Introduction Leeds is an area of high HIV prevalence of 2.3/1000 and in accordance with National UK guidelines for HIV testing we introduced routine opt out HIV testing to the acute medicine unit at St. James's University hospital in January 2015. Opt out testing is offered to patients between 16 and 65 years of age admitted to any of the acute medical areas.
Methods Ensuring high testing rates in this busy environment with rapidly changing medical staff is challenging and we have used a number of interventions to help sustain a high testing rate. These include providing weekly feedback and training to the acute medicine doctors and nurse practitioners, an electronic prompt on the Ordercoms pathology system and for patients who have blood tests in the emergency department, the facility to have HIV testing performed on samples sent to biochemistry. We employ a 0.5 WTE nurse to support this project.
Results Between January 2015 and February 2017 there have been 11,715 eligible patients admitted of which 7263 (61%) patients underwent HIV testing. HIV testing was highly acceptable to patients with almost no patients refusing the offer of an HIV test. 16 patients (0.22%) had a positive HIV test and 2 partners were subsequently tested positive. 10 of the 16 patients had a very late diagnosis with a CD4 count <200 cells/mm^3 and we identified many missed opportunities for earlier diagnosis. 2 patients had primary HIV infection and would almost certainly not have been tested otherwise.

P083 HOW DO HIV TESTING INITIATIVES IMPACT ON HIV TESTING RATES AND DIAGNOSIS IN PRIMARY CARE?

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Introduction Undiagnosed HIV leads to late presentation, increased morbidity, and contributes to onward transmission. It is estimated that in our area approximately 17% of those living with HIV are undiagnosed. Little is known about the impact of National HIV Testing Week (NHTW) initiatives in general practice (GP). In 2016 we implemented a 'pop-up' message alerting GPs that it was NHTW, with a 'one-click' pathway to adding an HIV-test to bloods requested for other reasons.
Methods Number of HIV tests carried out in GP and new HIV diagnoses made were collected between 20th August 2016 and 20th February 2017 and separated into the time period spanning 3 months pre-NHTW, NHTW itself and 3 months post-NHTW.
Results 464 HIV tests were performed in 37 GP practices in the pre-NHTW period (approx. 36/week), 96 test during NHTW and 534 tests in 3 month post-NHTW (approx. 41/week). 1 HIV-diagnosis was made in GP during the pre-NHTW period (c.f. 20 across all services), no new diagnoses in NHTW and 1 case (7 across all services) in the 3 month post-NHTW period.
Discussion Testing initiatives result in greater awareness across the city and an increase in HIV testing, which was sustained, although no increase in new HIV diagnoses. The decrease in HIV diagnoses in this study reflects the national trend of a reduction in HIV diagnoses despite increased testing; this is attributed partly to the efficacy and increased use of Pre-exposure prophylaxis (PrEP).

P084 ARE WE CONSIDERING HIV ENOUGH? AN AUDIT INVESTIGATING ROUTINE USE OF HIV SCREENING FOR PATIENTS AGED 18–50 PRESENTING WITH COMMUNITY ACQUIRED PNEUMONIA TO A PROVINCIAL HOSPITAL

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Introduction It is known that a significant proportion of people within the United Kingdom are unaware of their HIV infection and late diagnosis is associated with HIV related Morbidity and Mortality. The British HIV Association recommend routine HIV screening for patients with an HIV indicator illness. This includes Bacterial Pneumonia, a condition commonly encountered in hospital departments throughout the United Kingdom.
Methods We designed an audit to evaluate the use of routine HIV screening for patients aged 18-50 presenting to the Royal Devon and Exeter Hospital with Community Acquired Pneumonia. Using a coding search of all discharges between May 2015 and September 2015, 38 patients were identified. Inclusion criteria required each patient to have either a positive microbiological sample or consolidation present on a chest radiograph. Of the 38 patients identified, 7 were excluded who did not satisfy the minimum inclusion criteria.
Results Of the patients audited, 21 patients (67.7%) did not receive routine screening during their inpatient stay. One patient who was not tested had received testing immediately prior to their acute presentation. Two patients who were not tested had a significant history of intravenous drug use, an independent indicator for routine HIV screening. Of the 10 patients (32.3%) that were successfully screened for HIV, no samples tested positive.
Discussion Routine screening for HIV in all patients with bacterial pneumonia could aid early identification of HIV infection, reducing overall morbidity and mortality. This audit highlights the continuing need for raised awareness of routine HIV screening for patients with HIV indicator conditions, particularly, in areas of low prevalence of HIV infection.

P085 AN AUDIT OF NICE GUIDANCE PH33; INCREASING THE UPTAKE OF HIV TESTING IN BLACK AFRICANS

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Introduction In 2015, Wolverhampton had the highest rates (15.8 per 100,000) of newly diagnosed HIV in West Midlands and In the West Midlands incidence rates in the black African ethnic group remain much higher than those for other ethnic groups, with a relative risk of 34 compared with the white group in 2015. This clearly shows the importance of the NICE Guidelines PH33 which was published in 2011 which aimed to increase the uptake of HIV testing in Black Africans and we wanted to audit this guidance.
Methods A list of patients classified as being of Black African ethnicity who were admitted to the Acute Medical Unit at Royal Wolverhampton NHS Trust between April 2015 and January 2016 was obtained. Their medical notes and blood test results were retrospectively analysed for evidence of testing or any discussion of HIV tests.

Results 50 case notes were retrospectively reviewed. An HIV test was not offered in 87% of admissions despite 15% of them presenting with signs of clinical indicator diseases. Only 6 patients were offered a test during their admission, of which 5 of them accepted. 1 of these tests was HIV positive and the patient was referred for further care to the HIV service within the trust.
Discussion There remains a barrier to HIV testing in high risk populations in non-GUM settings despite NICE guidance published several years ago. Recommendations include the need to identify existing barriers by surveying doctors and providing education on how to overcome them, and the addition of prompts on clerking proformas may encourage universal testing.

P086 ROUTINE HIV TESTING IN PRIMARY CARE: DOES TARGETED TRAINING WORK?

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Introduction Late diagnosis of HIV infection remains a major barrier to tackling HIV. UK HIV testing guidelines recommend universal testing of all new registrants attending general practice (GP) where local HIV prevalence exceeds 2/1000. HIV prevalence in our city was 1.1/1000 with pockets of high prevalence centred on 6 zones of deprivation. We targeted GP practices in these areas to undertake routine HIV testing after in-house training and ascertained healthcare professionals' (HCP's) views in relation to HIV testing in primary care before and after training.
Methods 13 GP practices in 6 high prevalence areas were approached alongside public health to undertake routine HIV testing, with remuneration and training, delivered as a lecture and discussion. Pre and post -training questionnaires were done assessing attitudes and knowledge around testing.
Results 7 GP practices accepted. Pre and post training responses (49 in total) reported increased confidence around when to offer testing (40%), discussing testing (20%), and awareness of national guidelines (63%). Increased numbers offered tests to MSM (39%), patients from high risk countries (29%), and for indicator conditions (14%). The number of HCP's offering testing in the preceding month increased by 20%. Reasons for declining testing remained unchanged (83% self-perceived low risk, 50% stigma concerns) as were practical barriers which were predominantly time restraints.
Discussion Targeted training improved key areas of understanding and built confidence around routine HIV testing among local GP practices. Perceived barriers to testing and reasons that patients declined testing remained unaltered after training.

P087 INFORMATION GAPS FOR HIV POSITIVE PATIENTS DETAINED IN IMMIGRATION REFERRAL CENTRES (IRCS)

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Introduction HIV is over-represented in this high risk, vulnerable population. Detainees often have complex health needs which present challenges to chronic disease management. Transfer of information between care providers is crucial to maintain appropriate management of these vulnerable patients. We aimed to look at the information shared between health care providers for detainees referred to our HIV service.
Methods We reviewed all referrals from the local IRC to our HIV service between September 2014 and January 2017, looking at information provided on the IRC referral letter and supplied by their previous care provider.
Results Out of 24 referrals, the notes were available for 17. CD4 count, HIV RNA and HAART regimen were missing from 9, 10 and 1 of the IRC referrals respectively. Information was missing about adherence in 9, treatment interruption in 10, and co-medications in 11 referrals. 9 reported requesting information from previous HIV provider; this was not received in 4 cases. In the 11 cases where information was received from the previous HIV care provider, information was not included on co-medications in 8, hepatitis B status in 6, hepatitis C status in 8, resistance testing in 5, and HLAB*5701 status in 6 summaries.
Discussion We highlight the need for standardised information transfer between care providers in these patients. In Dec 2016 we devised a form to send to previous HIV service providers to collect the required information for safe prescribing prior to their GUM appointment. We plan to review whether this improves the quality of information received.

P088 ANTIRETROVIRAL TREATMENT ALGORITHM COMPLIANCE: A REGIONAL AUDIT AND SURVEY

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Introduction In 2015 BHIVA introduced new treatment guidelines and NHS England produced an algorithm for antiretroviral (ARV) treatment initiation, with a requirement to have regional and local multidisciplinary team (MDT) arrangements to aid decision making.
Methods 6 services within our regional clinical HIV network carried out a retrospective audit of 20 (or total if fewer) cases started on ARVs in 2015, and completed a survey of each centres MDT arrangements. Data from each centre was collated and analysed regionally.
Results Local MDT arrangements varied widely in number and composition of professionals. All centres reported a change in practice and discussed non-first line regimens. 98 case notes were included. 43/98 started due to CD4 <350, 17 for primary HIV infection or symptoms, 16 for Treatment as Prevention, and 14 patient choice. An increase in abacavir/lamivudine based regimens was seen after algorithm instigation in April 2015. Mental illness, HIV viral load >100K, patient choice and shift work were the commonest reasons for choosing non-first-line regimen. 90% overall compliant with the NHS England treatment algorithm.
Discussion MDT arrangements and interpretation of the algorithm varied in our network. Prescribing practices have changed throughout the region since algorithm introduction. Further work is needed as a network to ensure standardised ARV prescribing for both cost and equity of patient care.