and inaccuracy play a role in accurate HIV-status disclosure; a large proportion of perceived HIV-negative MSM are undiagnosed HIV-positive. The minimal preventative success of Serosorting is evident in the inefficiency of Serosorting to reduce risk of HIV-acquisition. Serosorting should not be recommended over conventional methods e.g. condom use to prevent HIV-acquisition. Serosorting was linked to minimal protective value where unprotected receptive anal intercourse was concerned; however compared to condom use, efficacy was significantly reduced, exposing serosorters to HIV risk.

Conclusion: Serosorting appears to be increasing. It is important to understand why MSM use it as a HIV risk-reduction strategy. Close behaviour-interventional support is required to protect those wishing to perform this high-risk practice. Research on this topic is limited in the UK; therefore research to determine prevalence is vital. Further research may assist development of new strategies to promote health of HIV-negative MSM in the UK and support MSM in making 'safer-sex' choices. Serosorting should not be recommended as a risk-reduction strategy to prevent HIV.

Abstract P13

Easy does it! – self-taken samples for Chlamydia and Gonorrhoea in HIV outpatients are acceptable and perceived as both reliable and comfortable by patients

A Croucher and T Buckingham

Brighton Sussex University Hospitals, Brighton, UK

Introduction: Self-taken samples increase testing for Chlamydia trachomatis and Neisseria Gonorrhoea in high-risk asymptomatic populations including HIV-outpatients. Women are offered self-taken vaginal samples; heterosexual men first-pass urine and MSM self-taken rectal and throat samples and first-pass urine. The acceptability of this method of testing is not well understood.

Methods: An anonymous paper survey was offered to all patients attending outpatient-HIV clinic June–July 2014. Data collected: age, gender, ethnicity, sexual-orientation; perceptions of self-taken samples; whether they tested that day, and why.

Results: 121 surveys were returned. Median age=45(20–69) years; 86% male; 68% white British; 73% homosexual. 61/121(50%) rated STI screening as 'very important', 48/121(39%) as 'worthwhile'. 117/121(96%) rated offering self-taken samples in routine HIV clinic as appropriate. 86/121(71%) found the instructions 'easy' to follow and 4/121(3%) 'difficult'. 78/121(64%) said that they thought that self-taken samples are as reliable compared to clinician-taken and 10/121(8%) thought they were more reliable. 60/121(50%) said self-taken samples were as comfortable as clinician-taken; 30/121(25%) said more comfortable. 33/121(27%) responders did self-sampling that day; 78/121(64%) did not. Participants' reasons for accepting self-taken samples included: 'It's easier/quicker than going to a GUM clinic' (37%); 'I prefer doing the swabs myself' (25%). Reasons for not self-sampling included: 'I haven't had any sex since my last sexual health screen' (26%); 'I was not offered a STI screen today' (20%); 'I prefer to go to a GUM clinic' (16%).

Conclusions: The self-swab STI screens are acceptable to patients attending HIV outpatients, and are perceived as being as reliable and as comfortable as clinician-taken samples.

Abstract P14

Stand up and be counted: reclaiming the value of community HIV nursing

S Barber

Bromley Healthcare, Beckenham Beacon, UK

Background: It has been argued that community HIV nursing is under threat. Recent changes in the structure of the NHS have led to revised commissioning structures for HIV treatment and care. The focus on outcomes, based on acute care, do not lend themselves as well to the community HIV nursing environment. The challenge is to find innovative ways to describe community HIV nursing and demonstrate the unique contribution made to the care of the most vulnerable people living with HIV. To do this requires an understanding of outcome measures and the ability to forge relationships with commissioners.

Method: A community HIV services review was conducted locally. At the same time, Bromley health care tasked its services to identify service specific quality metrics based on the 6 Cs and which best reflected patient safety, experience and effectiveness. Auditable indicators were then agreed for each of the quality metrics. Data was also captured using the 'Cassandra' matrix designed by Dr. A Leary to demonstrate typical service activity data. We entered into dialogue with our commissioners to agree a new service specification. We were able to use our quality metrics with their respective indicators to form the basis of our service monitoring and the data captured from 'Cassandra' to demonstrate to commissioners, the nature of our work.

Results/Discussion: We feel commissioners have a clearer understanding of our service and we have a new specification with defined outcomes and performance measures. Outcomes themselves originate from industry where success is achieved by applying quality control levels resulting in a better product or outcome. The best service improvements originate from 'the shop floor'. Such an approach reflects the neo-liberal political ideology and thus health care is now subject to market forces. Working within such a framework is a challenge. Arguably community HIV nursing has fallen behind in this culture because there are few defined standards or benchmarks. Commissioning structures are also unclear following NHS reforms implemented over the past 2 years.

Conclusion: This project shows that it is possible to develop quality measures and performance indicators suitable for community HIV nursing. Support from employers and fostering good relationships with commissioners is key to success. HIV community nurses need to continue to share ideas and examples of their practice and must demand more recognition from our own organisations, commissioners and national HIV bodies such as NHVNA and BHIVA.

Abstracts from the BHIVA Annual Conference held in Brighton 21–24 April 2015

Abstract P15

(BHIVA P10)

Pre-exposure prophylaxis fails to prevent HIV-1 infection or the establishment of a significant viral reservoirJ Fox¹, H Alexander², M Brady², L Else³, N Robinson⁴, C Willberg⁴, M Pace⁴, J Frater⁴ and S Fidler⁵

¹Guy's and St Thomas' NHS Foundation Trust, London, UK; ²King's College Hospital, London, UK; ³University of Liverpool, Liverpool, UK; ⁴University of Oxford, Oxford, UK; ⁵Imperial College London, London, UK

Background: Pre-exposure prophylaxis (PrEP) with antiretroviral therapy (ART) prevents HIV acquisition in randomised trials. Single agent tenofovir PrEP shows benefit over placebo and is comparable with Truvada (Tenofovir/FTC). We report 2 cases of HIV-1 acquisition amongst individuals receiving therapeutic levels of tenofovir for Hepatitis B infection.

Methods: Purified CD4 T cells were analysed by qPCR for HIV-1 DNA (Total and Integrated) and cell-associated unspliced HIV-1 RNA (CA-RNA). Thawed PBMC were stained with an activation panel (CD38, CD69, HLA-DR) and an exhaustion panel (Tim-3, Lag-3, PD1).

Results: Patient A received tenofovir 300mg od and maintained an undetectable Hepatitis B viral load for 4 years. Following HIV-1 seroconversion symptoms he tested HIV-1 positive two weeks after a negative test. Results at HIV-1 diagnosis were: CD4 584 (35%), CD4:CD8 ratio 1.19, HIV plasma viral load <50 copies/ml. The tenofovir trough level was between the 10th and 25th centile. The ART regimen was immediately intensified. Two days after HIV-1 diagnosis total HIV-1 DNA was 3.14 log copies/million CD4 cells and CA-RNA levels were 116 copies/1e6 copies 18s RNA. Patient B received tenofovir 300mg od for 3 years and maintained an undetectable Hepatitis B viral load. During a severe symptomatic seroconversion illness he demonstrated an evolving HIV-1 antibody response. Results at HIV-1 diagnosis were: CD4 count 550 cells/ μ l (24%), CD4:CD8 ratio 0.49, plasma HIV-1 viral load 103,306 copies/ml and a tenofovir trough drug level at the 75th centile. The ART regimen was immediately intensified. 12 days after HIV diagnosis, total HIV-1 DNA was 3.44 log copies/million CD4 T cells, and CA-RNA levels were 1236 copies/1e6 copies 18s RNA. For patients A and B, levels of total HIV-1 DNA were at the lower end of the range of values measured for SPARTAC participants (n=154) close to seroconversion (median 3.88 log copies (IQR 3.42–4.24)). Most markers of T cell activation and exhaustion were consistent with patients in SPARTAC. Patient A had higher levels of immune activation than Patient B with Z scores of 2.7, 3.9 and 2.4 for HLA DR, CD38 and CD69 on CD8 T cells, respectively, compared with a normalized population of healthy controls (n=17).

Conclusion: HIV-1 acquisition can occur despite therapeutic plasma levels of tenofovir. Immune dysfunction and measures of HIV-1 reservoir are detectable even in the presence of antiretrovirals around the time of HIV acquisition.

Abstract P16

(BHIVA P39)

A UK survey of HIV-positive people's attitudes towards cure researchR Simmons¹, K Porter¹, M Kall², S Collins³, G Cairns⁴, S Taylor⁵, M Nelson⁶, S Fidler⁷ and J Fox⁸

¹MRC CTU at UCL, London, UK; ²Public Health England, London, UK; ³Base, London, UK; ⁴NAM, London, UK; ⁵Birmingham Heartlands Hospital, Birmingham, UK; ⁶Chelsea and Westminster Hospital, London, UK; ⁷Imperial College London, London, UK; ⁸Guy's and St Thomas' Hospital, London, UK

Background: Involvement of people living with HIV (PLHIV) in the design of HIV research is important, particularly where there is risk of minimal personal benefit. With current work into HIV cure research (HCR), there is limited understanding of what type of cure PLHIV expect and how potential risks, including treatment interruption (TI), would affect participation. We present results of an international survey of PLHIV to define these issues and inform HCR.

Methods: A survey developed by CHERUB UK, community groups, clinicians, and government organizations, was completed by PLHIV June–November 2014 through HIV websites, advocacy forums, social media, and 12 UK HIV-clinics. The survey included desirability rating of potential endpoints, willingness to accept potential risks and concerns. Logistic regression examined the likelihood a person would endure substantial risks (severe/moderate side-effects without personal benefit/detectable VL for ≥ 6 months/CD4 drop to <200) in HCR.

Results: 982 PLHIV completed the survey, 87% were male, 79% white, 81% MSM. 51% were aged 25–44, 54% were UK-born and 69% were UK-residents. Median (IQR) time since diagnosis was 7yrs (2–17). 88% were receiving ARVs. Median time participants estimated a cure to be available was 10yrs (10,20). 95% men and 89% women would join a cure study whether a sterilising or functional cure (91% vs. 86%). Health and wellbeing (96%) and an inability to transmit HIV (90%) was regarded as more desirable than testing HIV negative (69%). 71% would participate in HCR with no personal benefits and 59% would accept substantial risks. PLHIV with a CD4 count of 201–350 vs. ≥ 350 [OR:2.11 95%CI 1.11–4.00] were more likely to accept risks, whereas those with little/no knowledge regarding HIV treatment and those aged ≥ 65 yrs vs. 45–64 yrs were less likely ([0.58, 0.37–0.90] and [0.18, 0.07–0.45], respectively). TI was acceptable for 62% of respondents; main concerns were: becoming unwell (82%), becoming infectious (76%), HIV disseminating through body (76%), detectable VL (72%) and lower CD4 (72%).

Conclusion: HCR and TI would be acceptable to PLHIV, irrespective of personal benefits. Demographics or immunological status had little impact on likely participation, with an optimal cure perceived as improved health and minimised risk of onward transmission rather than a change of HIV status. PLHIV should be involved throughout development of such studies

Abstract P17

(BHIVA P43)

Vertical versus horizontal HIV in young people aged 18–25

R Marcus¹, S Mohd-Afzal² and R O'Connell²

¹Barts Health, London, UK; ²Newham University Hospital, London, UK

Background: Of 77614 people accessing HIV care in the UK in 2012, 2516 (3.2%) were between 15–24 years old. 1603 (64%) of these were infected vertically. Well-established services and data exist to support transition from paediatric care, but less is available to guide best practice for young people with non-vertical HIV.

Aims: to investigate co-morbidities, HIV outcomes and retention in care in young adults (18–25 years) in an urban HIV clinic. To describe and compare young patients with vertical or horizontal acquisition to facilitate appropriate service provision for these two groups.

Methods: A retrospective review of medical records of 18–25 year olds registered at an urban HIV centre in 2013. Engagement in care is defined as having been seen in the preceding year.

Results: Of 60 patients between 18–25 years old registered at the HIV clinic, 38 (63%) had acquired HIV vertically. Of the 22 (37%) who acquired HIV horizontally, 16 (73%) were heterosexual, 4 (18%) MSM, 1 (4.5%) IVDU, 1 (4.5%) iatrogenic. In the study period, the mean age of the vertical group (VG) was 20, mean age at diagnosis 7.7 (range 0–19). The mean age of the horizontal group (HG) was 24, mean age at diagnosis 21. 34(89%) of the VG were on ART, but only 37% had an undetectable viral load (VL). ART was indicated and prescribed to 14(64%) of the horizontal group, 50% of whom had a suppressed VL. 61% of the VG with genotypic resistance assay availability had drug-resistant HIV, versus 25% in the HG. 31 (81.6%) in the VG were engaged in care and 20(91%) in the HG. Those in the VG had more AIDS-defining and chronic conditions. 6(27%) in the HG had documented STIs, 8% in the VG. 19% of females in the VG and 50% in the HG had previously been pregnant. Psychiatric co-morbidity was 26% in the HG, and 18% in the VG. Social issues such as financial problems and criminal activity were higher in the VG, but both groups had comparable levels of housing insecurity and domestic violence.

Conclusions: Young people with HIV are not a homogeneous group. Those with vertically acquired HIV have a higher HIV-related disease burden, with the ongoing effects of AIDS-defining and chronic conditions seen into adulthood. The incidence of sexually transmitted infections was higher in the HG. This could be due to successful prevention strategies in the VG, or more sexual activity in the HG. HIV services for these two groups of young people need to be carefully tailored to support and engage these patients successfully

Abstract P19

(BHIVA P108)

An investigation into general practitioner perceptions on HIV testing in England

K Martinez¹, T Addison¹, E Pike¹, R Walton¹, D Asboe², R Lowbury³, P James⁴ and Y Azad⁵

¹Halve It Coalition Secretariat, Farnham, UK; ²Chelsea and Westminster Hospital, London, UK; ³MEDFASH, London, UK; ⁴Combrook Medical Practice, Manchester, UK; ⁵NAT, London, UK

Background: Late and undiagnosed HIV statistics in England suggest that the rate of HIV test offering lags behind national guidance on testing. Since general practice represents a key opportunity for the offer of a test, the Halve It coalition decided to investigate General Practitioner (GP) knowledge, current practice, and perceptions on the barriers and solutions to offering an HIV test at a practice and community level.

Methods: The Halve It Secretariat surveyed 93 GPs over the first two days of the RCGP Conference, ACC Liverpool 2–4 October 2014. Respondents were approached by Halve It representatives during conference recesses and confirmed they were practising GPs. Respondents were then presented with the survey on tablet devices.

Results: The responses of 88 GPs were analysed according to inclusion criteria. 37.5% of GPs did not know whether they practise in an area of high HIV prevalence. Almost 30% of GPs who practised in an area of high HIV prevalence believed that they practise in an area where HIV prevalence is not high. The majority of GPs were unaware of key national guidance documents, including NICE public health guidance 33 and 34, and the BHIVA/BASHH/BIS UK National Guidelines for HIV Testing 2008 (59.1%, 56.8% and 67.0% respectively). 86.4% GPs indicated that they test for HIV in their practice. The most frequently reported challenge to HIV testing for GPs was time pressure (27%). Respondents thought that the most important contribution to scaling up testing involves increasing public awareness (17%).

Conclusion: This survey highlights that HIV testing is possible and acceptable to GPs in practice and that the majority are offering some testing; however, there is a gap in GP knowledge and implementation of key national guidance. The bodies responsible for the development of HIV testing guidelines should take steps to encourage their adoption in general practice, while GPs should be given a greater opportunity for education on when to offer a test and how to overcome their perceived barriers to testing. GPs should be reminded that lengthy pre-test counselling is not required in the majority of cases. Government should focus on steps it can take to raise awareness of HIV testing and encourage greater provision and uptake in general practice, particularly in high prevalence areas. We believe these factors can help augment the HIV tests being appropriately offered in general practice in line with national guidance.

Abstract P18

(BHIVA P94)

Interventions for tobacco cessation in people living with HIV and AIDS: Cochrane Review

E Pool¹, P Weatherburn¹, K Siddiqi², O Dogar² and R Lindsay³

¹London School of Hygiene and Tropical Medicine, London, UK; ²University of York, York, UK; ³University of Idaho, Idaho, USA

Introduction: Human immunodeficiency virus (HIV) is now a chronic disease with a near-normal life expectancy. However, tobacco use is highly prevalent amongst people living with HIV/AIDS (PLWHA) and results in high morbidity and mortality from cancer, cardiovascular disease and infections. Specific socio-economic, psychological and health system factors contribute to tobacco use and hinder cessation in PLWHA.

Aim: To conduct a systematic review and meta-analysis to assess the effect of tobacco cessation interventions on achieving abstinence in PLWHA.

Methods: Cochrane registers, Medline, Embase and PsychINFO were searched, in addition to grey literature sources. Studies were selected following report reviewing using pre-defined inclusion criteria. Data were extracted and bias was assessed in duplicate. Data analysis was undertaken in Review Manager (RevMan). Following this, subgroup and sensitivity analysis were undertaken.

Results: In total, 861 records were identified. Following screening and report review, thirteen studies were selected and contributed to the review. Twelve studies were included in the meta-analyses. All studies combined counselling and pharmacotherapy for the intervention, and gave usual care or a less intense intervention as control. Study design was variable. Risk of bias assessment showed that allocation concealment and blinding were poorly described. The funnel plot for short term outcomes was asymmetrical, indicating that publication bias was present. For long-term abstinence the meta-analysis showed no evidence in favour of the intervention compared to the control. For short-term abstinence there was evidence in favour of the intervention (RR 1.53, CI 1.16 to 2.04). There was insufficient data to fully assess the impact of tailoring cessation interventions for PLWHA. No studies investigated the effect of counselling or pharmacotherapy alone, therefore the objective of single focused intervention compared to combined interventions could not be assessed.

Conclusion: There is no evidence that the intervention is more effective than the control in the achievement of long-term tobacco cessation, although the confidence intervals do not exclude the possibility of an effect. The results for short-term cessation are promising although less clinically meaningful. More work is needed to translate these into long-term abstinence. There are a number of limitations including low quality evidence, low generalisability and high heterogeneity.

Abstract P20

(BHIVA P122)

Providing rapid HIV testing in their homes for men who have sex with men, recruited via social media

M Jones¹, K Aderogba¹ and L Drunis²

¹East Sussex Healthcare NHS Trust, Eastbourne, UK; ²Terrence Higgins Trust, East Sussex, UK

Background: In an English county with HIV prevalence of 1.7 per 1000 the three main towns have HIV prevalence >2 per 1000. The latest data from Public Health England suggests that 24% of HIV infections remain undiagnosed, the greatest number being amongst men who have sex with men.

Terrence Higgins Trust (THT) uses accounts on social media to provide health promotion to MSM.

Methods: Inspired by door-to-door HIV testing programmes in South Africa, the local sexual health service approached THT to suggest using its accounts with the social media websites Facebook, Grindr and Squirt to offer rapid HIV testing in the homes of MSM recruited via social media. A survey was placed on Facebook while THT-worker approach was used on Grindr and Squirt.

Testing was offered in one town and its immediate environs on Friday evening and Saturday afternoon during International HIV Testing Week 2014.

A clinical nurse specialist in HIV and HIV services coordinator (THT) visited men together; personal safety was assured using mobile phone technology and THT's remote provider; the test used was the Insti HIV1/HIV2 Rapid Antibody Test. Men were provided with information about local services, post exposure prophylaxis, condoms and lube.

Results: On Facebook 103 people clicked on the survey; 6 people completed it; 3 requested a HIV test at home and 2 made appointments. On Grindr THT approached 152 men online; 20 engaged in 'chat'; 6 requested a HIV test at home and 3 made appointments. Squirt elicited 50 contacts; 3 men engaged with THT online; no tests were requested. 5 rapid HIV tests were performed in the homes of MSM; the results were all HIV not detected. One man (age 38) had never had a HIV test; three estimated that it was many years since last testing; only one man was registered at the local sexual health clinic and had tested 2 years previously. All had engaged in unprotected anal intercourse; one had a partner recently diagnosed HIV positive. No tests were performed on the Friday evening.

Conclusion: Although a small number of tests were requested, these MSM proved to be at high risk of HIV acquisition and had either never tested or had not tested for many years. This pilot initiative demonstrates that home testing for MSM, recruited via social media may be successfully utilised to test hard to reach MSM at risk of HIV. Home testing MSM recruited via social media could be further piloted in areas with a higher population of resident MSM and higher HIV prevalence.

Abstract P21

(BHIVA P135)

'Positive Voices' a survey of the behaviour, experiences, and healthcare needs of people living with HIV: A pilot study methods and respondent characteristicsM Kall¹, A Nardone¹, V Delpech¹, R Gilson² and M Shahmanesh² on behalf of the Positive Voices Study Group¹Public Health England, London, UK; ²University College London, London, UK

Background: In the UK, robust data are needed to identify the met and unmet needs of people living with HIV (PLHIV) to inform HIV service planning and provision. We propose to supplement current HIV surveillance with a nationally representative survey to monitor the behavioural and healthcare needs of PLHIV. We present the methods, response rate, and respondent characteristics of the pilot of the 'Positive Voices' survey which aims to collect this data.

Methods: The survey instrument and methodology were developed using an iterative and participatory process of expert review, literature review, and qualitative methods with PLHIV and HIV providers. A protocol was designed as a pilot RCT of an anonymous, self-completed, web-based survey recruiting individuals from 30 HIV clinics in England and Wales, testing two recruitment methods (pre-selected vs sequential) for the clinic and a prize draw incentive for the patient. The survey covered a broad range of topics and took 20–40 minutes to complete. Primary outcomes were response rate, representativeness of respondents compared to SOPHID, and data quality measures.

Results: Between May–November 2014, 3,316 eligible patients were invited to take part in the pilot and 3,032 (91.4%) accepted the invitation. 779 people completed the online survey (25.7% response rate): 527 (68%) were MSM, 114 (15%) heterosexual men, and 135 women (17%) and 605 (78%) of white ethnicity. Median age of respondents was 47 years (IQR 40–54). Compared to SOPHID, respondents were older (median age 47 vs 43), white (78% vs 53%), and MSM (68% vs 47%). Regarding data quality, 94% of participants completing the survey once started, and item completion ranged from 88–100% with high internal validity and >90% linkage to clinical data in SOPHID records. Prize draw incentive had no effect on response rates, and pre-selected recruitment resulted in a higher response rate than sequential (30.7% vs 21.9%), and representativeness was similar for all study arms.

Conclusion: Recruitment of PLHIV through clinics was feasible with a response rate which reflects the limited-resource recruitment methods. The pre-selected recruitment strategy was the more resource-intensive, but was associated with a higher response rate. Weighting on a range of respondent characteristics will further improve representation and generalizability of survey results. Findings from this pilot study will inform the methodology used in the national roll-out of the survey in late 2015.

Abstract P23

(BHIVA P158)

Peer Navigators – can patient-led support contribute to clinical and well-being outcomes?A Anderson¹, J Anderson², M Fadojutimi¹, I Reeves² and M Wills²¹Positively UK, London, UK; ²Homerton University Hospital, NHS Foundation Trust, London, UK

Background: HUH is in a high HIV prevalence area with a diagnosed prevalence of 8.11 per 1000 (London average 5.8/1000).

- Approximately 1,100 adults receive HIV care at HUH.
- 75% women and 75% from ethnic minority communities
- Approximately 100 new diagnoses are made annually
- Approximately 50 women living with HIV give birth in the hospital.
- Significant numbers are within the immigration system, compromising their eligibility for statutory support and increasing their vulnerability.
- Poverty, housing and food security are common problems, exacerbated by welfare reforms

We wanted to increase capacity to meet growing support needs by appointing 'Peer Navigators' (PNs): patients trained and employed to provide peer support.

Methods: Working in partnership with Positively UK, 3 patients were appointed through a competitive selection process. They were trained and accredited, receiving an NVQ Level 2 in Peer Mentoring from the Open College Network. Supervision was provided by the clinic's Social Care Co-ordinator and Positively UK's Peer Case Worker. Support was provided during all HIV clinics. PNs worked with patients to identify needs and priorities, set action plans, work towards agreed goals and undertake advocacy with third party agencies. The service was evaluated internally using an outcome star, with patients self-assessing on a 10-point Likert scale upon registration, with reviews throughout, and upon completion of the support programme. Exit interviews with patients assessed to what extent needs had been met.

Results: 40 patients with high level needs were supported through 200 hours of one-to-one support; 70% had increased uptake of services ranging from benefits advice to immigration and hardship support. 76% reported an increase in disclosure and talking to others about HIV; 53% reported being in a better financial position. Adherence to HIV medications was generally high across the cohort nevertheless just under half said their understanding and adherence had improved, 23% reported a significant improvement. One Peer Navigator has since gained further employment as a result of the project

Conclusion: Embedding peer support within the clinic is an effective way of skilling up patients and providing essential peer support, information and advocacy. Collaboration and harnessing the skills of the clinic and voluntary sector were crucial to the success of the project. The Peer Navigator model is replicable and could be rolled out to other centres.

Abstract P22

(BHIVA P143)

Which patients start anti-retrovirals with a CD4 count above 500cells/μL and why? How do they compare to late treatment starters?T Pasvol¹, S Mohd-Afzal, L Jackson and R O'Connell

Barts Health NHS Trust, London, UK

Background: UK guidelines recommend that HIV positive patients with CD4 count <350cells/μL start anti-retroviral therapy (ART). In our HIV service we have both very late HIV presenters (CD4 <200), and increasingly, patients starting ART with CD4 >500 for clinical indications including prevention of onward transmission. We were interested in investigating clinical outcomes and potential service requirements for these patient groups.

Aims: to describe patients starting ART with CD4 >500 and CD4 <200; to investigate differences in patient characteristics and clinical outcomes in relation to CD4 count at start of therapy.

Methods: We performed a retrospective case-note review across two sites in an urban setting. All previously ART naive patients were included if they started ART with a CD4 count >500 or <200 between August 2013 and November 2014. Pregnant women starting ART solely for prevention of vertical transmission were excluded. Virological suppression was defined as viral load <200copies/ml within 6 months or by the end of follow up.

Results: 97 patients met our criteria, 92 patients were included. 69(75%) patients started ART with CD4 <200 and 23(25%) with CD4 >500. In the 23 starting ART with CD4 >500 median age was 36(range 24–62). 19(82.6%) were male. 14(60.9%) were white, 4(17.4%) black, 2(8.7%) Asian. In those starting ART with CD4 <200, median age was 41(range 17–76). 48(69.6%) were male. 21(30.4%) were white, 32(46.4%) black, 8(11.6%) Asian. 7(10.1%) had previously been lost to follow up.

Of those starting ART with CD4 >500, 11(47.8%) started to reduce risk of onward transmission, 4(17.4%) seroconversion illness, 3(13.0%) hepatitis co-infection, 7(30.4%) for other reasons including patient preference. Patients could have >1 indication.

74(80.4%) patients achieved virological suppression. Virological suppression was higher in those who started with CD4 >500 than in those who started with CD4 <200 (95.6% vs 75.4%; $P < 0.05$). Additionally, ART regimen switch within 6 months of starting was higher in those who started with CD4 >500 than in those who started with CD4 <200 (26.1% vs 15.9%)

Conclusion: In our service, patients that start ART with CD4 >500, including for prevention of onward transmission, are able to achieve high rates of virological suppression. In comparison, those that start with CD4 <200 have poorer virological outcomes. We need to improve earlier diagnosis and retention in care to optimise treatment outcomes in all our local HIV positive population.

Abstract P24

(BHIVA P167)

Developing nursing competencies for the delivery of integrated HIV and primary care servicesV Pearce¹, P Richards² and M Brady²¹V Pearce Consulting Ltd, Hove, UK; ²King's College Hospital, London, UK

Background: Increasingly people living with HIV (PLWH) are stable and nurses deliver their HIV care. BHIVA standards recommend better involvement of primary care, however there are no evaluated models, competency frameworks or training programmes to define how best to develop the workforce. We aimed to:

1. Develop an integrated competency framework for nurse-led care of stable HIV patients
2. Develop a competency assessment tool
3. Benchmark a sample of HIV and practice nurses against the competencies
4. Identify training needs to bridge the gap between current and required competency

Methods: We undertook a literature search on 'nurse led HIV management' and 'long term condition management' and used this to inform development of a competency framework. We designed an on-line competency assessment tool and asked HIV nurses and Practice Nurses to self-assess against each competency using 4 skill levels: No experience, require further development, competent and expert. Results: The literature review identified the National HIV Nurses Association (NHVNA) competencies as the most relevant and they formed the basis of the competency framework. The assessment tool was sent to 135 nurses. 17 HIV nurses (53%) and 15 practice nurses (47%) completed the assessment (24% response). There was a significant difference in existing knowledge and skills for HIV competencies between HIV and practice nurses. 65–76% of specialist nurses were expert whereas 60–65% of practice nurses had no experience. HIV nurses were competent or expert in the majority of areas relating to psychological and emotional well-being. Practice nurses were more likely to need further development or have no experience. For more 'generic' competencies the self-assessed level correlates more with experience and seniority. For men's and women's health, sexual health and contraception there was a spread of competency across both groups and less difference between the groups. Overall the gap between HIV nurses being competent in all areas was smaller than the gap for primary care nurses

Conclusions: We have developed a functional competency framework and assessment tool for nurses delivering integrated HIV and primary care services and identified skill gaps in both workforces. Training HIV nurses in aspects of primary care would be quicker than training practice nurses in HIV care. Further work is ongoing to design training packages, which could be used either in primary care or specialist services.

Abstract P25

(BHIVA P181)

Approaches to recruitment of patients presenting with Primary HIV Infection (PHI) into clinical studies

K Mahay, K Kuldaneik, J Thornhill and S Fidler

Imperial College London, London, UK

Background: Receiving a new HIV diagnosis can be a challenging and emotional time, particularly for individuals with Primary HIV infection (PHI). Clinicians may be reluctant to refer such individuals to research studies at this time, based on preconceived ideas that this group may be particularly vulnerable. However, clinical trials should be part of the discussion when starting ART. We present our experience of enrolling individuals with PHI into an observational study of immediate ART in the UK.

Methods: We reviewed referral pathways to a prospective PHI study at an HIV research centre in London over an 18-month period (Jun 2013–Dec 2014). PHI was defined as: (i) HIV +ve antibody (Ab) within 12 weeks of a previous –ve HIV Ab test, (ii) Incident RITA, (iii) 4th generation antigen (Ag) / Ab test, with a +ve p24 Ag in the absence of Ab. Individuals enrolled gave written informed consent and consented to initiate ART within 12 weeks from confirmed HIV diagnosis. We assessed the recruitment rate, referral source, and time from diagnosis to enrolment. Strategies to improve enrolment were introduced from June 2014. These include earlier identification of incident cases through: weekly liaison with diagnostic virology and Public Health England for RITA incident results; development of additional referral pathways through study updates at HIV departmental education and research team meetings; advertisements on social media and websites; and community peer support, enabling self-referral or referral from other sites as well as increased staff capacity.

Results: 85 individuals enrolled; 83 were male and median age 35 years, (range 30–39). 46/85 were referred locally, and 39 were external referrals. Median time from HIV diagnosis to study entry was 4 weeks (range 0.5–13). Clinicians referred twenty-five participants whilst 21 were from clinical nurse specialists. 2–3 participants were enrolled per month between June 2013–14 compared to 9–10 per month after June 2014 when enhanced publicity, and referral pathways were introduced.

Conclusions: Implementation of strategies supporting timely identification of individuals with PHI and pathways allowing early discussion around trials enhanced recruitment into studies in PHI at our centre. Development and support of PHI pathways by staff may improve recruitment to PHI studies as well as opportunity for enhanced clinical management.

Abstract P26

(BHIVA P185)

Whose stable infection is it anyway? Patient and staff perspectives of HIV as a stable condition

E Nixon¹, V Cooper¹, M Fisher¹ and J Scholes²¹Brighton and Sussex University Hospitals, Brighton, UK;²University of Brighton, Brighton, UK

Background: The HIV Care pathway indicates that up to 80% of people accessing HIV care in the UK have stable infection measured by CD4 and viral load and funding streams are planned based on these parameters. However, there is little evidence of how HIV is perceived as a stable long-term condition and how these perceptions influence service planning and utilisation. This research aimed to explore the perceived needs of people with HIV and the relationship with processes of care.

Methods: A grounded theory approach was adopted utilising semi-structured interviews with 13 HIV patients and 21 healthcare workers in one HIV clinic and two HIV centres. Constant comparative analyses of emerging data concepts were undertaken and a dimensional analysis strategy applied to develop conceptual categories and the connections between them. An academic theory was developed using an explanatory matrix. NHS ethics approval was obtained.

Results: 40 interviews were undertaken with 34 participants. Most patients described themselves as medically stable but did not view their stability in relation to CD4 and vL. Instead they perceived their HIV condition based on physical and social factors. Those with minimal illness/symptom experience preferred virtual models of care such as telephone or e-mail clinics. Patients with higher symptom/illness experience were more reliant on face to face interactions with their HIV care providers irrespective of CD4 and vL. Those who experienced uncertainty about their future health and those who had a negative social identity had a stronger attachment to HIV services.

The 21 healthcare workers were comprised of specialist and non-specialist staff from acute, community and 3rd sector settings. Healthcare workers perceived HIV as a long-term condition depending on job role, caseload and whether they viewed stable patients as 'well' or as 'requiring ongoing engagement in care' or as holistically complex. These perceptions influenced the model of care used.

Conclusion: This research indicates a broad perception of HIV as a stable condition that spans a spectrum of illness and health. These findings are in keeping with the Common Sense Model of illness representation and suggest that cognitive and emotional constructions of HIV influence how patients use services and how staff plan them. While further testing of this theory is needed, caution should be exercised in using over simplistic definitions of the stable HIV patient

Abstract P27

(BHIVA P34)

High prevalence of Recreational Drug Use (RDU) amongst HIV patients admitted to hospital, a unique opportunity to engage drug users with support services

E Elliot, S Tyebally, J Gasson, K Gedela, C Pavitt and M Nelson

Chelsea and Westminster Hospital, London, UK

Background: RDU continues to grow amongst HIV infected patients in the UK, particularly Men who have sex with Men (MSM), fuelling HIV and Hepatitis C transmission, mental illness, poor adherence to ARVs and drug-drug interactions in this population. Whilst high rates of lifetime RDU amongst HIV clinic attendees has been shown, there lacks data in the HIV inpatient population. Hospital admission offers a unique opportunity to engage drug users. We aim to establish and characterise current and past RDU amongst new admissions to a large London HIV inpatient unit, compared to a General Medical admission population.

Methods: An opt-out survey was administered to new admissions to the HIV inpatient ward over a 10-week period (cases) and to new admissions to Medical AAU over a 48hr period (controls). Data was collected on age, gender, sexuality, past/current recreational drug use and route, reason for admission, Hepatitis B and C status and contact with drug services. All patients were asked for consent to urine toxicology (tox) upon admission.

Results: Data was collected in 59/65 (90%) HIV positive individuals admitted over 10 weeks (72 episodes) and in 48/54 (89%) general medical admissions over a 48hr medical take.

	HIV inpatients	Controls
N	59	48
MSM	41 (70%)	1 (2%)
Mean age (range)	47 yrs (24-76)	64 yrs (17-94)
Current RDU (%)	26/59 (41%) MSM 19/41 (46%)	5/48 (10%)
Past RDU (%)	15/59 (25%) MSM 14/41 (34%)	9/48 (19%)
Symptoms on admission related to drug use	9/59 (15%) MSM 7/41 (17%)	0/48 (0%)
+ve Urine tox screen*	10/53 (19%)	1/47 (2%)

*Accounts for prescribed opiate false positives

None of the general medical patients reported sexualised drug taking or injecting drug use. Of the 26 HIV inpatients reporting current RDU, half admitted to sexualised drug taking (n=13), half to poly-drug use (n=13) and 1/3rd to injecting drugs (n=9). 27% had used in the last 24hrs and 35% in the last month. Only 7 (27%) were known to drug services. The main drugs used were: Cocaine (n=9), Crystal Meth (n=8) and Cannabis (n=7).

In total, 17/59 HIV inpatients had current or past infection with hepatitis B and 13/59 with hepatitis C; with 70% and 92% reporting current or past drug use respectively.

Conclusion: RDU was significantly higher in HIV inpatients than in our medical admissions sample population, and was associated with high-risk behaviour. Our data strongly supports the use of formal screening and drug services referral pathways at the time of admission to hospital to engage HIV positive drug users.

Abstract Author Index

A					
Addison, T	P19		Footo, E	O11	
Aderogba, K	P20		Fox, J	P15, P16	
Alexander, H	P15		Frater, J	P15	
Anderson, A	O5, P23		G		
Anderson, J	O5, P23		Gasson, J	P27	
Asboe, D	P19		Gedela, K	P27	
Attridge, S	O12		Gilson, R	P21	
Azad, Y	P19		Gorton, RE	P12	
B			H		
Barber, S	P14		Hartley, A	P1	
Barker, G	O10		I		
Barnes, A	O4, O6		Irvine, N	P8	
Bartlett, R	O1		J		
Bell, L	P7		Jackson, L	P22	
Benn, P	O7, P11		James, P	P19	
Blake, H	O9		Jelliman, P	O11	
Boddy, E	P3		Jones, M	O7, P11, P20	
Brady, M	P15, P24		Juma, A	O9	
Bruton, J	O3		K		
Buckingham, T	O8, P13		Kall, M	P16, P21	
C			Kerr, L	O1	
Caddick, S	O11		Kuldaneek, K	P25	
Cairns, G	P16		L		
Chidzomba, S	P9		Lindsay, D	O7, P10, P11	
Collins, S	P16		Lindsay, R	P18	
Cooper, V	P26		Lowbury, R	P19	
Croston, M	O7, P2, P10, P11		M		
Croucher, A	P13		Mahay, K	P25	
D			Mannix, T	O11	
Davies, P	O11		Marcus, R	P17	
Delpech, V	P21		Martin, M	P2	
Dinsmore, W	P7, P8		Martinez, K	P19	
Dogar, O	P18		McCarty, E	P7, P8	
Donnelly, C	P7, P8		McLuskey, J	P3, P5, P12	
Drunis, L	P20		Mellor, J	O2	
Dunne, A	O7, P10, P11		Mohd-Afzal, S	P17, P22	
E			N		
Elliot, E	P27		Nardone, A	P21	
Else, L	P15		Nelson, M	P16, P27	
Emerson, C	P7, P8		Nixon, E	P2, P26	
Evans, C	O9		O		
F			O'Connell, R	P1, P17, P22	
Fadojutimi, M	O5, P23		Ormiston, C	P9	
Fidler, S	P15, P16, P25		P		
Fields, M	P1		Pace, M	P15	
Fisher, M	P26		Pasvol, T	P22	
			Patterson, I	P8	
			Pavitt, C	P27	
			Pearce, V	P24	
			Petrak, J	O7, P10, P11	
			Pike, E	P19	
			Pool, E	P18	
			Porter, K	P16	
			Positive Voices Study Group	P21	
			Q		
			Quach, S	P7, P8	
			R		
			Rai, T	O3	
			Reeves, I	O5, P10, P23	
			Reynolds, H	O11	
			Richards, P	P24	
			Robinson, N	P15	
			Roche, M	P2	
			S		
			Scholes, J	P26	
			Scott, C	P10	
			Shahmanesh, M	P21	
			Shaw, R	P5	
			Sheedy, D	O7, P11	
			Siddiqi, K	P18	
			Simmons, R	P16	
			Spowage, L	P4	
			Stanford, J	P6	
			T		
			Taylor, S	P16	
			Thornhill, J	P25	
			Thornton, B	P1	
			Todd, S	P7	
			Turner, K	O9	
			Tyebally, J	P27	
			U		
			Ustianowski, A	O7, P10, P11	
			W		
			Walker, S	O7, P11	
			Walton, R	P19	
			Weatherburn, P	P18	
			Whitehead, T	O7, P10, P11	
			Willberg, C	P15	
			Wills, M	O5, P23	
			Wilson, Y	P7, P8	