

In March 2017, a total of 4 475 GPs received 'Advice HIV screening by GPs'. Between September and December 2017, 23 of the 25 selected GPs circles accepted the training offer and a total of 672 GPs attended the training (attendance rate 36%). In an additional process evaluation, the training's overall satisfaction rate was 8.5/10 and the advice was rated 8.2/10. Participants found it feasible (7.8/10) and acceptable (7.6/10) to implement the advice and had high intentions to do so among patients at increased HIV risk (100%), as well as among patients presenting with an HIV indicator condition (99.5%).

The impact of the interventions on the number of HIV diagnoses and HIV tests performed by GPs will be assessed via national HIV surveillance. By using the GPs' individual social and health insurance code, intervention conditions can be compared to the control condition. Data are being collected from 2016 (historical control) to December 2018. Final results will be available in 2019.

Additionally, to better understand how these interventions have been used in day to day practice, an evaluation study adopting telephone interviews and online survey will evaluate the interventions' acceptability and feasibility and their perceived effectiveness. Data were collected in May and June 2018 and the results will be available in 2019.

Decisions on the overall evaluation strategy have been based on the findings of the FGD study and advisory board input.

### **Sustainability of practice**

From the start, the HERMETIC project aimed at developing sustainable intervention, so a multidisciplinary advisory board was installed and extensive formative research was conducted. Formative research enabled the development of an intervention tailored to the reality of busy GP practices. The involvement of policymakers and GP umbrella organisation in the process of intervention development and their endorsement will facilitate the sustainability of this intervention. The evaluation will identify potential need for adaptation, which in turn may increase sustainability.

## **PHC2: Promotion of rapid testing for HIV in primary care (RHIVA2): a cluster-randomised controlled trial (United Kingdom)**

**Author(s):** Leber, Werner<sup>1</sup>; McMullen, Heather<sup>1</sup>; Anderson, Jane<sup>2</sup>; Marlin, Nadine<sup>1</sup>; Santos, Andreia C<sup>3</sup>; Bremner, Stephen<sup>1</sup>; Boomla, Kambiz<sup>1</sup>; Kerry, Sally<sup>1</sup>; Millett, Danna<sup>2</sup>; Mguni, Sifiso<sup>2</sup>; Creighton, Sarah<sup>2</sup>; Figueroa, Jose<sup>4</sup>; Richard, Ashcroft<sup>5</sup>; Hart, Graham<sup>6</sup>; Delpech, Valerie<sup>7</sup>; Brown, Alison<sup>7</sup>; Rooney, Graeme<sup>7</sup>; Sampson, Maria<sup>8</sup>; Martineau, Adrian<sup>1</sup>; Terris-Prestholt, Fern<sup>3</sup>; and Griffiths, Chris<sup>1</sup>

**Affiliation(s):** Centre for Primary Care and Public Health<sup>1</sup>; Queen Mary University of London, Homerton Sexual Health Services, Homerton University Hospital NHS Foundation Trust<sup>2</sup>; Department of Global Health and Development, London School of Hygiene & Tropical Medicine<sup>3</sup>; NHS City and Hackney<sup>4</sup>; School of Law<sup>5</sup>; Faculty of Population Health Sciences, University College London<sup>6</sup>; Centre for Infectious Disease Surveillance and Control, Public Health England<sup>7</sup>; Department of Virology, Barts Health NHS Trust<sup>8</sup>

**Country:** United Kingdom

**Setting:** Primary healthcare

**Source:** Journal article [11]

### **Background**

In 2016, Public Health England reported an estimated 89 400 people (0.16% of the adult population) in the United Kingdom were living with HIV and 5 164 patients were newly diagnosed [12,13]. The epidemic is disproportionately distributed among certain key populations, including men who have sex with men (MSM) (54% of new cases) and heterosexual men and women who identified as being of African Sub-Saharan origin (39% of new cases) [13].

Since 2008, the British HIV Association has recommended that there should be universal screening in general practices in areas with high diagnosed HIV seroprevalence (>2/1000 population) [14]. Although this recommendation was widely accepted and shown to be feasible, it was not widely adopted in primary care given there was no data at the time indicating that adoption of this practice led to a significant increase detecting the undiagnosed [15].

### **Description of good practice**

A cluster-randomised controlled trial was setup in 2010, targeting general practices in multi-ethnic, high risk and socio-economically deprived communities in the London borough of Hackney. The intervention consisted of a practice-based educational outreach programme with follow-up training for a nominated HIV lead nurse or healthcare assistant in each practice, integration of rapid HIV testing with the new registration health check, management of reactive rapid HIV tests, provision of free rapid HIV test kits and payment of £10 per test

completed. Control practices provided standard care, which included opportunistic and diagnostic HIV testing and on patient request.

The educational training programme was based on clinician behaviour change strategies, together with input from lessons learned by the researchers in implementing similar interventions [16]. Ninety-minute training sessions were held at individual practices, targeted the whole practice team and included didactic and interactive elements. Session leaders were trained to ensure intervention fidelity and rapid HIV test operators completed competency-based training. The nominated HIV lead coordinated rapid testing and quality assurance.

Forty general practices participated in the study and were randomly organised in two groups: intervention practices that were exposed to the educational training programme and control practices that received no training. Registration health checks were performed by a nurse or healthcare assistant who followed HIV testing prompts on an electronic template in computerised patient health records. Prompts were added to offer rapid HIV testing and were linked to bespoke Read codes [17] to record the following test outcomes: non-reactive, reactive, indeterminate, invalid and test declined. Read coding enabled remote data collection for testing activity by the Clinical Effectiveness Group at Queen Mary University of London.

Core components of the intervention included an offer of a rapid HIV test as part of the new registration health check, followed by a post-test discussion for patients with a non-reactive test result and immediate notification by the rapid test operator to the general practitioner of any patient with a reactive, indeterminate or twice-invalid test result for confirmatory serology sampling. The intervention was adaptable to each practice, which had the option to additionally offer rapid HIV testing in sexual health or contraception consultations.

### Evidence of impact

In the intervention group, 44 971 patients registered, of whom 11 487 were offered rapid HIV testing from 2010 to 2012. Of the 4 978 patients who accepted rapid testing (45% uptake), 11 were newly diagnosed with HIV. In addition, 2 728 patients had a serology HIV test as part of routine care, resulting in 18 additional new diagnoses by opportunistic testing and three new diagnoses via antenatal screening. In the control group, 38 464 patients newly registered, of whom 2 645 had a routine serology test for HIV, resulting in 21 new diagnoses. The mean CD4 count at diagnosis was 356 cells per  $\mu\text{l}$  in intervention versus 270 in control practices and the percentage of patients with a CD4 count less than 350 cells per  $\mu\text{l}$  was 55% in intervention practices, and 73% in control.

All patients diagnosed by rapid testing were transferred to the HIV clinic, showing that the links established between general practice and specialist services were safe and effective. Some patients who had previously defaulted on HIV specialist care re-engaged with specialist services following retesting in the intervention group, suggesting that primary care can play an important part in supporting individuals to re-engage with treatment and care.

The results support the hypothesis that an education programme promoting rapid HIV testing in general practice leads to increased and earlier HIV diagnosis.

Furthermore, a recent health economic analysis of the RHIVA2 trial demonstrated that HIV testing in general practices located in high-prevalence areas is cost-effective and may be cost-saving in countries with less efficient health services [18].

### Sustainability of the practice

This study used a quality assurance scheme, which included competency-based training for rapid HIV testing, regular electronic monitoring of point-of-care test results and a quality control assessment every two months using external control serum samples, enhancing patient safety by reducing the chances of incorrect rapid test results. Despite this, three intervention practices discontinued testing as a consequence of the pragmatic study design. Therefore, continued training and encouragement to test may be needed in order to ensure sustainability.

## PHC3: Comparison of two HIV testing strategies in primary care centres: indicator condition-guided testing vs. testing of those with non-indicator conditions (Spain)

**Author(s):** I Menacho<sup>1</sup>; E Sequeira<sup>2</sup>; M Muns<sup>3</sup>; O Barba<sup>4</sup>; L Leal<sup>5</sup>; T Clusa<sup>3</sup>; E Fernandez<sup>5</sup>; L Moreno<sup>5</sup>; D Raben<sup>6</sup>; J Lundgren<sup>6</sup>; JM Gatell<sup>5</sup>; F Garcia<sup>5</sup>; L Cayuelas<sup>2</sup>; V Aragunde<sup>2</sup>; M Vergara<sup>2</sup>; M Catalan<sup>2</sup>; MA Moreno<sup>2</sup>; G Hormigo<sup>2</sup>; A Siso<sup>1</sup>; Z Herreras<sup>4</sup>; L Sebastian<sup>2</sup>; L Benito<sup>1</sup>; A Picas<sup>1</sup>; J Hoyo<sup>1</sup>; MJ Giner<sup>1</sup>; D Cararach<sup>1</sup>; E Moles<sup>1</sup>; ML Moro<sup>1</sup>; P Arrabal<sup>1</sup>; D Roca<sup>3</sup>; S Prego<sup>3</sup>; X Ferrer<sup>3</sup>; A Egido<sup>3</sup>; C Ventosa<sup>3</sup>; S Garcia<sup>3</sup>; S Muñoz<sup>3</sup>; A Massana<sup>3</sup>; J Sole<sup>4</sup>; M Curiel<sup>4</sup>; Heras<sup>3</sup> and A Leon<sup>5</sup>

**Affiliation(s):** Consorci d'Atenció Primària de Les Corts, University of Barcelona, Barcelona, Spain<sup>1</sup>; Consorci d'Atenció Primària de l'Exemple Casanova, Grup Transversal de Recerca en Atenció Primària, IDIBAPS, University of Barcelona, Barcelona, Spain<sup>2</sup>; Centre d'Atenció Primària de Drassanes, University of Barcelona, Barcelona, Spain<sup>3</sup>;