

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.