

HIVPA Bulletin



February 2019



HIV Pharmacy Association

HIVPA News

Hello and welcome to the HIVPA bulletin.

This edition is packed with summaries from recent study days and news of exciting projects our members have been involved in. Thank you to all the authors for their valuable contributions. The bulletin is an essential resource for sharing good practice and success stories and we are always excited to hear from our members with any events you have been involved with. Perhaps you have attended a study day or conference which you would like to share some valued learning from, or you may have enjoyed recent success with a local project or initiative – please do get in touch with me via bronagh.mcbrien@mft.nhs.uk

As my first publication of the bulletin as HIVPA bulletin lead, I hope you all enjoy reading.

Bronagh McBrien (HIVPA Bulletin Lead)

Tribute

It is with great sadness that the British HIV Association (BHIVA) reports the death of Dr Mags Portman in the early hours of Wednesday 6 February 2019. She was 44.

BHIVA Chair, Professor Chloe Orkin, said:

"Mags Portman will always be an unforgettable human being. Her deeply felt convictions translated into true activism — an activism which helped to unite health professionals and the community to achieve PrEP for all. She has been widely recognised within her lifetime as being a prime mover, someone who has shaped the history of PrEP in the UK. It was a true privilege to work with her at the Royal London and to know her as a friend. She is loved by so many and will be so deeply missed."

Dr Mags Portman is survived by her husband Martin and their children, Edward and Freddie. An obituary is published in BuzzFeed News 12 February 2019.

<http://www.buzzfeed.com/patrickstrudwick/a-pioneering-doctor-who-helped-revolutionise-hiv-prevention>

HIVPA Committee

Sonali Sonecha has stepped down from her role on the HIVPA Expert Panel. The HIVPA committee would like to thank Sonali for her long service to HIVPA, her invaluable input to the committee and her involvement on the CRG and on national guidelines and policy writing.

Ojali Negedu has stepped down from committee as EHIVE and Communication representative, the HIVPA committee would like to thank Ojali for her hard work and contributions as a committee member.

A replacement for the EHIVE and Communication representative and also a new member of the patient information team will be advertised in the coming months

HIVPA News

Brexit Statement

BASHH, BHIVA, HIVPA and NHIVNA statement on management of antiretroviral supplies in preparation for a no-deal Brexit Scenario, January 2019

In 2018 the Department for Health and Social Care, in preparation for a no deal Brexit, wrote to pharmaceutical companies that supply UK medicines from, or via, Europe. Companies have been asked to stock **at least six additional weeks supply**, over and above their business as usual stocks, by 29 March 2019. We are confident this extra stock will allow usual duration prescriptions for everyone, even if there are short-term supply issues after March. Additional contingency planning has assessed specific antiretrovirals at risk.

Trust pharmacies, home delivery companies and community pharmacy partners should **not stockpile additional antiretrovirals beyond business as usual stock** – pharmaceutical companies are responsible for holding extra supplies. Clinicians do not need to issue longer, or earlier than usual, prescriptions and patients should be reassured that there is no need for concern about the supply of their medication and therefore no need to stockpile. Changes to predicted use of drugs could risk continuity of supply.

As is normal current practice, patients should be advised to ensure they have a buffer supply of medication to last **one month** beyond their next clinic appointment and to ensure their appointment is booked to reflect this.

Commissioning

NHS England commissioning policy for Bictegravir is anticipated to be available for consultation period shortly. We would encourage all our members to access this document and respond to the consultation process.

Juluca, the first licensed dual therapy for the treatment of HIV has been granted a marketing authorisation by the EMA. NICE and NHS England are reviewing trial data prior to the release of a commissioning statement

Gilead bursary

HIVPA, in collaboration with Gilead have made provision for bursary awards to be made available to assist pharmacists and pharmacy technicians to attend conference. Sacha Pires from Barts Health NHS Trust and Bronagh McBrien from Manchester Foundation Trust were successfully awarded the bursary this year. Applicants were reviewed and judged by a panel of HIVPA committee members and expert panel members. Congratulations to both!

Sponsors

HIVPA would like to thank all of our sponsors for their continued support in 2019

Gilead Sciences (UK) Ltd
Merck Sharpe and Dohme
Mylan
ViiV Healthcare
Dr Reddy's Laboratories (UK) Ltd

The support of our sponsors is essential to much of the work carried out by HIVPA including events such as study days and conference. Thank you!

Dates for your diary



Annual Conference

Crowne Plaza Hotel, Manchester City

Friday & Saturday, 14th and 15th June 2019

There are a wide variety of topics on offer over the two days, with some very experienced speakers that will cater for all our delegates, so book your place early to avoid disappointment.

Following on the success of previous years, we are pleased to announce that we will continue to be holding a number of technician and junior pharmacist focused sessions throughout the conference. There will 10 free technician spaces available on a first come first served basis.

HIVPA Conference Team and Committee are pleased to provide a copy of the first release of the Conference Programme for June 2019 available by clicking [here](#).

All pharmacists and technicians are encouraged to submit an abstract for the poster presentation at this conference and to be in with a chance to win the Ushma Patel Prize for Pharmacy Practice and research!

Submit **an abstract of 2500 characters (including spaces) or less** of the main poster presentation and poster to be sent by Friday 24th May, 2019 to hivpaoffice@gmail.com

All details about early bird payments together with information around abstract/poster submission deadlines and how to book are available by clicking [here](#), visiting our website at www.hivpa.org or email us at hivpaoffice@gmail.com.

Dates for your diary

HIVPA Study Days

HIVPA study days are open to any pharmacy, healthcare staff and those with a special interest in HIV so please feel free to share information about this event with your colleagues. Attendance at this meeting is free for HIVPA members. A small charge of £25 is required for non members, payable in advance.

The Study Days are held at the Pullman hotel, 100-110 Euston Road, London NW1 2AJ near Euston and Kings Cross train stations. [Pullman Hotel website](#)

To reserve your space on any of our Study Days please email Yvonne on hivpaoffice@gmail.com



30th April, 2019:

'Resistance and co-infections including Hepatitis B and C and Tuberculosis'

18th September, 2019:

'Comorbidities, drug-drug interactions and polypharmacy'

21st November, 2019:

'Prevention, Genitourinary medicine and health beliefs'

Dates for your diary

Clinical Pharmacy Congress

As affiliated partners of Clinical Pharmacy Congress 2019, HIVPA are pleased to be in a position to offer passes for the event, which takes place on 7/8 June 2019 at the ExCel in London.

For the 8th year running [The Clinical Pharmacy Congress](#) will welcome the pharmacy community through its doors and we would be delighted if you would join us at these two education packed days. Your guest pass will grant you access to:-

- Receive 100+ hours of educational content to get you revalidation ready for 2019
- Expand your knowledge with the latest clinical updates across 150+ sessions delivered by 150+ world-class speakers
- Network with the CPC community – catch up with peers, colleagues and old friends
- Grow your career prospects by networking with sector leaders
- Witness the latest innovations in clinical pharmacy and source new suppliers

CPC's world class conference programme will be delivered across lively sessions and interactive workshops, filled with specialised content to provide you with the education you need to improve patient outcomes.

Presenting at the event on behalf of HIVPA will be Richard Strang, our Faculty and Liaison Support Representative. Richard is based at University Hospitals of Leicester NHS Trust.

Healthcare Professionals can register now with the HIVPA's personalised discount code below to waive the £499+VAT entrance fee:-

Personalised URL: www.pharmacycongress.co.uk/hivpa

Personalised Discount Code: CPCHIVPA

UK healthcare professionals working within the NHS, private hospital, hospice, CCG, CSU, military, academic organisations or secure environments are eligible to use an education code to waive the FULL cost to attend The Clinical Pharmacy Congress.

HIVPA Study Days

Fake News

My talk at HIVPA this year was entitled 'Fake News!' and was aimed at thinking about some of the drivers of stigma that continue to exist, particularly when based on myths related to HIV infection and what it means to be HIV positive in 2018. I aimed to cover three main aspects during this talk. These were some of the common misconceptions associated with HIV/AIDS and their treatment, how common misconceptions about HIV/AIDS impacts social stigma and, finally, how stigma affects access to healthcare for persons living with HIV (PLWH). When thinking about misconceptions I think it's important to challenge what we think ourselves as practitioners. We may assume we understand someone's sexuality or how their HIV makes them think as a person. None of this is true and it is important to leave our own prejudices and beliefs outside of discussions when trying to understand what the individualized aspects are for a patient we are interacting with. I discussed some of the assumptions people make about the route of transmission, or what is (or isn't) 'risky'. I covered some of the assumptions people may make about HIV, including that HIV is the same as AIDS, that HIV people are infectious, even from casual contact, that only 'bad', 'naughty', or 'dirty' people get HIV. Of course some may also assume that 'their sexual behaviour is wrong, so of course they got HIV, they deserve it'. Whilst holding some of these factors in mind we also considered how they might impact on the recent statement that 'Undetectable = Untransmissible', what this might mean for PLWH, and how they may doubt it and need support and encouragement to believe in some of the evidence they are told about in clinical settings. Another common assumption might be that treatment is difficult or toxic, and we can all play a role in supporting people to realise

people to realise that this need not be the case. With regard to stigma, I covered different definitions of what this term means, and that many people have fears, prejudices or negative attitudes about HIV. Stigma can result in people living with HIV being insulted, rejected, gossiped about and excluded from social activities. At its extreme, stigma can even drive people to physical violence. People living with HIV often feel nervous about telling others that they have HIV due to the fear of stigma or discrimination. This can lead to isolation and feeling unsupported, which can have a significant impact on health and wellbeing. Stigma, whether perceived or real, often fuels myths, misconceptions and choices, impacting people's HIV education and awareness, and can result in people with HIV believing some of the things that other people say about HIV, even when these are not true. Stigma leads to people not being treated with dignity and respect. In terms of accessing healthcare, everybody living with HIV should go to a specialist HIV clinic to get the best possible treatment and care but we also discussed the rules of confidentiality and non-discrimination that apply in all healthcare settings. Solutions to stigma are something we can all be involved in, and I talked in particular about making sure the 'Real News' gets out there, in our discussions with friends, family, and colleagues, as well as with our patients. We can all keep giving the right messages, train staff and others, speak to friends and family and challenge their beliefs, share information and, ultimately, support our patients.

Tristan Barber

Chelsea and Westminster

HIVPA Study Days

Grantsmanship

Grantsmanship is the art of acquiring peer-reviewed research funding. It is a competitive process and requires the applicant to be able to sell their ideas. Writing a successful grant is like writing a bestseller, it requires the ability to blend facts with intrigue and style. There are about three stages to developing the grant; planning, writing and review.

The grant process starts with the identification of a funding call that fits the subject area you are interested in. Usually the research plan will include a comprehensive literature review to validate the gap you are saying exists which is what your research is trying to address. There is no other way round this except if a recent systematic review has been published in the subject area. Results from pilot studies and a publication track record in support of the proposal is advantageous but not essential and depends on the type of funding call. Some calls are tailored to assisting applicants undertake a pilot. The planning phase is when the lead applicant identifies collaborators. It is advisable to study previous successful grant proposals to the funder.

During the writing phase, it is absolutely vital to follow the guide provided by the funder. It is always good to assume the person reading your proposal is not an expert in your field but infinitely intelligent. Be clear, organized and detailed so that the reviewer is captivated. You want to avoid the reviewer having to read your proposal more than once to understand it. They won't have the time to do this!

The abstract should describe the entire research picture succinctly without leaving the reader puzzled or confused. If required to include a section for a lay audience, it is usually because this would be made public, hence it should be clear, concise accurate and be free of jargons.

The grant proposal should ideally state your hypothesis and address 2-4 specific aims which are realistic and can be addressed in the duration of the grant and within the budget requested.

The impact of the research is increasingly

an influential part of the proposal as the reviewer wants to know how your research will contribute to knowledge in the field, and its benefits to society, policy makers and those outside your discipline.

The methods and procedures should be carefully laid out pointing out the strengths and any weaknesses in your methods and how you plan to deal with them. The reviewer will be reassured to know you have thought about the weaknesses rather than having to point this out to you. You will place yourself in good stead if the environment for your research is appropriate for the kind of research you have set out.

The full proposal will usually be reviewed by two or three external reviewers who will provide a full report on your proposal and rank it based on scientific excellence. Depending on the type of funding call, interview of applicants with high ranking scores may be part of the selection process.

Give yourself plenty of time, get it reviewed by colleagues and check for errors. You don't want sloppy mistakes to undermine all the hard work you have put in. Good writing will not save bad ideas, but bad writing can kill good ones.

Preparing conference posters

The Collins English Dictionary defines a poster as "a large notice or picture that you stick on a wall or board, often in order to advertise something." The intention of an advert is to draw attention to something, in other words, an eye-catching display. An academic poster is no different, hence, creating a great poster requires a combination of creativity and scholarly activity. There should be a balance between images and texts used. Because most people would spend an average of 90 seconds reading a poster, it should be engaging and at the same time simple. Careful thought about the background, text and clever use of graphics makes a poster more likely to stand out.

It is preferable to use a light background with dark letters. Graphics and images also stand out better when the background is light. White space should constitute about 35% of the available space on the poster as this makes the poster easier to read.

The layout of the text is equally vital and should be cognizant of reader gravity; it should pull the

HIVPA Study Days

eye from top to bottom and left to right. Sans-serif font (e.g. Arial) should be used for titles and headings and serif font (e.g. Times New Roman) for texts. The title should be short, sharp and compelling and displayed with a minimum font size of 36 and should be readable from 6 feet away. The text for the body of the poster should include all the different sections of a scientific writing and should have a minimum font size of 24 and readable from 4 feet away. Text heavy posters are off-putting, rather say it with a picture and save a thousand words! Graphics should be simple, clean and clearly labelled.

Creating a great poster requires practice and remember, a poster is meant to serve as an aide-memoire, so resist the temptation to read out the content to any captive audience!

Collins Iwuji

Brighton and Sussex Medical School

Patient Centred Care

On 7th November 2018, Nina Barnett and Lelly Oboh delivered lectures and associated workshops on a coaching approach to person-centred care for people living with HIV.

The concept of person-centred and values based care in the context of PLWH was explored together with both demonstration and practice of the GROW model of coaching (1). This behaviour change model, originally used in business coaching, has been used to support patients with improving their health for approximately 20 years but is relatively new in the NHS. Participants were able to experience the benefit of a goal focused, participant-led conversation through practicing the coaching technique. This was followed by discussion of how this technique can be modified for use in health-related consultations, including developing a shared agenda, identifying both clinician and patient goals, and exploring both the current situation and the patients existing solutions, before making recommendations.

The use of the four E questions (2), used as part of the Centre for Postgraduate Pharmacy Education (CPPE) document (3) was introduced and the benefit of integrating these questions into short consultations was discussed.

Nina and Lelly outlined the patient-centred medication review process(4), which has been used to undertake holistic medication review for people with polypharmacy, to support participants in developing their medication review skills in short consultations. The event ended with participants having coaching conversations in pairs about how they would use their new knowledge and skills over the coming weeks within their practice to optimise medicines use.

1. Whitmore, J. Coaching for performance: Growing human potential and purpose: The principles and practice of coaching and leadership. Nicholas Brealey publishing. 2010.
2. Barnett, N. The new medicine service and beyond- taking concordance to the next level. Pharmaceutical Journal, 2011. 287(7681), p653.
3. www.consultationskillsforpharmacy.com/docs/docb.pdf (accessed 29.11.18)
4. Barnett NL, Oboh L, Smith K. Patient-centred management of polypharmacy: a process for practice. Eur J Hosp Pharm. 2016 Mar 1;23(2):113-7.

Nina Barnett

Lelly Oboh

HIVPA Study Days

Patient Centred Care

As specialist pharmacists, we regularly engage in consultations with patients living with HIV. Our consultations share a key goal, to enable patients to gain the best outcomes from their treatment. Having experienced patient consultations which went well and others which did not, I entered this study session with the expectation that it would help refine my patient consultation skills.

The session was delivered by Nina Barnett and Lelly Oboh, Consultant Pharmacists in the Care of Older People. It was a dynamic afternoon, loaded with audience participation. The focal point was the practical session which allowed the attendees to put the theory into practice.

The key take-home message was the importance of embedding person-centred care into our patient consultations. Person-centred care incorporates “use of clinician skills, evidence-based knowledge and patient perspective to provide personalised, co-ordinated care which enables people to make the most of their lives”. The aim is that the patient owns the change which is required. This is achieved by sharing the responsibility of the consultation with the patient. This involves negotiating a shared agenda with the patient and promoting a dynamic consultation where the patient generates potential solutions.

Research has shown that 60% of the content covered in patient consultations is not retained by the patient. In fact, they usually remember the first element, the scariest element and the most recent element discussed. This alarming fact reinforces the importance of person-centred care. The acronym AGROW is used to summarise the model which can be utilised to incorporate person-centred care into our patient consultations.

- **Agenda:** What would you like to talk about today?
- **Goal:** What do you want from this conversation? What is realistic for the patient to achieve?
- **Reality:** What is actually happening now? Define the problem(s).

- **Options:** What could you do?
- **Wrap-up:** What will you do, when, how, with who etc.

The Four E's were discussed as a tool to help support the AGROW model. This tool requires practitioner engagement and empathy with the patient in order to be successful.

- **Explore** – Patients' knowledge, patient's perception of benefit/ concerns, patient goals.
- **Educate** – Give patients the information they want, when they want it, integrating points for patient safety.
- **Empower** – Ensure the patient “owns” the decision(s).
- **Enable** – Facilitates the patient to work out how they'll implement the change(s).

In summary, this study session enabled me to refine my consultation skills and highlighted the importance of person-centred care. The AGROW model and Four E's tool can be used to incorporate person-centred care into any patient consultation. Upon reflection of my patient consultations following this study session, I have found that although time does not always allow for complete implementation of the AGROW model, negotiating a shared agenda has enabled me to incorporate a person-centred approach into my patient consultations.

Rory Grier-Gavin

Imperial College Trust

HIVPA Study Days

East Anglia Regional Study Day

A regional Study Day was held in East Anglia in January 2019. Organised and chaired by Portia Jackson, HIVPA Regional Lead and Regional Representative for East Anglia, the event was kindly sponsored by Gilead and was attended by specialist pharmacists and nurses, pharmacy technicians and clinical pharmacists working in the region.

The morning was dedicated to a workshop on person-centred care in medicines-related consultations in HIV facilitated by Professor Nina Barnett, Consultant Pharmacist, London North West Healthcare NHS Trust and NHS Specialist Pharmacy Service. After a presentation explaining the concept of person-centred care and considering the evidence for its use and its place on the national agenda, we moved on to explore its specific application to the case of medicines adherence and HIV and how it may be incorporated into our everyday practice. After examining the multiple challenges to medicines-taking in HIV, the session addressed the implementation of three behavioural methods – motivational interviewing, cognitive behavioural therapy and health coaching - to engage patients in a person-centred manner to identify and resolve their medicines issues with the aim of optimising medicines use. It focussed on the employment of these in short consultations which was invaluable given that in the highly pressurized environment in which most of us work, consultation time is limited. The session concluded with the opportunity for attendees to pair-up to role-play a consultation in order to put into the practice some of the techniques covered.

Dr Simone Antonucci, Senior Medical Scientist, Gilead, gave a Conference Update which provided concise summaries of some of the key studies presented at Glasgow 2018. These included 96-week data from two phase III randomised controlled clinical trials demonstrating non-inferiority of bicitegravir/emtricitabine (FTC)/tenofovir alafenamide (TAF) versus dolutegravir with FTC/TAF or abacavir/3TC in treatment-naïve adults with high baseline viral load or low baseline CD4 count and

results of retrospective analysis of the large, multicohort NA-ACCORD study which concluded that, in ART-naïve adults in the US and Canada, initiation of integrase inhibitor-based ART was associated with greater predicted weight gain compared with protease inhibitor-based or non-nucleotide reverse transcriptase inhibitor-based ART. Studies demonstrating the effectiveness, persistence and safety of FTC/TAF-based regimens in treatment-naïve and treatment-experienced patients were also presented as was Marzolini's Top 10 Drug Interactions in Day-to-Day Clinical Management of HIV, with antiplatelets, anticoagulants and corticosteroids taking the first three places in the hierarchy respectively.

The closing presentation was a case study-based session focussing on renal risk factors for HIV and their management by addressing three cases of patients approaching CKD stage 3. The session incorporated a comprehensive revision of renal function and assessment, including the role of the kidneys and the mechanism of filtration and the importance of urinalysis and the interpretation of albumin/creatinine ratio (ACR) and protein/creatinine ratio (PCR) results when evaluating renal function. The role of retinal binding protein in establishing glomerular function was also discussed. This was an interactive session, highlighting the importance of considering comorbidities which increase the risk of renal decline as well as the trajectory of eGFR readings over a period of time when making decisions about appropriate anti-retroviral therapy for a patient and the need to switch them from a potentially nephrotoxic to a less nephrotoxic regimen. The use of CKD calculators to assist in decision-making was also discussed.

Portia Jackson,

Specialist Clinical Pharmacist iCaSH

Chelsea Flower Show

HIV Pharmacists at Chelsea Flower Show

During the week of Chelsea Flower Show in May 2018, Jo Hales-Owen and Mel Snelling (HIV Specialist Pharmacists at the Oxford University Hospitals) along with Charlie Wells (HIV Specialist Nurse) volunteered on the CHERUB-HIV garden. The garden was the inspiration of Professor John Frater - one of the OUH HIV consultants and co-lead of CHERUB (Collaborative HIV Eradication of Reservoirs UK BRC), a group researching HIV cure. Designed by Naomi Ferrett Cohen it was her first ever show garden and won a Silver Gilt medal. Entitled 'A Life Without Walls' it aimed to show the journey of someone with HIV from when they are first diagnosed and in the relative safety of the clinic, through the barriers that stigma in the real world represents and on to the freedom that breaking down these barriers can give. At the end of the garden was a beautiful bench with the words 'Acceptance not Stigma' and the metalwork flowers were based on the handprints of children with HIV, created during a CHIVA workshop. Bright, colourful and open plantation was used at this end of the garden to symbolise the goal of an open and accepting environment for people living with HIV.

As those of us who work with people with HIV know so well there is still a great deal of stigma, including self-stigmatisation. One poignant moment that really illustrated this occurred when a lady who had talked to Mel returned later and spoke to Mel again - revealing that she had HIV but had not told anyone else her diagnosis.

Jo, Mel and Charlie had a great time enjoying the Chelsea Flower Show environment, imparting horticultural wisdom (a bit of mugging up was needed there!) and most importantly talking to people about HIV. It was a great opportunity to raise awareness of HIV as between the team we must have talked to hundreds of people and given out thousands of leaflets during Chelsea week. It was good to find that many people knew that HIV is a treatable condition though we found that many did not know about U=U (undetectable = untransmittable). A

number of people were astonished to find that there are children's HIV clinics in the UK and it was good to be able to explain that these are gradually disappearing due to prevention of mother to child transmission and the older children growing up and moving into adult clinics. Hopefully hearing that HIV is now such a treatable disease making the progression to AIDS completely avoidable may encourage more people to be tested for HIV.

If you would like to read more about the garden or the work of CHERUB, go to <http://www.ox.ac.uk/news/2018-05-18-hiv-researchers-create-chelsea-garden-raise-awareness-disease-stigma>

<https://www.medsci.ox.ac.uk/cherub-hiv-garden>

Mel Snelling

Oxford University Hospitals



Service Improvement

Establishing a specialist HIV pharmacy in-reach service rotating through DGH HIV Units

This was the first time I had presented a poster at conference, and was delighted and encouraged by it winning the Ushma Patel Poster Prize at HIVPA 2018. Presenting my work at HIVPA conference enabled me to network with delegates, discussing the outcomes of the project.

My role as HIV specialist pharmacist at County Durham & Darlington Foundation Trust (CDDFT) commenced as part of this project, which was funded through a Gilead fellowship grant in 2015-16. Prior to establishing an HIV pharmacy in-reach service at CDDFT, none of our patient cohort had previously seen a pharmacist.

Although a relatively small cohort (less than 200 at the time) this patient group had additional challenges. Only 50% patients permitted correspondence with their GP, increasing the risk of unrecognised drug interactions & polypharmacy.

Also being situated rurally (CDDFT serves a population living across a vast geographical area – 2423sqkm), meeting patient demands with numerous appointments was difficult with infrequent public transport and financial constraints being barriers to attendance.

The main objective of the project was to offer all patients on HIV treatment a pharmacist appointment during the 12-month period. Impact was assessed by focusing on patient adherence and knowledge, patient qualitative assessment of the clinic and detection of drug-drug interactions. The pharmacist clinic rotated across 3 sites, offering twice monthly clinic appointments along with their usual Consultant appointment.

The service was well received by patients, with 100% patient satisfaction questionnaire responders recommending the pharmacist clinic to others. Drug interactions were identified in 48% of all pharmacist reviews, many involving OTC medications. Deficient patient knowledge on optimal anti-retroviral (ARV) use was identified in 26% patients, the majority due to incorrect administration with/without

food. Drug interactions and deficient patient knowledge on optimal ARV use was identified in a greater proportion of patients >50 years of age.

The impact of this project was limited by the amount of patients the pharmacist was able to see in clinic. Although some clinicians encouraged patient attendance when the pharmacist was present, many patients did not. Due to the nature of the GUM service, where patients are booked into clinic slots at any time and any day of the week in order to offer maximum flexibility, this meant the majority of patients attended clinic slots without the pharmacist being present.

Going forward, as we recognise that those patients who did attend the pharmacist in-reach appointments stood to benefit greatly, we have designed a service based on a programme of virtual MDT review to address the needs of those aged 50 years and over. The MDT will meet on a monthly basis, consisting of a specialist HIV pharmacist, GUM Consultant, a GP and specialist GUM nurse practitioner.

The MDT process will consider if ARV prescriptions can be optimised, assess routine monitoring (according to BHIVA monitoring and treatment guidelines), review ARV and primary care prescriptions and highlight priorities for discussing the self management of risk factors for chronic disease with patients at their next clinic review appointment.

We hope that patients with greater risk factors can benefit from the expertise of the pharmacist as part the multi-disciplinary team regardless of date, location and frequency of clinic attendance. We are currently in the process of recruiting personnel, prior to setting up an initial pilot virtual MDT.

I plan to utilise the poster prize money to attend study days and networking opportunities with colleagues to broaden my experience, including attending the upcoming BASHH HIV master class in March 2019.

Jill Ross
CDDFT

Establishing a specialist HIV pharmacy in-reach service rotating through DGH HIV Units

Jill Ross, Dr Sarah Duncan
County Durham & Darlington NHS Foundation Trust (CDDFT)

INTRODUCTION

CDDFT was awarded a Gilead fellowship grant to fund a specialist pharmacy in-reach service for a population attending small local HIV services, between 2015-2016. 50% of our patient cohort did not permit correspondence with their GP, increasing the likelihood of problems arising from unrecognised drug interactions, and none had previously been offered an appointment with a specialist HIV pharmacist.

AIMS & OBJECTIVES

- To offer all CDDFT HIV patients on treatment an individual appointment with an HIV pharmacist during the project period, based on 2hr per week HIV pharmacist time allocation
- Assess the impact of pharmacist intervention: including patient adherence, knowledge of antiretroviral therapy (ART) requirements, detection of drug interactions, patient qualitative assessment of the pharmacy service and the impact on clinician knowledge of ART requirements and drug interactions

METHODS

- Patient questionnaires to assess adherence and patient ART knowledge were utilised in clinic by the pharmacist, with the intention that the same follow-up questionnaire be completed at the next appointment by the pharmacist/Consultant. The questionnaires assessed patient knowledge of food requirements with ART administration, missed doses within previous 4 weeks, timing of doses and patient knowledge of how CD4 & viral load had changed during treatment. A scoring system was assigned to each question answer
- Patient satisfaction questionnaires were offered to all patients attending clinic
- Pharmacist clinic slots ran on a twice-monthly basis, rotating between 3 sites. GUM Consultants and clinics were responsible for allocating clinic slots to patients
- A quiz was sent to all GUM Consultants at the beginning of the project, testing drug interaction knowledge (including OTC drugs) and administration requirements when taking HIV medications

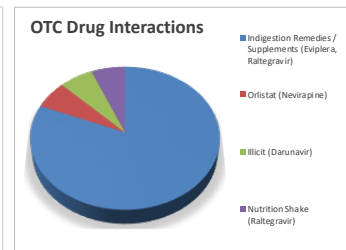
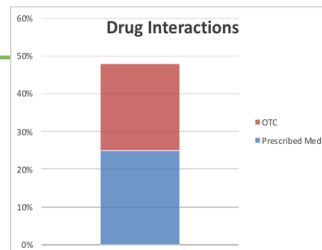
RESULTS

- 64 (39%) patients (based on 165 total) received an individual appointment with the HIV Pharmacist
- The pharmacist identified a 26% incidence of deficient ART knowledge in on when/how to take doses, of which 76% were due to incorrect administration with/without food. Patients were counselled on appropriate ART administration
- Drug interactions were identified in 48% of all pharmacist reviews (48% involving OTC medicines). In the subset of patients aged ≥ 50 years, drug interactions were identified in 53% of patients
- 21 Patient satisfaction questionnaires were completed (32% response rate)
 - 100% respondents would recommend the pharmacy clinic to other patients
 - 95% rated the service as 5 star (excellent)
- One completed consultant quiz was completed, achieving a score of 69% (9 out of a potential 13 correct answers). Feedback was provided
- 15 (23%) follow up adherence questionnaires were utilised in clinic, too small to statistically assess a change in patient adherence

Deficient ART Knowledge	Patients who completed adherence questionnaire (53)	Subset of patients ≥ 50 years (28)
<i>Administering ART with/without food</i>	11	7
<i>Incorrect dosing</i>	2	2
<i>Managing missed doses</i>	1	1
Total	14	10
%	26%	36%

DISCUSSION

- The specialist HIV pharmacy service was well received by patients and uncovered a significant number of previously unrecognised drug interactions (both prescribed and OTC medications) and areas of deficient knowledge around optimal antiretroviral use both amongst patients and clinicians
- The impact of the project was limited by the ability of the pharmacist to see patients in clinic. Pharmacist clinic days were limited in number across 3 sites and the majority of patients received appointments on alternative dates
- The results of this pilot, showing positive evidence of HIV pharmacist impact, have been used towards a further successful Gilead funding application, this time focusing on patients ≥ 50yrs. This will include virtual MDT review, in addition to review in clinic, so that patients benefit from the expertise of the pharmacist regardless of the date, location or frequency of HIV clinic attendance
- This study highlights that unrecognised drug interactions and lack of awareness on antiretroviral use are particularly pertinent to our older patients, with an increasing burden of co-morbidities, mental health needs and frailty





When the fight against HIV/AIDS seemed hopeless, Mylan delivered hope.

More than 40% of all people being treated for HIV/AIDS globally depend on a Mylan product.* Making medicines accessible to patients isn't our job, it's our mission.

* Based on 2017 patient estimates from UNAIDS for Eastern and southern Africa, Asia and the Pacific, Western and central Africa, Latin America, and The Caribbean

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