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?

Katrina Perez. *Doncaster and Bassetlaw NHS Trust, Doncaster, UK*

10.1136/sextrans-2017-053232.131

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)

[1]Sara Scofield, [1]Cecilia Priestley*, [2]Jane Fowler. *[1]Dorset County Hospital, Dorset, UK; [2]Dorset Healthcare, Dorset, UK*

10.1136/sextrans-2017-053232.132

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

[1]Bridie Howe*, [2]Conrad White, [3]Stephen Bushby, [4]Thomas Lavender, [5]Ashley Price, [5]Jonathan Foster, [6]Babiker Elawad, [3]Jane Hussey. *[1]New Croft Sexual Health, Newcastle upon Tyne, UK; [2]University Hospital North Durham, Durham, UK; [3]Sunderland Royal Hospital, Sunderland, UK; [4]James Cook University Hospital, Middlesbrough, UK; [5]Royal Victoria Infirmary, Newcastle upon Tyne, UK; [6]Northumbria NHS Trust, Northumberland, UK*

10.1136/sextrans-2017-053232.133

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.

P089 PJP DIAGNOSIS IN THE HAART & PCR ERA

Louise McCorry*, Peter Coyle, Eoin Walker, Suzanne Todd, Laura Bell, Stephen Megarity, Emma Kinghan, Michael Hunter. *Belfast Health and Social Care Trust, UK*

10.1136/sextrans-2017-053232.134

Introduction In the HAART era, Pneumocystis jirovecii Pneumonia (PJP) continues to be a major opportunistic infection. PJ PCR is increasingly available to support the diagnosis of PJP. A 'low level' PCR result may represent PJ colonisation or a poor-quality specimen. Upper airway samples such as throat swabs (T/S) are also more likely to yield a negative or low level positive.

Method Retrospective review of all HIV-infected adults with respiratory tract PCR-confirmed PJP and pneumonia over an 18 month period. Demographics, clinical features, management, clinical outcome and laboratory parameters were recorded.

Results 4/12 patients had negative T/S PJP PCR test before the diagnosis was confirmed. The mean cycle threshold (CT) value for throat swabs was *34.04*. The mean CT value for sputum was *32.05*.

Discussion PJP PCR is a useful investigation. PCR will detect more cases than traditional tests (direct organism visualisation). This leads to earlier PJP treatment and earlier screening for HIV. While there is a trend towards lower CT value results in sputum when compared with throat swabs, any positive PJP result should trigger the offer of a HIV test. Patients with a negative URT PCR and clinical suspicion of PJP should receive empiric treatment and where appropriate proceed to BAL, as per national guidance.

P090 FORMALISED LOOK-BACK IN NEWLY DIAGNOSED HIV TO IDENTIFY MISSED OPPORTUNITIES IN OTHER CLINICAL SETTINGS: FIRST GET OUR OWN HOUSE IN ORDER!

Kate Horn*, Sophie Ramsden, Arnold Fernandes. *Royal United Hospitals Bath NHS Foundation Trust, Bath, UK*

10.1136/sextrans-2017-053232.135

Introduction HIV late diagnosis is one of three key indicators on sexual health in the Public Health Outcomes Framework. The British HIV Association (BHIVA) Standards of Care for People Living with HIV advocates the use of 'look backs' in the case of late and very late diagnosis of previous engagement with health care services to identify missed opportunities and areas for shared learning and development.

Methods Further to the look-back exercise undertaken on late and very late diagnoses presenting 2012–2016, we extended the use of the standardised look-back tool to ALL new diagnoses from late 2016 onwards.

Results In addition to anticipated missed opportunities being identified in the late and very late presentations, we identified 2 missed opportunities in much earlier presentations from within our own service! They related to failure to repeat the HIV test at test of cure (TOC) for gonorrhoea and subsequent Hepatitis vaccination appointments. In both cases the initial negative HIV test had been within the potential window period.

Discussion As a result of the look-back exercise we have learnt a valuable lesson about the fallibility of our own service and shared the learning within our multi-disciplinary team. We

Abstract P089 Table 1 Patients with PJP (in order of immunosuppression)

Age at HIV diagnosis, gender, behavioural risk	Category	CD4+ count at PJP diagnosis, PJP severity	PJP test 1 (Ct value, site)	PJP test 2 (Ct value, site)	Clinical outcome
	Known HIV				
39/M/IDU	On ART for 4 weeks, not on PJP prophylaxis	200, mild	37.0, TS	n/a	Survived
38/M/MSM	Defaulted from care, not on ART	10, severe	Neg., TS	32.5, TS	ICU care, survived
	Missed opportunity to diagnose HIV				
53/M/MSM	Unexplained diarrhoea and weight loss	70, severe	30.0, SPU	26.2, SPU	ICU care, deceased
43/F/heterosexual	Unexplained lymphadenopathy and weight loss	50, severe	26.4, SPU	Neg., TS	Readmitted with hypoxia, survived
32/F/heterosexual	Campylobacter gastroenteritis	50, severe	36.4, TS	25.3, SPU	ICU care, survived
56/M/unknown	–	30, severe	Neg., TS	31.5, SPU	ICU care, deceased
39/M/heterosexual	Unexplained weight loss	20, mild	Neg., TS	25.0, SPU	Survived
62/M/MSM	Unexplained weight loss	20, mild	26.0, BAL	n/a	Survived
55/M/MSM	Bacterial pneumonia	20, mild	33.0, SPU	n/a	Survived
52/M/heterosexual	–	10, severe	30.3, SPU	34.9, SPU	ICU care, survived
57/M/MSM	Unexplained weight loss	10, severe	39.0, SPU	n/a	ICU care, survived
52/M/heterosexual	Chronic diarrhoea, bacterial pneumonia	0, severe	Neg., SPU	28.0, SPU	ICU care, hypoxia requiring long-term home-O_2

Note- **BAL** broncho-alveolar lavage; **F**: female; **M**: male; **ICU**: intensive care unit; **IDU**: intravenous drug user; MSM men who have sex with men; **n/a**: not available; **Neg.**: PCR not detected; **SPU**: sputum, **TS**: throat swab
PJP severity ('mild': mild-moderate, or 'severe': moderate-severe, by BHIVA criteria)