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TRANSFORMING THE UK'S RESPONSE TO HIV

Policy briefing

Police occupational health policies and blood borne virus training: protecting health?

June 2012

Introduction

NAT first became aware of possible inaccuracies in police occupational health policies (OHPs) and blood borne virus training when we noticed a number of media reports which stated that police were having HIV tests in situations where there was no risk of HIV transmission. This was a cause of concern, not only because it is a waste of police time and resources, but also because it causes the individuals involved unnecessary alarm and spreads myths about the way the virus is transmitted.

Inaccurate policies and training materials may also inadvertently increase HIV-related stigma. People living with HIV often face stigma and discrimination because of misunderstanding about the virus. A recent survey conducted on NAT's behalf by Ipsos MORI found that only 30% of adults can correctly identify, from a list of possible routes, all the ways HIV can and cannot be transmitted. There was a link between poor knowledge and negative and judgemental attitudes towards people living with HIV.[1] If police do not have up-to-date knowledge about HIV and the way the virus is transmitted this may mean that people living with HIV are treated inappropriately when held in custody. In reality, HIV is the least infectious blood borne virus and there is no known case of occupational transmission in a police setting.

NAT decided to review a sample of police OHPs and training materials to see how accurate the information about HIV was. This summary report sets out common themes found across the materials where the content was inaccurate or misleading and where additional information would be beneficial. It also provides examples of good practice.

NAT now plans to build on the findings of this report by developing guidance for police on HIV and working with the relevant police bodies to improve the quality of OHPs and training available to the police.

[1] http://www.nat.org.uk/Media%20library/Files/Communications%20and%20Media/HIV_awareness_report_2011DOWNLOAD.pdf

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Methodology

NAT has an excellent track record of working in partnership with the police on a range of issues, from improving investigations of HIV transmission to addressing HIV-related hate crime. We contacted the National Policing Improvement Agency (NPIA), the Association of Chief Police Officers (ACPO), the Association of Chief Police Officers in Scotland (ACPOS), the Police Federation and the relevant police training colleges to discuss this review. We would like to thank police colleagues from these institutions who provided valuable advice during the course of the project.

NAT decided to review materials in fifteen police constabularies across the UK. The areas were selected to represent a wide geographical area, including constabularies with both high and low HIV prevalence. The review included Wales, Northern Ireland and Scotland. Throughout this report quoted materials have been anonymised. However, NAT has contacted the individual constabularies involved to provide feedback on their materials. Although the majority of police constabularies provided their materials willingly, in some areas it was necessary to use the Freedom of Information Act (FOIA) to ensure we received materials in a timely way. Indeed, some colleagues were willing to provide materials but said it would be quicker to put in an FOIA request than to ask for the documents in another way.

NAT analysed the policies and training materials. We then looked across the findings to identify common areas of concern and examples of good practice. These are set out in the findings section below. Based on the findings we have developed a series of recommendation for improving police BBV OHP and training materials which can be found at the end of the report.

Examples of media headlines

"Woman who bit police officers, forcing one to have a HIV test, has prison sentence cut" 23 April 2012

"Stabbed cops given HIV tests: Agonising wait for 4 officers knifed at butcher's" 21 Nov 2011

"*FRONTLINE cops want protective hoods for thugs - to stop them SPITTING on them: Dozens of police officers undergo tests for HIV and hepatitis in recent years after being splattered with saliva*"
1 August 2010

Findings from the review

Although there were some examples of good practice within the OHPs and training materials analysed, there were a lot of examples of inaccurate and misleading information, both about the way HIV is transmitted and about the reality of living with HIV. In addition, some policies had inappropriate and discriminatory advice about how to treat people living with HIV in custody. We have divided the findings into nine areas. Anonymised examples are given in each area, both of poor practice but also where accurate and relevant information was provided.

The National Policing Improvement Agency (NPIA) Circular

In October 2011 the NPIA released a circular providing guidance on BBVs for all Chief Officers of Police in England. This helpful document aims to promote safe practices and procedures, generate greater awareness amongst police staff about BBVs and ensure sensitive and informed treatment of people who have a BBV. It also highlights the need for Chief Officers to provide training/education to ensure police staff have appropriate knowledge about BBVs to deal safely, confidently and appropriately with potential BBV incidents. This circular been found at:
http://www.npia.police.uk/en/docs/NPIA_Circular_05-2011_Blood_Borne_Viruses_guidance.pdf

In addition in July 2011 the National Clinical Director for Urgent and Emergency Care for the Department of Health wrote to all NHS Acute Trust Chief Executives, Medical Directors and Directors of Nursing in England, to clarify that NHS A&E departments are the appropriate place for police who may have been exposed to a BBV to have such injuries assessed and where necessary treated. Police forces and the NHS should make local arrangements to ensure that police can access emergency care when needed. .

Transmission

The most common area of factual inaccuracy within OHPs and training materials was around routes of transmission of HIV. This is very important as incorrect information about how HIV is transmitted can unnecessarily alarm police staff, causing them to think they may have been put at risk when they have not. It could also lead to unnecessarily cautious treatment of people living with HIV in police custody.

Examples of HIV transmission routes cited include:

- Sharing toothbrushes and razors
- Dental surgery
- Spitting (one policy even suggests the provision of spit hoods to police officers)
- “Kissing in the transfer of goods from mouth to mouth”
- Scratching
- “Handling or lifting of persons”
- Exposure to ‘infected’ saliva, urine, sputum or faeces

There is no risk of HIV transmission from any of these activities. **NAT recommend that materials both accurately state what HIV transmission routes are and also state how the virus cannot be transmitted.** For example, it would be useful to make clear that HIV is only transmitted via semen and vaginal fluids, blood and breastmilk and in fact 95% of HIV cases in the UK are the result of sexual transmission.[1] HIV is not transmitted through contact with other bodily fluids such as saliva, urine or vomit. Policies should stress that you cannot get HIV from social contact such as touching, coughing and sneezing, or sharing toilet seats, cutlery or swimming pools. This is in line with the NPIA circular that notes that "Although the operational risk to police officers and staff from blood-borne viruses is very low, they need to understand how the infections can and cannot be transmitted - both for their own protection and to ensure the appropriate and sensitive treatment of others."[2]

In other policies there was a disproportionate emphasis on some extremely low risk transmission routes (such as skin piercing and tattooing – these are very low risk and would only be a concern if sharing unsterilized equipment). Many policies mentioned biting as a transmission route and although this presents a theoretical risk this should be properly qualified. For HIV transmission to occur the person biting you would have to be

[1] Health Protection Agency (2011) *HIV in the United Kingdom 2011*http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317131685847
[2] National Policing Improvement Agency Circular, Blood-borne viruses: guidance to the police service, 10 October 2011.

very infectious, have to have blood in their mouth and have to bite you so severely that they pierced the skin deeply. Even then the risk of transmission would be low. There has never been a case in the UK of infection from biting and in fact with over 60 million people infected with HIV worldwide, there have only ever been four possible reports of HIV being transmitted through biting, all of which occurred in extremely specific and unusual circumstances.[3] For this reason **NAT recommends that biting is not listed as a transmission route, or that if it is, it is clear that this presents a negligible risk.**

Many policies mention the risk of HIV transmission from discarded needles. This is another example of where infection may be theoretically possible but where there has been never been a known case of HIV infection in the UK.[4] Despite this, the majority of materials had a disproportionate amount of information about needle stick injuries often providing inaccurate data. Many policies quoted the statistic, "1 in 300 needlestick injuries result in HIV infection." This is actually the statistic for needlestick injuries in a healthcare setting where the patient was known to be HIV positive. Injuries from discarded needles in the community are far less likely to lead to HIV infection. This is because needles rarely contain fresh blood, the injury does not occur immediately after the needle was used and any virus present has been exposed to drying and environmental temperatures. In addition given the relatively low level of HIV prevalence amongst injecting drug users (estimated 1 in 250), the individual whose blood it was was probably not HIV positive.[5] So the "1 in 300" statistic vastly overstates the risk of HIV infection from a needlestick injury in the community. Even within a healthcare setting there have only been five definite cases of HIV transmission from this route, and none since 1999. **NAT therefore recommends that police materials update their content on needlestick injuries to make clear the difference in risk between needle stick injuries inside and outside healthcare setting**

Some OHPs did provide useful and accurate information about HIV transmission routes, noting that HIV is the least infectious BBV. For example one policy states:

"The risk of transmission of HIV at work is extremely remote (i.e virtually nil)."

Although it would not be helpful to stigmatise other BBVs, police agencies NAT contacted during the course of the review emphasised that HIV is the BBV that police staff are most concerned about. It is therefore important for policies to be clear on what the limited number of transmission routes are for HIV and underline the fact that HIV is actually the BBV that people are least likely to contract at work. HIV is a lot less infections that other BBVs, with the World Health Organisation noting that Hepatitis B is fifty to one hundred times more infectious than HIV.[6]

NAT recommends that materials make clear that HIV is the BBV which poses the least threat to police staff and that it is significantly less infectious than Hepatitis B and Hepatitis C.

There has recently been widespread recognition of the impact of HIV treatment on infectiousness and transmission.[7] However, none of the materials mentioned this fact even though it is extremely relevant. In fact, one policy incorrectly stated, "Once infected, an HIV positive person remains infectious to others for the rest of their lives." If someone has been diagnosed with HIV, is adhering to their treatment and has as a result a very low level of virus in their body (an undetectable viral load), it is extremely unlikely they can pass on HIV to others. Recent data from the Health Protection Agency found that in 2010, 85% of patients had an undetectable viral load (<50 copies/ml) one year after beginning antiretroviral therapy.[8] **NAT recommends that police materials include a reference to the impact of treatment on infectiousness to further reassure police staff about the very low risk of HIV infection.**

[3] http://www.hivaware.org.uk/be-aware/common-myths.php
[4] http://www.aidsmap.com/Discarded-needles/page/2124827/
[5] The Health Protection Agency estimates that 1 in 250 IDUs in the UK is living with HIV, increasing to 1 in 111 in London. http://www.nat.org.uk/Our-thinking/People-in-greatest-need/Injecting%20Drug%20Users.aspx
[6] http://www.who.int/mediacentre/factsheets/fs164/en/
[7] http://www.nat.org.uk/Media%20library/Files/Policy/2011/NAT_TreatmentasPrevention2011.pdf
[8] Health Protection Agency (2011), *HIV in the United Kingdom: 2011 report*. http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317131685847

Risk assessment and access to PEP

Current NPIA guidance suggests that if a member of police staff has been exposed to a potential BBV they should attend A&E for a risk assessment. NAT would recommend that all policies and training materials reflect this guidance. In addition, NAT would suggest that materials provide greater clarity about when an exposure incident has occurred. Some policies make very clear that where contact is between a body fluid and intact skin there is no risk of BBV transmission: "If the skin has not been penetrated or mucous membranes contaminated, the individual should be reassured that the risk is insignificant and that no treatment is necessary." In other policies this is less clear and there is a risk that police staff may unnecessarily attend A&E when no exposure incident has occurred. **NAT therefore recommends that policies make clear that there is no need to attend A&E if body fluids have only been in contact with intact skin and that certain bodily fluids, such as urine, present no risk of BBV infection.**

In addition, NAT have heard that police staff are often very concerned about contracting HIV and may seek post-exposure prophylaxis (PEP) when it is not necessary. **We would therefore recommend that policies make clear that PEP will only be provided in very specific circumstances.** For example the most recent PEP guidance from the British Association for Sexual Health and HIV (BASHH) states that PEP should not be provided for needlestick injuries when a needle has been discarded in the community because of the extremely low risk of HIV transmission (there has been no known case). The table below is taken from the recent UK guideline for the use of PEP and states when PEP should be recommended and when not:[9]

Table 4 Situations when post-exposure prophylaxis (PEP) is considered (IV, grade C)

	Source HIV status			
	HIV-positive			
	Viral load detectable	Viral load undetectable	Unknown from high prevalence group/area*	Unknown from low prevalence group/area
Receptive anal sex	Recommend	Recommend	Recommend	Not recommended
Insertive anal sex	Recommend	Not recommended	Consider†	Not recommended
Receptive vaginal sex	Recommend	Not recommended	Consider†	Not recommended
Insertive vaginal sex	Recommend	Not recommended	Consider†	Not recommended
Fellatio with ejaculation‡	Consider	Not recommended	Not recommended	Not recommended
Fellatio without ejaculation‡	Not recommended	Not recommended	Not recommended	Not recommended
Splash of semen into eye	Consider	Not recommended	Not recommended	Not recommended
Cunnilingus	Not recommended	Not recommended	Not recommended	Not recommended
Sharing of injecting equipment	Recommended	Not recommended	Consider	Not recommended
Human bite§	Not recommended	Not recommended	Not recommended	Not recommended
Needlestick from a discarded needle in the community			Not recommended	Not recommended

*High prevalence groups within this recommendation are those where there is a significant likelihood of the source individual being HIV-positive. Within the UK at present, this is likely to be men who have sex with men and individuals who have immigrated to the UK from areas of high HIV prevalence (particularly sub-Saharan Africa)
†More detailed knowledge of local prevalence of HIV within communities may change these recommendations from *consider* to *recommended* in areas of particularly high HIV prevalence
‡PEP is not recommended for individuals receiving fellatio i.e. inserting their penis into another's oral cavity
§A bite is assumed to constitute breakage of the skin with passage of blood

The information provided about PEP itself was very varied. Whilst some policies provided accurate up-to-date information about how and when to access PEP, many did not. Accurate information about PEP is important, particularly as the window for accessing it is only 72 hours, and the sooner it is accessed the more effective it is likely to be. When PEP was mentioned, most policies suggested trying to access it within the hour. Whilst it is helpful to make sure the urgency of accessing PEP is understood, by not mentioning the 72 hour window, this may mean staff who have left it several hours will not bother to seek PEP when it still could have some benefit for them.

NAT recommend that policies include information about PEP including reference to the most recent guideline on PEP and details of the 72 hours access period.

[9] http://www.bhiva.org/documents/Guidelines/PEPSE/PEPSE2011.pdf

Emergency HIV Prevention - PEP (Post Exposure Prophylaxis)

If someone has been exposed to the risk of HIV infection within the last 72 hours, PEP must be considered. This reduces the chance of any HIV exposure becoming an HIV infection. PEP is not a 'cure' for HIV but it may prevent HIV from entering cells in the body and so stop someone from becoming infected. PEP normally consists of three anti-HIV drugs. It should be taken for a month, and it is important top take all of the doses, at the right time and in the right way.

Although PEP is not 100% effective, there have been very few reports of HIV infection after the use of PEP. HIV treatment can cause side-effects which tend to be worst when you first start taking them, and if you are taking PEP you could experience some unpleasant side-effects such as feeling sick, diarrhoea, tiredness, and generally feeling unwell.

Resuscitation

The NPIA guidance makes clear that the risk of infection from mouth-to-mouth resuscitation is extremely low. Resuscitation is normally required because of cardiac arrest and the NPIA guidance states that mouth-to-mouth resuscitation should not be delayed because of concerns around contracting a BBV. It goes on to state that if blood is present in the mouth then a Resuscu-\shield or Pocket Mask should be used if available but if not resuscitation should continue regardless. **This is not made clear in all policies and should be clarified to ensure that resuscitation is not withheld from people who need it.**

Language

In some instances the language used to refer to HIV and people living with HIV was inappropriate and stigmatising. For example one policy referred to 'homosexuals', 'prostitute men and women' and 'intravenous drug abusers'. These phrases are now considered out-dated and offensive. Instead the terms 'gay and bisexual men', 'sex workers' and 'injecting drug users' are more appropriate. A further training material we reviewed referred to HIV as a "natural borne killer" and used sensationalised images (for example a picture of Myra Hindley) and sound to generate fear about contacting the virus. Although police need to understand the importance of following universal precautions to avoid infection, this training material generated unnecessary levels of fear and hysteria about HIV whilst providing very little accurate factual information about the virus.

Many materials referred to AIDS when they actually meant HIV. With the huge advances in treatment, very few people in the UK will develop AIDS (see below).[10]

What is HIV? HIV (Human Immunodeficiency Virus) is a virus that attacks the body's immune system - the body's defence against diseases. There is currently no cure for HIV, but there are treatments.

What is the difference between HIV and AIDS? The terms HIV and AIDS (Acquired Immune Deficiency Syndrome) do not mean the same thing. When someone is described as 'living with HIV', they have the HIV virus in their body. A person is considered to have developed AIDS when the immune system is so weak it can no longer fight off a range of diseases with which it would normally cope. There are a number of 'AIDS-defining' illnesses, but these have become less common in the UK due to the advancement of HIV treatment.

[10] NAT's publication Guidelines for reporting HIV provides useful information about appropriate terminology to use when writing about HIV and people living with HIV. See: http://www.nat.org.uk/Media%20library/Files/Communications%20and%20Media/Media%20Guidelines/Guidelines%20for%20Reporting%20HIV%202010/journalist%20guidelines%20FINAL.pdf

NAT recommends policies are reviewed to ensure that language is appropriate and that the term AIDS is only used in very specific circumstances.

Living with HIV

Several policies and training materials had out-of-date information about living with HIV. Many stated that HIV will inevitably lead to the development of AIDS after a number of years. Documents do not seem to have been updated to reflect the huge advancements in treatment that mean that most people living with HIV will have a near normal life expectancy, lead active lives and will not go on to develop AIDS. Instead, HIV is referred to as "a potentially fatal condition" and in another document, people living with HIV ""live continually with the fear of a life threatening illness which involves pain, disability and possible death."

Where treatment is mentioned, its effectiveness is often underestimated:
"The only form of treatment for HIV is antiretroviral medication which slows the progression from HIV to AIDS."
The use of 'only' suggests this is an inadequate treatment, and the use of 'slows' suggests that it is inevitable that people living with HIV, even those on treatment, will go on to get AIDS when this is not the case. As mentioned above, there is no information about the impact of treatment on infectiousness.

In addition, where statistics were given about the numbers of people living with HIV they were often out-of-date, in one case dating back to 2000.

NAT recommends that policies are updated to include accurate information about the effectiveness of treatment which means that most people living with HIV will have near normal life expectancy, lead active lives and will not go on to develop AIDS.

Several policies stated that there are no symptoms of HIV infection, even though between 70-90% of people will experience symptoms of primary HIV infection.[11] Primary or early HIV infection refers to the first few months following HIV transmission. This is the period between HIV first entering the body and the time that HIV antibodies can be detected in the blood. Symptoms of primary HIV usually occur around 10 days after transmission and are most commonly the *combination* of a fever, sore throat and a rash (maculopapular). This 'triad' is unusual in otherwise healthy people. These symptoms disappear within two to three weeks and it can then be several years before other symptoms are experienced, at which point the patient may be very ill. **Stating that there are no symptoms HIV infection is misleading and policies should be amended to ensure people are aware of the symptoms of primary HIV infection which present a vital window of opportunity to diagnose HIV.**

Testing

It was notable that very few materials provided information about HIV testing but this is one area where there is a lot of confusion and mis-information. Where HIV testing was mentioned the information was inaccurate. For example, one policy stated that there is a three month window between an exposure incident and when an accurate test can be performed. In fact, developments in testing technologies mean that it is now possible to get an accurate test result within one month of possible exposure. This is in contrast to Hepatitis B and C where it can take up to six months for antibodies to appear, so there is a considerable wait before you can be sure you have an accurate test result.[12] The policy went on to state that if you have a test you have to disclose this fact to mortgage and insurance companies. This presents a disincentive to test and is inaccurate as only a positive test result needs to be communicated (not a simply having an HIV test or receiving a negative result).

Another policy stated: "The decision whether or not to be tested for HIV is finely balanced. There may be clinical advantages to treatments." This is very misleading and needs to be updated in the light of modern

[11] http://www.nat.org.uk/Media%20library/Files/PDF%20documents/primary%20infection%20final.pdf
[12] See www.britishlivertrust.org.uk for more information on Hepatitis testing.

treatment. HIV testing should always be recommended as advances in treatment mean that those that test positive can go on to live a full and active life. Not testing however may mean the virus goes undetected causing serious harm to an individual's immune system and meaning they may unintentionally pass the virus on to others.

NAT recommends that materials include up-to-date information on HIV testing to reassure staff that have been subject to an exposure incident that they will be able to test for the virus within one month and that there are enormous benefits of testing and being diagnosed at an early stage. The different window periods for tests for different BBVs should also be made explicit.

Confidentiality

Some policies had examples of good practice around confidentiality. One policy noted with regard to information about someone's HIV status, "…this is very sensitive information and should not be disclosed to others without the expressed consent of the individual concerned." This follows on from the NPIA guidance which makes clear the importance of confidentiality: "Sensitive information about a person's health should be treated as confidential. It is unnecessary, insensitive and a serious breach of confidentiality and the Data Protection Act 1998 to label or mark a detainee's cell, cutlery, crockery etc. to denote their infectious status."

However other policies were less clear, for example: "There is a need to respect the confidentiality of persons suffering from communicable diseases such as AIDS and Hepatitis but there is also a legal and moral duty regarding the health and safety of others." Such wording is confusing and leaves room for misinterpretation. The phrase "a legal and moral duty regarding the health and safety of others" could be used to justify unacceptable confidentiality breaches.

NAT therefore recommends that all materials make clear that confidentiality is vital when dealing with HIV and that someone's HIV status should not be disclosed without their consent.

Treatment of people living with HIV in custody

There were some examples of good practice about the treatment of people living with HIV in custody, which highlighted the need to treat people with respect and sensitivity. In addition, many policies correctly noted that many people with a BBV may be unaware of their status and therefore universal precautions should apply and all members of the public should be treated in the same way.

However, it was of concern that in two policies, staff are advised to segregate those that may have a BBV; "Segregation of prisoners presenting significant risks may be necessary"; "Keep the prisoner separate from others and do not allow the sharing of facilities with other persons." One policy goes on to suggest providing disposable cups and cutlery and notes that "Interviews by custody visitors must be conducted through cell door inspection hatch".

These proposals are utterly unnecessary and would stigmatise people in custody who have disclosed their status and potentially breach their confidentiality. In addition, under the Equality Act 2010 it is unlawful to discriminate against people living with HIV in employment, housing, education and training, provision of goods and services, and trade union membership. Discrimination against someone with HIV includes treating someone less favourably than others who are not HIV positive.

Rather than this unhelpful material, policies should make clear that people with BBV do not need to be segregated and that people living with HIV are protected against discrimination under the Equality Act 2010. Instead, materials should provide information about meeting the needs of people who disclose their status in custody – for example safeguarding confidentiality. An example of such good practice taken from one policy is given below:

"Police officers, special constables and support staff can help by being well informed about BBVs and how they are transmitted and by dealing with infected persons confidently and sensitively. BBVs are not spread by ordinary social contact and there is no medical reason why a person should be isolated."

In addition, **NAT recommends that policies have some information about ensuring that people living with HIV who have disclosed their status have timely access to their treatment as regular adherence to treatment is vital for its success.**

Why people with HIV must take their treatment

It is extremely important that people with HIV who have started treatment can continue to take it every day, on time, without fail. HIV treatment must be taken at least once a day, sometimes twice or three times a day, depending on the drugs. If someone misses a dose of their treatment there is a possibility that HIV in that person's body will become drug-resistant and the treatment will no longer work. The fewer treatment options open to someone with HIV the more at risk they are of no longer having drugs available which will work for them.

With HIV treatment people must take almost all their pills as prescribed. This means missing no more than one dose a month if someone is taking once-daily therapy, or two doses a month if someone is taking twice-daily therapy. With HIV treatment doctors insist on 'treatment adherence' of 95%.

Further sources of information

Although some policies did signpost staff to further sources of information, many did not. Where information was provided it often related to hepatitis rather than HIV. **NAT would recommend that all policies and training materials had links to further information about BBVs, including HIV**.[13]

Conclusion and recommendations

NAT's review of police OHPs and BBV training materials found some areas of good practice but also several areas of concern. It is therefore important that police constabularies across the country review their materials and ensure that they are up-to-date and provide accurate and relevant information in line with the recent NPIA guidance. This will not only enable police to protect themselves from BBV transmission but also ensure they treat people living with HIV with sensitivity and with respect.

Although accurate materials are vital, it is also important that all police receiving training about HIV so that misconceptions they may have about the virus and how it is passed on can be addressed. Without training even the most accurate policies will not be effective in reducing police fear about HIV transmission at work.

Based on the findings of this review NAT recommends:

Police staff should be provided with induction and refresher training on HIV, including accurate information about how the virus is spread, the extremely low risk of HIV transmission at work and how to treat people living with HIV sensitively and appropriately

[13] NAT's website HIVaware - http://www.hivaware.org.uk/be-aware/faqs.php - provides easily accessible information that everybody needs to know about HIV.

Police training and OHP materials should:

- state what HIV transmission routes are and also state how the virus cannot be transmitted (e.g. social contact, spitting, scratching etc)
- not list biting as a transmission route, or if it is included, make clear that this presents a negligible risk
- update content on needlestick injuries to make clear the difference in risk between needle stick injuries inside and outside a healthcare setting
- make clear that HIV is the BBV which poses the least threat to police staff - it is significantly less infectious than Hepatitis B and Hepatitis C.
- include a reference to the impact of treatment on infectiousness to further reassure police staff about the very low risk of HIV infection
- make clear that there is no need to attend A&E if relevant body fluids have only been in contact with intact skin and that certain bodily fluids, such as urine, present no risk of BBV infection.
- make clear that PEP for HIV will only be provided in very specific circumstances and that the window period for accessing PEP is 72 hours
- ensure that resuscitation is not withheld from people who need it
- ensure that language is appropriate avoiding terms such as “drug abusers” “homosexuals” “prostitutes” and only using the term AIDS in very specific circumstances
- include accurate information about the effectiveness of treatment which means that most people living with HIV will have near normal life expectancy, lead active lives and will not go on to develop AIDS
- not state that there are no symptoms HIV infection but instead provide information on early HIV infection which present a vital window of opportunity to diagnose HIV.
- include up-to-date information on HIV testing to reassure staff that have been subject to an exposure incident that they will be able to test for the virus within one month and that there are enormous benefits of testing and being diagnosed at an early stage. The different window periods for tests for different BBVs should also be made explicit.
- make clear that confidentiality is vital when dealing with HIV and that someone’s HIV status should not be disclosed without their consent
- make clear that people with a BBV do not need to be segregated (as universal precautions apply to all people in police custody) and that people living with HIV are protected against discrimination under the Equality Act 2010.
- provide information about ensuring that people living with HIV who have disclosed their status have timely access to their treatment
- include links to further information about BBVs, including HIV

NAT
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