



NHIVNA Annual Conference

11th – 13th June 2025

Book of abstracts

001

“I am someone”: an Interpretative Phenomenological Analysis of relationships for Black Women living with HIV in the UK

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Abstract

Background

A leading factor in determining people’s psychosocial experiences of living with HIV is HIV-related stigma. Black women living with HIV experience layers of marginalisation and stigmatisation at the intersects of their identities. Such experiences exist reciprocally between others and the self, and within the self.

Objective

On this backdrop, this study aimed to explore the experiences of Black women living with HIV in the UK, and their relationships with the self, others and healthcare.

Methods

Semi structured interviews were conducted with nine Black women living with HIV in the UK. An Interpretative Phenomenological Analysis (IPA) methodological approach was used.

Results

Four main themes, each with sub-themes, were generated: (1) Policing, (2) Silenced and distanced from society, (3) Keeping two worlds apart, and (4) HIV: The uninvited teacher.

Conclusion

Findings highlighted Black women living with HIV feel policed, silenced and distanced from society, as well as their attempts to manage such experiences. The findings also highlighted the importance and power of HIV education and safe spaces for empowering Black women living with HIV. Considering these findings, clinical implications and future research are discussed.

Keywords: HIV, Women, Black African, Black Caribbean, Relationships, IPA

002

Achieving the unachievable: injectable antiretrovirals (ARVs) for 4 patients with HIV viraemia unable to take oral treatment

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Abstract

We describe four people living with HIV (PLWH) intolerant of oral therapy for largely psychological reasons. They were unable to achieve or maintain virological suppression with oral therapy, resulting in significant immune suppression (75%), or requiring hospital admission.

All were discussed at local complex case and regional HIV treatment MDTs, with external expert advice sought. All were ineligible for injectable therapy via NHSE commissioning criteria, due to viraemia and/or resistance. Successful application for trust and Gilead funding enabled them to access injectables: cabotegravir/rilpivirine (CAB/RIL), CAB/RIL & lenacapavir (CAB/RIL/LEN) or CAB & LEN.

Age, Gender & Ethnicity	ART history & Resistance	Injectable ART (Funding)	Oral lead in	Dose 1, month 0 VL (cp/ml)	Dose 1, month 0 CD4 count	VL at 1 month (cp/ml) VL at last injection (cp/ml)
43 Cis-female Black-African 2007	PI-based ART, off treatment 15 years Nil	Monthly CAB/RIL	Nil	7280	109 (8%)	37 Dose 3 (month2) <20
44 Cis-female British Asian	NRTI, NNRTI, PI & INSTI	(Trust) until suppressed for 2 doses	Odefsey - 7 weeks	256	139 (25%)	29 Dose 3 (month 2) blip

2007 sexual	Nil confirmed viraemia on Eviplera					of 114, repeat <20
37 Cis-female Black African 2005 perinatal	Intermittent treatment since 2005 K103N, D67N	Monthly CAB/RIL (Trust) & 6- monthly LEN (Gilead) until suppressed for 2 doses	Symtuza	47,000	399 (26%)	55 Dose 3 (month 2) not detected
38 Cis-male Black African 1996 perinatal	Intermittent treatment since 1996 Extensive NRTI, NNRTI mutations plus M36I	Monthly CAB (Trust) & 6- monthly LEN (Gilead) until suppressed for 2 doses	Biktarvy	220,000	92 (4%)	2 weeks = 40 1 month = 30 Dose 3 (month 2) 20

The advent of injectable therapy offers hope for virological control in PLWH unable to take oral therapy. We implore acceleration of revised injectable CAB/RIL NHSE commissioning criteria, and the NHSE commissioning of Lenacapavir. This will widen access to these life-saving treatments, overcoming barriers to oral-ART and potentially improving retention-in-care. The early success in these cases strengthens the urgency for revised criteria for injectable HIV therapy.

003

Don't forget frailty – a community perspective

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Abstract

Background:

Frailty is not a new phenomenon, but it only gains prominence in HIV care in the last few years. Whilst there is no gold standard definition of frailty, NHS England defines frailty as “a loss of resilience that means people don't bounce back quickly after a physical or mental illness, an accident or other stressful event”.

NHS Right Care defines frailty as “a distinctive state of health related to the aging process, usually characterised by a complex mix of physical, mental health and social needs. It is a condition where the body's inbuilt reserves are eroded, meaning people are vulnerable to sudden changes in their health triggered by seemingly small events such as minor infections or a change in medication”.

The prevalence of frailty amongst people living with HIV remains unclear. However, concerns regarding frailty normally seen in the older population are now presenting in people living with HIV 10 years or earlier than in the general population.

People who are living with frailty are more likely to experience: more falls, higher rates of death, increased hospitalisation, polypharmacy, multiple co-morbidities and higher rates of depression.

Our HIV Clinical Nurse Specialist Team (CNS) provides clinical support for patients in the community with complex care needs. We work with several HIV specialist clinics across multiple sites.

In this presentation we will be focusing on frailty, its identification, diagnosis, management and outcomes from a community CNS perspective.

Method:

A comprehensive review of our caseload was carried out to identify people living with HIV and frailty using the Fried Phenotype frailty assessment tool.

We currently use this tool to assess frailty as part of our initial assessment and annual health review.

We will present a case study to demonstrate how the community CNS contributes to the identification and management of frailty.

Findings:

We found that in our caseload, 70% of our cohort are over 50 out of which 90% are frail.

Management:

As community CNS' we are in a position to identify early triggers that could result in frailty. There is no single method in the management of frailty, but it requires a multi-disciplinary approach.

Conclusion:

While the Fried Phenotype tool is useful, we have found in the community we need a more holistic tool, covering physical and mental health, environment, social, and socioeconomic situation.

Anabolic-androgenic steroid (AAS) use and prevalence of associated conditions within a clinic population of people living with HIV

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Abstract

Background:

Anabolic-androgenic steroids (AASs) are a class of image and performance-enhancing drugs (IPEDs) used predominately for aesthetic purposes, their estimated use varies greatly. AASs are often combined with other IPEDs to increase results and reduce side effects in processes known as “stacking” and “cycling”. AAS use has also been associated with, potential blood-borne virus transmission, riskier sexual practices in gay men, other substance misuse and potential drug interactions in people with HIV. Despite the associated harms, there is a reluctance from IPED users to disclose their use to healthcare professionals (HCPs). This has been attributed to stigma, lack of HCP awareness around IPED use and the promotion of abstinence over harm reduction strategies. This audit aimed to assess the burden of AAS misuse and its known sequelae within a clinic population of people living with HIV.

Methods:

A search of AAS use listed either as a condition or medication was conducted on the electronic health records of registered patients in an urban HIV service of >4,600 patients, in February 2025 using SQL. The search terms were taken from a drug and alcohol charity's website, drugs associated with “stacking” and “cycling” were also included. Data cleaning was performed manually on Microsoft Excel to exclude those not misusing AASs. These records were then searched for adverse health events associated with AAS use. The included data set was then tabulated on Microsoft Excel.

Results:

62 patients were identified in the initial search, 18 were excluded due to prescribed AAS use, 44 were included for further analysis of demographics and associated conditions. There were four different areas within the clinic record where AAS use was found to be recorded. The sample is majority white (70.5%) and over the age of 40 (72.7%). Most identify as gay (88.6%) and male (100%). Most individuals had a history of other substance misuse (65.9%). The most common comorbidities were depression (27.3%), history of hepatitis C infection (18.2%), erectile dysfunction (13.6%) and anxiety (11.4%). Limited or no cases were found of hepatitis B, hyperlipidaemia, fertility issues, hair loss, previous myocardial infarction, hypertension, acne or gynaecomastia.

Conclusion:

In our audit, AAS use and its associated harms are being documented inconsistently. These data likely underestimate AAS use and sequelae, greater rigour and congruent documentation are needed to better identify indiscriminate AAS use to ensure the harms associated are minimised.

005

A convergence of challenges: Living with HIV and being treated for cancer.

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Abstract

Background: With the advent of effective ART to treat HIV, individuals live with a normal life expectancy. Cancer is now the leading cause of morbidity and mortality in PLWH (Lurian et al, 2019). The presentation and management of malignancies, in PLWH, is changing. This study looked to audit current oncological practice in a tertiary cancer centre, against the approved European AIDS Clinical Society (EACS) 'Cancer: Treatment and Monitoring' guidelines (2018). Additionally the audit will assessed key themes against The National Clinical Practice Guidelines in Oncology (2018): Cancer in People Living with HIV, National Comprehensive Cancer Network (NCCN), to assess concordance and areas for improvements in care.

Methods: A comprehensive, retrospective audit of patient medical records, having been diagnosed with both a malignancy and HIV, and accessing the tertiary care cancer centre from March 2018- March 2023 was undertaken. An audit tool was developed to examine these records in line with the EACS guidelines and NCCN recommendations for people living with a dual diagnosis of cancer and HIV.

Results: Seventy- two patient records met inclusion criteria for examination within this audit. The audit findings supported the general literature that the face of malignancy in people living with HIV is changing from a traditional prevalence of AIDS defining cancers (Kaposi's sarcoma, Diffuse B cell lymphoma and invasive cervical cancer) which made up 17% (n=12) of patients audited, instead, to cancers associated with aging, cancer risk factors and coinfection with other oncogenic virology, 83% (n=60) of the audit cohort. Cancer is being diagnosed at a younger age in the HIV population, and outcomes are worse with 57% (n=32) of the audit cohort receiving treatment with palliative rather than curative intent. There is a paucity of knowledge around EACS and NCCN guidelines within the tertiary care centre, resulting in 100% (n=72) non-concordance when case notes were audited against these approved guidelines, although areas of exceptional practice were noted.

Conclusion: The care of those with a dual diagnosis of HIV and cancer, is complex and multifaceted. Education, guideline implementation, health promotion and prevention are the cornerstones to enabling positive change for the future; in addition to effective collaborative working between specialities and a multidisciplinary approach to supporting this specialised patient cohort. A funded specialist workstream is now underway to address the findings of this audit and improve equity and care.

HIV services at the crossroads: the role of the voluntary sector and needs of communities

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Abstract

Background

HIV Outcomes UK explores the state of HIV Voluntary, Community, and Social Enterprises (VCSEs) across the UK. These organisations play a vital role in improving health-related quality of life for people living with HIV and delivering the UK's HIV Action Plans. This research assesses the capacity and sustainability of the sector, highlights good practice (including VCSE collaboration with healthcare professionals) and recommends how to strengthen the infrastructure of support for people living with HIV.

Method

We conducted two surveys: one with HIV VCSEs and another with people living with HIV. Findings guided focus groups and interviews with stakeholders across the UK, including VCSE staff, healthcare professionals, commissioners, and communities. Findings were analysed and summarised in final report.

Results

Survey results from 51 HIV VCSEs and focus group discussions underscored their pivotal role in the HIV response, providing wrap-around care that complements clinical services and addresses health inequalities, but highlighted critical sustainability challenges.

Most commonly reported services offered were peer support, social activities, information provision and counselling. Over the last three years, 18 organisations (41%) reported staff reductions, 23 (53%) used cash reserves and 14 (32%) closed certain services, often due to rising costs and service decommissioning. 16 (36%) expressed concern about their future ability to deliver services, with two specifically mentioning complete closure. Collaboration, committed staff and volunteers, and the co-production and leadership of communities were among reported strengths.

From survey results of 322 people living with HIV, 81% reported improved wellbeing after using HIV VCSE services, and 78% felt better equipped to navigate healthcare systems. Most needed services included counselling, mental health support, and peer support, while housing and legal support were least accessible for those who needed to access them.

Conclusion

HIV VCSE services are vital for supporting communities and advancing the UK's 2030 goal of ending new transmissions.

Despite their clear value, the sector faces unprecedented challenges that threaten its future and the support for people living with HIV. Across the board organisations are seeing demand for services rise and change, cuts to statutory services and contracts, and a decline in key areas of funding.

Without urgent action, the UK risks missing its 2030 targets and won't meet the holistic evolving needs of people living with HIV. Governments and commissioners must ensure sustainable, multi-year funding, address regional disparities, and further integrate VCSE services into national/regional HIV strategies and care pathways.

007

Overcoming challenges to attending HIV services: developing a clinic-based outreach team

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Abstract

Background:

Current challenges in HIV care include an increase in complex comorbidities, ageing, stigma and social challenges, which impact people's ability to engage with standard services. Decommissioning of community HIV Clinical Nurse Specialist (CNS) has further reduced the ability of services to support these individuals. We describe the development of outreach CNS service using existing workforce within an HIV clinic.

Methods:

Referrals to the outreach CNS, allocated 4 hours per week, supported by health adviser, peer support worker and consultant, were reviewed. Reasons for referral, demographic and HIV parameters and hospital admissions at the time of referral and to date were described.

Results:

Between June 2022 - January 2025, 25 individuals were referred; 40% female, mean age 55.7 [standard deviation SD:12] years, 52% black ethnicities, media index multiple deprivation 5 [interquartile range IQR:4-7], nadir media CD4 197 [IQR:69-526] cells/uL and HIV viral load 1280 [IQR:50-50200] copies/ml. Reason for referral included 16 (64%) unable to attend due to immobility/mental health or resident in care/nursing home or mental institutes, 7 (28%) re-engagement in care and 2 (8%) supporting ward discharges 96% report mental health, 16% mobility and 28% drug/alcohol issues. 82 home visits were provided; 40% now attend clinic with support and of those not in care at time of referral, 100% remain re-engaged. At last follow up 96% had a viral load <200 copies/ml and mean CDE4 611 [IRQ: 367-796] cells/ml and only one was admitted to acute services for HIV related issues. Development of trusting relationship in the community with the CNS was instrumental in supporting people to move from outreach to clinic follow follow up. Estimated savings for the NHS for re-engagement in care for one individual are approximately £400.000, demonstrating cost effectiveness for the project.

Conclusion:

Bringing care to individuals in the community has supported those previously not in care to be on effective treatment, reduced admissions to acute services and facilitated early discharges from the

ward. The project has not impacted on staffing demand within clinic and may provide a model of care for services without access to community CNS outreach.

Evaluating the role and impact of non-medical prescribers in HIV care at a large inner-city clinic: A retrospective review

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Abstract

Background: Non-Medical Prescribers (NMPs) have been part of UK healthcare since 1992. At the Northern Sexual Health, Contraception and HIV Service in Manchester, NMPs including nurses, pharmacists, and an advanced clinical practitioner have led HIV follow-up clinics since 2015. NMPs are broadly supported by medical colleagues, and patients often find consultations with them more person centred. However, concerns about managing complex cases persist. The British HIV Association (BHIVA) recognises the challenges faced by an aging HIV population, highlighting the need for cost-effective, comprehensive care. This study aimed to evaluate NMP-led consultations within the HIV service, focusing on adherence to BHIVA standards of care and patient satisfaction.

Methods: A retrospective review was conducted on the records of 500 patients seen by an NMP between January and July 2022. Data on interventions related to HIV care, general health, and well-being were collected from clinical notes and GP letters. Interventions discussed with a medic were excluded. Between July and August 2024, patients were given a questionnaire after their appointment to assess their satisfaction with their consultation with an NMP.

Results: 831 interventions were made by NMPs, with common areas including HIV medication adjustments, cardiovascular risk management, STI screening, and bone health. The most frequent interventions in patients over 40 were cardiovascular related (33%). Patients under 40, the primary interventions were STI treatment (35.6%) and HIV medication adjustments (24.6%). Mental health support or onward referral was provided to 45 patients (9%), and social referrals were made for 16 patients (3.2%). Patient satisfaction from the survey conducted was positive, with 94.1% of respondents satisfied with their visit and 88.2% willing to see an NMP again.

Conclusion: NMPs in the HIV service were competent in managing follow-up appointments and demonstrated high patient satisfaction. The findings highlight NMPs' ability to make appropriate interventions, assess general health, and order further investigations. As age increased, NMPs effectively managed more complex health needs, including cardiovascular health and medications. Although mental health and social referrals were lower than expected, many discussions occurred, with some patients declining further intervention. Overall, NMPs provide cost-effective care, alleviating financial strain whilst supporting medical teams.

Case Study: The Role of a Multidisciplinary Team in the Management of Progressive Multifocal Leukoencephalopathy

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Abstract

This case study presents the clinical management of a 60-year-old male patient diagnosed with both HIV and Progressive Multifocal Leukoencephalopathy (PML). It explores his clinical presentation, diagnostic process, treatment strategies, and the challenges associated with managing PML in an older adult population. Additionally, the study emphasizes the importance of a multidisciplinary approach in achieving positive outcomes in the management of PML.

Introduction to Progressive Multifocal Leukoencephalopathy (PML)

Progressive multifocal leukoencephalopathy (PML) is a rare, but often fatal, demyelinating condition caused by the John Cunningham virus (JCV). This polyomavirus, first isolated in 1971 from a patient named Cunningham (Cunningham, 1971), primarily affects immunocompromised individuals, including those living with HIV/AIDS. The disease is associated with severe neurological damage and is typically seen in patients with advanced immunosuppression, such as those undergoing chemotherapy, organ transplant recipients, or those with HIV/AIDS (Mesran et al., 2024). Reactivation of JCV within the central nervous system leads to progressive white matter damage, which can severely impair cognitive, motor, and visual functions (Major et al., 2000). Currently, there is no effective antiviral treatment specifically targeting JCV, and the condition is associated with a high mortality rate (Naro et al., 2022).

Approximately 4 to 8 % of patients with advanced HIV disease develop PML (Hou & Major, 2005; McGuire, 2003), and it remains one of the most significant neurological complications in this population.

Pathophysiology of HIV and PML

HIV is transmitted through mucosal surfaces, most commonly through sexual contact or sharing needles. The virus primarily targets CD4+ T-helper cells, attaching to the CD4 receptor and co-receptors such as CCR5 or CXCR4 (Doms et al., 2009). Once inside the host cell, the HIV RNA genome is reverse transcribed into DNA and integrated into the host's genome, leading to the production of new viral particles. As the infection progresses, the immune system becomes increasingly weakened, particularly with a decline in the CD4+ count below 200 cells/ μ L. This immunosuppression places individuals at risk for opportunistic infections, including PML.

PML occurs when the JCV, which remains latent in healthy individuals in kidneys, bone marrow, and lymphoid tissues, reactivates in the setting of immune suppression. The virus targets oligodendrocytes in the central nervous system (CNS), resulting in widespread demyelination. Clinically, this leads to progressive neurological deficits that can be devastating (Zhao et al., 2014).

Patient Background

The patient is a 60-year-old male who presented to an acute care facility with a three-week history of progressive confusion. His social history includes chronic excessive alcohol consumption (15 cans of beer per day), marijuana use, and regular cocaine use. These factors may have further contributed to his compromised immune status. Additionally, his BMI was 17.3, classifying him as underweight, a known risk factor for poor outcomes in HIV (NICE, 2014). Following initial stabilization, he was transferred to a rehabilitation center for ongoing care and management.

Clinical Presentation:

Upon presentation, the patient exhibited several neurological deficits, including confusion, behavioral changes, right-sided neglect, hemianopia, aphasia, and dysarthria. His cognitive impairment and risk of falls led to 1:1 nursing care. Notably, his underweight status was an additional concern, as malnutrition can exacerbate the effects of HIV and impede recovery (NICE, 2014). The patient's complex presentation warranted a comprehensive, multidisciplinary approach to address both the neurological and nutritional aspects of his care.

Laboratory Tests and Investigations:

Initial blood tests confirmed the diagnosis of HIV, with a viral load of 200,022 copies/mL (log 5.3) and a CD4+ count of 59 cells/ μ L, indicating advanced HIV disease. Brain imaging, including an MRI scan, revealed a confluent white matter lesion in the left parietal lobe and the splenium of the corpus callosum, consistent with PML. The presence of JCV in the cerebrospinal fluid (CSF) further confirmed the diagnosis. Follow-up MRI scans showed increasing white matter signal abnormalities, highlighting disease progression, with oedema implicating the left frontal region.

The patient's cognitive and behavioral changes, including personality shifts, aphasia, and visual-spatial difficulties, were consistent with frontal lobe involvement. After eight weeks of initiating antiretroviral therapy (ART), the patient was diagnosed with PML-IRIS (immune reconstitution inflammatory syndrome), which can occur in HIV patients with low CD4+ counts upon initiating ART. This syndrome is characterized by paradoxical inflammation in response to immune system recovery, further complicating the management of PML (Summers et al., 2019).

Management Strategy:

The cornerstone of HIV treatment is antiretroviral therapy (ART), which the patient was started on immediately upon diagnosis. His ART regimen included Truvada (Emtricitabine and Tenofovir Disoproxil fumarate) and Dolutegravir. These medications effectively suppress HIV replication and help restore immune function, thereby preventing further deterioration and improving the patient's CD4+ count from 59 to 114 cells/ μ L within two months. His viral load decreased from 200,022 to 35 copies/mL, indicating a favourable response to ART.

To address the perilesional oedema associated with PML-IRIS, oral prednisolone was prescribed. Although corticosteroids are often used to reduce inflammation in PML-IRIS, they carry risks, such as steroid-induced diabetes, which the patient developed. The management of his diabetes involved

insulin and metformin therapy. In addition, the patient received Pembrolizumab, an immune checkpoint inhibitor, and Co-Trimoxazole prophylaxis to prevent opportunistic infections.

Managing the patient's polypharmacy regimen was crucial to prevent drug interactions and adverse effects. Close monitoring ensured that the patient did not experience significant drug-related complications (Maher et al., 2014). As a result, he tolerated the treatment well, and his condition gradually improved over several months.

Multidisciplinary Approach to Care:

The patient's recovery highlighted the importance of a multidisciplinary approach. A collaborative team, including nurses, dietitians, physiotherapists, psychologists, and social workers, played a crucial role in managing the various aspects of his care.

Nursing Care: The nursing team provided continuous care, managing medication administration, assisting with activities of daily living, preventing pressure ulcers, and providing 1:1 supervision to mitigate fall risks.

Nutritional Support: Given the patient's low BMI, a dietitian developed a personalized nutritional plan, focusing on increasing calorie intake and providing supplements to improve his nutritional status. Over the course of four months, the patient gained weight, and his BMI increased from 18.5 to 24.6 kg/m², a promising indicator of recovery (NICE, 2014).

Physiotherapy: Initially bedridden, the patient was unable to sit or stand independently. Through intensive physiotherapy, he regained functional mobility and balance. After several months, he was able to walk with the assistance of a Zimmer frame, demonstrating significant progress in his physical rehabilitation.

Psychiatric and Cognitive Support: The patient also received psychiatric support to address his cognitive impairments and mood disturbances. Quetiapine was prescribed to manage mood fluctuations, and speech and language therapy was crucial in improving his ability to communicate, ultimately enhancing his quality of life. Additionally, cognitive therapy was initiated to support his recovery of mental function.

Occupational Therapy: This therapy aimed to improve his ability to perform daily tasks independently, such as feeding himself and personal hygiene. Occupational therapists helped improve his upper limb function, which enhanced his independence and overall well-being.

Social Work: Social workers ensured that the patient's living situation was safe and assisted with caregiver education, particularly in medication management and fall prevention.

Conclusion

This case study illustrates the complex clinical management of PML in an HIV-positive patient, emphasizing the challenges of diagnosing and treating this rare but severe condition. The role of a multidisciplinary team, integrating specialists across nursing, nutrition, rehabilitation, psychiatry, and social work, was crucial in improving the patient's health and quality of life. This comprehensive

approach is essential in managing the multifaceted needs of patients with HIV-associated PML, ultimately leading to better health outcomes and greater patient satisfaction.

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O10

Individualised care: listening, support and building relationships

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Abstract

Background

James* is a 67 year old cis male, married to a woman but sexually active with men (Wife unaware). Admitted to hospital from prison. He was HIV tested on admission to critical care with pneumonia – initially thought to be PJP, viral load >1 million and CD4 75.

Extended stay in hospital -discharge complicated as prison sentence completed during inpatient stay. Safety concerns and threats of violence before discharge due to conviction – temp accommodation required. Several meetings with family to organise.

James was guarded about discussing HIV. Visited regularly as inpatient to build rapport, and deliver support and education around HIV. He declined mental health support and input from 3rd sector organisations initially. So we needed to establish a safe place he could communicate within.

He had a positive result for Syphilis and admission with shigella. Then extended episodes of diarrhoea which did not resolve, leading to challenging discussions around STIs and sexuality.

Antiretroviral therapy not thought to be the cause of his diarrhoea and several investigations and discussions with James into the cause but did not find anything.

Conclusion

A different pathway of support was tailored to James' individual needs. Consistency with a CNS who can co-ordinate his care has been vital and building a relationship as an inpatient was important initially.

A non-judgemental and supportive environment was created to allow James to ask for further support, when he was ready and continuing to work with him and educate him about what support was available.

When he did agree to it, the benefits of mental health input and 3rd sector are reflected in his now full engagement in Waverly care and improvement in mood.

Following a switch in his generic brand of TDF/FTC, James' diarrhoea stopped, when this had not been thought to be the cause. Pharmacy are now sourcing this brand for him, which has improved his wellbeing and outlook.

Family relationships complicated, as James allowed his wife to control the narrative in clinic visits, which was detrimental to his recovery and assistance to navigate this was essential.

Having a CNS who is able to visit patients on the ward at the time of their diagnosis, and have one-to-one conversations especially when it is about sexual history is vital.

O11

Neurodiversity and delay in diagnosis

Mrs Julia Rogers

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Abstract

Steve was diagnosed with HIV late. He didn't fit the stereotype he was white, heterosexual and had what were deemed learning difficulties.

By the time he had been diagnosed he was seriously ill with PML and disseminated MAI

He remained in hospital for 5 weeks following a fit.

His adherence to medication was excellent but his CD4 always remained low.

It became apparent from talking to Steve that he suffered from OCD and neurodiversity

He was treated for AGW within the sexual health clinic but struggled to adhere to any treatments and found LN2 therapy painful.

Due to his neurodiversity, he would also take a lot of clinic time up as he would do things in his time, not schedule appointment times.

He saw 2 other medical professionals about the AGW and the GP had referred him to the surgical team for removal of the warty lesions.

After 6 months on the NHS waiting list his family paid for a review by a private Colorectal surgeon. He was told that it was 99% likely to be a basal cell or squamous cell carcinoma. and was referred back into the NHS for treatment under the 2-week rule.

I was on leave for his first appointment, so his sister accompanied him, when a biopsy was mentioned under GA or admission to hospital he refused, because he was scared another 2 weeks went by. When he was issued a further appointment and it was agreed by the surgeon that he would do the biopsy under spinal if the anaesthetist agreed and that I could accompany Steve on the day.

Each professional we saw together I advised that if they clearly explained things as if they were doing an OSCE Steve was good at understanding and would process this information, often phoning me back to check what he thought was correct.

The day of the biopsy I was not 100% sure he would even go into theatre, but he managed with me talking to him whilst the spinal was inserted and then in recovery.

The NHS at this point provided a flexible and patient led service.

Following that there were numerous appointments and referrals elsewhere to finally tell Steve he had a squamous cell carcinoma with secondaries in his groin lymph node and lung and 3-6 months to live or? 6-9 with radiotherapy and chemotherapy.

O12

Engaged or not engaged - that is the question

Ms Jane Brown

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Abstract

In 2023 there were two patients I met who had been admitted to hospital. I attend the inpatient MDT for our clinic every Tuesday.

I was particularly affected by these two patients who both went on to die from end stage HIV.

I had a lot of contact with them both, spread over several admissions and was very upset that either had to die in today's society where there is HIV treatment available, but there were specific issues for each that made them feel there was no future for them.

I also wanted to reflect on the term's we use: engaged and not engaged as there can be a lot of contact with some patients that does not necessarily end with them being able to take HIV treatment and the results that we as a team would hope for.

One aged (51) was made homeless when his mother refused for him to return to her. He was resolute in his decision not to re-start HIV treatment but accepted weekly phone contact, GP contact and contact with his housing team from myself as his HIV nurse. He accepted engagement with palliative care and was eventually admitted to a local hospice, where I was his only visitor and he died there.

The other younger man (37) never became undetectable but was unable to let us know that he was not taking his treatment, he also became very malnourished and there was investigation and support offered around possible anorexia. He accepted peer support and was visited regularly on the ward and then at home, he reported feeling bullied in his relationship and chose to be discharged to the care of his parents. They brought him to the clinic for reviews, but his condition deteriorated, and he was admitted to hospital where he died. He gave the impression to everyone that he had everything to live for.

It strikes me that these two men both had a lot of engagement with and from the HIV extended teams but could not ultimately accept their HIV diagnosis or treatment. But I am still so upset that either had to die and despite lots of input they were still unable to find a reason to live.

Poster abstracts

A001

Barriers and facilitators to integrating peer support within all London HIV Clinics

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Abstract

Background

BHIVA Standards of Care and the NHVNA Person-Centred Model of HIV Nursing Care recommend access to peer support, yet few clinics offer this in-house. Following successful pilot projects, London's Fast-Track Cities Initiative commissioned the Getting to Zero Programme to integrate peer support workers in every London clinic, re-engage people lost to care and refer into support and advice services to address non-clinical needs.

London voluntary sector organisations (VSOs) Metro (South), Positive East (East) and Positively UK (North, partnering with NAZ, Plushealth, Sophia Forum) are expanding outreach to clinics that hadn't previously benefited from in-house peer support.

Methods

Regular Quality Improvement workshops supported VSO/NHS partnerships to implement change ideas to reduce barriers and develop equitable approaches to service provision.

Monthly programme meetings supported VSO leads to share challenges, strategies and solutions, alongside regular meetings between VSO and clinical leads.

Updates to London HIV Clinical Forum provided opportunities to engage clinicians and reduce barriers.

Results

Peer support is now available in 26 of 27 clinics. Workers are integrated within multidisciplinary team (MDT) meetings in 67% of Trusts.

Recruitment challenges were reduced by signposting applicants between organisations.

VSO/NHS leads developed a standardised wellbeing needs assessment and a Cerner electronic patient record (EPR) form is being created. Differing EPR systems will require adapted versions.

Clinical engagement was variable, leading to slower protocol implementation in some Trusts.

NHS bureaucracy or excess caution delayed access to honorary contracts, NHS emails and EPR access to input interventions (33% are still not able to report via EPR), with one case requiring Integrated Care Board (ICB) input to ensure equity.

Gatekeeping around opt-out newly diagnosed referrals has slowed implementation (only 30% have fully adopted). Some healthcare providers have had difficulty in moving from offering a referral to simply

stating 'the peer support worker will call you'.

Work is underway to support Trusts outside of the Programme with pre-existing peer support to achieve the same standards.

Conclusions

Implementation has been slow, but with 18 months remaining we anticipate resolving any remaining barriers, integrating peer support workers within every HIV clinic and standardising data reporting and referral pathways.

The Tavistock Institute will conduct an evaluation of the full programme, to make the case to ICBs to fund the work as standard practice. Successful implementation should provide a template for national roll-out, as per the recommendations for the 2025 HIV Action Plan.

A003

Development of a HIV annual review pathway facilitated by non-medical prescribers (NMPs).

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Abstract

Background: Most people living with HIV taking anti-retroviral therapy (ARV) are virologically suppressed and require less monitoring. An annual review pathway was developed within our clinic to reduce the number of appointments, travel to clinic and increase patient choice.

Yearly face to face appointments were offered to patients who met the inclusion criteria. A health questionnaire was sent by text to patients 6 months post annual review and reviewed virtually by the NMPs. If no new health concerns were identified a further prescription was generated.

Methods: A retrospective case note review was undertaken to identify selected patients for yearly visits followed by virtual NMP review between March 2023 and April 2024.

196 patients were identified. The majority were male (79%, n=155). The median age was 45 years (range 26 – 76) and median length of HIV diagnosis was 16 years (range 3 - 40). 195 (99.4%) patients had an undetectable viral load at initial appointment with a median CD4 count of 660 (range 239 -1405). 188 (95.9%) patients met the inclusion criteria for annual reviews with 84 (42.8%) patients having at least one stable co- morbidity.

Out of the 189 patients who returned for 12 month follow up 183 (96.8%) remained virologically suppressed. 1 patient had stopped ARV, 3 patients remained detectable on repeat samples and 2 have not yet returned for repeat. There were no new resistant mutations identified. 188 (98.7%) and 187 (98.4%) of patients had no significant changes to FBC or renal/ liver parameters respectively.

148 (75.5%) continued on yearly appointments. Reasons for exclusion were change to ARV (n=17), transferred care out (n=6), abnormal bloods (n=3), detectable viral load (n=2) , new medical conditions (n=2) and concerns re adherence (n=1).

The median distance patients travel from home to clinic was 5 miles (range 0 – 138). By not attending for a 6 monthly appointment a total of 3,989 miles of travel (by road) was not undertaken contributing to a potential reduction in carbon footprint. This equates to a reduction of 1,354kgCO₂e (all car mileage) and 1,219kgCO₂e (modal breakdown).

Conclusion: The annual review pathway allows appropriate patients with choice contributing to the avoidance of unnecessary appointments, reduction in carbon footprint and saves the cost of blood tests and clinical time. The use of NMPs ensures safe prescribing and appropriate use of skill mix within the clinic.

A004

Assessing the impact of long-acting injectable anti-retroviral medication on the mental health of people living with HIV.

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Abstract

Background

The psychological morbidity associated in living with HIV has been well documented. A significant proportion of mental health deterioration has been attributed to either stigma related to oral pill taking or side effects associated with certain antiretroviral medications. In practice mental health assessments are conducted utilising clinically validated questionnaires. Commonly used are the Patient Health Questionnaire – 4 as a screening tool, and both the Patient Health Questionnaire-9 and Generalised Anxiety Disorder -7 for assessing depression and anxiety respectively. These assessments are routinely undertaken at registration into our service, then once a year or when clinically indicated due to a deterioration mental health.

Long Acting Injectables (LAIs) studies have celebrated the positive psychological improvements these medications have had beyond the reduction of onerous adherence issues. We wanted to review the influence this is having in our cohort of people receiving LAIs, to see both the positive and negative outcomes these innovative medications are having on their psychological wellbeing.

Method

Retrospective case note review of electronic patient records of all those who are receiving or have received LAIs since April 2022.

Inclusion criteria – Those who started long acting injectables greater than six months ago with a documented psychological assessment completed pre and post commencement of LAIs.

Results

52/102(51%) patient who started LAIs had a documented history of formal psychological assessment prior to and following commencement of tis medication.

46/52 (88%) were male, 42/52 (81%) were men who have sex with men, 38/52 (73%) identified as white UK. Age ranged between 31-69 (median age 50 years old).

29/52(56%) had a previous regimen containing an integrase inhibitor.

18/52 (35%) had switched from an oral regimen containing rilpivirine.

33/52(64%) of patients had no significant changes in their pre or post psychological screen assessment following commencement of LAIs.

11/52 (21%) of patients had increase in anxiety or depression scores and 8/52 (15%) patients had a decrease in anxiety or depression scores from their baseline assessment following commencement of LAIs.

Only 1/52 (2%) who stopped long acting injectables cited a deterioration in mental health for wanting return to an oral regimen.

Conclusion

In the majority of patients (79%) there appeared to be no detrimental change in peoples mental health following commencement of LAIs. However psychological assessments are important interventions in monitoring mood changes in people living with HIV who are changing antiretroviral medications, to evaluate the impact new medications pose .

A005

Migration: Are we allowing enough consultation time for PLWHIV who have migrated to the UK?

Mrs Jenifer Pritchard

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Abstract

Background: The author observed an increase in the number of migrated PLWHIV who have attended six HIV clinics in England over the last twelve months. These clinics include two in big cities, three in suburban districts and one rural clinic.

Migrants can face many challenges when coming to a new country including social, financial, legal and political barriers that hinder their access to healthcare. (Ross J, Cunningham CO, Hanna DB, 2018)

Many of these new patients have come to the UK to work, predominantly in healthcare.

Most migrated PLWHIV who attend these six clinics have limited, if any, documentation from their previous clinic. Important medical information, and information pertinent for HARS reporting such as resistance profiles, previous treatment, Nadir CD4s is often unknown.

The author has also noted that many migrated patients contact the HIV when they have less than one weeks' worth of ARVs, even though they might have been in the country for at least three months. Factors contributing to this could include undocumented migrants living with HIV fear imprisonment or deportation.

With this increase in patient numbers, do the doctors and nurses of these clinics feel that they allow adequate time per consultation?

Methods: The authors developed an anonymous survey of six questions (with an option to add comments or suggestions at the end) which was sent to HIV consultants and HIV clinical nurse specialists. Data is collected via email.

Results: Interim results show that all staff have noticed an increase in patient numbers.

Most clinics have had to make more appointments available.

Most staff believe the increase in patient numbers have impacted how they deliver care.

Staff have reported language barriers have prolonged appointments and backed clinics up.

Discussion: It is important that every patient accessing a HIV clinic feels that they are given sufficient time during their appointment to discuss all matters relating to their health and wellbeing and it is vital that access to HIV services is easily accessible.

The World Health Organization recognises that access to health care including HIV prevention, care and treatment is a fundamental right for all. (Juarez SP, 2019)

Conclusion: Sufficient appointment time needs to be available to all PLWHIV and services such as interpreting and translation are a must.

A006

Exploring missed opportunities for HIV testing

Mrs Suzan Potts

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Abstract

Late HIV diagnosis is multi-faceted with significant negative health impacts for newly diagnosed patients. Early detection and diagnosis of HIV is therefore crucial. Despite national efforts to promote early detection, a substantial proportion of individuals continue to be diagnosed at an advanced stage and is reflected in national statistics.

By understanding the reasons for late diagnosis, targeted interventions can be applied to improve testing.

This paper investigates missed opportunities for HIV testing in primary and secondary care, exploring strategies to improve earlier diagnosis.

A retrospective look-back exercise was conducted on all patients newly diagnosed with HIV over the past 12 months, using a standard operating procedure (SOP) specifically developed to identify cases of late HIV diagnosis (with a CD4 count <350). The analysis identified cases where earlier testing opportunities were missed due to HIV not being considered as a differential diagnosis

Every late diagnosis is reported as an untoward incident and investigated as “potential patient harm,” prompting a 72 -hour rapid review of hospital records. Clinical leads of services are required to respond to the requests for information.

Due to limited access to primary care records correspondence is sent to the primary care provider, informing of the late diagnosis, and encouraging a look back, reflection and sharing of learning outcomes.

The look back revealed 40% of newly diagnosed patients were identified late, aligning with national figures. Missed opportunities occurred both in primary and secondary care settings, where clinical indicators suggestive of HIV were not recognized or actioned. Barriers included lack of awareness, stigma, and failure to integrate routine HIV testing into diagnostic pathways.

Following completion of the investigation, training is offered to staff as the aim is to not apportion blame, simply to work together to improve awareness, consider HIV as a differential diagnosis, identify and improve the barriers to testing.

As a result of this initiative a recent education session was delivered to the Gastroenterology team, highlighting a recent case with missed opportunities for sharing and discussion

By working together, we can tackle barriers to testing, increase prompt diagnosis and treatment of people living with HIV, and reduce onward transmission. Strategies such as targeted education, electronic prompts in clinical systems, and expanding routine testing in high-prevalence areas will enhance early detection. Collectively, we can achieve and end new HIV diagnosis by 2030.

A007

Reducing smoking in people with HIV: is vaping the answer?

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Abstract

Background: Around 6 million people aged 18 and over smoked cigarettes in 2023, accounting for 11.9% of the population. The highest proportion is in the 25-34 age group (14%). The long-term effects of smoking are well documented with increased risk of heart disease, respiratory disease and cancers leading morbidity outcomes. The highest average of current smokers can be found in rural areas and lower socioeconomic communities and the lowest average in more affluent areas. Greater numbers of individuals with HIV can be found in lower socioeconomic communities so it is not inappropriate to consider smokers among these individuals. Smoking cessation policies recommend the use of e-cigarettes (vaping) to assist with transition from smoking to non-smoking. In 2023 around 5.1 million people used an e-cigarette. However, the long-term effects of vaping are unknown as this is a recent phenomenon in historical terms. The aim of this study is to explore whether vaping is appropriate to prevent or cease smoking in the general population.

Method: Cemented in critical realist philosophy, this study undertook a critical review to identify appropriate concepts of harm reduction, risks and benefits of vaping and behaviour change, through a theoretical lens of public health. As is usual with this type of review, an inductive approach was taken to identify appropriate evidence that could influence future health behaviours and clinical practice.

Results: Harm reduction is essential for enabling individuals to cease smoking. Whilst vapes have been shown to assist with changing addictive behaviours, they have become attractive to younger adults with 15.8% of 16-24 years olds using them daily or occasionally. This is the highest use of vaping in the UK population. Vaping is arguably a safer method of nicotine delivery than smoking, as the vapour does not contain the harmful toxins found in cigarette smoke. However, there is still a risk of heart and lung disease when vaping and uncertainty surrounding its long-term impacts. Vaping does reduce smoking behaviours alongside other smoking cessation activities, but individuals should be supported with behaviour change to cease vaping when they are ready.

Recommendations: Practitioners should be understanding of vaping behaviours of their clients. Smoking cessation services need to be consistent across rural and urban populations. Currently it appears that vaping reduces smoking of cigarettes, but longer-term studies of health-monitoring is required.

A008

The changing face of HIV in Brighton: an 11-year review

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Abstract

Introduction/Background

Nationally, rates of new HIV diagnoses have declined over the past 11 years. However, the introduction of the 'HIV opt-out testing' initiatives have led to several regions reporting increased rates and changes in demographic characteristics. Understanding these data may help inform and target future HIV prevention strategies.

We aimed to describe the rates and characteristics of new HIV diagnoses locally over an 11-year period.

Method

Using our Electronic Patient Record system, we extracted anonymised clinical data for all patients diagnosed with HIV using GUMCAD 'H1' coding between 01/01/2014 – 31/12/2024. We collected data including date of HIV diagnosis, age at diagnosis, country of birth, gender at birth, and sexuality. Statistical analyses were performed to calculate p-values using chi-square trends to explore any changes in demographic characteristics over the study period.

Results

293 individuals were coded with 'H1 – new HIV diagnosis' during the 11-year period. (Table 1) Overall, rates of new HIV diagnoses have reduced over the last 11 years, however, have plateaued during the last 5 years. There has been an increase in the proportion of HIV diagnoses in non-UK born ($p=0.03$) and non-MSM ($p=0.02$). The median age of individuals diagnosed with HIV during the study period has remained stable. Rates of HIV diagnoses described may not accurately reflect the true rates of HIV locally and will be limited by erroneous clinical coding.

Conclusion

There has been a shift in demographics (country of birth) and sexuality (non-MSM) of people diagnosed with HIV locally over the 11-year review period. Upscaling and targeting HIV prevention strategies to identify new HIV diagnoses and early initiation of treatment remains essential to achieving the national ZERO HIV by 2030 targets. These strategies should include people who were not born in the UK and non-MSM groups.

A009

Inside HIV research: What patients think about taking part

Mr Tom Fernandez, Mr Tom Allan, Mr Jonathan Edwards, Ms Jia Bo He, Ms Katie Spears, Ms Abigail Tobin

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Abstract

Background

Research sponsors strive for representation across different patient demographics to improve the validity and application of research findings. Whilst equitable recruitment into studies underpins this, many factors can influence uptake.

Aims

To explore our patients' awareness of research activity within the clinic. To gauge what proportion had been invited to take part and those agreeing to participate. To explore patients' experience of being involved as well as facilitators and barriers to participation.

Methods

We developed a survey to collect data and distributed it sequentially to every patient attending clinic to avoid any selection bias until we reached 310 responses - equivalent to 10% of our caseload.

Results

Responses collected closely matched our overall clinic cohort for age, gender and ethnicity and thus deemed a representative sample.

Of the respondents, 75% were aware of research being undertaken within the clinic with 62% having been asked to take part. Of those asked to take part, 79% agreed, and 85% found the experience either excellent or good

Positive aspects of taking part included more time with the clinical team, increased monitoring, better access to treatments and the altruistic aspect of benefitting others. However, factors such as the frequency and timing of additional visits and clashes with work or other commitments were major barriers to participation.

Factors that might improve future participation included better quality information, remote or less frequent visits, financial assistance and more time to decide whether to take part

Over 60% of respondents expressed a clear interest in being contacted about future research – including some who had never taken part before.

Discussion

This audit illustrates a high level of patient awareness of research attributed to a research-focussed clinic culture. However, the proportion of respondents not aware of research warrants further work to ensure equity of access to studies.

Favourable feedback on the experience of taking part boosted team morale but also illustrated areas for improvement around building trust, explanation of research and communicating findings.

Nurses working in research are in a strong position to influence study sponsors to reduce barriers to taking part in research through considerate study design, improving patient information and providing better financial support.

The high level of interest for taking part in future research is worth harnessing to maximise access to research and improve recruitment into studies.

A010

Blue print for business case

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Abstract

Purpose: To identify and evidence the need to increase the HIV Community Clinical Nurse Specialist (CNS) team in order to improve patients access to care.

Method: Data was collected of all referrals to the HIV Community CNS team which included patients attending clinics and inpatient admissions. The patients were grouped by borough to identify highest geographical areas of need. An audit was conducted of all local HIV CNS colleagues across London to see which areas have HIV CNS coverage, and if these CNS's would visit patients registered to Chelsea and Westminster Hospital. Demographic data was collected of those attending outpatient clinics to identify if there is an aging population. Patient Reported Outcome Measures and patient feedback forms were used to provide evidence of the impact from the service of those already accessing HIV community CNS support. Case studies of HIV Community CNS interventions were also presented to show impact of reduced inpatient admissions/emergency attendances and adherence support/engagement in care.

Results: Multiple areas were identified with high need for input from the community CNS team, these were Hounslow, Ealing, Wandsworth, Hertfordshire and Kensington & Chelsea. The CNS team also found an inequality of care provision within our clinics, which created a "post-code lottery" for our patients depending on which area they lived. These were evidenced and presented to our HIV Directorate Board, who were in agreement for 1 full-time member of staff to be contracted permanently to cover Hounslow and Ealing. This post was then advertised and filled, within 5 months via NHS Jobs.

Conclusion: There is an increasing need for community support for people living with HIV, which is now a clinic or "post-code lottery". By collating evidence of gaps/inequality of care provisions, the HIV Community CNS team were able to evidence the "post-code lottery" experienced by patients registered with their clinics. With further evidence of patient need, the HIV Community CNS team were able to justify to senior leads the need for further members of staff, which resulted in the creation of a further job post. This has improved patient access to care.

A011

Investigating the Barriers to HIV Care Retention in Rural Communities in the UK

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Abstract

This research aims to explore the barriers to HIV care retention in rural areas of the United Kingdom (UK). This topic was chosen due to the importance of HIV care retention on the management of HIV in the UK, and the UK's ongoing aim to maintain UNAIDS' target of 95-95-95. During the systematic research collection process, thirteen primary research papers were identified to be included in this study. These papers were gathered after creating a unique database search term using Boolean operators and identifying inclusion and exclusion criteria. Furthermore, the process of the data collection process was expressed utilising a PRISMA diagram. Finally, the Critical Appraisal Skills Programme (CASP) tools were used to encourage effective critical appraisal of the evidence. Through the critical appraisal process, three themes were identified to assist with answering the research aim: 1) to ascertain the urban/rural disparities between persons living with HIV (PLWH); 2) To understand the retention of HIV service users in rural areas; and 3) To identify how participant characteristics affect healthcare outcomes among PLWH. The findings from the critical analysis highlight the need for further development of early HIV identification and care retention strategies. It is recommended that the National Health Service (NHS) should further broaden the "opt-out" campaign, where emergency departments across the NHS test for blood-borne viruses during routine blood tests. By extending the programme to other areas of the NHS, such as primary and elective care departments, further development in early HIV detection can be made and could result in greater health outcomes and retention in care services among rural-dwelling PLWH. Furthermore, the critical analysis highlights the need for further research in the UK to be conducted, as all thirteen papers included in this study were conducted in the United States of America (US). Whilst the findings from these studies can be applied to the population of the study, caution has been taken due to differences between the UK and the US such as healthcare differences (UK's National Health Service (NHS) vs. US's insurance-based system), rural areas of the US covering vaster distances than rural areas of the UK, and differences in health and social policy. This piece of research is not without its limitations, with the inclusion of only American research papers being a necessary but limiting flaw in the design of the study.

A012

Understanding the Interpersonal Experiences of People Living with HIV, Interacting with UK Healthcare Professionals: A Systematic Review and Meta-Synthesis

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Abstract

People living with Human Immunodeficiency Virus (HIV) experience repeated contact with healthcare professionals (HCPs) due to varying health needs. Research has found that people living with HIV in the UK report experiences of HIV-related stigma and discrimination from HCPs. Interactions with HCPs impact the medical and psychosocial outcomes for this population. Understanding said interactions for people living with HIV, e.g., what they find helpful or unhelpful, can inform how HCPs are supported to work with this group. A systematic review was conducted of qualitative studies reporting on the interpersonal experiences of interactions with HCPs for people living with HIV in the UK. Electronic databases PsycInfo, MEDLINE, EMBASE, Web of Science, CINAHL Plus, ASSIA, ProQuest Dissertation and Theses, as well as grey (unpublished) literature were searched. Of the 2,391 identified studies, 22 met inclusion criteria. Using a thematic synthesis approach three analytical themes were generated. These were (1) Care depends on the carer: HIV awareness and education is key, (2) Being seen as the HIV diagnosis, and (3) Person-centred care; with the latter two analytic themes having sub-themes. Our findings show that healthcare experiences appear dependent on HCP's HIV awareness and education. There is a need for a more comprehensive and holistic approach in line with person-centred care for people living with HIV, as well as greater HIV awareness and education for HCPs. Supporting HCPs in this way will likely improve people's experiences of healthcare interactions and therefore encourage engagement with healthcare services.

Keywords: HIV, United Kingdom, Healthcare professionals, Experiences, Qualitative

A013

Two and a half years of LA-CAB / RPV: the story so far.

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Abstract

Background

The FLAIR and ATLAS studies have demonstrated that Long Acting Cabotegravir and Rilpivirine (LA-CAB / RPV) injections administered two monthly is comparable with daily oral treatment and can provide an alternative treatment option for People Living With HIV (PLWHIV). The injectable treatment became available to our service in November 2022.

Method

A quantitative, retrospective electronic case note review of patients prescribed Cabotegravir plus Rilpivirine since November 2022 to date. Data was collected and analysed using an Excel Microsoft spreadsheet.

Results

Age ranged from twenty-seven to sixty years old at time of commencing injections. Time since diagnosis ranged from two to twenty years. They include four females and twenty-one males. Ethnicity: two Black African, one Asian, one Greek, twenty-one Caucasian.

Twenty-five people commenced on Oral Lead in (OLI) Cabotegravir plus Rilpivirine. Four people, all males withdrew during this phase due to side effects.

Number	Day stopped	Symptoms
1	4	Severe headache and insomnia
2	7	Facial rash
3	14	Decline in mental health
4	19	By day 10 decline in mood, dizziness and severe fatigue.

First injections administered November 2022. Currently twenty people on injectables, two on waiting list. To date one viral blip of 90 copies/ml which returned to undetectable three weeks later. No virologic failures. No injection site reactions. All injections have been administered within the flexible dosing window.

Two people withdrew from the injections at Month 2, one started new job and could no longer commit to the dosing schedule. The second had ongoing nausea, reduced appetite and weight loss, BMI borderline underweight so decided to stop. One person transferred their care to Manchester.

Conclusion

In our experience LA-CAB / RPV has very successful, it has transformed the lives of those on the regimen. Feedback has been extremely positive, reducing pill burden, fear of indirect disclosure and opening up opportunities to travel more freely. There has been difficulty in creating and maintaining capacity for more frequent consults. Many other patients have expressed interest should the dosing intervals become longer or the medication self-administered.

A014

Assessment and interventions for adherence- a retrospective analysis within HIV services in the UK and Ireland (UKI)

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Abstract

Background:

The benefits of antiretroviral treatment to people living with HIV and public health depend on assiduous and sustained adherence. However, this remains challenging for many individuals and their care providers. Appropriate assessment and interventions are critical for achieving optimal clinical outcomes, improving health related quality of life and supporting public health targets of reducing HIV transmission.

To support generation of evidence in this field, a market research study was designed to gain insights into assessment and interventions for adherence within HIV services in UKI.

Materials and Methods:

The study was managed by Opinium market research agency. An online survey link was disseminated to healthcare professionals (HCPs) in multiple UKI HIV centres. To ensure accuracy of data, HCPs randomly selected a maximum 20 notes and reviewed these for the period 2021- 2023. No identifiable information was recorded or shared with resulting data presented at an aggregate level.

Results:

Presenting final results from analysis of 18 services including 339 patient notes with demographics reflective of UKI population.

The majority of respondents reported adherence has become more challenging to assess and address in the past 2 years, their service has the staffing capacity to provide adherence assessments however fewer feel they have capacity and resource for interventions.

94% state they routinely assess adherence with 39% using a tool and lack consistency in doing so.

Only 28% of respondents report their service have adherence assessment and interventions accessible to people whose first language is not English.

Of notes reported on, one in eight did not have documented adherence assessments, the majority that had were documented by doctors and a low percentage by pharmacists. On measurements used the majority was patient estimate and low usage of scaled questionnaires reported.

One in five experienced a decline in adherence since 2021. For those experiencing adherence issues most were identified through proactive monitoring during routine face to face appointments. 91% received support for this; primarily HIV clinic led.

Conclusions:

This data indicates adherence remains a priority for HIV services however may suggest key gaps in resource, assessment tools and interventions in practice particularly from a health equity perspective.

A015

A review of the patient cohort and experience of injectable antiretroviral therapy at a large inner-city clinic

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Abstract

Background: Injectable antiretroviral therapy (ART) with cabotegravir and rilpivirine has been well established as a non-inferior treatment option to traditional oral therapy. It is considered beneficial for adherence and presents an option for patients with physical, psychological or psychosocial barriers to pill-taking. Studies and real-world data have shown patients prefer injectable ART to oral therapy. Implementing injectable ART into routine clinic practice has presented several challenges including staff availability, increased clinic costs, extra monitoring and clinic scheduling.

Materials and methods: We reviewed the medical records for patients approved for injectable ART at the HIV Multi-Disciplinary Team (MDT) meeting between April 2022 and April 2024 at The Northern Contraception, Sexual Health and HIV Service in Manchester. Data gathered included MDT outcome, key demographics and virological control. We also describe patient experience based on questionnaire responses.

Results: 88 referrals were made to MDT. 25 (28%) were approved for injectable ART. Of these, 8 (32%) declined or didn't commence therapy and 3 (12%) discontinued due to adverse reactions. The most common reasons for MDT referral were patient interest (20.5%), adherence (24.7%), psychological need (17.8%) and travel (11%). Of the 14 (56%) patients who initiated injectable ART, 13 (92.8%) identified as White British men who have sex with men (MSM). 2 (14.3%) patients had a detectable viral load after their first injection. None of these patients had the oral lead in but fully suppressed at injection 2. Patient feedback was favorable with 8 (100%) of questionnaire respondents expressing they preferred injectables to traditional oral ART. 14 patients (100%) remain undetectable 23 months after implementing injectable ART within the clinic.

Conclusions: Injectable ART remains a safe and feasible option for many patients and satisfaction rates are high. Feasibility of administration in clinic means we must limit capacity. NHS England commissioning criteria also restricts patient eligibility. Novel ways of delivering injectable ART, such as homecare, needs to be explored. It is imperative to ensure patients of all backgrounds, particularly woman and those from ethnic minorities are aware of the availability.

A016

What can we learn from new HIV diagnoses to inform future strategy.

ANP Yvonne Wilson, Dr Carol Emerson

Belfast Health & Social Care Trust, Belfast, United Kingdom

Abstract

Background

Combination HIV prevention methods and testing is widely available throughout our region. Belfast has signed up to the FastTrack Cities initiative aiming to eliminate HIV transmissions by 2030. This audit examines the new diagnoses in our service over a three-year period in an attempt to identify missed opportunities, barriers to access and areas for targeted interventions.

Method

A retrospective case note review of new registrants to our HIV service between January 2022 and December 2024. Data was collected and analysed using a Microsoft Excel spreadsheet.

Results

During this timeframe one hundred and ninety-three new patients registered care with our service. One hundred and twelve had been previously diagnosed elsewhere, eighty-one were a first-time diagnosis. Twenty-two females, fifty-nine males. Age ranged between eighteen and seventy-eight years old, median thirty-five. Thirty-six were MSM, twenty-six heterosexual, seven weren't recorded and twelve had their risk recorded as Person Who Injects Drugs (PWID). Forty-eight were diagnosed outside GUM services. Twenty-four (29.6%) had previously had an HIV test in the United Kingdom, time from last test ranged from twelve years to one month, fifteen had tested within the previous year. Forty-three percent had a CD4 count of 350 or less, eight people had an AIDS defining illness at diagnosis. Approximately forty-four percent of the people newly diagnosed were from outside the UK & Ireland, their time in UK ranged from thirteen years to a few months.

Conclusion

Seventy-one percent of people newly diagnosed with HIV over this time period were not previously engaged in regular HIV testing or prevention interventions. A significant number of people were from outside the UK and had recently arrived, there needs to be ongoing campaigns encouraging testing and providing information on how and where to access free services. Unfortunately, forty-three percent were late diagnoses. Encouragingly, fifty-nine percent were diagnosed outside of GUM, this is reassuring that clinicians are considering HIV as a differential diagnosis. The increasing number of diagnoses within the PWID group is very concerning. Significant investment is required to provide community addiction support, education on safer injecting practice, provision of PEP and PrEP within the community and retaining patients in HIV care. While we have made many achievements over the past few years

including a successful PrEP service, we clearly have to use this information and continue our efforts to adapt to reach new at-risk groups if we are to meet the target by 2030.

A017

Understanding the complex needs of living well with HIV – with a focus on cardiovascular disease (CVD) – exploratory perspectives from an expert group

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Abstract

Background

Numerous studies have shown that people living with HIV have higher risks of CVD compared to the general population. Furthermore, the 2022 Positive Voices report found 46.7% of all people living with HIV reported to have been diagnosed with a cardiovascular condition or diabetes and over 60% had an unmet need in managing CVD risk factors. The underlying mechanisms and risk factors are multifactorial. The British HIV Association guidance suggests that CVD risk assessment and pharmacological management are combined with a holistic approach to lifestyle modifications including smoking cessation and dietary advice, and those people requiring further support should be signposted to or referred for multidisciplinary support.

Materials and Methods

Representatives from cardiology, dietetics, psychology, and community groups were purposely selected to provide their knowledge and insights into how to best address the needs of people living with HIV who are at risk of initial or further CVD complications. Input was gathered via semi-structured expert meetings plus review of existing materials and the findings analysed to (1) explore areas of best practice, (2) identify potential barriers and (3) compile approaches aligned to guidance for implementation.

Results

Whilst there is a multitude of assets and local areas of excellence, in general the referral pathways and support materials are fragmented, inconsistent and lack a central point of reference. Key themes included:

- Needs are multifactorial
- Materials don't reflect the diverse population that services see, e.g. Eatwell plates are aimed at a Western diet. Our experts have created others, but availability is sporadic
- The need to understand the complexities and barriers to behaviour change.

- Acknowledging poverty – technological, financial and food choice and availability.
- Services are stretched; there is a postcode lottery for weight management services.
- Guidance and advice need to lead to lifestyle modifications which are individualised, realistic, and sustainable.

Conclusions

CVD in HIV needs to be managed in a holistic manner, with bespoke, person-centred advice. Healthcare professionals and third sector support would benefit from the bringing together of the plethora of resources available, to aide them in giving advice to people living with HIV to better support them in making small, realistic, and sustainable changes. A simple tool or guide could provide this much needed resource.

A018

The Lived Experiences of Older Racially Minoritised Groups Living With HIV: A Systematic Review of Qualitative Studies

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Abstract

Background Human Immunodeficiency Virus (HIV) remains a global public health concern, particularly among racially minoritised groups. Medical advances mean that the total number of people aging with HIV is increasing. Despite this, older racially minoritised individuals living with HIV face unique challenges shaped by intersecting factors such as age, race and sexual identity and continue to experience stigma, discrimination and socioeconomic barriers that impact their access to care and quality of life.

Aim The systematic review aimed to explore that lived experiences of these individuals focusing on inequalities that persist and coping strategies used to navigate stigma, disclosure, support systems and the aging process while living with HIV.

Methods Eight databases (MEDLINE, PsycINFO, CINAHL, EMBASE, AMED, Scopus, Sociology Collection and the British Nursing Index) were searched for qualitative English language studies published between 1994-2024. Nineteen studies from a total of 2923 were eligible for inclusion. The National Institute for Health and Care Excellence (NICE) Quality Appraisal Checklist for Qualitative Studies was used to assess the quality of the included studies.

Results A thematic analysis of findings identified six major themes (1) Layers of HIV stigma and discrimination (2) Disclosure, selective disclosure and non-disclosure (3) Support Mechanisms (4) Thriving with HIV (5) Socioeconomic barriers to HIV and (6) Faith, empowerment and vulnerability.

Conclusion Through centring lived experience, this review highlights the need for more intersectional research to address complex needs of the population. The review evidences key research gaps including the underrepresentation of transgender individuals, women and experiences of those living outside of the United States. The themes identified suggest that further research that recognise the historical context of systemic racism and stigma in healthcare is needed to better meet the needs of these older adults living with HIV and the importance of culturally sensitive interventions and policies to improve health outcomes with a focus on quality of life outcomes for this growing population

A019

Thinking Outside the Box: Improving Engagement for Vulnerable Patients Living with HIV

Mrs Lisa Walker

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Abstract

Aim

This poster demonstrates how we proactively identify and support vulnerable patients with chaotic engagement or repeated DNAs by implementing flexible, patient-centred interventions that improve engagement and health outcomes.

Objectives

- Identify patients who are particularly vulnerable and at risk of disengagement
- Provide a personalised, flexible approach to care tailored to individual needs
- Gain behavioural insights to understand patterns and barriers affecting engagement
- Gather ongoing feedback from patients and stakeholders to monitor, adapt, and improve our engagement strategies.

Method

- **Improved Communication:** A mobile phone was purchased, enabling patients to send text messages directly to the team.
- **Proactive Patient Monitoring:** A rolling list of patients identified as vulnerable or at risk of disengagement has been created.
- **Strengthened Multi-Agency Working:** We are exploring the introduction of safeguarding supervision sessions to improve collaboration across healthcare and social care teams, and to break down barriers that impact engagement.
- **Outreach Service Development:** An outreach model has been developed, enabling the team to deliver care in patients' homes when appropriate, increasing flexibility and accessibility.
- **Updated DNA Process:** Our DNA Standard Operating Procedure (SOP) has been updated to incorporate specific considerations for hard-to-reach patients

Results

- **Improved Communication:** The introduction of the mobile phone has increased patient-initiated contact.
- **Enhanced Oversight of Vulnerable Patients:** Regular MDT discussions have improved team awareness of at-risk individuals.

- **Improved Flexibility and Access:** Home visits through the outreach service have enabled patients who would otherwise disengage to receive essential care and support in familiar, non-clinical environments.
- **Strengthened Multi-Agency Links:** Early engagement with safeguarding and external partners has highlighted opportunities to improve information sharing and joint working.
- **Reduced Inequalities:** By personalising our approach and offering alternative modes of engagement, we are starting to address some of the inequalities that prevent our most vulnerable patients from accessing routine HIV care.

Conclusion

Adopting a flexible, patient-centred approach has strengthened engagement with some of our most vulnerable patients living with HIV. Improved communication, proactive monitoring, and tailored outreach have begun to reduce barriers to care. Ongoing collaboration and safeguarding supervision will further support this work, helping to reduce health inequalities and improve outcomes for this complex cohort. Continued evaluation and patient feedback will guide future service development.

A020

How do women living with HIV experience loneliness?

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Abstract

Loneliness is a complex feeling of disconnection that can be difficult to overcome. Some people report more frequent loneliness, such as women with long-term conditions and/or disabilities. Research indicates loneliness is stigmatised and likewise, HIV is a socially stigmatised long-term condition that can increase people's risk of social and psychological vulnerabilities. There is limited research exploring in depth the influences of living with HIV and how loneliness is experienced in women across the gender spectrum. Methods: The Silences Framework (Serrant-Green, 2011) was adopted to seek unheard experiences relating to living with HIV and constructions of loneliness. Silences were heard on an international scale via qualitative online one-to-one interviews with women who identified as living with HIV and having experienced loneliness. Data analysis was thematic and reflexive. Overarching themes were categorised as Micro, Macro level and Agency. Micro level themes were loss and restrictions, Macro were stigma and gender inequality. Agency included empowerment via peer support, advocacy and support from specialised HIV healthcare providers. Conclusion: women living with HIV experience a range of complex micro and macro level barriers that influence their everyday lives and these influences can act as a barrier to meaningful connection. Peer support was crucial to helping women gain agency to overcome the barriers. Healthcare providers are key to identifying women and advocating the benefits of peer support. More women-centred research is required to better understand the needs of women living with HIV in terms of ongoing peer group support and to better understand how agency is achieved.

A021

Increasing and promoting prep uptake in the black african and caribbean heritage communities living in bristol: A service improvement proposal to expand prep accessibility in pharmacies facilitated by nurses.

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Abstract

Abstract

Introduction and background

In the United Kingdom (UK) the Black African and Caribbean global majority heritage groups remain disproportionately affected by HIV. Urban areas in Bristol are considered to have a “high” prevalence of HIV. Currently, level 3 specialist sexual health services (SHSs) in Bristol do not meet the PrEP needs of this population. The UK government pledged their commitment in eliminating all new HIV transmissions by 2030 publishing the “Towards Zero: the HIV Action Plan for England” which sets out preventative strategies to achieve this objective. One strategy is to expand accessibility of PrEP to diverse settings other than level 3 SHSs. Expanding PrEP accessibility to pharmacies in Bristol is key in reducing this health inequality.

Aim and objectives

The aim is to expand the accessibility of PrEP to pharmacies in Bristol and having nurses and pharmacists working collaboratively. The objectives are to promote and increase PrEP uptake in the Black African and Caribbean world majority heritage groups living in Bristol.

Service improvement plan

The model of improvement framework following the Plan-Do-Study-Act (PDSA) cycle is utilised in this proposal to highlight the service improvement needed i.e., expanding PrEP accessibility to Bristol pharmacies, where consultations are led by nurses.

- **Plan:** collaboration of local authorities commissioning PrEP, level 3 SHSs and pharmacies setting out clear aims and objectives. Arranging for one pharmacy to commence the PrEP trial.
- **DO:** The nurse’s role in pharmacies will consist of assessing, educating, and initiating PrEP for patients and arranging a follow up appointment.
- **Study:** PrEP initiation and continuation will be reported to the GUMCAD STI surveillance system, and this data will help in the evaluation of this pilot. Patient feedback questionnaires will be utilised to understand possible barriers.
- **Act:** The decision-making process utilises the “adopt, adapt and abandon” evaluation process.

Discussion

PrEP has been shown to be effective and an essential tool in preventing acquisition of HIV, and is a cost-effective treatment compared to that of HIV. Countries like South Africa and USA have successfully implemented availability of PrEP in pharmacies optimising its accessibility with positive results optimised by the involvement of nurses. Amendment of policies are needed in the UK for pharmacies to stock PrEP, improving accessibility and ensuring equitable access to PrEP.