Abstract P85 Table 1   HIV testing in Rural Scotland

Testing Location	2012	2014
Antenatal	3583	3427
Sexual health	2668	3281
General Practice	425	890
Ward mix	288	209
Gastoenterology outpatients	305	357
Renal	206	261
Occupational health	230	244
Termination of pregnancy	253	247
Prisons	340	594
General outpatients	34	20
Rheumatology	10	103
Haematology	31	74
Emergency department + Acute Assessment Unit	51	64
Addiction services	64	267
Paediatrics, ENT, Respiratory, Cardiology, Gynaecology, ICU, Mental health, Maxillofacial, Neurology, Ophthalmology, Orthopaedics, Dermatology, Needlestick source testing	70	147
Total	8558	10185

In 2012 there was one new HIV diagnosis, this was in the sexual health service. In 2014 there were four new diagnoses, two in sexual health and two in ENT.

Discussion/conclusion This work has been helpful to show where HIV testing is being performed. This work allows us to target specific departments and encourage relevant testing and optimise patient testing pathways. We plan to repeat this work as we are aware of current initiatives in several departments such as the acute admission unit. We will also compare our results with the four other health boards through the West of Scotland sexual health MCN. In future work we will also be able to look at 'Reasons for testing' as this will be clearly recorded using the new test order system.

P86   AN AUDIT OF TIME TAKEN TO REACH UNDETECTABLE VIRAL LOAD IN THERAPY-NAÏVE HIV-POSITIVE PATIENTS INITIATING ART

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Background The primary aim of antiretroviral therapy (ART) is to reduce morbidity and mortality due to chronic HIV infection. Central to ART is viral suppression, and this has been used as a proxy for disease burden. BHIVA guidelines recommend that patients achieve undetectable viral loads (<50 copies/mL) within 6 months of initiating ART.
Aim To assess the proportion of patients achieving undetectable viral loads within 6 and 12 months of initiating ART at a dual-site HIV service in Grampian.
Methods A retrospective case notes review was conducted of HIV-positive patients attending clinics between January 2013 and December 2013. Data was collected using a standardised proforma and imported into SPSS 23 for statistical analysis.
Results Twenty-four case notes were audited (GUM = 15, ID = 9). The median age of patients was 39.5 years. Median baseline viral load and CD4 count were 77,355 copies/mL and 382 respectively. Overall, 70.8% of patients achieved undetectable viral load within 6 months and 95.8% achieved undetectable viral loads within 12 months (mean = 4.48 months, 95%

CI = 3.50–5.70). A Kaplan-Meier survival analysis showed that patients with a baseline viral load of <100,000 copies/mL achieved undetectable viral load sooner compared to those with >100,000 copies/mL (3.43 months, 95% CI = 2.34–3.66 vs. 6.11 months, 95% CI = 4.28–7.94; log-rank p = 0.013).
Conclusion This audit has identified potential barriers to viral suppression, such as late diagnosis and late commencement of ART. These areas must be addressed to ensure the target of 75% of patients with an undetectable viral load within 6 months of initiating ART can be achieved.

P87   USE OF POCKET-SIZED HIV TESTING GUIDELINE CARDS TO INCREASE HIV TESTING IN MEDICAL INPATIENTS

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Background/introduction HIV is a chronic treatable condition with an excellent prognosis. There remains, however, a high morbidity and mortality due to late diagnosis, with approximately 1 in 4 HIV patients unaware of their condition. Healthcare professionals have previously seen many of these patients without the diagnosis being made. Rotherham's HIV prevalence is 1.05 per 1000. Late diagnosis made in 56%.
Aim(s)/objectives To increase HIV testing in general medical inpatients.
Methods We obtained a list of all medical inpatients in March 2014 who had been coded with a condition that should prompt HIV testing in accordance with BHIVA 2008 guidance.
We reviewed the number of HIV tests requested on medical inpatients during the 1-month period. In June 2014, we delivered a presentation at the Medical Grand Round and two subsequent teaching sessions for staff on HIV testing. We produced a pocket-sized card for staff to attach to the back of their ID badges listing the indications for testing. We compared the proportion of HIV tests performed before and after this intervention.
Results In March 2014, there were 69 patients with clinical indicators for HIV testing. Of those 32 were tested (46.4%). In June 2014, following the intervention, there were 58 patients with clinical indicators and 40 (69.0%) of those were tested.
Discussion/conclusion Following our educational intervention, almost 70% of patients were tested appropriately representing a 22.6% increase from baseline. We plan to re-measure this at a later date to assess whether this increase in uptake of testing has been sustained.

P88   ROUTINE HIV TESTING IN ACUTE GENERAL MEDICINE USING A NON-PHYSICIAN IMPLEMENTED MODEL

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Background/introduction UK national guidelines recommend routine HIV testing in general medical admissions and primary care in areas where the HIV prevalence exceeds 2/1000 in the local population. The guidelines recommend further operational research to assess the feasibility and efficacy of different

approaches to routine testing. A recent study showed that when a physician led model of testing is in place, 39.7% of all general medical patients are offered HIV tests.

Aim(s)/objectives Assess the feasibility and acceptability of a non-physician directed (NPD) model of HIV testing.

Methods Retrospective cohort study involving a review of the proportion of all medical admissions offered tests by a NPD model of HIV testing.

Results 57.9% (1973/3409) of all general medical admissions aged 18–79 were offered HIV tests. Acceptability was high with 96.7% (1908/1973) of offered patients having HIV tests. The mean age of patients offered and tested was 56.8 years.

Discussion/conclusion This study demonstrates superior feasibility and efficacy of a non-physician directed model of routine HIV testing. Although cost and culture remain important barriers of employing this strategy in many hospitals, the use of allied health professionals may be an important step in achieving National and International guidelines for HIV testing.

| P89 | DISCUSSION OF PARTNER NOTIFICATION, HIV TRANSMISSION, MEDICO-LEGAL ISSUES AND VOLUNTARY SECTOR SUPPORT AT FIRST HIV SPECIALIST REVIEW: AUDIT REPORT |

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Background/introduction BHIVA testing guidelines recommend that partner notification, transmission of HIV and the medico-legal issues are discussed with patients at their first review with an HIV specialist. This should ideally occur within 48 h but no later than 2 weeks after diagnosis. Consideration of additional support from the voluntary sector is also advised.

Aim(s)/objectives To audit the documentation of the recommendations above.

Methods A retrospective audit of electronic clinic letters and paper records of all HIV patients diagnosed at our service between 01/2008–04/2014.

Results Overall, 182/187 (97%) had all the information discussed with them and documented in the notes. In 2008, three patients had missing information. One failed to return following a positive test so all information was missing. One had no record of voluntary sector discussion. One was missing information about transmission and medico-legal issues. In 2011, another patient tested positive and failed to return for review so all information was missing. In 2013, one patient had a missing record of medico-legal issues discussion. In all other years all information was discussed and recorded in patient records.

Discussion/conclusion Each of the recommendations were discussed and documented in nearly all cases, with an improvement noted after 2008 (the year the guidelines were published). Each recommendation has important public health implications with the potential to reduce onward transmission. The provision of voluntary sector information is crucial for providing patients with additional support during the challenging time following diagnosis and has the potential to impact on future retention in care.

| P90 | HOSPITALISATION IN HIV PATIENTS: ARE THE CAUSES OF ADMISSION CHANGING? |

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Background With an ageing HIV cohort and increasing use of antiretroviral (ART) therapy it may be expected that HIV associated morbidity causing hospitalisation is changing.

Aim To describe hospital admissions over 2 years, and compare this to 2006 data to ascertain if there has been any change.

Methods Retrospective case review of HIV admissions during 2013–14. Patient diagnoses were classified as AIDS related, HIV related, ART toxicity related, and non-HIV related, with one main admission diagnosis.

Results 286 patients were hospitalised during 2013–14, accounting for 458 admissions. Mean age was 48 years, and 71% (203/286) of patients were on ART on admission. 35% (99/286) patients were admitted more than once in the same calendar year. CD4 count was <200 cells/mm^3 in 25% of admissions. 15% (69/458) were admitted for AIDS related causes compared with 20% reported in our 2006 data (p = 0.23). Pneumocystis pneumonia (PCP) was the commonest diagnosis, comprising 33% (23/69) of AIDS admissions. 40% (185/458) of admissions were HIV related, including bacterial causes which accounted for 31% (142/458) of all admissions. Non-HIV causes accounted for 45% (204/458) of hospitalisations. There were no admissions for ART toxicity.

Discussion The number of admissions in HIV patients remains high, with a fifth of patients severely immunocompromised on admission. Although admissions secondary to AIDS-defining diagnoses have decreased this is not statistically significant. There is a need to improve strategic HIV testing to prevent late diagnosis and AIDS related conditions, with increased promotion and access of testing in non-GU settings.

| P91 | HIV IN SCOTLAND: PREDICTING THE NUMBER OF PEOPLE WHO ARE UNDER CD4 MONITORING AND RECEIVING ANTIRETROVIRAL THERAPY |

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Background/introduction The number of people living with HIV in Scotland has increased in recent years as a result of the widespread use of antiretroviral therapy, improvements in testing, inward migration and new infections. Since these increases are expected to continue, it is imperative that HIV specialist care services understand how the number of people requiring care is going to change over time.

Aim(s)/objectives To predict the number of HIV positive individuals who are under CD4 monitoring (and thus in HIV specialist care) and receiving ART in Scotland for 2013–2020.

Methods Using CD4 monitoring data collected in Scotland for 2007–2012 we develop a statistical model that groups the HIV infected population into several categories depending on their CD4 count and ART status. The model is based upon a Markov